The production of an appropriate and culturally sound isiXhosa translation of the International Classification of Functioning, Disability and Health (ICF) Checklist

Mzolisi ka Toni

Dissertation submitted in partial fulfillment of the research requirements of the Master of Philosophy in Disability Studies

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November 2007

Declaration

I, Mzolisi ka Toni, hereby declare that the work in this dissertation is based on my original and personal inputs and from the support, advice and guidance received from my supervisor and those that are close to me and directly or indirectly interested in this area of work. In a case where I have borrowed the ideas of others, acknowledgements are made and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

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MZOLISI KA TONI

DATE November 2007

Abstract

This study arose out of the necessity to have an isiXhosa version of the ICF Checklist to use in a study on the living conditions of people with disabilities in the Eastern and Western Cape provinces of South Africa carried out by a partnership between the University of Cape Town, the University of Oslo, The Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology (Sintef) and Disabled People South Africa (DPSA). The purpose of translating the ICF Checklist was to make sure that the tool was appropriate and culturally sound for use by isiXhosa speaking disabled people in the Eastern and Western Cape.

The English Version of the ICF Checklist was given to the two forward translators with instructions that they should produce an isiXhosa version that was culturally and linguistically appropriate rather than literally correct. The Consensus Team then met and compared the two isiXhosa versions. Once the isiXhosa version was developed, it was given to the backward translator who was asked to produce an English version. This process helped the Consensus Team to choose the definitive isiXhosa words and phrases. At each stage, agreement was reached, but there were certain words that the Consensus Team had difficulty with because of differences between English and isiXhosa sentence construction and the meanings in the two languages.

The results show us that a tool developed in a Western context is bound to have cultural and linguistic clashes when applied in an African context. The result of the process was a linguistically and culturally appropriate isiXhosa version of the ICF Checklist. This version, as with the English ICF Checklist version, still needs to undergo reliability and

validity testing. It is hoped that the use of the instrument in this study will contribute to the body of knowledge on the cultural applicability of the ICF Checklist within the South African context.

Acknowledgements

This study would not have been possible if I was not surrounded by family, friends and institutions that were interested in my development and were convinced that I have value to add to the transformation of our beautiful country. My sincere thanks goes to Prof Jelsma without whose support, encouragement, patience and honesty this study would not have come to fruition. She was able to challenge and engage me in critical discussions so that I could stretch my thinking. I am also indebted to Prof Ruth Watson, for having the privilege to share in her knowledge and thinking in the development of this study and from that sharing derived immeasurable fulfilment.

I would also like to thank Prof Lorenzo for being my support base and telling and reminding me that I could do it, Prof Amosun, Ms Siphokazi Gcaza and Ms Martha Geiger for their professional guidance. I am also grateful to the translators Mrs Pamela Maseko, Mr Zalisile Baab Mkhontwana, Mr Nicholas Matyida and the Consensus Team for the good work that enabled us to produce the final isiXhosa version of the International Classification of Functioning, Disability and Health (ICF) Checklist (isiXhosa version). My appreciation also goes to Professor BB Mkhonto and his wife for their valuable input in shaping my deeper understanding of some of the isiXhosa terms and their origins with regard to describing disability.

I am also honoured to be part of and associated with the Disability Movement in South Africa especially the leadership of Disabled People South Africa (DPSA) led by Cde

Lewis Nzimande, that has shaped my political understanding of disability and allowed me to be part of the MPhil in Disability Studies programme. My memory goes back to the late Sis Majorie January who persuaded me to engage Prof Lorenzo so that DPSA and UCT should ensure the realisation of this programme. Last but not least my deepest thanks to my PA, Marléna Slaverse, for her support in putting this study into an accurate and readable document.

My warmest thanks to my wife Nombasa for being there for me and for her deep love and unbelievable understanding during the trying times – Amantlane, oMkhondwane, Mfusane, Ndendela, Gxididi, Nqabane noDingi bayabulela Mntungwa. To my two wonderful daughters Nhlanhla and Nomaxabiso and to my only son Mihlali who made sure that I remained a loving and caring father.

This study is dedicated to disabled people in South Africa especially those at OR Tambo District Municipality in the Eastern Cape. For us to be valued for who we are and for the things we want in life there is an urgent need to understand our history and we must always stay true to the Disability Movement slogan "Nothing about us without us".

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Glossary of terms and abbreviations

Disability – is a social construct [and not a description of a medical condition in the individual] that represents the outcome of the interaction between impairments and the negative environmental impacts on the individual, in recognition that society is constructed, both through the characteristic of its build environment and functioning, on the one hand, and the prevailing attitudes and assumptions on the other, which results in restricted opportunities for disabled people to participate on an equal basis, and failure of society to adapt to and accommodate their needs; and the term 'disabled' has a corresponding meaning" (Disabled People South Africa, 2006)

Disabled People versus People with Disabilities 'Disabled People' is a term used by the Disability Movement to illustrate the impact of the inaccessible environment to those with impairments. 'People with Disabilities' is the term which evolved from shifting the focus from the impairment to elevate the importance of the person – i.e. 'person-first' terminology – and this is mostly used in government and policy documents. These terms are therefore used interchangeably in dialogues between governments, policy makers and the Disability Movement.

DPI	Disabled Peoples International
DPSA	Disabled People South Africa
ICF	International Classification of Functioning, Disability and Health

ICF terminology: (World Health Organization, 2001)

Body functions are the physiological functions of body systems (including psychological functions).

Body structures are anatomical parts of the body such as organs, limbs and their components.

Impairments are problems in body function and structure such as significant deviation or loss.

Activity is the execution of a task or action by an individual.

Participation is involvement in a life situation.

Activity limitations are difficulties an individual may have in executing activities.

Participation restrictions are problems an individual may experience in involvement in life situations.

Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives. These are either barriers to or facilitators of the person's functioning

SINTEF – The Foundation for Scientific and Industrial Research at the Norwegian Institute of Technology (NTH)

1 Introduction

1.1 Background

A joint research study was initiated in 2003 by the following parties: University of Cape Town (Faculty of Health Sciences); University of Oslo (Section of Medical Anthropology, General Practice and Community Medicines, SINTEF) and Disabled People South Africa (DPSA). The partners joined together to study the living conditions of disabled people through exploring and testing aspects of the International Classification of Functioning, Disability and Health (ICF) (World Health Organization, 2001) in a South African context. The study included both a survey of living conditions and a qualitative study that it was hoped, would contribute, in particular, to the local knowledge and experience of disabled people. The research study intended to generate knowledge and contribute to a broader discussion on how the ICF model works holistically and could be used across disciplines and further, whether the Model maintains knowledge of experience in such a way that a target population is reached. As the ICF checklist was to be used primarily with isiXhosa speaking people, it was imperative that an isiXhosa translation be available. This study documents the production of this translation. This could be seen as the beginning of a journey where this work could be used as a stepping stone in South Africa and in the continent. This matter would also be further explored under Chapter 6 - Conclusion and Recommendations.

The ICF grew out of the experience gained with its predecessors, the International Classification of Impairments, Disability and Handicap (ICIDH), versions 1 (World

Health Organisation, 1980) and 2 (World Health Organisation, 1999). It is said to be a multi-purpose classification designed to serve various disciplines and sectors. The WHO has two health status classification systems, the *International Statistical Classification of Diseases and Related Health Problems* ICD-10 (World Health Organisation, 1992) and the ICF (World Health Organization, 2001), which fit together as the core of the 'family' of classification systems. The ICD classifies "diseases", and has evolved from a list of **"causes of death"**. It has a medical orientation and has given rise to a number of applications and adaptations. The ICF by contrast, classifies "**human functioning"** at the level of the body, the whole person, and the person within the complete social and physical environmental context. These classifications can then be used to identify a variety of consequences of health conditions including diseases, disorders, injuries and other conditions. Thus, the ICF complements the ICD and its applications and adaptations. An abbreviated version of the ICF, the ICF checklist, has been developed for situations in which more detailed coding is not required (World Health Organisation, 2003).

These instruments developed by WHO have had little input from the developing world. There is no African Collaborating Centre, Task Force, Network of consultant listed under the Acknowledgement section of the ICF (World Health Organization, 2001).Consequently there may be a bias towards western concepts, which might be less sensitive to other cultures. This area will further be explored in Chapter Two, as it is important for the reader to get a better background on the origin and incremental stages

of the ICF as a tool that could be used to classify levels of functioning and contextual factors.

1.2 Rationale for study

If the ICF tool is an international benchmark with which to measure disability and identify needs of disabled people, then there is a need for an increased level of awareness and understanding of the ICF within the disability sector (Hurst, 2003). It is for this reason that the researcher was motivated to be part of the research initiative that looks at the relevance of the ICF tool within the South African context. As a disability activist and a disability studies scholar subscribing to the principles of self-determination, inclusion and rights based approach to disability, the researcher has to be knowledgeable and understand how the ICF works before he could interrogate the relevance of the ICF concept. Hence, the study has to establish if the ICF checklist is relevant, user-friendly and appropriate across culture and language to isiXhosa speaking disabled people, through the documentation of the translation process of the ICF into isiXhosa.

1.3 Problem Statement

The introduction of ICF debate in South Africa especially within the disability sector has been received with serious concerns and reservations. In a workshop on it's forerunner, ICIDH-2 (World Health Organisation, 1999) organised by the Office on the Status of Disabled Persons in May 2000 the following were raised as concerns about the introduction and applicability of the tool in the South African context.

- That the use of the ICIDH-2 is labour-intensive and time consuming. Already there is a lack of rehabilitation personnel, so there is a concern that countries in Southern Africa would not have resources to implement it.
- It further contains terminology that is not applicable in the South African context.
- The tool is too complex and will likely create misunderstandings and the coding exercise indicates that it is subjective.
- The workshop also cited moral and legal concerns about classifying people. It is also not gender sensitive, and still seems to be medically based. There is a fundamental critical question whether disabled people and their organisations will apply the tool, as the user perspective is absent.

In the long run, a consequence may be that the users will be the losers, considering the power relationship that exists between experts and others (Office on the Status of Disabled Persons, 2000).

As mentioned above, the involvement of African representatives was limited in this process, as is evidenced by the lack of any African collaborating centre or NGO listed contributing to the process of development in the ICF Handbook (World Health Organization, 2001). It is, therefore, imperative that the relevance and validity of the ICF be determined in Africa, especially in view of Ingstad and Whyte's description of how context and culture influence the situation for disabled people (Ingstad & Whyte, 1998). This is critical in an empowerment process. In order to obtain a user perspective on the ICF, its conceptual meaning and application, and the involvement of users is central to

the development of such a tool. In South Africa members of the Disability Movement, as well as people whose first language is isiXhosa will be amongst those who apply the ICF either in research or in other contexts. It was therefore important to involve them in the production of the isiXhosa version of the ICF Checklist (World Health Organisation, 2003), so that the concepts and constructs of the ICF could be subjected to scrutiny and interrogation.

1.4 Aims and objectives of the study

The aim of the study was to translate the original English version of the ICF checklist into isiXhosa and to document the problems encountered in the process.

The specific objectives were:

1.4.1 To facilitate the forward translation (English to isiXhosa) and backward translations (isiXhosa to English) of the ICF checklist.

1.4.2 To reach consensus on the conceptual and linguistic meanings produced by the forward and back translations.

1.4.3 To interrogate the conceptual and linguistic meanings of the ICF as they emerge during the process

1.4.4 To adjust, adapt and consolidate the final isiXhosa version of the ICF checklist.

1.5 Conclusion

The central question was whether the ICF could be adequately translated into isiXhosa so that the information gathered could permit comparison of data across countries, health care disciplines and services. In Chapter Five, the researcher has been able to interrogate this question to find out whether it was possible to develop a linguistically and semantically acceptable isiXhosa version, which could advance the rights-based approached espoused by the Disability Movement. Furthermore, this may provide some evidence of the validity of ICF within a South African context.

This version could allow for a "new way to talk about health" (Bruyere & Peterson, 2005) by presenting a common scientific conceptual scheme for describing functional problems in order to improve communication between different groups, such as researchers, health care workers, disabled people and others across countries and cultures.

On the other hand, if it was not possible to produce a satisfactory isiXhosa version, then it might be that the ICF does not incorporate universally acceptable concepts of disability.

The study translated the ICF into an African indigenous language specifically isiXhosa. The translation was conducted by a researcher who is intimately involved in the Disability Movement and whose mother tongue is isiXhosa. For this reason it was

envisaged that the process of translation would allow the researcher to examine the ICF as a tool for studying and understanding the disability phenomenon. Therefore the purpose was to interrogate the meaning of the core concepts in the South African context and to carry out a research study that would benefit disabled people.

2 Literature review

2.1 Introduction

The literature review covers the different models which attempt to explain the concept of 'disability'. The subsequent section deals with the influence of these models on the development of the ICF. Its history and purpose will be discussed and the critique of the ICF by the disability sector will be presented. A section on the number of disabled people who are likely to be affected by the use of any instrument designed to investigate aspects of disability is included. Finally the issues relating to language, culture and translation are raised.

Literature was sourced through a search of Pub Med, CIHNAHL and the unpublished documents that relate to the ICF and the Disability Movement in South Africa.

2.2 Models of disability

Historically there have been two extreme models which have been used to explain disability and these are known as the "medical" and "social" models of disability (Barnes & Mercer, 1996). The ongoing discourse between the disability activist and the professionals is whether or not disability is a 'health condition' and, consequently, that there is something wrong with the person that needs to be fixed so as to fit into the environment (medical model) (Oliver, 1998). On the other hand, the Disability Movement maintains that the environment creates the disability; therefore, there needs to be normalisation of the environment to allow everyone to participate equally in it (social model) (Finkelstein, 1989). This model forms the basis of the Standard Rules pertaining

to the equalisation of opportunities for peoples with disabilities (United Nations, 1994) This has been one of the core issues that influenced the formation of the Disability Movement led by Disabled Peoples' International in 1981 in Singapore (DPI, 1981). During this first World Congress, the key issues dominating the Congress were identity, dignity and rights. Hence the crafting of a definition that disability has to do with the way society treats disabled people and the barriers in the environment that restrict their participation. Further to the definition, they also crafted fundamental values and basic rights, the right to education, rehabilitation, employment, and economic security, independent living, participate in social and cultural activities, influence and equality (DPI, 1981). Since then there has been continuing dialogue and debate about these models and definition of disability, with the most recent milestone being the acceptance by the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2007). This section will outline the components of these models and give the historical background to their development.

2.2.1 Medical Model

The question could be asked what does the "medical model" mean? This is a term that receives a lot of critique by those who are critical of medical practices, whilst health professionals tend not to see themselves as biased towards medical model but believe that it is their scientific understanding of the body (Marks, 1999). The traditional view within social science and medicine was to assume that the social disadvantage experienced by disabled people was an individual problem caused by impairment (World Health Organisation, 1980). If the problem was an individual one, then the most appropriate social response was either to correct the impairment or to help the person 'come to terms'

with their assumed disadvantage, by negotiating different less valued social roles. Everything began from impairment and biological difference. It was the biological deficit that caused the restriction of activities that resulted in a loss of normal social roles. Consequently, it came as little surprise to rehabilitation professionals and policy makers that disabled people appeared to be socially excluded and dependent on the care of non-disabled people in society. If the problem for disabled people was seen as their impairment then the only solution was to manage or correct the impairment (Watermeyer, Swartz, Lorenzo, Schneider, & Priestley, 2006).

Historically, 'disability' meant something very specific in this model – an individual limitation that prevented a person with 'impairment' from performing everyday tasks in the normal way, often resulting in a social 'handicap'. The dominant model was the causal one as described above (Oliver, 1998).

2.2.2 Social Model

The International Year of Disabled Persons in 1981 began to alter the way in which disability was perceived by emphasising that the environment was a strong decisive factor with respect to the possibilities of individuals participating in the society. The Disability Movement realised early on that their "Voice" needed to be heard loud and clear if they are to lead the struggle to redefine disability (Finkelstein, 1989).

During 1981 and the following decade, many countries produced official policies, laws and plans of action to ensure the human rights of persons with special needs. In 1983, the United Nations General Assembly, taking cognisance of the social model of disability,

adopted a World Programme of Action Concerning Disabled People (United Nations, 1982), which was followed by the Decade for Disabled Persons (1983 – 1992). The overall objectives of the World Programme for Action were to promote effective measures for prevention of disability, rehabilitation and the realisation of the goals of "full participation" of disabled people in social life and development, and of "equality" (United Nations, 1982). The Programme comprised 22 Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (United Nations, 1994) and reflected the social model, by promoting disabled people as full members of society who are entitled to the same rights and privileges as everyone else. The Rules include preconditions and targets, and recommend implementation measures.

After Democracy in 1994, the South African government and Disabled People South Africa agreed that the way disability was perceived needed to be changed, so that in the new South Africa, disabled people would be able to claim their rights through the Constitution and various policies that were intended to integrate disability. In his foreword, the current President, Honourable Thabo Mbeki, said at that time:

> 'among the yardsticks by which to measure a society's respect for human rights, to evaluate the level of its maturity and its generosity of spirit, is by looking at the status that it accords to those members of society who are most vulnerable, disabled people, the senior citizens and its children.' (Office of the Deputy President, 1997).

The White Paper on Integrated National Disability Strategy (Office of the Deputy President, 1997) was therefore one of the key responses from South Africa. It was guided by the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (United Nations, 1994) with the intention of shifting society's approach from medical to social model.

There was a clear determination on the part of the Disability Movement in South Africa to stay clear from a debate around specific disability definition in this policy document and no definition was included. Consequently this issue is still the subject of open debate. Hence, you find disability definitions specific to services and socio-economic rights like the Employment Equity Act definition in South Africa (South African Government, 2006)

Since these early developments, both the UN and the Disability Movement worldwide have moved with determination to advance the process towards a more obligatory instrument. The development of the UN Disability Convention, was therefore initiated in the early 90's. In March 2007, we witnessed 81 countries signing the Convention and South Africa was one of these countries. The Convention on the Rights of Persons with Disabilities encompasses the definition of disability and flag key principles of respect, dignity, non-discrimination, participation, inclusion, equality of opportunity and gender and accessibility. Furthermore, it obligates states parties to promote full realisation of all human rights and fundamental freedoms for all persons with disabilities without any discrimination of any kind. In the fifty (50) articles, it covers issues of employment, education, rehabilitation, independent living, health and setting up of a committee on the

rights of persons with disabilities (United Nations, 2007). These milestones demonstrated the resolve on the part of the Disability Movement to promote their rights and equal participation.

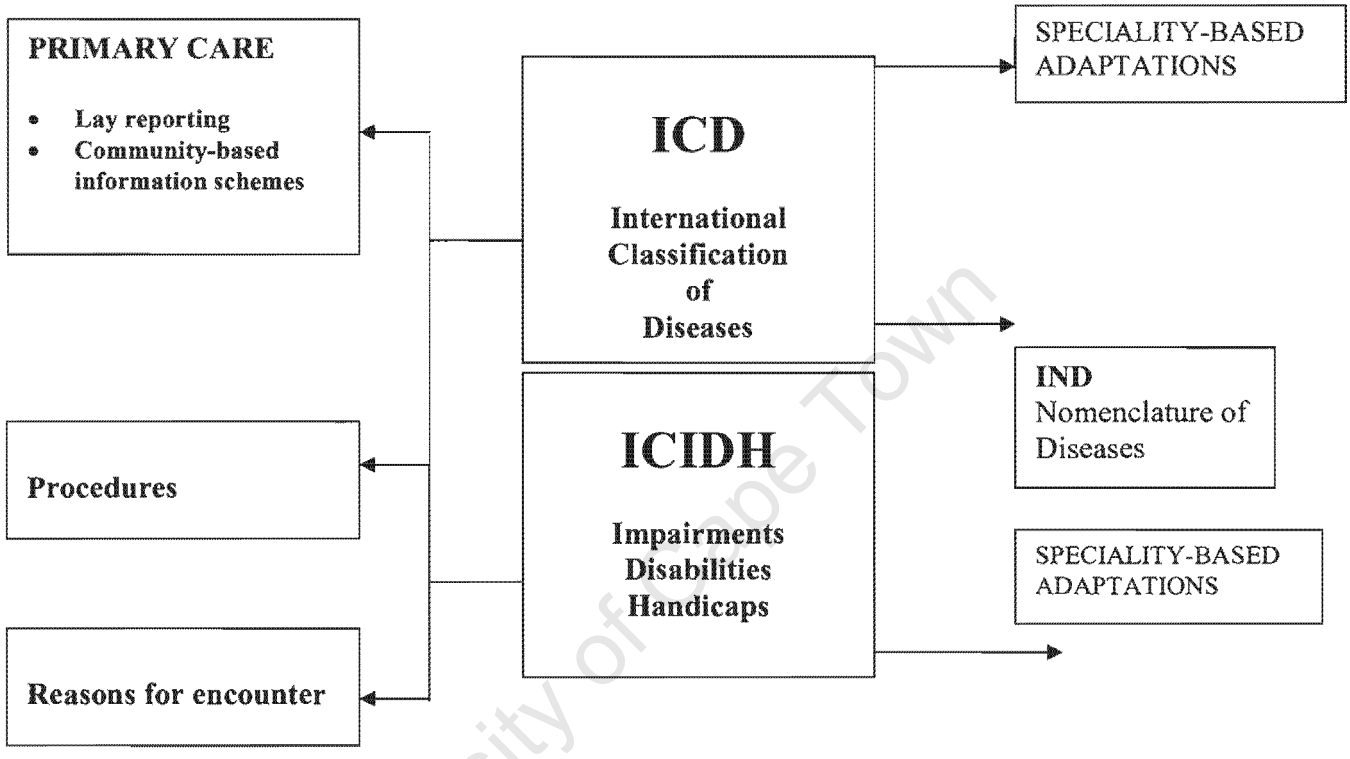
In section 2.7 there will be a discussion whether it is not possible to find a middle road between the two models.

