EXPLORING EXPERIENCES OF VISUALLY IMPAIRED PEOPLE IN ACCESSING REHABILITATION SERVICES IN THE UMKHANYAKUDE DISTRICT, PROVINCE OF KWAZULU-NATAL

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ABSTRACT

The collapse of apartheid in South Africa called for the eradication of power imbalances and discrimination against all marginalised and vulnerable groups including visually impaired people. However, despite the initiatives to eradicate power imbalances, disabled people seem to be excluded from this process as they still do not enjoy the same opportunities as non-disabled people.

Services for people with disabilities have been initiated including rehabilitation and mental health services. However, spinal cord injuries and assessment centres for people who are disabled are either subsidised or directly managed by the Department of Health. Regrettably though, these rehabilitation units, centres and institutions exclude rehabilitation services for people with visual impairment. This study therefore attempts to explore visually impaired people's experiences in accessing rehabilitation services in uMkhanyakude District. Furthermore, it seeks to examine visually impaired people's involvement in decision-making by the government and non-mental organisations on issues pertaining to them.

Using Anti-oppressive practice theory as the theoretical lens, issues of power, empowerment, resistance, and oppression are explored. A qualitative research design was adopted to gather data by interviewing and facilitating a focus group with visually impaired people in the study area. Purposive sampling techniques were used and a sampled population of 15 participants was reached. The population of the study involved totally blind and partially sighted people. The data gathered was analysed using thematic analysis.

Access to health, education, employment, and rehabilitation services is the fundamental right of every human being including visually impaired people. The study discovered that visually impaired people experienced challenges in accessing educational, vocational, training and psycho-social rehabilitation services. Access to information and services appeared to be difficult for the participants, for example, the publicly available information is unavailable in braille and access to services which could improve their independence is unavailable or inaccessible. The findings further reflect that visually impaired participants' voices are silenced on issues pertaining to their rights in family or public spaces, and this contributes to their social isolation.

CANDIDATE DECLARATION

I, Bawinile Albertina Mdunyelwa, declare that this dissertation entitled: **Exploring Experiences of Visually Impaired People in Accessing Rehabilitation Services in the uMkhanyakude District, Province of KwaZulu-Natal** represents my own work and is submitted to fulfil the requirements of the degree of Masters in Social Work at the University of KwaZulu-Natal, Howard College Campus, Durban. The contribution of any supervisors and others to the research and to the dissertation was consistent with normal supervisory practice. I confirm that no part of this dissertation has been submitted for publication in advance of its submission for examination. This dissertation contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma.

BZ

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TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION, ORIENTATION, AND CONTEXTUAL FRAMEWORK OF THE STUDY

CHAPTER TWO: THEORETICAL FRAMEWORK AND LITERATURE REVIEW

CHAPTER THREE: RESEARCH METHODOLOGY

CHAPTER FOUR: EXPERIENCES OF VISUALLY IMPAIRED PEOPLE ON ACCESSING REHABILITATION SERVICES

CHAPTER FIVE: CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

REFERENCES

LIST OF TABLES

CHAPTER ONE

INTRODUCTION, ORIENTATION, AND CONTEXTUAL FRAMEWORK OF THE STUDY

1.1. Introduction

This chapter provides the background, orientation and purpose of the study, the research problem, the rationale, significance, and the philosophical stance. A description is given of the research design, the research methods applied and the data analysis techniques used, as well as the population from which the sample was chosen.

1.2. Background to the study

The Constitution of South Africa, Act 108 of 1996, clearly states that all South African citizens with and without disabilities are entitled to the fundamental rights to access quality health care (The Department of Justice and Constitutional Development 1996). In view of this focus on improving the quality of life for all South Africans, services for people with disabilities such as rehabilitation and mental health services have been initiated. Further, in some provinces, assessment centres for and spinal cord injuries in disabled people are subsidised or directly managed by the Department of Health. Regrettably, these rehabilitation units, centres and institutions provide limited rehabilitation services for people with visual impairment (Framework and Strategy on Disability and Rehabilitation 2015). The National Department of Health working document (2007) reflects that rehabilitation services for people with visual impairment are provided by non-governmental organisations (NGOs) with limited funding from the donors. This donor-dependent funding model is inadequate and greatly limited and in turn this affects the quality of services provided to visually impaired people, especially those who reside in rural areas.

