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**DISABILITY AND SERVICE DELIVERY: PERSPECTIVES OF SERVICE
USERS IN A RURAL COMMUNITY IN THE EASTERN CAPE**

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**Research report presented in partial fulfillment of the requirements for the degree
of Masters of Philosophy in Disability Studies at the University of Cape Town**

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DECLARATION

I, Mpilo Henry Booii, hereby declare that this research report is my own original work and that all sources have been accurately reported and acknowledged, and that this document has not previously in its entirety or in part been submitted at any university in order to obtain an academic qualification.

M H Booii

Signed by candidate

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ABSTRACT

Background:

Since the advent of democracy in South Africa rural and disabled people have lagged behind in terms of access to services, and that has implications on their enjoyment of socio-economic rights. Although exclusion from access to services is documented in literature, little research has been done to explore rural and disabled people's perspectives on inclusive service delivery.

Purpose:

The purpose of this study was to contribute to the literature regarding inclusive service delivery in health, education and social development and citizen participation in rural areas. Insights into perspectives of rural citizens are pertinent for improved and inclusive service delivery.

Aim:

The aim of this study was to describe the perspectives of rural people regarding disability inclusive public sector service delivery in social development, health and education in a remote village in the Eastern Cape, South Africa.

Objectives:

The following were the objectives of the study:

- a) To describe residents' awareness of available health, education and social development services
- b) To describe how changes in service delivery over time have influenced perspectives of citizen rights
- c) To identify what sources of information used in formulating perspectives on service delivery
- d) To identify perceived barriers and/or facilitators to accessing services
- e) To describe unmet needs of the residents with respect to the selected services.

Methodology:

Case study methodology was used to capture the perspectives of residents in one rural village as a central case example. Trend analysis and mapping were used as methods of participatory rural appraisals (PRA) to obtain the participants' perspectives pertaining to disability inclusive service delivery in the case village. Using purposive sampling, 23 participants were identified by village gate-keepers for participation in the study.

Findings:

The research revealed that people living in this rural community perceived disability inclusive service delivery as complex, interactive and multi layered. They identified physical (road infrastructure and buildings), personal/behavioural (the level of trust in service delivery systems) and administrative/planning (staff and management) affecting accessing health, education and social development services. Rural people have come to understand that improved service delivery relies on various structural factors like improved infrastructure, proper planning and administration. Also rural residents have developed lack of trust in the service delivery system, particularly health care due to historically poor services in the sector. Hindrances towards disability inclusive service delivery included physical factors (poor roads and inaccessible public buildings) and non-physical factors (local cultural perspectives).

Recommendations:

Taking the context (geo-political location, history, culture) of rural areas into account would make a positive contribution towards improved policy implementation and inclusive service delivery. Rural residents' perspectives remain significant in determining successful inclusion of disabled people and participation of rural communities to ensure improved service delivery.

Keywords:

Disability, rural, inclusive service delivery, community participation, policy implementation

ABBREVIATIONS AND ACRONYMS

ANC	African National Congress
AsgiSA	Accelerated shared growth initiative for South Africa
BEE	Black Economic Empowerment
CBO	Community Based Organisations
CRDP	Comprehensive Rural Development Program
DPO	Disabled People's Organisations
GEAR	Growth Employment and Redistribution
IRDS	Integrated Rural Development Strategy
JIPSA	Joint Initiative on Priority Skills Acquisition
LED	Local Economic Development
NARYSEC	National Rural Youth Services Corps
NGO	Non-governmental Organisation
NGP	New Growth Path
NHI	National Health Insurance
PPP & P	People informing policy: power and progress
PRA	Participatory Rural Appraisals
RDP	Re-distribution and Development Program
SANPAD	South African Netherlands Partnership for Alternatives in Development
SASSA	South African Social Security Agency

DEFINITION OF TERMS

- **Child support grant:** “A means-tested cash benefit for poor children between the ages of 0 and 13 years” (Triegaardt, 2005: 249)
- **Chronic poverty:** “Chronically poor people are those who experience deprivation over many years, often over their entire lives and who sometimes pass poverty onto their children” (Chronic Poverty Research Centre, 2004:1)
- **Citizen engagement:** A democratic process of engaging people, deciding, planning, and playing an active part in the development and operation of services that affect their lives (DPLG: South Africa, 2004).
- **Community-based rehabilitation:** “A strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities” (ILO/UNESCO/WHO, 2004: 1)
- **Disability-environmental restrictions:** External (e.g. attitudes of other people, physical barriers, exclusionary policies and services) or internal factors (e.g. personality traits, sex, level of education) which limit disabled peoples access to equal opportunities and participation in society (World Health Organisation: ICF, 2006).
- **Disability Grant:** A monetary award made to an adult who has a permanent irreversible health condition, moderate to severe difficulties in functioning, and is unable to work or to do the same or similar work, or maintain themselves, in the same manner they were doing before the onset of disability (Department of Social Development: South Africa, 2005).
- **Disability:** This is an umbrella term that describes the outcome of the interaction of a person’s health condition with the context in which they live (World Health Organisation: ICF, 2006).
- **Disability-activity limitations:** Restrictions experienced in functional performance as a result of impairment (World Health Organisation: ICF, 2006).
- **Health:** “A state of complete physical, mental and social well-being and not

merely the absence of disease or infirmity (World Health Organisation, 2001)

- **Inclusive development:** Refers to the use of disability and rehabilitation services to include people with disabilities in key mainstream development strategies (Chapell & Lorenzo, 2010).
- **Participation:** 'Participative techniques include loosening of bureaucratic rigidities by establishing task teams for projects consisting of management, unions, end-users and community representatives (stakeholders), participative planning and increasing the capacity of civil society to take part in decision making' (DPLG: South Africa, 2005).
- **Primary Health Care:** "Essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community." (WHO 1978: item VI p3)
- **Public participation:** Refers to an open, accountable process through which individuals and groups within various communities can exchange views and influence decision-making (Department of Provincial and Local Government (DPLG), South Africa, 2005).
- **Rehabilitation:** Refers to a process that enables a person with disabilities to attain and maintain maximum possible independence, full physical, mental, social and vocational ability and full inclusion in every aspect of life (Adapted from CRPD)
- **Rural:** Rural cannot be summarized by a simple definition, because it is a complicated and indistinct conception. It is suggested that the appropriate definition should be determined by the question being addressed. For the purposes of this study, rurality refers to the manifestation of rural characteristics (distance from city, population density and size, infrastructure, and state and quality of life the people), which take urban as criteria of reference within a specified area (du Plessis, Beshiri & Bollman, 2002).

- **Service delivery:** refers to “provision of goods or services by the government or other organizations to those who need or demand them” (McLennan, 2009 p. 21)
- **Social inclusion:** Refers to strategy of social change that seeks to dismantle disabling barriers in society to enable group in disabled people to be involved in various life situations in the community (Shakespeare & Watson, 2002).
- **Structural poverty:** “The complex social dynamics and power relations that limit the distribution of resources, and adversely influence the physical and systemic restructuring of society” (Bhorat & Kanbur, 2006).

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CHAPTER ONE: BACKGROUND

1.1. Introduction

This chapter provides an overview of the study rationale and clarifies key research focus areas including context, with reference to key policies. The research problem, question, aim and objectives are presented.

1.2. Background

This research report describes the perspectives of people in a rural village, in the Eastern Cape, South Africa, regarding disability inclusive public sector service delivery in health, education and social development services. Across the world, people with disabilities ¹ have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities (World Health Organization (WHO), 2011). The poor health and education outcomes are partly due to barriers in accessing services that able-bodied society has long taken for granted, including employment, transport as well as information (WHO, 2011). These difficulties are intensified in rural and disadvantaged communities. Difficulties in accessing services associated with disability are intensified in rural areas due to general lack of access roads and unnavigable terrain and increased costs (Maart, Eide, Jelsma, Loeb, & Ka Toni, 2007).

The costs of providing services are increased due to the spatial dispersion of rural populations (Department of Provincial and Local Government (DPLG), 2000). Essential services are usually located in urban centres and rural people incur increased costs on transport in order to access those services (Mbeki, 2008)

¹ In the international literature, this is the acceptable term used. However, the disability community and organizations in South Africa prefer to use the term 'disabled people' because the term emphasizes the person rather than the condition. The term 'disabled people' will be used henceforth.

Moreover, rural areas are often politically marginalised, leaving little opportunity for the rural poor to influence government policy (World Health Organisation, 2011). As a result, such conditions have led to structural exclusion of rural people, as they remained economically deprived with fewer opportunities for social improvement than non-rural areas (Chakwizira, Nhemachena, Dube, & Maponya, 2010).

The social and political history of South Africa continues to play a major role in the marginalisation of rural and disabled people and continues to shape policy implementation. For over forty years, the systematic process of racial segregation ensured that the majority of the population of the country, particularly Black² people, were relegated to the least developed areas with fewer social and economic opportunities and least access to basic public services such as health care and education. As a result, poverty and unemployment levels increased as many people were deprived of essential health, education and social services; some sought access by migrating to urban areas (du Toit & Neves, 2004). The impact of historical conditions on the under-development of rural areas is compounded for rural disabled people who face additional marginalisation and exclusion due to disability (Chakwizira, *et al.* 2010). It is against this backdrop that South Africa invested significantly on policies aimed at redressing the past inequalities in service delivery. Before describing relevant national policies providing background to the current study, it is essential to provide a description of how the current study is situated within the broader research project carried out in Mount Frere. The following is the description of the People informing Policy: Power and Progress project (PPP & P).

1.3. The People informing Policy: Power and Progress project

The current study forms part of the first phase of the PPP & P research project, which began in 2005 in Mpoza village near Mount Frere in the Eastern Cape. The

²'Black people' is a general term used in South Africa to refer to all non-White population race groups (Employment Equity Act, 1998).

PPP & P project was funded by the South African Netherlands Partnership for Alternatives in Development (SANPAD). The PPP & P project was conceived out of another research project funded by the same organisation that was investigated the relationship between disability, poverty and occupation³ (PDO) in disadvantaged communities (Watson & Duncan, 2007).

The PDO study was first implemented in the Cape Flats in the Cape Metro region in the Western Cape. It was replicated in rural villages in response to the PDO study findings which indicated that the majority of the people making up the Cape Flats population, particularly the isiXhosa speaking areas within the Cape Flats, came out of the Eastern Cape's rural areas. The rural-urban migratory patterns within households played a significant role in their livelihood occupations and the social structures that supported disabled household members (Watson & Duncan, 2010; Duncan, Swartz, & Kathard, 2011). A survey of 102 households in 15 villages in a rural area in Umzimvubu local municipality of the Alfred Nzo district revealed the extent to which disabled people, their households and communities were marginalised by poor service delivery in health, education and social development (Watson & Duncan, 2010).

One of the recommendations that came out strongly from the PDO study was the need to explore how service providers and service users can collaborate in promoting policy implementation for improved service delivery hence the PPP & P study (Appendix 3). Using a case study rural village as a point of reference, the PPP&P study consisted of three phases. Phase 1 involved gathering information from service providers and service users about their perspectives on the rights and the policies that guide service delivery for disabled people in health, education and social development. The current study reports on second part of phase 1: service

³'The ordinary things that people do every day and the way they expend their time, energy, interest and skills in meeting their needs' (Christiansen et al 1995, p. 1015)

users perspectives. The perspectives of service providers form the basis of second sub-study conducted by other researchers (Sherry, Duncan & Watson, 2012).

Using participatory action research methodology, phase 2 was conducted during 2011 – 2012 period. It consisted of two parts. Using Q-methodology, the first part of phase 2 measured disability perspectives rural residents and service providers from health, education and social development (Duncan, *at al.* 2011). Using PRA and interview methods, the second part of phase 1 consisted of series of workshops on disability and related policies with purpose of developing basic disability policy literacy amongst a sample of rural citizens. The participatory research process on which the PPP & P study is based will conclude with an after measure of perceptions about disability and service delivery in the study community using the same Q-sort.

The PPP & P study will conclude in 2013 when phase 3 is implemented. Phase 3 will involve an ethnographic study of the community processes involved with disability inclusive development emanating from the impact of the PPP & P study. It is the purpose of the PPP & P to contribute to the literature in understanding of the processes involved in policy implementation in rural areas. The following section provides a brief description of some of the policies concerned.

1.4. Policy frameworks for service delivery in the new democratic South Africa.

1.4.1. Transformation and reform

A major mission of the post-apartheid democratic government was to restructure, transform and redistribute essential health, education and social services to the majority of the country's population (Gray & Mitchell, 2007). The need for restructuring was necessary to achieve social inclusion and reflect the ideals of the new constitution made for and by the people, to usher in an inclusive society with democratic values. Some of these major restructuring plans were preceded by policy

frameworks that aimed to guide how the restructuring was to unfold. Key among these policies was the Reconstruction and Development Program (RDP), the Growth Employment and Redistribution (GEAR), Accelerated Shared Growth Initiative for South Africa (AsgiSA) and recently the New Growth Path (NGP). The following section provides a description of each of these policies.

1.4.1.1. The Reconstruction and Development Program (RDP)

The main strategy to achieve services redress came through the African National Congress' (ANC) vision document for the first democratic elections of 1994, the Reconstruction and Development Program (RDP). The RDP became the first framework for the country's socio-economic policy when the ANC ascended to power post elections (Sender, 2002). The chief aim of developing and implementing the RDP was to address the socio-economic problems brought about by the Apartheid regime. The RDP specifically aimed to alleviate poverty and address the massive shortfalls in social services across the country. Amongst its main targets was the provision of water and sanitation for everyone, the electrification of 2.5 million houses and opening access for all to education, health care facilities and basic social services (Phillip, 2010).

Proponents of the RDP policy applauded it for providing 'an integrated and sustainable program for social development, a people-driven process that aimed to provide peace and security for all, build the nation, link reconstruction and development and deepen democracy' (Gray & Mitchell, 2007 p. 83). The RDP policy played a major role in guiding the improvement of access to basic health, education and social services for the majority of the historically marginalised population in the early years of the new democratic dispensation. More than 500 clinics and 200 schools were built between 1995 and 1997, and social grants recipients also increased substantially (Aliber, 2003). An increased number of previously marginalised people had access to basic services such as health, education and social grants (McLennan, 2009). Access to disability grants was also increased

substantially providing improved conditions for disabled people (Swartz & Schneider, 2006). The policy further encouraged participation of various segments of society in government processes to ensure inclusive service delivery.

Inclusive service delivery⁴ was but one of the strengths of the RDP policy document. The policy encouraged various sections of society to participate, such as business and civic organisations (Sender, 2002). In addition, RDP policy's consideration of a free market economy allayed worries from those sectors that had viewed the ANC as controlled by communist values and boosted investor confidence, thereby advancing the contribution of the private sector in social and economic redress (Aliber, 2003). Therefore, the RDP was not mainly about the government's role in social and economic redress process, but also about providing space for all citizens to participate and contribute to the improvement of the new democratic society. The South African disability movement was proactive and vocal during this period, ensuring that policy makers were cognisant of the need to put in certain measures to ensure disabled people's participation and contribution (Heap, Lorenzo, & Thomas, 2009).

Citizen participation in service delivery processes is one of the major components of a strong democracy (Ramphele, 2008). The RDP advocated for the provision of space for historically excluded communities and less powerful groups and individuals in society to gain 'voice' and participate more actively in the service delivery process (Aliber, 2003). The policy called for efforts to extend organisation to marginalised communities like the rural areas (Sender, 2002). RDP further appealed to individuals, groups and communities to actively participate in democratic processes and be empowered through school governance, residents' associations and other forms of organisation.

⁴ Inclusive service delivery refers to an approach in service provision that seeks to remove barriers to participation and discrimination of marginalized groups in society (Lindsay, 2003)

However, not much could be achieved by the RDP policy because, not only was it hurriedly crafted for the election campaign, it also set targets that were too ambitious (Sparks, 2003). As a result, the move towards delivery was very slow as much of the first two years of the ANC administration were spent on planning (McLennan, 2009). A further setback in service delivery also came when, within those first two years of democratic rule, the whole RDP policy was abandoned as a national strategy due to economic policy shifts in the ANC. The targets for improved public sector service delivery to the historically marginalised and excluded communities like the rural poor and disabled people was consigned to the individual government departments at provincial levels like health, education or social development departments, without any attempt to assess capacity to deliver on the policy goals (Gray & Mitchell, 2007). As a result, the gains were stalled by challenges related to lack of capacity such as funding and staff shortages. Services to the poor did not improve as RDP priorities competed with increasing political squabbles that shifted attention away from capacity and delivery issues (Ngoma, 2009). The department of education in the Eastern Cape Province, for instance, was consistently met with delivery failures as it was hit political patronage and staff shortages that could not support the high delivery demands at local level (Ngoma, 2009). A new policy was envisaged to deal with such delivery challenges.

1.4.1.2. The Growth Employment and Redistribution (GEAR)

In an effort to improve on the failures of the RDP, a new strategy known as Growth, Employment and Redistribution (GEAR), was introduced. Unlike the RDP, which focused on 'bottom-up' infrastructure development, GEAR had a comprehensive development thrust that focussed on 'filter down' macro-economic development (Gray & Mitchell, 2007). GEAR had five main objectives: discipline in the fiscus and monetary policy; increasing public and private investment; pursuing stable exchange rate; reducing tariffs; and encouraging a strategy of export-led growth (Gumede, 2009). Despite fierce opposition by organised labour due to lack of consultation and the strategy's support for the Black Economic Empowerment

(BEE) program, GEAR became the main government strategy for development and service delivery from 1997 to 2004 (Institute for Democracy in Africa (IDASA), 2010).

Inasmuch as GEAR was trumpeted as an excellent policy, it also failed to improve on service delivery. The majority of citizens experienced minimal positive change although the country attained substantial economic growth (du Toit, 2003; IDASA, 2010). Some commentators point out that although new policies, such as the Integrated Sustainable Rural Development Strategy (ISRDS) and National Rehabilitation Policy (NRP) aimed at improved grassroots service delivery were in place, evidence of implementation was very little (du Toit, 2007; du Toit & Neves, 2006; Ramphela, 2008; Rule, Lorenzo, & Walmarans, 2006). Many factors influenced the slow implementation including insufficient allocation of funds, lack of infrastructure, corruption and problems with administration (Institute for Democracy in Africa (IDASA), 2010). According to Habib (2010), the country acquired a disturbing record of formulating excellent policies which it then had difficulty implementing. In particular, poverty alleviation and improved service delivery for disabled citizens in remote rural regions of South Africa had been very slow (IDASA, 2010). The slow roll out of excellent disability inclusive policies for disabled people in rural areas exacerbated their already impoverished conditions. Little or no attempts were given to various development initiatives like income generating projects and development of skills and that led to over reliance on disability grants, which were already proven to be unsustainable (Swartz & Schneider, 2006). Recognising these challenges, the ruling party introduced another policy shift, with a central focus on skills development and job creation.

1.4.1.3. The Accelerated Shared Growth Initiative for South Africa (AsgiSA)

Recognising the constraints faced by the GEAR framework, the ANC led government launched a new policy framework in 2006 called the Accelerated Shared Growth

Initiative for South Africa (AsgiSA). In his state of the nation address in 2006, President Thabo Mbeki asserted that one-third of the population of South Africa was excluded from the mainstream economy, thus did not benefit from the growth and service delivery gains experienced by the country at the time. Therefore, the new AsgiSA policy was aimed at economic growth and distributing such gains more widely. The overall target of the AsgiSA policy was to halve poverty and unemployment by 2014 (Office of the President, South Africa, 2006a). Among the six factors that were understood to constrain growth and stifled service delivery, AsgiSA identified skills shortage as an area that needed concerted attention.

The Joint Initiative on Priority Skills Acquisition (JIPSA), a subsidiary to AsgiSA, aimed to develop strategies to fast-track skills development to support the AsgiSA objectives (Office of the President, South Africa, 2006b). The JIPSA initiative resulted in another project called Jobs for Growth program. Run by two ministries, Land Affairs and Agriculture and Trade and Industry, the Jobs for Growth program was aimed at creating about a million jobs over the next three to five years, particularly in semi-urban and rural areas (Centre for Development and Enterprise (CDE), 2007). Deputy President Phumzile Mlambo-Ngcuka clarified that the Jobs for Growth program would ensure that rural areas did not have to depend on cities for jobs and basic service delivery. The Jobs for Growth program also appealed for a concerted effort to ensure inclusion of marginalised groups, such as women and disabled people (Office of the President, South Africa, 2006b).

Although AsgiSA was still in line with the previous policies in the sense that it aimed to reduce poverty, decrease unemployment and improve infrastructure, the reality was that most rural communities in the country experienced little or no improvement at all. Rural areas still lagged behind in terms of economic development and service delivery (Galvin, 2010). Compared to urban areas, most rural areas in South Africa are still characterised by high levels of illiteracy (Gardiner, 2008), and inequalities in health services and poor basic social services (Booyesen, 2003; Evratt, 2009; Harris *et al.*, 2011). The failures of AsgiSA were partly

blamed on lack of consultation and participation by various stakeholders such as civil society and the broader community. Participation of communities and civil organisation such as DPOs, NGOs and CBOs would have revealed structural challenges, like poor roads, that impeded service delivery (Booyesen, 2003). Also benefits of centralised policy formulation, such as the case in AsgiSA, did not trickle down to lower structure as there was a mismatch in priorities between lower and national structures (du Toit, 2010; McLennan, 2009). Thus there was a need for a new approach in service delivery that would allow for interaction between various government structures and other sectors of society like DPOs to ensure alignment of government priorities and people's expectations on the ground. Understanding ways that could improve alignment between government priorities and community expectations could contribute to improve effectiveness of service delivery systems in rural areas.

1.4.1.4. *The New Growth Path (NGP)*

Appreciating the challenges faced by previous policies, on his maiden state of the nation address in 2009, President Jacob Zuma announced a new approach to economic growth and development, the New Growth Path (NGP) (Nattrass, 2011). NGP does not depart from the basic vision of the previous policies, which was to share the countries growth and benefits with the marginalised groups. The policy aims to usher improvement in the lives of poor people by focusing on job creation (Department of Economic Development, South Africa, 2009). NGP targets to create 5 million jobs by the year 2020 (Department of Economic Development, South Africa, 2009). The policy further speaks about increasing capacity and infrastructure in the former Bantustan⁵ areas, which still fall short in terms of delivery of services. NGP recommends that improved service delivery for poor rural areas can be achieved through rigorous implementation of a rural development policy and by increasing

⁵ Race-based development was the main feature of the Apartheid regime. Semi-independent states were created for major ethnic groups in the country (Christopher, 1994). Transkei, one of the 7 Bantustan states is the context of the current study.

budgets for health, education and social services in those areas (Department of Economic Development, South Africa, 2009).

However, the NGP has been heavily criticised since its announcement for lack of detail. Natrass (2011) considers the NGP much more of a vision than a policy framework as it gives little attention to the details on how its highly ambitious targets are to be achieved. The policy also relies on a number of structural, organisation and ideological changes that are still open for debate in the country⁶. Such debates may delay the implementation process, thus having devastating implications on rural development and service delivery (Tregenna, 2011).

Also, throughout the NGP document, there is little evidence of real commitment by the State to deliver the infrastructure required to successfully implement the policy. With such lack of ownership by the State, it is unlikely that the private sector will find reason to shift focus from central urban development to rural development (Natrass, 2011) The potential resistance to rural infrastructure development is likely, once again, to entrench the marginalisation of rural disabled people and their households. Knowing more about ways rural residents view service delivery will shed light on barriers and opportunities for citizen engagement with government towards improved access to services. Participatory development can contribute to making NGP a reality (Tregenna, 2011). More needs to be known about how rural communities, including disabled people perceive factors that influence service delivery.

1.5. The realities of rural areas, disability and service delivery in South Africa

The above review of economic development policies illustrates some of the disparities between urban and rural communities in South Africa and has argued that more needs to be known about rural communities including disabled people

⁶ There are still debates about the role of local municipal authorities in rural areas where large populations are still subject to traditional leadership (Cameron, 2006).

regarding their perceptions on service delivery. Despite the history of pro-poor policies, structural poverty still remains one of the main characteristics of rural areas in South Africa (du Toit, 2008). Due to low economic development opportunities and limited access to basic services, people in rural areas find it difficult to escape the reality of poverty (Neves, Samson, van Niekerk, Hlatshwayo, & du Toit, 2009). The challenges are greater for disabled people who, in addition to participation restrictions created by structural and other forms of poverty, also have to overcome functional limitations associated with their health condition (Maart, Eide, Jelsma, Loeb & Ka Toni, 2007). Several sources (Department for International Development – UK, 2000; Grut & Ingstad, 2005; WHO, 2011; World Bank, 2006; Yeo & Moore, 2003; Yeo, 2005;) have described the interaction and co-dependence between poverty and disability.

In 2000, in an attempt to deal with the needs of rural poor and marginalized communities the South African government introduced an Integrated Sustainable Rural Development Strategy (ISRDS). The ISRDS promised to introduce a coordinated approach by various government departments and the private sector to improve inclusive service delivery and provide opportunities for employment in rural areas (DPLG, 2000). Citizen engagement was identified as critical for successful implementation. Local NGOs, CBOs and DPOs were to be consulted to ensure that local economic development (LED) plans reflected the aspirations of local people (DPLG, 2000). Specific areas for development were identified in agriculture, tourism and infrastructure and local government and public sector departments were encouraged to seek additional funding to develop these areas (DPLG, 2000). The presidency had the task of coordinating the implementation process.

It was not long until the IRDS was met with implementation challenges. The IRDS advocated for decentralization of the implementation process. But for some reason that never happened as the coordination role regarding implementation still remained with the presidency in Pretoria, and that seemed to be the major

weakness (IDASA, 2010). The local authorities in the rural communities ended up creating plans that did not reflect the critical tenets of IRDS. Also evident was the lack of citizen's engagement regarding critical priority areas like inclusive service delivery and employment opportunities (Galvin, 2010). Thus the objectives of the IRDS of poverty alleviation in rural areas through coordinated inclusive service delivery are still to be realized. More needs to be known about the perspectives of rural citizens on service delivery in order to avoid repeating the same mistakes.