2.3 The development of the ICF

The World Health Organisation has developed an International Family of Classifications, the flagship of which is the International Classification of Disease (ICD) which was developed in 1977 and is now in the 10th revision (World Health Organisation, 1992). The stated aim of the classifications is to provide a unified and standard framework for the description of health and health related states.

There was a realisation that there was a need to describe the consequences of health conditions and in 1980 the International Classification of Impairment, Disability and Handicap (ICIDH) (World Health Organisation, 1980) was published. In response to pressure from disability activists and rehabilitation professionals the ICIDH was amended in an attempt to integrate the two approaches to disability. This was followed by a revised version, the ICIDH2 draft version in 1999 (World Health Organisation, 1999) and the definitive version, the International Classification of Functioning, Disability and Health (ICF) in 2001 (World Health Organization, 2001) (See Figure 1).

Figure 1: WHO Family of International Classifications – 1999



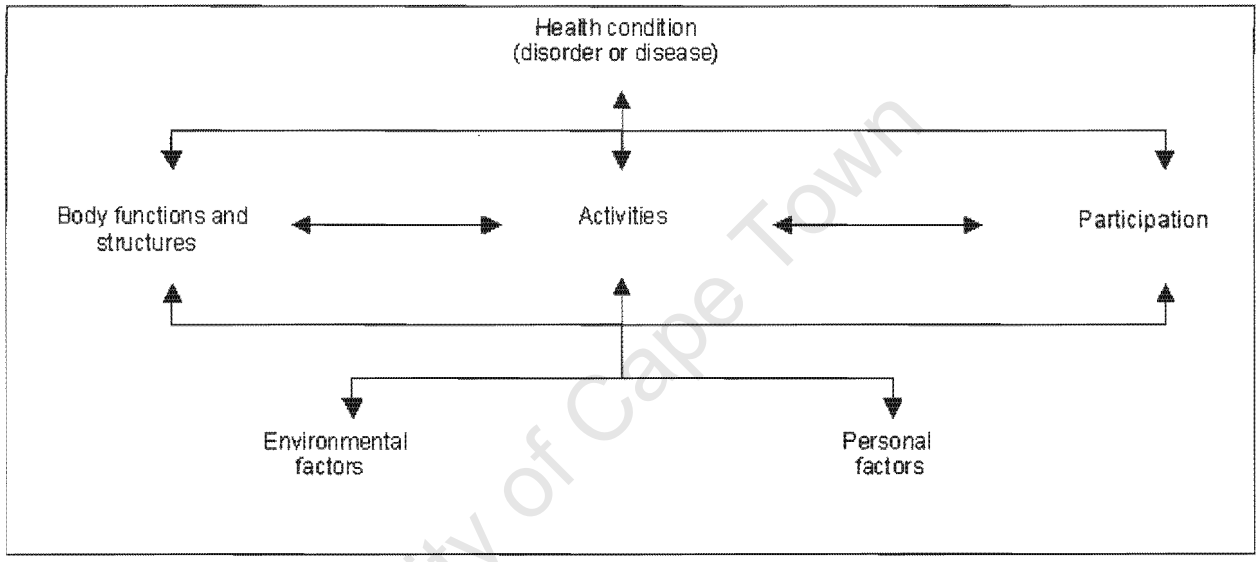
Source : World Health Organisation, 2002

The ICIDH clearly reflected the medical model of disability in that disability was seen to be as a direct result of a health condition which leads to an impairment and results in disability (World Health Organisation, 1980).

The ICF followed the ICIDH and was the result of a development process that was in progress for two decades (de Kleijn-de Vrankrijker, 2003). Through this process a new conceptual scheme emerged in the disability research arena. In this scheme, the interrelatedness of health condition, impairment, disability and the environment was

clearly spelt out in that the disability process is no longer seen to be linear but rather circular. (Figure 2)

Figure 2: Interactions between the components of ICF



Source : World Health Organisation, 2001

The diagram above indicates that the health condition is only one contributor to a person's functional ability and that contextual factors such as environment and personal factors are equally important. Each factor influences the others in a dynamic relationship in that a change in one can bring about a change in another.

In contrast to the ICIDH, the interaction between disability and health condition works in two directions; the presence of disability may even alter the health condition itself (World Health Organization, 2001)

2.4 Description of the structure of the ICF

The ICF uses functioning as an umbrella term to encompass all body functions, activities and participation and disability is used to cover all aspects of impairments, activity limitation or participation restriction. It lists environmental factors that interact with all these constructs thereby enabling the user to record useful profiles of individuals functioning in various domains (World Health Organization, 2001). (Annexure A: ICF Checklist). There are three major classification sections, that of impairment (consisting of b-codes impairment of body function and s-codes: impairment of structure), activity and participation (d-codes) and environmental factors (e-codes) (See Table 1). Personal factors are not coded.

The ICF can be used at different levels depending on the amount of detail required or available. In addition to the basic descriptive coding there are also qualifiers which elaborate on the degree of functioning or impairment of functioning in each domain and the degree to which contextual factors help or hinder functioning (World Health Organization, 2001). The ICF checklist, (World Health Organisation, 2003)which is available on the Web, consists of 126 items, grouped under the different codes mentioned above.

Table 1: An overview of the ICF

SECTION	COMPONENT	DOMAINS
Functioning and Disability	Body	Functions of body systems (b) Body structures (s)
	Activities and Participation	Life areas tasks, actions (d)
Contextual Factors	Environmental Factors	External influences on functioning and disability (e)
(Not coded)	Personal Factors	Internal influence on functioning and disability

(World Health Organization, 2001)

2.4.1 Utilisation of the ICF

The ICF has been used in a variety of studies, including epidemiological (Maart, Eide, Jelsma, Loeb, & Toni, 2007), clinical (Okochi, Utsunomiya, & Takahashi, 2005) and conceptual (Peterson, 2005). In this section the studies will be described under headings, which indicate the type of study, the medical condition. The study was primarily concerned with impairments and activity limitations (medical model usage) or participation limitation and environmental barriers (social model usage).

2.4.2. Medical model uses

There have been several studies using the ICF in the clinical setting. Jelsma et al (2006) used the ICF checklist to describe the functioning of 12 people with HIV in South Africa. Problems were noted in the areas of emotional functioning and drive, with several people reporting an increased sensitivity to sound (Jelsma, Brauer, Hahn, Snoek, & Sykes, 2006).

Relationships with community members were more of a problem than relationships with the family and intimate relationships. The most significant problems were related to disclosure and stigmatisation. However, the ICF was found to be time consuming to use and the absence of an isiXhosa version was noted.

Mayo et al used the ICF with patients who have had strokes to test the validity of the codes against a quality of life measure, the SF12. They concluded that it was possible to "translate" most of the HRQoL contained in the SF12 into ICF codes (Mayo et al., 2005).

The German WHO ICF Collaborating Centre, under Stucki, has produced a number of papers, which describe how focus groups of experts identified core sets of codes relevant for a particular medical condition. These core sets were intended for use in different clinical settings (Stucki et al., 2002) which were then tested. Grill reported on the use of core codes in acute and rehabilitation facility settings (Grill, Ewert, Chatterji, Kostanjsek, & Stucki, 2005), while Stucki developed core sets for rheumatoid arthritis (Stucki et al., 2004). Cieza et al, reported on linking rules to "translate" information gained through the use of other instruments into the ICF codes (Cieza et al., 2005). This means that information gathered using for example, a quality of life instrument like the SF36, can be recoded using the ICF classification.

2.4.3. Social model uses

Maart et al (Maart et al., 2007) used the isiXhosa version documented in this study in the Eastern and Western Cape on a sample of disabled people in South Africa. Of these

people 377 (79.4%) lived in the Eastern Cape, and 98 (20.6%) in the Western Cape. Physical problems were reported by 66.9 % of the sample, 17.9% had an intellectual impairment and 12.2% had visual and hearing.

They reported that respondents from the urban area reported experiencing more barriers in the categories of Products and Technology, and the Natural and Built environment; while the respondents from the rural area experienced more barriers with attitudes. Negative attitudes were significantly greater among the rural population than the urban. An equivalent percentage of people in the respective areas identified barriers in the service category.

Jelsma et al, (2007), as part of the above study, examined the receipt of disability grants. They reported that holders of disability grants displayed significantly more problems related to technology assisting mobility and policies and services relating to mobility and transport (p=.04 and p=.02 respectively). Those who did not receive grants reported more barriers with regard to the attitudes of health workers (p=.03) but not with regard to any other aspect of social support.

The ICF has also been applied to national disability survey data sets and Hendershot and Crews, compared data on visually impaired people in different countries by using ICF codes to make the data comparable (Hendershot & Crews, 2006).

2.5. Review of the ICF Debate in South Africa

The way in which the ICF dialogue or debate evolved in South Africa, and why this study is of particular interest to the researcher and the Disability Movement in South Africa, is part of the background to this study.

The ICF was introduced to South Africa through the national Office on the Status of Disabled People (OSDP) in The Presidency when they hosted a World Health Organisation (WHO) representative in 2000 (Office on the Status of Disabled Persons, 2000). This representative came to present the consolidated final stages of the transformation of the ICIDH2 to ICF. The disability sector was dissatisfied with this process, as it seemed that the WHO came with an intention of persuading the South Africans to endorse the tool. A concern was raised that the ICF was a complex tool and training would be needed as in the absence of training it was likely to be misused(Office on the Status of Disabled Persons, 2000). It would therefore become a barrier for disabled people in accessing their rights or services i.e. social grants. It became apparent that the WHO was not willing to provide funding or resources for training in the use of the ICF for users such as members of the Allied Health professionals, government officials in health, social development, education, labour and disabled people themselves. The stance taken was that it was the responsibility of the government in that particular country to ensure that critical stakeholders are capacitated adequately to understand the tool. Other concerns raised, included a fear that the ICF tool used first world country examples to explain the concepts in the domains. In addition the emphasis was still on the level of physical functioning as the starting point was the body and physiology.

Although there was a great improvement in the ICF compared to the ICIDH, the classification continues to highlight the health condition as a primary focus to all the other components, impacting on the individual.

During the Disability Equity Seminar held in Johannesburg in June 2000, the Disability Movement, led by DPSA, resolved that the ICF tool should not be used in its current format as disabled people did not want to be further classified and 'be put into boxes' before they receive services (Disabled People South Africa, 2002). However it has become evident from various disability consultative forums that regardless of the Disability Movement's opposition to the tool, it is an international benchmark and work related to it will be done in the country by various independent entities.

Looking at the principles of self-determination espoused within the Integrated National Disability Strategy (Office of the Deputy President, 1997), it is crucial that any disability-related work being done in the country needs to be done in consultation with the disability sector. The introduction of the ICF debate was found to be an imposition on the sector; hence various concerns were raised about its applications. The disability sector revisited the ICF issue specifically the area of participation in the ICF, which outlines various societal and environmental barriers.

There was a realization that there was a need to apply the ICF framework as it had implications for the integration of disabled people within their communities as well as

implications for service delivery. South Africa has made an attempt to use the ICF framework in the Social Assistance area. The proposed assessment tools for disability and care dependency grants incorporate positive aspects of the ICF. Consideration for the allocation of grants is based on evidence of Functioning, and recorded as Activity Limitations, albeit confirmation of a health condition is still a requirement (Margie Schneider, personal communication, 2006). This presents a radical move from the current method applied by the Department of Social Development, which is primarily based on the presence and severity of a health condition, as confirmed by a medical doctor (Cape Gateway, 2005). The new approach recognises that it is not enough to assess a person's impairment only but that the environment in which the person lives, and how this environment either facilitates or hinders the person's functioning, must be taken into account.

Finding the common ground in terms of the problem of definition has been the key factor that seems to create a divide between the disability activist and health professionals in their understanding of the disability concept hence the emergence of the two models. As described above, these developments have led to the adoption of the definitive version of the WHO International Classification of Functioning, Disability and Health (ICF). There has been a serious debate around this schema, as the argument advanced is that it still focuses on health and the association of disability with health is the one that is still distrusted by the Disability Movement. In an attempt to summarise the discussion, the two schemas are explained below.

The disability movement has managed to use the social model to break the association of disability with illness, arguing that it is more political than personal, that it has to do with discrimination, poverty and under-development (Finkelstein, 1989; Priestley, 1999).

The other school of thought is that the social model is not an answer to all the challenges faced by disabled people. It is unable to respond to individual needs of disabled people whilst the medical model is seen to be able to address some of these individual needs such as assistive devices (French, 1993).

Although the social model has firmly addressed the role played by the external environment in contributing significantly to disability, and there is a recognition of this fact by proponents of the social model, there might be a need to find common ground, because these two models used collaboratively could further advance the status of disabled people in the world.

In the 2005 DPI Position Paper on the Definition of Disability, The Secretary of DPI stated that:

" The International Classification of Functioning (ICF) defines disability as the outcome of the interaction between a person with an impairment and the environmental and attitudinal barriers he/she may face.

This, I propose, could be utilised for the moment as our preferred definition with the hope that we can have an improved definition when time on our World Council allows for a debate on this issue." DPI Position Paper on the Definition of Disability (Disabled Peoples' International, 2005).

Disabled People South Africa, in the process of amending their constitution, had to consider an appropriate definition, which seems to make an attempt, to recognise the role of the two models as follows:

> "Disability – is a social construct [and not a description of a medical condition in the individual] that represents the outcome of the interaction between impairments and the negative environmental impacts on the individual, in recognition that society is constructed, both through the characteristic of its build environment and functioning, on the one hand and the prevailing attitudes and assumptions on the other, which results in restricted opportunities for disabled people to participate on an equal basis, and failure of society to adapt to and accommodate their needs; and the term 'disabled' has a corresponding meaning" (Disabled People South Africa, 2006).

Given this debate and the illustration of WHO and DPI model, the gap is narrowing and common ground is beginning to emerge.

2.6 Existing Data on Disability in South Africa

South African data about the situation of disabled people, and in particular the relationship between disabled people and poverty, is inadequate. In addition, collection of data generally is neither co-ordinated nor collected in a collaborative fashion. The Eastern Cape, i.e. the province where this research was undertaken, is economically underdeveloped and has a population of 6.8 million, making it the third largest province

in South Africa. The majority of people speak isiXhosa, followed by English and Afrikaans (Statistics South Africa, 2005).

There have been several attempts to determine the prevalence of disability, as defined by a health condition. A house-to-house survey to determine "disablement" in a township area of Cape Town, South Africa estimated a 4.4% prevalence rate (CI 3.2-5.6%) (Katzenellenbogen, Joubert, Rendall, & Coetzee, 1995). The Census 2001 included questions relating to disability and the results as indicated in Table 2 show that the Eastern Cape had the second largest number of disabled people in South Africa (Statistics South Africa, 2005). The numbers of males and females are similar and, by total, the Eastern Cape, in which most of the residents speak isiXhosa, is second only to Kwa-Zulu Natal in the prevalence of disability. It is clearly important to have valid instruments with which to explore functioning in this population.

Table 2: Number of disabled persons by province and sex

	Number of Disabled People			% Of disabled males and females compared to total population		
Province	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
Western Cape	96 549	90 301	**186 850**	4.4	3.9	**4.1**
Eastern Cape	173 229	199 037	**372 266**	5.8	5.8	**5.8**
Northern Cape	23 620	23 353	**46 973**	5.9	5.5	**5.7**
Free State	87 758	97 619	**185 377**	6.8	6.9	**6.8**
Kwazulu-Natal	219 685	250 903	**470 588**	5.0	5.0	**5.0**
North West	105 169	106 054	**211 223**	5.8	5.7	**5.8**
Gauteng	164 588	167 023	**331 611**	3.7	3.8	**3.8**
Mpumalanga	87 319	94 874	**182 193**	5.8	5.8	**5.8**
Limpopo	124 128	144 774	**268 902**	5.2	5.0	**5.1**
South Africa	**1 082 043**	**1 173 939**	**2 255 982**	**5.1**	**5.0**	**5.0**

Source : Statistics South Africa, 2005

Table 3 below gives figures relating to the specific types of disability in the O R Tambo district in the isiXhosa speaking Eastern Cape.

Table 3: Total numbers of impairments of function reported by population group and gender in a rural majority isiXhosa speaking district, O R Tambo in the Eastern Cape province of South Africa.

Disability	**African/ Black**		**Coloured**		**Indian/ Asian**		**White**	
	Male	Female	Male	Female	Male	Female	Male	Female
Sight	6918	12261	20	26	5	3	5	7
Hearing	7556	8287	20	24	3	0	15	3
Communi-cation	1606	1550	4	6	0	0	3	7
Physical	10497	11258	58	27	0	3	8	7
Intellectual	4497	4370	21	15	0	4	4	0
Emotional	4588	4524	19	13	0	0	0	0
Multiple	3472	4946	8	14	5	0	6	13

(Statistics South Africa, 2005)

With regard to the impairments of function, the Census 2001, indicated that in a representative rural, isiXhosa speaking area, the most common impairment was that of physical functioning, followed by sensory impairments.

The national disability survey undertaken in 1998/99 represented an important contribution to the understanding of disability (i.e. more than a health condition or impairment) in the country (Schneider, 1999). A nationally representative population based on a survey of 10 000 households was carried out to determine the prevalence of disabilities as well as describe the disability experience as reported by disabled people or their proxy reporters (Schneider, 1999) The first survey records the national disability prevalence rate as 5.9%, with the Eastern Cape the highest and North West the lowest. The focus of the survey attempted to go beyond the traditional categories of impairment through the use of activity limitation categories put forward in an earlier version of the ICF (ICIDH-2, beta-1 version). The results were a count of the number of people with reported disabilities or activity limitations, as well as a qualitative analysis of the respondents' personal experience of their disability. The research used both focus groups and life story analysis to provide a more detailed understanding of the experience of disability. These life stories or experiences emphasised the intolerance of society, the experience of segregation, lack of support, understanding and social attitudes, all of which had a 'disabling' effect and impacted profoundly on the lives of the people surveyed.

2.7 Language

South Africa is a culturally diverse nation with eleven official languages. The cost and complexity of translation of the ICF into all indigenous languages is clearly not possible at this stage. isiXhosa is the second most widely spoken African language in South Africa, being used by 18% of the population (Hirschowitz, 2000). The translation of the

ICF Checklist into isiXhosa provides another opportunity to explore the applicability of these instruments to indigenous languages. The challenge remains that there has been little work in this area especially in South Africa and in Africa (Jelsma et al., 2004). The terminology referring to disability used in the various indigenous languages like isiXhosa, has been very discriminatory (Mqayi, 1914; Soga, 1989). Therefore, it is anticipated that this area of work will begin to generate a lot of political debate and may gradually improve the use of some of these terms across communities, countries, languages and culture.

2.8 Culture

The element of culture, especially within the group of isiXhosa speakers, has very entrenched cultural roots and beliefs. One of the focus areas of the study was to consider the influence of culture whilst translating the ICF Checklist. Culture related to language, has to do with social structure, philosophic outlook, basic values and ways of behaving and interacting. It refers to "patterns of human activity and the symbolic structures that give such activity significance" (Wikipedia, 2007). The relationship between language and culture has been summed up by sociolinguists and ethnographers as follows:
"Language can be studied not only with reference to its formal properties...but also with regard to its relationship to the lives and thoughts and culture of the people who speak it" (Edgar Gregerson, 1977: cited by Kaschula & Anthonissen, 1995; p. 15).

From early in the last century, it was noted that in various communities, the evolution of culture can be influenced by movement of people from rural to urban settings and culture

has now taken an inclusive approach of considering knowledge, beliefs, art, morals, law, custom and other capabilities and habits acquired by men as a member of society (Tyler, 1920). There are generally two expressions of culture: shared values, beliefs, knowledge, skills and practices that underpin behaviours by a social group at a particular point in time; and, creative expression, skills, traditional knowledge and cultural resources that form part of people's lives and of society, and can be the basis for social engagement and enterprise development (Rao & Walton, 2004).

