

**FORMATIVE EVALUATION OF HELDERBERG ASSOCIATION FOR
PERSONS WITH DISABILITIES**

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Degree of MPhil in Programme Evaluation



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COMPULSORY DECLARATION:

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List of Acronyms

CBR	Community-Based Rehabilitation
COO	Chief Operating Officer
DSD	Department of Social Development
HAPD	Helderberg Association for Persons with Disabilities
ICF	International Classification of Functioning Disability and Health
NGO	Non-Governmental Organisations
SPSS	Statistical Package for the Social Sciences
WCAPD	Western Cape Association for Persons with Disabilities
WHO	World Health Organisation

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ABSTRACT

Purpose

The peer support programme as run by Helderberg Association for Persons with Disabilities (HAPD) uses people who have disabilities to support people with disabilities in their own community. The purpose of this formative evaluation is to explore the roles and responsibilities of peer supporters and the needs in the community. This evaluation would help HAPD explore which areas of the peer support programme could be improved.

The evaluation explored the relationship between addressable and non-addressable needs, the types of disabilities and the needs identified of the people with disabilities. Exploring these relationships would allow HAPD to understand which needs they are more likely to address and which areas they could improve their support in.

Problem

In South Africa, community-based rehabilitation has been evaluated but there are no evaluations that focus on the roles and responsibilities of peer supporters and the relationship between the needs that are addressed.

HAPD employs and assists in the training of local people with disabilities to support people within their own community, drawing from the resources already in the community. If the peer supporters' roles and responsibilities are not well-defined to address the needs of the community, the programme would fail. The needs of the community need to be identified to understand the community and possibly addressed the needs by providing emotional support, information, and referring cases to other service providers in the community.

The evaluation explores the types of disabilities identified, the needs of the people with disabilities in the community, as well as the number of needs addressed. This information would allow HAPD to have a better understanding of the variety of home visitations the peer supporter could face and would need to provide support in.

Methods

The evaluation used a descriptive research design, which mainly used quantitative methods to evaluate the programme. The evaluator used some qualitative methods to enhance the understanding of the programme, these methods include a focus group with peer

supporters, collecting and analysing programme documents, and interviewing the chief operating officer.

The evaluator explored the relationships between the types of disabilities and the needs that were identified in home visitations. The disability categories were: physical, sensory, intellectual, and psychiatric disabilities. The needs categories as grouped by HAPD were: Health & Wellness and Education & Employment and Transport & Housing and Family & Social needs.

Results

There were 608 usable entries for home visitations; 43% had more than one home visitation, 79% had a physical disability and 39% of the needs were related to Health & Wellness, and 73% of the needs were addressable. There was a significant relationship between having an addressable need and the type of need category identified but no relationship between disability categories. Education & Employment needs and Health & Wellness needs were more likely to be addressed than any other need. Needs related to Transport & Housing and Social & Family issues were not as likely to be addressed.

Conclusion

The formative evaluation of HAPD has found that the roles and responsibilities are well-defined if implemented with the WCAPD. There is a need to increase the training in counselling topics and to provide counselling to the peer supporters.

The importance of creating of referral network based from an asset-based community development perspective was also recommended as it provides tangible and valuable information on the capacities, skills and services available in the community.

The evaluation also highlighted some areas of improvement regarding the record keeping of training material, improvement of data collection, follow-up of home visitations, and clearer categorising of needs and disabilities. HAPD can consider evaluating the mechanism of support the peer supporters provide to the community and how the associate organisations form part of this process.

1. INTRODUCTION

The Helderberg Association for Persons with Disabilities (HAPD) runs a peer support programme in the Western Cape province of South Africa. This peer support programme is committed to building the community by supporting people with disabilities from the inside out. HAPD uses people with disabilities from the community to be peer supporters and trains them to support their peers who are disabled and address their needs.

It is estimated that at least 10% of the world's population lives with a disability, with a large part of people with disabilities living in the developing world. It is also estimated that most people with disabilities are the biggest minority worldwide. People with disabilities remain marginalised, struggle with health conditions, are in poverty, have poor access to basic services and struggle to find employment (WHO, 2011).

In South Africa, it is reported that 7,5% of the population has a disability and that most of these individuals live in resource-poor communities and remain poor and degraded (Statistics South Africa, 2011). The Western Cape province of South Africa contributes to 14% of the welfare grants related to disability (Statistics South Africa, 2017). The Helderberg and Stellenbosch area alone has over 3600 people with disabilities receiving grants (Department of Social Development, 2016). HAPD works with the poorest of the poor in the communities they serve in the Helderberg area.

People with disabilities have fewer opportunities to socialise, are discriminated against, and face stigmas associated with having a disability. It is difficult to mobilise communities to recognise people with disabilities as valued members of a community and that people with disabilities can positively contribute to the community (WHO, 2010f). Programmes that focus on asset-based community development do not focus on the deficiencies but allows people within the context to drive the change, thus breaking the cycle of dependence (Kretzmann & McKnight, 1993).

To address the global need to support people with disabilities, Community-Based Rehabilitation (CBR) was initiated by the World Health Organisation (WHO) following the Declaration of Alma-Ata in 1978 (WHO, 2010d). CBR is a core strategy for the improvement in the quality of services to people with disabilities. CBR places equal emphasis on inclusion,

equality and socio-economic development as well as rehabilitation of all people with disabilities (CREATE, 2015). CBR recognises the potential of people with disability to contribute and drive community development.

In 1994 the International Labour Organisation (ILO), United Nations Educational Scientific and Cultural Organisation (UNESCO) and World Health Organisation (WHO) produced a “Joint Position Paper on CBR” to promote a common approach to the development of CBR programmes. This paper describes CBR as a strategy within community development for the rehabilitation, equalisation of opportunities, and social inclusion of all adults and children with disabilities (ILO, UNESCO, & WHO, 2004). In 2010 the CBR guidelines were developed in response to this paper to provide support for CBR managers and other stakeholders on how to develop and strengthen CBR programmes (WHO, 2010d). These guidelines are still used in the implementation of CBR programmes across the world and in South Africa.

Over the last 30 years, the South African Department of Social Development (DSD) has implemented several CBR programmes over the whole country (CREATE, 2015). The DSD funds numerous projects in South Africa to support people with disabilities in poorer communities and have integrated different CBR components and elements in programmes across the country. The following section provides a brief description of the CBR guidelines followed by a programme description of HAPD and how it supports people with disabilities in the community.

1.1 Community-Based Rehabilitation Guidelines

The overall objectives of the CBR guidelines are provided in the *CBR Guidelines: Introductory Booklet* (WHO, 2010d) are to:

- Provide guidance on how to develop and strengthen CBR programmes.
- Promote a strategy for community-based inclusive development.
- Support stakeholders to address the basic needs and enhance the quality of life of people with disabilities.
- To encourage stakeholders to facilitate the empowerment of people with disabilities.

Every CBR booklet includes a CBR matrix that gives an overall visual representation of CBR. The matrix illustrates the different components which make up a CBR strategy. The CBR matrix is described in the guidelines and includes activities for each component (WHO, 2010d). Individual programmes in every country determine the components that they would focus on. The matrix as seen in *figure 1* illustrates the five components and the respective five elements below it.

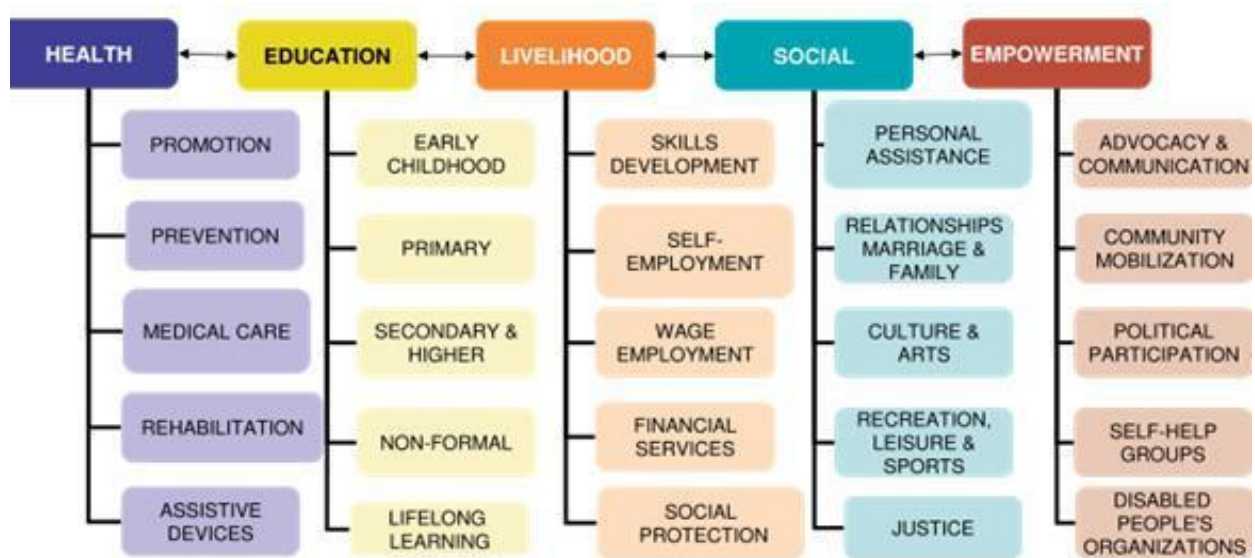


Figure 1. CBR Matrix. (WHO, 2010)

All five components relate to the multi-sectoral approach of CBR, this includes the health, education, livelihood, social, and empowerment component.

The health component focuses on the health potential of people with disabilities, and their family is recognised and empowered to enhance their existing levels of health (WHO, 2010c).

The education component focuses on providing assistance in accessing education and lifelong learning, giving people with disabilities a sense of dignity and effective participation in society (WHO, 2010a).

The livelihood component focuses on supporting people with disabilities to gain access to a livelihood, have access to social protection measures and the ability to earn enough income to support their families and communities (WHO, 2010e).

The social component focuses on the active inclusion of people with disabilities in the social life of the community and the family. People with disabilities should have the opportunity to participate in social activities as it has a strong impact on a person's self-esteem and quality of life (WHO, 2010f).

The empowerment component brings together all other components and it is fundamental for improving the quality of life and the human rights of people with disabilities (WHO, 2010f). This component focuses on the ability of people with disabilities and their family members to make their own decisions and assume responsibility for changing their lives and influencing their communities.

The peer support programme of HAPD integrates the five components and some of the elements of the CBR matrix to support people with disabilities in the communities they serve, the following section describes the HAPD peer support programme.

1.2 HAPD Programme Description

In South Africa, the Western Cape Association for Persons with Disabilities (WCAPD) uses peer supporters, also known as community-based facilitators, in their provincial CBR programmes (WCAPD, 2015). The WCAPD also use peer supporters who are people with disabilities in their branches across the province, including HAPD. People form the community as seen an asset in building relationships and breaking the cycle of dependency (Kretzmann & McKnight, 1993).

Helderberg Association for Persons with Disabilities has been running as a non-profit organisation since 2003 and the peer support programme evaluated has been implemented by HAPD from 2015. The peer support programmes' main goal is to provide support to people with disabilities that were not previously available in rural communities of Helderberg. The Helderberg communities include Macassar, Kayamandi, Franschhoek, and Cloeteville.

The training of peer supporters is one of the important focus areas of the peer support programme with the WCAPD providing the CBR training and the HAPD providing the other elements of the training. The peer supporters are trained to do home visitations where they provide emotional and informational support to people with disabilities. Every home visitation and the details related to the visitation is written a on paper-based client management tool. The data gained from all the home visitations were collected monthly and transferred to MS Excel. This client management tool is shared with the chief operating officer (COO) and reported to WCAPD.

The peer supporter collects data that includes age, sex, contact details, disability type, and the needs that can be addressed. This information creates an up-to-date and complex picture of what is happening within the community as well as focusing the training of the peer supporters to the relevant needs and the disability types.

The home visitations aim to provide emotional support and informational support if it is needed. For example, a person with a disability might be recently diagnosed and might not know where to find better crutches, or they might need help in making their home more accessible. Another might not know that they are able to receive a social grant, or they might not know where to apply. Another would like to find employment and does not know where to receive training or register as a job seeker. The peer supporters would arrange follow-up visitations if it was needed. If a need was identified and if it was urgent it would be referred to a partner organisation or HAPD immediately.

Each home visitation was an individual visit and the peer supporters also gained information about the resources already available to the people in the community. These resources were shared at monthly meetings and the COO could add the resources to the existing network.

Table 1 represents the categories of needs, as grouped by HAPD, in the community. It also includes the components of the CBR Matrix. Table 1 includes the descriptions on the client management tool; the researcher added the CBR components and elements. Although the components are separated in the CBR Matrix, HAPD has combined the results in the

following categories: Health and Wellness, Housing and Transport, Education and Employment, and Social and Family Issues.