Many positive outcomes can be drawn out of the ongoing debate about policy implementation and service delivery in rural areas. However, little attention has been given to the importance of citizens' participation in the debate, particularly the rural poor and disabled people (Davids, 2007). According to Ramphela (2008) citizen's participation is essential for improved service delivery and for any democracy to hold. To that effect, several government policy and statutory documents, (including the Schools Act, National Health Act, White Paper on Local Government, Municipal Service Partnerships, Rural Development Framework and Municipal Community Partnerships, Disability Framework for Local Government), serve as the legislative cornerstone advocating for and promoting the need for public participation. These policy documents have given effect to various forms of public participation in government processes like ward committees, school-governing bodies, community policing forums, traditional authorities and other forms of civil organizations including disabled people's organizations. Knowing more about citizen's perspectives on service delivery will provide insights on how to engage various stakeholders to advance public participation.

Some of the key agents of participation include active society, access to information and social inclusion (Nyalunga, 2006). Rural residents, including disabled people may be active, but often lack access to information and the necessary resources through which to mobilize service delivery. High levels of illiteracy⁷ and poor

⁷Illiteracy rate in rural areas was estimated at 70% prior to the beginning of the *KhaRiGude* campaign in 2007 (Buccus, Hemson, Hicks, & Piper, 2007).

infrastructure⁸ remain some of the main deterrents to public participation for rural and disabled people (WHO, 2011). To that extent, rural residents including disabled people remain trapped in structural poverty due to lack of improved and inclusive services over a sustained period of time (du Toit & Neves, 2005). Lack of citizenship participation and sustained engagement has been identified as one of the major factors that have led to state's failure to ensure realisation of rights for these communities. Despite the call for participation of rural citizens, including disabled people, little is known about their perspectives on service delivery in their local communities.

1.6. Problem statement

In most rural areas, citizens remain passive recipients of poor services and little or no attempt is made to engage them and give them space for 'voice' so that they can contribute to their own development. Little is known about rural citizens', including disabled people's understanding of inclusive service delivery in a South African context.

1.7. Purpose

The purpose of this study was to contribute to the literature regarding disability inclusive service delivery in health, education and social development and citizen participation in rural areas. Knowing more about the perspectives of rural citizens is pertinent for inclusive service delivery and meaningful participation in service delivery and forms an integral part of a democratic society (Mubangizi, 2004).

⁸Most rural areas in South Africa have poor access roads, no access to clean water, poor school building and clinics and no electricity (ISRDS, 2000).

1.8. Research question

How do rural residents including disabled people understand factors that influence inclusive service delivery?

1.9. Assumptions

The following were research assumptions are based on literature regarding service access and provision in rural areas.

- Rural locations are characterised by poor delivery of socio-economic services because:
 - Rural residents, including disabled people, are not aware of service centres where they can access various health, education and social development services.
 - Rural residents have limited knowledge of their rights and service entitlements.

1.10. Aim

The aim of this study was to describe the perspectives of residents including disabled people, regarding inclusive delivery of health, education and social services in a deep rural community in the Eastern Cape province, South Africa.

1.11. Objectives

Objectives of this study were:

- a) To describe residents' awareness of available health, education and social development services
- b) To describe how changes in service delivery over time have influenced perspectives of citizen rights

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- c) To identify what sources of information used in formulating perspectives on service delivery
 - d) To identify perceived barriers and/or facilitators to accessing services
 - e) To describe unmet needs of the residents with respect to the selected services.

1.12. Summary

This chapter builds a rationale for the study by situating it within the context of South African economic policy. It has described how the democratic government had adopted a number of economic policy frameworks to improve service delivery and social inclusion in South Africa and argued that, despite these progressive policies, more efforts are required to improve the living conditions of historically marginalised groups such as rural communities and disabled people. It also discussed the contribution of citizen engagement and participation in government processes for the realisation of citizen rights and indicated the lack of information about the perspectives of rural residents regarding service delivery. With the aim of addressing the latter, the chapter concluded by presenting the research problem, purpose of the study, research question, aim and objectives. The current study intends to contribute to the literature on poverty alleviation through inclusive service delivery by exploring issues of citizens' engagement. It will attempt to identify and describe some of the critical factors that define rural residents', including disabled peoples' understanding of inclusive service delivery in a South African context.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter will provide a discussion of available literature pertaining to realisation of human rights in South Africa. Realisation of human rights pertains to the fundamental tenets of inclusive service delivery and policy implementation for rural poor and disabled people. The chapter will conclude with a section on the role of awareness of rights by rural and disabled people and the need for citizen engagement as strategy towards the democratic nation-building project.

2.2. Human rights in South Africa

Human rights are the fundamental liberties that protect the individual from intrusive exercise from the state, other individuals and corporate entities (Davids, 2007). The Constitution of South Africa recognises human rights and groups them into two broad categories; namely civil and political rights and socio-economic rights. Civil and political rights include rights such as the right to life, freedom of expression, freedom of association, freedom of assembly, right to vote and freedom of movement (Mubangizi, 2004).

This study will focus on the second category of rights, the economic, social and cultural rights (socio-economic rights) of citizens. Stipulated in Section 24 to 29 of Chapter 2 of the constitution, these rights are those entitlements and claims that guarantee people's economic and social well-being like food, shelter, health services, water, education and clean and healthy environment. As a result it is the legal and moral duty of the state to put measures in place to ensure respect, protection, promotion and fulfilment of these rights (Davids, 2007).

Socio-economic rights can be further differentiated into two kinds, namely: qualified and unqualified rights. Qualified rights differ from unqualified socio-economic rights in the sense that they are progressively realisable while unqualified rights are realised immediately (Davids, 2007). For instance, of interest to the current study is

the right to access to basic health and social services, emergency medical treatment and basic education including adult education, which is regarded as unqualified socio-economic rights, while qualified rights include access to health care, food, water and social security (Davids, 2007 & Khoza, 2007). It is essentially these services that rural and disabled communities have been excluded from (WHO, 2011). Efforts made in advancing these rights need to be cognisant of historical exclusion of rural and disabled people to ensure that these communities also enjoy these rights.

The differentiation between qualified and unqualified rights is necessary for the realisation of socio-economic rights. The South African Constitution compels the state to take reasonable legislative and other measures, within the limitations of available resources, to progressively realise the qualified rights (Khoza, 2007). Over a number of years the Constitutional Court, through case law, has provided interpretation and clarity on what is meant by 'reasonable legislative and other measures', 'within available resources' and 'progressively realisation' (Mbazira, 2006).

The test of reasonableness pertains to five elements, which include allocation of resources, prioritising (short and long term needs), allocation of human and financial resources, reasonable implementation and publication/accessibility to the public (Mbazira, 2006). In terms of the 'available resources' phrase, the state is required to show that it is using available means and channels when realisation of a certain right is limited by resources (Davids, 2007). It is also important in this regard to show how the state plans to boost the available resources so that the right/s is realised in the long run (Mbazira, 2006). The capacity of rural residents to engage the state in this regard depends, in part, on improved access to information, which still remains a challenge (Hovey & Cheswick, 2009). One of the aims in the current government strategy to build *Thusong* or Multi-purpose Community centre is to deal with the information vacuum in rural areas (Chief Directorate: Provincial and Local Liaison, 2001a). Access to information empowers rural and disabled

people to engage effectively with various government structures and be aware of various measures needed for fulfilment of rights.

'Progressive realisation' is interpreted in that, if a certain right cannot be realised immediately, the state should take measures to immediately realise the right, followed by measures intended to improve the quality of socio-economic goods and services (Mbazira, 2007). In its interpretation of this phrase, the Court indicated that some of the rights are interdependent and cannot be realised in isolation, and therefore reasonableness and progressive realisation also pertains to those rights that are necessary for the improvement of the other (Davids, 2007). The progressive realisation of disabled people's rights is a step towards inclusion in the broader community (Heap, Lorenzo, & Thomas, 2009). Without the knowledge of what disabled people perceive as inclusive service delivery, it would be difficult to gauge success.

2.2.1.State's commitment to inclusive service delivery and fostering citizen's participation and engagement

Progressive realisation of rights can be achieved by continued engagement with the citizens and fostering public participation (Nyalunga, 2006). The issue of public participation has been receiving increasing attention in South Africa, from both government and civil society sectors including disabled people's movements (Matsebula, Schneider, & Watermeyer, 2006). The publishing of the draft National Guidelines on Public Participation in 2005 also gave momentum to the spirit of involved citizenship. Some of the intricate issues in public participation include; service delivery, development, and policy formulation and is also about maintaining good order at the local government level (Buccus, Hemson, Hicks, & Piper, 2007). The National Framework on Disability for Local Government published in 2007 also strengthened the voice of disabled people. The voices of disabled people were reflected in this document stating that 'involving vulnerable groups in society, such as disabled people, will avoid perpetuating existing inequalities' (DPLG, 2009 p. 8).

Nowhere has the emphasis on public participation been more keenly felt than in local municipalities. Local government is the main delivery agent for improvements in housing, health care and infrastructural development (such as electrification, water reticulation and constructing roads) (DPLG, 2009). Such services are fundamental to the realization of socio-economic rights. Public participation is often driven by specific socio-economic goals that seek to improve enjoyment of socio-economic rights, and ensure a better life for all, especially for those who have been historically marginalized in South Africa (Fung, 2006). In a study on community participation conducted in three local municipalities in Kwazulu-Natal, (Buccus, *et al.* 2007) reported that rural people largely depended on State's goodwill to initiate platforms for participation rather than being an institutional requirement.

Similarly, (Klentjes, *et al.* 2010) found little evidence of participation in the development of disability related policy in South Africa. Some of the reasons cited by the participants included stigma and inaccessible platforms for participation (Klentjes, *et al.* 2010). Challenges in accessing community participation platforms should be central to the government's efforts to improve inclusive service delivery for rural and disabled people. Local government structures should also be wary of possible politicisation of public participation activities. (Botes & van Rensburg, 2000) found that politicisation of public participation was a common phenomenon amongst officials. With such possibilities for manipulation, rural and disabled people should be empowered through various initiatives at local level to ensure that they are aware of the intentions of public participation platforms. There are various government instruments in South Africa that empower citizens for public participation.

Central to various government policies is the requirement for local authorities to consult with communities to ensure that services meet the needs of the people. Guidelines for the Operation of Ward Committees and the Draft National Framework for Public Participation both published in 2005 (Davids, 2007) are some of the policies that provide procedures to the local authorities regarding engaging

citizens and fostering social inclusion. Additional legislative frameworks advocating for and promoting the need for public participation and social inclusion include (but not limited to) the following: Integrated National Disability Strategy, (1997), Mental Health Care Act, (2000), National Rehabilitation Policy, (2000), South African Schools Act, (1996), Education White Paper 6, (2001), Social Development Policy on Disability, (2009) and Disability Framework for Local Government, (2009). To date, research on community participation has mainly been limited to participation of parents in school governing bodies (SGB). Very little was found in health care and social development.

Parent's participation education of their children was given significance by the promulgation of the South African Schools Act (SASA), (1996). The SASA mandates the establishment of democratic structures that involve various stakeholders in all public schools to ensure support for the teaching staff in the management of the school. Parents must be involved to ensure that school services reflect the aspirations and expectations of their communities (Department of Education, 1996). A study investigating experiences of educators with SGB's schools found that parents SGB members in township schools were ineffective in their functions as they did not understand their functions within the broader SGB committee (Van Wyk, 2004). Educators reported that parents' lack of capacitation in the roles of SGB lead to poor and narrow understanding of SGB tasks relating to management of the school (Van Wyk, 2004). These findings were confirmed by another study instigating parents' understanding of their voice in SBG.

Mncube (2007) investigated the nature and extent of parental involvement in rural KZN schools. He found that participation of parents in SGB was limited. The reasons for limited participation pertained to lack of training and experience in governance issues (Mncube, 2007). Participation in the SGB was also confounded by low literacy levels of parents in the area. Literacy level seemed to be one of the determining factors of participation in the SGB rural areas (Mncube, 2007). Such findings

illustrate the need for careful consideration to the characteristics of the rural context when implementing policy.

The need to consider rural context was also illustrated in the fact that majority of clinics that did not have clinic committees were located in the largely rural provinces of the Eastern Cape and Limpopo (Padarath & Friedman, 2008). The National Health Act (NHA), (2004) requires that clinic committees be formed in all government local clinics by stakeholders in local communities, including parents, to increase local responsiveness of health care services. The promotion of community participation in the NHA is based on the assumption that it would facilitate the identification of locally determined needs and the monitoring of related achievements (Department of Health, 2004). Contrary to the requirements of the NHA, Padarath & Friedman, (2008) found that, in the Eastern Cape, although 73% of the 485 clinics that participated in the survey reported having clinic committees, less than 15% of the clinic committees were functional. These were the results of the study that investigated the status of clinic committees. Reasons for dysfunction were attributed to lack of capacity and limited understanding of what is entailed in the duties of clinic committee members. The implication of this are dire for service delivery in rural areas.

2.2.2. Public participation and service delivery in rural areas

Local and international experts have observed with admiration the sophistication and the good ideals expressed in South African public sector policies, but have also noted the gaps between rights, policies and laws and the people's lived experiences of poor service delivery in the country (Jansen, 2007; Creamer, 2010). The spate of service delivery protests seen in the country in the past few years have been interpreted by some commentators as evidence of frustration and anger by poor and marginalised communities at the slow pace of service delivery (Alexaner, 2010; Ngwane, 2010).

Between January and July 2012, Municipal IQ recorded 113 of such protests. Municipal IQ is a unique web-based data and intelligence service specializing in the monitoring and assessment of all of South Africa's 283 municipalities. This grim picture was also confirmed by severe backlogs in the country's progress towards achieving Millennium Development Goals (MDG). The country still performed poorly on employment and the poor have the lowest share of the quartile to national consumption (Ndlangisa, 2012). Based on these observations, Municipal IQ encouraged municipalities to work hard at building constructive participatory channels and ensure that they are accessible and effective, and that councillors and community leaders are empowered with accurate information on the ground (Allan & Heese, 2012). Although there are reports of political meddling in service delivery protests (Allan & Heese, 2012; Sama Yende & Mataboge, 2012), the poor are yet to experience the gains brought in by the advent of democracy and the recent economic growth. The number of service delivery backlogs are a testimony (IDASA, 2010).

Rural communities are also experiencing significant backlogs in terms of delivery of basic services. Challenges in rural communities include poor or lack of access to socio-economic and cultural infrastructure and services, public amenities and facilities, and government services (Nkwinti, 2010). In such conditions, disability adds further deprivation to the already grim circumstances (WHO, 2011). Access to disability grant has been reported to have some effect in ameliorating these conditions for disabled people in rural areas (du Toit, 2008; M. Loeb, Eide, Jelsma, Ka Toni, & Maart, 2008. du Toit, (2010) has, however, argued that people with disabilities in rural areas still remain the most vulnerable to poverty when considering other measures of poverty like education, health and employment.

The increased levels of poverty for rural residents, including disabled people have been blamed on the lack of capacity and motivation in local government officials to engage the citizens and foster public participation (Buccus, *et al.* 2007). The principle of community participation is internationally accepted as a desirable

feature of any successful service delivery system. In Uganda, (Devarajan & Reinikka, 2004) found that increased community participation improved transparency in the government. Faced with community complaints of poor service delivery in schools emanating from parents, the central government began publishing monthly transfers of funds in newspapers, broadcasting information on local radios and required parents to post information on inflows of funds in their primary schools (Devarajan & Reinikka, 2004). Proving that additional vigilance from community is necessary for improved services.

Despite the progressive legislative frameworks sought to create a conducive atmosphere for meaningful community participation, the general lack of capacity and commitment from local authorities to prioritize community engagement have proved to be major hindrances for progress (Nyalunga, 2006). In practice there has not been any real change, the legislations have not yet yielded any major results in as far as improving access to services for rural residents including disabled people. In a study investigating the level of black parents in education, (Singh & Mbokodi, 2004) found that the lack of success in implementation of the outcomes based education (OBE) curriculum in black schools was due to limited involvement of parents in the curriculum development process. Other obstacles to implementation include, party politicization of development and participatory structures, lack of access to information and failure to recognize and work closely with community-based organizations (Buccus, *et al.* 2007). The launch of the Comprehensive Rural Development Program (CRDP) in 2009 was aimed at dealing directly with some these challenges.

2.2.3. Dealing with challenges of citizen engagement

CRDP focuses on improving economic, cultural and social infrastructure, public services and facilities and installing information and communication technology (ICT) infrastructure to improve access to information (Rural Development and Land Reform Department, South Africa, 2010). In addition the National Rural Youth

Services Corps (NARYSEC) was also launched the 2010. The main goal of NARYSEC is to develop a cadre of young community paraprofessionals and artisans who will take responsibility for the development of their own communities (Rural Development and Land Reform Department, South Africa, 2010). Delivering the Friday Mavuso⁹ lecture in 2010, Rural Development and Land Reform minister Gugile Nkwinti, highlighted his concern about the low number of disabled youth who enlisted to participate in the NARYSEC program. Out of 3 000, only 123 young persons with disabilities have been enlisted after the conclusion of the recruitment and selection process in seven provinces (Nkwinti, 2010). Realizing the implications of the low-intake the minister raised the following questions:

- Is the environment within rural villages, where young persons with disabilities reside, conducive to enabling them to function effectively in providing a service at the end of their training?
- Was the recruitment and selection process, which was followed, appropriate to attract persons with disabilities?
- Did we manage to penetrate the deep rural villages?

The above questions are pertinent to issues of inclusive service delivery and improving the poor living conditions of disabled people in rural communities. It also highlights the pertinent role empirical studies can play in identifying not only the barriers to but also the facilitators of citizen participation and social inclusion of disabled people. (Chakwizira, *et al.* 2010) conducted a study to investigate barriers that hindered disabled people from accessing basic services in two rural villages in Mpumalanga Province, South Africa. The study findings indicated that although on average PWDs in rural areas faced similar travel and movement challenges as those in urban areas, the complexity and peculiarity of rural local level travel and movement may not necessarily demand the same range of interventions that

⁹Friday Mavuso was a disability activist and a founding member of Disabled People South Africa (DPSA), a national organisation representing the interests of disabled people. The annual lecture is held to commemorate his contribution to the advancement of the living conditions of disabled people in the country.

typically would resolve similar challenges in an urban setting (Chakwizira, *et al.* 2010).

The NARYSEC may have failed in attracting increased numbers of disabled rural youth because of its lack of cognizant given to rural mobility challenges. It is also possible that such information never reached disabled people because of the way it was presented. How information is presented is also a key determinant of inclusion or exclusion for disabled people. (Maart, Eide, Jelsma, Loeb, & Ka Toni, 2007) found that more in addition to the physical barriers to information faced by disabled people in rural areas, there were also non-physical barriers such as access to information. It is important to note that access to information also involves making information available in an accessible format for the local people, such as sign language for deaf people. If that is not considered, it may result in lack of awareness of opportunities like the NARYSEC amongst disabled people.

2.2.4. Public awareness of rights and services in poor and rural communities

For realization of rights and improved living conditions, it is important for the public to aware what these rights are and what kind of services they are entitled to. The Community Agency for Social Enquiry (CASE) conducted two major surveys to gauge the level of awareness of the South Africa poor peri-urban and rural communities in 1998 and 2000. Both surveys found low levels of awareness of socio-economic rights and services (CASE, 2000). Mubangizi, (2004) also confirmed these findings when he conducted a similar survey in the rural areas of Kwazulu-Natal in which it was found that rural residents were unaware of service entitlements that were key to their enjoyment of socio-economic rights. A subsequent campaign to educate citizens about their rights and services still failed

to improve the conditions in rural areas as it was mainly limited to peri-urban areas and townships¹⁰ (Mubangizi, 2004).

Logistical challenges such as poor or inaccessible roads and high levels of illiteracy were cited as some of the challenges hindering the positive outcomes of the rights education campaign into the rural areas (Mubangizi, 2004). For the efficacy of community consultation, participatory mechanisms should involve disadvantaged groups such as women, the rural poor, and the disabled people in decision making processes (Nyalunga, 2006). With reported low levels of awareness by rural residents and disabled people, it may be difficult to imagine them engaging and participating in relevant government structures. Citizen capacitation in the context of a grossly underdeveloped infrastructure is a real challenge for inclusive service delivery.

A number of suggestions have been noted to effectively deal with the challenge of inclusive service delivery, and to change the living conditions of rural residents, including disabled people. Fung, (2006) proposed that effort geared towards improving inclusive service delivery in disadvantaged and rural communities should include local authorities that;

- Make an effort to create clear communication channels between service providers and community-based structures.
- Make an effort to facilitate two-way flow of information between service users and providers across sectors.
- Encourage service providers to implement outreach programs.
- Capacitate all stakeholders working with issues of community consultation

Against the backdrop of these and other recommendations for improved service delivery, the purpose of this sub-study was to contribute to the literature regarding citizen participation in inclusive service delivery in rural areas.

¹⁰ Township refers to communities adjacent to main urban or industrial areas that developed as government labor reserves during Apartheid government (Cloete, 1992).

2.3. Summary

This chapter provided a review of the literature on the realisation of human rights by the citizens of South Africa. Of interest to this study are socio-economic rights and their implications on social inclusion of disabled people. It has illustrated based on the review of policy documents and research articles that realisation of socio-economic rights still lags behind for rural communities and disabled people. The literature indicates that poor service delivery has devastating implications for disabled people in rural areas. This chapter also highlighted challenges regarding citizen engagement and community participation in an effort to foster inclusive service delivery. Legislative measures taken by the state have not been implemented because of lack of citizen engagement, lack of capacity in local authorities and significantly low awareness of rights in poor rural communities. In summary the literature review has argued that improved citizen engagement is essential to deal with some of the implementation challenges that stifle most policies in South Africa's rural areas.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter provides a brief description of the research context before proceeding to a detailed description of the methodology used for the current sub-study. A description of the research design and sample; the processes of community entry, the rationale for the methodology; the data gathering methods and approaches to data analysis will also be described. Furthermore, pertinent issues associated with research ethics and rigour including trustworthiness is discussed.

3.2. Research context

This study, which formed part of Phase 1 of the PPP&P project, was conducted in rural area of the Alfred Nzo district in the Eastern Cape province of South Africa. Bordering on Lesotho in the north-eastern part of the province, the district's geography is mountainous and is characterised by high rainfall and grasslands vegetation (McCann, 2005). Driving through the area, one can notice obviously barren cultivation (*iintsimi*¹¹) fields, a testimony to an area that was historically active with subsistence farming (du Toit & Neves, 2005).

The PPP&P project including the current study involved three sub-villages that fall under ward 12 & 13 in Umzimvubu (see Appendix 6). The ward system introduced by the democratic dispensation for local government administration is different from the previous Transkei Bantustan administration. Whereas the research area was one local administrative area during the Transkei administration consisting of 17 villages under a single chief, it is currently divided into three wards each with its

¹¹*iintsimi* plots of arable land allocated to individual families during the Transkei government. Magistrates allocated the land only on recommendation of the chief and headman, who were assisted by their tribal authorities. Plot holders paid a perpetual quitrent and the Transkeian government registered their titles to holdings (Vosloo, Kortze, & Jeppe, 1974)

own ward councillor (Municipal Demarcation Board, 2011)¹². Wards 11, 12 & 13 form part of the Umzimvubu local municipality's 26 wards. The Umzimvubu local municipality is one of the four local municipalities that form the Alfred Nzo district municipality.

Alfred Nzo District Municipality is one of the most rural municipalities in the Eastern Cape Province (DPLG, 2007). As a result it is listed as one of the 15 rural nodes targeted for the Integrated Sustainable Rural Development Program (ISRDP) (DPLG, 2007). The Umzimvubu Local Municipality is further classified as a municipality that requires additional support according to the Nodal Economic Profiling (NEP) project, indicative of the marginalisation of the rural communities represented in the current study (Office of the President, South Africa, 2009).

Two magisterial areas/towns, namely: Mount Frere and Mount Ayliff make up Umzimvubu Local Municipality and they are both situated along the N2 route (Appendix 4). The N2 connects Mount Frere and Mount Ayliff to two main towns in the area, namely: Umtata and Kokstad. Mount Frere is approximately 77 Km away from Kokstad and 120 Km from Umtata. Mount Ayliff is the administrative centre of the district municipality, while Mount Frere is the administrative centre of the local municipality. The area of interest to the current study falls under Mount Frere magisterial area within the Umzimvubu local municipality. The three sub-villages that form the PPP&P case study are located approximately 2 hour drive inland on a under developed gravel road from the N2 near Mount Frere.

3.2.1. Population

There is no information available as yet on the basic demographic characteristics of the people in the research area, however, data from the 2001 census gives

¹²The process of demarcation of rural municipalities that were historically administered by chiefs and traditional authorities was a challenging task for the democratic government, majority of which are still faced with service delivery problems (Cameron, 2006)

demographic characteristics of the people in the province, in the Alfred Nzo district and the Umzimvubu municipality. The Umzimvubu local municipality has a very young population; of all the male adults aged 18 to 65, slightly above 37 per cent of them are less than 26 years old and the corresponding percentage of females also below 26 years is almost 29 per cent (Statistics South Africa, 2001). Table 1 below presents a summary of the population sizes of the people aged 18 – 65 and their sex distribution in the region.

Table 1: Total population and percentage contributions to the provincial population

	Eastern Cape		Alfred Nzo		Umzimvubu	
	Male	Female	Male	Female	Male	Female
Total population	1,403,489	1,787,452	93,428	13,559	65,530	91,742
% of province			6.7	7.6	4.7	5.1
% of local municipality					70.1	67.7

Source: Statistics South Africa 2001

There is also no specific information available regarding the prevalence of disability in the area. Local government data indicate that 2.69% of Umzimvubu Local Municipality accesses disability grant (Local Government Year Book, 2011). Provincial estimates indicate that prevalence of disability in the Eastern Cape is between 4 – 5.1 per cent (Statistics South Africa, 2001).

3.2.2. Economic activity

There is very little economic activity in the area. The municipal classification, which is a method of organising municipalities according to their economic activity and administrative capacity, classifies Alfred Nzo as category C2 municipality indicating that it has low urbanisation, as well as limited municipal staff and budget capacity (McCann, 2005). Umzimvubu local municipality also reflects similar characteristics

in that it has significantly low levels of access to basic services and key development challenges include lack of basic infrastructure, limited access to finance, high illiteracy, and vulnerability to HIV/AIDS on the part of the economically active population (McCann, 2005; Local Government Year Book, 2011).