Deaf persons do not always regard themselves as disabled people and see themselves as different because they share a 'deaf culture'. Steven Brown (2002) sums up disability culture as people who have forged a group identity, who share a common history of oppression and a common bond of resilience. People who generate art, music, literature and other expressions of their lives and their culture infused from their experience of disability. Most importantly, disabled people are proud of their disability claiming it as part of their identity. Further to this, Devlieger (1998) discusses the impact of cultural norms, expectations and stereotypes especially with regard to those who are seen to be in the margins of a certain society.

2.9 Translation

Translation is one of the key tools that assists and enriches language development. It can be understood as a negotiation process between the source text, the author of the source text, the cultural framework in which the original text (e.g. the ICF) is born, and also the target text (e.g the isiXhosa translation) and the cultural framework in which it is

expected to be read (i.e. the isiXhosa culture), with the translator acting as a 'negotiator' between source and target text (Umberto, 2003). There is an evident increase in multinational and multi-cultural studies and therefore an obvious need to translate instruments from English or other source languages into locally used languages (Kim et al., 2005). Numerous researchers have translated instruments from English into other languages and documented the process. These include translations into Spanish (Read D, Bethell C, Blumberg SJ, Abreu M, & C, 2007); Japanese (Fujiwara et al., 2003) Xhosa (Jelsma, Amosun, Mkoka, & Nieuwveld, 2004)) and Shona (Jelsma, Chivaura, De Cock, & De Weerdt, 2000).

Having read the articles and materials cited above about translation, whilst the need to test the validity and reliability of what is being translated, is emphasised (Jelsma, De Weerdt, De Cock, Mielke, & Mhundwa, 2002), it is further important to note that translation is not about transferring words from other language to another, there is also meaning of the words and cultural implications. For example, in isiXhosa you say 'ithanga' for a thigh and depending on the context, that same word could mean 'pumpkin'. In their ICF Translation package the WHO suggest the following.

> Translation followed by back-translation as a common process used to assess the understandability of the source text and trace any inaccuracies or ambiguities in the source text that would need to be addressed to improve or otherwise be taken into account when finalising the source text. (World Health Organization, 2005) p3).

Translation can result in the production of reliable and valid instruments, provided that a rigorous procedure is followed. For example, the Reliability and Cultural Applicability of the Greek Version of the International Personality Disorders Examination (Fountoulakis et al., 2002) resulted in a reliable version. However, it was concluded that cultural variation might limit its applicability in international comparisons. In the European Quality of Life 5- Dimension (EQ-5D) translation into isiXhosa case study it is noted that there were concepts that proved difficult to transfer across the languages and cultures (Mkoka, Jelsma, & Vaughan, 2003). A poor translation process would further limit a particular instrument's applicability across communities and cultures.

2.10 Conclusion

Whilst the social model has radically altered ideas about the concept of disability, relationships have changed for the better between disabled people, government, professionals and their communities, although there is still a lot of work to be done to advance the status of disabled people. It is important that disabled people continue to drive this debate so that the introduction and the changes in instruments, like ICF, do not necessarily undermine what the social model stands for but rather advance what the disability movement has achieved so far. The translation of the ICF presents another opportunity for disabled people to engage with government and professional workers in the ongoing effort to do this.

3. Methodology

It was suggested that isiXhosa speaking people who are socially disadvantaged should form the focus of this study. The methodology of this study was purely descriptive, in that the process of the translation of the ICF into isiXhosa was documented. A descriptive, narrative approach was taken to describe the process by which consensus was achieved and difficult words and concepts translated.

3.1 Participants

The translators participating in the consensus team were drawn from different backgrounds. Two individuals, who were experienced in the field of translation and fluent in both isiXhosa and English were selected and recruited on the basis of availability. They did the forward translations. The backward translation was undertaken by another individual.

3.1.1 Translators

One of the forward translators was a lecturer in the African Languages and Literature Department of the University of Cape Town. She previously was a Coordinator for the National Language Project, had several publications and was a conference research presenter. She had no knowledge of medical terms, which enabled her to have a neutral approach. The other forward translator was an occupational therapy Masters student who was familiar with the medical terms used in the ICF. The reason for having a person with no knowledge of medical terms and a person with knowledge of medical terms was to avoid bias and ensure the validity of the ICF checklist terms/concepts. The backward

translator's first language was isiXhosa, but fluent also in English. He held a MA in Education and had been a school principal for many years. He worked as a consultant providing translation services. He was also not familiar with medical terminology.

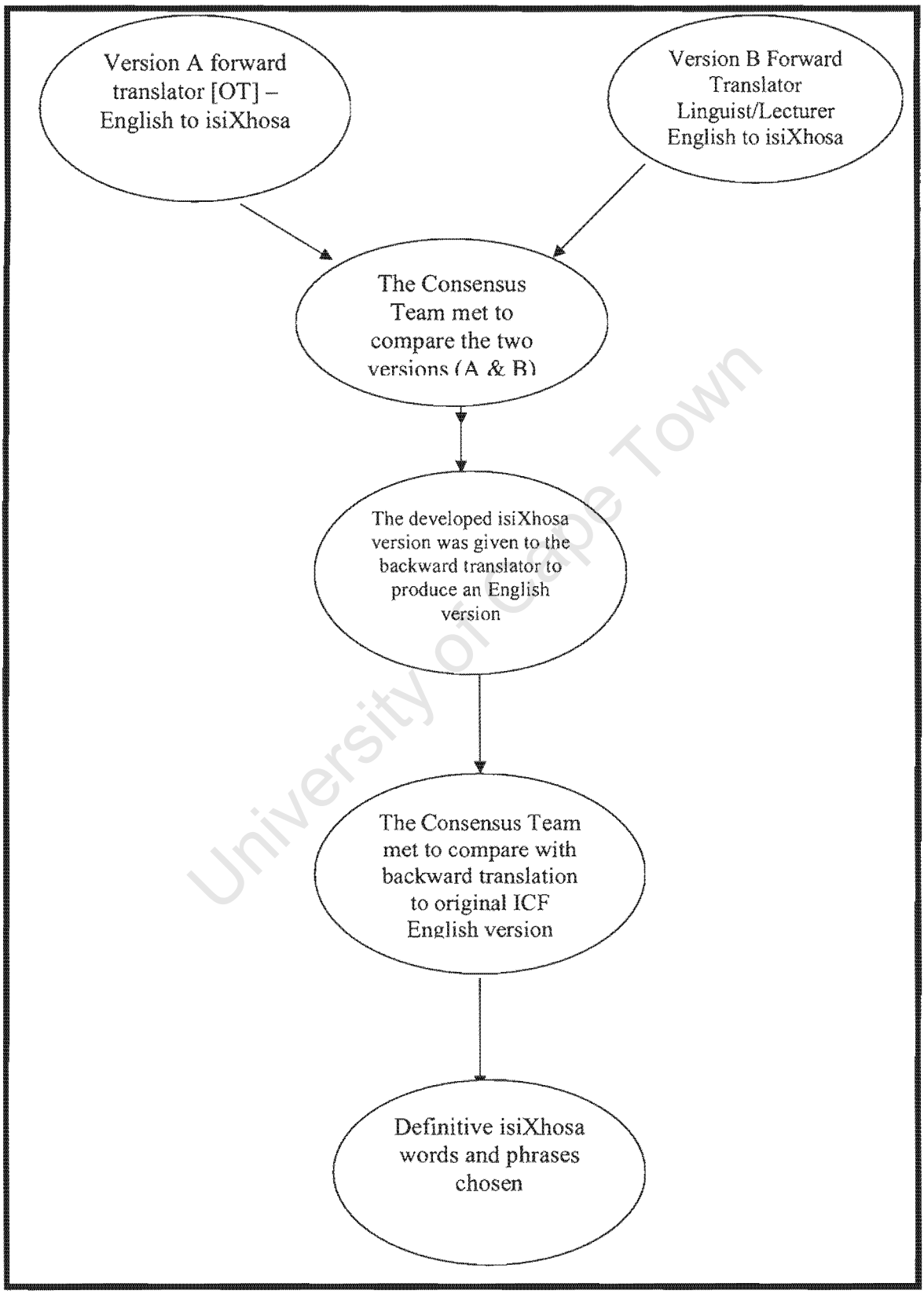
3.1.2 Consensus Team

The consensus team consisted of three participants in addition to the investigator and the two translators. The backward translator did not participate in the first consensus meeting, but did contribute to the second. The six members of the team included:

- The investigator: a disability rights activist who was isiXhosa speaking. The role of the investigator in this collaborative study, was to reflect with the group, ask questions and record the process.
- two isiXhosa speaking occupational therapists who were active in the disability movement ;
- an English speaking physiotherapist who had experience of the translation process into isiXhosa.
- and the two translators.

Not all team members attended all consensus meetings at the same time.

Figure 3: Diagramatic representation of the procedure.



3.2 Instrumentation

The translation of the ICF full version (World Health Organization, 2001) or the ICF short version (World Health Organization, 2001) were considered to be outside the scope of this study so the ICF Checklist (World Health Organisation, 2003)was translated (Appendix I). Spreadsheets were developed in which the English Version was listed in the first column and the isiXhosa version completed in the next column by the forward translators. For the backward translation, the first column consisted of the isiXhosa version and the backward translator filled in the English version (see copy of spreadsheet in Appendix II). All discussions of the Consensus Team were tape-recorded. A professional transcriber was used to transcribe the recorded information.

3.3 Procedure

An overview of the procedure is represented in Figure 3, above. The English Version of the ICF was given to the two forward translators with instructions given by the investigator that they should produce an isiXhosa version that was culturally and linguistically correct, rather than a literal translation. For this study the isiXhosa version translated by the occupational therapy student is identified as version A and the one translated by the Lecturer was identified as version B. The consensus group then met and compared the two isiXhosa versions. Each word/phrase of each sentence was examined and, if necessary, discussed by the team. In most cases, the team could agree on a linguistically and culturally appropriate word. In those cases where consensus could not be reached, the words or phrases were flagged for examination after the backward

translation. If necessary, reference was made to an English-isiXhosa dictionary (Fisher, Weiss, Tshabe, & Mdala, 1985)

Once the isiXhosa version was developed, it was given to the backward translator who was asked to produce an English version. The consensus group then met to compare the backward translation to the original ICF English version. Once again each word/phrase was discussed and debated and reference made to the previous deliberations. At this stage, the definitive isiXhosa words and phrases were chosen.

The procedure for identifying the cultural and linguistic difficulties can be described in terms of five stages:

- Identification of ambiguous phrases or clauses in the isiXhosa translation
- Linguistic sense-making (eg. how would the phrase be interpreted in rural versus urban contexts.
- Examining cultural nuances of acceptable versus unacceptable phrases.
- Applying Disability-sensitive terminology in diverse isiXhosa contexts.
- Attending to needs beyond the given language (e.g. borrowing from isiZulu – which is a common habit in contexts where diverse languages exist side by side).

3.4 Ethical considerations

Ethical approval was obtained from the Faculty of Health Sciences Research Ethics Committee of the University of Cape Town. Caution was practiced around sensitive

terms/concepts in the checklist during the process of translation by the consensus team e.g the term cohabitation in the demography (as explained in Chapter 4 in the Results section). At all stage of the deliberations, every participant's contribution was valued and considered. Payment was made for the use of professional time.

3.5 Data analysis

The analysis was based on the transcripts of the discussion proceedings by the consensus team, who then discussed the nuances of the words contained in the different sections of the ICF checklist until they reached agreement about their meaning and relevance in the context of an isiXhosa speaking person.

The analysis started when the consensus team received the two translated ICF isiXhosa versions. Analysis was structured using the domains, and the sub-categories of the ICF checklist. The consensus team proof read these versions and discussed the linguistic meaning of the concepts in the context of isiXhosa mother tongue speakers. Then there was a further consideration by the team of the cultural appropriateness of the suggested concepts. Thereafter, comparisons of the concepts used in the two versions were made. When the team's options were exhausted a decision was made about the most suitable concept, which was also linguistically and culturally sound. At each stage, consensus was reached but there were certain words that the Consensus Team had difficulty with because of differences between English and isiXhosa sentence construction and the meanings in the two languages. All deliberations were audio-recorded and transcribed. (See Appendix III).

The process took place over six months. Four consensus meetings were held to reconcile the two versions and to produce a definitive version for back translation into English. Two consensus meetings were held to produce the final English version. Each meeting lasted approximately three hours.

This chapter has addressed objective 1.5.4, which speaks to the forward and backward translations process.

The final isiXhosa version is presented in Appendix IV.

4. Findings

4.1 Introduction

This section presents the discussion and conclusion around the choice of specific words. The findings are based on the transcripts of the proceedings and on the researcher's personal experience of the process. The following sections would provide a better understanding and meaning of how the process has unfolded. At each stage, consensus was reached but there were certain words that the Consensus Team had difficulty with because of differences between English and isiXhosa sentence construction and the meanings in the two languages. The numbers in the text refer to the item on the checklist.

4.2 ICF Checklist

4.2.1 Title of the classification

International Classification of Functioning, Disability and Health.

It was decided that the English ICF would remain as part of the title, so that people familiar with the Classification would recognise that this was another language version. There was no debate over the words International or Classification, although these were literally translated as Classification International. However, there was a long, interesting debate within the Consensus Team around the term 'functioning', whether it was referring to the everyday functioning or functioning of the limbs. In isiXhosa it is not possible to separate the 'doing' or 'being' from the agent, therefore 'functioning' was translated literally as *lokusebenza komntu,* which means the functioning of a person.

Finding an appropriate word for disability which was not demeaning was difficult. The isiXhosa word, *imbedlenge* that is used colloquially literally translates into someone who is unable to do anything for himself or herself. The word for someone with a physical disability is *isiqhwala* which means cripple. The word for someone who is unable to communicate due to hearing and speech impairments is *isidalwa* which implies that the person is a creature, a person who is not really regarded as being a person as he is unable to participate in society in any way. The group decided to 'borrow' a Nguni word from isi-Zulu, *ukukhubazeka* which is a neutral term for disability which does not send a negative signal.

The title literally translated then becomes 'the workings of the person, disability and the person's health'.

4.2.2 Demographic Information

In H1 (2) Key respondent was translated as the "actual person who gave the answers". Other respondents (3) was 'other people who gave the answers'. Case ID was literally translated as 'history number'.

The section on personal information (A) presented a few cultural rather than linguistic problems. Name also presented a problem as a woman, would refer to a married female whilst female would refer to both married and unmarried. A female has a name by which she is known at her home but when she marries she changes both first and second names. For example, a woman who is named Bulelwa Belu, when she gets married, she is given

a new name, as Nombasa Toni, by her husband's family, when she is received by his family. Because of influence of globalisation, cultures are also evolving, also pushed by feminism, where married women, in this case, would retain their identity, hence she will be referred to as Nombasa Belu-Toni. It was concluded that it was not necessary to specify which name to give.

Divorce A.6 (4) – meaning *uqhawulo-mtshato*. There is no single word or expression that describes divorce in isiXhosa hence it was translated to mean 'a marriage that is broken or severed' (*ukuqhawula umtshatho*). In the isiXhosa culture it would be inappropriate and embarrassing to ask any female or male if they are Cohabitating A.6 (6) meaning *bayahlalisana*. The norm is that once a man and woman start an intimate relationship, the end goal of this would be marriage. This marriage is a contract which goes beyond the two of them and includes the two families. The man is also expected to pay *lobola* to formalise the relationship between the two families. Cohabitating is therefore discouraged because it undermines this tradition. However it was translated by a phrase, which means the same thing, i.e. staying with another person but it was recommended that this question not be asked unless it was essential to the study being undertaken.

In terms of the concept of work, a distinction needs to be made between work in relation to doing any purposeful activity e.g. gardening and work in terms of employment at a job or in a position e.g. a store manager. In A7 (1) Work – (*sebenza*) *uyasebenza* was discussed, but was rejected as it does not necessarily mean working for an income and could also mean doing chores at home. It was agreed to use the word *phangela* meaning

'working for a living or income'. Retired meaning *umhlala-phansi* was translated by one of the translators as *upenshele*, a word derived from the English word pensioner. However, it was decided to rather use the grammatically correct isiXhosa words *udla umhlalaphantsi.* This was an example of having to decide between a colloquial, anglicised word and the linguistically correct isiXhosa version that not everyone uses.

4.2.3 Impairments of Body Functions

A major problem was that there are no words in isiXhosa which can be used to distinguish between the concepts of disability and impairment. It was difficult to find a word which was disability friendly in isiXhosa or even to translate disability (see above). *Ukhubazeko,* an Nguni word which is commonly used in isiZulu, was agreed to be used. Ultimately this word was used for both disability and impairment. Significant deviation was translated by *elahlukileyo* rather than *elinxaxhileyo* as it conforms better to the overall meaning of the phrase. (Note – principle : a phrase may offer a glimpse of a better meaning than a word). The first word means a difference in an object from the norm whereas the second word refers to doing something differently to what was agreed or expected.

4.2.4 Short-list of Body Functions

Mental functions b1.b117

The words relating to Intellectual functions include retardation and dementia in the English version. The Consensus team objected to the word retardation and preferred to use a word meaning mental handicap. The first isiXhosa translation described dementia as *ukungabi nangqondo* or *igeza* which literally means a person who is "losing it."

This kind of labelling has (further) negatively worsened and isolated mentally disabled persons even further and therefore the final version was translate(s)ed as *ukudodobala ingqondo nokungabikho.* This means that something has had an impact on the mind which stops it from functioning properly.

Pain (b280) was translated differently by the two translators. *Iintlungu* means emotional pain, as experienced when losing a loved one, whereas *Ubuhlungu*, the word finally chosen, means pain which one is able to touch and isolate.

In the target population, the prevalence of increased blood pressure was high and the concept of Blood pressure (b435) meaning *uxinzelelo lwegazi* is familiar to people. The English words were included with the isiXhosa phrase to ensure understanding.

The Consensus Team had an interesting debate with regards to translating the Functions of the Cardiovascular, Haematological, Immunological and Respiratory Systems (b4) and Functions of the Digestive, Metabolic and Endocrine Systems (b5). When reflecting on the two forward translations, it was noted that the two translators had translated the word 'systems' differently. The Version A translated b5 as *'Ukusebenza kwee-isistimu*

zokwetyisa namadlala' but the Version B translated it as *yomxokomezelo wometyiso*. The Consensus Team was aware that this was difficult and not part of the day-to-day vocabulary of this specific community and, therefore, it would be interesting to see how they would respond to it. It was suggested that the word *yomxokomezelo* might not be as well understood in the Western Cape as in the Eastern Cape; this is why the Version A uses 'system'. It was concluded that, as the words used were nouns, e.g. heart and it's vessels, blood rather than cardio-vascular; haematological; the word systems could be excluded, as the English ICF does in b6. However, it is used under body structure, as these are generally more anatomical descriptors.

The Consensus Team was also concerned that lay people would have difficulty understanding that the Immunological (b4) was implicated in HIV/AIDS so *Izikhuseli-mzimba*/Immune system allergies meaning *izinto ezingahambelani nomzimba* (literally Body protectors/immune system allergies) was used.

Functions of the Digestive, Metabolic and Endocrine Systems (b5)

After discussion it was agreed that the digestive system begins from the mouth but when you ask somebody about it s/he will only focus on the stomach as the place where the process starts.

The word for Urination b620) caused some debate. Certain words are used as euphemisms in order to show respect in specific contexts. The word *ukuntsontsa* is used in the case of a female whilst *ukuchama* is used in the case of a man, in both areas

(Eastern and Western Cape). Finally the more direct but less "polite' word *ukuchama* was chosen as everyone would understand this. The content validity of the English version of the ICF was questioned, as the ability to have children, Procreation, was not included in the b6 "Genitourinary and reproductive" functions. The item from the full version of the classification, b660, "Procreation Functions" was added to the isiXhosa version.

Similarly it was decided to add b810, Protective functions of the skin to b8, Functions of the Skin, as albinism is a common condition amongst the target population. The need to find appropriate words to describe impairments was highlighted as the word for albino is *inkawu,* a word meaning ape. It was agreed to use i-Albino as an example of a problem with protective functions.

4.2.5 Short list of body structures

There was difficulty in the use of the descriptors and qualifiers, mild, moderate, severe and complete impairment. The translator ranked the problems as being "very low" (mild), "mild" (moderate), "severe" (severe) and "fully fledged" (extreme). Similarly the qualifiers of Section 2, Activity Limitations and Participation Restriction, were translated as "slightly difficult" (mild), "mildly difficult" (moderate), "very difficult" (severe) and "extremely difficult" (complete difficulty). The word *Luphakathi* was the only word found to describe the concept of a quantity being "in the middle". This word did not back translate to moderate but no other word could be found. However, the rank ordering of magnitude was retained.

There were no major issues regarding the translation of the body structures, apart from ensuring that all aspects of the structure were included (e.g. blood vessels as well as heart). Immune system (s4) was translated by the words *Izikhuseli-mzimba,* literally body protectors system.