Table 1
Category of needs and details

Need Category	Details of Needs	CBR Component & Element(s)
Health and wellness	Needs related to assistive devices, needs for exercise, general health problems and dealing with new disability	Health: promotion, assistive devices, prevention & rehabilitation Social: Recreation, leisure & sports
Housing and transport	Problems with accessibility to home, information on transport resources, access to clinics, and transport issues to attend clinics	Health: assistive devices Empowerment: community mobilisation
Education and employment	Include needs related to wanting to get a job or be trained, or ability to work.	Education: non-formal & lifelong learning
Social and family issues	Applying for social welfare grants, family troubles, and drug addiction of self or family members. Included boredom, crime, and need for food parcels.	Health: Promotion Social: Relationships & Justice

The peer support programme evaluation includes the home visitations from 1 March 2016 to 31 April 2017. The programme consisted of four peer supporters, three males and one female, who worked part-time and were paid monthly. They were required to work a maximum of 60 hours a month which was paid by WCAPD; HAPD reimbursed travelling and phone expenses related to home visitations. The COO was the peer support programme facilitator during this year and coordinated the training of peer supporters and coordinated all

activities related to the peer support programme. The COO was assisted by a part-time administrator to type up the home visitations information and other admin related duties.

The operational costs of HAPD was funded by the DSD, The Lotto, trust funds, local municipality funding and private donors. Fundraising efforts have also included some social enterprise activities such as workshops on disability for people in the corporate sector focussing on raising awareness of disability in the sector. HAPD serves as a branch of WCAPD and receives funding from WCAPD to pay peer supporter salaries.

1.2.1 Programme activities. The programme activities include the training of peer supporters, feedback on home visitation and assisting in referrals to other service providers if needed. HAPD employs, trains, and develops the skills of people with disabilities to become peer supporters. An important element in the peer support programme theory for HAPD is the use of peer supporters that have a disability. HAPD believes that peers with a disability could support other people with disabilities in a significant way. The selection of peer supporters are based on the following criteria:

- Be a person with a disability
- Live in the community they are working in
- They have the time and energy to reach out to and serve people with disabilities
- Ability to read and write English
- The peer supporter must have the potential to, with training, fulfil the roles expected
- Very good communication and relationship skills
- Passion and compassion to support others
- Non-judgemental, trustworthy, is a role model, respect confidentiality of people with disabilities, and a natural leader.

HAPD coordinated two full-day face to face meetings a month; with one of the meetings being a training session. The second meeting was the monthly meeting to discuss any important home visitations or ask for help in the referral to other service providers. This time was also used to complete the home visitation records. The peer supporters could discuss the

cases with each other to reflect on the home visitations and learn from each other and explore the resources available to people with disabilities in the community.

One aspect of the training was based on components of CBR and other topics were arranged by the COO, WCAPD was responsible for training on CBR topics. All the CBR components were covered in training for the year, but there was only one session on every component and its elements. The COO organised training on other topics to develop a better understanding of health, disability, other services of NGO's, and to aid in the development of skills needed to be a peer supporter. These skills would include time management skills, understanding oneself, how to work in groups, and communication skills. The COO invited Non-Governmental Organisations (NGO) or other service delivery organisations to do training in the areas of need that have been identified.

The aim of the CBR training for the peer supporters fits into the education component of the CBR guidelines. Although it was not formal training it can lead to the fulfilment of the potential of the peer supporters, improve a sense of dignity and self-worth. This training also builds capacity for home visitation and therefore leads to effective participation in society and their empowerment (WHO, 2010a, 2010b). The CBR training of peer supporters also fits into the empowerment component. The peer supporters are given the opportunity to communicate issues in public forums and discuss the needs of people with disabilities. The training drives the advocacy and the communication component by allowing the peer supporters to advocate for others and participate in the community (WHO, 2010b).

1.2.2 Target population. There are two sets of beneficiaries of the HAPD program. They include the peer supporters who are the primary beneficiaries of this programme. The skills development and capacity building of the peer supporters are an important element of the programme.

The people with disabilities in the community are the secondary beneficiaries of the peer support programme and are the target beneficiaries. HAPD focuses on supporting adults of any age with any disability in the poorest, previously disadvantaged areas of Helderberg. These areas are selected as they have the highest concentration of welfare grants; according to Statistics South Africa, (2010).

HAPD is the only public benefit organisation that supports adults with disabilities in the area. Although the needs of children with disabilities are also captured as part of the home visitations, they are immediately referred to existing organisations that focus on supporting children with disabilities.

1.2.3 Peer supporter activities. After the first month of training, the peer supporters start doing home visitations. However, the peer supporters will continue to receive training throughout the year. The peer supporter finds the people with disabilities in the community by using snowball sampling. As they live in the area they work, they will know other people with disabilities in their community. With each visitation, they ask for names of other people with disabilities they might know. The peer supporters also ask at the local clinic if there could be any people with disabilities recently admitted or sent home after rehabilitation. By using snowball sampling or being referred by the clinic the peer supporter can arrange the first home visitation.

In this home visitation, the peer supporter would ask open-ended questions about the life of the people with disabilities and document if there were any needs that could be addressed. The home visitations include sharing a personal experience of the peer supporter, listening, giving emotional support, and providing information about the network of HAPD. After the visitation, the peer supporter fills out the client management tool, which would include details of the beneficiary: name, age, gender, disability, address, and then a narrative paragraph is written about the need identified. This session also serves as raising awareness of the resources available to people with disabilities and connecting them with other NGO's, municipal services, networks and service providers that are available.

The peer supporter will most likely share health and disability-related information at the first visitation and will do a possible follow-up visitation. Follow-up visits are arranged by the peer supporter as they have time available and depending on the urgency of the needs identified. However, it is not clear how the follow-up visitations are confirmed or selected.

The other main activity of the peer supporter programme includes raising awareness in their community and strengthen the potential of the work they can do (Kretzmann & McKnight, 1993). The peer supporters act as advocates for change by contacting and visiting

clinics, schools, training centres, workplaces and other organisations to promote accessibility and inclusion (ILO et al., 2004). Although awareness-raising is an important activity it was not part of this evaluation.

The following section will explore the evaluations on CBR and the common recommendations made to support the best practice for CBR programmes. This literature review is used as the background to the programme theory and the evaluation of HAPD.

2. LITERATURE REVIEW

2.1 Disability Models

Programmes designed to address the needs of people with disabilities very much depend on the programmes' understanding of disability and how they go about including people with disabilities in the programme. In the nineteenth and twentieth centuries, development in science helped to create an understanding that disability has a biological or a medical basis and is associated with different health conditions. Disability was only seen as a medical problem and the original medical model of support to people with disabilities focused on the cure and the provision of medical care by professionals. As disability was better understood, a social context emerged, and disability became defined as a societal problem rather than an individual medical problem. The social model of disability shifted attention away from the individual towards the social barriers created by the environment and others (WHO, 2010d).

Danforth (2001) suggests the social model is preferred to the earlier medical model, where disability was a condition or problem and providing the person with medical support would solve the problems that people with disabilities face. The ILO, UNESCO and WHO (2004) suggest that the social model of disability acknowledges the medical aspect of disability but suggest it is the environmental barriers that limits the participation of people with disabilities. It is the perception of people and the environment that limit the person with a disability.

As depicted by the cartoon in *figure 2*, the medical and social models are illustrated as opposing each other. The medical model suggests by providing prosthetics that people with disabilities would be able to find their way up the stairs. The social model suggests that the environment creates the barrier and by providing better access the people with disabilities would be able to go where they need to be (Miller, 2014).



Figure 2. Social Model vs Medical model (Miller, 2014)

The social model was advocated and conceptualized by people with disabilities and it highlights the perceptions of the society and that these perceptions of ability exclude people with disabilities. The social model finds it crucial to address how people, groups, and organisations construct meaning about disability (WHO, 2011). Asset-based community development also focussed on the capacities, skills and assets of the community instead of what they lack or what the problems are (Kretzmann & McKnight, 1993).

Programmes develop their activities around the model they follow, and this determines how people with disabilities are supported. If they are mere recipients of help in whatever form or if they can participate and take ownership of change (Kretzmann & McKnight, 1993; WHO, 2011). The focus in the disability sector lies in an asset-based approach and not a deficit-based approach.

HAPD integrates the social model in the peer support programme, acknowledging that using peer supporters that have a disability allows the opportunity for people with disabilities to challenge the community norms. HAPD aims to support the people with disabilities and their needs, but also realises that the common attitudes, beliefs, and structures of society put people with disabilities at a social and economic disadvantage.

HAPD raises awareness within communities by using people with disabilities as peer supporters, allowing the peer supporters to become empowered in their own community. This

approach of working with people with disabilities and using their disability as an advantage, allows the peer supporters to be more effective. It affords people with disabilities the chance to be positive examples in the community (Davidson et al., 2005; WHO, 2010c). This approach allows the peer supporters to be empowered in how they interact with their environment.

Rule, Lorenzo, and Wolmarans (2006) suggest that the ownership of CBR programmes need to be directed by people with disabilities, where people with disabilities become more than just the service recipient but a service provider. The peer supporter contributes to their community; challenging the perceptions others and breaking the cycle of dependence. Their abilities and strengths are used to develop the community, thus the peer support programme integrates the asset-based community development framework into the programme (Kretzmann & McKnight, 1993).

2.2 Peer Supporters

CBR guidelines use the term CBR facilitators or CBR workers, which are defined as the people who work at community level, they are a central part of disability programmes (Rule et al., 2006; WHO, 2010b). The WCAPD and HAPD refer to a CBR facilitator or worker as a peer supporter. Peer supporters will mostly be used in the following description of their role and CBR facilitators/workers will be used referring to research that includes that specific definition.

An impact evaluation of CBR programs, which included a baseline follow-up and an audit of records in Palestine found that it was the contribution of the work of CBR facilitators at individual and family level that brought about the direct and unique impact in the community (Eide, 2006). A qualitative research design which used participatory methods in exploring the impact of CBR programs focusing on CBR facilitators found that the unique element of seeing people with disabilities in their home brought about a special connection. People with disabilities were CBR facilitators who were local, available and approachable (Chappell & Johannsmeier, 2009). Peer supporters in their own community can make a positive contribution to CBR programs.

Peers who are people with disabilities and understand the context of being a person with a disability, also understand the community and the culture they work in. Of the trained CBR facilitators in South Africa, just over a quarter of them are people with disabilities or family members of people with disabilities (Rule, 2006). It is difficult to find studies that suggest that people with disabilities are better peer supporters. By using an asset-based community development approach allows the programmes to strengthen the potential of the people they serve, by using them in the program (Kretzmann & McKnight, 1993).

A concept analysis of peer support for the nursing profession analysed by Dennis (2003), suggest peer supporters can emerge from lay individuals who are eligible to support others and can be selected by the community to be lay helpers. If lay individuals are chosen by health programmes and trained, they can develop into peers or into paraprofessionals in time. *Figure 3* represents the development of lay workers into peers and then paraprofessionals as suggested by Dennis (2003).

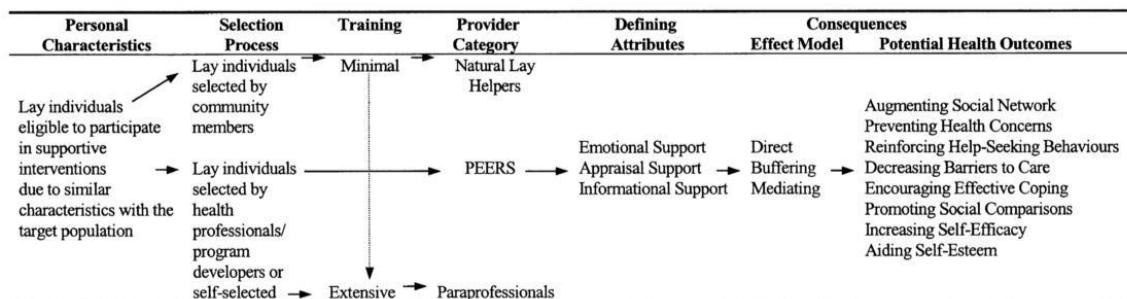


Figure 3. Conceptual distinctions of peer support by Dennis (2003).

Dennis (2003) also provides a definition of peer support and suggests it is the provision of assistance and encouragement by an individual considered equal. Although noted as a rudimentary interpretation in the health sector, the paper further suggest that these common attributes of peer support can stretch across all settings. HAPD integrates these attributes as most of the programme falls within the health-related component of the CBR matrix. Peer supporters with a disability are seen as ‘equal’ to the people they serve.