Despite the significant challenges, Alfred Nzo district is endowed with a number of resources that afford great potential for long-term economic growth, including an abundance of land, exceptional soil quality, and good climatic conditions (DPLG, 2007). As a result, significant opportunities for growth and employment exist in the agricultural, forestry and eco-tourism sectors, provided the area's latent potential can be unlocked. This is one of the main elements targeted by government to increase economic activity in the area (DPLG, 2007). If such opportunities could be developed, disabled people also stand to benefit through employment and as a result of employment equity measures. Employment Equity Act, (1998) requires that reasonable accommodation of measures be put in place in various employment industries, so as to curtail the number of disabled people who are unemployed. Also Alfred Nzo disability policy promotes employment of disabled people in local industries (Alfred Nzo District Municipality, 2009). Implementation of both of these policies would improve economic participation of disabled people.

3.2.3. Access to services

Prior to 1995, all services in the area were provided by the former Transkei homeland government, and a legacy of severe service backlogs and high poverty levels remain (DPLG, 2007). In Mpoza there are two clinics which provide the community with basic primary health care services¹³. Other health services can be accessed at the district hospital about 35 Km away. If patients require any specialised services, they are referred to Umthatha Hospital Complex where they

¹³Basic primary health care services include immunisation, contraception, emergency contraception and termination of pregnancy, antenatal care, treatment of sexually transmitted diseases, HIV related services, TB services, community services and outreach (including rehabilitation and home based care), emergency transport services, school health services (Reagon, Irlam and Levin, 2004).

are transported by government subsidised patient transport. Patients have to take their own transport from the district hospital to the villages, incurring an average cost of R40 per return trip.

Although there have been notable improvements in recent years regarding services and infrastructure, Alfred Nzo's development is highly constrained by severe backlogs in water, electricity and sanitation provision, and areas away from main highways remain difficult to access (DPLG. 2007;2011). A recently opened *Thusong* centre¹⁴ with facilities for social services, police, post office and a community hall was yet to be fully operational. At the time of the study, none of the facilities were functional apart from the hall and the social services offices partially used by social grants administrating agency (SASSA) for grants registration. The main reason given by the service providers for this situation was lack of staff (Sherry, Duncan & Watson, 2010).

The area also has generally low education levels (du Toit & Neves, 2007; DPLG, 2007). Literacy levels are very low in ULM with the estimation of illiteracy at 72%, which impacts greatly on the provision of information to people, particularly with reference to written documents in any language (DPLG, 2011). Each of the three villages included in the study had one pre-school and one junior secondary school. One of the villages has a senior secondary school¹⁵. Special schooling for disabled children is limited to one school for the intellectually impaired in Mount Ayliff.

¹⁴*Thusong* or Multi-purpose community centers (MPCC) are defined as those centres that have at least six government departments offering services(Chief Directorate: Provincial and Local Liaison., 2001b)

¹⁵Unlike the rest of South Africa, schools in this area were organised into junior secondary school, which begins from grade R to grade 9, and senior secondary schools, which begin from grade 10 to grade 12 (Matric). This organisation of the school system was unique to the Transkei Bantustan state (Cloete, 1992).

3.3. Methodology

3.3.1. Research Design

A qualitative descriptive design was used to obtain information required for this sub-study on the perspectives of service users within the larger PPP&P project. Qualitative methodology was chosen because the researcher wanted qualitative descriptors for the larger study. In qualitative descriptive studies the researcher seeks to describe certain aspects of an experience or a selected event (Sandelowski, 2000). In a way, the researcher chooses what to describe. But these descriptions must always accurately convey events in their proper sequence, or have 'descriptive validity', and the meanings participants attributed to those events, or have 'interpretive validity' (Miles & Huberman, 1994).

According to Durrheim (2006) qualitative descriptive studies aim to describe a phenomenon accurately through various methods such as case studies. Furthermore, qualitative research might attempt to describe the social practices of a particular group, or a small-scale event like a political demonstration (Babbie & Mouton, 2001). Whatever the researcher chooses to observe, what is important is to identify the facts, and the meanings participants give to the facts, and then convey them in a coherent and useful manner (Sandelowski, 2000).

A case study approach becomes appropriate in situations where there are no clear boundaries between the phenomenon and context that the researcher has chosen to describe (Baxter & Jack, 2008), as it occurred in the current study. A case study was chosen because the case was the perspectives residents in that particular village, but the case could not be considered without the context, rurality, and more specifically the location of the area. . Also a choice of a case study was essential as a contribution to the larger study, which was a case study. the rural area was a setting where the perspectives were formulated. It would have been impossible for the researcher to

capture the facts about rural residents' perspectives without considering the context in which they were formulated.

3.3.2. *Theoretical Premise*

The theory of public participation was used as a framework in answering the research question. Central to participation theory is that engaged citizenship promotes social inclusion and curtails marginalisation of the less 'powerful' sectors of society (Webler, 1999). Preserving legitimacy, justice and effective governance are constant struggles of any democratic society. Public participation in government processes can legitimise policies, advance re-distribution of power and resources and improve policy implementation (Fung, 2006). Participation is valuable to the extent that it is redistributive of power that enables poor citizens to be *socially* included (Arnstein, 1969).

In many countries rural and disabled people suffer significant amount of political injustice. Rurality has become a signifier for poverty in many areas in South Africa (du Toit, 2008), and disabled people have poor access to services the world over (WHO, 2011). This situation has resulted in structural marginalisation of rural and disabled people. At the foundation of this marginalisation is the dichotomy; wherein 'they' (structure, organisations, experts) have power and 'we' (the oppressed, grassroots, marginalised) do not (Chambers, 1997). When some groups cannot influence the political agenda, decision making, or gain relevant information to assessing how well policy alternatives serve their interests because they are excluded, unorganised, or too 'weak', they are likely to be ill-served by laws and policies (Fung, 2006). Participatory mechanisms have been proven to increase the justice of democratic governance towards improving the lives of poor and marginalised people.

Poor and marginalised people are capable of analysing their own realities and they should be enabled to do so (Kumar, 2002). The assumption that 'they know' and 'we

are ignorant', which usually develops, leading to those who are dominant and powerful finding it difficult to learn from those who are subordinate perpetuates exclusion (Chambers, 1997). Through participatory methods implicit relationships between power and knowledge can be defused. Including marginalised groups through various participatory mechanisms can improve their lives by creating popular pressures that can influence authorized officials to act justly (Fung, 2006).

3.3.3. Methodology & Methods

Participatory rural appraisal (PRA) was used in the study in answering the research question. PRA methods fall within the family of participatory research and are intended to enable local people to conduct their own analysis of the situation, and often plan and take action (Kumar, 2002). Participatory research is a means of closing the power gap, of remedying the power inequities through processes of knowledge production, which strengthen the voice, organisation and action of marginalised groups (Gevanta & Cornwall, 2001). In PRA, participant observation is mainly used in conjunction with other methods like participatory mapping, where local people make their own maps of their local surroundings like the village (Chambers, 1993). Trend analysis may also be used where people give narratives of local history in relation to selected events or identified phenomenon (Chamber, 1993). What these data gathering methods emphasise is the knowledge of rural people which is usually overlooked and usually not maximally utilised by other methods of data collection (Bhandari, 2003).

The use of PRA to gather information from villagers served an important function during phase 1 of the PPP& P project because it allowed the local residents to engage with each other about their own context. It laid a participatory foundation for Phase 2, which involved a series of workshops on disability and related policies (the topics for the workshop emerged from dialogue amongst participants). During Phase 1 different groups representing different constituencies within the selected villages were invited to participate in two different PRA activities that were

facilitated by the researcher (see sampling below). Participatory methods allowed for all members of the group to contribute their perspectives as opposed to one or two dominating, thus limiting the chances of bias (Kumar, 2002). The two PRA methods used for data collection were trend analysis and participatory mapping.

3.3.3.1. Trend analysis

Trend analysis entails people's accounts of the past, of how things close to them have changed over time (Chambers, 1993). Participants were asked to provide recollections of trends pertaining to health, education and social development services and how these trends have affected their perspectives on citizen rights, service delivery and disability policy implementation. This required some participants in each representative group (see sampling below) taking different roles, like one being a scribe for instance. The participants were given an opportunity to discuss and reach consensus amongst them on how to approach the activity and the researcher acted as a facilitator of the process.

3.3.3.2. Participatory mapping

Mapping entails construction of a three-dimensional model of the community indicating dwellings, points of significance and other landmarks or resources that were of value to the community in terms of service delivery in the identified sectors of health, education and social development (Chambers, 1993). With regards to the current study, each of the groups was asked by the researcher (facilitator) to map out the area covering the sub-villages of Mpoza (see sampling of villages below). Using multi-coloured chalks they drew on a black rubber carpet showings various services points which they perceived as being important in terms of accessibility and relevance in meeting their needs (see Appendix 8 - 11).

The use of the rubber carpet had been chosen during the pilot study (see below) when rainy weather could not allow the use of the ground outside as recommended

in PRA. Traditionally, the completed map produced through the mapping and modelling exercise is usually a three dimensional structure (Kumar, 2002). The participants were given an opportunity to discuss and reach consensus amongst themselves on how to approach the activity and the researcher acted as a facilitator of the process (see Appendix 12 – 14).

In addition, the researcher and the research assistant kept meticulous field and reflective notes. These notes were consolidated during the briefing between the research team members. The briefing also allowed the research team to compile a repertoire of local terms and phrase used to describe certain events or objects. Compiling a phrase or word repertoire allowed the research team access into the meanings that participants gave to the facts and events as they unfolded.

3.3.3.3. *Probing and discussion.*

On completion of the mapping activity the researcher facilitated a discussion amongst the participants by posing question to probe deeper for deeper nuances about the maps. For list of probes see appendix 8 & 9 for list of probes.

3.3.4. *Gaining Access*

The PPP & P project was launched with a start-up workshop held in Mount Frere in October 2009. The people who attended the start-up workshop were representatives of the villages involved in the poverty, disability and occupation study as well as local and regional representatives from the Departments of Health, Education and Social Development. The PPP&P start-up workshop was aimed at discussing the recommendations of the previous SANPAD project in the area (Duncan & Watson, 2010) and also to seek guidance from the leaders on the shape and procedures that should be followed in rolling out the PPP&P study.

A second workshop was held to identify representatives of services users in Mpoza area. The second workshop had two principal aims. The first aim was to identify key individuals that could be consulted in the subsequent two stages of the PPP&P project. The second aim was for the community to identify a village or cluster of villages that could become a case study of service delivery and citizen engagement. The community stakeholders at the first workshop felt it was necessary to bring together a smaller group of people who would represent and be accountable to the community during the implementation process of the PPP&P study. As a result the stakeholders elected a team of advisors referred to as the 'research advisory group (RAG). The RAG consisted of men and women who played different roles in the community. A total of 12 people formed the RAG, whose task was to liaise and provide further guidance to the research team on the subsequent steps of the research process. Table 2 below lists the stakeholders.

Table 2. Composition of the advisory group			
Constituency	Number	Male	Female
Traditional leadership/authority	2	1	1
<i>NopoyiThusong</i> Center (manager)	1	1	
Local School Teacher	1		1
Community Rep	3	2	1
Ward Committee (local municipal representatives)	2	1	1
Community Development Workers ¹⁶	2	1	1
Total	11	6	5

The second aim of the workshop of the PPP & P was to circumscribe the scope of the study by identifying an exemplar village. Defining the scope of the study was necessary for practical (the amount of funding available) and logistical reasons (accessibility of deep rural locations in terms of time and human resources). The area under study consists of 15 villages and covers a vast area. It was recommended

¹⁶Community development workers (CDW) are multi-skilled public servants in the community to help people access government services and poverty alleviation projects (CPSI, 2005).

that at least three villages falling within two larger villages¹⁷ should be included in the PPP & P study based on the following criteria that emerged through deliberations with the RAG, the tribal chief and two of his headmen:

- Population size: between 100 and 120 households with a population size of approximately 5000
- Allocated community development worker (CDW) familiar with service structures
- Co-operative headman who was willing to participate in the PPP& P study (based on participatory ethics see below)
- Established social structures who could act as representatives of the whole community
- Community members belonging to a disabled people's organisation (DPO)
- Some access to services (e.g. primary health care clinic, schools) pertaining to the current study i.e.:
 - Health
 - Education
 - Social development¹⁸

Using the above criteria, three villages were identified from which the study sample would be selected. The flow chart below in figure 1 indicates the series of steps taken by the research team and the community during the community entry process.

¹⁷ During the Transkei Bantustan rule local authorities were organised into administrative area (A/A) under a single Chief or Headman (Transkei Authorities Act, 1965). In the new local government demarcation (Local Government and Municipal Demarcation Act, 1998), these areas are organised into wards (see Appendix 6). Some services like those provided by community development workers are allocated accord to wards.

¹⁸ Health, education and social development departments were specifically chosen as the focus of the sub-study because these services impacted directly on the residents' socio-economic rights.

3.3.5. Implementation

3.3.5.1. Community entry

Community entry refers to the process, principles and techniques of community mobilization and participation, and it involves recognizing the community, its leadership and people, and adopting the most appropriate process in meeting, interacting and working with them (Tahreen & Oumar, 1997). With regard to the current study, the researcher and members of the PPP&P project team were invited to an *imbizo*¹⁹ at the Mpoza Great Place²⁰ where the RAG and other community leaders introduced the Phase 1 sub-study to the community. Another aim of attending the *imbizo* was to discuss the basic principles and procedures employed in PRA methodology with the RAG. The research team further sought counsel from the advisory group on whether it was appropriate to engage people in such procedures in their community. After the meeting with the RAG, it was recommended that the members of advisory group participate in a pilot study of the PRA methods in order to advise the researcher about applicability and/or modifications.

3.3.5.2. Pilot study

A single day was initially intended to pilot both methods of data collection. However, due to other commitments and unavailability of some of the members of the RAG, the methods were piloted over two days. On the first day the mapping and modelling was conducted, followed by trend analysis on another day in the following week. The pilot study was conducted to determine three main issues:

- The suitability PRA methods for the people of the village
- The feasibility of the planned study
- And to identify potential challenges in the research protocol which might pose challenges to the quality of the data

¹⁹ A term used to refer to traditional meetings in the villages.

²⁰ A term used to refer to the compound of the local chief

The pilot study provided an opportunity to affirm and sharpen the research question, and to gain fresh insights into the research process (Babbie & Mouton, 2001). With regards to the current study, the pilot study provided an opportunity for the research team to familiarise themselves with the research setting and observe the performance of the protocol and data collection methods.

Subsequent analysis of the pilot data revealed a number of procedural and methodological challenges to the study. One of the procedural challenges related to the practical execution of the mapping exercise. It was concluded that the mapping be done indoors in the community hall²¹ at the Great Place. Chairs were removed and the floor was used to make the map. Different coloured chalk was used to draw the map and different objects like small boxes, stones were used to represent the geography and various points of interests. Some of the objects were identified verbally. This procedure was retained for the main Phase 1 study into perspectives of service users with one change. Instead of drawing with the chalk on the floor, black leather sheet was used. This change allowed the researcher to have the map on an easy-to-store format that could be moved around as stored data rather than having to clean the floor after every mapping exercise.

Another factor that emerged during the pilot study was that the information yielded during the trend analysis exercise was richer and more detailed than the information emanating from the mapping exercise. The discussion during the trend analysis appeared to come with natural ease. It became clear that the participants enjoyed sharing the common history of their own community. As a result of this observation, it was decided that the order of data collection methods be swapped around in the main study, such that in every meeting with the participants, trend analysis came first followed by mapping. In all the meetings (except for education),

²¹The hall was constructed from mud blocks and was used as administrative offices of traditional authority of the A/A during the Transkei government.

this appeared to set the participants at ease and allowed them to participate freely while triggering each other's memories about service delivery in their own villages.

At the end of the second day of the pilot study, after the RAG had experienced the PRA process, they were requested to provide the names of the key informants representative of a range of constituencies in the identified villages.

3.3.5.3. Study population

The study population consisted of the residents of a single village in Umzimvubu Local Municipality.

3.3.5.4. Sampling strategy

Maximum variation sampling was chosen for sampling participants. Maximum variation sampling is a form of purposive sampling where the researcher selects a small number of units/cases that maximize the diversity relevant to the research question (see sampling criteria below) (Sandelowski, 2000). The ultimate goal of maximum variation sampling is to obtain cases deemed information rich for the purposes of the study (Wesenaar, 2006). This method of sampling allowed the researcher to explore common and unique manifestations of residents' perspectives across a whole range of phenomenally and or demographically varied cases.

3.3.5.5. Study sample

The following criteria were used to identify informants who could provide representative information towards answering the research question. Representivity refers to the community groupings identified by the advisory group (see Table 5 below).

- Key informants with longitudinal historical knowledge of services and other social issues in the village

- Members of recognised social groupings/organisations so as to ensure perspectives were representative of gender and age
- People with disabilities
- Parents or caregivers of people with disabilities or living with a person with disability

Out of the 32 informants that were recommended by the advisory group, 23 were able and willing to participate in the study²². Table 3 below illustrates the demographic characteristics of the sample.

Table 3. Overall sample age and gender representation			
Female	Male	Total	Age range
12	11	23	17 – 72

The participants were further divided into three groups, namely education, health and social development groups as per the focus of the study. Table 4 below illustrates the age range and gender distribution per sector. The participants were assigned to each group based on the recommendations of the research advisory group.

Table 4: Age range and gender representation per group				
Sector	Female	Male	Total	Age range
Education	4	4	8	32 - 72
Social Development	3	4	7	17 – 68
Health	4	4	8	38 – 65
Total	11	12	23	

²²As indicated in the implementation process diagram, the research team sought informed consent from all individual participants recommended by the RAG.

It was also imperative to ensure that the community groupings that were identified in the villages were represented. Therefore, at all the meetings, an attendance register was taken and the participants were asked to indicate which community group they belonged to. Some of the participants belonged to more than one group. Table 5 below illustrates some of names of the groups that were represented and the number of people that representing the groups. Figure 1 is an illustration of the community entry, pilot study and the sampling process.

Table 5: Community groupings represented

Group name	Social composition	Focus issue	Representation per session		
			Education	Health	Social dev.
Traditional Authority	Men and women	Traditional leadership	1	2	1
Traditional Health care	Men and Women	Health and Spirituality	1	1	0
Clinic committee ²³	Men and Women	Clinic & Community liaison	2	3	2
Disability forum ²⁴	Men & Women (Youth)	Disabled people's interests	1	1	1
School Governing Body ²⁵	Men & Women	Parent-School liaison	4	3	3
Nobechunu Development Trust ²⁶	Men & Women	Farmers' interests	1	1	1
Malangabi ²⁷	Men (Youth)	Traditional entertainment	1	0	1
Inkctyo ²⁸	Women (Youth) lead by older women	Indigenous education	1	1	0
Church	Men & Women	Spirituality			
Mpoza male Soccer team	Men (youth)	Sports (soccer)	0	0	1
Uqoqosho ²⁹	Men & Women (Youth)	Traditional entertainment	0	1	0

²³The clinic committee consisted of community members who were democratically elected at the imbizo. Their main role was to liaise with the community and the clinic staff, particularly with regards to community needs and complaints about the clinic services.

²⁴The disability forum was made up of disabled people and other concerned individuals. The forum evolved from an initiative by the local municipality to organize disabled people for purposes of targeted services delivery.

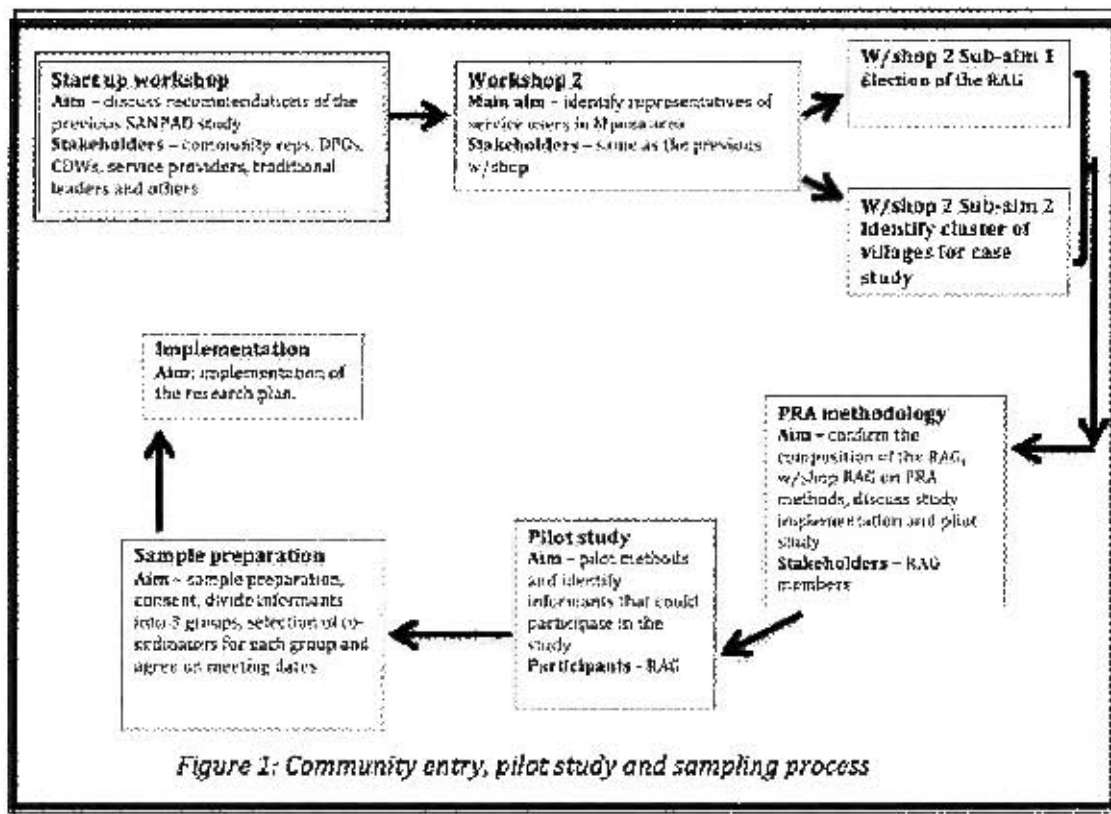
²⁵School governing body (SGB) consists of educators, non-educators staff and parents of children that go to the local junior school. The role of the SGB, particularly the parents, is to liaise with the parents and the school.

²⁶Mainly consisted of men and women who were involved in farming activities. Their role was to arrange meetings and workshops with the Department of Agriculture.

²⁷Traditional/cultural entertainment group composed of young men.

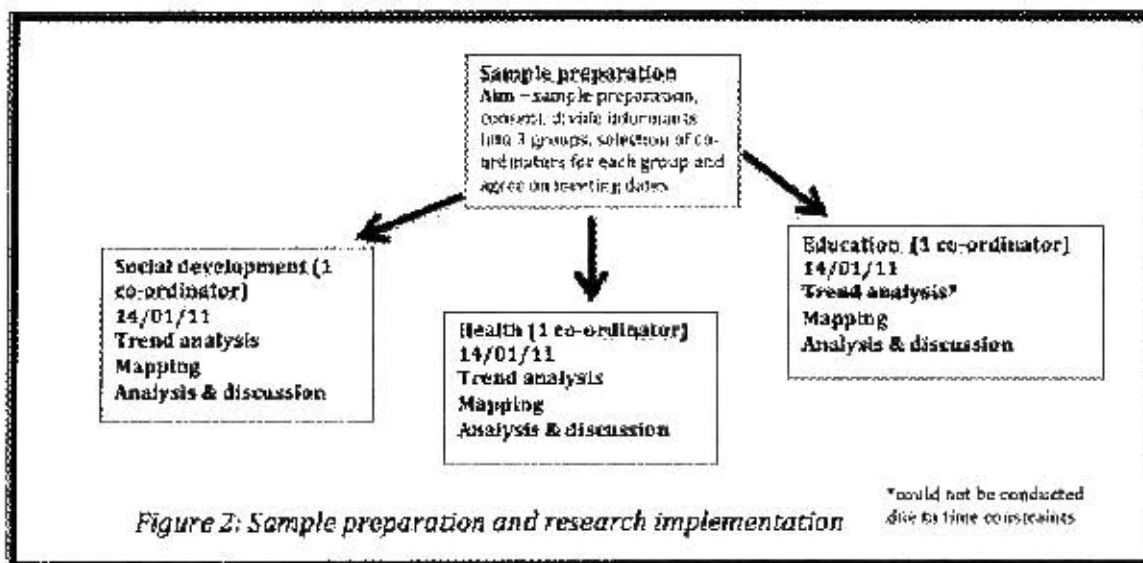
²⁸A yearly event for young girls in the area with the main aim of encouraging abstinence from premarital sexual activities.

²⁹Traditional/cultural entertainment group composed of young men and women.

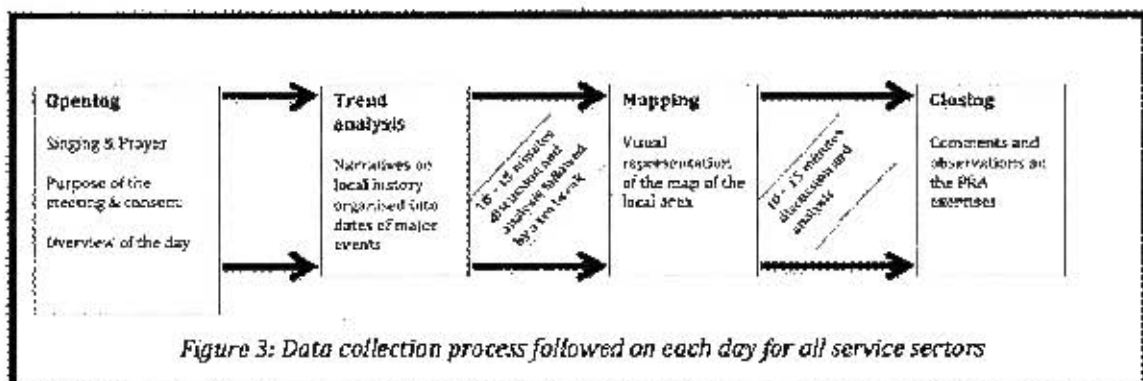


3.3.5.6. Data collection

Before data collection began, all the recommended key informants were invited to a meeting with the research team and the advisory group. The aim of the meeting was to provide information about the research study and obtain consent (see Appendix 1: consent and information sheet). Another aim was to discuss the best way to allocated informants into three service sectors and agree on dates of meetings for data collection. Figure 2 below illustrates the process of sample preparation, consent and implementation.