4.2.6 Activity limitations and participation restrictions

As mentioned previously, it is impossible to have an abstract noun in isiXhosa, there has to be a person doing or experiencing this. It was, therefore, difficult to translate Activity and Participation without also having an agent. The literal translation of the phrase chosen *Ubunzima bokwenza izinto neengxaki ezifunyanwa ngumntu ekuthatheni inxaxheba kwizinto zobomi* is 'difficulty in doing something and problems that the person gets in participating in life activities'.

The problem of translating mild, moderate etc. has been discussed above. Not specified and Not applicable (no 9) were translated similarly by one translator. Number 9 was then changed to *Andibhekisi kuwe,* which literally means 'I'm not referring to you'.

Watching (d110) was changed from *ukujonga* which means 'seeing, your eyes are open so you can see', to *ukubukela,* which implies that what is seen is integrated and interpreted, e.g. like watching a game of soccer.

The first term used for (Mobility d4) was too narrow and described movement of the limbs rather than of moving the body from one place to another and did not include the

ability required to move about in a wheelchair. *Intshukumo nemo yokuhamba* was used, which literally means moving the entire body.

There are two isiXhosa words meaning to lift and carry objects (d430), one referring to picking up a child or person and the other to lifting objects. *Ukuphakamisa,* which means lifting up objects and moving from place to place was used. *Ukuhamba,* walking, was used rather than *hamba,* meaning walk, to translate the idea of being able to move around in (e.g). a wheelchair and not only to walk using one's legs, or Moving around using equipment (d465). The words chosen for Self-care, literally means caring for oneself and was accepted.

No other words or phrases were controversial in the rest of this section. *Ubuqabane,* the word used for (d770), Intimate relationships is based on the word for comrade, a reference to the comradeship experienced during the struggle against apartheid and implies that we are in this together. It was noted that the word used in (d870) Economic Independence, for independence, *ukuzimela,* can also mean hide away, but in the context the respondents would understand that it means independence.

It is difficult to make a distinction between Community, Social and Civic Life (d9) in isiXhosa *Ubomi kuluntu nasekuhlaleni* was used which literally means the life of the community, where they live.

4.2.7 Environmental factors

As this section generally deals with more concrete constructs, it was easier to translate than the other sections and there was less debate around word choice.

Once again the qualifiers of mild, moderate and severe needed to be amended. One translator used a word for barriers which referred only to physical barriers such as accessible roads, etc. *Izithintelo* was then used which means things that could prevent us from doing things and facilitators *eziluncedo* things that could assist us to do things.

In (e250) the difference between Sound and noise was discussed and another word which means sound was added to the original word. This then became *isandi/ingxolo*. In (e3) Support and relationships, the same root-word for relationship was used as for (d7) to ensure consistency.

5. Discussion

This chapter discusses the findings as debated and agreed by the Consensus Team. It will look at the choice of the Consensus Team, the challenges of the translation process and general problems encountered. A closer interrogation of some of the concepts will be presented and finally it will examine the meaning and commonalities of some of these findings with other studies done locally and in other countries of the world. It is concluded that the isiXhosa version of ICF can be used to gather data in South African isiXhosa communities and that this data could be used across health care disciplines and different countries as it would conform to the concepts evident in the English version.

5.1 Participants

The choice of participants in this study was carefully thought through so as to enrich the outcome. They were participants with adequate qualifications in the medical, disability, linguistics and teaching fields representing different sectors. This diverse group of participants provided interesting and valuable debate because of the different backgrounds and experiences to the subject. The inclusion of lay people, disabled activists (*"Nothing about us without us"*), different cultural groups and professional expertise was also seen as important in enriching the debate.

Although a rigorous process might be followed, it has been pointed out that if the translation process is led by someone with greater authority or power, the process might not end up with a true translation but rather one that reflects the researcher's point of view (Herdman, 1998). It could result in the imposition of a "colonialist, Western ....

framework". In fact, the translation process itself can mirror power imbalances and has been reported to reflect the racial imbalances entrenched during the apartheid era (Drennan, Levett, & Swartz, 2004). As mentioned above, the current translation was driven by isiXhosa speaking people, several of whom were disability activists and, hopefully, these pitfalls were avoided.

The need for a multi-disciplinary team has been recognised by other researchers and was utilised, for example, to translate the EQ-5D into Shona (Jelsma et al., 2000), This kind of consideration in the choice of translators and consensus team was similar to that used in a cross-cultural adaptation and validation of the SF36 quality of life instrument (Bullinger et al., 1998). The value of such a team was further proven by the level of debate and disagreements as indicated in the Results section.

5.2 Translation process

The approach used was very interesting for the members of the consensus team in that it considered the Afro-centric approach of putting heads together in testing the strength and quality of ideas and input. It was a lengthy process requiring dialogue and debate, for the purposes of finding clarification and deriving meaning of ICF concepts in the Xhosa context. In this process of translation the consensus team also realised the value of diversity and the power of language in education as our knowledge and understanding of the area of disability was deepened beyond just the words utilised in the ICF checklist.

Too often studies use indigenous language versions of European language instruments with no details regarding translation process (Jelsma et al., 2000). As can be seen from this study, this can lead to considerable misunderstanding and can undermine the validity of the instrument and the study. In isiXhosa translation (Mkoka et al., 2003) and Shona translation (Jelsma et al., 2000), in which the word for "mobility", *ukuhamba-hamba* meaning to be mobile in isiXhosa, whilst in Shona the same word means sleeping around, which in isiXhosa is *ukuhula*. This obviously would have had a major impact on the data collected! Researchers in Africa have to start by validating their instruments and this presents more of a challenge to undertaking valid research.

The methodology of the translation process is similar to several other papers reporting on translating different instruments. Forward translation, synthesis of translation, backward translation and review by an expert committee have been used to translate the EQ-5D into Xhosa (Mkoka et al., 2003) and Shona (Jelsma et al., 2000) and the Oswestry Disability Index and the Roland – Morris Disability Questionnaire into Japanese (Fujiwara et al., 2003) All of these translations were subsequently found "to be valid and reliable".

5.3 Challenges faced in the translation

5.3.1. Linguistic issues

IsiXhosa is a more personalised language than English in that there always needs to be a subject to the verb, i.e. someone or something must be doing the action. It is difficult to translate abstract nouns, such as feeling and emotion without reference to the person who is feeling or experiencing the emotion. For example, disability and pain cannot be

translated with a single word but need to be linked to the person who might have a disability or the body part which might be painful.

Some words were found to be too complicated to translate, such as system, which would mean *umxokomezelo* the words used would not be part of the daily discourse of the people especially those living in urban areas. On some occasion the English word might be more understandable to isiXhosa speaking person and it might be appropriate to use it in its original English version. In some cases because of growing interactions amongst people and languages and where a word is not able to be translated in isiXhosa phonological approximation takes place. For example, we used the word *isistimu* instead of *umxokomezelo*.

5.3.2. Culturally appropriate words

In isiXhosa, the word, divorce, is also difficult, to translate appropriately, although it could be translated as *ukugqhawulwa komtshato* meaning broken marriage. In isiXhosa culture a woman does not get divorced. If a serious conflict arises between husband and wife, the wife is then taken back to her parents. This situation was described a century ago by Mqayi (Mqayi, 1914) but remains the same today in many traditional isiXhosa societies. Co-habitation is a concept that is not acceptable in the Xhosa culture as the emphasis is that if you are interested, as a man, in a woman, to get into an intimate relationship it is expected that the goal would be marriage. The man is therefore expected to get his family delegation to negotiate with the woman's family as the focus is the bringing together and building up of a lasting relationship between the two families. The

key in bringing the two families together is the lobola which is marked by ikhazi, meaning the cows that are used as lobola, which would result in multiplication and further prosperity for the two families (Soga, 1989).

However, it is acknowledged that with the large scale migration to the urban areas, many of these traditional modes of behaviour could change. Since the advent of a democratic system of government, the so called "pass-laws" which required that Black Africans needed permits to prove employment and consequent right to residence in cities, has been repealed. This has resulted in a free movement of people from areas in which there is high unemployment into urban areas and has led to a dramatic increase in population. The black population of the township areas around Cape Town has grown from approximately 700,000 in 1993 to an estimated 1,226,000 people in 2005 (City of Cape Town, 2005). In August, 2005, it was estimated that 500 000 people were still living in informal settlements and that a further 16 000 people move to the informal settlements of Cape Town every year (Staff Reporter, 2005). The question arises as to whether the translation should be true to tradition or accommodate the language and behaviour of the more Westernised urban migrants. The translators decided to follow a middle road between the more traditional and more Westernised discourses.

The word, urination, in isiXhosa could have different meanings when it is used between males and females. For females, it is referred to as *ukuntsontsa* and in males, it is *ukuchama*, this could be the result of how this activity takes place between males and females and the respect that is accorded to females. Other translators have also had to

deal with culturally sensitive words. In Fujiwara's report of translations into Japanese, it is noted that a question relating to sex in teenagers in the original was excluded from the translation as it was found to be culturally inappropriate (Fujiwara et al., 2003).

5.3.3. Words related to stereotyping of disability

The cultural stereotyping of disability was apparent in the lack of appropriate words for some of the concepts. In addition stereotyping of the women's role is also present in the culture. It was difficult to find an appropriate word for disability as explained in Chapter 4, but in the English-Xhosa dictionary disability is explains as *ubulwelwe,* which could virtually mean a person who is poor and dependant on others to fend for himself (Fisher et al., 1985). Xhosa people also use the word, *isidalwa,* referring to a person who has intellectual, hearing and/or speech impairments, which literally means a person created by God. Originally the word was not meant to be insulting and acknowledges that a disabled person is God's creation and what God has created needs to be respected (Kropf, 1915) . Ancestor worship is very prominent among the Xhosa people. They believe the ancestors reward those who venerate them and punish those who neglect them. It is understood that the connection with God (whom is referred to as Qamata) is through your ancestors and there is a strong sense of loyalty on this. That is why the belief and the respect not to interfere with what God has created in this case *isidalwa* is taken in that context (Kropf, 1915).

However, use of this word would currently be offensive and paternalistic as it separates that person from others and leads to isolation. The word also implies that nothing can be

done to change this situation and therefore the association with others is not possible or necessary.

The general problems encountered also include some cultural nuances around knowledge, attitudes, beliefs, perceptions ***and*** myths. Words like albino which when translated into isiXhosa, would be *inkawu ("or monkey")* although it has nothing or no relation to *inkawu* but heavily influenced by cultural nuances that this person because of his or her skin pigmentation is believed that he or she does not die. If you contest this belief, people would ask, have you ever seen a grave of a person with albinism?

5.3.4 Concepts embedded in the ICF

English is a very rich language, drawing as it does on so many root languages. It is, therefore, easier to make fine distinctions between words with similar but nuanced meanings, than it is in many other languages. It was, for example, difficult to find words that would differentiate between similar but separate concepts such as impairments, disability and activity limitations. On the other hand, by challenging the language, new words and meanings can enter into everyday usage.

The ICF is a complex instrument and many of the concepts were difficult to translate into isiXhosa. There was also similar translation experience with other instruments, to other languages like Korean (Kim et al., 2005) , Japanese (Fujiwara et al., 2003), Greek (Fountoulakis et al., 2002) and Shona (Jelsma et al., 2000) . However, it might still be a useful instrument for trying to organise information related to disability and functioning.

Words that appear simple and obvious in English, such as 'walking', 'system' or 'social life' are often not that easy to translate into other languages. (e.g. see 4.2.6 re mobility) The other challenge posed by this process of translating a tool like ICF Checklist into isiXhosa is that one has to accommodate the fact that some isiXhosa concepts would not be the same between rural and urban communities e.g. *'ukuxuluba'* meaning to throw a stone which would be used in a rural setting as compared to *'ukugqaya'* which is normally used in an urban setting.

Mobility related concepts seem to be difficult to translate into non-English languages and in a Japanese translation of pain measurement instruments, "travelling" was replaced by the term "transportation in a vehicle"(Fujiwara et al., 2003). In a report on a Korean translation, it was stated that travelling usually means a "tour for pleasure or business trip" and a supplementary term "transportation" was added (Kim et al., 2005).

The difficulties in translating Community, Social and Civic Life (d9) were similar to those experienced by Japanese translators who stated that the term "social life" is uncommon in Japanese and translated this into "relationships with others except for a work situation" (Fujiwara et al., 2003). In the Korean translation "social life" was translated as "get-together, social gathering" as has been identified before, an equivalent single word could not be found (Kim et al., 2005).

Procreation is culturally very important and the inability to have children could be perceived as some type of disability which could result in a married woman getting

rejected by her husband (Jelsma et al., 2000). This is even more so when the woman is disabled. The ICF checklist does not include coding of reproduction and in the isiXhosa context this is an important omission.

5.4 Limitations of the Study

Documentation of the translation process from the sessions of the Consensus Team to the final production of the isiXhosa version of the ICF presented some challenges. The sequence of sessions with the Consensus Team was at times documented poorly as the audio recording quality varied and sometimes the transcriber could not follow the discussions. As the translation was linked to the bigger study, 'Living conditions of People with Disabilities in the Eastern and Western Cape provinces of South Africa' (Maart et al., 2007), there were also unavoidable delays caused by unavailability of the members of the team and sometimes delays in completion of the forward and backward translation.

Another limitation was that although the isiXhosa version was used in the main study, there was not enough time to field test the new version. There may have been problems on the ground with the use of specific words which was not reported to the translators.

6. Conclusions and recommendations

The process of translation was challenging but rewarding. In almost every case consensus could be reached and the final translation was acceptable to all participants in the process. It is suggested that the process of having two forward and one backward translation, followed by consensus meetings, led to the production of an accurate and culturally acceptable instrument.

However, further studies on the validity and reliability of the instrument still need to be undertaken as the instrument has not yet been tested in practice. It is suggested that this be undertaken to ensure that the ICF is indeed measuring what it is meant to measure.

6.1 Applicability of ICF

As indicated in Chapter Two there has been a progressive approach in the development of the ICF to respond to health challenges of the day. In the earlier chapters, many writers have shown how the ICF can be used in different contexts to assess or validate and also provide a scientific basis for understanding and studying health and health-related states, outcomes and determinants. There is a justification that ICF within this study can be translated and applicable in isiXhosa although this still needs to be validated. The debate on whether ICF addresses challenges raised in the social model continues to be an issue that needs to be further explored.

6.2 Recommendation

When the investigator set out to undertake the study, one of the objectives (1.5.4) in Chapter One, was to adjust, adapt and consolidate the final isiXhosa version of the ICF checklist. This objective was not fully achieved as the isiXhosa version still needs to be field-tested and its validity and reliability established.

It is, however, recommended that the isiXhosa version be used in preference to the English whenever appropriate, considering that the English version has similarly not been tested for reliability and validity within the South African context.

Just as the original ICIDH redefined words such as handicap and gave them different meanings, the translation of the ICF into isiXhosa should lead to the introduction into everyday language of words that are more neutral and less derogatory than the words currently in use. The issue of terminology is critical in promoting dignity on the part of disabled people. For example, the very word used to denote disability in isiXhosa, *imbedlenge* is used colloquially to describe someone who is unable to do anything for him/herself. It is therefore recommended to 'borrow' a Nguni word from isiZulu, *ukukhubazeka* which is a neutral term for disability and does not send a negative signal.

It is recommended that similar translations be undertaken of other disability related instruments to ensure that acceptable terminology is used and enters colloquial language.

In the process of translation, it became clear that there is a need to define and clarify both personal and social attributes with regard to human functioning. There has been a healthy progression in the development of the conceptual basis of the ICF and there is now some meeting point between the medical and social models of disability. However, whether or not the ICF is the only instrument or even the instrument of choice to interrogate disability issues is still debatable. The principle in which the study was conducted could be extended to Africa in view of the investigator's reservation about the way the ICF has been developed so far. The greater involvement of disabled people and their opinion could further raise the level of debate and may lead to improvement of terminology across culture and languages. One could imagine the richness of the debate if we were to explore within the Nguni group the different terms used to describe disability, the reasoning behind those terms and how, with the involvement of disabled people, we might be able to generate a new body of knowledge around the very same terms.

It is clear that the body that drives the instrument, i.e. the WHO, is primarily concerned about health and there is still a need for other input into the debate around the definition and conceptualization of disability.

The insight gained from translation and in particular, the comparison of the different meaning of words, especially disability, has led to the thought that the study opens the way to begin a debate on what disability really means in the minds and behaviour of indigenous people.

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8 Appendices

Appendix I – The ICF Checklist

ICF CHECKLIST

Version 2.1a, Clinician Form

for International Classification of Functioning, Disability and Health

This is a checklist of major categories of the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization . The ICF Checklist is a practical tool to elicit and record information on the functioning and disability of an individual. This information can be summarized for case records (for example, in clinical practice or social work). The checklist should be used along with the ICF or ICF Pocket version.

H 1. When completing this checklist, use all information available. Please check those used:
[1] written records [2] primary respondent [3] other informants [4] direct observation

If medical and diagnostic information is not available it is suggested to complete appendix 1: Brief Health Information (p 9-10) which can be completed by the respondent.

H 2. Date __ __ /__ __/ __ __ **H 3. Case ID** _ _ , __ __ , __ **H 4. Participant No.** __ __ , __ __ , __ __ __

Day Month Year CE or CS Case No. 1st or 2nd Evalu FTC Site Participant

A. DEMOGRAPHIC INFORMATION

A.1 NAME (optional) First _____ FAMILY _____

A.2 SEX (1) [ ] Female (2) [ ] Male

A.3 DATE OF BIRTH _ _/_ _/_ _ (date/month/year)

A.4 ADDRESS (optional)

A.5 YEARS OF FORMAL EDUCATION _ _

A.6 CURRENT MARITAL STATUS: (Check only one that is most applicable)

(1) Never married [ ] (4) Divorced [ ]
(2) Currently Married [ ] (5) Widowed [ ]
(3) Separated [ ] (6) Cohabiting [ ]

A.7 CURRENT OCCUPATION (Select the single best option)

(1) Paid employment [ ] (6) Retired [ ]
(2) Self-employed [ ] (7) Unemployed (health reason) [ ]
(3) Non-paid work, such as volunteer/charity [ ] (8) Unemployed (other reason) [ ]
(4) Student [ ] (9) Other [ ]
(5) Keeping house/House-maker [ ] (please specify) _____

A.8 MEDICAL DIAGNOSIS of existing Main Health Conditions, if possible give ICD Codes.

1 No Medical Condition exists
2 ..... ICD code: __. __. __.__. __
3 ..... ICD code: __. __. __.__. __
4 ..... ICD code: __. __. __.__. __
5 A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known

PART 1a: IMPAIRMENTS of BODY FUNCTIONS

☐ Body functions are the physiological functions of body systems (including psychological functions).
☐ Impairments are problems in body function as a significant deviation or loss.

First Qualifier: Extent of impairments **0 No impairment** means the person has no problem **1 Mild impairment** means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days. **2 Moderate impairment** means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days. **3 Severe impairment** means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days. **4 Complete impairment** means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days. **8 Not specified** means there is insufficient information to specify the severity of the impairment. **9 Not applicable** means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

Short List of Body Functions	Qualifier
b1. MENTAL FUNCTIONS	
b110 Consciousness	
b114 Orientation (time, place, person)	
b117 Intellectual (incl. Retardation, dementia)	
b130 Energy and drive functions	
b134 Sleep	
b140 Attention	
b144 Memory	
b152 Emotional functions	
b156 Perceptual functions	
b164 Higher level cognitive functions	
b167 Language	
b2. SENSORY FUNCTIONS AND PAIN	
b210 Seeing	
b230 Hearing	

b235 Vestibular (incl. Balance functions)	
b280 Pain	
b3. VOICE AND SPEECH FUNCTIONS	
b310 Voice	
b4. FUNCTIONS OF THE CARDIOVASCULAR, HAEMATOLOGICAL, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS	
b410 Heart	
b420 Blood pressure	
b430 Haematological (blood)	
b435 Immunological (allergies, hypersensitivity)	
b440 Respiration (breathing)	
b5. FUNCTIONS OF THE DIGESTIVE, METABOLIC AND ENDOCRINE SYSTEMS	
b515 Digestive	
b525 Defecation	
b530 Weight maintenance	
b555 Endocrine glands (hormonal changes)	
b6. GENITOURINARY AND REPRODUCTIVE FUNCTIONS	
b620 Urination functions	
b640 Sexual functions	
b7. NEUROMUSCULOSKELETAL AND MOVEMENT RELATED FUNCTIONS	
b710 Mobility of joint	
b730 Muscle power	
b735 Muscle tone	
b765 Involuntary movements	
b8. FUNCTIONS OF THE SKIN AND RELATED STRUCTURES	
ANY OTHER BODY FUNCTIONS	

Part 1 b: IMPAIRMENTS of BODY STRUCTURES

- Body structures are anatomical parts of the body such as organs, limbs and their components.
- Impairments are problems in structure as a significant deviation or loss.