The distinct attributes that repeatedly emerge that correspond to the peer support programme include emotional support and informational support. HAPD uses these two components and integrates it into the programme, equipping the peer supporter with the skills and creating a platform where people with disabilities are driving the change.

2.2.1 Emotional support. Peers who are people with disabilities can provide emotional support as they understand and have experienced first-hand the barriers and challenges people with disabilities face. It could range from having limited access to public and health services, knowledge of disability rights and limited understanding and knowledge of their own disability (CREATE, 2015). A peer supporter cannot help in every single home visitation they do but they are able to understand the emotional impact of having a disability.

Boothroyd and Fisher (2010) explored the *Peers for Progress Programme* which found that emotional and social support is a key function of peer support. It is also an important element in measuring and evaluating the effect that peer support offers. Peers encourage the use of skills in dealing with stress, they also create opportunities and are available to talk about negative emotions. When the peer supporter shares their own experience of their situations and success, the peer supporter can help the people with disabilities understand their problems and situation better (Davidson et al., 2005). A two-phase outcome evaluation of peer support for women with breast cancer highlighted that the women receiving support felt less anxious after a visit, especially if the peer supporter had similar problems (Dunn, Steginga, Occhipinti, & Wilson, 1999).

When people with disabilities are emotionally supported it allows the people with disabilities to make sense of their environment (Davidson et al., 2005) and in turn empowers them to see the different opportunities that are available. The emotional support of people with disabilities can lead to their empowerment which is a core cross-cutting theme for enabling people with disabilities to access all opportunities (ILO et al., 2004; WHO, 2010b). CBR facilitators address a major need regarding the psychological needs of people with disabilities (Chappell & Johannsmeier, 2009).

2.2.2 Information support. A crucial contribution that peer supporters can make, includes providing information about disability and information on the services available in

and outside the community (ILO et al., 2004). Rule et al. (2006) explores the challenges of CBR within South Africa and suggest that CBR programmes need to have formal links with the Departments of Education, Social Services, Health, Labour and Housing to be successful.

The ability to develop a network of service providers and build awareness in the community is one of the foundation outcomes and principles of CBR and asset-based community development (Kretzmann & McKnight, 1993; WHO, 2010). Peer supporters can link people to clinical care, they can become a liaison to other health services and can empower people with disabilities to seek quality care (Boothroyd & Fisher 2010). Peer supporters can also link people with disabilities to many other service providers and this referral network that they build is a critical element to the development of the community that people with disabilities live in (Rule et al., 2006).

A thematic qualitative analysis of 37 CBR evaluations by Kuipers, Wirz, & Hartley (2008) found that a critical element linked to informational support is the referral network. A referral network requires active collaboration across organisations, government departments, and international NGO's to enhance the networks available. The on-going process of building and maintaining networks and relationships is crucial to the work of a peer supporter.

Peer supporters initially provides information to people with disabilities about the service HAPD offers, they also learn about the resources already available. The peer supporter and the people with disabilities become resources to each other. CBR projects cannot work in isolation, if there is no network and collaboration it will not succeed (ILO et al., 2004).

Boyce and Ballantyne (2000) argue that disability, rehabilitation and evaluation depend on information and that CBR programmes should focus on gathering and disseminating information. They also suggest that evaluating the referral network of CBR programs is one of the stepping stones to explore if the CBR programmes focus on empowerment of the people with disabilities in the community. An article by Lightfoot (2004) which examined the strengths and weaknesses of CBR for social workers suggest that the referral network is essential to keeping projects sustainable.

The roles and responsibilities of peer supporters should be well-defined and include the emotional and informational support they provide and need. The roles and responsibilities should also be supplemented by training.

2.3 Roles and Responsibilities of the Peer Supporter

Chappell and Johannsmeier (2009) evaluated the impact of CBR facilitators delivering CBR programmes by using qualitative methods and found that there was a lack of clarity in the roles of CBR facilitators. CBR programmes face challenges in bringing all stakeholders to the table and defining roles and responsibilities as the need for support to people with disabilities is so large. Many health professionals don't understand the role of CBR facilitators and could not use them due to not having a clear understanding of their roles (Chappell & Johannsmeier, 2009).

Major weaknesses found in the evaluation of CBR programmes globally are management-related. The thematic qualitative analysis of disability and development programmes by Kuipers et al. (2008) provide that the weaknesses in CBR programmes include lack of policy frameworks, implementation strategies, organisational, administrative, and personal management structures. If the management of the organisation is not well run the roles and responsibilities will not be well-defined.

Although CBR programmes do provide quality care and services to people with disabilities (Chappell & Johannsmeier, 2009; Davidson et al., 2005; Dennis, 2003), the roles and responsibilities of peer supporters require a complex interconnected support system where the implementing agent needs to take considerable time in defining their roles and responsibilities.

The roles and responsibilities of peer supporters need to be tailored to individuals, community contexts, and people with disabilities need to be part of this process. (Madden et al., 2014). The process of describing the roles and responsibilities can be influenced by many elements, such as the community and the training of the peer supporters. If peer supporters are from the community in which they work, they add a unique and positive aspect to community development (Boothroyd & Fisher, 2010). On the other hand, if peer supporters are local it can add some strain to the scope of support they provide, and they can be asked to do more

than the roles requires or they might not do what is expected (Chappell & Johannsmeier, 2009). The roles and responsibilities need to be well-defined to allow peer supporters to manage the support they provide.

An important element that influences the implementation of CBR programmes consistently is the training and support the peer supporters receive. The support they receive is crucial to the sustainability of the programme.

2.4 Peer Support Training

A systematic review of CBR in Southern Africa found that training is a common activity in CBR programmes, as well as educating the community on disability (M’Kumbuzi & Myezwa, 2016). HAPD coordinates training of the peer supporters every month and sees training as one of the important aspects of providing substantial and relevant support to people with disabilities. The training that peer supporters receive can have a major influence on their performance and their ability to provide support. (Ravesloot et al., 2007).

Kuipers et al. (2008) found in the thematic qualitative analysis of CBR evaluation reports that a major theme that emerged consistently was the content of training. The article states that training CBR workers on types of disability and adaptations of environments have been major recommendations to CBR projects. Programmes need to integrate these themes in the training schedule.

Rule et al. (2003) explores the challenges of implementing CBR projects and suggest there is a need to develop accredited training for CBR facilitators. Accredited training will allow peer supporters to become registered and employed as professionals. Rule et al. (2003) further says that the training for CBR workers in higher education institutions mainly focuses on rehabilitation with less consideration of equal opportunities and social integration. There is a gap in the provision of formal training for CBR facilitators. CBR programmes like HAPD provides opportunities for people with disabilities to learn and be empowered by the training, but it is not formal training.

Evaluations in CBR have highlighted the importance of CBR curricula to be enhanced and understood by all staff and stakeholders, at all levels. CBR training is fundamentally

based on training within the community for the community. A strengths, weaknesses, opportunities and threats analysis of CBR evaluations by Sharma (2007) found that the training of CBR workers was a common suggestion as an opportunity to improve CBR programmes. The training of peer supporters should be empowering, (Rule, 2013) equipping them with the knowledge and skills to support people with disabilities with various needs. The training of CBR facilitators or peer supporters is a challenge in CBR.

The following section describes the programme theory of HAPD developed by the evaluator to set the foundation for the evaluation of the peer support programme.

2.5 Programme Theory

A programme theory helps the programme staff and other stakeholders to understand what the programme will achieve, as well as which variables contributed to the programme outcomes (Donaldson & Lipsey, 2014; Rossi, Lipsey, & Freeman, 2004). A programme theory can assist programme managers and evaluators to design evaluation questions and tools to measure the performance of programmes. As programmes do not stand alone but within its context (Donaldson & Lipsey, 2014), the programme theory can identify important moderators and mediator of change. If the programme theory is plausible the programme would be more likely to reach its outcome.

A programme theory as defined by Chen (2006) was created for the peer support programme of HAPD to assist in the design of the formative evaluation. The programme theory as represented in *Figure 4*, represents the action model and the change model. The action model block represents a systematic plan for arranging staff, resources, setting, and support organisation to reach its target population and provide the intervention service. The six components include the implementing organisation, implementers, associate organisations, ecological context, the service delivery protocol, and the beneficiaries, all of which influence each other in the implementation of the programme (Chen, 2006). The blocks were populated by using the HAPD programme description.

The change model represents the underlying causal processes of the HAPD programme. It includes the programme activities as the determinants and the mechanism

which drive the programme to reach the long-term/distal outcome. If the peer supporters are trained on types of disabilities, CBR, and how to do home visitations the peer supporters will be able to do home visitations. As the peer supporters do home visitations they will be able to identify the needs in the community. After the needs are identified the peer supporters could emotionally support people with disabilities, share information, and connect people with disabilities to other resources in the community if they need it. If the peer supporters can address the needs of people with disabilities in the community, they could improve the support available to people with disabilities.

The evaluator was able to construct the programme theory from programme documents and the evaluators' own understanding of the programme. The action model and the change model were presented to the COO at an interview and to the peer supporters during the focus group discussion. They were able to review the theory of change and make suggestions regarding the action and change model. The programme theory was then edited and presented again to the COO for final approval.

It is not assumed that when a peer supporter does a home visitation that they would help every time. There could be people with disabilities that have the adequate resources and support. HAPD then served as a link between other services that they might need in the future or can be connected to themselves. Although HAPD does not use an asset-based community development approach explicitly as an underlying principle in the programme theory. Please find the theory of impact model depicted in *Figure 4*.

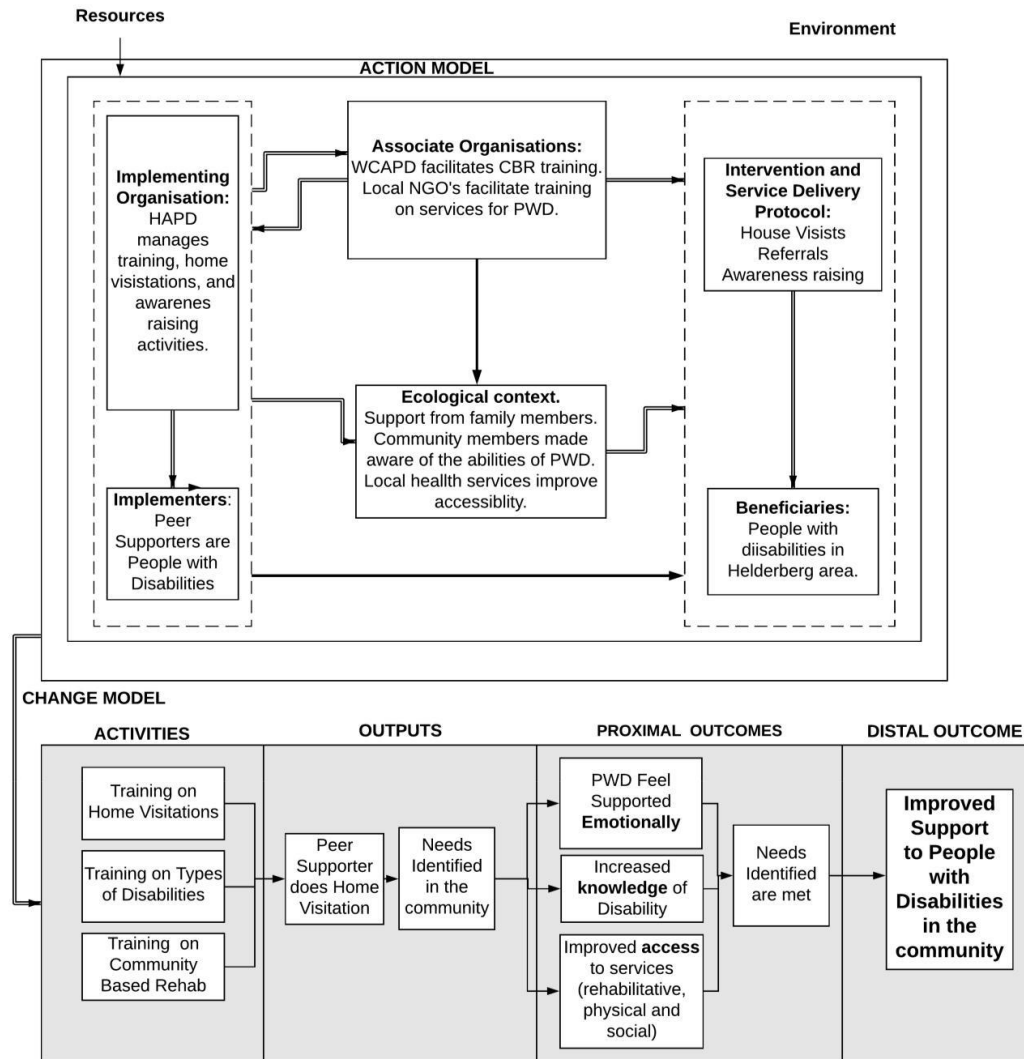


Figure 4. Theory of Impact Model of HAPD.