Data collection was done on three separate days at one of the study villages. Three Fridays of the month of January 2011 were agreed on as suitable dates on which to meet the participants for data collection. Each day was dedicated to one services sector. All group activities were facilitated in IsiXhosa. The researcher, together with the research assistant took field notes of the activities and met after each meeting for debriefing and translation. Trend analysis (see Appendix 10 & 11) and maps (see Appendix 12 – 14) created during the PRA exercises formed one set of data. Another set of data came from verbatim information emanating from the discussions about maps and during the trend analysis and was translated into textual data. Field notes and debriefing discussions with the research assistant were also translated and recorded textually. Figure 3 below illustrates the data collection process followed on each day.



3.3.5.7. Role of the researcher and the research assistant

In PRA methods the researcher and research assistant are required to take facilitating roles with the objective of ensuring maximum participation of the participants (Chambers, 1993). Therefore, it was essential that both the researcher and research assistant were skilled in managing group dynamics. A workshop and a pilot study (described above) were conducted to familiarise the researcher and the research assistant with managing group dynamics in a PRA activity (Bhandari, 2003).

3.3.5.8. Management of data

The researcher made two copies of each map or diagrams on an A3 size paper so that one copy is left with the participants. The participants decided who would keep the data, as it had to be accessible to the community when required. This was essential in PRA methods as the participants are regarded as the owners of the data (Bhandari, 2003). The rest of the data, which consisted of textual information, was kept safe by the researcher for further analysis. The results were reported to the community as part of the larger study on the 28th of November 2012.

3.3.5.9. Data analysis and interpretation

There is no distinct technique suggested for analysing data in PRA methodology. However, like many qualitative methods of information gathering, it is understood that PRA can produce rich findings on which to base interpretations and make hypotheses (Kumar, 2002). For the purposes of this study, qualitative content analysis was chosen as a strategy for analysis. Content analysis is a dynamic form of analysis of verbal and visual data that is oriented toward summarizing the informational contents of that data (Sandelowski, 2000). It is also important for the researcher to note that the accumulation of mass of notes awaiting review can be confusing if analysis begins when data collection is completed. Qualitative research

is generally characterized by the simultaneous collection and analysis of data whereby both mutually shape each other (Babbie & Mouton, 2001). Analysis was concurrent with data collection in order to avoid losing sight of the direction of research, and also to identify emerging issues for further investigation (Kumar, 2002). Content analysis is reflexive and interactive as researchers continuously modify their treatment of data to accommodate new data and new insights about those data.

Furthermore, the researcher kept the analysis related to the purpose and the scope of the study. A meticulous process of data organisation was followed. Transcribed data was arranged according to categories or key issues (Bhandari, 2003) Categorisation and coding of data was according to the objectives of the study. The use of pre-existing coding systems allowed the researcher organise the vast amount of data into manageable portions focusing on the scope of the study (Miles & Huberman, 1994). Data analysis occurred in four levels. For the summary of the analysis process see Appendix 15.

Level one of the analysis process began once the data was gathered. The research team sat together and consolidated the field notes into a fine note, that is, a detailed, clearly written and consolidated field notes (Kumar, 2002). The information organisation and initial analysis followed the sequence of: field note, fine note then final note (Kumar, 2002 & Bhandari, 2003). The end result, which was the final note, became the basis for further discussion, analysis and report preparation.

In the current study, at the end of each exercise, the researcher allowed for opportunity for discussion and analysis with the participants. This is one of the major characteristics of the PRA methodology as it allows for the participants to reflect on the information they provided and also allows the researcher to probe further (Kumar, 2002).

The purpose of the second briefing session was to discuss the group dynamics and consolidate the field notes, discuss issues relating to translation of other terms as all the PRA exercises were conducted in isiXhosa and to develop a fine note. Also part of the second briefing session was the preliminary analysis to pick up on verbatim quotes, key words and phrases relating to the five objectives of the study. This also allowed for further reflection by the team, where each member discussed some of the significant moments during the PRA exercises from both notes and memory. All the reflection notes from each team member were put together and formed an additional data set for separate analysis and categorisation in answering the research question. The result of the process was a translated fine note of trend analysis, maps, discussion with the participants and reflection notes that were all captured into a word document for further in-depth analysis by the researcher.

Level two of the analysis process involved sub-categorising similar phrases and quotes describing topics related to each of the objectives. Information was organised according to the date and the focus of the PRA exercise, such that the fine note for social development services was first, then health services and lastly education services. Analysis involved identifying words and phrases or codes that related to each of the five categories created according to the objectives of the study. This process was followed for each of the service sectors that were understudy. The end result was level three of the analysis process where categories were sub-categorised and salient points and key issues emerging from PRA process were identified. Level four of the analysis process involved integration of information. Each of the sectors had five categories that were in turn compared for links and patterns such that key themes could be identified. The comparison also allowed for an opportunity to check for plausibility of the information provided.

3.3.5.10. *Trustworthiness and Rigour*

According to Bhandari, (2003) the quality of the research process in PRA research is established by means of sequencing techniques. Although there is little consensus

on how to do it (Campbell, 2010), sequencing techniques involves the creation of an audit trail, whereby the researcher creates an account of method and data collection process which can stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions; and to produce a plausible and coherent explanation of the phenomenon under scrutiny.

Furthermore, Chambers, (1993) claims that the 'power' derived from the experience of using techniques involving participants is a mix of enjoyment, enlightenment and that brings a level of trust between the researcher and participants. However, due to the lack of literature about data analysis in PRA, some researchers in the field advise that using quality assurance measures from the wider social science literature, like triangulation and trustworthiness (Campbell, 2010).

In the current study, a number of measures were taken to ensure credibility of the research process. Firstly, a pilot study was conducted. The pilot study provided an opportunity for the researcher to identify any challenges that would confront the researcher in the methodology. Preliminary data analysis in the pilot study was essential in identifying factors that could compromise rigour in the main study (Babbie & Mouton, 2001). Secondly, a meticulous record of events was maintained and the process of data analysis was documented in detail. A codebook as suggested by Creswell (2009) where memos about the codes, definitions and translations were written to allow for alignment between data and codes.

Thirdly, the researcher employed triangulation, which is the use of different methods for collecting data (Peshkin, 1993). This allowed for the researcher to examine the evidence sources and use it to create a coherent justification for the themes (Creswell, 2009). With regards to the current study, two different data collection methods (mapping, trend analysis) were used to allow for better understanding of the phenomenon. Peshkin (1993) also states that using different data sources improves trustworthiness as the phenomenon can be understood from

different perspectives. Maximum variation sampling ensured that the participants were as diverse as possible and allowed for participation of individuals with varying perspectives for example, see table 5 above.

3.4. Ethical considerations

3.4.1. Ethical clearance

Ethical clearance to conduct the study was obtained from the University Of Cape Town Faculty of Health Sciences Human Ethics Research Committee (Ethics number: 428/2010). No changes in the protocol held any ethical implications. The process of community entry and all its principles were adhered to at all times. The ethical considerations for this study were guided by the declaration of Helsinki (2008) and the principles are clarified below.

3.4.2. Informed consent

Informed consent meant that participants were given adequate information about the research project explained to them in the language they could understand before agreeing to be involved. The decision to withdraw was respected without prejudice (Wessenaar, 2004). Verbal informed consent was obtained from all participants in the study. It is important to recognise that, as much as the community knew researcher from his professional work in the local clinic, he was still considered an outsider. Duncan & Watson, (2010) observed that groups and communities could be suspicious of the researcher's motives. And that could influence the response to and shape of the research process. In such situations it is important to consider seeking informed consent from participant a process rather than a once off event (Duncan & Watson, 2010). This was the approach taken in the current study and process occurred over two stages.

Firstly community permission was sought through the community entry process (described above). The study and the research process were firstly introduced to the community through the village 'gate keepers'. This provided an opportunity for community elders and the rest of the community to ask questions and also allowed the researcher to ensure that any material expectations were dealt with accordingly (Duncan & Watson, 2010).

The second stage was about seeking individual consent. Individual consent was sought when the research assistant invited all the participants that were recommended by the advisory group to the Great Place in the village. The invitation to the research preparation meeting (described above) was conducted in such a way that each participant indicated consent before they attended the meeting. This was to reduce any possible influence by the researcher in the participants' decision to participate. The researcher was known amongst the community as a health care professional. That understanding of the researcher as a service provider could have influenced the decision of some of the participants as it may have suggested material benefits. The plausibility of the findings was triangulated with literature and findings of the bigger study. Although the research assistant was available to act as a broker, the researcher acknowledges that some information could have been filtered during data collection. Also, in attempt to diffuse such power issues, the researcher did not participate in this stage but took time to explain the content and the principles of consent (see Appendix 1) to the research assistant and the RAG members who agreed to assist in contacting the selected informants.

The explanation related to ensuring that all the informants understood and were clear about what was expected of them and that there would be no compensation for participation. Assisted by two of the members of the RAG, the research assistant managed to visit each of the selected informants and invite them to the sample preparation meeting. At the meeting, the researcher also reiterated the content and the process of the research to the participants in the local language. The researcher clearly indicated that participation in the research process was voluntary and none

of the participants were obliged to be part of the study. The participants were requested to indicate consent verbally. Verbal consent was chosen as a method of indicating consent in this study to avoid the possibility of excluding illiterate members of the community.

3.4.3. Confidentiality

In a group situation, some of the participants might not be comfortable to share sensitive information and their knowledge for fear of prejudice or victimisation by other community members (Wessenaar, 2004). Therefore, it is the duty of the researcher to explain to the participants the importance of confidentiality and what measures are to be taken to ensure that. However, this was not possible in the current study due to the nature of PRA methodology. All the participants came from the same community and were familiar with each other. For that reason, it was possible that they had information about other members of the community that could have assisted the research process but may have been too sensitive to share. Such participants might have refrained from sharing the information. This was one of the limitations of the study.

3.4.5. Autonomy

In the current study, it was also important to stress to the participants that their participation in the research process was purely out of their own will, and they were allowed to withdraw at any time without prejudice. This was very important to explain because the researcher was known in the community as a health care provider. It was possible that his authority as a health service provider may have influenced some of the participants' decision to get involved in the research. Also the involvement of the traditional authority in the advisory group may have played a role in making some participants feel they have a duty not to disappoint the local Chief.

In dealing with the dilemma of autonomy and to manage the apparent power issues, the sample preparation meeting also provided an opportunity to explain to the participants that their participation was voluntary and that the researcher's role in the community would not be affected if any of them decided to withdraw from the process. Furthermore, the local chief and other members of the advisory group were also allowed to explain their role and participation in the project.

3.4.6. Beneficence

The community of Mpoza and Mount Frere in general is characterised by high levels of unemployment, which in turn contributes to the high levels of structural poverty in the area (du Toit & Neves, 2007). For that reason, it was possible that some of the participants' decision to participate was motivated by hope that some form of an incentive would be provided. It was also possible that the fact that the research team was associated with Cape Town, a place where some of the people in the area had left for to find work might have had an effect on the expectations of the people. In dealing with the participants' expectations, the researcher explained that no financial or other benefit would be incurred by any of the participants by getting involved in the research project. It was repeatedly clarified that the research process was not intended to assist disabled people directly, but by ensuring that the authorities heard their needs through dissemination of the research findings. The researcher also made a commitment to the participants that referrals to relevant authorities would be made as need arose. The researcher's commitment to ensure a follow up after each referral demonstrated demarcation between the roles of researcher and service provider.

3.5. Summary

This chapter provided a background of the PPP & P project and located this research report within the first phase of the project. It provided a picture of the context in which the research was conducted. The chapter detailed the structural poverty and poor socioeconomic conditions of the community compelled that these conditions. PRA methodology was chosen for the data gathering process. The steps taken to ensure the proper implementation of the study were described and the methods used to avoid any compromise to the quality of the study were identified. It concluded by discussing the ethical considerations that were addressed to protect the research participants.

CHAPTER FOUR: FINDINGS

4.1. Introduction

This chapter presents the findings gathered through participatory rural appraisal data collection methods: trend analysis and mapping exercise. The data gathered was analysed in line with the study objectives. The chapter highlights the key interpretive patterns that emerged through the data analysis process. In addition to the descriptions of emergent categories and key issues, tables are also included for further illustration of the findings.

4.2. Awareness of services

Both the mapping and trend analysis exercise provided most of the information regarding participants' awareness of services in the area. The content of discussions indicated that groups representing various constituencies in the community as well as individual participants held different levels of awareness about health, education and social development services. Some groups listed and described services with greater factual knowledge and awareness than others.

'...here I have the policy³⁰. It clearly states that we should be included and have access to work opportunities. But we don't get that. We not even represented in the local committees'.

However the general trend noted in the timeline activities was that Mpoza was characterised by limited service points during the early years of democratic rule in the country, but over time the situation gradually improved to a wider range of services. It was noted in trend analysis charts that events were few and far apart in

³⁰ Alfred Nzo district municipality published a policy in 2008 providing guidelines for inclusion of disabled people in employment opportunities in various departments and all projects managed or funded by the municipality

the 1990s, while there were more detailed and wider range of services in the past five to ten years.

Also evident was that, unlike education, a significant proportion of health and social development service centres were historically situated in town, a distance of about 40 km away from the villages. The participants described how they used to rely on poor transport services when going to the hospital in town. Poor road infrastructure was the main reason that there were few *quqas*³¹ that were willing to service the route between town and Mpoza.

'...there were very few quqas in those days because the roads were very bad, especially during rainy seasons'.

But the situation gradually changed. One of the significant precursors for the change was the construction of the health clinic in 1995. Immediately after the construction was completed, the construction of one of the main roads from the N2 route followed. According to the participants, the road construction led to an increase in the number of *quqas*, making it easier for the villagers to reach town.

'...after the road was completed, more quqas were willing to service the route [between Mpoza and town]. It became easier for people to go to town more often than they used to [before the road was constructed]'.

During the period following the road construction, residents noted mobile clinics visiting the villages more frequently than they use to.

'...the mobile [clinic] visited the villages more frequently and also began to reach further villages'.

The increased visits by the mobile clinics were significant for disabled people in the villages. Disabled people could be assisted by the mobile clinic staff to apply for

³¹*Quqa* a local term used to refer to private transport operators that transport people between the villages and town.

disability grants thereby saving costs. Visiting the social services office and the hospital in town was too expensive for them. Very few disabled people had identity documents at the time. Mobile clinic staff assisted villagers with health needs and also facilitated applications for identity documents and disability grants. The following provides findings on villagers' awareness of specific sector services.

4.2.1. Education

Participants' awareness of education services in their area was evident in their ability to not only describe available education services but to also categorize these services into five different types. The first type of education services was mainstream government or public schools and a special school for disabled children. The second type of education services was public adult education, which included both adult basic education and training (ABET)³² and *KhaRiGude*³³. The third type of education related to vocational training provided by the local government, specifically for disabled people. The fourth type of education was related to food security provided by an NGO in partnership with the Department of Agriculture. And the last form of education was mainly life-skills training provided by different community groupings and other government departments like *stokvels*³⁴, financial management skills from the social workers and agriculture related training from the Department of Agriculture. The following is a description of different kinds of education services and the differences in community access and participation in each case. Table 7 below provides a summary of education services described by the participants and their accessibility to community members.

³² Adult Basic Education and Training (ABET) program began in 1995 aimed at providing skills training. Some level of literacy is required for admission (Basic Education Department, South Africa, 2009)

³³ *KhaRiGude*: A mass education campaign established in 2003 by the former minister of education Mrs. Naledi Pandor to eradicate illiteracy (Basic Education Department, South Africa, 2009)

³⁴ In South Africa the term *stokvel* refers to a group people who usually come together and decided contribute towards saving a certain amount of money through monthly instalments. When and how the money is used depends on the initial objective of the group. Majority of *stokvels* save for Christmas holidays or unforeseen events, like death (Galvin, 2010).

Table 7: Described education services and service providers

Services	Government			NGO/Gov. partnership	Community groupings
	Public education	Local Gov.	SSASA/Dept. of Soc. Dev.		
Primary schools	x				
Secondary schools	x				
Pre-schools	x				
Adult education <i>KhaRiGude</i>	x○				
Vocational Training		x ○	x		
Life skills			x○		x
Food security/Agricultural				x	
Special schools	○				

x = Accessible to the whole community ○ = Accessible to disabled people

4.2.1.1. Primary and secondary education

Participants' descriptions of education provided by government entities in the three villages could be categorised into three levels: pre-schools, junior secondary schools and senior secondary ³⁵ schools (commonly known as high schools). The participants were also aware of a special school in the nearby town of Mount Ayliff.

Each of the three villages included in the study has one pre-school and one junior secondary school. Junior secondary schools were the longest serving form of education services in the area.

'...all the villages have always had a junior [secondary school]. High schools were only recently built. [Local] Municipality started building

³⁵The organisation of schooling in the form of junior secondary (grade R-9) and senior secondary schools (grade 10-12) is a phenomenon typical in the Transkei area of the Eastern Cape, a legacy of the former Bantustan administration (CCP, 2009).

pre-schools around 2000. Before then some villages did not have pre-schools.

Although there were high schools in other villages, the participants mentioned a number of factors that hindered people from proceeding to high school. These factors included distance from home, financial and cultural pressures that stressed the need for many young men to find work after the ninth grade, while young women were expected to marry and start families. According to the participants, such circumstances made it uncommon in their villages for learners to proceed to high school after the ninth grade.

However, from 1995 onwards two high schools were built in the area. One of the high schools, opened around 2005, was built through a Japanese funded project. The two high schools brought a significant change in terms of improving access to secondary education in the area although the participants indicated that additional high schools were still needed in the area.

'...children (in this village) still have to go to other places to find school. That is why the scholar transport is important...'

The availability of the road, constructed in the early 1990's made it possible for some learners to find schools elsewhere. The Japanese funding made it possible for the school to be built according to universal access specifications from the Department of Public Works, to make it accessible for disabled children.

However, to the disappointment of some villagers, the school has never enrolled a disabled child. The participants were also not aware of the enrolment of disabled children in other nearby schools. One of the main reasons for the schools to have no disabled children enrolled to date was the lack of awareness of disabled children's rights by parents.

'...some parents don't know what to do with their [disabled] children. They don't know where to even begin. They are not aware of their rights.'

A number of *nomkhayas* (village health workers) and community development workers (CDW) concurred this. According to one of the *nomkhayas*, mothers of disabled children tend to be less vigilant on matters of education for their disabled children, as opposed to issues that relate to access to a disability grant for instance.

'...you find that a disabled child is getting disability grant but when you ask about school, nobody gives you an answer. I think they don't think it's important'.

This lack of vigilance was also attributed to other factors: firstly, parents were not aware of available policies and laws that could help them pursue their children's rights;

'...very few parents know what to do about education of their [disabled] children'.

Secondly, parents did not believe that the local schools were suitable for their disabled children;

'...the schools here were not built to accommodate disabled children. Even teachers and the children at the school are not used to having disabled children around'.

And thirdly, most parents were not aware of the nearest special schools where their disabled children could be enrolled.

'...some parents don't know where to find a special school for their children'.

It was also noted that although some parents were aware of the nearest special schools, they were easily demotivated by the costs and amount³⁶ of procedures and paperwork required before the child could be enrolled.

'...to get a child accepted in a special school you need to go to the hospital, social workers and other places. That usually takes a number of days. Sometimes you have to go to town over and over again'.

4.2.1.2. Adult education

Adult education was differentiated into two types. Adult Basic Education and Training (ABET) classes, which were provided in local schools after hours, and *KhaRiGude* which were provided by community members who had registered as teachers. A number of participants had accessed ABET education since it began around 1998. The participants indicated that the two forms of education were different in terms of their usefulness to the community.

It appeared that adult literacy provided a level of independence for those who were able to attend. ABET content was useful to the extent that it allowed many pensioners to manage their grant money.

'...before ABET [education began] many pensioners were easily manipulated by family members as they were not able to count or write'.

It was also noted that ABET education has become less popular. Participants mainly provided information on the two sites that were available at the time of the study but were not aware of villagers who were enrolled. The participants did emphasise,

³⁶A round trip fro Mpoza village to Mount Ayliff would cost R110 person. The price would double for a wheelchair user. The parent would need several visit to the hospital to get doctor's assessment required for admission to a special school.

however, that access to the ABET site was limited to those who could walk. Inability to walk independently hindered some of the elderly people from attending.

A number of villagers were however involved in the *KhaRiGude* adult literacy project. *KhaRiGude* enrolled more learners, had more teachers and engaged more community members than ABET. Community involvement was in two parts, as teachers and learners.

KhaRiGude teachers visited their learners at their own homes. Learners mainly provided their times of availability and teachers would structure their visits accordingly. Each teacher had to have at least 10 learners and was expected to have visited each learner at least once a week. Visiting learners at their home was not difficult as all the teachers were from the same village. As a result *KhaRiGude* was perceived to have enrolled a large number of learners since its inception.

The participants could not provide the current numbers of enrolled learners and registered teachers in the *KhaRiGude* project³⁷. However, one of the *KhaRiGude* teachers, who was also a village health worker, estimated that in the Mdlazi area there could be about 30 learners. All teachers were local community members who had to have completed at least grade 12 for them to be registered for the adult education course provided by the Department of Basic Education. Enrolment of learners was open to all who wanted education but were not willing to attend mainstream ABET education. The youngest learner mentioned to have enrolled was in his early 20's and the oldest learner was in her 80's.

Participants were generally more aware of the activities of *KhaRiGude* than public schools. It was also further noted that the level of involvement of community members was generally higher in *KhaRiGude* than that of public schools. This was

³⁷The number of registered *KhaRiGude* teachers at the time was 18 according to the ABET coordinator allocated in the area.

indicated by the fact that almost all the participants in the education group contributed to the discussion about *KhaRiGude*.

Some participants even posed critical comments regarding the number of *KhaRiGude* teachers. A respected elder in the community indicated that the number of *KhaRiGude* teachers was 'too much'. It was perceived that the increased number of teachers compromised the value of the project in some way.

'...There are too many KhaRiGude teachers now. That is not good. It is hard to make sure that everything goes right in such a big number'.

The participants even went further to propose a maximum number of teachers in each village.

'...I think 10 teachers in this village is enough'

However some participants felt different. They had positive perceptions about the growth of the *KhaRiGude* project. Those who once enrolled learners felt that the increased number of teachers was a positive thing. They felt that the *KhaRiGude* project was only compromised by the 'lack of enthusiasm' of some of the learners. Some people who enrolled did not commit for the duration of the courses. The reasons for dropping out were not provided. Some participants indicated that learning to operate a bank auto teller machine (ATM) was one of the most important things to have been learnt from *KhaRiGude*.

4.2.1.3. Vocational & life skills training

The participants described vocational and life skills training as another form of education services provided by the local government and the Department of Social Development. The vocational training was limited to selected people who

participated in the Umzimvubu Disability Forum³⁸. According to the participants, the training was intended to provide skills for starting income generating projects. The local government intended to finance the disability forum with the initial capital.

Life skills education began when social workers from SASSA and the Department Social Development started doing weekly visits. According to the participants this form of education had been useful in educating disabled people and pensioners on financial management skills and their rights to access social grants. This form of education also extended to the community groupings, especially *stokvels*, locally referred to as *oogqebha*.

4.2.1.4. *Training in food security & agriculture*

The food security program was a venture between an NGO called *Lima*³⁹ and the Department of Agriculture. Villagers reportedly participated in different ways in the program. One form of participation entailed learning about food security. The participants could not provide much detail on the specific content of this form of education, however, they mentioned a number of homes in the village where the agricultural equipment is kept and people meet in some of those homes for the program purposes including education. None of the participants were aware of disabled people who had participated in these activities.

³⁸ Umzimvubu Disability Forum was formed in 2006 by disability activists on invitation by the local municipality in order to provide a forum for the municipality to interact with disabled people regarding service delivery issues.

³⁹ *Lima* was an NGO that encourages and assist rural people to be involved in agriculture. It works in collaboration with the department of agriculture in the area.

Table 8. Salient findings regarding the awareness of education services

a) Disabled people remain excluded from most education services in the area
b) Improved service delivery for the community including disabled people hinges on improved infrastructure
c) Local people, including family members of disabled people are not aware of available information regarding disability rights
Main perspective: Improved local infrastructure and awareness on disability rights are pivotal for disability inclusive education.

4.2.2. Health

Health services in Mpoza were differentiated into three types: firstly government/public health services, which included mobile clinics, village health workers, a local clinic and the hospital in town; secondly traditional health care and thirdly health services that were more erratic such as those rolled out through events and campaigns⁴⁰. Although the participants were not always aware of the source of some of the services provided during the campaigns, they indicated that government departments provided some services, while NGO's also provided some services. Each of these types of services met different health care needs for different villagers.

Participants were both aware and reported accessing specific services from various service points. Mainstream government health care provided a variety of services that were different from traditional health care. The services provided by one type of health care might overlap with other, but with varying emphasis. Table 9 is an illustration of various kinds of services provided by different types of care. Also indicated on the table are those services that were known to be accessible to disabled people in the community.

⁴⁰On the official opening of the Nopoyi *Thusong* centre in May 2009, service providers were also invited to provide various services at the event. They included a range of departments such as Home Affairs, Health, Social Development and SASSA.