First Qualifier: Extent of impairment	Second Qualifier: Nature of the change
0 No impairment means the person has no problem **1 Mild impairment** means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days. **2 Moderate impairment** means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days.	**0** No change in structure **1** Total absence **2** Partial absence **3** Additional part **4** Aberrant dimensions **5** Discontinuity **6** Deviating position **7** Qualitative changes in structure,

3 Severe impairment means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days.

4 Complete impairment means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days.

8 Not specified means there is insufficient information to specify the severity of the impairment.

9 Not applicable means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

including accumulation of fluid

8 Not specified

9 Not applicable

Short List of Body Structures	First Qualifier: Extent of impairment	Second Qualifier: Nature of the change
s1. STRUCTURE OF THE NERVOUS SYSTEM		
s110 Brain		
s120 Spinal cord and peripheral nerves		
s2. THE EYE, EAR AND RELATED STRUCTURES		
s3. STRUCTURES INVOLVED IN VOICE AND SPEECH		
s4. STRUCTURE OF THE CARDIOVASCULAR, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS		
s410 Cardiovascular system		
s430 Respiratory system		
s5. STRUCTURES RELATED TO THE DIGESTIVE, METABOLISM AND ENDOCRINE SYSTEMS		
s6. STRUCTURE RELATED TO GENITOURINARY AND REPRODUCTIVE SYSTEM		
s610 Urinary system		
s630 Reproductive system		
s7. STRUCTURE RELATED TO MOVEMENT		
s710 Head and neck region		
s720 Shoulder region		
s730 Upper extremity (arm, hand)		
s740 Pelvis		

s750 Lower extremity (leg, foot)		
s760 Trunk		
s8. SKIN AND RELATED STRUCTURES		
ANY OTHER BODY STRUCTURES		

PART 2: ACTIVITY LIMITATIONS & PARTICIPATION RESTRICTION

- Activity is the execution of a task or action by an individual.. Participation is involvement in a life situation.
- Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may have in involvement in life situations.

The **Performance qualifier** indicates the **extent of Participation restriction** by describing the persons **actual performance** of a task or action **in his or her current environment.** Because the current environment brings in the societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in the actual context in which they live. This context includes the environmental factors – all aspects of the physical, social and attitudinal world that can be coded using the Environmental. The Performance qualifier measures the difficulty the respondent experiences in **doing things, assuming that they want to do them**.

The **Capacity qualifier** indicates the **extent of Activity limitation** by describing the **person ability** to execute a task or an action. The Capacity qualifier focuses on limitations that are inherent or intrinsic features of the person themselves. These limitations should be direct manifestations of the respondent's health state, **without the assistance**. By assistance we mean the help of another person, or assistance provided by an adapted or specially designed tool or vehicle, or any form of environmental modification to a room, home, workplace etc.. The level of capacity should be judged relative to that normally expected of the person, or the person's capacity before they acquired their health condition.

Note: Use Appendix 2 if needed to elicit information on the Activities and Participation of the individual

First Qualifier: *Performance* *Extent of Participation Restriction*	**Second Qualifier:** *Capacity (without assistance)* *Extent of Activity limitation*

0 No difficulty means the person has no problem
1 Mild difficulty means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.
2 Moderate difficulty means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the persons day to day life and which happens occasionally over the last 30 days.
3 Severe difficulty means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the persons day to day life and which happens frequently over the last 30 days.
4 Complete difficulty means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the persons day to day life and which happens every day over the last 30 days.
8 Not specified means there is insufficient information to specify the severity of the difficulty.
9 Not applicable means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

Short List of A&P domains	**Performance Qualifier**	**Capacity Qualifier**
d1. LEARNING AND APPLYING KNOWLEDGE		
d110 Watching		
d115 Listening		
d140 Learning to read		
d145 Learning to write		
d150 Learning to calculate (arithmetic)		
d175 Solving problems		
d2. GENERAL TASKS AND DEMANDS		
d210 Undertaking a single task		
d220 Undertaking multiple tasks		
d3. COMMUNICATION		
d310 Communicating with -- receiving -- spoken messages		
d315 Communicating with -- receiving -- non-verbal messages		
d330 Speaking		
d335 Producing non-verbal messages		
d350 Conversation		
d4. MOBILITY		
d430 Lifting and carrying objects		
d440 Fine hand use (picking up, grasping)		
d450 Walking		
d465 Moving around using equipment (wheelchair, skates, etc.)		
d470 Using transportation (car, bus, train, plane, etc.)		
d475 Driving (riding bicycle and motorbike, driving car, etc.)		
d5. SELF CARE		
d510 Washing oneself (bathing, drying, washing hands, etc)		

d520 Caring for body parts (brushing teeth, shaving, grooming, etc.)		
d530 Toileting		
d540 Dressing		
d550 Eating		
d560 Drinking		
d570 Looking after one`s health		
d6. DOMESTIC LIFE		
d620 Acquisition of goods and services (shopping, etc.)		
d630 Preparation of meals (cooking etc.)		
d640 Doing housework (cleaning house, washing dishes laundry, ironing, etc.)		
d660 Assisting others		
d7. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS		
d710 Basic interpersonal interactions		
d720 Complex interpersonal interactions		
d730 Relating with strangers		
d740 Formal relationships		
d750 Informal social relationships		
d760 Family relationships		
d770 Intimate relationships		
d8. MAJOR LIFE AREAS		

d810 Informal education		
d820 School education		
d830 Higher education		
d850 Remunerative employment		
d860 Basic economic transactions		
d870 Economic self-sufficiency		
d9. COMMUNITY, SOCIAL AND CIVIC LIFE		
d910 Community Life		
d920 Recreation and leisure		
d930 Religion and spirituality		
d940 Human rights		
d950 Political life and citizenship		
ANY OTHER ACTIVITY AND PARTICIPATION		

PART 3: ENVIRONMENTAL FACTORS

- Environmental factors make up the physical, social and attitudinal environment in which people live

and conduct their lives.

Qualifier in environment:	**0** No barriers	**0** No facilitator
Barriers or facilitator	**1** Mild barriers	**+1** Mild facilitator
	2 Moderate barriers	**+2** Moderate facilitator
	3 Severe barriers	**+3** Substantial facilitator
	4 Complete barriers	**+4** Complete facilitator

Short List of Environment	**Qualifier barrier or facilitator**
e1. PRODUCTS AND TECHNOLOGY	
e110 For personal consumption (food, medicines)	
e115 For personal use in daily living	
e120 For personal indoor and outdoor mobility and transportation	
e125 Products for communication	
e150 Design, construction and building products and technology of buildings for public use	
e155 Design, construction and building products and technology of buildings for private use	
e2. NATURAL ENVIRONMENT AND HUMAN MADE CHANGES TO ENVIRONMENT	
e225 Climate	
e240 Light	
e250 Sound	
e3. SUPPORT AND RELATIONSHIPS	
e310 Immediate family	
e320 Friends	
e325 Acquaintances, peers, colleagues, neighbours and community members	
e330 People in position of authority	
e340 Personal care providers and personal assistants	
e355 Health professionals	
e360 Health related professionals	
e4. ATTITUDES	
e410 Individual attitudes of immediate family members	
e420 Individual attitudes of friends	
e440 Individual attitudes of personal care providers and personal assistants	
e450 Individual attitudes of health professionals	
e455 Individual attitudes of health related professionals	
e460 Societal attitudes	

e465 Social norms, practices and ideologies	
E5. SERVICES, SYSTEMS AND POLICIES	
e525 Housing services, systems and policies	
e535 Communication services, systems and policies	
e540 Transportation services, systems and policies	
e550 Legal services, systems and policies	
e570 Social security, services, systems and policies	
e575 General social support services, systems and policies	
e580 Health services, systems and policies	
e585 Education and training services, systems and policies	
e590 Labour and employment services, systems and policies	
ANY OTHER ENVIRONMENTAL FACTORS	

Part 4: OTHER CONTEXTUAL INFORMATION

4. 1 Give a thumbnail sketch of the individual and any other relevant information.

4.2 Include any **Personal Factors** as they impact on functioning (e.g. lifestyle, habits, social background, education, life events, race/ethnicity, sexual orientation and assets of the individual).

Appendix 1:

ICF CHECKLIST

Version 2.1a, Clinician Form

for International Classification of Functioning, Disability and Health

This is a checklist of major categories of the International Classification of Functioning, Disability and Health (ICF) of the World Health Organization . The ICF Checklist is a practical tool to elicit and record information on the functioning and disability of an individual. This information can be summarized for case records (for example, in clinical practice or social work). The checklist should be used along with the ICF or ICF Pocket version.

H 1. When completing this checklist, use all information available. Please check those used:
[1] written records [2] primary respondent [3] other informants [4] direct observation

If medical and diagnostic information is not available it is suggested to complete appendix 1: Brief Health Information (p 9-10) which can be completed by the respondent.

H 2. Date __ __/__ __/__ __ ***H 3. Case ID*** __ , __ __ __ , __ ***H 4. Participant No.*** __ __ , __ __ , __ __ __

Day Month Year CE or CS Case No. 1st or 2nd Evalu FTC Site Participant

A. DEMOGRAPHIC INFORMATION

A.1 NAME *(optional)* First _____ FAMILY_____

A.2 SEX (1) [ ] Female (2) [ ] Male

A.3 DATE OF BIRTH _ _/_ _/_ _ *(date/month/year)*

A.4 ADDRESS *(optional)*

A.5 YEARS OF FORMAL EDUCATION _ _

A.6 CURRENT MARITAL STATUS: *(Check only one that is most applicable)*

(1) Never married [ ] (4) Divorced [ ]
(2) Currently Married [ ] (5) Widowed [ ]
(3) Separated [ ] (6) Cohabiting [ ]

A.7 CURRENT OCCUPATION *(Select the single best option)*

(1) Paid employment [ ] (6) Retired [ ]
(2) Self-employed [ ] (7) Unemployed (health reason) [ ]
(3) Non-paid work, such as volunteer/charity [ ] (8) Unemployed (other reason) [ ]
(4) Student [ ] (9) Other [ ]
(5) Keeping house/House-maker [ ] *(please specify)* _____

A.8 MEDICAL DIAGNOSIS of existing Main Health Conditions, ***if possible give ICD Codes.***

1. No Medical Condition exists
2. ..... ICD code: __. __. __.__.
3. ..... ICD code: __. __. __.__.
4. ..... ICD code: __. __. __.__.
5. A Health Condition (disease, disorder, injury) exists, however its nature or diagnosis is not known

PART 1a: IMPAIRMENTS of BODY FUNCTIONS

- Body functions are the physiological functions of body systems (including psychological functions).
- Impairments are problems in body function as a significant deviation or loss

Qualifier:
Extent of impairments

0 No impairment, **1** Mild impairment, **2** Moderate impairment
3 Severe impairment, **4** Complete impairment, **8** Not specified
9 Not applicable

Short List of Body Functions	*Qualifier*
b1. MENTAL FUNCTIONS	
b110 Consciousness	
b114 Orientation *(time, place, person)*	
b117 Intellectual *(incl. Retardation, dementia)*	
b130 Energy and drive functions	
b134 Sleep	
b140 Attention	
b144 Memory	
b152 Emotional functions	
b156 Perceptual functions	
b164 Higher level cognitive functions	
b167 Language	
b2. SENSORY FUNCTIONS AND PAIN	
b210 Seeing	
b230 Hearing	
b235 Vestibular *(incl. Balance functions)*	
b280 Pain	
b3. VOICE AND SPEECH FUNCTIONS	
b310 Voice	
b4. FUNCTIONS OF THE CARDIOVASCULAR, HAEMATOLOGICAL, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS	
b410 Heart	
b420 Blood pressure	
b430 Haematological *(blood)*	
b435 Immunological *(allergies, hypersensitivity)*	
b440 Respiration *(breathing)*	
b5. FUNCTIONS OF THE DIGESTIVE, METABOLIC AND ENDOCRINE SYSTEMS	
b515 Digestive	
b525 Defecation	
b530 Weight maintenance	
b555 Endocrine glands *(hormonal changes)*	
b6. GENITOURINARY AND REPRODUCTIVE FUNCTIONS	
b620 Urination functions	
b640 Sexual functions	
b7. NEUROMUSCULOSKELETAL AND MOVEMENT RELATED FUNCTIONS	
b710 Mobility of joint	
b730 Muscle power **b735** Muscle tone	
b765 Involuntary movements	
b8. FUNCTIONS OF THE SKIN AND RELATED STRUCTURES	
ANY OTHER BODY FUNCTIONS	

Part 1 b: IMPAIRMENTS of BODY STRUCTURES

- Body structures are anatomical parts of the body such as organs, limbs and their components.
- Impairments are problems in structure as a significant deviation or loss.

First Qualifier: *Extent of impairment*	**Second Qualifier:** *Nature of the change*	**Third Qualifier** *(suggested):* *Location*
0 No impairment **1** Mild impairment **2** Moderate impairment **3** Severe impairment **4** Complete impairment **8** Not specified **9** Not applicable	**0** No change in structure **1** Total absence **2** Partial absence **3** Additional part **4** Aberrant dimensions **5** Discontinuity **6** Deviating position **7** Qualitative changes in structure, including accumulation of fluid **8** Not specified **9** Not applicable	**0** More than one region **1** right **2** left **3** both sides **4** front **5** back **6** proximal **7** distal

Short List of Body Structures	**First Qualifier:** *Extent of impairment*	**Second Qualifier:** *Nature of the change*	**Third Qualifier:** *Location*
s1. STRUCTURE OF THE NERVOUS SYSTEM			
s110 Brain			
s120 Spinal cord and peripheral nerves			
s2. THE EYE, EAR AND RELATED STRUCTURES			
s3. STRUCTURES INVOLVED IN VOICE AND SPEECH			
s4. STRUCTURE OF THE CARDIOVASCULAR, IMMUNOLOGICAL AND RESPIRATORY SYSTEMS			
s410 Cardiovascular system			
s430 Respiratory system			
s5. STRUCTURES RELATED TO THE DIGESTIVE, METABOLISM AND ENDOCRINE SYSTEMS			
s6. STRUCTURE RELATED TO GENITOURINARY AND REPRODUCTIVE SYSTEM			
s610 Urinary system			
s630 Reproductive system			
s7. STRUCTURE RELATED TO MOVEMENT			
s710 Head and neck region			
s720 Shoulder region			
s730 Upper extremity *(arm, hand)*			
s740 Pelvis			
s750 Lower extremity *(leg, foot)*			
s760 Trunk			
s8. SKIN AND RELATED STRUCTURES			
ANY OTHER BODY STRUCTURES			

PART 2: ACTIVITY LIMITATIONS & PARTICIPATION RESTRICTION

- *Activity is the execution of a task or action by an individual.. Participation is involvement in a life situation.*
- *Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may have in involvement in life situations.*

The Performance qualifier describes what an individual does in his or her current environment. Because the current environment brings in the societal context, performance can also be understood as "involvement in a life situation" or "the lived experience" of people in the actual context in which they live. This context includes the environmental factors – all aspects of the physical, social and attitudinal world that can be coded using the Environmental Factors.

The Capacity qualifier describes an individual's ability to execute a task or an action. This construct indicates the highest probable level of functioning that a person may reach in a given domain at a given moment. To assess the full ability of the individual, one would need to have a "standardized" environment to neutralize the varying impact of different environments on the ability of the individual. As standardized environment may be: (a) an actual environment commonly used for capacity assessment in test settings; or (b)where this is not possible, a hypothetical environment a uniform impact.

Note: Use Appendix 2 if needed to elicit information on the Activities and Participation of the individual

First Qualifier: ***Performance*** ***Extent of Participation Restriction***	**Second Qualifier:** ***Capacity (without assistance)*** ***Extent of Activity limitation***
0 No difficulty	**0** No difficulty
1 Mild difficulty	**1** Mild difficulty
2 Moderate difficulty	**2** Moderate difficulty
3 Severe difficulty	**3** Severe difficulty
4 Complete difficulty	**4** Complete difficulty
8 Not specified	**8** Not specified
9 Not applicable	**9** Not applicable

Short List of A&P domains	***Performance Qualifier***	***Capacity Qualifier***
d1. LEARNING AND APPLYING KNOWLEDGE		
d110 Watching		
d115 Listening		
d140 Learning to read		
d145 Learning to write		
d150 Learning to calculate *(arithmetic)*		
d175 Solving problems		
d2. GENERAL TASKS AND DEMANDS		
d210 Undertaking a single task		
d220 Undertaking multiple tasks		
d3. COMMUNICATION		
d310 Communicating with -- receiving -- spoken messages		
d315 Communicating with -- receiving -- non-verbal messages		
d330 Speaking		
d335 Producing non-verbal messages		
d350 Conversation		

Short List of A&P domains	*Performance Qualifier*	*Capacity Qualifier*
d4. MOBILITY		
d430 Lifting and carrying objects		
d440 Fine hand use *(picking up, grasping)*		
d450 Walking		
d465 Moving around using equipment *(wheelchair, skates, etc.)*		
d470 Using transportation *(car, bus, train, plane, etc.)*		
d475 Driving (riding bicycle and *motorbike, driving car, etc.)*		
d5. SELF CARE		
d510 Washing oneself *(bathing, drying, washing hands, etc)*		
d520 Caring for body parts *(brushing teeth, shaving, grooming, etc.)*		
d530 Toileting		
d540 Dressing		
d550 Eating		
d560 Drinking		
d570 Looking after one`s health		
d6. DOMESTIC LIFE		
d620 Acquisition of goods and services *(shopping, etc.)*		
d630 Preparation of meals *(cooking etc.)*		
d640 Doing housework *(cleaning house, washing dishes laundry, ironing, etc.)*		
d660 Assisting others		
d7. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS		
d710 Basic interpersonal interactions		
d720 Complex interpersonal interactions		
d730 Relating with strangers		
d740 Formal relationships		
d750 Informal social relationships		
d760 Family relationships		
d770 Intimate relationships		
d8. MAJOR LIFE AREAS		
d810 Informal education		
d820 School education		
d830 Higher education		
d850 Remunerative employment		
d860 Basic economic transactions		
d870 Economic self-sufficiency		
d9. COMMUNITY, SOCIAL AND CIVIC LIFE		
d910 Community Life		
d920 Recreation and leisure		
d930 Religion and spirituality		

d940 Human rights		
d950 Political life and citizenship		
ANY OTHER ACTIVITY AND PARTICIPATION		

PART 3: ENVIRONMENTAL FACTORS

- *Environmental factors make up the physical, social and attitudinal environment in which people liveand conduct their lives.*

Qualifier in environment:
Barriers or facilitator

0 No barriers — **0** No facilitator
1 Mild barriers — **+1** Mild facilitator
2 Moderate barriers — **+2** Moderate facilitator
3 Severe barriers — **+3** Substantial facilitator
4 Complete barriers — **+4** Complete facilitator

Short List of Environment	*Qualifier barrier or facilitator*
e1. PRODUCTS AND TECHNOLOGY	
e110 For personal consumption *(food, medicines)*	
e115 For personal use in daily living	
e120 For personal indoor and outdoor mobility and transportation	
e125 Products for communication	
e150 Design, construction and building products and technology of buildings for public use	
e155 Design, construction and building products and technology of buildings for private use	
e2. NATURAL ENVIRONMENT AND HUMAN MADE CHANGES TO ENVIRONMENT	
e225 Climate	
e240 Light	
e250 Sound	
e3. SUPPORT AND RELATIONSHIPS	
e310 Immediate family	
e320 Friends	
e325 Acquaintances, peers, colleagues, neighbours and community members	
e330 People in position of authority	
e340 Personal care providers and personal assistants	
e355 Health professionals	
e360 Health related professionals	
e4. ATTITUDES	
e410 Individual attitudes of immediate family members	
e420 Individual attitudes of friends	
e440 Individual attitudes of personal care providers and personal assistants	
e450 Individual attitudes of health professionals	
e455 Individual attitudes of health related professionals	
e460 Societal attitudes	
e465 Social norms, practices and ideologies	

E5. SERVICES, SYSTEMS AND POLICIES	
e525 Housing services, systems and policies	
e535 Communication services, systems and policies	
e540 Transportation services, systems and policies	
e550 Legal services, systems and policies	
e570 Social security, services, systems and policies	
e575 General social support services, systems and policies	
e580 Health services, systems and policies	
e585 Education and training services, systems and policies	
e590 Labour and employment services, systems and policies	
ANY OTHER ENVIRONMENTAL FACTORS	

Part 4: OTHER CONTEXTUAL INFORMATION

4. 1 *Give a thumbnail sketch of the individual and any other relevant information.*

4.2 *Include any* ***Personal Factors*** *as they impact on functioning (e.g. lifestyle, habits, social background, education, life events, race/ethnicity, sexual orientation and assets of the individual).*

Appendix 1:

BRIEF HEALTH INFORMATION

[ ] Self Report **[ ] Clinician Administered**

X.1 Height : __/__/__ cm *(or inches)*

X.2 Weight: __/__/__ kg *(or pounds)*

X.3 Dominant Hand *(prior to health condition)*: Left [ ] Right [ ] Both hands equally [ ]

X.4 How do you rate your physical health in the past month?