It can be assumed that the programme theory of HAPD is a plausible theory and will lead to an increased support for people with disabilities if all the components are implemented as designed. If the programme theory is plausible the next level within the hierarchy of evaluation is exploring the implementation/process of the programme (Rossi et al., 2004).

After evaluating the implementation/process of the programme the outcomes of the programme can be evaluated. The following section elaborates on the background of choosing

the evaluation questions for the formative evaluation of HAPD which include process and outcome evaluation questions.

2.6 Evaluation Design

The evaluator was working as an administrator at HAPD from February 2017 to April 2017 and from May 2017 to November 2017 as the fundraiser. The evaluator was familiar with HAPD and as the opportunity became available to do an evaluation with any organisation that has implemented a programme for more than a year, the evaluator asked permission from the course convener to evaluate HAPD. Although the evaluator was employed by the organisation there were no financial benefits to the evaluator and it did not affect the conditions of employment.

The COO agreed to do a formative evaluation to explore the areas where the peer support programme could improve, especially as HAPD would be integrating the peer support programme into their new community development programme in the future. The evaluator had built a rapport with the peer supporters before the evaluation and was familiar with the programme which would allow a unique understanding of the implementation process.

A formative evaluation allows the evaluator to make recommendations regarding the implementation of the peer support programme (Rossi et al., 2004; Wholey, Hatry, & Newcomer, 2010). The formative evaluation for HAPD included a process evaluation and an evaluation of the proximal outcome.

The process evaluation was used to explore whether the peer supporters' roles and responsibilities were well-defined and how it compares to the needs identified of people with disabilities in the community. If their roles and responsibilities are clearly defined they are more likely to support a person with a disability. These roles and responsibilities should reflect the needs of people with disabilities in the community. If the roles and responsibilities were not well-defined then the peer supporters would not be able to support the people with disabilities well (CREATE, 2015; European Commission, 2004; M'Kumbuzi & Myezwa, 2016).

Understanding the roles and responsibilities of peer supporters well could help transfer some of the responsibility of specialised services needed to relevant professionals in the community (Price & Kuipers, 2000). The roles and responsibilities should also consider the physical barriers related to access to the community that peer supporters face being a person with a disability themselves. If these barriers are not addressed they will not be able to fulfil their role as a peer supporter (WHO, 2011).

The peer support programme at HAPD had only been implemented for a year and a distal outcome evaluation would not be possible as it would require more baseline information of the people with disabilities and more years of implementation (Rossi et al., 2004). This proximal outcome evaluation explored the needs and the types of disabilities of people with disabilities in the community, and which of these characteristics made it more likely to have a need that could be addressed. This information would help HAPD understand who they mostly support, and which characteristics are associated with needs they provide support in. The details of classifying needs as addressable needs are discussed in the methodology.

2.6.1 Process Evaluation Questions 1

- a. Are the roles and responsibilities of peer supporters well-defined by HAPD?
- b. Do peer supporters fulfil their roles and responsibilities as expected by HAPD?
- c. Do the roles and responsibilities reflect the need of the people with disabilities in the community?
- d. Are the roles and responsibilities relevant considering that peer supporters are people with disabilities?

2.6.2 Process Evaluation Questions 2

- a. How many home visitations have the peer supporters done in the communities they serve?
- b. How many client needs were identified by peer supporters?

2.6.3 Proximal Outcome Evaluation Question 3

- a. Was the programme able to address certain types of disabilities or needs categories better?

3. METHODOLOGY

3.1 Design

This evaluation used a descriptive design to evaluate the peer support programme. A descriptive design allowed the evaluator to explore the characteristics of the people with disabilities in the client management tool (Bernard, 2006). The details in the client management tool were used to calculate the frequencies of disability categories, needs identified and the needs that could be addressed. Descriptive and inferential statistics were used to compile tables related to evaluation questions, exploring demographic details of people with disability, and calculating odds ratios to determine the likelihood of some needs addressed over others.

The descriptive design was enhanced by using qualitative approaches to explore the roles and responsibilities of the people with disabilities. The qualitative approaches used to explore the roles and responsibilities included a focus group with peer supporters, collecting and analysing programme documents, and interviewing the COO. (Ritchie, J. Lewis, 2003).

As there were no previous evaluations or research on the peer support topic in this context and it was not structured around a hypothesis or experiment, a descriptive design was preferred. It was not possible to create a control group due to time restrictions, resources available, and the nature of the evaluation did not require control groups to be created.

A descriptive design might only reflect the unique sample of peer supporters and the people with disabilities visited by HAPD, however, it could bring understanding to the complex nature of being a peer supporter and the diverse community they serve. The results of this research could be helpful to other organisations that work for and with people with disabilities in South Africa.

3.2 Data Providers

The data providers consisted of two sets of participants: the COO of HAPD and four peer supporters. Information gathered from each data provider was used to answer or supplement all evaluation questions.

The COO was able to provide resources and was available for an interview and ad hoc questions when reviewing documents. The four peer supporters (three males and one female) working at HAPD were able to provide qualitative information regarding their roles and responsibilities as peer supporters, their training, and their experience as people with disabilities being peer supporters.

3.3 Primary Data Collection Materials

3.3.1 Interview with COO. The semi-structured questions for the interview included the following themes: the roles and responsibilities of peer supporters and the training provided by WCAPD and HAPD. Please see Appendix A for the questions. The discussion and answers to the interview questions were written down as the interview progressed and analysed after the interview to identify categories and drawn into themes. These themes were derived inductively as there were no themes or categories developed before the interview.

3.3.2 Focus group discussion with peer supporters. There was one focus group which explored the roles and responsibilities of peer supporters and the experience of being a peer supporter with a disability. Please see Appendix B for the questions.

A focus group with all four peer supporters present were preferred over individual interviews as the evaluator was interested in the experience of the peer supporters' attitudes, feelings, experiences and reactions as a peer supporter group. As there were only 4 participants it allowed the evaluator to explore themes in-depth with the peer supporters at the monthly meetings (Freitas, Oliveira, Jenkins, & Popjoy, 1998).

It was also easier logistically to see the peer supporters on the days they were scheduled to attend training. The peer supporters face some challenges to move beyond their community unless they come to the HAPD premises for training or meetings; another benefit is that the transport costs of the peer supporters are covered for these training days.

As the evaluator was familiar with the peer supporters they were relaxed when the focus group started. The evaluator explained the purpose of the evaluation and reminded the peer supporters that their answer would be confidential and that no names would be shared

with the COO or any other party. They were also given time to read and sign the consent forms.

Initially, the focus group was recorded but the researcher later found that the recording was unclear and could not be transcribed. Fortunately, the answers were written on a flip chart and the evaluator asked the peer supporters, during the focus group, if they agreed that their own words were correctly written on the chart. The evaluator was able to determine the degree of consensus on a topic in a focus group and explore themes that could support the data collected from other parts of the study (Bernard, 2006). The evaluator asked the questions one by one and the peer supporters expressed their opinions and experience with each other in the focus group. The evaluator allowed for themes that arose from the questions and answers to be explored. The focus group was an hour and half long.

The information written on the flip chart was analysed to identify categories and in turn themes to understand the roles and responsibilities. No categories or themes were chosen before the focus group (Bernard, 2006). The themes were compared to the themes found in the interview with the COO to answer the evaluation questions.

3.4 Secondary Data Materials

All the secondary data materials were analysed using the thematic analysis approach. The data was organised, generated into themes, coded, tested to explore emergent understanding, seeking alternative understanding, and writing-up of the data according to the evaluation questions (Ritchie, J. Lewis, 2003).

3.4.1 Home visitation data set. The organisation provided the evaluator with an excel summary of the home visitations which was composed of a set of longitudinal data of 765 data entries of home visitations seen by 4 peer supporters over a period of one year of the implementation cycle, 1 April 2016 to 31 March 2017. Each peer supporter collected the following information from every home visitation and wrote it on a client management tool:: name, date, gender, contact details, address, race, length of visit, disability and possible need identified.

A narrative explanation of the needs identified, or the problems discussed was filled out by the peer supporter. Space was provided on the client management tool to indicate the follow-up process, but this was rarely completed. Entries that had no physical documents, no dates and no names were not considered and 608 home visitations were used in the analysis.

3.4.2 Training schedule. An HAPD donor report included a table with the training schedule, containing dates, topics, and duration of training, Please see Appendix F.

3.4.3 Programme documents. HAPD had programme documents available regarding the roles and responsibilities which included a bullet point list of activities. HAPD also provided the evaluator with an activity description from WCAPD which included time frames and details for all the activities for a peer support programme. The evaluator compared the bullet point list and the activity description and created a table to explore the differences and similarities in the roles and responsibilities. Please see Appendix D and E for these documents.

3.5 Procedure

3.5.1 Ethics. Ethical clearance was requested and granted by the University of Cape Town Department of Commerce REF: REC 2018/010/099. Please see Appendix I for more information. The evaluator was working at HAPD during the evaluation as an administrator and later as a fundraiser, to reduce any conflict of interest there was no financial benefit requested or offered for doing the evaluation. The evaluator also set meetings times outside the normal working hours to separate roles the evaluator had.

The COO signed a consent form for the use of its data. Peer supporters provided informed consent before they participated in the focus group. They were free to withdraw from the research at any time. Please see Appendix C for the peer supporter consent forms.

None of the peer supporters had an auditory or visual impairment. None of the peer supporters in the focus group had an intellectual disability thus the evaluator did not need to consider parental or consent forms from a guardian (National Disability Authority, 2009).

The client management tool had already been typed up in MS Excel format by HAPD, and the programme documents were requested by the evaluator and provided by HAPD. The

identity of all beneficiaries was protected as all information provided by the programme was kept confidential on a password protected computer.

3.6 Data Analysis

3.6.1 Answering evaluation question 1. a. Are the roles and responsibilities of peer supporters well-defined by HAPD? The activity descriptions from WCAPD and the list of roles and responsibilities from HAPD were analysed and compared and used as the reference to determine what was defined as roles and responsibilities. Comparing the lists of the roles and responsibilities to each other and using the focus group the evaluator could explore if there were any gaps and if the roles and responsibilities were well-defined.

b. Do peer supporters fulfil their roles and responsibilities as expected by HAPD? To determine if the peer supporters fulfilled their roles and responsibilities the interview with the COO, programme documents and the focus group was used to explore the question.

c. Do the roles and responsibilities reflect the need of the people with disabilities in the community? The client management tool was used to calculate the percentage of needs and the physical disability types of the people with disabilities in the community. The physical disability categories were categorised in more detail as it provided information on the vast amount of disabilities that were identified.

There were over 15 different types or names for disabilities in the client management tool. As this was too many categories to use they were condensed to make it easier to analyse. Table 2 represents the disability categories created and the details mentioned in the client management tool (WHO, 2011).

Table 2
Categories of Disabilities

Disability Category	Details in the Client management tool
Physical Disability.	Mobility Impairment, Stroke, Amputation, Cerebral Palsy, Polio, Head Injuries or Anything Related
Sensory Disability	Vision or Hearing Loss or Anything Related
Intellectual Disability	Intellectual Impairment Or Anything Related

Peer psychiatric Mental Health Problems or Anything Related
Disability

The percentages and frequencies of the disability categories and needs were compared to the roles and responsibilities to determine if it reflected the need of people with disabilities.

d. Are the roles and responsibilities relevant considering that peer supporters are people with disabilities? The focus group with the peer supporters explored the roles and responsibilities as experienced by peer supporters and their own experience of being a person with a disability. Please see Appendix B for the focus group discussion questions.

3.6.2 Answering evaluation question 2 and 3. 2. a. How many home visitations have the peer supporters done in the communities they serve? The client management tool was available in an MS Excel dataset and transferred to IBM Statistical Package for the Social Sciences (SPSS) 24 statistical software. Initially, there were 765 entries for home visitations, but after cleaning the data 608 home visitations were available for analysis. Entries that had no physical documents, no dates and no names were not considered.

This list of 608 visitations was a combination of new clients and re-visitations, the frequencies and totals were calculated for each. 48% were new visitations, i.e. new clients, and these entries were used in the description of age, sex and race.

b. How many client needs were identified by peer supporters? The needs are represented by the needs identified in the community. After the data was transferred to SPSS 24 the categories of disabilities and needs were created and coded to nominal values of 1, 2, 3, and 4 for each category. This allowed the qualitative data to be represented in nominal categories to be analysed (Field, 2013). The entries and column headings were double checked to make sure that entries were labelled, and entered correctly. Please refer Table 1 for the categories of needs and the details.