The World Health Organisation (WHO) reports that blind and partially sighted people constitute approximately 285 million worldwide (WHO, 2012). According to the WHO, 39 million are blind and 246 million have low vision (WHO, 2012). Statistics South Africa (Stats SA, 2012) indicates that there are approximately 1, 1 million citizens with visual impairment in South Africa with an estimated one million of them living in the province of KwaZulu-Natal alone. The Disability Action Research Team (DART, 2002) argues that although a significant number of people in the province of KwaZulu-Natal are visually impaired, very little is known about how the majority of these persons live or the problems they encounter.

1.3. Problem statement

In support of the above, Bhagotra et al. (2008: 49) states:

> Visual impairment requires rehabilitation services. If visually impaired people are not rehabilitated, they may encounter denial of the disability, resentment, or a feeling of bitterness about having become a victim of the condition; feeling of inferiority in comparison to healthy people or feeling of low self-esteem, anxiety, and depression.

In view of this, rehabilitation for the blind is the combined and coordinated use of medical, social, educational, and vocational means for training and retraining the individual to the highest possible level of functional ability (Bhagotra et al., 2008).

Whilst there are various categories of rehabilitation services for the blind, this study focuses on training and psycho-social rehabilitation which constitutes mobility and daily living skills training, psycho-social adjustment, and sensory stimulation (Bhagotra et al., 2008: 48). Training and psycho-social rehabilitation for visually impaired people is excluded from the public rehabilitation programmes and policies. The public programmes only concentrate on medical and educational but exclude vocational, training and psycho-social rehabilitation for visually impaired people, and this creates dependence and disempowerment of visually impaired people.

The limited coverage of rehabilitation services for the visually impaired people in public rehabilitation policies and service delivery clearly poses a challenge to visually impaired people's accessing rehabilitation in the public service. Further, limited research in the field of rehabilitation for visually impaired people exacerbates the challenges of rehabilitation policy development and rehabilitation service implementation. The researcher, a visually impaired person employed by the KwaZulu-Natal Department of Health (Disability and Rehabilitation

Unit), and who initiated the blind people's organisation realises and recognises the gaps in policy, service provision and research on rehabilitation for the visually impaired people. These observations have initiated an interest in conducting this explorative-descriptive study to understand the experiences of people with visual impairment.

In most countries sighted people tend to sympathise with people who acquired visual impairment as they regard losing sight as living in total darkness. Sighted people also reflect on both the negative aspects of this disability and the myths about it. These myths originate from the stereotypes that non-disabled people have of visual impairment. For example, visually impaired people share special gifts, like better hearing, touch, smell to substitute the absence of sight (Papadaki et al., 2013).

The experiences of visually impaired people do not exist in isolation but are also interconnected with socio-cultural and political systems. While the South African Constitution, with specific reference to its Bill of Rights, guarantees equality and human dignity of all South African citizens, visually impaired people's rights continue to be violated through different forms of attitudinal barriers (South Africa Parliament, 1996: *Constitution, Act No. 108.* Republic of South Africa). There is a stigma attached to being a visually impaired person in this country as well as in other countries. Goffman suggested that the 'stigmatised' such as the dwarf, the blind man, the disfigured are generally viewed as not quite human (Goffman, 1963). For Goffman (1963), the application of stigma is the outcome of situational considerations and social interactions between the normal and the abnormal.

This situation is not unique to South Africa as the majority of visually impaired people find themselves abandoned by community and their families when they lose their sight (Mabaso, 2012). Nonetheless, visually impaired people's experiences in accessing rehabilitation services are the focal point of this study. The expression and construction of grief among visually impaired people is often within the cultural lens which is explored qualitatively in this study. Social isolation, discrimination and oppression are some of the ways that compromise dignity and social equality of visually impaired people which is a basic human right.

The Department of Health's vision is that health care for all is in line with constitutional imperatives. However, visually impaired people find it difficult to enjoy the constitutional rights of access to health services especially rehabilitation. Furthermore, the academic discourse neglects research on the experiences of visually impaired people in accessing rehabilitation and enjoyment of basic constitutional human rights.

1.4. Rationale

The rationale for this study was guided by the fact that the researcher is both a social worker and a disability advisor employed by the Department of Health (KwaZulu-Natal). Part of her duties includes developing and monitoring disability and rehabilitation policies, coordinating and implementing disability and rehabilitation services. The researcher observed that there are large numbers of visually impaired people especially from rural areas who do not access rehabilitation especially training and psycho-social rehabilitation services. During consultation with visually impaired people, several challenges were presented which are a result of poor access to psycho-social rehabilitation.