Very good [ ] Good [ ] Moderate [ ] Bad [ ] Very bad [ ]

X.5 How do you rate your mental and emotional health in the past month?

Very good [ ] Good [ ] Moderate [ ] Bad [ ] Very bad [ ]

X.6 Do you currently have any disease(s) or disorder(s) ?

[ ] NO [ ] YES

If YES, please specify: _____

_____

X.7 Did you ever have any significant injuries that had an impact on your level of functioning?

[ ] NO [ ] YES

If YES, please specify _____

_____

X.8 Have you been hospitalized in the last year?

[ ] NO [ ] YES

If YES, please specify reason(s) and for how long?

1. _____; ___. ___. ___ days
2. _____; ___. ___. ___ days
3. _____; ___. ___. ___ days

X.9 Are you taking any medication (either prescribed or over the counter)?

[ ] NO [ ] YES

If YES, please specify major medications

1. _____
2. _____
3. _____

X.10 Do you smoke?

[ ] NO [ ] YES

X.11 Do you consume alcohol or drugs?

[ ] NO [ ] YES

If YES, please specify average daily quantity

Tobacco: _____
Alcohol: _____
Drugs: _____

X.12 Do you use any assistive device such as glasses, hearing aid, wheelchair, etc.?

[ ] NO [ ] YES

If YES, please specify

_____

X.13 Do you have any person assisting you with your self care, shopping or other daily activities?

[ ] NO [ ] YES

If YES, please specify person and assistance they provide

_____

X.14 Are you receiving any kind of treatment for your health?

[ ] NO [ ] YES

If YES, please specify:

_____

X.15 Additional significant information on your past and present health:

_____

_____

X.16 IN THE PAST MONTH, have you cut back (i.e. reduced) your usual activities or work because of your *health condition*? (a disease, injury, emotional reasons or alcohol or drug use)

[ ] NO [ ] YES If yes, how many days? _____

X.17 IN THE PAST MONTH, have you been totally unable to carry out your usual activities or work because of your *health condition*? (a disease, injury, emotional reasons or alcohol or drug use)

[ ] NO [ ] YES If yes, how many days? _____

Appendix 2:

GENERAL QUESTIONS FOR PARTICIPATION & ACTIVITIES

The following probes are proposed as a guide to help the examiner when interviewing the respondent about problems in functioning and life activities, in terms of the distinction between capacity and performance Take into account all personal information known about the respondent and ask any additional probes as necessary. Probes should be rephrased as openended questions if necessary to elicit greater information.

Under each domain there are two kinds of probes:

The first probe tries to get the respondent to focus on his or her ***capacity*** *to do a task or action, and in particular to focus on limitations in capacity that are* ***inherent or intrinsic features of the person*** *themselves. These limitations should be direct manifestations of the respondent's health state, without the assistance. By* ***assistance*** *we mean the help of another person, or assistance provided by an adapted or specially designed tool or vehicle, or any form of environmental modification to a room, home, workplace and so o. The level of capacity should be judged relative to that normally expected of the person, or the person's capacity before they acquired their health condition.*

The second probe focuses on the respondent's ***actual performance*** *of a task or action in the*
person's actual situation or surroundings, and elicits information about the effects of environmental barriers or facilitators. It is important to emphasize that you are only interested in the extent of difficulty the respondent has in doing things, ***assuming that they want to do them****. Not doing something is irrelevant if the person chooses not to do it.*

I. Mobility

(Capacity)

(1) In your present state of health, how much difficulty do you have walking long distances (such as a kilometer or more) without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present surroundings, how much of a problem do you actually have in walking long distances (such as a kilometer or more)?

(2) Is this problem walking made worse, or better, by your actual surroundings?

(3) Is your capacity to walk long distances without assistance more or less than what you actually do in your present surroundings?

II. Self Care

(Capacity)

(1) In your present state of health, how much difficulty do you have washing yourself, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your own home, how much of a problem do you actually have washing yourself?

(2) Is this problem made worse, or better, by the way your home is set up or the specially adapted tools you use?

(2) Is your capacity to wash yourself without assistance more or less than what you actually do in your present surroundings?

III. Domestic Life

(Capacity)

(1) In your present state of health, how much difficulty do you have cleaning the floor of your where you live, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your own home, how much of a problem do you actually have cleaning the floor?

(2) Is this problem made worse, or better, by the way your home is set up or the specially adapted tools you use?

(3) Is your capacity to clean your floor without assistance more or less than what you actually do in your present surroundings?

IV. Interpersonal Interactions

(Capacity)

(1) In your present state of health, how much difficulty do you have making new friends, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present situation, how much of a problem do you actually have making friends?

(2) Is this problem making friends made worse, or better, by anything (or anyone) in your surroundings?

(4) Is your capacity to make friends, without assistance, more or less than what you actually do in your present surroundings?

V. Major Life Areas

(Capacity)

(1) In your present state of health, how much difficulty do you have getting done all the work you need to do for your job, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your present surroundings, how much of a problem do you actually have getting done all the work you need to do for your job?

(2) Is this problem fulfilling your job requirements made worse, or better, by the way the work environment is set up or the specially adapted tools you use?

(3) Is your capacity to do your job, without assistance, more or less than what you actually do in your present surroundings?

VI. Community, Social and Civic Life

(Capacity)

(1) In your present state of health, how much difficulty do you have participating in community gatherings, festivals or other local events, without assistance?

(2) How does this compare with someone, just like yourself only without your health condition?

(Or: "...than you had before you developed your health problem or had the accident?)

(Performance)

(1) In your community, how much of a problem do you actually have participating in community gatherings, festivals or other local events?

(2) Is this problem made worse, or better, by the way your community is arranged or the specially adapted tools, vehicles or whatever you use?

(3) Is your capacity to participate in community events, without assistance, more or less than what you actually do in your present surroundings?

Appendix 3:

GUIDELINES FOR THE USE OF ICF CHECKLIST VERSION 2.1A

1. This is a checklist of major categories of International Classification of Functioning, Disability and Health (ICF) of the World Health Organization . The ICF Checklist is a practical tool to elicit and record information on the functioning and disability of an individual. This information can be summarized for case records (for example, in clinical practice or social work).

2. This version (2.1a) is for use by a clinician, health or social care professional.

3. The checklist should be used along with the ICF full or short version which is scheduled for publication in September 2001. Until then the ICIDH-2 Final Draft, full version, WHO, 2001 will serve as reference document for the ICF checklist. The raters should familiarize themselves with the ICIDH-2 Final Draft by attending a brief educational programme or self-taught curriculum.

4. All information from written records, primary respondent, other informants and direct observation can be used to fill in the checklist. Please record all sources of information used on the first page.

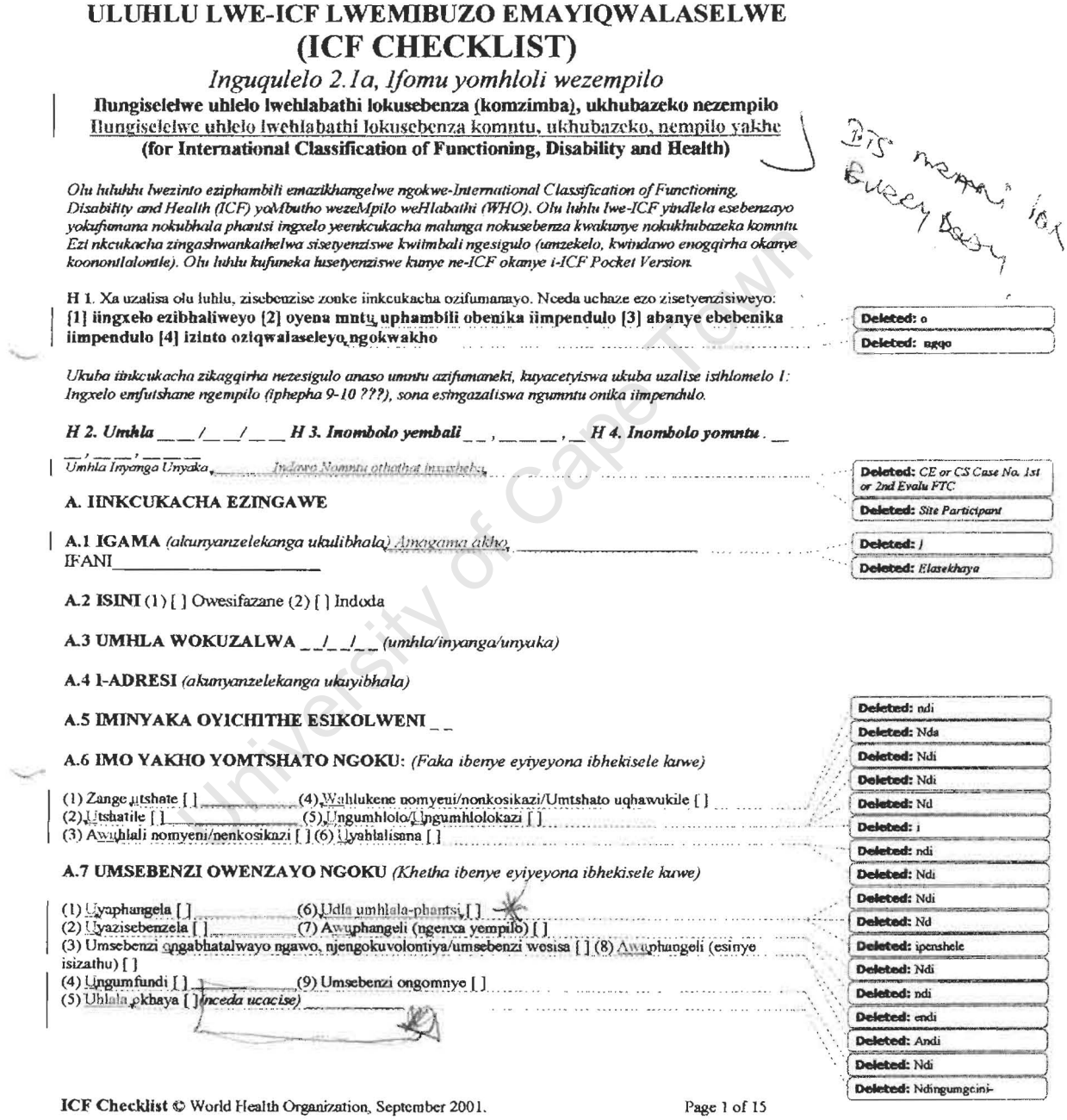
5. Parts 1 to 3 should be filled in by writing the qualifier code against each of the function,
structure, activity and participation term that shows some problem for the case being evaluated. Appropriate codes for the qualifiers are given on the relevant pages.

6. Comments can be made regarding any information that can serve as the additional qualifier or that is thought to be significant for the case being evaluated.

7. Part 4 (Environment) has both negative (barrier)and positive (facilitator) qualifier codes. For all positive qualifier codes, please use a plus (+) sign before the code.

8. The categories given in the checklist have been selected from the ICF and are not exhaustive. If you need to use a category that you do not find listed here, use the space at the end of each dimension to record these.

Appendix II – The translation spreadsheet



ULUHLU LWE-ICF LWEMIBUZO EMAYIQWALASELWE

(ICF CHECKLIST)

Inguqulelo 2.1a, Ifomu yomhloli wezempilo

Ilungiselelwe uhlelo lwehlabathi lokusebenza (komzimba), ukhubazeko nezempilo

Ilungiselelwe uhlelo lwehlabathi lokusebenza komntu, ukhubazeko, nempilo yakhe

(for International Classification of Functioning, Disability and Health)

Olu luluhlu lwezinto eziphambili emazikhangelwe ngokwe-International Classification of Functioning, Disability and Health (ICF) yoMbutho wezeMpilo weHlabathi (WHO). Olu luhlu lwe-ICF yindlela esebenzayo yokufumana nokubhala phantsi ingxelo yeenkcukacha malunga nokusebenza kwakunye nokukhubazeka komntu. Ezi nkcukacha zingashwankathelwa sisetyenziswe kwiimbali ngesigulo (umzekelo, kwindawo enogqirha okanye koonontlalontle). Olu luhlu kufuneka lusetyenziswe kunye ne-ICF okanye i-ICF Pocket Version.

H 1. Xa uzalisa olu luhlu, zisebenzise zonke iinkcukacha ozifumanayo. Nceda uchaze ezo zisetyenzisiweyo:
[1] iingxelo ezibhaliweyo [2] oyena mntu uphambili obenika iimpendulo [3] abanye ebebenika iimpendulo [4] izinto oziqwalaseleyo ngokwakho

Ukuba iinkcukacha zikaggirha nezesigulo anaso umntu azifumaneki, kuyacetyiswa ukuba uzalise isthlomelo 1: Ingxelo emfutshane ngempilo (iphepha 9-10 ???), sona esingazaliswa ngumntu onika iimpendulo.

H 2. Umhla ___/___/___ ***H 3. Inombolo yembali*** _ _ , _ _ _ _ , _ _ ***H 4. Inombolo yomntu*** . _ _ , _ _ _ , _ _ _ _

Umhla Inyanga Unyaka *Indawo Nomntu othotha inxwebela*

A. IINKCUKACHA EZINGAWE

A.1 IGAMA *(akunyanzelekanga ukulibhala)* *Amagama akho* _____
IFANI_____

A.2 ISINI (1) [ ] Owesifazane (2) [ ] Indoda

A.3 UMHLA WOKUZALWA _ _/_ _/_ _ *(umhla/inyanga/unyaka)*

A.4 I-ADRESI *(akunyanzelekanga ukuyibhala)*

A.5 IMINYAKA OYICHITHE ESIKOLWENI _ _

A.6 IMO YAKHO YOMTSHATO NGOKU: *(Faka ibenye eyiyeyona ibhekisele kuwe)*

(1) Zange utshate [ ] (4) Wahlukene nomyeni/nonkosikazi/Umtshato uqhawukile [ ]
(2) Utshatile [ ] (5) Ungumhlolo/Ungumhlolokazi [ ]
(3) Awuhlali nomyeni/nenkosikazi [ ] (6) Uyahlalisana [ ]

A.7 UMSEBENZI OWENZAYO NGOKU *(Khetha ibenye eyiyeyona ibhekisele kuwe)*

(1) Uyaphangela [ ] (6) Udla umhlala-phantsi [ ]
(2) Uyazisebenzela [ ] (7) Awuphangeli (ngenxa yempilo) [ ]
(3) Umsebenzi ongabhatalwayo ngawo, njengokuvolontiya/umsebenzi wesisa [ ] (8) Awuphangeli (esinye isizathu) [ ]
(4) Ungumfundi [ ] (9) Umsebenzi ongomnye [ ]
(5) Uhlala ekhaya [ ] *(nceda ucacise)* _____

ICF Checklist © World Health Organization, September 2001. Page 1 of 15

Deleted: o
Deleted: ngqo
Deleted: CE or CS Case No. 1st or 2nd Evalu FTC
Deleted: Site Participant
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A.8 Isigulo esiphambili onaso NGOKWENGXELO KAGQIRHA, *ukuba unako, nika iikhowudi ngokwe-ICD.*

1. Akukho sigulo onaso
2. ..... Ikhowudi ngokwe-ICD: __. __
__. __ __
3. ..... Ikhowudi ngokwe-: __. __.
__. __ __
4. ..... Ikhowudi ngokwe-: __. __.
__. __ __
5. Sikhona isigulo onaso (isigulo/isifo, ukhubazeko, umenzakalo) kodwa asivuxilongwanga ngugqirha ngaso

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Deleted: kusebenza kwamalungu

ICANDELO 1a: UKUKHUBAZEKA NGOKUSEBENZA KOMZIMBA

- Xa kuthethwa ngemisebenzi yomzimba kuthethwa ngemisebenzi yezixokelelwano zomzimba *(body systems)* (oku kubandakanya nemisebenzi yengqondo).
- Ukukhubazeka kuthetha iingxaki ekusebenzeni umzimba kuba ilungu elithile lomzimba lisebenza ngendlela engatshongo khona/*eyaklukileyo/enxaxhileyo* okanye ilungu elo lingekho konke.

Inkcazelo: **0** Alukho ukhubazeko. **1** Ukhubazeko luphantsi kakhulu, **2** Ukhubazeko luphakathi nje
Ubungakanani bokhubazeko **3** Ukhubazeko olubi **4** Ukhubazeko olupheleleyo, **8** Aluchazangwa **9** Alubhekiselanga kuwe

Uludwe olufutshane lwemisebenzi yomzimba	***Inkcazelo***
b1. IMISEBENZI YENGQONDO	
b110 Ukuba sezingqondweni	
b114 Ukuqonda apho ukhoyo *(ixesha, indawo, umntu)*	
b117 Ingqiqo *(kubandakanya ukudodobala ingqondo nokungabi nangqondo (igeza))*	
b130 Amandla, ukukhuthala nodlamko	
b134 Ukulala	
b140 Ukugqalisela/ukumamela ngenyameko/Ukumisa ingqondo	
b144 Ukukhumbula izinto	
b152 Uvakalelo	
b156 Ukuqonda nokuqwalasela izinto	
b164 Ukuqonda izinto ezintsokothileyo/kwinqanaba eliphezulu	
b167 Intetho/Ulwimi	
b2. IMISEBENZI "YEMITHAMBO-LUVO" KUNYE NEENTLUNGU	
b210 Ukubona	
b230 Ukuva (ngeendlebe)	
b235 Ukuchathisa	
b280 Iintlungu	
b3. ILIZWI KUNYE NENTETHO	
b310 Ilizwi	
b4. IMISEBENZI YENTLIZIYO, EYEGAZI ("UKOPHA"), IZIKHUSELI-MZIMBA NEYEMIPHUNGA/NEYOKUPHEFUMLA	
b410 Intliziyo	
b420 Amandla elihamba ngawo igazi emithanjeni/i*Blood pressure*	
b430 Igazi	
b435 Izikhuseli-mzimba *(izinto ezingahambelani nomzimba, uvakalelo olubukhali/hypersensitivity)*	
b440 Ukuphefumla	
b5. IMISEBENZI YESISU (YOMXOKOMEZELO WOMETYISO), EYOKUGUQULWA KOKUTYA EMZIMBENI NEYAMADLALA OMZIMBA	
b515 Ukwetyiswa kokutya	
b525 Ukuzithuma	
b530 Ukugcina ubunzima bomzimba wakho	
b555 Amadlala *(iinguqu ezenzeka ngenxa yamadlala)*	
b6. IMISEBENZI YAMALUNGU OKUNTSONTSA NOKUZALA	
b620 Ukuntsontsa	
b640 Isondo/Ukulalana	

Appendix III – Example of transcript of deliberation
Meeting on 18 August at 19h00 – 3rd tape
Present : MT, SG, PM

Section 1b – it was discussed whether to sue elixaxhileyo or elahlukileyo and one suggested that a check-up can be done on section A to conform which word to use to be consistent and elahlukileyo was then used . It was agreed that one must look at the first translated version and the other look at the second translated version for easy comparison and it was noted that the 1st translator skipped other words.
Section 1b – 1st qualifier – the extent of disability
Second qualifier – the status of change in the body, here it was discussed whether there was total absence or partial absence or there is an additional part. It was debated whether to use limb or organ and the dictionary was consulted and both words were found to be correct.
Third qualifier – proximity of the limb to the body. It was clarified that the distance referred to here is the actual impairment from the body eg. one with fingers that are not working: the fingers are far from the body whereas the shoulder is near. It was also said that in Xhosa there is no specification when we talk in every day language as we don't talk about impairment that is far away or near it is just an impairment/disability.
Uhamba upetyeka ukuqina kwezihlunu muscle strength eg. people who has a low muscle tone, the first translator wrote muscle tone ithoni yesihlunu which a person will not understand. One suggested that itoni yesihlunu be used and at this point muscle tension was checked on the dictionary. It was agreed to use voluntary movement of the body parts.

Functions of the Skin and Related Structures

B8 functions of the skin and related parts. It was suggested that we put albinism also but it was said it was going to be difficult because this is a condition where a child is born with, it is deeper. Functions of the skin and relation structures – Imisebenzi yolusu, you do get a lot of pigmentation – umntu ongenalidalibala here it was noted that no one will understand this and one suggested that albinism (Inkawu) be put in brackets but also this did not sound right. There are protective functions of the skin and afterwards in brackets albinism must be added as this survey has to be educative as well. Imisebenzi yokukhusela ulusu. The protective functions of the skin became difficult to translate because there are two adjectives (functions of the protective of the skin) explained that it is the skin that is being protected and also it was said that it means that it is the skin that is protecting then was agreed to say imisebenzi yolusu ekhuselayo changed to say imisebenzi ekhuselayo yolusu and in brackets i-Albino was to be added as an example. It was noted that this is an interesting condition as there is stigma attached as well as disability.