3.6.3 Answering evaluation question 3. Was the programme able to address certain types of disabilities or needs categories better? Addressable needs would indicate the peer supporters could support the people with disabilities with information and/or emotional support. A non-addressable need is a need that could not be addressed as it would

fall outside the scope of work or training of the peer supporter. Table 3 provides details on addressable and non-addressable needs in different need categories.

Table 3
Categories on Needs and Classification of Addressable or Non- addressable Needs

Need Category	Addressable Need	Non- Addressable Need
Health & Wellness	People with disabilities need assistive devices. Information on bedsores. Need for exercise	Need daily personal assistance. Other health problems regarding Organs Medication-related
Education & Employment	Would like to find work. Want information on skills development	Struggling to find alternative schools for children.
Transport & Housing	Need information of transport provided by clinics. Information regarding accessible government homes	Request transport House infrastructure problems
Social & Family Issues	Assistance with grant application	Family members using drugs. Family issues Divorce Safety

Needs were categorized as addressable or non-addressable by using the peer supporters experience and the evaluators understanding of the program. The totals of these categories were tabulated and cross-tabulated with disability and need categories. The crosstabulation and Chi-square test of independence was run on SPSS 24 to determine whether the addressable or non-addressable needs were statistically independent or if they were associated

with the different need or disability categories (Michael, 2001). The odds of having needs addressed were also calculated to explore the relationships between the needs and disability categories.

4. RESULTS

The results of this evaluation are based only on one programme and therefore the findings cannot be generalised. There were only four peer supporters to provide information about their experience in working in the community. The peer supporters all have disabilities, but they only represent physical disabilities. As the range and types of disability vary across the community there could be a limitation to the support they could provide to people with disabilities that have different disabilities.

As most of the home visitations represented physical disabilities, there could be a suggestion that a peer supporter is more likely to support a person with the same disability. Thus, the home visitations might skew towards only seeing people with disabilities that have addressable needs, although the peer supporters are trained to support all types of disabilities. The following results aim to answer the evaluation question within this context with the data available.

4.1 Process Evaluation Question 1

4.1.1. Are the roles and responsibilities of peer supporters well-defined? The HAPD roles and responsibilities list had bullet points for each activity and this allowed the evaluator to identify each activity. As it was only one word per activity, it created some difficulty to understand the complete role of the peer supporters. It was also difficult to determine the priorities between each activity or the sequence of implementation of different activities.

The WCAPD activity description of the roles and responsibilities included clearer details on each activity and gave specific information around time allocations for activities. Table 4 list the main activities for HAPD and WCAPD and the notes provide comments on details that differ or are similar.

Table 4
WCAPD and HAPD Main Activity list

Activity Name		Notes
WCAPD	HAPD	
Home Visitations	Support Adults with Disabilities & Their Families	HAPD lists steps about home visitations WCAPD adds details of minimum and maximum times for home visitation.
Group Sessions	-	HAPD lists the details of group sessions as part of the home visitation sessions. WCAPD provides details on how to organise a session for PWD only, separate from the sessions from awareness raising sessions.
Awareness Activities	Awareness-Raising & Advocacy	WCAPD specifies this activity amongst local or broader public. Time-frames for awareness raising activities included time limitations.
Branch Related Tasks	-	Not mentioned in HAPD list. This includes supporting the branch in any tasks, could be part of skills development for peer supporter.
-	Networking	HAPD lists details regarding the exact tasks to link to new service providers. WCAPD described the Networking activity as Awareness raising for the PEER SUPPORTER.
Mentoring/ Training	-	Training was not listed as activity in HAPD. WCAPD defined mentoring as monthly meetings, individual consultations, and training.
Admin	Administration	HAPD & WCAPD has similar descriptions. WCAPD adds details of the maximum hour to claim for admin and supports PWD with more flexible admin hours if they might have difficulty with writing.
Other activities	-	Other activities not listed in HAPD list. WCAPD includes all other activities/meetings/ events related to disability but indicated that the coordinator should monitor it.
-	Accountability & Reporting	HAPD list other skills needed to be a peer supporter related to accountability and reporting.

Although the list of HAPD does not read as easily as the WCAPD list, the WCAPD adds the descriptions of the activities to make the roles and responsibilities easier to understand. There was still not exact clarity on the priorities of each activity, but the roles and responsibilities of a peer supporter could be understood from these lists.

Using both lists, the roles and responsibilities can be suggested to be well-defined from an administrative and implementation perspective. If they are not used together the peer supporters might not understand their roles. There were some missing elements in the roles and responsibilities stated by all the peer supporters in the focus group that indicated that there are emotional demands made by their work environment that needs to be considered.

In the focus group, the peer supporters were asked to list the main activities of a peer supporter. The following broad categories were listed: providing information, emotional support to people with disabilities, planning visitations, using a diary, visiting the clients, listening to them and writing up notes on the client management tool. The evaluator made notes of the details and these activities were reflected in the roles and responsibilities of HAPD.

The peer supporters expressed that they felt like they fulfil many roles in the community, they felt like social workers, physiotherapists, psychiatrists, a doctor, and a close friend. The peer supporter mentioned being called at different times of the day to help with daily tasks, to attend special events, and speak to family members.

The peer supporters mentioned that fulfilling so many roles was very tiring. They felt that they were more than just a peer supporter; the all the peer supporters agreed that they are the “angels of disability”. They are seen by the community as people who can do anything and who knows everybody.

The peer supporters feel under pressure regarding all the roles that they are requested or expected to fulfil by people with disabilities in the community. This mostly refers to the roles that fall outside their job description.

The evaluator asked about the positive aspects of these ‘other’ roles they mentioned, peer supporters said that it made them feel confident in the community and that they felt they were needed.

The evaluator asked about the negative aspects of these roles; all the peer supporters reinforced the following comments as they were mentioned:

“Gets hectic”

“They always expecting something”

“It takes a lot of energy”

“They come with a lot of personal problems”.

The peer supporters said that initially, they needed to get used to being a “crutch for someone”. This suggests that there is an important emotional component to the roles and responsibilities of peer support that is not reflected in the list described by WCAPD and HAPD. The emotional component is a critical element that the support peer supporters provide.

The list of roles and responsibilities of HAPD was presented to the peer supporters after they had discussed their own roles and responsibilities; they commented that the list was very detailed. The peer supporter said they did not know that the work would be so detailed and demanding when they applied for the position. They all confirmed when one peer supporter commented that the list was missing the emotional aspect of the work they do.

In answering the evaluation question 4.1.1 it can be confirmed that the roles and responsibilities are well-defined from an administrative perspective if they are used together but there is a crucial element missing regarding the emotional demand that is placed on the peer supporters. It also highlights the demanding role that they fulfil and that they need support in their role.

4.1.2. Do peer supporters fulfil their roles and responsibilities as expected by HAPD? The COO expressed that HAPD employs people with disabilities that had no or very little working experience and by efforts in training, mentoring and support, HAPD supported them to develop into a peer supporter. The interview with the COO suggested that HAPD aims to develop peer supporters to fulfil their role as peer supporters, to train people with disabilities to have the skills to do needs assessments, provide specific information and informational support, and network within the community.

Each month a training day and a monthly meeting consisted of supporting the peer supporter and developing skills to improve the knowledge base in CBR, building confidence in home visitations, and understanding of services in the community. The monthly meetings included discussion on targets and setting realistic goals for each peer supporter regarding home visitations and other activities. These sessions allowed the peer supporters to grow into their roles as peer supporters. The meetings also served as a platform where the peer supporters supporting each other in the experiences they had.

The peer supporter needed to submit proof of all home visitations they had done by completing the details on the client management tool, if this was not submitted monthly it could delay the payment of their wages. The client management tool was proof of the work that they had done.

It was a benefit to have the roles and responsibilities well-defined from an administrative point and allowed the COO to monitor peer supporter activities. The client management tool allowed the COO to keep track of activities and targets and the COO could follow-up if a peer supporter did not meet these goals as expected from HAPD each month. All peer supporters would report to the COO on the targets they did not reach, and the COO could discuss the details and find ways that peer supporters could meet the goals. This support would include counselling of peer supporters and motivating them to achieve their targets.

The peer supporter did mention they needed the help of a social worker. A social worker would specifically help the peer supporters cope with the emotional stressors that were expected from working with difficult cases. Difficult cases could be referred to the social worker and in turn, help them be more effective in providing a referral to a professional.

In answering evaluation question 4.1.2 it can be assumed that the peer supporters were able to fulfil their roles and responsibilities as expected by HAPD, but that a social worker would could improve the service they provide.

4.1.3. Do the roles and responsibilities reflect the need of the people with disabilities in the community? The need in the communities that the peer supporters serve can be represented by the variety of needs identified and by the types of disabilities that were identified with each home visitation. The needs and the disabilities create a clear but complex picture of home visitations and the unique challenges that people with disabilities face.

Table 5 below represents the details of categories and percentage of different needs of people with disabilities in the community. The results derived from the analysis are interpretive and do not have the same power or validity as a response to an item on a questionnaire, but it did help HAPD see the current needs that could be addressed. The highest needs fall within health and wellness needs which contribute to 29.9% of needs identified. The second highest needs highest relate to transport and housing at 19.7%.

Table 5
Percentage of Needs Identified

	Health & Wellness	Transport & Housing	Social & Family Issues	Education & Employment	No Needs Identified
Percentage of needs identified	29.9%	19.7%	16.3%	12.5%	21.6%

Note: N = 608.

It was difficult to categorise the disabilities mentioned in the client management tool as there were numerous types of disabilities named in the client management tool, to overcome this challenge the disabilities were categorised into four main types of disability: physical, sensory, intellectual, psychiatric and other. Please see Table 2 for details within the

types of disabilities. The following Table 6 represents the percentage of categories of the four main disabilities in the community.

Table 6
Percentage of Disabilities Categories

Physical Disability	Sensory Disability	Intellectual Disability	Psychiatric Disability	Other	No Disability Identified
79%	7%	6%	0.5%	6%	1.5%

Note: N = 608.

Physical disabilities were 79% of the disabilities identified, this category was explored further to distinguish the different physical disabilities. There was some challenge to analyse some of the descriptions of the physical disabilities. For example, when a stroke was noted, it was not clear if it caused mobility impairment or a sensory impairment. As stroke and mobility impairment were listed in the client management tool as separate disabilities, they were categorised as separate physical disabilities in the table. Table 7 below represents the categories of physical disabilities found in the client management tool. Please note that other physical disabilities related to physical disabilities include muscular dystrophy, spina bifida, arthritis, polio, meningitis, cerebral palsy, and head injuries.

Table 7
Percentage of Different Types of Physical Disabilities

Mobility Impairment	Stroke	Other	Amputee	Total
38%	25%	20%	17%	100%

Note: N = 480.

Mobility impairment has the highest percentage in the physical disability category at 38% but the client management tool does not provide enough information regarding the details of the disability. 25% of the physical disabilities could be related to stroke and 20% to any other kind of combination of physical disability.

Tables 5, 6 & 7 show the variety of disabilities the peer supporters encountered in home visitations as well as the main categories of needs. The lists of roles and responsibilities as described in the previous questions provides details needed for home visitations, support in how to disseminate specific information to people with disabilities and address the different needs in a systematic way. It cannot, however, list all the combinations of disabilities and the needs that peer supporters encounter.

An example would be where one person with a disability could have a physical disability and have a transport related problem that could be addressed by providing information of clinic transport. Another person with a disability could also have a physical disability and a transport need, but the peer supporter would not be able to provide transport. Thus, in some home visitations the peer supporter can address a need but they would not be able to for another visit, although they have the same disability and need categories.

In answering question 4.1.3 it can be seen from the list of roles and responsibilities that it aims to equip the peer supporter to systematically address different activities that are needed to support people with disabilities in the community but it is not clear if the roles and responsibilities can reflect the complex and complete nature of the community. Disability is diverse and needs a diverse plan of action (Hanass-Hancock et al., 2017).

4.1.4. Are the roles and responsibilities defined considering that peer supporters are people with disabilities? One of the key criteria for being a peer supporter is the ability to visit a person with disabilities at their home although it was a bit of a challenge as all the peer supporters had a physical disability. In the focus group, the peer supporters discussed how having accessibility constraints made it difficult to visit people with disabilities but that it could be overcome if they phoned in advance and knew the address. The peer supporters said they were always aware of the weather and how that influenced their home visitations.

The peer supporters discussed that able-bodied people could do home visitations much easier as they would have fewer physical barriers to deal with. The peer supporters did feel though that people with disabilities could understand people with disabilities better than able-bodied people could. They suggested that if an able-bodied person had someone close to them

with a disability it would help them understand disability better than only have a theoretical background. The peer supporters felt being a person with disabilities was an advantage.