The researcher also observed that the literature reflects that disabled people face various barriers which excludes them from the rest of the social environment (Oliver, 1990). These barriers make it difficult for disabled people to live a normal life. A study conducted by Beograd confirms this when mentioning that:

> This is mainly reflected in the attitude of the community and co-residents for that matter, mainly because of the preconceived negative notions against such people or disability (2013: 81).

Disabled people are further denied access to essential services as the WHO estimated in 2001 that only 1% of disabled persons in the developing world have any access whatsoever to rehabilitation or other institutional disability-related services (Barnes & Mercer, 2005: 4).

A study conducted in the United Kingdom (UK) in 2008 seems to suggest that two percent of recently registered blind and partially sighted people receive supportive counselling in the first year after diagnosis (Douglas et al. 2008). This reflects poor access to supportive services after diagnosis. Furthermore, the Royal Institute for the Blind (RNIB) also reflects that in Great Britain of the 100 people who lose their vision each day, only eight will be offered some form of counselling. This calls for improved advocacy to increase the availability and access to support which can be offered to people who have been diagnosed. Moreover, the period after diagnosis is associated with poor mental health and risk of suicide.

Visual loss is associated with impaired psychological wellbeing of the person diagnosed. Therefore, a referral to relevant professionals for intervention is important and they must be encouraged to access this service to support them to facilitate better coping mechanisms. (Rackley, 2015; Papadaki et al., 2013). However, the availability of these services poses a challenge. For example, in the UK these services are offered by local associations. However, there are few therapists skilled in offering psychological therapy specialised in the area of visual loss. In this regard, clients who receive a diagnosis of having a condition that might affect their sight, or those who are born blind, are supposed to be referred to relevant professionals or encouraged to access emotional support services to assist them in dealing with this and other factors associated with having visual impairment. This might pose a challenge as some of the literature reflects that the accessibility and availability of psychological therapy specific to visual loss is occasionally available through local associations around the UK and there are very few therapists, whether sighted or blind or partially sighted, who specialise in this area (Southwell, 2012). South Africa is no exception as training in orientation and mobility, and psycho-social activities of daily living are provided by non-governmental organisations (National Department of Health Working Document, 2007).

Policymakers and employers often view and conceptualise persons with disabilities as a personal tragedy, impaired body, or an individual misfortune (Papadaki et al., 2013). In view of this, visually impaired people might also be affected in accessing rehabilitation services due to stereotypes and negative attitudes from the policy makers. Further, limited research in the field of blindness exacerbate the inadequacy of rehabilitation service provision in the public service as most of the literature focusses on medical rehabilitation and not on training and psychosocial rehabilitation.

The researcher realised the gaps in policy, service provision and research on rehabilitation services for blind and partially sighted people which include:

a) A lack of emotional support when visual impairment is acquired.

b) Health institutions fail to recognise feelings of denial, and a sense of bereavement that often a person goes through at the time of visual loss.

c) Visually impaired people receive limited or no counselling at the time of diagnosis which leads to the experience of depression.

Recognising the wide range of gaps for provision of training in orientation and mobility, and activities of daily living including psycho-social rehabilitation, this study was initiated. Furthermore, the experiences of visually impaired people in accessing public rehabilitation services creates social gaps that this study aims to contribute to filling. On the basis of these gaps, a scientific framework for understanding lived experiences and access issues for blind and partially sighted people was proposed.

The study would make a significant contribution by drawing the attention to the experiences of the visual impaired and the access to rehabilitation services for this sub-group. Furthermore, the findings from this study could be used to inform the development of rehabilitation policies, norms and standards and service delivery models. The researcher's experiences during the 1990s when she was part of the formation of a disabled people's organisation and her professional experience as a social worker generated an interest on how rehabilitation could support and empower people with visual impairment and their families.

The researcher has a vested interest in the area of rehabilitation for visually impaired people as rehabilitation is essential as it assist in enhancing the quality of life of people with visual impairment. Framework and Strategy for Disability and Rehabilitation Services in South Africa (FSDR) also points out that "rehabilitation services make the vital, practical link between medical treatment and the translation of a person's restored capacity into a productive and health promoting social and economic life" (FSDR 2015-2020: 8). Marson (2003) concurs that rehabilitation is a very vital medium through which blind persons are assisted to live a relatively 'normal' life.

The researcher's contextual reason is informed by the roles and responsibilities of Disability and Rehabilitation units within the South African government as prescribed by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006). It is also informed by the Department of Health's key roles of health and rehabilitation service provision, namely human resources development, access to health and rehabilitation and access to quality care for all South Africans.