Table 9: Services provided by each type of health care

Services	Government services				Traditional health	NGO
	Clinic	Mobile clinic	Hospital (in town)	<i>Nomakhaya</i>		
Primary care	XO	XO	XO	X	XO	
Emergency care	XO		XO		XO	
Health promotion	XO	XO		X		XO
Treatment for chronic diseases	XO	XO	XO		XO	
Assistive devices			O			O
Identification and Referrals	XO	XO	XO	XO		

X – Accessible to the whole community O = Accessible to disabled people

4.2.2.1. Government/public health care

Participants noted that public health services in the area were once situated in town but the construction of better roads brought change and mobile clinics were introduced. Although mobile clinics have, over time, become supplementary to the clinic, they remain the oldest form of health care that was easily accessible without having to travel to town. The participants gave stories about mobile clinics beginning from early 1995, emphasising that this service ‘changed the lives’ of many community members including disabled people as they enabled access to other services such as social grants and specialised health care at the hospital.

‘...nurses in the mobile clinics identified children and other people who needed further assistance they would be referred. They would also arrange for home affairs and social grants’

However, it was also noted that mobile clinics were not always helpful because they often lacked the necessary medical supplies and expertise. Few villagers had clinic

registration cards and could not receive mobile clinic services. The building of the local clinic was significant in improving the effectiveness of local health care services. To most participants, the clinic represented an imperative point of access to mainstream health care. It also reduced travelling costs significantly.

Other participants indicated that the clinic was also an option, or alternative to the hospital service in town. Some participants felt that the clinic could never replace the role of the hospital. Even with the presence of the clinic, the hospital still remained the ultimate service provider.

'...when you go to the hospital, you get everything. Doctors don't come to the clinic. Sometimes you never get all the medicines you need[at the clinic]'.

Another alternative was the *nomakhayas*⁴¹. The local clinic and the mobile clinics were not effective in reaching all the villages in which case the *nomakhayas* provided an important bridging service.

'...Although, the mobile clinic can reach further villages, there are those people who are still far [not reachable by the mobile clinic]. The nomakhayas assist in identifying individuals that need health assistance in [unreachable] villages'.

The village health workers managed to ensure that those who were difficult to reach such as disabled people and the aged were identified and arrangements were made to receive health services elsewhere. The *nomakhaya* would arrange transport to the clinic or sometimes the hospital. Clinic nurses would get involved in the process. One main reason cited for nurses' non-involvement was lack of staff, as they would

⁴¹*Nomakhayas* work as a liaison between the clinic and the community through home visits. They were trained with basic CPR skills and each was issued with a first aid kit. They report to the local clinic. Most of them used to be volunteers in a local NGO where they received the training. But that changed in 2006 when their services were handed over to the provincial government. They now receive a stipend of R1200 from the government.

have to attend to other patients visiting the clinic. One of the *nomakhayas* stated that:

'...it's difficult. Sometimes you can call the ambulance or ask the sister at the clinic to help. But its hard if the person cannot go to the clinic. You end up looking for transport yourself'.

4.2.2.2. Traditional health care

Traditional health care was presented as an alternative to mainstream government health services. However, *nomakhayas* discouraged the use of traditional health care because some of the treatments of the traditional health practitioners are believed to cause disability.

'...We always tell people to stop using Isigidi⁴² during pregnancy. It makes the baby get disabled'

However, most of the participants disagreed. Traditional health care could never be done away with due to a number of reasons: the limited operating hours of the clinic;

'...the clinic opens during the day. In cases where an emergency occurs at night, traditional health practitioners are helpful. The traditional health practitioners will help in stabilising the person until the clinic opens in the morning and they would take them to the clinic.

And perceived inability of mainstream medicine to deal with certain illnesses;

'The use of traditional health care is very important in treatment of 'plate'⁴³. Amalawu⁴⁴ can treat it. 'Plate' cannot be treated in the clinic or the hospital'.

⁴²*Isigidi* is a traditional herb/medicine usually given to pregnant women to shorten the labour period during birth (2012).

⁴³*Plate* refers to babyhood or childhood illnesses understood by rural communities to be associated with the birthing process. The most common symptom of these afterbirth illnesses is diarrhoea (Personal communication with Dr.Mthobeli Guma, medical anthropologist at Guma Holdings South Africa).

⁴⁴*Amalawu* is term used to refer to traditional healers or diviners who have spiritual abilities to dispel bad omens that can befall a family (Schneider, 2004).

Some participants acknowledged that there was space for both mainstream and traditional health care to deal with different health care needs of the community.

4.2.2.3. *Other health services*

These services were specifically related to access to assistive devices for disabled people. Participants told stories of various events in the past where people would be invited to meetings at *Thusong* centre or the Great Place where crutches and wheelchairs would be distributed. The participants were not aware of the source of these services.

'...Sipho⁴⁵ got his wheelchair at the imbizo at the great pace last year. He was given a wheelchair by some people who were invited there'.

⁴⁵Not his real name

Table 10 below highlights some of the salient finding regarding awareness of health services by the participants.

Table 10: Salient findings regarding awareness of health services
a) Major roles of the mobile clinic and <i>Nomakhayas</i> included: <ol style="list-style-type: none"> I. Identification and referral and II. Limited primary health care⁴⁶ for the residents including disabled people.
b) Traditional health care is a significant part of the broader health care system, and remains useful in meeting specific health care needs.
c) <i>Nomakhayas</i> and the residents have opposing beliefs about use of traditional health care, leaving patients with an option between two health care systems.
d) Access to assistive devices for disabled people still limited. They need to go to hospital or approach NGOs to access this service.
<i>Main perspective: There is limited understanding of service entitlements from health care facilities and a belief that local health facilities do not always meet patients' needs/expectations.</i>

4.2.3. Social development

Participants were aware of two main forms of social development services; government services and those delivered by NGO's, some in partnership with government. Government services included social grants⁴⁷ and identification of needy families for social assistance such as food parcels. Social workers from town would also visit needy families as recommended by the *nomakhayas* or community development workers CDW⁴⁸.

⁴⁶The term primary health care (PHC) is used here in a narrow sense of primary level health services delivered by departments of health, and does not include the broader conceptualisation of PHC such as in the Alma Ata Declaration

⁴⁷Different types of social grants are: disability grant, foster care grant, old age pension, child support grant and poverty relief grant

⁴⁸Community Development Workers (CDW) are employed by the Department of Local Government to be liaison between local government and other departments.

Although CDWs and *nomakhayas* were not employed under the department of social development, they were reported to be responsible for monitoring and implementation of some social development services. One of the responsibilities of CDWs in this regard was supervision of state funded income generating projects in the area, which always had a short life span. The CDWs were also responsible for liaison between government agencies and various NGOs operating in the area. NGO's activity was quite common in the area through funding and management of income generating projects. At the time of the study, only the poultry project in Msongonyane was functional. Other projects had either closed down or were dysfunctional, the participants reported. The reason for the dysfunction was due to poor supervision by CDWs.

4.2.3.1. *Government services*

Social development services were historically only accessed in town. It seemed that distance made it difficult for most villagers to access the service. The construction of the Glen Holy gravel road from the N2 route brought significant change. Distance and poor infrastructure affected access to services. Improved roads after 1995 made it possible for villagers to access both social grant identity documents application.

“...the construction of the gravel road made it easy to reach town. We were able to go to town for application for social grants. Application of disability grants was also made easier as the people were able to go to the hospital in town”

The Table 11 shows the services that were described by the participants and the service points or personnel who provided the services.

Table 11: Social development services

Services	Government service points/personnel					NGO
	SASSA offices in town	Social Development/ SASSA offices @ Thusong	Mpiti Shop	CDW's	income generating projects	
Application for social grants	XO	XO				
Payments of social grants			XO			
Application for ID	XO	XO				
Employment						XO
Food parcels		XO				XO
Identification and referrals				XO		
Supervision of projects				X		
Home visits (once a week)		X O		X O		

X = Accessible to the whole community O = Accessible to disabled people

The improvement of local infrastructure was significant because of the impact on social well-being. The installation of taps, for instance, not only was perceived have reduced cholera and related illnesses but also made it easier for some disabled people in the area to fetch water themselves instead of hiring people for fetching water for them in the river.

...when the taps were installed, illness like cholera decreased. Also it became easier for disabled people to fetch water. They can't go to the river. They have to rely on other people or pay relatives to get water for them.

In addition to the road, other infrastructure changes mentioned by participants included building of toilets, installation of taps and building of Nopoyi *Thusong* centre. The participants recognised that changes in infrastructure also indirectly affected other services in the area.

Participants reported that the construction of Nopoyi *Thusong* centre was intended to 'bring services to the people' such as social development department offices and home affairs department offices but these have not yet become fully operational.

The construction of Nopoyi *Thusong* centre might have brought the participants the hope of improved services, but they soon learnt that the presence of infrastructure does not necessarily mean the availability of services. The opening of the *Thusong* centre did not bring the promised change in services leading to a level of frustration and disappointment.

"The centre is not fully functional because it is still under the control of the province. A board needs to be elected to manage the activities. But that is not possible. The centre needs to be transferred to the local municipality first. Now we have police using a house [belonging to one of the residents] instead of the centre. They cannot use the centre because there is nothing there. How can we get the security we need during social grants payments?"

Security was the main reason for social grant payments being done at a local shop rather than the *Thusong* centre. For the residents, proper security at the *Thusong* centre was needed before they could allow social grants payments to be relocated. As a result the Mpiti⁴⁹ shop in the local community remained crucial for the villagers for this purpose.

In addition to the *Thusong* services, there were also services provided by the community development workers (CDW). CDW's were important for identifying

⁴⁹A local supermarket in Mdlazi area

homes that needed social assistance and disabled children who did not receive social grants. Their main role was to assist the families to find the required documentation for registration. Such families could also be included in the (SASSA) visits.

4.2.3.2. *NGO services*

The CDW's were also expected to supervise the income generating projects in the area. A number of these projects had closed down at the time because they lacked proper supervision. The main concern for the participants was that the CDW's were 'not doing their job'. The prevailing perception amongst the participants was that the CDW's were 'lazy and not committed'

'...CDW's are supposed to monitor the projects and report to [the department of] social development. They are lazy to do that as they should'.

Table 12: provides a summary of the salient finding regarding awareness of social development services in by the participants.

Table 12. Key findings regarding awareness of social development services
a) Accessing social development services at the local <i>Thusong</i> centre, rather than town, was regarded as an improvement in service provision by the department.
b) The residents were not satisfied with the current role played by the CDWs.
c) Social development services were limited to social grants administration. There was little or no evidence of other services ⁵⁰ , thus delivering an incomplete service package.
<i>Main Perspective: Services users can monitor service delivery, with more vigilance on the services that are provided within the community than those provided from outside the community.</i>

4.3. Effect of the changes in service delivery on the perception of socio-economic rights

The second objective of the study was to describe how the changes in service delivery affected the villagers' perception of socio-economic rights. There were a number of key issues that were identified as defining participant's perceptions on rights and these are described below.

⁵⁰In addition to management and administration of social security, social assistance and social insurance, the department is primarily responsible for developmental social welfare services such as social support services, community development, community based services, social integration of marginalized communities, advocacy and community based rehabilitation. Secondary roles involve, provision of transport, provision of assistive devices, promoting employment opportunities, facilitating for inclusive education processes, provision of medical rehabilitation, economic empowerment to people with disabilities (Department of Social Development, 2005).

4.3.1. *Poor infrastructure compromised the right to access to services*

On all the maps drawn by the participants it could be clearly noticed that government services points were built along the main gravel road. Trend analysis also revealed that construction of roads was significant in improving the accessibility of services for the villagers. Participants emphasised that for health services, the building of the gravel road made it possible for the mobile clinics to reach further villages.

Similarly, social development services such as weekly visits by the social workers also improved with the construction of roads. The building of the *Thusong* centre also provided enough office space for the social workers to spend more time in the village. As a result more families could be assisted, as social workers did not need to leave immediately to return to their offices in town.

One of the local junior secondary schools had to be moved from the original location to a site along the main road because the road leading to the original site was inaccessible during the rainy seasons. But the participants were concerned that the school was still built with prefabricated material in spite of promises from the education authorities to provide brick buildings for the school.

At the end of junior secondary school, learners had to find school elsewhere as there were only two high schools closest to the three villages included in the study. During the discussions of maps and the trend analysis, it was clear that the government scholar transport was very important for learners to reach their schools. According to the participants many learners relied on the scholar transport as their schools were far and parents could not afford transport fare. However, disabled children did not benefit from the scholar transport like their non-disabled peers. There was no scholar transport to the special school. This was a concern for some of the participants. One of the parents clearly indicated that a similar service for disabled

children would allow mothers to send their children to school, as public transport is not user friendly⁵¹.

4.3.2. Availability of service points, does not necessarily mean access

As much as the participants could identify different service points on the map and even list them verbally, they also raised concerns about difficulties experienced in obtaining the actual services as promised by policy. For instance, some of the participants were concerned about the fact that their disabled children could not be accepted at the special school in Mount Ayliff, and that was why their children were not in school.

Although the *Thusong* centre was officially opened a year ago, the promise of bringing a number of essential services closer to the community had not yet been realised. The centre was still not fully functional. Social workers come once a week, while the satellite police station and the post office had never been opened. Similarly, despite mobile clinics visiting the villages regularly they do not always have enough stock of medicines or registration cards. As a result people still end up being referred to the clinic or the hospital in town.

4.3.3. Improved services minimised chances of victimisation for the vulnerable

Improved local infrastructure, particularly with regards to access to clean water, was also discussed as a pertinent element in the improvement of the lives of villagers. During the mapping of social development services, some participant emphasised that it was important to identify water taps on the map. The discussion on installation of taps was also central during the trend analysis of health services.

⁵¹Wheelchair users paid double on local public transport for a single trip to town.

Two main issues surfaced: how the taps have made access to water for disabled people easier and how the installation of taps in the villages reduced the incidence of diarrhoea in children. When disabled people had to hire people to fetch water for them that increased chances of exploitation, as some people would want to charge them unreasonable amounts.

One of the community leaders, a chair of the local water committee, mentioned that before the taps were installed there were too many cases of diarrhoea in the community and most of them ended up in the hospital. And with very poor ambulance services in the area, the people lost a lot of money, as they had to hire transport from local community members.

4.3.4. Parents played a role in facilitating access to services for disabled children

During mapping of the education services, participants discussed the role of parents, particularly the mother, in the education of disabled children. It was agreed that education for a disabled child depended on the mother finding a suitable school. The reason for disabled children not being at school was reportedly due to their mothers' lack of effort in finding proper schools.

'Disabled children are not in school because their mothers are not trying to find school for them'.

It was also suggested that disabled children with an educated mother were more likely to be at school than those with uneducated mothers. For some participants, the fact that some of the mothers in the area were illiterate made it difficult for them to seek information that could assist them to find schools for their children. As a result, the mother's lack of awareness led them to be less proactive about their children's education.

'Disabled children whose mothers are nurses or teachers are in schools. Their mother tried to find special schools for them'

Participants discussed the fact that educated mothers are likely to be employed, which could mean that they can afford to pay for their children to be in special schools. Also the disability grant that the disabled child receives might be the only source of income for a poor family, thus discouraging mothers from finding a suitable school as that would result in the household no longer having access to the disability grant.

4.3.5. Enjoyment of rights requires activism

Disabled people in the village had become more vocal over time regarding their access to rights. One of the disabled representatives challenged community leaders about their unwillingness to familiarise themselves with government policies.

'...here I have the policy. It clearly states that we should be included and have access to work opportunities. But we don't get that. We not even represented in the local committees'.

Showing a copy of the local municipality's policy regarding inclusion of disabled people in infrastructure projects, the participant claimed that leaders 'refused' to familiarise themselves with the policy. He further claimed that the local disability forum would continue to fight for inclusion as citizens in the community.

'...Although we may be young, we shall continue to fight for inclusion. (Addressing one of the community elders directly) Please father, consider us when these opportunities come'.

4.3.6. *Community leaders ignore local disability inclusive policies*

During the trend analysis of social services, it became apparent from the local disability representatives that disabled people were not included in the local infrastructure projects. Although there were guidelines from the local municipality regarding disability inclusion, these were not implemented. For some of the participants, the lack of implementation was deliberate by the community leaders. The lack of interest by community on disability inclusion was also evident in the fact disabled people had never been represented in the infrastructure committees.

'Disabled people are not in the committee. But we all know that disability inclusion is part of the policies of the municipality. I have a copy. The policy says we [disabled people] must be included.'

4.3.7. *Reasonable accommodation... to an extent*

In the discussion about the lack of representation of disabled people in infrastructure projects, one of the community leaders indicated that participation of disabled people was difficult. The main reason for the difficulty including disabled people was that villagers were usually employed to do manual physical labour. It appeared that there was as a perception among community leaders that disabled people could not do manual physical labour.

'...Disabled people need to do easy jobs. Sometimes the kind of work in some projects is heavy. Maybe if there are easy jobs maybe they can do them.'

Table 13: provides a summary of the salient findings regarding participants' perceptions of rights.

Table 13: Key findings regarding participants' perception of rights
a) The right to access to services for the community, including disabled people was compromised by poor infrastructure.
b) Exploitation of disabled people amounted to violation of their human rights
c) Women and disabled people themselves could better deal with issues relating to disability rights. It was not the role of the whole community (men).
d) Community leaders did not prioritise disability rights, because they did not trust that disabled people had the necessary abilities to contribute to society.
Main perspective: Efforts must be made to promote human rights, but that is not the role of the whole community. Promotion of disability rights in particular, is the role of women.

4.4. Sources of information used to formulate perspectives on service delivery

The third objective of the study was to describe the sources of information used by residents to inform their perspectives on service delivery. The data revealed that service providers were the main source of information for the residents, including disabled people. These included, nurses, *nomakhayas*, CDWs, teachers and social workers. For some disabled people, information from family members and friends was the basis of their decisions.

'We listen to what the nurses and nomakhayas advise us to do. The CDWs also give us information on what to do when trying to apply for a grant or find a school for a disabled child'

'One lady advised me to go to the hospital. One of her children is disabled'.

"A teacher from the school visited my grandmother after school to enquire about my schooling. She advised her that I should be in school. She said it was not right for a child to stay at home"

However, the introduction of *nomakhayas* and CDW's appears to have made an impact in terms of educating the mothers about the rights of disabled children. Some of the parents mentioned that their interaction with the CDW's or *nomakhayas* were the main reasons they began to pursue disability grants or attempted to find a school for their disabled children.

'The nomakhaya helped me to find a grant for my child'

'The CDW used to visit one of the families in the village and she advised them to find the school for the child'

Other residents also used local community institutions as sources of information. These included *Imbizo*, church meetings and *stokvels*. Participants mentioned that they began to seek social assistance for their children after they had attended a local *Imbizo* where an NGO was invited to interact with the community. Other participants told a story of a local Catholic pastor who worked with disabled people. Amongst other things, the pastor's work involved educating disabled people about their rights and assisting them to obtain assistive devices like wheelchairs.

'...Father used to invite disabled people to the church on Sunday afternoons. He gave them food and second hand clothing. But he also spoke to them about things they can do to improve their lives. And he also assisted some to get grants'

Table 14: provides a summary of the salient findings regarding participants' sources of information.

Table 14: Key findings regarding sources of information

a) Service providers: <ul style="list-style-type: none">• Nurses (at the clinic)• <i>Nomakhaya</i>• CDW• Teachers• Social workers
b) Local networks and community meetings <ul style="list-style-type: none">• Family and friends• <i>Imbizo</i>• <i>Stokvel</i>• Church meetings
<i>Main Perspective: Perspectives on service delivery are based on information obtained from local sources.</i>

4.5. Barriers and facilitators to access to services

The fourth objective for the study was to describe some of the barriers and facilitators to accessing services as perceived by the villagers. It was apparent that most of those factors that were perceived as facilitators could also be perceived as barriers. The contradictions surfaced during discussions with different participant voicing different perspectives. Below is the discussion of some of the items that presented as contradictions.

4.5.1. Infrastructure

Significant infrastructure included roads, the clinic, *Thusong* centre, building of toilets and the communal taps. However, the geography of the area and local transport was not user friendly making it difficult for disabled people to access

services. The types of mobility devices available to disabled people were not appropriate for the terrain.

4.5.2. Community attitude

Although both the clinic and the local primary school were built on a land allocated by the local chief and the community attitude was conducive to development and improved services, disabled people were disappointed at the local community leaders' persistent ignorance of local policy regarding inclusion of disabled people.

4.5.3. Community groupings

It was noted that different sectors of the community interacted differently when the discussion focused on certain types of services. For instance, women were more vocal when talking about the local churches; finding schools for disabled children and the *KhaRiGude* campaign. However, the concern indicated earlier about *KhaRiGude* by one of the participants regarding the number of teachers involved, may be a perception of a lack of trust in women to sustain the service.

"...there are too many teachers in KhaRiGude. That is not right".

4.5.4. Income generating projects

A number of income generating projects such as traditional and contemporary handcrafts, brick making and poultry projects were identified as important sources of income. The projects were instrumental in the employment of disabled people and women.

On the other hand, none of the four handcrafts projects was functioning at the time of the study. Only the bricks and the poultry project were functioning and

offices. However, the availability of *Nomakhayas* and CDW's had assisted a number of villagers about seeking social assistance.

'The Nomakhaya's (and CDW's) have identified a number of disabled children in the area who were just kept at home doing nothing. Some of these children were kept in backrooms or behind closed doors as if they never existed. ...but those parents now know that what they did was wrong and that they can receive help form the clinic and social workers'

The above quote also illustrates another perspective that emerged describing instances of lack of support and information from service providers to services users. Disabled children that were identified in mainstream school ended up spending longer time at home because their parents were not given enough information about their child's problem. As a result, some of the parents did not know what to do when they were told in school that their children had learning difficulties due to a disability. As a result they ended up in closed backrooms as described in the above quote.

4.5.6. Family support

Participants indicated that due to the terrain and geography of the area, family members have to assist their wheelchair bound relatives to get to social grant pay points or social workers at *Thusong* centre. Those who had mobility, sight or communication impairments were identified as a group that was most reliant on relatives to obtain information about and access to most services in the area.

'Some people disabled people cannot speak for themselves you know. So a nurse may not know what do. But when a willing family member is around its different. He can explain treatment to them'

However, during the same discussion some participants raised concerns that in many cases, relatives are more interested in exploiting the disabled person for the grant than in assisting them in accessing development opportunities such as attending school or securing a job.

'It is sad you know. Some disabled people are only taken outside because it's payday. No one is willing to help them with anything at any other time of the month. Once they get the money, they just use it'.

Participants also indicated that some disabled people were wheeled into service point in wheelbarrows not because the relatives were not aware what to do to access assistive devices, but because they were not interested in securing appropriate assistive devices for their relative.

'You see some disabled people on payday in wheelbarrows. They [family members] can get a wheelchair. But the money is more important to them'.

generating an income. The demise of many of the income generating projects was perceived to be due to lack of monitoring by the CDW's.

'...CDW's are supposed to monitor the projects and report to [the department of] social development. They are lazy to do that as they should'.

4.5.5. Service providers

Services providers, identified throughout the study as being local community members namely clinic nurses, *nomakhayas* and community development workers (were seen as providers of critical information in facilitating service access⁵²). The information provided by teachers regarding the importance of attending school for children was an important factor that encouraged parents to register their out-of-school children. Similarly for disabled children, teachers and clinic nurses were identified by some parents as the main sources of information regarding identifying suitable schools for placing their children. One participant keenly expressed that had it not been for the social workers that visited people's homes, some of the disabled children would still be out of disability grant system.

'Some parents don't know these things. Yes there are other parents that may have the information but the majority of parents in this area don't know how to proceed when looking for school for their (disabled) children. Sometimes nurses and teachers do assist with useful information, just to give direction on where to start'.

The *Nomakhayas* and CDW's were another cadre of service providers who were identified as useful in providing information that facilitated service access. Information regarding health and social development services was difficult to disseminate due to lack of staff and poor transport at clinics and social development

⁵²Other professionals such as therapists or local government such as ward councillors and traditional leaders were not mentioned important information providers.

Table 15: provides a summary of the key findings regarding facilitator and barriers to access to services

Table 15: Key findings regarding barriers to and facilitators of access to local services	
Facilitators	Barriers
Infrastructure: <ul style="list-style-type: none"> • Road, Clinic, <i>Thusong Centre</i> • Transport – scholar transport is highly valued. • Elderly have one free ride per month on subsidized government buses 	Infrastructure: <ul style="list-style-type: none"> • General geography and gravel road difficult to navigate and clinic not accessible for people with mobility impairments including wheelchair users • Disabled people cannot use the local transport (<i>Quqas</i>)
Community attitude: <ul style="list-style-type: none"> • Clinic and school built on Chief's land 	Community attitude: <ul style="list-style-type: none"> • Disabled people not represented in local infrastructure committees • Gendered roles in care of disabled people
Community groupings: <ul style="list-style-type: none"> • Allow voice & information exchange for some groups (e.g. church & <i>KhaRiGude</i> for women) 	Community groupings: <ul style="list-style-type: none"> • Too many teachers in <i>KhaRiGude</i> compromises proper monitoring.
Income generating projects: <ul style="list-style-type: none"> • Employment opportunity for community including disabled people 	Income generating projects: <ul style="list-style-type: none"> • Poor monitoring hinders sustainability • 'Laziness' of CDW's to monitor projects contribute to their demise/closure
Service providers: <ul style="list-style-type: none"> • <i>Nomakhays</i>, CDWs provide helpful information regarding the process of application for social assistance. 	Service providers: <ul style="list-style-type: none"> • Lack of support and information by teachers lead to disabled children being out of school for unnecessarily longer periods
Family support: <ul style="list-style-type: none"> • Enable disabled people to access services 	Family support: <ul style="list-style-type: none"> • Some disabled people are exploited and have no say over the use of their DG
Main perspective: The area has different forms of resources to facilitate service access, albeit partially.	

4.6. Unmet needs

The last objective of the study was answered by the last part of all the trend analysis exercises, which dealt with the future aspirations of the residents regarding service delivery. Some of the unmet needs mentioned by the participants included security during social grants payments, affordable and accessible transport, availability of assistive devices at clinics, proper functioning mobile clinics and construction of a special school in Mount Frere.

With regards to security during grant payments, the participants were concerned about the fact that the satellite police station at *Thusong* centre was not functioning. Participants believed that if the police station would function, some of the muggings that occur during grant payments could be avoided. The concern was also raised by some of the disability representatives who indicated that opening the satellite police station would allow SASSA to move the grants pay point to the *Thusong* centre thereby increasing access and security

Another concern from the disability representatives was the fact that transport was expensive and not accessible. Government subsidised busses were still inaccessible for disabled people. Bus drivers were neither responsible nor interested in helping the disabled people onto and off the bus. Busses were not equipped to accommodate wheelchairs. As a result travelling to the market in town was expensive for disabled people who had to opt for using local *quqas*. Busses were cheaper, while *quqas* were more expensive and charge an extra fee for a wheelchair.