B515 Ukwetyiswa kokutya. Ukwetyiswa has to be used with food not alone because even when a cow is chewing its cut we cay iyetyisa.

B525 Ukuzithuma – sitting privately in the toilet

Genitourinary and Reproductive Functions
B6 functions of the genital part: urinary and reproductive. The word ukuntsontsa whih was used on the 1st translated version was found to be polite and it was agreed to change it to ukuchama as it is known that Xhosa is not a polite language in its nature.
B640 Sexual function – Isondo/ukulalana. One of the participants was not happy with b640 because it did not differentiate between sexual and reproductive functions and this distinction was fond to be very important. Differentiating between having intercourse and having children (giving birth) is very especially in our culture. The sentence only said sexual functions, it did not have genital and reproductive functions and it was suggested that one has to be put in because even when surveys on the equality of life are done people often say for example "not sexual functions but having children". It was suggested to make a note on the red book that b6 is confining although it is broad it does not cover reproduction. Due to the importance of reproduction it was suggested that it be included on the checklist as b660.

B310 functions of voice and speech. The 1st translator wrote imisebenzi yeliswi nokuthetha and the word ukuthetha was found to be incorrect in this context as it means to talk and the word intetho meaning speech was used.

Functions of the heart, blood, immune system, lungs for breathing. In the discussion it was stated that it is not just the heart because one might be having problems with blood vessels. In response one said that for any cardio-vascular ailment, people will say it is the heart or can say it's the chest and not being aware that it is more than that. One mentioned anything that is cardio-vascular is referred to as the heart. It was agreed to say the functions of the vessels. When asking people about the heart, one can then go deeper and ask about the conditions of the heart and go on asking whether the person has a heart condition, low/high blood pressure or any heart disease or disorder.
B420 blood pressure: one mentioned the word uxinizelelo but it was said that it will not be correct because it means concentration whereas the sentence mean the rate at which the blood travels in the veins.

Appendix IV – IsiXhosa version of the ICF checklist

ULUHLU LWE-ICF LWEMIBUZO EMAYIQWALASELWE

(ICF CHECKLIST)

Inguqulelo 2.1a, Ifomu yomhloli wezempilo
Ilungiselelwe uhlelo lwehlabathi lokusebenza (komzimba), ukhubazeko nezempilo
Ilungiselelwe uhlelo lwehlabathi lokusebenza komntu, ukhubazeko, nempilo yakhe
(for International Classification of Functioning, Disability and Health)

Olu luluhlu lwezinto eziphambili emazikhangelwe ngokwe-International Classification of Functioning, Disability and Health (ICF) yoMbutho wezeMpilo weHlabathi (WHO). Olu luhlu lwe-ICF yindlela esebenzayo yokufumana nokubhala phantsi ingxelo yeenkcukacha malunga nokusebenza kwakunye nokukhubazeka komntu. Ezi nkcukacha zingashwankathelw zisetyenziswe kwiimbali ngesigulo (umzekelo, kwindawo enogqirha okanye koonontlalontle). Olu luhlu kufuneka lusetyenziswe kunye ne-ICF okanye i-ICF Pocket Version.

H 1. Xa uzalisa olu luhlu, zisebenzise zonke iinkcukacha ozifumanayo. Nceda uchaze ezo zisetyenzisiweyo:
[1] iingxelo ezibhaliweyo [2] oyena mntu uphambili obenika iimpendulo [3] abanye ebebenika iimpendulo [4] izinto oziqwalaseleyo ngokwakho

Ukuba iinkcukacha zikagqirha nezesigulo anaso umntu azifumaneki, kuyacetyiswa ukuba uzalise isihlomelo 1: Ingxelo emfutshane ngempilo (iphepha 12-14), sona esingazaliswa ngumntu onika iimpendulo.

H 2. Umhla __ __/__ __/__ __ ***H 3. Inombolo yembali*** __ __ , __ __ __ , __ ***H 4. Inombolo yomntu .***
__ __ ' __ __ ' __ __ __
Umhla Inyanga Unyaka *Indawo Nomntu othathat inxaxheba*

A. IINKCUKACHA EZINGAWE

A.1 IGAMA *(akunyanzelekanga ukulibhala) Amagama akho* _____
IFANI_____

A.2 ISINI (1) [ ] Owesifazane (2) [ ] Indoda

A.3 UMHLA WOKUZALWA __/__/__ *(umhla/inyanga/unyaka)*

A.4 I-ADRESI *(akunyanzelekanga ukuyibhala)*

A.5 IMINYAKA OYICHITHE ESIKOLWENI __

A.6 IMO YAKHO YOMTSHATO NGOKU: *(Faka ibenye eyiyeyona ibhekisele kuwe)*

(1) Zange utshate [ ]
(2) Utshatile [ ]
(3) Awuhlali nomyeni/nenkosikazi [ ]
(4) Wahlukene nomyeni/nonkosikazi/Umtshato uqhawukile [ ]
(5) Ungumhlolo/Ungumhlolokazi [ ]
(6) Uyahlalisana [ ]

A.7 UMSEBENZI OWENZAYO NGOKU *(Khetha ibenye eyiyeyona ibhekisele kuwe)*

(1) Uyaphangela [ ] (6) Udla umhlala-phantsi [ ]
(2) Uyazisebenzela [ ] (7) Awuphangeli (ngenxa yempilo) [ ]
(3) Umsebenzi ongabhatalwayo ngawo, njengokuvolontiya/umsebenzi wesisa [ ] (8) Awuphangeli (esinye isizathu) [ ]
(4) Ungumfundi [ ] (9) Umsebenzi ongomnye [ ]
(5) Umgcini-khaya (ukuhlala ekhaya) [ ]*(nceda ucacise)* _____

A.8 Isigulo esiphambili onaso NGOKWENGXELO KAGQIRHA, *ukuba unako, nika iikhowudi ngokwe-ICD.*

1. Akukho sigulo unaso
2. ..... Ikhowudi ngokwe-ICD: __. __. __.__. __
3. ..... Ikhowudi ngokwe-: __. __. __.__. __
4. ..... Ikhowudi ngokwe-: __. __. __.__. __
5. Sikhona isigulo onaso (isigulo/isifo, ukhubazeko, umenzakalo) kodwa awuxilongwanga ngugqirha ngaso

ICANDELO 1a: UKUKHUBAZEKA NGOKUSEBENZA KOMZIMBA

- Xa kuthethwa ngemisebenzi yomzimba kuthethwa ngemisebenzi yezixokelelwano zomzimba *(body sytems)*, (oku kubandakanya nemisebenzi yengqondo).
- Ukukhubazeka kuthetha iingxaki ekusebenziseni umzimba kuba ilungu elithile lomzimba lisebenza ngendlela eyahlukileyo okanye ilungu elo lingekho konke.

Inkcazelo: **0** Alukho ukhubazeko, **1** Ukhubazeko luphantsi kakhulu, **2** Ukhubazeko luphakathi nje
Ubungakanani bokhubazeko **3** Ukhubazeko olungamandla **4** Ukhubazeko olupheleleyo, **8** Aluchazangwa
9 Alubhekiselanga kuwe

Uluhlu olufutshane lwemisebenzi yomzimba	***Inkcazelo***
b1. IMISEBENZI YENGQONDO	
b110 Ukuba sezingqondweni	
b114 Ukuqonda apho ukhoyo *(ixesha, indawo, umntu)*	
b117 Ingqiqo *(kubandakanya ukudodobala ingqondo nokungabikho sezingqonweni)*	
b130 Amandla, ukukhuthala nodlamko	
b134 Ukulala	
b140 Ukumisa ingqondo	
b144 Ukukhumbula izinto	
b152 Uvakalelo	
b156 Ukuqonda nokuqwalasela izinto	
b164 Ukuqonda izinto ezintsokothileyo kwinqanaba eliphezulu	
b167 Intetho/Ulwimi	
b2. IMISEBENZI YEMITHAMBO-LUVO KUNYE NEENTLUNGU	
b210 Ukubona	
b230 Ukuva (ngeendlebe)	
b235 Ukuba nesiyezi/ukugxadazela *(vestibular)*	
b280 Iintlungu	
b3. IMISEBENZI YELIZWI KUNYE NENTETHO	
b310 Ilizwi	
b4. UKUSEBENZA KWENTLIZIYO, NEGAZI, NEZIKHUSELI-MZIMBA NOKUPHEFUMLA	
b410 Intliziyo	
b420 Amandla elihamba ngawo igazi emithanjeni/i*Blood pressure*	
b430 igazi	
b435 Izikhuseli-mzimba/*Immune system (izinto ezingahambelani nomzimba)*	
b440 Ukusebenza kwemiphunga (Ukuphefumla)	
b5. IMISEBENZI YESISU (YOMXOKOMEZELO WOMETYISO) , EYOKUGUQULWA KOKUTYA EMZIMBENI NEYAMADLALA OMZIMBA	
b515 Ukwetyiswa kokutya	
b525 Ukuzithuma	
b530 Ukugcina ubunzima bomzimba wakho	
b555 Amadlala *(iinguqu ezenzeka ngenxa yamadlala)*	
b6. IMISEBENZI YAMALUNGU OKUCHAMA NAWOKUZALA	

b620 Ukuchama	
b640 Isondo/Ukulalana **b660 Ukufumana abantwana**	
b7. IMISEBENZI YEMITHAMBO-LUVO, IZIHLUNU, AMATHAMBO KUNYE NENXULUMENE NEENTSHUKUMO	
b710 Ukushukuma kwalapho kudibana khona amalungu	
b730 Amandla ezihlunu **b735** Ukutyhafa nokuqina kwezihlunu	
b765 Ukuzishukumela kwamalungu	
b8. IMISEBENZI YOLUSU NEYAWAMANYE AMALUNGU ANXULUMENEYO	
B810 Imisebenzi ekhuselayo yoluso (i-albinism)	
NAWUPHI NA OMNYE UMSEBENZI WOMZIMBA	

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Icandelo 1 b: UKUKHUBAZEKA KWAMALUNGU OMZIMBA

- Amalungu omzimba ngamalungu afana, umzekelo, nengalo, umlenze, njalo njalo.
- Ukukhubazeka kuthetha iingxaki kwilungu elithile lomzimba ngenxa yokuba ***lahlukile*** okanye lingekho.

Inkcazelo yokuqala: ***Ubungakanani bokhubazeko***	**Inkcazelo yesibini:** ***Isimo senguqu***	**Inkcazelo yesithathu** ***(iyacetyiswa):*** ***Apho lukhoyo***
0 Alukho ukhubazeko **1** Ukhubazeko luphantsi kakhulu **2** Ukhubazeko luphakathi nje **3** Ukhubazeko olungamandla **4** Ukhubazeko olupheleleyo **8** Aluchazwanga **9** Alubhekiselanga kuwe	**0** Akukho nguqu kwilungu **1** Alikho kwaphela **2** Inxenye yelungu ayikho **3** Ilungu elongezelelweyo **4** Ukungalingani okusisikhwasilima? **5** Ukungapheleli kwelungu **6** Ukunxaxha kwelungu **7** Iinguqu eziphawulekayo kumalungu, oku kubandakanya ukuqokelelana kwamanzi endaweni enye **8** Aluchazwanga **9** Alubhekiselanga kuwe	**0** Ngaphezu kwendawo enye **1** ekunene **2** ekhohlo **3** kumacala omabini **4** ngaphambili **5** ngasemva **6** lukufuphi ***(proximal)*** **7** lukude ***(distal)***

Uluhlu olufutshane lwamalungu omzimba	**Inkcazelo yokuqalar:** ***Ubungakanani bokhubazeko***	**Inkcazelo yesibinir:** ***Isimo senguqu***	**Inkcazelo yesithathu:** ***Apho ikhoyo***
s1. UBUME BEMITHAMBO-LUVO			
s110 Ubuchopho			
s120 Umnqonqo kunye nemithambo-luvo esemacaleni			
s2. IMEHLO, INDLEBE KUNYE NAMANYE AMALUNGU ANXULUMENEYO			
s3. AMALUNGU ASEBENZA EKUKHUPHENI ILIZWI NENTETHO			
s4. UKUSEBENZA KOMXOKOMEZELO WENTLIZIYO, WEZIKHUSELI-MZIMBA KUNYE NOWOKUPHEFUMLA			
S410 Umxokomezelo wentliziyo nokuhamba kwegazi			
S430 Umxokomezelo wokuphefumla			
s5. UBUMEBOMXOKOMEZELO WOMETYISO, NOWOKUGUQULWA KOKUTYA EMZIMBENI NOBAMADLALA OMZIMBA			
s6. AMALUNGU ANXULUMENE NOMXOKOMEZELO WOKUCHAMA NOKUZALA			
s610 Umxokomezelo wokuchama			
s630 Umxokomezelo wokuzala			
s7. UBUME BAMALUNGU ANXULUMENE NENTSHUKUMO			
s710 Ummandla wentloko nentamo			
s720 Ummandla wamagxa			
s730 Umntla *(ingalo, isandla)*			
s740 Amanqe			
s750 Amazantsi *(Umlenze, unyawo)*			
s760 Isiqu			
s8. ULUSU NOKUNYE OKUNXULUMENEYO			

NAWO NAWAPHI NA AMANYE AMALUNGU OMZIMBA			

ICANDELO 2: UBUNZIMA BOKWENZA IZINTO NEENGXAKI EZIFUNYANWA NGUMNTU EKUTHATHENI INXAXHEBA KWIZINTO ZOBOMI

- *Ukwenza kuthetha ukwenziwa kwento ethile ngumntu. Ukuthatha inxaxheba kuthetha ukuzibandakanya kwizinto zobomi.*
- *Ukungabi nako ukuwenza kakuhle umsebenzi kuthetha ubunzima obuthi bufunyanwe ngumntu xa esenza umsebenzi othile. Imiqobo ekuthatheni inxaxheba kuthetha iingxaki umntu angathi abe nazo ekuzibandakanyeni kwizinto zobomi .*

Inkcazelo yokwenziwa komsebenzi kuchaza oko kwenziwa ngumntu kwindawo akuyo ngoku. Kuba indawo akuyo umntu ngeli xesha ibonisa imeko akuyo kwezentlalo, ukwenziwa komsebenzi kungathetha "ukubandakanyeka kwizinto zobomi" okanye "amava okuphila" abanawo abantu kwiimeko zokwenene abaphila kuzo. Le meko ibandakanya zonke izinto ezibangqongileyo – zonke izinto ezibambekayo zemvelo, ezentlalo, iingcinga nokuziphatha kwabantu, nto ezo ezinokuqukwa phantsi kwezinto zendalo nezingqongileyo.

Inkcazelo yokubanamandla okwenza izinto ichaza indlela umntu akwazi ngayo ukwenza umsebenzi okanye isenzo esithile. Oku kuthetha into umntu angayenza ngokugqibeleleyo kummandla othile ngexesha elithile. Ukuze umntu abe nako ukuhlola izinto anako ukuzenza ngokupheleleyo, kufuneka abe kwindawo "esemgangathweni" omisiweyo ukuze kuthothiswe ifuthe elinokubangwa ziimeko ezahlukileyo zokusingqongileyo ekwenzeni izinto ngumntu okhubazekileyo. Indawo esingqongileyo esemgangathweni ingathetha: (a) indawo yokwenene eqhele ukusetyenziswa ukuhlola amandla omntu ekwenzeni izinto ; okanye (b) apho oku kungakwazekiyo ukwenzeka, indawo elinganisa indawo yekwenyani

Qaphela: Sebenzisa Isihlomelo 2 ukuba ufuna ukufumana ulwazi ngokwenza izinto nokuthatha inxaxheba komntu

Inkcazelo yokuqala: Ukwenziwa komsebenzi ***Ubungakanani bemiqobo ekuthabatheni inxaxheba***	**Inkcazelo yesibini:*Amandla okwenza izinto (ngaphandle koncedo)*** ***Ubungakanani ekuthintelekeni ekwenzeni izinto***
0 Akukho nzima **1** Kunzima kancinci **2** Kunzima phakathi nje **3** Kunzima kakhulu **4** Kunzima kwaphela (awukwazi ukuyenza) **8** Akuchazangwa **9** Akubhekiselanga kuwe	**0** Akukho nzima **1** Kunzima kancinci **2** Kunzima phakathi nje **3** Kunzima kakhulu **4** Kunzima kwaphela (awukwazi ukuyenza) **8** Akuchazangwa **9** Akubhekiselanga kuwe

Uluhlu olufutshane: Ukwenziwa kwezinto nokuthatha inxaxheba	***Inkcazelo yokwenziwa kwezinto***	***Inkcazelo ngamandla okwenza izinto***
d1. UKUFUNDA NOKUSEBENZISA ULWAZI		
D110 Ukubukela		
D115 Ukumamela		
D140 Ukufunda ukufunda okubhaliweyo		
D145 Ukufunda ukubhala		
D150 Ukufunda ukubala *(izibalo)*		
D175 Ukusombulula iingxaki		

d2. IMISEBENZI NGOKUBANZI NEZINTO EZIYIMFUNEKO EKUPHUMEZENI IMISEBENZI		
D210 Ukwenza umsebenzi omnye		
D220 Ukwenza imisebenzi emininzi ngaxeshanye okanye ngokulandelelana		
Uluhlu olufutshane: Ukwenziwa kwezinto nokuthatha inxaxheba	***Inkcazelo yokwenziwa komsebenzi***	***Inkcazelo ngamandla okwenza izinto***
d3. UNXIBELELWANO		
D310 Ukunxibelelana ngentetho nokwamkela imiyalezo ethethwa ngomlomo		
d315 Ukunxibelelana nokwamkela imiyalezo engathethwa ngomlomo		
d330 Ukuthetha		
d335 Ukunika imiyalelo ngomzimba okanye ngaphandle kwamazwi		
d350 Ukuncokola		
d4. INTSHUKUMO NEMO YOKUHAMBA		
d430 Ukuphakamisa nokuphatha izinto (umz. ukuphatha into uyise kwenye indawo)		
d440 Ukusebenzisa isandla **ukuphatha izinto ezincinci***(ukususa izinto, ukubamba)*		
d450 Ukuhamba		
d465 Ukuhamba usebenzisa izinto zokunceda ukuhamba *(*iwheelchair [isitulo esinamavili], ii*skates, njalo njalo.)*		
d470 Ukusebenzisa izithuthi zokuhamba *(imoto, ibhasi, uloliwe/itreyini, inqwelomoya, njalo njalo.)*		
d475 Ukuqhuba (*ukuqhuba ibhayisikile nesithuthuthu, ukuqhuba imoto, njalo njalo)*		
d5. UKUZINAKEKELA		
d510 Ukuzihlamba *(ukubhafa, ukuzosula, ukuzihlamba izandla, njalo njalo)*		
d520 Ukuzinakekela iindawo ezithile zomzimba *(ukuxukuxa, ukucheba intshebe, ukuzicoca ngokubanzi, njalo njalo.)*		
d530 Ukusebenzisa indlu yangasese		
d540 Ukuzinxibisa		
d550 Ukuzityisa		
d560 Ukusela		
d570 Ukujongana impilo yakho		
d6. UBOMI BASEKHAYA		
d620 Ukuzifumanela izinto noncedo olulolunye *(ukuziyela ezivenkileni, njalo njalo)*		
D630 Ukuzilungiselela ukutya *(ukupheka, njalo njalo)*		
d640 Ukwenza umsebenzi wendlu *(ukucoca indlu, ukuhlamba izitya, ukuhlamba iimpahla, uku-ayina, njalo njalo)*		
D660 Ukunceda abanye		
d7. UNXULUMANO NOBUDLELANE NABANYE ABANTU		

D710 Unxulumano nabantu ngokubanzi		
D720 Unxulumano oluntsokothileyo		
D730 Unxulumano nabantu ongabaziyo		
D740 Ubudlelane obusesikweni/nabantu bangaphandle		
d750 Ubudlelane obungekho sesikweni/ nabantu oqhelene nabo/ nabasekuhlaleni		
D760 Ubudlelane nosapho lwakho		
D770 Ubudlelane kwezothando		
Uluhlu olufutshane: Ukwenziwa kwezinto nokuthatha inxaxheba	***Inkcazelo yokwenziwa komsebenzi***	***Inkcazelo ngamandla okwenza izinto***
d8. EZONA NDIMA ZIBALULEKE NGAMANDLA EBOMINI		
D810 Imfundo ongayifumananga esikolweni		
D815 Imfundo yabantwana abangaphantsi kweminyaka emithandathu		
D820 Imfundo oyifumene esikolweni		
d830 Imfundo kumaziko emfundo ephakamileyo/ imfundo enomsila		
d850 Umsebenzi ofumana umvuzo ngawo		
d860 Isakhono sokusebenzisa nokulondoloza imali		
d870 Ukungenisa imali nokuzimela ngozemali		
d9. UBOMI KULUNTU NASEKUHLALENI		
d910 Ubomi ekuhlaleni		
d920 Ukuzonwabisa nezinto ozenzayo ngexesha elilelakho		
d930 Ezenkolo nokuphila ngokwasemoyeni		
d940 Amalungelo oluntu		
d950 Ubomi bezepolitiki namalungelo njengommi		
NAYO NAYIPHI NA ENYE INTO NEZINTO OTHABATHA INXAXHEBA KUZO		