The peer supporters explained that although they face some physical barriers to see the people with disabilities they know that because they themselves are people with disabilities and have experienced the stressors themselves, that they can give hope and can “help our peers excel”.

The peer supporters mentioned that working with someone with the same disability was easier, but even if it was a different disability they could support people with disabilities to overcome emotional stress. The COO also expressed that it depends on the type of support that was needed and that a peer supporter with a disability could assist any person with a disability as it created a unique emotional connection and opportunity to support another.

In answering question 4.1.4 it was difficult to determine if the tasks on the list of roles and responsibilities were designed with people with disabilities in mind, or if it was designed for able-bodied people or both. The main restrictions seemed to be having the correct assistive device for the terrain and accessibility to the community, which could be mitigated by planning visitations and minding the weather.

An important element is that the programme theory is built on the premise that a person with disabilities will be able to better support another person with disabilities as compared to someone that does not have a disability. So even if an able-bodied person would fulfil the roles and responsibilities the peer supporter with a disability would be a better fit according to the programme theory of HAPD.

4.2 Process Evaluation Question 2

4.2.1. How many home visitations have the peer supporters done in the communities they serve? To explore the details of the home visitations this section below describes the age, gender, race, the frequency of visitations and a summary of the amount of home visitations.

There were 608 usable entries for home visitations; this included a combination of first visitations for the year and re-visitations(s). 48% of the home visitations were new visitations

for the year, i.e. new clients (N=290). This sample was used in the description of age, gender and race. Table 8 below is a summary of the details of the first home visitations.

Table 8
Age, Gender and Race of New Clients

Category	Age	Gender	Race
Amount	42 Years Average (<i>SD</i> = 16,4). Male 39 Years, (<i>SD</i> = 17). Female 43 Years, (<i>SD</i> = 18).	62% Male, 38% Female.	76% Coloured, 24% African.

Note. N=290. New clients as indicated on the client management tool.

62% of the first visitation were male and 38% female, 76% were coloured and 24% African. The average age for first visitations was 42 years (*SD* = 16.4), the average age for males was slightly younger at 38 years, (*SD* = 15.7) and females almost the same at 43 years, (*SD* = 18).

The number of times a name was added to the client management tool allowed the evaluator to determine how many times a person with disabilities was visited. There were 344 first visitations for the year, but 290 of those were indicated as new clients. Thus 54 clients were clients before March 2016 and were re-visited, thus it was a first visitation for the year, but not a new client. Table 9 reflects the frequency and percentage of home (re)-visitations for the year.

Table 9
Frequency and Percentage of Visitations and Re-Visitations

Category	Frequency	Percentage
One Visitation	344	56.6
Two Visitations	133	21.9
Three Visitations	74	12.2
Four Or More Visitations	57	9.4
TOTAL	608	100

Note. N=608.

Around 57% of the people with disabilities received one visitation. 43% of the home visitations received two or more visitations, 23% received three or more home visitations and 9% received four or more home visitations. As the follow-up section of the client management tool was not completed, it was not possible to explore why the people with disabilities were seen more than once. In answering this question 608 home visitations were done where 48% were new clients.

4.2.2. How many client needs were identified by peer supporters? It is interesting, and possibly concerning, to note that 21.6% of the visitations had no need identified. No need identified could mean that there was no actual need for that home visitation, the person did not feel free to talk, or that the home visitation notes were incomplete. Please refer to Table 5 which represents the percentage of “need identified” for all home visitations. Table 10 below excludes the “no needs identified” category.

As the “no needs identified” category was not considered, it decreased the sample to 433. Table 10 shows the distribution where all home visitations had a need identified.

Table 10
Needs Categories – Excluding “No Needs Identified” category

	Health & Wellness	Housing & Transport	Social & Family Issues	Education & Employment	TOTAL
Percentage	39%	24%	21%	16%	100%
Frequency	169	104	91	69	433

Note: N = 433

Health & Wellness needs increased by 10%, from 29% to 39% of the selection but all the needs categories remain in the same order. Please refer to Table 1 for the details on the different needs in the categories.

4.3 Proximal Outcome Evaluation Question 3

4.3.1 Was the programme able to address certain types of disabilities or needs categories better? As a reminder, an addressable need in this evaluation is a need that the peer supporter could provide support in. Support would mainly include providing information, emotional support, and/or other support in assisting with a need within their scope of work and training. Although this is a limited definition of the real need experienced by the person with disabilities, it creates the platform from which the peer supporters work. Table 11 represents the frequency and percentage of addressable and non-addressable needs in the community.

Table 11
Percentage of Addressable vs Non- Addressable Needs

	Addressable	Non-Addressable
Frequency	315	118
Percentage	73%	27%

Note: N = 433

73% of the needs identified were addressable. This is a high percentage. The assumptions are that according to their roles and responsibilities and training, the peer supporter should be able to, at least, provide information regarding their need. This caused many of the needs to be addressable as providing information would be a relatively straightforward task. The non-addressable needs are needs where providing information or emotional support could not address or alleviate the need. Please see Table 3 for more details on addressable and non-addressable needs.

The following sections explore the association between an addressable need and the category of disability or the category of need the people with disabilities had.

4.3.2 Disability category and addressable needs. To explore if a non-addressable need was associated with any type of disability category it was compared in a joint frequency distribution also called a cross-tabulation (Michael, 2001). This cross-tabulation contains the number of cases that fall into each combination of categories. The categories must have

enough observations in each category to be considered (Field, 2013). The psychiatric disability category had too few entries and was not considered. Table 12 represents the top 3 disability categories that had enough entries to do the cross-tabulation on SPSS 24.

Table 12
Top Three Disability Categories

	Physical	Sensory	Intellectual	Total
Frequency	359	35	30	424
Percentage	85%	8%	7%	100%

Note: N=424. Psychiatric disability not considered as it only had 9 entries.

The crosstabulation and Chi-square test of independence was run on SPSS to determine whether the non-addressable needs were statistically independent or if they were associated with the different need or disability categories (Michael, 2001). Table 13 represents the cross-tabulation of disability categories with the addressable or non-addressable need categories. Percentages and observed count versus expected count were included to calculate odds ratios if the association was significant.

Table 13
Cross-tabulation Addressable and Non-Addressable Needs in Different Disability Categories.

	Physical Disability	Sensory Disability	Intellectual Disability	Totals
Addressable Need*	75% (269 vs 266)	74% (26 vs 26)	63% (19 vs 22)	314
Non-Addressable Need*	25% (90 vs 93)	26% (9 vs 9)	37% (11 vs 8)	110
Totals	359	35	30	424

Note. N = 424.

$\chi^2 = 1.94$, df =2. $p < .379$. *Percentage and (Observed versus Expected Count).

There was a non-significant association between the type of disability identified and if the need was addressable $\chi^2 (2) = 1.94$, $p < .379$. The type of disability that the people with

disabilities had was not associated to having an addressable or non- addressable need. The peer supporters were just as likely to provide support to a person with a physical disability, sensory disability, or intellectual disability.

The evaluator also explored the different types of physical disabilities as mentioned in Table 7. The type of physical disability that includes stroke, amputees, mobility impairment, or other physical impairments. These did not have a significant association with an addressable need $\chi^2 = 7.644$, $df = 3$, $p < 0.54$. Table 14 represents the cross-tabulation of the types of physical disabilities with the addressable or non-addressable need categories.

Table 14
Cross-tabulation Addressable and Non-Addressable Needs in different Physical Disability Categories.

	Amputee	Mobility Impairment	Stroke	Other	Totals
Addressable Need	15% (41 vs 47)	36% (99 vs 104)	28% (76 vs 69)	77% (58 vs 53)	274
Non- Addressable Need	23% (25 vs 19)	42% (46 vs 41)	19% (20 vs 27)	16% (17 vs 21)	108
Totals	66	145	96	75	382

Note. N= 382.

$\chi^2 = 7.644$, $df = 3$. $p < 0.54$.

*Percentage and (Observed versus Expected Count).

The peer supporters were just as likely to provide support to a person with any type of physical disability.

4.3.3 Need category and addressable need. There was a significant association between the need category and having an addressable need $\chi^2 (4) = 94.54$, $p < .000$. This means the peer supporters were more likely to provide support in a certain need category compared to other need categories. Please see Table 15 below.

Table 15
Cross-tabulation Addressable and Non-Addressable needs in Different Need Categories.

	Education & Employment	Health & Wellness	Transport & Housing	Social & Family Issues	Totals
Addressable Need	91%	89%	62%	44%	
Obs. vs Exp.	63 vs 51	150 vs 125	65 vs 78	36 vs 60	314
Non- Addressable Need	9%	11%	38%	56%	
Obs. vs Exp.	6 vs 18	19 vs 44	40 vs 27	45 vs 21	110
Totals	69	169	105	81	424

Note. N = 424.

$\chi^2 = 94.54$, $df = 4$, $p < .001$.

Obs. = Observed, Exp. = Expected.

The percentages in Table 15 reflect the percentages of the total observations in each category. The peer supporters were able to provide support in 91% of Education & Employment needs, 89% of Health & Wellness cases, 62% of Transport & Housing cases, and 44% of Social & Family Issues cases. The percentages are useful, but it would be more useful to explore the odds of having an addressable need or comparing the odds of addressable needs between different need categories. The odds and odds ratio calculations would help HAPD determine which needs they are more likely to meet.

Calculating the odds and odds ratio of having an addressable need in different categories was used by using the observed counts as shown in Table 15 and the equations illustrated below. Please see Table 16 for the complete table of calculations. The calculations below are used as an example.

Odds of Addressable Need (comparing need categories)

$$\begin{aligned}
 &= \frac{\text{Freq. of Addressable Need in Category A}}{\text{Freq. of Addressable Need in Category B}} \\
 &= \frac{\text{Freq. of Addressable Health and Wellness Need}}{\text{Freq. of Addressable Transport and Housing Need}} \\
 &= \frac{150}{65} \\
 &= 2.31
 \end{aligned}$$

The odds of a person with disabilities having an addressable need in Category A were calculated by using the observed frequencies in Category B. For example, 150 Health & Wellness compared to 65 Transport & Housing needs were addressable. By calculating 150/63, the people with disabilities were 2.31 times more likely to have an addressable Health & Wellness need compared to a Transport & Housing need.

Comparing the same two categories to calculate the odds of having a non-addressable need: 19/40 = 0.48, this means that the peer supporters were 0.48 less likely to have a non-addressable need in the Health & Wellness category compared to a Transport & Housing need. Explained in another way, Transport & Housing needs were not as easy to address compared to Health & Wellness needs.

The odds ratio determines the odds of having an addressable need comparing two categories divided by the odds of not having an non-addressable need comparing the same categories. The odds ratio was calculated by using the following equation:

Odds Ratio of Addressable Need

$$\begin{aligned}
 &= \frac{\text{Odds of Addressable Health and Wellness Need vs Transport and Housing}}{\text{Odds of Non-Addressable Health and Wellness Need vs Transport and Housing}} \\
 &= \frac{2.31}{0.48} \\
 &= 4.81
 \end{aligned}$$

Combinations of every category were calculated, and the totals were transferred to Table 16. Table 16 present the odds of addressable and non-addressable needs by comparing all categories. The odds ratio, confidence interval, and significance level were calculated and tabulated by using SPSS 24 to determine if the odds fall within the true population sample (Field, 2013).

Table 16
Odds of Addressable, Non-Addressable Needs and Odds Ratios Calculations of Need Categories

Categories	A. Odds of addressable need	B. Odds of Non-Addressable need	Odds ratio = A/B*	95% Confidence Interval	Significance Level
Education & Employment vs Social Family Issues	63/36 = 1.75	6/45 = 0.13	13.46	5.1006 to 33.7735	P < 0.0001
Health & Wellness vs Social & Family Issues	150/36 = 4.17	19/45 = 0.42	9.93	5.1622 to 18.8652	P < 0.0001
Education & Employment vs Transport & Housing	63/65 = 0.97	6/40 = 0.15	6.47	2.5611 to 16.3019	P = 0.0001
Health & Wellness vs Transport & Housing	150/65 = .31	19/40 = 0.48	4.81	2.6166 to 9.0206	P < 0.0001
Transport & Housing vs Social Family Issues	65/36 = 1.81	40/45 = 0.89	2.03	1.1268 to 3.6616	P = 0.0184
Health & Wellness vs Education & Employment	150/63 = 2.38	19/6 = 3.12	0.76	0.2868 to 1.9713	P = 0.5620

Note: N = 424.

*Odds Ratio of having an addressable need when comparing categories.

A person with disabilities with an Education & Employment need is 13.46 times more likely to have an addressable need compared to a Social & Family Issues need. A person with disabilities with a Health & Wellness need is 9.93 times more likely to have an addressable need compared to a Social & Family Issues need.