Also expensive for the villagers was the fact that they had to travel to the clinic even when the mobile clinic had visited because it was not properly stocked. One of the community leaders mentioned he had met people from further villages a number of times and they complained that they came to the Mpoza clinic because the mobile clinic had no medicines. But if the mobile clinic were functioning properly, such incidences would be avoided.

Participants felt that mobile clinics should stock assistive devices, particularly crutches and wheelchairs⁵³. This was the view of some of the disability representatives. For the participants, travelling to the clinics and mostly the hospital to get assistive devices was expensive and not always possible for disabled people.

Lastly, the participants were also concerned about the fact that disabled children in Mount Frere had to travel to other places to find special schools. The participants indicated that building a special school in the local town would decrease the number of disabled children who are out of school.

Table 16: provides a summary of the key findings regarding unmet needs

Table 16: Key findings regarding unmet needs
a) Local security during social grants payments
b) Affordable and accessible transport for the community and disabled people
c) Availability of assistive devices at local and mobile clinics
d) Properly stocked and functional mobile clinics
e) Construction of a special school in Mount Frere
<i>Main perspective: Unmet needs related to the improvement of the already available services, no new services were identified. Limited awareness of service entitlements.</i>

⁵³Most assistive devices like wheelchairs, crutches and hearing aids need to be customised for the patient. They are not made in a 'one size fits all'. A skilled therapist must be involved in the issuing the device.

4.7. Summary

This chapter provided findings according to the objectives of the study. A number of core perspectives held by service users about service delivery in health education and social development in this rural community were identified. Service delivery in this rural area was complex, interactive and multi layered: physical, personal (behavioural) and administrative (planning). Physical factors related to poor local infrastructure and fact that awareness on disability rights was regarded as pivotal for disability inclusive education. Personal factors related to limited understanding of service entitlements from various sectors and a belief that local health facilities do not always meet patients' needs/expectations. As a result rural people have come to understand and respond to service delivery in particular ways, which warrant consideration in policy design and roll out. Residents recognised that efforts must be made to promote human rights, but those efforts were gendered. Women were regarded as more akin to disability related matters. Thus, from the perspective of the case study rural residents, policy implementation is a process that works best when the context (geo-political location, history, culture) of rural areas is taken into account.

CHAPTER FIVE: DISCUSSION

5.1. Introduction

The following chapter provides a discussion of the findings set out in the previous chapter, in relation to the objectives of the study and other relevant literature. It will aim to unpack the descriptions provided by the participants to define their perspectives regarding realization of rights and service delivery. The discussion will argue that local perspectives on the structure of service delivery in this rural area were that service delivery was a complex, interactive and multi layered: physical, personal (behavioural) and administrative (planning). There were certain dynamics, such as trust in service providers and local culture that determined how rural people understood and responded to service delivery, and these dynamics warranted consideration in policy design and roll out. Taking the context (geopolitical location, history, culture) of rural areas into account would have a positive contribution towards policy implementation and inclusive service delivery. Unintended consequences could be avoided by considering local dynamics about governance and power issues.

5.2. Perspectives on structure of service delivery

Participants held a particular view about the structure of service delivery in their local community. The local service structure was made up of three basic elements, namely: infrastructure, types of services provided by various departments and availability of service providers. Figure 4 below provides a schematic representation of the conceptualisation of service structure by Mpoza residents. In the form of a shelter, socio-economic rights constitute a roof, resting on three pillars representing the three service sectors or departments. The departments' services are in turn resting on the local infrastructure, because without the infrastructure the whole service delivery establishment would fall apart.

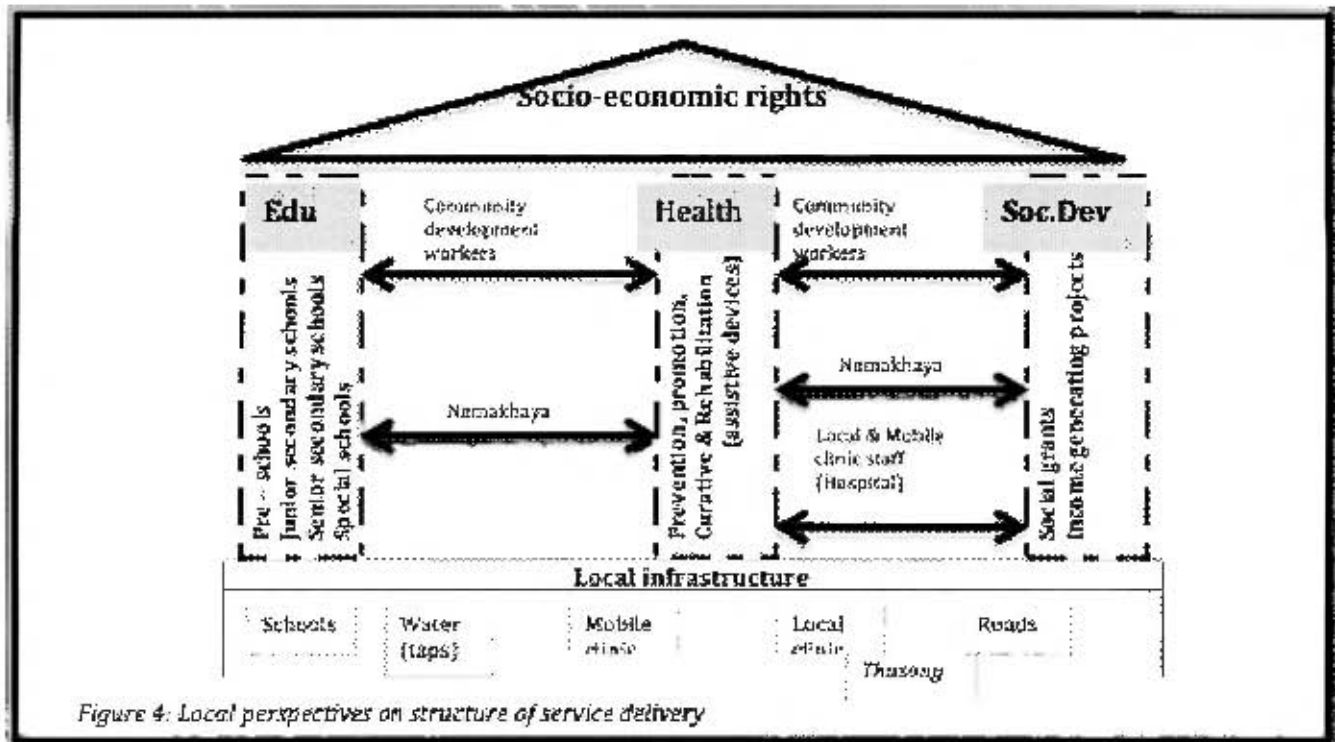


Figure 4: Local perspectives on structure of service delivery

Improved schools and clinics, better roads and building of the *Thusong* centre were an indication of the government commitment to provide the right foundations for proper delivery of local socio-economic services. The same approach is also reflected in government programs. Improving local infrastructure of rural areas was at the centre of the 2007 presidential nodal economic profiling project (Office of the President, South Africa, 2007). As part of this project, the chief aim of building *Thusong* centres was to reduce distances between rural communities and centres service deliver (Chief directorate: Provincial and Local Liaison., 2001b). The findings suggest a strong alignment between participants perspectives on service structures and that reflected in policy. This finding bodes well for stepping up citizen engagement in service delivery because rural citizens could contribute positively in policy implementation.

5.2.1. Improved service delivery hinges on improved infrastructure

All three groups recognised the mutual relationship between local physical infrastructures and provision of services. This perspective underpins the spate of the so-called service delivery protests that have plagued the country since 2006. A common message of service related unrest was the lack of infrastructure and basic services (Alexander, 2010). Mpoza residents viewed poor roads and inadequately built schools and clinics as having a negative effect on schooling and provision of health care respectively. These are strong RDP goals and have featured strongly in the government's drive to provide decent infrastructure in rural areas. In his analysis of the successes of the ISRDP, Evratt, (2009) found evidence to suggest that improved infrastructure, although minimal, managed to change the perceptions of service delivery amongst rural residence. With a history of high poverty levels and poor access to basic services in Mount Frere (du Toit & Neves, 2008) it was possible that the effect of new services was significant for the local community. Residents seemed to appreciate changes that came as a result of these efforts, as they could identify new services from the Department of Social Development that were introduced in their local area as a result.

On the contrary, there is evidence to suggest that rural disabled people have difficulty navigating their surroundings due to under developed roads and inaccessible buildings. The interrelationship between environment, disability and participation is well documented (Imrie & Thomas, 2008). (Maart, *et al.* 2007) found that physical barriers to participation were more common in rural disabled residents than urban residents. Similarly Chakwizira, *et al.* (2010) reported that rural disabled people had difficulty using local transport to access local services. Similar difficulties were also reported in this study. Disabled people reported difficulties using local *quqas* and government-subsidised buses. This was the only form of transportation available in the area. This indicates that disability inclusive development should be approached from a broader perspective, considering other stakeholders, like transport operators. The government showed commitment to

inclusive development by improving roads, but the improvement was not significant for disabled people as it did not remove other barriers posed by transport operators.

5.2.2. Availability of infrastructure does not mean availability of services

On the other hand, residents also noted that the construction of access gravel roads and building of a new clinic over the years improved access to some health care services, but not to the extent of what was expected by the residents. According to (McLennan, 2009) improving service delivery involves more than just redistribution of resources; the process needs to also involve shifting established social structures and norms. Residents noted that, although improved infrastructure had brought positive changes in services delivery, services still fell short of the residents' expectations. This highlighted one of the failures of the RDP policy. The building of the clinics, roads and schools was evidence of the impact of the infrastructure drive underpinning the RDP policy, but the lack of services indicated by residents was also evidence of some of its failures.

Ngoma, (2009) explains that lack of attention given to capacity development in various government departments such as the Provincial Department of Education in the Eastern Cape, resulted in a number of problems for the department that affected its human resource and funding at lower levels. In this study residents noted with much disappointment an unfortunate trend in the local area of having improved infrastructure but still lacking access to essential services. Common in various health services reported by the residents was the lack of ability of services to meet the residents' needs. There was also evidence of number of problems in local PHC clinics hampering provision of a comprehensive primary health care service at local clinics such as lack of staff and unavailability of medicines. A 2003 Primary Health Care services survey (Reagon, Irlam and Levin, 2004) reported significant service problem in a number of rural clinics which were attributed to lack of trained PHC nurses and constant lack of medicines and equipment. The residents of Mpoza

perceived a level of disconnection between what was promised and the reality on the ground. This disconnection was evidence of the so-called unfortunate disjuncture between policy and implementation in the country.

A number of explanations have been provided in literature for this disconnection. While Jansen, (2007) regards the policy-implementation disjuncture a result of an aspiration for political symbolism within the ruling party, Wildeman, (2008) believes it is a result of a lack of correspondence in funding priorities between central, provincial government and local government. The main crux of the RDP policy was emphasis on decentralisation of some of the government functions, which lead to difficulties in maintaining consistency in the service delivery system. The lack of funding coordination at the lower levels of government brought the disconnection between policy formulation and implementation. Policies were formulated centrally, while provinces and local governments had autonomy over where to put funds (Wildeman, 2008). Residents attributed the disconnection between policy and services to staff shortages and lack of funding within the affected departments. This was the information they have been told by service providers when they enquired about it.

On the day of the launch, Premier of the Eastern Cape, Mbulelo Sogoni promised that the *Thusong* centre in Mpoza was set to bring closer government services and information to people who have been travelling about 80 kilometres to access government services in the town of Mount Frere Sogoni, (2009). However, it was unfortunate that funding for staff for the *Thusong* centre might have not been a priority for the provincial and local government. When lower arms of government, critical for citizen engagement, are not prioritised for funding and staffing, it is unsurprising that there is perpetual lack of citizen participation and poor service delivery at these levels as observed by Mpoza residents.

Literature has noted the significance of human capital in a successful service delivery system. Human capital gives life to an organisation, and subsequently the

service delivery system Pillay, (2009). Infrastructure may be improved, but without essential and skilled people filling the offices, the government buildings are as good dead. This was manifested in poor service provision, of which Mpoza residents found unacceptable. The fact that *Thusong* centre was not fully functional as a multi-purpose centre as was intended left residents with an idea that service delivery means more than just buildings. Lack of attention given to human resources has cost implications for health care users in rural areas. In a study investigating household cost of health care in rural South Africa, (Goudge, Gilson, Russell, Gumede, & Mills, 2009) reported that rural households incurred more than 4.5% of the total household income. In a situation where a household member had to receive a complex sequence of treatments, more than 45% of the household income was spent on transport alone. These costs could double or even triple for disabled people, such as those diagnosed with mental illness. In most PHC clinics, there are no nurses trained in management of mental illness, as a result all mental illness cases end up being referred to the nearest hospital (Petersen et al, 2009).

The new policy on re-engineering of primary health care in South Africa introduces a strategic shift in funding for human resource. One of the human resource for health (HRH) strategies focuses on developing human capital in rural and underserved areas. Although not very detailed, the policy outlines some of the key steps required to boost health care funding and retain critical staff (Matsoso & Strachan, 2011). Such a move is highly needed to improve accessibility in rural areas. Inclusive service delivery could also improve by ensuring that there is enough funding directed to training the local clinic staff on CBR.

5.2.3. Limited understanding of service entitlements

Residents displayed limited understanding of service entitlement from all three departments investigated. In all three departments, there were various laws and policies that define what was to be expected of each department. These policies include the National Rehabilitation strategy, the National White Paper 6 and the

National Policy on Disability from the Department of Social Development. The following section discusses the implication of the lack awareness, by residents, of services described in these policies.

- *Limited understanding of the right to a comprehensive primary health care (PHC) package.*

A comprehensive PHC package includes CBR programs for disabled people (Department of Health, 2001). CBR programs support people with disabilities to attain their highest possible level of health care. Mpoza residents were not aware of these entitlements. The lack of awareness about rehabilitation services may be attributed to a number of reasons.

Firstly rural residents in South Africa have been reported to have very little access to information due to structural, political and economic marginalisation (Mubangizi, 2006). Poor rural residents were found to have less information about their rights than urban and peri-urban (township) residents. In a study investigating factors affecting antenatal utilisation in a rural area in South Africa, Myer & Harrison, (2003) found that limited understanding of clinic services provided to pregnant women was among the reasons for the lack of utilisation of antenatal care services. Although, the women reported knowledge of the need to attend clinic during pregnancy, 61% of the 22 women interviewed reported late for their first antenatal visit (Myer & Harrison, 2003). In the 61% that reported late for antenatal care, the most commonly cited reason for reporting late was that they hadn't noticed any illness thus saw no reason to use antenatal services. These findings were made at a time when free antenatal care including testing for syphilis and STD and medication for the prevention of HIV transmission from mother to child was provided for free to pregnant women in South Africa. Interestingly Myer & Harrison, (2003) also observed that the women were more likely to draw upon their own belief systems, without obtaining an understanding of biomedical reasons as to the importance of receiving antenatal care services.

A similar observation was made in a study investigating the low uptake of free cataract surgery services provided to rural residents in Kwazulu-Natal. Rotchford, *et al*, (2002) found that perceptions of disability amongst people with cataract were likely to be based on local traditional beliefs than on objective biomedical reasons. The lack of understanding of the benefits of surgery and the role of rehabilitation in improving their lives impacted on kinds of services they were able to access from the clinic (Rotchford, *et al*, 2002). Mpoza residents also displayed similar characteristics.

The current study found that residents were unaware of CBR programs that offered services regarding disability prevention and information about the contribution that medical, educational, psychosocial and vocational rehabilitation could make in promoting the health, functioning, productivity and social inclusion of disabled people. CBR programs facilitate inclusive health by working with the health sector to ensure access for all people with disabilities, advocating for health services to accommodate the rights of people with disabilities and be responsive, community-based and participatory (WHO, 2011). The only visible service that related to rehabilitation in Mpoza was provision of assistive devices. However, according to the NRP (2001) disability inclusive health services involve more than just access to assistive devices.

Disabled people should access CBR programs that look beyond the person's condition and consider inclusion and participation in the broader community (Department of Health, 2001). The lack of awareness regarding service entitlements confirms the observations made by the CASE (2004) survey and Mubangizi, (2004). This lack of awareness could be explained by the fact that residents relied on service providers for information regarding services. Of all the service providers that were identified as critical information providers, rehabilitation therapists did not feature.

In Mount Frere, rehabilitation therapists were employed in the hospital in town and only provided weekly outreach visits to about eight clinics in the area. As a result therapists' visits at single clinic were seven weeks apart. Such time was unrealistic to achieve any positive outcomes for a rehabilitation program. Lack of access to CBR programs has far reaching implications on inclusive service delivery and participation. The need for community participation purported in various legislative instruments in the country, more than providing communities to exercise their democratic freedoms, could entrench the already existing inequalities if CBR programs continue to be unavailable in rural communities.

However, there are positive advances by the department of health towards improving primary health care services. The new plan regarding the re-engineering of primary health care could cast a light in this respect. PHC services as envisaged by the plan will focus on outreach services, emphasizing promotion and prevention services, including necessary rehabilitation and curative services (DoH, 2011). Such an approach to PHC services extends beyond what has been traditionally provided in local health care facilities. Municipal ward-based PHC agents will be entrusted with the role of facilitating the promotion and prevention services in their local areas (DoH, 2011). Although, the document is scanty on how rehabilitation services will feature in the services provided by these agents, the agents could be CBR trained to provide full package of health that is inclusive of disabled people. The agents could be trained based on the WHO CBR components relating to health, education, livelihood, social and empowerment (WHO, 2011).

- *Limited awareness of the rights of disabled children to inclusive education*

The study found that residents believed that disabled children could only be educated in special schools. There was consensus amongst group members that building a special school in Mount Frere would improve disabled children's access to education. This belief was contrary to Education White Paper 6 policy. The policy advocates for inclusion of disabled learners in mainstream public schools (DoE,

2000). Inclusive education provides an opportunity for disabled people to participate in their communities. However, disabled children in this rural area remain excluded from mainstream education system. There were a number of reasons that could explain why residents believed in special schooling for disabled children.

Firstly, the care and education of disabled children was believed to be role of mothers. It seemed as Though the whole community (men) was expected to ensure that disabled children were educated, let alone in a mainstream school. Such a belief could have prevented any discussion of the matter in male dominated School Governing Body (SGB) meetings. Karlsson, (2002) reported that structure and the processes of SGB in rural communities still perpetuate the pre-democratic era power relations of race, class and gender inequalities. Men controlled majority of SGB committees, and there was no evidence of gender parity (Karlsson, 2002). The current study did not establish the composition of the SGB committees of the local schools, however, considering Karlsson (2002) findings, it may be possible that the issue of inclusive education could have never made it to the SGB agenda because such space was not for discussion of women issues.

On the other hand, low levels of policy literacy in rural communities could have been liable for residents' belief in special education. CASE (2006) study revealed that low policy literacy levels were highly prevalent amongst rural residents. Lack of access to service delivery information in rural areas was also identified as one the challenges that the Comprehensive Rural Development Strategy (CRPD) attempted to address (Office of the President, South Africa, 2007). Such low levels in policy literacy could be attributed to the broader community challenges brought about by structural poverty. When considering other measures of poverty such as education and health, rural areas still lag behind (du Toit & Neves, 2008). It was for the similar reasons that Mncube, (2007) found that rural parents involved in SGB did not understand the voice given to them by the South African Schools Act, 1998. As a

result their participation was mainly limited to fundraising and other non-curriculum related activities.

Lastly, van Wyk (2004) also reported that both teachers and parents in school governance were unaware of various prescriptions regarding inclusive education. Evidence confirming this claim was also reported by Sherry, Watson & Duncan (2011) who conducted first sub-study to the PPP & P project. The study reported that education officials and teachers in Mount Frere district were unaware of what is entailed in the White Paper 6 policy (Sherry, Watson, & Duncan, 2011). Resident reported that a secondary school had been built in the area according to universal access prescriptions from Department of Public Works, but the school had never enrolled a disabled learner. This also illustrates a point discussed earlier about availability of infrastructure not translating to availability of services. But it was interesting to note that the local understanding of education services was not inclusive of disabled children. This reemphasises the point made earlier regarding policy implementation in that it should go beyond just providing resources. In Mpoza, disabled children were denied their right to education because of parents' attitudes and lack of understanding of their rights. The problem was even confounded by the fact that even service providers lack basic grasp of what the policy prescribes (Sherry, Watson & Duncan, 2011).

- *Limited insight into the functions of social development as a citizenship resource*

The Department of Social Development's policy on disability states 'DSD is the key implementer and responsible for the provision and delivery of the following services to people with disabilities: social grants, social support services, community development, community based services, social integration, advocacy and rehabilitation' (Department of Social Development, 2005; p 25). However, residents mainly reported improvement to access to social grants. Social development was only considered instrumental in helping families that needed

social assistance. This was evident in the fact that more than 36 % of the total population of Umzimvubu municipality relied on social grants as the only form of household income (Local Government Yearbook, 2009). With such a high unemployment rate and majority of those forming the labour force⁵⁴ being economically inactive (du Toit & Neves, 2007), reliance on social assistance was not unexpected. Although asserted by government as gains of the previous RDP policy, sustainability of this method of poverty alleviation has been questioned. Neves *et al*, (2009) reported positive effect of social grants as a strategy for poverty alleviation, but also noted an increased number of social grant recipients who preferred a proper job than relying on a social grant.

Similarly (Evratt, 2009) reported similar findings in his investigation of the impact of the ISRDP program in 13 of the rural nodes selected for the program. The study reported positive infrastructure developments and improvements in social services particularly access to social grants (Evratt, 2009). These findings indicate evidence of the impact of some of the gains of the AsgiSA policy. The study also reported that there was a strong indication by many rural residents that a 'proper' job was more preferable than a social grant (Evratt, 2009). Evidence of job aspirations by disabled people who had access to social grants was also uncovered in the current study. Disability representatives reported that their job aspirations were often overlooked by local community leaders, despite having knowledge of the need to include disabled people in skills development and employment opportunities. Some of the reasons given for excluding disabled people indicated that the community had never been properly engaged about the disability policy. The reason given by some of the participants that disabled people cannot do heavy jobs illustrates that there was lack of appreciation of what inclusion means, and the role of reasonable accommodation measures as stated in the policy. Such observations showed how lack of engagement with the community had lead to exclusion of disabled people in

⁵⁴Labour force refers to the people within the age group that can be legally employed in South Africa (15-64 years). In Umzimvubu labour force amounts to 51% of the total population (Local Government Yearbook, 2009).

employment and skills development opportunities. As result they only used DSD for social grants.

Department of Social Development is responsible for supporting jobs and self-employment through income generating projects. The department is also tasked with identifying skills development needs for those seeking self-employment. Facilitation of skills is essential for sustainable rural development (Office of the President, Republic of South Africa, 2007). Department of Social Development is tasked with identifying potential trades in local areas that could be developed into income generating projects. In 2009 only 1051 (1.0%) people in the whole Umzimvubu municipality were involved in some form of income generating craft projects (Local Government Yearbook, 2009). The lack of insight into other roles of social development could explain such low levels of participation income generating project and over reliance on social grants. Allowing citizen participation could raise awareness and change such perception for the whole community and disabled people.

5.3.4. Overlapping and unclear boundaries in governance

Overlapping governance structures and geo-political boundaries seemed to cause a level of confusion amongst service users. The confusion impacted negatively on service access and implementation of accountability mechanisms. Participation in ward, clinic and SGB committees should foster community accountability in government structures (DPLG, 2005). However, such accountability mechanism would be difficulty to coordinate for residents of the study village due to different and overlapping boundaries.

Social and health services were delivered according to municipal boundaries, while education services were planned and delivered according to different boundaries. In addition, traditional leadership boundaries were not the same as municipal boundaries. Traditional leadership was still according to the old Transkei

Authorities Act of 1964. Traditional leadership still remained the main avenue for communicating with people in a large scale in Mpoza. In rural communities *Imbizo* also serves as a powerful institution because of the power that it is accorded by the people (Cameron, 2006). As a result service delivery in this area still operated within a context of a traditional rural African society where traditional leadership still had significance as opposed to most urban areas in South Africa. According to Cameron, (2006) local government and traditional leadership tend to have more conflicting than complementing roles in rural areas causing confusion amongst residents as to who should to be held accountable for what role.

In Mpoza, this confusion in boundaries led to lack of collaboration between service providers as certain responsibilities fell outside the jurisdiction of local managers. An example was the *Thusong* centre, which was still under the management of the Eastern Cape Province. This made it difficult for local services such as social development, police and the post office to deploy staff creating an unnecessary delay in delivery. Residents also indicated that the slow implementation of service delivery from the *Thusong* was due to lack of accountability to the community as the community board had not been appointed at the time.

Residents also experienced difficulties forming committees around education and social development services intended for early childhood development. Education services were managed through the circuit office in Mount Frere, while social development services are managed according to the local government boundaries with the head office being in Mount Frere. Moreover, Umzimvubu Local Municipality was responsible for implementing early childhood development programs in collaboration with Department of Education such as building preschools (DPLG, 2007). It was the role of CDWs to mobilise the community and ensure participation in implementation of such services (Department of Public Works, 2004). This overlap in boundaries could explain why CDWs found difficulties in coordinating and mobilising community around early childhood development. With such poor

coordination, parents lacked information regarding school placement of their disabled toddlers, leading to delays in starting school amongst disabled children.