Icandelo 3: IZINTO EZISINGQONGILEYO

- *Izinto ezisingqongileyo zizinto ezibonakaloyo, ezentlalo nezimvo zabamntu apho abantu bahlala khona, nalaapho benza khona izinto zabo zemihla ngemihla.*

Inkcazelo yokusingqongileyo:
Izinto ezizizithintelo okanye eziluncedo

0 Akukho zithintelo **0** Akukho zinto ziluncedo
1 Izithintelo zimbalwa **+1** Izinto eziluncedo zimbalwa
2 Izithintelo ziphakathi nje **+2** Izinto eziluncedo ziphakathi nje
3 Izithintelo zininzi kakhulu **+3** Kukho izinto eziluncedo kakhulu
4 Izithintelo ngokupheleleyo **4** Izinto ziluncedo ngokupheleleyo

Uluhlu olufutshane lokusingqongileyo	***Inkcazelo yesithintelo okanye yento eluncedo***
e1. IMVELISO NEZOBUGCISA	
e110 Aza kuzisebenzisa ngokwakhe umntu *(ukutya, amayeza)*	
e115 Aza kuzisebenzisa kubomi bakhe bemihla ngemihla	
e120 Aza kuzisebenzisa ekuhambeni ngaphakathi nangaphandle, nakwezothutho	
e125 Izinto zokunceda kunxibelelwano	
e150 Isimo, ukwakhiwa nezinto zokwakha noyilo lwezakhiwo eziza kusetyenziswa nguwonke-wonke	
e155 Isimo, ukwakhiwa nezinto zokwakha noyilo lwezokhiwo eziza kusetyiswa ngumntu bucala/ekhayeni lakhe	
e2. INDALO ESINGQONGILEYO KWANOTSHINTSHO OLWENZIWE NGABANTU KUYO	
e225 Imozulu	
e240 Ukukhanya	
e250 Isandi/ingxolo	
e3. INKXASO NOLWALAMANO	
e310 Kwizizalwane zakho/IZALAMANE	
e320 Kubahlobo	
e325 Kubantu oqheleneyo nabo, kubalingane bakho, kubantu osebenza nabo, kubamelwane nakubahlali	
e330 Kubantu abasemagunyeni	
e340 Kubantu abakubonelela ngoncedo nabantu abakuncedisayo	
e355 Kubantu abalolongiweyo kwezempilo	
e360 Kubantu abasebenza kumaziko ancedisana nawezempilo	

Uluhlu olufutshane lokusingqongileyo	*Inkcazelo yesithintelo okanye yento eluncedo*
e4. IMO- NGCINGA	
e410 Imo-ngcinga yezizalwane zakho	
e420 Imo-ngcinga yabahlobo bakho	
e440 Imo-ngcinga yabantu abakubonelela ngoncedo nabantu abakuncedisayo	
e450 Imo-ngcinga yabantu abasebenza kumaziko ezempilo	
e455 Imo-ngcinga yabantu abasebenza kumaziko ancedisana nawezempilo	
e460 Imo-ngcinga yoluntu	
e465 Izithethe, iinkolelo neendlela abenza ngazo izinto abantu ekuhlaleni	
E5. IINKONZO, IINKQUBO NEMIGAQO-NKQUBO	
e525 Iinkonzo, amalungiselelo nemigaqo-nkqubo ngezindlu	
e535 Iinkonzo, amalungiselelo nemigaqo-nkqubo yezonxibelelwano	
e540 Iinkonzo, amalungiselelo nemigaqo-nkqubo yezothutho	
e550 Iinkonzo, amalungiselelo nemigaqo-nkqubo enxulumene nezomthetho	
e570 Iinkonzo, amalungiselelo nemigaqo-nkqubo enxulumene nezentlolontle yoluntu	
e575 Iinkonzo, amalungiselelo nemigaqo-nkqubo enxulumene nenkxaso kwezentlalo ngokubanzi	
e580 Iinkonzo, amalungiselelo nemigaqo-nkqubo enxulumene nezempilo	
e585 Iinkonzo, amalungiselelo nemigaqo-nkqubo ezemfundo noqeqesho	
e590 Iinkonzo, amalungiselelo nemigaqo-nkqubo engezemisebenzi nengqesho	
NAZO NAZIPHI NA IZINTO EZINGOKUSINGQONGILEYO	

Icandelo 4: EZINYE IINKCUKACHA EZIFANELEKILEYO

4. 1 *Nika imbali emfutshane kwakunye nazo naziphi na iinkcukacha ezifanelekileyo ngomntu lowo.*

4.2 *Bandakanya nazo naziphi na* ***izinto ezingaye umntu*** *ezinganefuthe ekwenzeni kwakhe izinto (umz. ubomi abuphilayo, izinto aqhele ukuzenza, imvelaphi yentlalo, imfundo, iziganeko zobomi, uhlanga, iimpawu zesini kunye nezinto eziziziphiwo kuye umntu.*

Isihlomelo1:

IINKCUKACHA EZIMFUTSHANE NGEZEMPILO

[ ] Ingxelo enikwa nguye ngokwakhe umntu ngugqirha **[ ] Ingxelo enikwa**

X.1 Ubude: __/__/__ cm

X.2 Ubunzima: __/__/__ kg

X.3 Esona sandla ubusisebenzisa *(phambi kwesimo sempilo okuso)*: Esasekhohlo [ ] Esasekunene [ ]
Zozibini izandla ngokulinganayo [ ]

X.4 Ungayichaza njani impilo yakho ngokomzimba kule nyanga igqithileyo?

Intle kakhulu [ ] Intle [ ] Iphakathi nje [ ] Imbi [ ] Imbi kakhulu [ ]

X.5 Ungayichaza njani impilo yakho yengqondo neyomphefumlo kule nyanga igqithileyo?

Intle kakhulu [ ] Intle [ ] Iphakathi nje [ ] Imbi [ ] Imbi kakhulu [ ]

X.6 Ingaba kungoku nje unesifo/izifo okanye ukuphazamiseka ngokwasempilweni?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nika iinkcukacha:

_____

_____

X.7 Ukhe wenzakala kakubi kangangokuba oku kwachaphazela indlela owenza ngayo izinto?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nika iinkcukacha:

_____

_____

X.8 Ukhe walaliswa esibhedlele kunyaka ophelileyo?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nika isizathu/izizathu, neentsuku owazilala esibhedlele

1. 1. _____; ___. ___. ___ iintsuku
2. 2. _____; ___. ___. ___ iintsuku
3. _____; ___. ___. ___ iintsuku

X.9 Ingaba ngoku uthatha amayeza (owakhutshelwe ngugqirha, okanye ozithengeleyo kwindawo yamayeza)?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nceda unike amagama amayeza aphambili owasebenzisayo

1. _____
2. _____
3. _____

X.10 Uyatshaya?

[ ] HAYI [ ] EWE

X.11 Uyabusela utywala okanye uyazisebenzisa iziyobisi?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nceda unike uqikelelo lokuba usela kangakanani na, okanye utshaya kangakanani na ngemini

Icuba: _____
Utywala: _____
Iziyobisi: _____

X.12 Ingaba zikhona izixhobo zokukuncedisa ozisebenzisayo, njengeeglasi zamehlo/iindondo, isincedisi-kuva, isitulo sokuhamba, njalo njalo?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nceda unike iinkcukacha

X.13 Ingaba unaye umntu okuncedisa ukuba wenze izinto zakho zemihla ngemihla, ukuba ukwazi ukuzinakekela, okanye ukuzikuyela ezivenkileni?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nceda uchaze umntu okuncedayo, noncedo akunika lona

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X.14 Ingaba lukhona uhlobo oluthile lonyango olufumanayo ngesimo sempilo yakho?

[ ] HAYI [ ] EWE

Ukuba uthi EWE, nceda unike iinkcukacha

X.15 Iinkcukacha ezizezinye ezibalulekileyo malunga nesimo sakho sempilo ngaphambi koku, nangoku:

_____

_____

X.16 KULE NYANGA IDLULILEYO ingaba unciphise imisebenzi yakho obuqhele ukuyenza ngenxa *yesimo sakho sempilo*? (isigulo, umenzakalo, izizathu zomphefumlo, ukusebenzisa utywala neziyobisi)

[ ] HAYI [ ] EWE

Ukuba uthi EWE, ziintsuku ezingaphi? _____

X.17 KULE NYANGA IDLULILEYO ingaba akubanga nako konke ukwenza izinto oqhele ukuzenza okanye umsebenzi wakho ngenxa *yesimo sakho sempilo* (isigulo, umenzakalo, izizathu zomphefumlo, ukusebenzisa utywala neziyobisi)

[ ] HAYI [ ] EWE
Ukuba uthi EWE, iintsuku ezingaphi? _____

Isihlomelo 2:

IMIBUZO NGOKUBANZI MALUNGA NOKUTHATHA INXAXHEBA NEZINTO EZENZIWAYO

Le mibuzo ilandleayo iyacetyiswa njengesikhokelo esiza kunceda umhloli xa enodliwano-ndlebe nomntu onika iimpendulo malunga neengxaki anazo ekwenzeni izinto nemisebenzi yakhe yemihla ngemihla, xa kufunwa ukucacisa umahluko phakathi kwamandla okwenza izinto nokwenziwa komsebenzi. Zithathele ingqalelo zonke iinkcukacha akunikileyo ngaye umntu, ubuze nemibuzo engeminye xa ukubona kuyimfuneko oko. Imibuzo ingabuzwa ngenye indlela, yenziwe ukuba inganiki impendulo ethe ngqo ukuba oko kuyimfuneko, ukwenzela ukufumana ulwazi olubanzi nolucacileyo.

Phantsi kwesihloko ngasinye kukho iintlobo ezimbini zemibuzo evavanyayo:

Umbuzo wokuqala uzama ukwenza ukuba umntu ophendula imibuzo agqalisele kumandla akhe okwenza izinto okanye umsebenzi othile, ugqalisele ikakhulu kwizithintelo ***emandleni akhe okwenza izinto*** *ingakumbi ezo* ***anazo*** ***ngemvelo/ngendalo umntu.*** *Ezi zithintelo kufanele ukuba zibe zibangwa ngqo sisimo sezempilo saloo mntu unika iimpendulo, engasebenzisi zinto ziluncedo. Xa sithetha* ***ngezinto eziluncedo*** *sithetha uncedo olufumana komnye umntu, okanye isixhobo okanye isithuthi esilungiselelwe imeko yakho, okanye nayiphi na inguqu eyenziweyo kwindawo ekungqongileyo njengegumbi lakho, ikhaya lakho, umsebenzi wakho, njalo njalo. Inqanaba lamandla okwenza umsebenzi kufuneka lijongwe ngokuthekelelwa kwelo lesiqhelo lilindekileyo kumntu lowo, okanye amandla omntu okwenza izinto phambi kokuba abe kuloo meko yempilo akuyo*

Umbuzo wezibini ugqalisela ***kanye kwindlela enza ngayo izinto*** *umntu lowo uphendula imibuzo, okanye kwimeko yakhe ngqo, okanye kwindawo emngqongileyo, kwaye ufuna ulwazi malunga nefuthe elinazo izithintelo okanye izinto eziluncedo kwindawo emngqongileyo. Kubalulekile ukuba ugxininise ukuba unomdla kuphela kwindlela athi afumane ubunzima ngayo lowo uphendula imibuzo ekwenzeni izinto,* ***sithi ke umthatha umntu lowo njengomntu ofuna ukuzena ezi zinto.*** *Ukungenzi nto akungeni ndawoukuba umntu ukhetha ukungenzi nto.*

I. Imo yokuhamba

(Amandla okwenza izinto)

(1) Kwisimo sempilo okuso ngoku, kunzima kangakanani ukuhamba umgama omde (umz. ikhilomitha nangaphezulu) ungakhange ufumane ncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwento)

(1) Kwindawo ohlala kuyo ngoku, ziingxaki zini onazo ekuhambeni umgama omde (umz. ikhilomitha nangaphezulu)?

(2) Ingaba le ngxaki yakho yenziwa mbi okanye ngcono yimeko yezinto ezikungqongileyo kwindawo okuyo?

(3) Ingaba amandla akho okuhamba imigama emide ngaphandle kwezinto eziluncedo angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

II. Ukuzinakekela

(Amandla okwenza izinto)

(1) Kwisimo sempilo okuso ngoku, kunzima kangakanani ukuba uzihlambe ngaphandle kokufumana uncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu, ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwento)

(1) Ingaba unengxaki yokuzihlamba ngokwakho ekhayeni lakho?

(2) Ingaba le ngxaki yenziwa nzima ngakumbi, okanye ngcono ngendlela ikhaya lakho elilungiselelwe ngayo, okanye ngezinto ezenziweyo ukuze zilungele isimo okuso?

(3) Ingaba amandla akho okuzihlamba ngaphandle kolu ncedo angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

III. Ubomi basekhaya

(Amandla okwenza izinto)

(1) Kwimo yempilo okuyo ngoku, kunzima kangakanani ukucoca phantsi/umgangatho wendawo ohlala kuyo ngaphandle koncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu, ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwezinto)

(1) Ekhayeni lakho unengxaki engakanani kanye ekucoceci phantsi/umgangatho?

(2) Ingaba le ngxaki yenziwa mbi kakhulu, okanye yenziwa ngcono, yindlela ikhaya lakho elilungiselelwe ngayo okanye zizixhobo ezizodwa ezilungiselelwe isimo sakho?

(3) Ingaba amandla akho okucoca phantsi/umgangatho wakho ngaphandle kolu ncedo angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

IV. Unxulumano nabanye abantu

(Amandla okwenza into)

(1) Kwisimo sempilo okuso ngoku, kunzima kangakanani ukwakha ubuhlobo obutsha nabantu, ngaphandle kokufumana uncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu, ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwezinto)

(1) Kwisimo sempilo okuso ngoku, unengxaki enkulu kangakanani ekwakheni ubuhlobo?

(2) Ingaba ingxaki yokwakha ubuhlobo yenziwa mbi kakhulu, okanye ngcono yinto ethile (okanye ngumntu othile) kwindawo ekungqongileyo?

(3) Ingaba amandla akho okwakha ubuhlobo ngaphandle koncedo angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

V. Ezona ndima zibaluleke ngamandla ebomini

(Amandla okwenza into)

(1) Kwisimo sempilo okuso ngoku, kunzima kangakanani ukwenza wonke umsebenzi ekufuneka uwenzile, ngaphandle kokufumana uncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu, ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwezinto)

(1) Kwisimo sempilo okuso ngoku, unengxaki engakanani ekwenzweni wonke umsebenzi ekufuneka uwenzile?

(2) Ingaba le ngxaki ebanga ukuba ungakwazi ukuwenza umsebenzi wakho yenziwa mbi, okanye ngcono ngendlela indawo osebenza kuyo emi ngayo, okanye zizixhobo ezilungiselelwe wena ukuba uzisebenzise?

(3) Ingaba amandla akho okwenza umsebenzi ngaphandle koncedo angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

VI. Ubomi kuluntu nasekuhlaleni

(Amandla okwenza into)

(1) Kwisimo sakho sempilo ngoku, uneengxaki kangakanani ekuthatheni inxaxheba kwiindibano zoluntu ekuhlaleni, kwiminyhadala nakwimibhiyozo engeminye, ngaphandle koncedo?

(2) Ungasithelekisa njani isimo sakho nomnye umntu, ofana nawe ntonje ongekho kwisimo sempilo okuso wena?

(Okanye: "...Ungasithelekisa njani nemeko yakho phambi kokuba ube kwesi simo sempilo ukuso, okanye phambi kokuba uvelelwe yingozi?)

(Ukwenziwa kwezinto)

(1) Ekuhlaleni ingaba unengxaki na ekuthatheni inxaxheba kwiindibano zoluntu, kwiminyhadala okanye kwimibhiyozo engeminye?

(2) Ingaba le ngxaki yenziwa mbi, okanye ngcono yindlela uluntu lwakho olumi ngayo, okanye zizixhobo ezilungiselelwe ukunceda wena, okanye izithuthi ozisebenzisayo, okanye nayo nantoni na oyisebenzisayo?

(3) Ingaba amandla akho okuthatha inxaxheba kwiindibano zoluntu, ngaphandle koncedo, angaphezulu okanye ngaphantsi kunokuba usenza kwindawo okuyo?

Isihlomelo 3:

IZIKHOKELO MALUNGA NOKUSETYENZISWA KWEMIBUZO YE-ICF EMAYIQATSHELWE, INGUQULELO 2.1a

1.Olu luluhlu lwezinto eziphambili ngokwe-International Classification of Functioning,Disability and Health (ICF). Olu luhlu lwe-ICF luluhlu omalusetyenziswe ukufumana nokubhala phantsi iinkcukacha malunga nokwenziwa kwezinto, nokukhubazeka komntu. Ezi nkcukacha zingashwankathelwa zize zisetyenziswe kwimbali ngesigulo (umzekelo, kwindawo enogqirha okanye oonontlalo-ntle).

2. Le nguqulelo (2.1a) ilungiselelwe ukuba isetyenziswe ngoogqirha, oonompilo okanye oonontlalontle.

3. Olu luhlu kufuneka lusetyenziswe kunye nenguqulelo epheleleyo okanye emfutshane ye-ICF nepapashwe ngoSeptemba (eyoMsintsi) 2001. (The publication has already come out, therefore the rest of the information is irrelevant, hence it has not been translated into isiXhosa).

4. Zonke iinkcukacha ezivela kwiingxelo ezibhaliweyo, ezisuka kumntu onika iimpendulo, abanye abantu abanika iimpendulo nezifunyanwa ngokujonga ngqo imeko zingasetyenziswa ukuphendula le mibuzo. Nceda uzichaze kwiphepha lokuqala zonke iindawo ofumene kuzo iinkcukacha.

5. Amacandelo 1-3 kufuneka azaliswe ngokufakela ikhowudi yenkcazelo (qualifier code) ecaleni kwegama elichaza umsebenzi ngamnye, ilungu lomzimba, ukwenziwa kwento nokuthatha inxaxheba. Ikhowudi kufuneka ibonise ingxaki nembali yesigulo saloo mntu uhlolwayo. Zinikiwe iinkcazelo ezifanelekileyo kumaphepha afanelekileyo.

6. Umntu angawenza amagqabantshintshi malunga nolwazi olunikiweyo nangasebenza njengenkcazelo engaphezulu okanye ukuba umntu ucinga ukuba zibalulekile iinkcukacha ezo ekuhloleni isigulo eso somntu.

7. Icandelo 4 (Okusingqongileyo) lineekhowudi zenkcazelo ezimbi (izithintelo) nezintle (izinto eziluncedo). Kuzo zonke iikhowudi zeenkcazelo ezintle sebenza u-+ phambi kwekhowudi.

8. Iindidi ezinikiweyo kolu luhlu lwemibuzo zikhethwe kwi-ICF kwaye aziphelelanga. Ukuba ubona ukuba kufuneka usebenzise udidi olungadweliswanga apha, nceda usebenzise isithuba esisemazantsi kwesihloko ngasinye ukubhala iinkcukacha ezo.

Mzolisi ka Toni
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12 May 2008

Associate Professor JM Jelsma
Faculty of Health Sciences
University of Cape Town
Observatory

Dear Professor Jelsma

Re: Corrections to "The production of an appropriate and culturally sound isiXhosa translation of the ICF Checklist"

This is to confirm the following corrections made in the text of the dissertation, as recommended by the two examiners.

1 Terminology related to 'disabled people' versus 'people with a disability', with cognisance of 'person-first' terminology, has been clarified in the Glossary (page xi).
2 The original research question (previously at the end of the Introduction chapter, i.e. section 1.4) and terminology related to qualitative research have been removed. The study report is now a careful description of the process of translating the ICF into isiXhosa.
3 The sections dealing with 'Language' (2.7) and 'Culture' (2.8) have been expanded with additional references and with specific attention the relationship between the two, as recommended by the examiners.
4 The 'researcher' has been redefined as 'the investigator' in keeping with the above point (2.) and his positioning as a collaborative participant in the consensus team has been clarified. (Section 3.1.2).
5 The procedure for identifying cultural and linguistic difficulties has been added (Section 3.3).
6 Recommendations have been expanded and stated more clearly.
7 Typographical and other specific corrections have been made in the text and have been documented on the attached grid.

I hope that all the requirements have been met to your satisfaction.

Sincerely yours

Mzolisi ka Toni