A Person with disabilities with an Education & Employment need is 6.47 times more likely to have an addressable need compared to a Transport & Housing need.

A Person with disabilities with a Health & Wellness need is 4.81 times more likely to have an addressable need compared to a Transport & Housing need.

A Person with disabilities with a Transport & Housing need is 2.03 times more likely to have an addressable need compared to a Social & Family Issues need.

The Health & Wellness and Education & Employment odds ratio was the only odds ratio that had a confidence interval which included 1. This indicated that there would be no difference in the categories (Field, 2013); the two needs are just as likely to be met.

To answer question 3, it was easier to provide support in Health & Wellness needs as the peer supporters were trained in this category throughout the year. The Education & Employment needs were also easier to provide support in as it would be 'easy' to provide information on education and employment. Transport & Housing needs were also more difficult to address as these problems also sit within the infrastructure of the community and are difficult to change. The peer supporter could refer persons with disabilities to a transport service provider but could not provide transport. Social & Family needs were also difficult to address as the peer supporter could not change the immediate problems that the people with disabilities faced.

4.4 Conclusion

The formative evaluation of HAPD has found that the roles and responsibilities are well-defined if implemented with the WCAPD. There is a need to increase the training in counselling topics and to provide counselling to the peer supporters.

The importance of creating of referral network based from an asset-based community development perspective was also recommended it provides tangible and valuable information on the capacities, skills and services available in the community.

The evaluation has also highlighted some areas of improvement regarding the record keeping of training material, improvement of data collection, follow-up of home visitations, and clearer categorising of needs and disabilities. HAPD can consider evaluating the mechanism of support the peer supporters provide to the community and how the associate organisations form part of this process.

5. DISCUSSION

The discussion is divided into the main findings found in the evaluation followed by the recommendations and limitations of the study. Recommendations for the peer support programme are noted throughout the main findings and in the main recommendations section.

5.1 Peer Support Roles and Responsibilities

HAPD has administratively well-defined roles and responsibilities if it is combined with the list form WCAPD. The peer supporters receive training from HAPD and WCAPD regarding their roles as peer supporters and thus would be able to understand their role from an administrative perspective. This suggests good management from HAPD as it has been found as a common weakness within CBR programs (Kuipers et al., 2008).

The emotional component of the peer supporters' role was not listed in the roles and responsibilities by HAPD or WCAPD. HAPD should add the emotional component to the descriptions of roles and responsibilities and incorporate training on counselling. The training on counselling would also help the peer supporters understand where their scope of emotional support lies and with this training would allow them to better communicate their role. Peer supporters will be more effective if they knew where their responsibilities regarding the emotional support lie.

Peer supporters provide emotional support to people with disabilities and it also suggests that the peer supporters would need an emotional support system for themselves. Although the monthly meetings create the platform for discussion it needs to be addressed in the programme planning.

5.1.1 Referral network. HAPD aims to build the capacity of the community by networking with local stakeholders, and HAPD adapts the training of the peer supporter to the main health and wellness needs of the community. Networking and adapting programmes to the needs of the people with disabilities are sustainable factors listed in the CBR Guidelines (WHO, 2010d).

The different categories of needs were addressed or not addressed depending on the context of every person with a disability and the resources available to peer supporters. The

resources in the community also contribute to the support available and could be a major inhibitor or support to CBR programs. As the HAPD peer support programme will grow in its capacity it is crucial for HAPD to document the referral network and resources available in the community (Lightfoot, 2004).

HAPD should focussed on using an asset-based community development approach as it will strengthen the capacities, skills and abilities already in the community (Kretzmann & McKnight, 1993). This not only creates a structured process in dealing with difficult cases, but it provides tangible and valuable information on the resources and services available in the community.

5.1.2 Client management tool. The client management tool included the details of the home visitations, but it is not clear why some people with disabilities received one visitation and others received more than one. The mechanism behind why there were not more visitations could suggest areas of improvement of the service of the peer support programme. It was not possible to explore this mechanism as the follow-up section of the client management tool was incomplete.

Providing support to the family is mentioned in all the CBR guidelines, however, the client management tool and programme documents provide very little information on the participation of the family. The family is an important part of CBR programmes and asset-based community development, the support that peer supporters provide to the family would be an interesting and much-needed element to explore for HAPD. The peer supporter programme could arrange group sessions for parents and guardians to help explore needs and develop activities around supporting people with disabilities in relation to their family.

5.2 Peer Support Training

The training schedule indicates that there was only one day of training on most of the CBR components and elements for the year. This would not be an adequate amount of training sessions for the peer supporters to holistically understand CBR. The training of peer supporters is the most important element of the peer support programme as it provides the informative foundation for doing home visitations .HAPD has kept retained attendance

records and asked the peer supporters to do reflection on the training which is good practice, but HAPD did not have enough information available to evaluate the benefit of the training.

HAPD needs to retain all training documents to be able to monitor and evaluate the training conducted by WCAPD and others. Evaluating the training can determine if specific training programmes should continue, expand, and how to improve the training for the future (Kirkpatrick & Kirkpatrick, 2009).

HAPD could explore areas to improve the training of peer supporters on rights for people with disabilities as working within the community they will be able to see opportunities and advocate for change. The peer supporters specifically requested more training on the rights of people with disabilities, HAPD can incorporate this suggestion and create other opportunities to suggest training topics.

The Education Component in the CBR guidelines (2010), suggests creating opportunities for lifelong learning, which include adult education, continuing education, professional development, and self-directed learning. The peer support programme does provide the peer supporter with the opportunity for lifelong learning but does not have the capacity to support the educational development of other people with disabilities in the community. HAPD could explore skills development workshops to expand the scope of service and provide an opportunity to empower the community.

5.3 Characteristics of People with Disabilities and Needs Identified

It is interesting to note that around 22% of home visitations had no need identified. This could be due to people with disabilities having adequate support at the time, they did not feel free to discuss the matter with the peer supporter, the home visitation was not implemented well, or the client management tool was not filled out properly. HAPD needs to explore why these home visitations had no needs identified as this is a large percentage of the total home visitations. It is not assumed that there are always needs, but the client management tool should be able to capture needs and resources already available.

As peer supporters are providing information or making referrals to other service providers it is easy to categorise the need as addressed. This does unfortunately not indicate to

which extent the people with disabilities were supported or how their life has improved. HAPD is more likely to support people with disabilities who have Education & Employment needs as well as Health & Wellness needs. It is not easy to provide support in Education & Employment in the long term, but peer supporters can provide the people with disabilities with information on training or provide forms to register with a recruitment agency. The Health & Wellness needs were simpler to address as the resources available to people with disabilities are easier to access and there are support systems already available i.e. clinics and hospitals.

Health & Wellness support also depends on the type of information the person with disabilities would need. Many people with disabilities need information regarding their disability and help with assistive devices. Health & Wellness needs were also more likely to be addressed as the peer supporter had received training throughout the year and they might understand many of the physical disabilities needs as they all have physical disabilities.

Needs related to transport were harder to provide support in as providing transport was not possible, but peer supporters could provide information about transport to clinics or provide information on service providers.

Social and family issues were also difficult to provide support in. In these cases, emotional support would be the main area of support, but also information regarding applying for social grants would be easier to address. People with disabilities face challenges as many able-bodied people do with family stressors, family members that stealing, drug addiction and other social problems. HAPD could improve their service to people with disabilities and their families by training peer supporters to run support groups for families.

This peer support programme would be able to better support people with disabilities by considering the following recommendations in the peer support programme.

5.4 Recommendations

1. HAPD aims to develop the community by working with stakeholders in the community to support people with disabilities but it is not always clear if it uses an asset-based community development approach. HAPD could fall into the trap of seeing the needs before seeing the capacities and skills in the community.

2. HAPD should integrate the emotional component of the peer supporters into the roles and responsibilities and facilitate the training in counselling for the peer supporters.
3. HAPD should explore the need to support the peer supports with counselling.
4. It would also benefit HAPD to better support people with disabilities in the community by adding support groups for people with disabilities and their families.
5. HAPD would benefit by creating and documenting the referral pathway the peer supporters have created. HAPD will be able to explore how the needs are best addressed and integrate that into future programmes. This would include exploring why some people with disabilities received more than one home visitation.
6. Needs have been identified in the client monitoring tool, but the follow-up section of the form was not completed well and does not help HAPD understand how needs were addressed. If the details are filled out it could also help create the referral pathway and the mechanism of how the peer supporters addressed the need. It will also allow the future evaluations to explore the mechanism of support that the peer supporter provides.
7. HAPD would benefit from creating a monitoring system that measures the following areas of training: how the reaction was to the training, if the peer supporter's knowledge increased, how their behaviour changed, and how it has benefitted the organisation. (Bates, 2004; Chapman & Kirkpatrick, 2009). If the training is monitored and evaluated HAPD would be in a better position to train the peer supporters in future programmes. This would also allow HAPD to understand where peer supporters need the most help.
8. The client management tool allows HAPD to have data available for processing information but there are some limitations to the data entry. HAPD could pre-define the categories of needs and disabilities which will allow the peer supporters and administrator to be on the same page. It will also make it easier to capture and access the needs and disabilities in the community.

5.5 Limitations of the Evaluation

As mentioned in the results chapter, the results of this evaluation are based only on one programme and therefore the findings cannot be generalised. There were only four peer supporters to provide information about their experience in working in the community. The peer supporters all have disabilities, but they only represent physical disabilities. As the range and types of disability vary across the community there could be a limitation to the support they could provide to people with disabilities who have different disabilities.

As most of the home visitations represented physical disabilities, there could be a suggestion that a peer supporter is more likely to support a person with the same disability. Thus, the home visitations might skew towards only seeing people with disabilities that have addressable needs, although the peer supporters are trained to support all types of disabilities. The following results aim to answer the evaluation question within this context with the data available.

This evaluation was focussed on quantitative data but there was a technical difficulty in recording the focus group and could have led to a loss of some rich elements to the discussion of the experience of peer supporters. Themes that arose in the focus group could have been explored in more detail and could have strengthened the validity of the results.

The client management tool was typed into the excel sheet by 3 different administrators and some details about needs or the priorities of needs could have been perceived differently. For example, if two needs were identified in a home visitation one administrator would only write the first one and the other would only write the one that seemed more important. This difference could have influenced the amount and percentage of needs identified.

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APPENDIX A

COO Interview

Defining the Roles and Responsibilities of Peer Supporters,

1. How would you describe the main roles and responsibilities of the peer supporters?
2. How were the roles and responsibilities determined for the contracts of employment for the peer supporters?
3. How were peer supporters selected?
4. Why does HAPD use peer supporters who are people with disabilities?

Discussing the Themes that are Covered in the Training Provided by HAPD.

1. How is the training schedule determined for training the peer supporters by WCAPD?
2. How often was the training?
3. Who determines the schedule for training for the peer supporters by HAPD?
4. How do you as COO determine which training themes should be covered?
5. How are the needs of the community identified?
6. Which areas of training will be explored in the future?
7. Could there be a gap in the training that peer supporters received? Why? Why not?
8. How often was training?
9. How long was every training session?
10. Did the peer supporters get certified for any training?
11. Was there any form of feedback to HAPD on training?
12. Who attended training?
13. Did peer supporters form part of the process of choosing training topics?
14. Which organisations other than HAPD and WCAPD did training?

APPENDIX B

Peer Support Focus Group Questions

This focus group will include writing the answers on a flipchart. Although some of the questions can be answered straightforwardly the evaluator will probe for more information on each topic to explore ideas that are raised.

Session 1 Roles and Responsibilities Questions

1. How do people with disabilities get help in the community?
2. What are the main goals of HAPD?
3. What are the main activities to reach this goal?
4. What are the roles and responsibilities of your job as a peer supporter?
5. Please look at this list of roles and responsibilities created by HAPD. How do they compare?
6. Why do you think they are the same/different?

The following questions are related to you as a person with disabilities is a peer supporter.

1. What kind of support do people with disabilities need?
2. What are the strengths and weaknesses of being a peer supporter with disabilities?
3. Who do you think anybody will also be able to support people with disabilities? Why/Why not?

APPENDIX C

Focus Group Consent Form

You are being asked to take part in an evaluation to explore the implementation of the peer support programme. This research has been approved by the Commerce Faculty Ethics in Research Committee.

We are asking you to take part because you are a peer supporter and your participation is an important part of the service delivered by HAPD.

Please read this form carefully and ask any questions you may have before agreeing to take part in the evaluation.

What the study is about: The purpose of this study is to explore:

- if peer supporters' roles and responsibilities are well-defined,
- if the training received is adequate to the roles and responsibilities,
- your experience as a peer supporter and a person with disabilities.
- determining how many needs were addressed in the community.