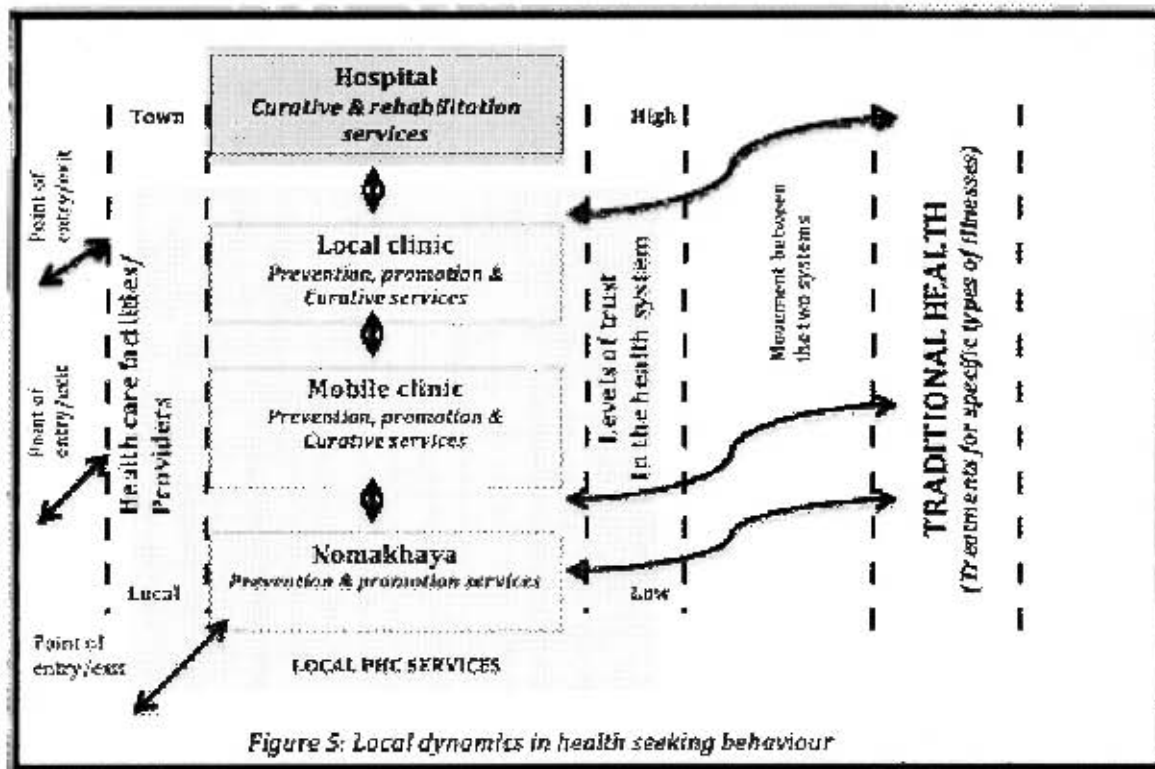
5.3. Perspectives on dynamics of service delivery

In addition to the structural factors, there were other non-physical factors that affected Mpoza residents' perspectives about and access to services. These factors were evident in the residents' descriptions about different ways through which they sought health care and other services. These factors were lack of trust in the local PHC system and perceived lack of activism amongst disabled people.

5.3.1. Lack of trust in local services

Residents alleged that local PHC system services were unacceptable, thus they could not trust that available services could meet their health care needs. Trust is commonly understood as "the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor's interests" (Hall, Dugan, Zheng, & Mishra, 2001 p. 653). The level of trust accorded to a service provider is one of the basic elements that determine variations in health seeking behavior. Residents reported that services provided by PHC staff; nurses at the clinic, *nomakhayas* and the mobile clinic were of 'low' standard because they lacked enough expertise.

On the other hand, services received from the hospital in town were of 'higher' standard, as doctors were available to provide 'correct' treatment for illnesses. Acceptability, which is, the social and cultural distance between health care systems and their users (Dyer, Abrahams, Mokoena, & van der Spuy, 2004) has been found to have significant influence in determining service users trust in health services (Gilson, 2007). This perception was the underlying determinant of residents' health seeking behaviour. Figure 2 below provides an illustration of the residents' health care seeking behaviour in this rural community.



Health service seeking behaviour has been reported to be instrumental in determining access to health services in poor communities (Gilson, 2007). Figure 2 shows perspectives of Mpoza residents of various tiers of local PHC services with district services provided by the hospital at highest tier. PHC and district hospital services represent 'western' forms of health care, as opposed to traditional health care, which runs parallel to the 'western' health care system. Traditional health care becomes an option for the residents in certain instances. The arrows between the health systems represent some of these movements from one health care system to the next.

On either side of the 'western' health care system are two different scales, one for distance and the other for the levels of trust. It appeared that trust levels increased as one moved higher in the tiers such that, a clinic sister was more trusted than a *nomakhaya* but not trusted as much as the doctor in the hospital in town. This observation confirmed an analysis by (Thiede, Akweongo, & McIntyre, 2007) where

they asserted that geographical location, distance from people, affordability and facility opening hours were not the only elements that affected health care usage. Patient trust in health provider to provide a 'good' quality service seemed to be the determinant for choosing to bypass the local clinic and traveling (at significant additional costs) to the hospital in town.

Service user's tendency to question the quality health care services has also been observed elsewhere in the country. Gilson & McIntyre, (2007) asserted there has been a growing perception amongst South African poor communities that government provided health care is of 'poor' quality. Analysing household survey on access and utilisation of health care between 1994 -2003, Gilson & McIntyre, (2007) noted a worrying trend of worsening community perceptions of the quality of publicly provided care. Negative perceptions about the quality of health led to users making certain choices about their health and their lives as observed in this study.

Lack of medicines and registration cards were reported as one of the reason why residents preferred to go to the hospital rather than use the local clinic or mobile clinic. According to Kautzky & Tollman, (2005) the history of poorly organized, inefficient and often ineffectively managed, Bantustan health services that struggled to provide adequate medical and public health care may have led to villagers developing coping strategies by seeking other forms of health services. The historical disadvantage could explain why villagers lost confidence in the ability of local services to deal with their health care needs and may have pushed them to seek alternatives.

Another important alternative source of health care services reported by the residents was traditional health care. Traditional healers were considered important alternative service providers. Traditional medicine approaches are a common alternative for rural communities in South Africa (Baker *et al.* 2006; Kale, 1995; King, 2012). There were a number of reasons for using traditional medicine. Firstly there were beliefs that certain illnesses could not be treated through

'western' medicine. For instance *plate* and epilepsy were regarded as illnesses that could only be properly managed through traditional medicine approaches. No evidence was found to support such perceptions in literature; however, several studies have reported instances where patients delayed seeking health care on the advice of a traditional healer. Baker *et al.* (2006) reported that seeking traditional health care was a common phenomenon amongst TB patients in rural Limpopo resulting in dire consequences. The study found that out of 133 patients treated for TB over a period of 6 months, 24 had visited traditional healers prior to starting TB treatment and had worse performance with higher likelihood of death. The sample of the study might be too small to make general conclusion but it does illustrate some of the negative consequences of the dynamics of health seeking behaviour in rural areas.

Secondly, the local clinic opening hours also played a role in residents' health seeking behaviour. Unlike a traditional healers who consulted 24 hours a day, the clinic only operated during office hours. The lack of staff, medicines and equipment reported by residents, and also confirmed by literature (Christianson *et al.* 2002; Gilson & McIntyre, 2007; Klentjes *et al.* 2010) may explain why the clinic could only operate during the day. So even if a person would have preferred to go to the clinic, it was not an option because services were not available at night. For these residents, despite availability of a health care facility in their local area, their right to emergency care as espoused in the constitution was still to be fulfilled.

Also poor ambulance services both at night and sometimes during the day pushed people to seek alternative health care services. With poor ambulance services, the only option available for a sick person was to hire a *quqa* at a very high price to take them to the hospital in town. With such high costs of health care for many rural communities (Goudge, *et al.* 2009), consulting a traditional healer may be a cheaper option. In the current study, a single incident was reported where a person died after consulting a traditional healer. The incident prompted a meeting to register local traditional healers at the local clinic. This was recommended by the national

Department of Health as a step towards dealing with deaths as a result of traditional healer interventions (Pretorius, 2000). There was not much research done to determine the success of such initiatives. However, such participatory platforms could allow for community engagement and curtail negative consequences of lack communication between the two parallel systems (Cain, 2011; King, 2012).

Improving service delivery in rural communities requires innovative strategies that could deal with lack of community trust in service providers and management failures. The new human resource for health care (HRH) strategy may deal with some of these issues. The national Health Department has acknowledged the perpetual, unintended exclusion of rural people, including disabled people, from equitable health services, as result the new HRH strategy involves innovative strategies aimed at retaining staff and ensures that rural health facilities are properly funded (Matsoso & Strachan, 2011). The introduction of local health teams is envisaged to promote community participation to ensure that local people are engaged in their own health care needs.

5.3.2. Insufficient disability activism

Participants believed that parents of disabled children were not proactive enough in seeking education, rehabilitation and social security services for their children. This reason was given to explain why disabled children were more likely to be out of school. Illiteracy amongst the parents (mothers) was also another reason given for the perceived inability to be proactive about disabled children's rights. Illiteracy was known to be significantly high in the area (du Toit & Neves, 2008). Residents believed that disabled children with educated parents (mothers) were more likely to be in (special) schools, while those children with illiterate mothers remained excluded. Illiteracy in rural areas has been reported to be the basis for marginalisation and lack of participation in governance and involvement in children's schooling in rural areas (Buccus, *et al.* 2007; Mncube, 2007; Singh & Mbokodi, 2004; Van Wyk, 2004).

Singh & Mbokodi, (2004) reported that illiteracy was the main reason for the lack of parental involvement in children's education in rural areas. Also a qualitative study by Mncube (2007) reported that illiteracy amongst parent SGB members was disempowering in SGB meeting. The inclusion of parents in children education matters in rural school was mainly for compliance reasons (Lewis & Naidoo, 2004; Mncube, 2007). The introduction of the *KhaRiGude* campaign was aimed at decreasing levels of illiteracy in rural areas. Enrolment in *KhaRiGude* was reported to be high amongst Mpoza residents. Interestingly, participants reported that the number of women enrolled in *KhaRiGude* was higher than that of men. Although other reasons were provided for this gender difference in *KhaRiGude* enrolments, such as improved financial skills, this also could explain local expectations of women being responsible for education. Whether that perception translated to an increased involvement of women in local SGB is unclear. But it does provide insight into rural people's perceptions regarding education.

There was, however, little evidence of disabled people involvement in *KhaRiGude*. The fact that *KhaRiGude* classes were provided at the learner's homes should count in favour of disabled people who may experience mobility and other barriers. The reason for this lack of involvement of disabled people was blamed on their lack of activism. This could be true because activism in communities is believed to increase participation and access to rights (Fung, 2003). This was also demonstrated clearly in South Africa during the early years of democracy (Heap, Lorenzo, & Thomas, 2009). However, this activism was limited to urban areas. Disability associations were not as organised in rural areas as in urban areas, as a result advances in disability rights were only confined to urban areas in the country (Christianson et al., 2002).

Data revealed that local cultural factors were the main hindrance for disability activism in Mpoza. The difference in age between local disability activists (youth) and community leaders (elders) appeared to be a cultural barrier when challenging

the local status quo. It has been reported that the ways of rural people are deeply embedded in their cultural practices (Pretorius, 2000). Age in most African communities is a status marker and can determine how people interact with each other (van Kessel & Oomen, 1997). In this study, the fact that disabled people involved in the disability forum were younger than community leaders meant that disabled people could not challenge them on their perceptions about disabled people. As result, although there was a local policy on disability, community leaders' negative stereotype about disabled people and employment remained entrenched as changing their perceptions would have been associated with giving in to the youth. The perpetual entrenchment of such perceptions is not good for disability inclusion. Participation of disabled people will remain side-lined until local beliefs about disability and gender change.

5.4. Summary

This chapter has discussed the findings of the study in relation to the literature. Mpoza residents perceived service delivery in terms of structure and process. Fundamental to a proper service delivery structure was improved local infrastructure, planning and administrative factors and organisation of service provider. Although infrastructure had improved significantly in Mpoza since the dawn of democracy, not much attention has been given to human capital, organisational capacity and accountability factors that could improve community participation. Also the local history of service delivery has lead to majority of residents to lose trust in the service delivery system. Cultural factors still remain some of the hindrance in against disabled people asserting themselves and making their voice counted. As result, Mpoza residents, including disabled people remained excluded with poor access to services and enjoyment of their rights. These perspectives remain significant in determining successful inclusion and participation of rural communities to ensure improved service delivery.

CHAPTER 6: CONCLUSIONS

6.1. Introduction

This chapter will provide a summary of the study and conclusions. The study assumptions will be revisited. The study limitation will also be described, including how these limitations could have impacted on the conclusions of the study. The chapter will end by presenting recommendations for further research.

6.2. Revisiting study assumptions

Prior to the study implementation two assumptions about rural residents, including disabled people's perspectives on service delivery were presented based on literature review. This exercise is recommended in qualitative research as quality assurance measure. The research process was essentially about investigating the relationship between the research claims and evidence. Cho & Trent (2006) refer to this exercise as the degree to which researchers' claims about knowledge corresponds to the reality (or research participants' constructions of reality) being studied. The preceding chapter attempted to provide context and deliver a descriptive account of the participants' reality in this particular rural area. By revisiting the assumptions, this section will attempt to distinguish research claims from descriptive evidence. It is important to note that descriptive studies never seek to ensure transferability, because, in a purposive description, correspondence between actualities and texts is neither possible nor necessary, but the interpretive component matters most (Cho & Trent, 2006). However, distinguishing claims from evidence, providing the strongest evidence for more important claims, and exposing the judgments of the researcher for readers to scrutinize are all methods for addressing the standards applied in qualitative research (Seale 1999). The following section identifies areas of correspondence and faults between evidence provided by the research and initial assumptions and attempts to delineate conclusions that can be drawn from the study.

6.2.1. Evidence on awareness of service centres

The aim of the study was to describe the perspectives of rural residents, including disabled people regarding inclusive service delivery in health, education and social development. The findings and discussion have unpacked the residents' perceptions regarding the structure and dynamics of service delivery in their local area. The study highlighted some of the key issues that were perceived to be fundamental for improved service delivery for disabled and able-bodied members of the community. The identified key issues illustrate a high level of awareness, amongst the participants, regarding a complex interrelationship between various structural constraints that have impacted negatively on local service delivery systems. The local infrastructure (roads, clinics, school and *Thusong*) had not improved enough to ensure provision of better and inclusive socio-economic services in the area. The study also showed how such conditions had impacted on the residents' enjoyment of socio-economic rights as addressed in the Republics' Constitution (1996) and the UN Convention on the Rights of Persons with Disabilities (WHO, 2006). This was illustrated in the residents' descriptions of barriers to services and unmet needs with respect to selected services. We can therefore conclude that these residents possessed knowledge of the local area and the kind of services offered to allow them to enjoy their rights. Employment of participatory mechanisms by government and various organisations in their endeavours to improve service delivery in this rural community could allow them access to this information that may prove useful in improving service responsiveness.

6.2.2. Evidence on awareness of service entitlements

The study further described structural issues that affect service responsiveness in a rural community. It also showed that the local residents' awareness of service entitlement was affected by community perceptions regarding what entailed a trustable service, roles of various members of the community and local cultural practices. Local residents' lack of trust in service delivery systems such as health

care, did not only affect their health seeking behaviour, but also their service expectations and understanding of entitlements. As a result their lack of understanding of service entitlements posed a significant challenge for improved service delivery for the residents including disabled people.

Similarly, the perception that women were responsible for ensuring the education of disabled children and that disability activism was non-existent not only had an implications on disabled children's rights to education but also local views on disability matters. Cultural practices constrained activism, such that local disability inclusive policies could not be implemented. The elevation of culture over policy proved detrimental to disability rights. It can, therefore, be concludes that attempts to improve service delivery in rural areas should provide space for local citizens to engage with service delivery processes because their perspectives can be valuable in improving effectiveness. Rural residents perspectives about service delivery structure and processes illustrate that citizen participation should form the basis of service delivery endeavours.

6.3. Study limitations

Participatory methods that were used allowed for members of the community, including disabled people, to become active members in the research process. But the use of the carpet and chalk (during mapping), as opposed to the ground outside may have limited some participants' ability to express their conceptual knowledge of the area in the most explicit manner. Writing (drawing in this case) could have caused the least literate members of the groups to be more anxious in presenting their opinions as they may have difficulty imagining how the opinions could be expressed on a drawing. However, the researcher made attempts to facilitate participation of all the participants by also incorporating descriptions and discussions during the drawing and after the drawing of the map had been completed.

The intention of the study was not to provide a prototype of a rural community from which general conclusions could be made, but intended to provide a thick description of the reality of services delivery in this rural area. The reader is therefore, cautioned against making general conclusions from the study findings as experiences of rurality may transpire in many other ways than those described in the study. The researcher hopes, however, that this study will provide a pointer into one way in which we can understand disability inclusive service delivery in a rural area and, subsequent need for rural citizens engagement in service delivery processes. The researcher is also aware of the power issues in th study, that his position of power would have introduced bias and hindered some community members from speaking.

6.4. Recommendations

On reflection of the findings and discussion, the following recommendations were put forward:

- Create local participatory spaces between communities and service providers or expand existing forums (e.g. People's Health Movement) to strengthen engaged citizenship.
- Step up dissemination of information about disability and increase in-service community based health and development workers about disability prevention.
- Expand capacity of ward-based teams in health, education, and social development, labour and local government to address disability.
- Roll out access to community based rehabilitation services: bring health therapists to where people live. It is too expensive for poor people to travel to hospitals to receive therapy.

6.5. Summary

This chapter provided some of the salient conclusions that could be drawn for the findings of the study. These conclusions related to rural residents awareness of service centres and understanding of their service entitlements. Rural residents showed a complex understanding of the structure of service delivery in this rural area. According to the residents' service delivery was multi layered: physical, personal (behavioural) and administrative (planning). There were certain dynamics that determined how rural people understood and responded to service delivery, and these dynamics warranted consideration in policy design and roll out. Policy implementation could improve when the context (geo-political location, history, culture) of rural areas was taken into account. Unintended consequences could be avoided by ensuring inclusive participation that could reveal local dynamics about governance and power issues.

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Appendix 1: Information sheet

Good day

My name is Mpilo Booï. I am a student from the University of Cape Town, studying Disability Studies. I am currently trying to find information about the views of the people of your village about health, education and social development services.

I would like to ask you to help me in putting the information together. If you agree, you will be one of the people who are going to be involved in different group activities where you will be talking about different things related to service delivery in your village. The activities will take about 60 - 90 minutes of your time. The activity will be tape recorded so that I can listen carefully to what you are saying without having to take a lot of notes. If you chose to help me in the study, please know that you have the following rights:

- Your decision to help me is up to you, you are not forced to help me.
- If you want to stop helping me putting together the information at anytime, you can stop. That will not have any effect on you.
- You will not receive payment for being part of this study but you will be paid back any money spent on transport to attend the focus groups
- You can decide that you don't want the tape recorder to be switched on while we are talking; that means I will have to write notes down.
- If, because of being part of the study, you become distressed and need help, proper counselling will organised for you with appropriate department.
- Remember that your name and the name of your village will not be used. This is to ensure that nobody can find out that the information was given by you or your village.
- All the records of the activities will be kept in a safe place, where only the researcher will have access to.

Since you will be helping me with other people in a group, this will help you and your community to understand how you can access services better. It will also help me to understand service delivery in rural areas better. After all the information has been put together, a workshop will be provided to the people of your village where they will find out about other things that they can do to access services in a better way.

Ethics approval has been obtained from the University Of Cape Town Faculty Of Health Sciences Human Ethics Research Committee. If you would like to be part of this study, please complete the consent form attached to this page. If you wish to find out more information, please feel free to contact me or any of the following people:

Thank you.

Sincerely,

Researcher
Mpilo Booï
(039) 255-8284 (office)
071 608 3654 (cell)
Email: madzikane.audio@gmail.com

Research Supervisor
Dr. Lebogang Ramma
(011) 021-406-6954 (office)
073 153 3803 (cell)
Email: lebogang.ramma@uct.ac.za

Chair of Ethics Committee
Prof. Marc Blockman
Faculty of Health Sciences
Observatory
(021) 406 6492

Consent form

The study has been clearly explained to me by the researcher, Mpilo Boozi, and I have had a chance to ask questions and have them answered to my satisfaction. I have freely chosen to help in gathering the information for this study. I am aware that I can change my mind about helping at anytime and chose to stop helping without any effect on me or my life. I have been informed that agreeing to take part in this study will not be of any personal benefit to me. I have also been told that any information I provide will remain confidential and that this consent form will not be linked to the answers I give. I have been given contact numbers that I may call if I have any questions or concerns about the research.

Participant's signature/thumb print

Date

Researcher's signature

Date



20 September 2010

HREC REF: 428/2010

Mr M Booï
Health & Rehab, F Floor
OMB

Dear Mr Booï

PROJECT TITLE: SERVICE DELIVERY AND DISABILITY; THE PERSPECTIVES OF SERVICE USERS ON SOCIO-ECONOMIC RIGHTS IN A RURAL COMMUNITY IN THE EASTERN CAPE

Thank you for submitting your new study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the FHS HREC has formally approved the above-mentioned study.

Approval is granted for one year until 28 August 2011.

Please send us an annual progress report (website form FHS 016) if your research continues beyond the approval period. Alternatively, please send us a brief summary of your findings so that we can close the research file.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the REC. REF in all your correspondence.

Appendix 2: Inkcukacha ngophando

Molweni

Igama lam ndingu Mpilo Boo. Ndifunda kwiDyunivesithi yase Kapa. Ndenza uphando malunga neembono zabahlali kule lali yakuni ngokuphathelele nokuhanjiswa kweenkonzo zempilo, ezemfundo kunye nezoontlalo-ntle.

Umqweno wam kukuba ndikucele ube yinxalenye yoluphando. Xa uvuma, uzakuba ngomnye wabantu endizakuncedisana nabo ngokuthi udlale indima neqela labanye abahlali bale lali kwingxoxo esizakuzibamba sixoxa ngembono zenu kula masebe mathathu achaziweyo ngasentla. Ezingxoxo zizakwahlukana kathathu kodwa wenu awunyanzelekanga uba udlale indima kuzo zontathu. Ubude bengxoxo enye ingaba yimizuzu engama-60 ukuya kuma-90. Ndzakusebenzisa isithwebuli-mazwi (tape recorder) khonkuzi ndikwazi ukumamelisisa into yonke ethethwayo. Uba uyavuma ukuba yinxalenye yoluphando, ze uqaphele ke uba unamalungelo ngokuphathelele noku kulandelayo:

- Ukuba yinxalenye kwakho koluphando kusisgqibo sakho. Akukho nto ikunyanzelisayo
- Ungasijika isigqibo sakho noba kunini. Loo nto ayizuthintela indlela ufumana ngayo inkonzo okanye indlela ophatheka ngayo ekuhlaleni.
- Akunyazelekanga uba uvume intetho yakho ithwetyulwe (tape recorded). Loo nto ithetha ukuba ndizakunyanzeleke uba ndibhale phantsi okuthethwayo.
- Ukuba udinga uncedo oluthile, uyakucetyiswa ngokufanele ukwenze, okanye udityniswe nabantu abanokukuncede.
- Ukhumbule uba igama lakho kunye nelali osuka kuyo alizukavela koluphando. Oko kukuqinisekisa ukuthi konke okuthethiweyo akunakweyanyaniswa namntu uthile okanye ilali ethile.
- Konke okuqokelelwe kwingxoxo zabahlali, kuyakugcinwa kwindawo ekhuselileyo esetyenziswa ngumphandi kuphela de kube sekupheleni kophando.

Uzancedisana nabanye abahlali ukunikeza olwazi. Oko kuzakunceda nawe uba ubenolwazi malunaga neendlela ongazenza ukufumana uncedo oluhulo. Izanceda nam ke loonto ndibe nolwazi oluthe vetshe ngokuhanjiswa kweenkonzo ekuhlaleni. Ulwazi lonke esilufumeneyo nizakulwaziswa ningabahlali niphinde nifundiswe iindlela eningathi nizisebenzise ukufuna inkonzo.

Oluphando luvunyiwe yikomiti yemigaqo yezophando yaseDyunivesithi yaseKapa. Xa uvuma ukuba yinxalenye yoluphando, nceda ugwalise iphetahana apha ngezantsi ubonakalise ukuba uyavuma. Xa ufuna inkcaza ethe vetshe; tsalela aba bantu balandelayo:

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Iphepha-mvume

Uphando luchaziwe kum ngendlela ecacileyo ngumphandi u-Mpilo Boozi, kwaye yonke imibuzo enbendinayo iphendulakile ngokwanelisayo. Akukho nto indinyanzelisileyo ukuba ndivume ukuba yinxalenye yoluphando, ndizivumele ngokwam. Ndiyayiqonda neyokuba ndingajika ingqondo yam ndihle nomcinga ndiyeke ukuba yinxalenye yoluphando ngaphandle kokuchaphazela indlela endifumana ngayo inkonzo nentlalo yam ekuhlaleni. Ndazisiwe ukuba andizukufumana siboncelo ngokuba yinxalenye yolu phando. Ndazisiwe ukuba igama lam kunye nelali alizupapashwa khonukuze ndoyanyaniswe nokuthethiweyo. Ndinikeziwe neenombolo zomxeba endingazitsale xa ndifuna inkcukacha ezithe vetshe.