What we will ask you to do: If you agree to be in this study, we will conduct a focus group interview with all the peer supporters. The focus group interview will include questions about your job as peer supporter as a person with disabilities, the training you have received, the home visitation you do, the challenges you face, and questions related to your experience as a peer supporter at HAPD.

The focus group and a training questionnaire will take about 2 hours of your time and will be conducted in a morning session confirmed and approved by HAPD.

Risks and benefits: The evaluator does not anticipate any risks to you participating in this study other than those encountered in day-to-day life.

Compensation: This focus group will be confirmed by HAPD and you will receive your standard working hour's payment at this time. Lunch and refreshments will be served after the session.



Your answers will be confidential. The full transcripts of this evaluation will be kept private. In any sort of report or quotes, to explain concepts, that will be made public we will not include any information that will make it possible to identify you. If you feel uncomfortable about the use of quotes, the evaluator will seek your permission to use it. Evaluation records will be kept in a locked file; only the evaluator will have access to the records. If we audio-record the interview, we will destroy the tape after it has been transcribed, which we anticipate will be within two months of its taping.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationship with HAPD. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this evaluation is Zani Bothma. Please ask any questions you have now. If you have questions later, you may contact Zani Bothma at zanibothma@gmail.com or 0738357276.

Statement of Consent: I have read the above information and have received answers to any questions I asked. I consent to take part in the study.


Name of Participant	Date	Signature

Name of Researcher	Date	Signature

You will be given a copy of this form to keep for your records.

APPENDIX D

WCAPD Peer Support Programme

ACTIVITY	DESCRIPTION	SUGGESTED TIME
<p>Home-visit / Individual interview</p> 	<ul style="list-style-type: none"> • Individual contact with a person with a disability or parent/caregiver • Home visit or one-on-one session providing support and information to that person. • No more than 4 home visits for the same client per month. • Process note and claim form must be completed for each home visit. 	<ul style="list-style-type: none"> • Home-visit usually lasts 30 – 60 min, but not more than 2 hours with the client. • Travelling time (by foot, taxi, etc.) is included in home-visit time on the claim form. • Travelling time cannot exceed 1 hour per home visit and should ideally be specified by the peer supporter on the process note. peer supporters should plan their visits to limit travelling time.
<p>Group session</p>	<ul style="list-style-type: none"> • A planned group session for a group of people with disabilities (adults or children) or for parents/caregivers of persons with disabilities. • Attendance register signed by group participants MUST accompany the process note and claim form. • Purpose/topic of the session must be clear. • Not to be confused with an awareness-raising activity • Not more than 2 Supporters involved per group session. • Must be planned, coordinated and presented by the P. 	<ul style="list-style-type: none"> • Group session usually lasts between 1 – 2 hours, but not more than 3 hours. • No limit on the number of group's month, but peer supporter Coordinator should monitor to ensure groups are relevant. • Any planning, preparation or administration performed beforehand for group sessions can be claimed as 'Admin'.

	<p>Supporter (not the Coordinator, SW, etc.)</p> <ul style="list-style-type: none"> • In the case where a peer supporter only assists with the logistics of a group session (i.e. hand out invites), they can claim for ‘APD tasks’ or ‘Other’, but not for a group session since they did not run or facilitate the group themselves. • A peer supporter who purely attends a group session as a client (does not ‘work’ in any way) cannot claim for that session. 	
<p>Awareness Activities</p>	<ul style="list-style-type: none"> • Any activity performed by the peer supporter that raises awareness about disability, disability rights, APD activities or the Peer Support Programme amongst the local or broader public. This includes talks, puppet shows, etc. • A P. Supporter purely attending an event or awareness activity as a client cannot claim, UNLESS they assisted in some way. • Awareness activities can be performed in group-format (talking at International Day or talking to a group of clients in the clinic waiting room), but this does not qualify as a group session. • Can also be performed one-on-one, i.e. with the head-nurse at the clinic, manager at the crèche, etc. • Process notes must be completed for each awareness activity. 	<ul style="list-style-type: none"> • The time frame will depend on the specific activity and information provided on the process note. • The time frame to be monitored by the coordinator and the time-frame must match or be reasonable for work done.
<p>Branch-related tasks</p>	<ul style="list-style-type: none"> • Any task or activity assigned to the peer supporter by an APD staff member, ideally through the peer supporter 	<ul style="list-style-type: none"> • No specific time-limit per activity, but the total time spent on branch-related tasks per month should ideally not exceed 12 hours

	<p>Coordinator of the branch (to ensure the task is relevant).</p> <ul style="list-style-type: none"> • Admin assistance to the branch, the filing of PEER SUPPORTER documents for the Coordinator, assistance with events and specific projects, etc. • Specific tasks can be assigned to certain peer supporters with the aim of skills development and growth. • Process notes must be completed for branch-related tasks. 	(2 days).
Mentoring / Training	<ul style="list-style-type: none"> • This includes monthly meetings, individual consultations and mentoring and training (both internal and external by other training providers). • Claiming for any external training must be approved by the peer supporter Coordinator to determine its relevance to Peer Support. • Process notes must be completed for all external training attended but need not be completed for internal training and mentoring provided by APD branch or WCAPD. 	<ul style="list-style-type: none"> • No specific time limit
Admin	<ul style="list-style-type: none"> • Any time spent on the P. Supporter own administrative tasks, i.e. writing process notes and completing claim forms. • Any preparation, planning, and administration to prepare for group sessions are also claimed as 'Admin'. • This does not include administrative tasks performed for the branch (this is branch-related tasks). • Process notes do not need to be completed for Admin, but 	<ul style="list-style-type: none"> • Admin time can easily be miscalculated or over-estimated and we, therefore, recommend the following: • peer supporter can claim approximately 1 hr admin for every 5 hrs worked, which means a maximum of 14 hrs admin per month.

	<p>the P. Supporters must describe exactly what Admin they did on the Claim Form e.g. process notes for 4 home visits.</p>	<ul style="list-style-type: none"> • This time-recommendation should be flexible for peer supporter who really struggle with writing and peer supporter Coordinators can use their discretion to allow more time.
<p>Other</p>	<ul style="list-style-type: none"> • Any other meetings or actions to address challenges and barriers experienced by persons with disabilities and their families – must relate to disability. • Recommended that these ‘other activities’ are strictly monitored by the peer supporter Coordinator. • Process notes must be completed for “Other” activities. 	<ul style="list-style-type: none"> • No specific time limit but should be monitored by the peer supporter Coordinator.

APPENDIX E

HAPD List of Peer Supporter Roles and Responsibilities.

A. Support Adults with Disabilities & Their Families:	B. Awareness-Raising & Advocacy:	C. Networking:	D. Administration:	E. Accountability & Reporting:
a. Identifying people	a. How to Id & take part in community meetings/activities	a. Gather info	a. Reporting skills	a. Prioritising
b. Establishing a relationship with people with disabilities	b. Advocacy for disability	b. Establishing a relationship with other partners	i. Writing skill	i. Punctuality & attendance at meetings
i. Finding people	i. Knowledge of disability	i. Finding people	ii. Listening skill	ii. Id. & executing a plan of action
ii. First contact	ii. Knowledge of rights	ii. First contact	iii. Summarise important info	iii. Recording important dates & info
iii. Identify needs	iii. Effective & acceptable advocacy	iii. Share needs	b. Systematic, accurate admin	iv. Identify problems
iv. Plan of action	c. Raise awareness	iv. Plan of action	i. Filling in and checking forms	b. Effective communication
c. Gather info	i. Id. Target audiences	c. Fitting into branch activities	ii. Timely completion of forms	i. Feedback to coordinator
d. Distribute info	ii. Gaining permission	i. Teamwork	iii. Self-management	c. How to maintain confidentiality
e. Community profiling	iii. Presenting to groups	ii. Presentability	c. Planning	
i. Barriers	iv. Distributing information to individuals	iii. Conforming to branch ethos	i. Effectively use existing forms/info to plan for future	

			visits etc.	
ii. Assets		1. Knowledge of branch & activities		
f. Mobilise into groups		iv. A positive image of org.		
i. Support		v. Appropriateness		
ii. Income		vi. Being informed		
iii. Change facilitate				

APPENDIX F

List of Training Types Available For 2017

Date	Time	Topic	Presenter	Training provider
2016/07/21	9 - 4	Disability & Employment	Three facilitators	HAPD, Altitude Supported Employment
2016/07/28	9 - 4	Community Based Rehabilitation (CBR) Intro and Health Module	Tay Yassiem	WC APD
2016/08/11	9 - 4	Monthly meeting & Sensitisation : Hearing Loss	PS Co-ordinator & Erica Du Toit	HAPD & WC APD
2016/08/16	9 - 2	CBR Social Work Module	Roeline Robyn	WC APD
2016/08/23	9 - 3	CBR Education Module	Tay Yassiem	WC APD
2016/08/30	9 - 2	Individual Social cases: Group discussion	Roeline Robyn	WC APD
2016/09/15	9 - 12	Monthly meeting & Disability issues: Inclusion & Mobility impairment	Co-ordinator, Erica du Toit & Will Scott	HAPD & WC APD
2016/09/29	9 - 4	CBR Livelihood Module	Tay Yassiem	WC APD
2016/10/13	9 - 12	Monthly meeting & Disability issues : Accessibility	PS Co-ordinator & Erica Du Toit	HAPD & WC APD
2016/10/27	9 - 4	CBR Empowerment Module	Tay Yassiem	WC APD
2016/11/07	9 - 2	Health & Exercise Promotion workshop 1	Candace Vermaak	Bridging Abilities
2016/11/10	9 - 12	Monthly meeting & Disability issues : Disabling conditions	PS Co-ordinator & Erica Du Toit	HAPD & WC APD
2016/11/24	9 - 12	Individual Social cases: Group discussion	Roeline Robyn	WC APD
2016/12/05	9 - 4	Health & Exercise Promotion workshop 2	Candace Vermaak	Bridging Abilities
2017/01/12	9 - 2	Monthly meeting (Action reflection, feedback & admin)	PS Co-ordinator	HAPD
2017/01/26	9 - 4	Individual Social cases & Supporting children with disabilities	Roeline Robyn & Lynette Barkhuysen	WC APD & Senecio
2017/02/09	9 - 2	Monthly meeting (Action reflection, feedback & admin)	PS Co-ordinator	HAPD
2017/02/23	9 - 2	Active listening skills & Personality types	Zani Bothma & Co-ordinator	HAPD
2017/03/08	9 - 2	Health & Exercise Promotion workshop 3	Candace Vermaak	Bridging Abilities
2017/03/14	9 - 4	Individual Social cases & Monthly meeting	Co-ordinator & Roeline Robyn	HAPD & WC APD

APPENDIX H

Confirmation of Research

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8 February 2016

TO WHOM IT MAY CONCERN

Thank you very much for your willingness to enable one of our Master's students to work with a programme from your organization. I appreciate your contribution to the education of our students.

The student will need programme information from you and we request that you or a designated person meet with them regularly to provide access to this information. Your cooperation in this regard will ensure that the student meets deadlines and provides you with a high quality evaluation. In order to keep track of the student's interactions with your organization, we request that you copy the supervisor on all correspondence to the student.

Please note that our students are required to work within the ethical framework of the Faculty of Commerce when collecting information from programme documents or programme recipients. This framework deals with anonymity of data sources, sensitivity when requesting information from people and responsible reporting of results.

We also undertake and ensure you that the student will display professional behaviour at all times while working in your organization or on your programme. At the end of the process, you will receive a useful report which will enable you to make informed decisions regarding your programme.

In order to comply with the rules of the Faculty of Commerce, we request you to sign below to indicate that the student will have access to programme data and records and where applicable, to programme recipients.

Thank you very much.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Adillah Boodhoo'.

ADIILAH BOODHOO
ACTING CONVENER: MPHIL PROGRAMME EVALUATION

AGREEMENT TO ACCESS PROGRAMME RECORDS AND/OR RECIPIENTS:


AUTHORISED PERSON


ORGANISATION for Persons
with Disabilities

02/03/16
DATE

APPENDIX I



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UCT Commerce Faculty Office

01 October 2018

Ms Zani Bothman
 School of Management
 Studies
 University of Cape Town

REF: REC 2018/010/099

Dear Zani Bothma,

Evaluation of Helderberg Association for persons with disabilities.

We are pleased to inform you that your ethics application has been approved. Unless otherwise specified this ethical clearance is valid for 1 year and may be renewed upon application.

Please be aware that you need to notify the Ethics Committee immediately should any aspect of your study regarding the engagement with participants as approved in this application, change. This may include aspects such as changes to the research design, questionnaires, or choice of participants.

The ongoing ethical conduct throughout the duration of the study remains the responsibility of the principal investigator.

We wish you well for your research.

Modie Sempu
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