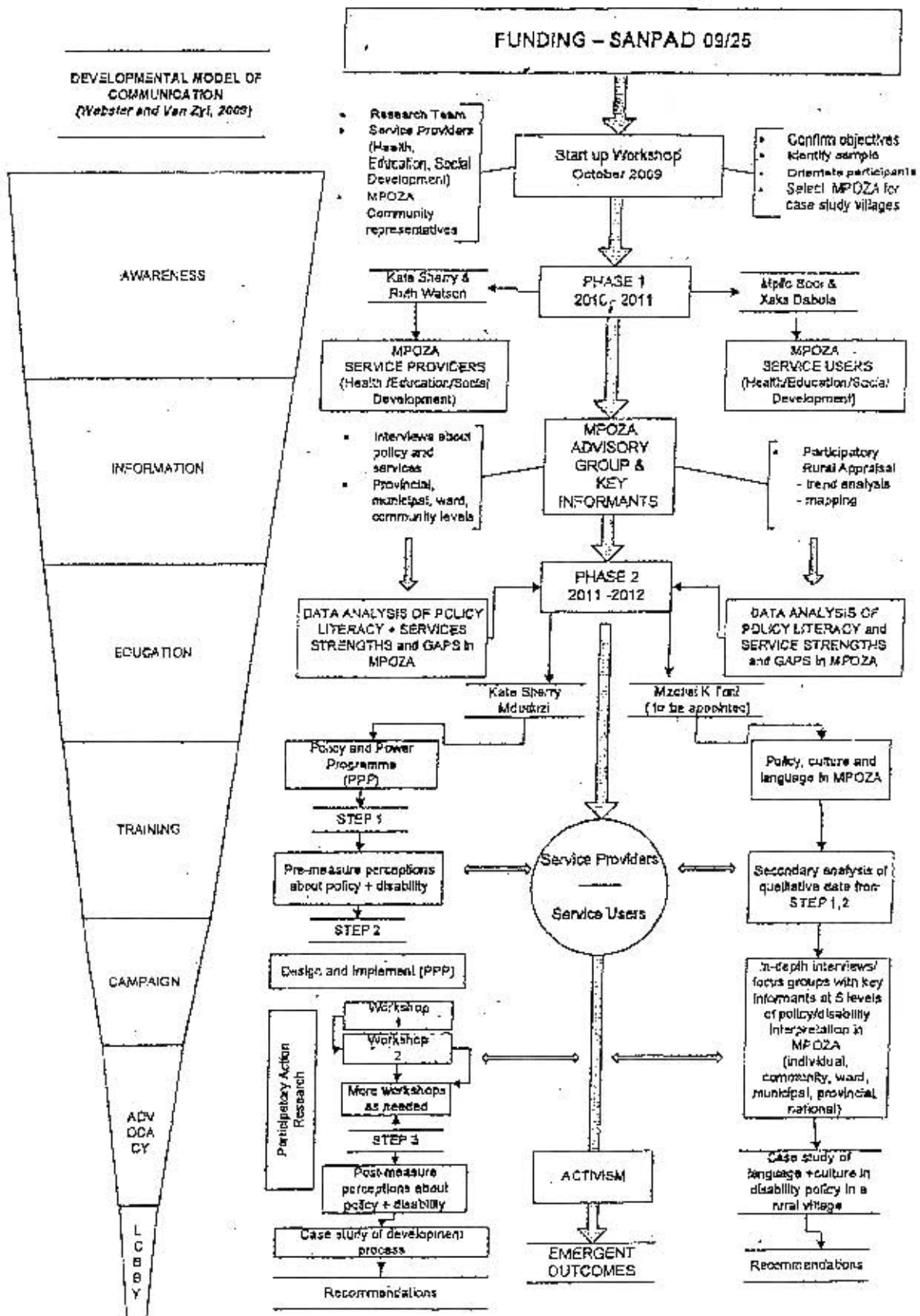
Tyikitya/Beka umnwe

Usuku

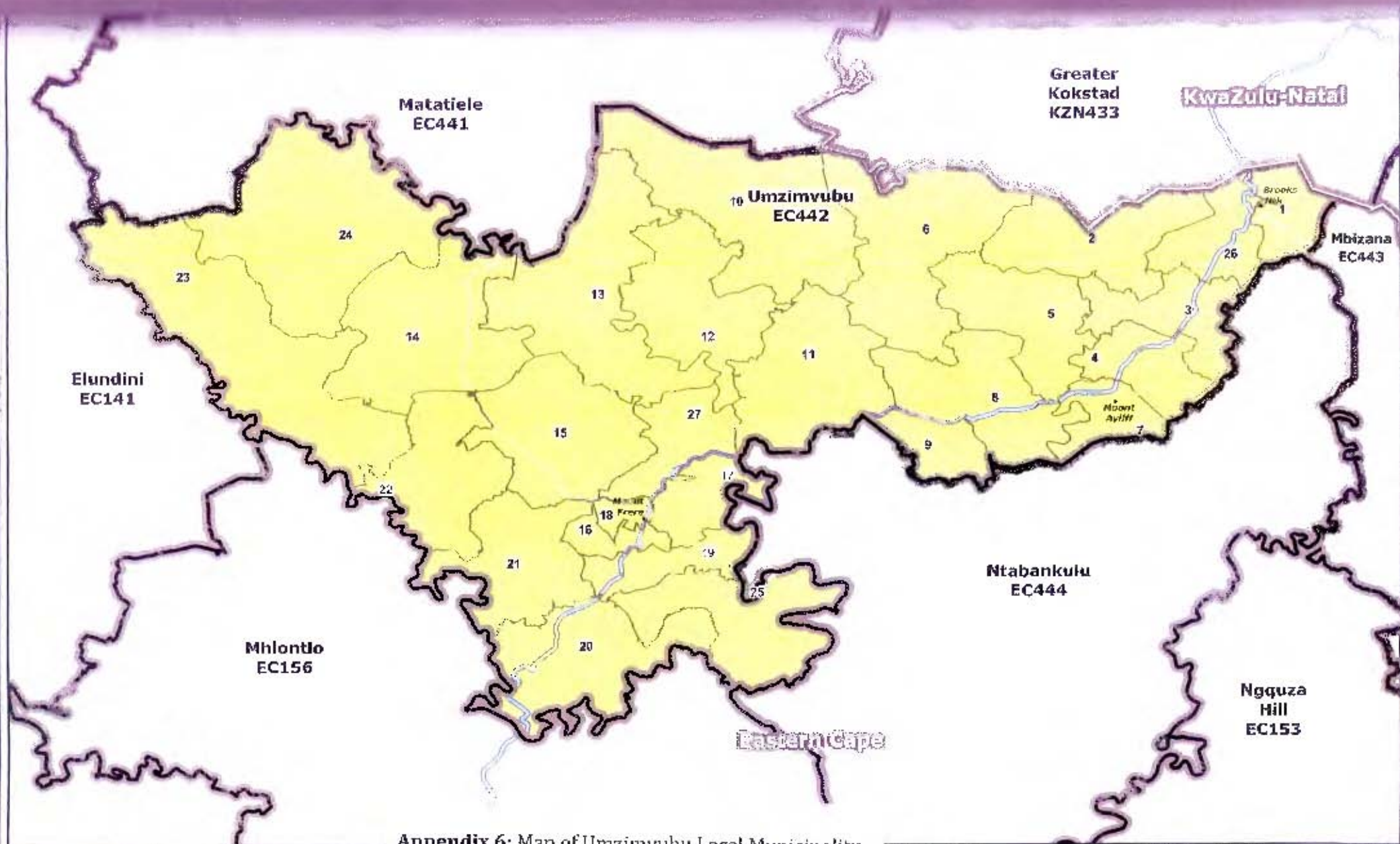
Umphandi tyikitya

Usuku

Appendix 4: The People informing Policy: Power and Progress project



UCT (O.T.) and SANPAD RESEARCH in MPOZA village, Alfred Nzo district.



Appendix 6: Map of Umzimvubu Local Municipality

Legend

- Provincial Boundary
- Municipal Boundary
- Ward Boundary
- Towns
- National Roads
- Mainroads

**Umzimvubu
Local Municipality
(EC442)**



DATE
July 2011

MAP NUMBER

Additional information relating to this map can be obtained by contacting the Municipal Demarcation Board at:

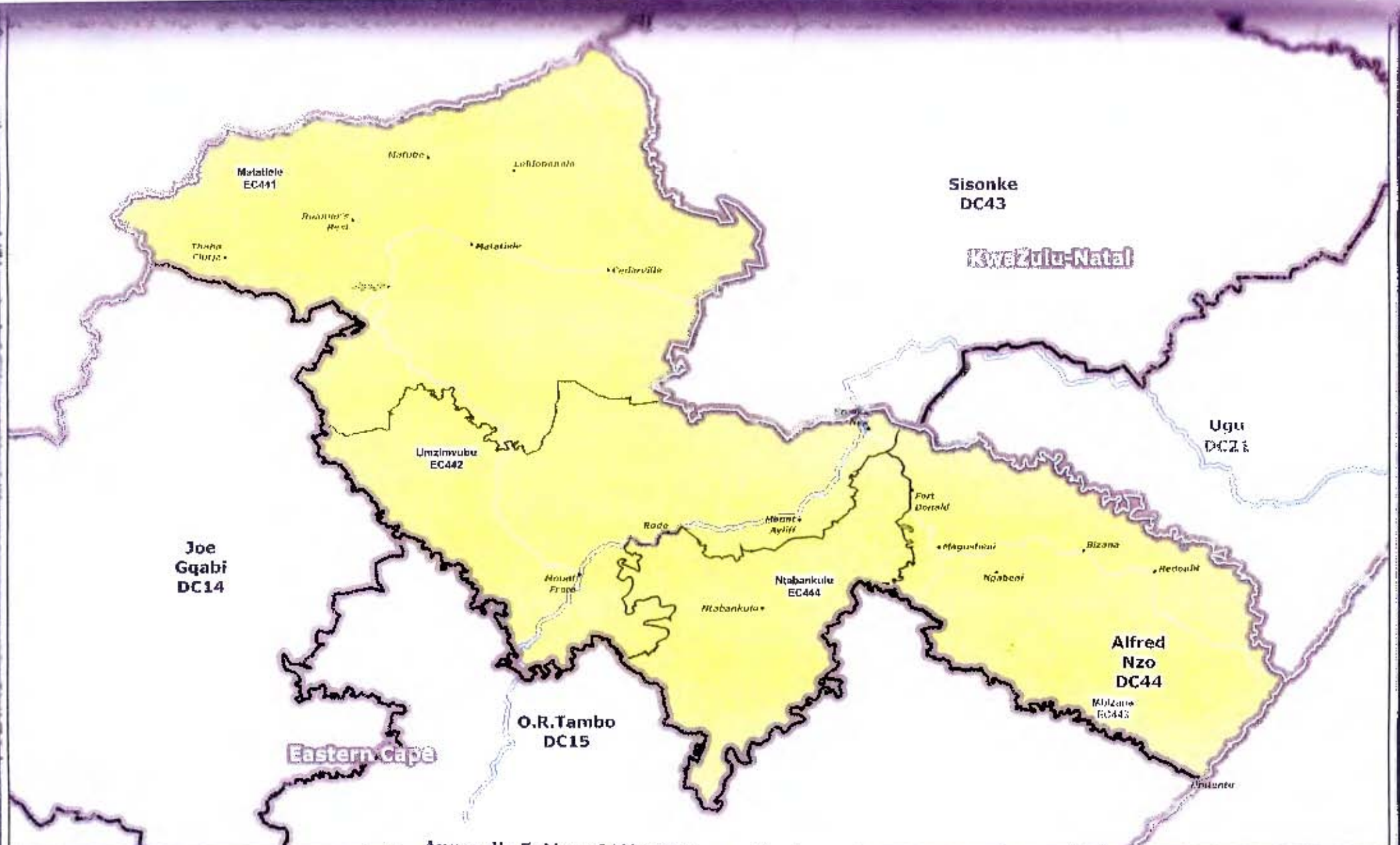
Tel: (012) 342 2481 Fax: (012) 342 2481

email: info@demarcation.org.za

Website: www.demarcation.org.za

Address: Depots, Box 256, Justice Centre





Appendix 5: Map of Alfred Nzo municipality

Alfred Nzo
District Municipality
(DC44)

Legend

- Provincial Boundary
- District Municipality Boundary
- Local/Metro Municipality Boundary
- Towns
- National Roads
- Main roads

NOT TO SCALE

DATE
July 2011

MAP NUMBER
41

Additional information relating to this map can be obtained by contacting the Municipal Demarcation Board at:
Tel: (012) 342 2481 Fax: (012) 342 2480
email: info@demarcation.org.za
Website: www.demarcation.org.za
Address: Private Bag X29, Hatfield 0029



Appendix 7: Diagram of traditional and local government administration. Drawn by the researcher based on account of the local chief.

MPOZA A/A
UNDER CHIEF MDUTYANA



LUTATANI A/A
UNDER CHIEF MAKALILA



VILLAGES INCLUDED IN THIS STUDY

EACH OF THESE VILLAGES HAS 1 - PRE-SCHOOL & 1 - J.S.S.	<u>MDLAZI</u>	ALL 3 VILLAGES SHARE ACCESS TO: ① THUSONGA ② LUTATANI B.S.S ③ CLINIC
	<u>MTSILA</u>	
	<u>SIKOLWENI</u>	

EACH OF THE WARDS HAD ONE CDW

Key

- BHODI - SUB-HEADMAN
- HEADMAN - TRIBAL LEADER WITH ADMIN. RESPONSIBILITIES
- WARD COMM - WARD COMMITTEES
- CHIEF - TRIBAL LEADER WITH POLITICAL RESPONSIBILITIES
- A/A - ADMINISTRATIVE AREA

A/A DEMARICATION BASED ON THE OLD TRANSKEI AUTHORITIES ACT OF 1965 (COETE, 1992)
 LOCAL GOVERNMENT (WARDS) BASED ON LOCAL GOV. BOUNDARIES ACT

Appendix 8

Schedule of cues for PRA activities

Participatory mapping and modelling exercise

We are going to all participate in a mapping and modelling exercise of the village of Mpoza. Using the ground, small stones, paper and anything else you can find suitable we request that you show us (researcher and research assistants) the structure of your village. Everybody is part of the exercise and every contribution is valuable. Our role is to assist and learn from you about your village.

After we finished drawing the map of the village, we shall then have a discussion about the map and the village.

1. Please draw on the ground a map of the village indicating geographical points, roads, clinics, schools and other service centres available in your village.

Discussion cues

2. Which, in your own opinion, would you say are the points of significance in the village with regards to the following services, please state the reason why:
 - a. Health services
 - b. Education service
 - c. Social development
3. What would you say about the adequacy of these service centres in servicing the residents, including people with disabilities?
4. In your opinion, please state with reasons; what would you like to change about the current state of the above mentioned services in your village.

Appendix 9

Schedule of cues for PRA activities

Participatory mapping and modelling exercise

Sicela nizobe umfanekiso welali yenu yase Mpoza apha phantsi. Sicela nisebenzise amatye, amaphepha, nantoni na enibona ifanelekile nibonise umfanekiso-ngqondweni welali iyonke. Kubalulekile ke ukkuba sisebenzisane sinciphisa khonukuze wonke umntu abe negalelo kuyo yonke into esiyenzayo. Injongo yako kone oku kukufunda ngelali yenu.

Emva koba sigqibile ukuzoba lomfanekiso, sizakuxoxa ngawo sibonisane.

1. Sicela ke nenze kunene nibonise imfanekiso-ngqondweni nibonise iindlela, iiklinikhi, izikilo, indawo yeenkonzo zonontlalo nezinye izinto enibona zibalulekile ekuhlaleni.

Discussion cues

2. Ziziphi indawo, ngokokubona kwenu ongathi zibalulekile ekuhambiseni ezinkonzo zilandelayo, nika izizathu:
 - a. Ezempilo
 - b. Ezemfundo
 - c. Ezentlalo-ntle
3. Ungathini ngezindawo zizonke ngokufikeleleka kwazo kubahlali, nabantu abakhubazekileyo?
4. Ngokokubona kwenu, yintoni eningathanda itshintshwe ngesimo sezinkonzo sizibatuleyo elalini, nika izizathu?

TRIPS REPORT | TRENDS ANALYSIS OF SOCIAL DEVELOPMENT SERVICES

RACE HALL

DATE: 24/01/11

PARTICIPANTS	PEA TEAM
3 FEMALE	MALU
4 MALE	XAKS

Appendix 10: Trend analysis for social development

DATE	EVENT	COMMENTS
15 TO 19 99	Road construction from Glen Holly to Hkunguini	<ul style="list-style-type: none"> - Gravel/Dirt road was constructed from NZ route to the MPOZA Clinic and beyond to further villages - Road brought better access to town; people from villages able to visit social development offices for registration of social grants. - Application for disability grants made easier as as villagers were also able to access the hospital in town. - Many people did not have ID books new road made it easier for people to apply for them in town
00	Opening of the leather Crafts project (Mtsile)	<ul style="list-style-type: none"> - A number of Women and disable people were employed by the project Project currently is functional - Project has since closed down because they relied on the abattoir in Mt Ayliff for raw hide. The abattoir has closed down and the project had no other way of obtaining the raw hide at low costs.

2000 cont.

The use of duggerid ~~stew~~ alcohol was very high amongst the youth in the area at the time. There were also higher default rates for those taking mental health treatment. As a result people with mental illness ended up disabled.

- Training on the dangers of eating meat from sick animals and also how to identify them.
- Some of them were trained in weighing children.

2000

Soil erosion project.

- People were trained on how to repair eroded lands and use different types of material to close ditches & gullies.
- People from esiklaheni were trained on how to do these things.
- Currently erosion is bad in the area. The resident would love a project of the similar sort to return, and people who received training before could lead the project.

Registration of traditional healers at the local clinics

- Mr M, a local traditional healer and a respected elder in the community was already registered by that time. He was living in Gauteng project was introduced in the Pictone area.
- Some of the local traditional healers participated in the registration but not all.
- Amalawa, those with expertise on how to treat flats were also registered.
- Education of the toxicity of some of the traditional herbs like, isigidi, umtho-mentene used to relieve women from labour pains/ was also part of the education.

2
Traditional healers were invited to a workshop @ MABA clinic

- Traditional healers were allowed to work in partnership with the clinic. But not all known traditional healers in the community attended the workshop, as a result there are people who end up disabled as a result of using toxic traditional herbs.

(Prescribing inaccurate is dangerous)
Comments: Mr. M

- Izigidi was specifically discouraged @ these workshops.

(But the fact that there not many traditional healers who attended, means that there are people who still use the herb and that leads to disability)
Comment: Nomethey

Wkchairs & Crutches issued to disabled people.

- Issuing of assistive devices occurred at different events around this year.
- A number of people who were in need of these services received them.
- There was also assistance received from UCT researchers

Massive food Project

- Large scale cultivation of field (mostly corn)
- People had food
- Jobs were created in fencing, planting & ploughing
- People with disabilities did not participate in the project.

- (Disability activists in the area are facing and that poses a challenge when trying to advocate for disability inclus in employment opportunities)
Comments MR B.

- District Municipality (ALFRED NZO) has a disability policy providing guidelines for inclusive employment but it has never been implemented in respect
(Disability REP HAD THE POLICY COPY)

Gov. subsidised buses introduced

- Provide transport from villages to town.
- old age pensioners over the age of 80 year get a free ride once a month
- There are no special arrangements for disabled people, such as the free ride once a month.

AGRIC. DEPT gives people vegetable seeds

- People had to register to get the seeds, about 100 people had registered.
- Most disabled people in the area did not participate
- Vegetable gardens have helped people to save money as they do not have to buy vegetables anymore.
- Some people received more than they could use and they were asked to share.

{ But sharing depends on the people's willingness to share

Comment: MR B.

RE Future

understanding Disability

- People do not understand disability! A man in the community who had kidney failure has to ~~go~~ get treatment at Nelson Mandela every month but he is considered as disabled as a result he is excluded participating in many activities in the community, especially those that pertain to disability.

Employment of disabled people.

- Accommodation of disabled people in projects that usually occur in the community
- Skills development for disabled people is needed in the area
- Disabled people do not participate in community activities as citizens, that has to change.

PARTICIPANTS	RATE
4 FEMALE	M PULO
4 MALE	XAKS

DATE: 21/01/11

Appendix 11: Trend analysis for health services

YEAR	EVENT	COMMENTS
FEB 1994	Beginning of mobile clinics	<ul style="list-style-type: none"> - Many villages far from the clinics started receiving health care services - Village health care workers (nometkhiya) were also introduced around this time and they worked with the mobile clinics - Children needing health care, identified by the village health workers received health care quicker than before. - People with disabilities were also assisted with their health care needs - People with disabilities could not reach the clinic and found it difficult to use public transport - Sometimes mobile clinics are not properly equipped and don't have clinic cards to register people.
999	A man passes away after an unknown traditional healer in the village	<ul style="list-style-type: none"> - The campaign on registration of local traditional healers was revived and their education about toxicity of some of the herbs they used. - The need to get traditional health practitioners collaborate with the formal health care system was mostly talked about at the clinic meetings (with the local clinic committee)
	Launch of village health workers	<ul style="list-style-type: none"> - Their main focus was to identify families and children needing health care in the village and refer them to the clinic or the mobile clinic. - Also encourage people to build proper toilets - Received training on mental illness and the dangers of substance abuse, such as dagga

2 to

Introduction
of CDWs

- One of their main responsibility was to monitor income generating community projects

- CDW did not do their job very well as a number of community project have closed down

- CDWs were also responsible for identifying homes in need of social assistance and those with disable people

Building
of toilets
&
Installation
of taps

- Improved access to water for disabled people. Before taps were installed, they would have to hire someone to collect clean water for them. They also needed to hire people to do their laundry. But now they collect their own water and do laundry next to the tap

- Incidence of diseases such as Cholera decreased

- Community member got jobs as they were contracted by municipality to build the toilets. But disabled people did not participate.

- Committees were elected to co-ordinate these activities but disabled people were not represented

- People know that disabled people need to be included and get involved but that is rarely reflected in practise

- Corn fields (untsimi) that lay inactive for many years were revived by this project, supported by the municipality

- Community members participated as liaison officers: they kept fertiliser, seed and other ploughing implements at their homes. Disabled people did not participate in this project.

- More food was available in the villages.

- Improved access to various gov. departments, such as social dev. & home affairs as people no longer needed to go to town for those services

- Before Thusong was opened, application for ID's was difficult esp. for disabled people. An ID book is required for application for social grant.

- SASSA social workers visit occasionally and conduct home visits, with the help of CDWs who identify families in need of social assistance.

008
MASSIVE
FOOD
PROJECT

009
OPENING
OF NEARDYI
MULTI-
PURPOSE
CENTRE
(THUSONG)

sq
anti

- SASSA Social workers also teach people about the importance of saving money

- SASSA visits allowed for swift assistance of needy families and child headed households

- However the centre is not fully functional, as was expected by the residents due to a number of reasons:

① Centre still under management of the provincial administration.

② Board not elected to coordinate activities and deal with complaints

- Police station also not functional, but is crucial claiming payment of disability grants

- There is a satellite police station in a village away from MPOZA and police are accommodated in a house.

LAUNCH OF HEALTH CENTRE

- Assistive devices could be accessed at the clinics as therapists from hosp visit once a month. (AD: limited to w/c and ~~h~~catches)

SURE

IMPROVED ACCESS TO MORE ASSISTIVE DEVICES

- Not all assistive devices are accessible at the clinic esp. heavy ones.



- (i) PAY POINT SOCIAL HALL
- (ii) SURE MARKET
- (iii) PAIN SOCIETY
- (iv) RECTOR HIRE

- (i) PAY POINT SOCIAL HALL
- (ii) SURE MARKET
- (iii) PAIN SOCIETY
- (iv) RECTOR HIRE

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- (iv) RECTOR HIRE

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- (iv) RECTOR HIRE

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- (iv) RECTOR HIRE

- (i) PAY POINT SOCIAL HALL
- (ii) SURE MARKET
- (iii) PAIN SOCIETY
- (iv) RECTOR HIRE

Employment opportunities in the food project
 Liaison officers in need of
 many for work in fields
 MA SURE Project
 Employment opportunities in the food project
 Liaison officers in need of
 many for work in fields
 MA SURE Project

Appendix 1a: The analysis process

Level 1	Preparation of field notes into line note and final note.				
	Duplicating maps, trend analysis charts. Arranging and translating quotes from the discussions				
Level 2	Sub-categorise similar phrases and quotes describing topics related to each of the objectives				
	Objective 1	Objective 2	Objective 3	Objective 4	Objective 5
Social development	Different types of social development services in the area as described by the participants.	"...the construction of the gravel road made it easy to reach town. We were able to go to town for application for social grants. Application of disability grants was also made easier as the people were able to go to the hospital in town"	"...Father used to invite disabled people to the church on Sunday afternoons. He gave them food and second hand clothing. But he also spoke to them about things they can do to improve their lives. And he also assisted some to get grants"	"The centre is not fully functional because it is still under the control of the province. A board needs to be elected to manage the activities. But that is not possible. The centre needs to be transferred to the local municipality first..."	"...CDW's are suppose to monitor the projects and report to [the department of] social development. They are lazy to do that as they should".
Health services	Different types of health services in the area as described by the participants.	"...when the taps were installed, illness like cholera decreased. ...it became easier for people with disability to fetch water.	"...The clinic opens during the day. In case where an emergency occurs at night, traditional health practitioners are helpful"	"Some people disabled people cannot speak for themselves you know. So a nurse may not know what do. But when a willing family member is around its different. He can explain treatment to them"	"...When you go to the hospital, you get everything. Doctors don't come to the clinic. Sometimes you never get all the medicines you need"
Education	Different types of education services in the area as described by the participants.	"...The schools here were not built to accommodate disabled children. Even teachers and the children at the school are not used to having disabled children around".	"...very few parents know what to do about education of their [disabled] children"	"...Some parents don't know what to do with their [disabled] children. They don't know where to even begin. They are not aware of their rights."	"The centre... is still under the control of the province. A board needs to be elected to manage the activities. But that is not possible... [It] needs to be transferred to the local municipality.
Level 3	Categorise the sub-categories and identify salient points emerging from IPA process				
Reflections Reflective notes	Participants are highly aware of their local area and have ascribed specific local meanings to their environment	Accessibility from the main roads appears to be the key factor in terms of the location of service centres.	Various sources of information and circumstances account for service users' decisions to prefer to use one service over the other	The community appears to avoid responsibility for some of the factors that may be barriers or facilitators.	When the service delivery machinery fails you on the little that they have already provided, it is difficult to imagine that it will successfully meet additional service delivery needs.
Interpretations	Core issues				
	limited understanding of service entitlements	Service delivery hinges on infrastructure	Different circumstances drive people to make certain choices.	Whose role is it to ensure education for disabled children?	Meeting the needs of service users requires coordinated effort from various government organs
Level 4	Integration of categories				
	Service delivery in this rural area was complex, interactive and multi layered: physical, personal (behavioural) and administrative (planning).	Rural people have come to understand and respond to service delivery in particular ways, which warrant consideration in policy design and roll out.	Policy implementation process could work when the context (geo-political location, history, culture) of rural areas is taken into account.		