These fundamental rights are important to improve the quality of life of people with visual impairment and thus far, there is limited literature on how these services are received by people with visual impairment.

This research therefore aims to explore the visual impaired people's experiences in accessing rehabilitation services and thus to identify factors that contribute to the creation of an enabling environment in which people with visual impairment can influence and maintain their optimal physical, emotional, social, and economic functional levels (Disability and Rehabilitation policy, 2008). The research is conducted in the context wherein rehabilitation for visually impaired people does not form part of either the policy imperatives or objectives.

1.5. Location of the study

The study was located in the uMkhanyakude District, situated in North Eastern KZN and bordering Mozambique to the North, the uMfolozi River to the South, Swaziland, the N2 and Zululand – DC26 to the West and the Indian Ocean to the East. According to the 2011 Census, the population of the District is 666 526 (Statistics South Africa, 2011). It is a typical rural district with limited NGOs and three special schools for children with intellectual disabilities. There are no schools specialising in children with visual impairment. From the researcher's work experience and engagement with some of the disabled people's organisations from eThekwini Metro and uMgungundlovu Districts, the district has a great number of visually impaired people who cannot access rehabilitation services and thus are mostly referred to as remote districts.

1.6. Aim of the study

The overall aim of this study is to explore the experiences of visually impaired people in seeking access to rehabilitation services in KwaZulu-Natal, uMkhanyakude District.

1.7. Research problems and objectives

Setting research objectives and answering one's research questions are the steps that must be taken towards achieving the aim of a study. According to Parahoo (2006), a research question assists the researcher to focus on the questions which need to be answered and are therefore fundamental to the research process. In addition, the research question is closely connected to the research topic or a problem being investigated. Further, according to Babbie (2013), the question needs to be narrow and specific. The study research objectives and questions were as follows:

1.7.1. Research objectives

a) To explore the experiences of people with visual impairments when trying to access rehabilitation services (including the provision of assistive devices).

b) To explore feelings and reactions of visually impaired people in relation to these experiences.

c) To explore how people with visual impairments articulate their own rehabilitation needs.

d) To explore visually impaired people's views on the currently available rehabilitation services and how they could be improved.

1.7.2. Research questions

a) What are the experiences of visually impaired people when trying to access rehabilitation services (including the provision of assistive devices)?

b) What are the feelings and reactions of visually impaired people in relation to these experiences?

c) How do people with visual impairments articulate their own rehabilitation needs?

d) What are the views of visually impaired people on the currently available rehabilitation service and how could they be improved?

1.8. Underlying assumptions

Leedy and Ormrod (2005: 62) view assumptions as constituting "what the researcher takes for granted and they serve as the basic foundation of any proposed research; what researchers may tacitly assume others may never have considered". In addition, assumptions can be viewed as something the researcher accepts as true without concrete proof (Ellis and Levy, 2010).

The underlying assumptions in this study were:

a) Rehabilitation policies and services should include all elements, including independent living training, psycho-social rehabilitation, orientation, and mobility.

b) Various barriers, including lack of information, trained personnel, budget constraints, that hinder provision of rehabilitation services and access to assistive devices in the uMkhanyakude District.

c) Barriers to accessing rehabilitation services for visually impaired people result in feelings of loneliness, depression, a sense of resentment and stress among visually impaired persons in uMkhanyakude District.

d) Policy development processes require the involvement and/or inclusion of the affected parties to ensure quality of services. Visually impaired persons from uMkhanyakude District are generally excluded from these processes, and this results in some important aspects of service provision not being considered.

1.9. Theoretical framework

In this study the anti-oppressive theory was the most appropriate theoretical framework as the study focused purposively on the most oppressed population that is largely excluded from main spheres of public and economic life and disconnected from rehabilitation services. The outcome of oppression is mistrust and gradual loss of identification with social and political institutions and the values and goals they represent. In order to hear silenced voices, the study of the oppressed requires multiple strategies to connect this group to research projects and to overcome barriers of mistrust and alienation (Subrayen, 2011).

Oliver argues that research has failed people with disabilities on at least three counts. Firstly, it has failed to accurately capture and reflect the experience of disability from the perspective of disabled people themselves. Secondly, it has failed to provide information that has been useful to the policy-making process and has contributed little to improving the material conditions under which disabled people live. Thirdly, it has failed to acknowledge the struggles of disabled people themselves and to recognise that disability is not simply a medical or welfare issues, but a political one as well (Oliver, 1990: 2). The result of this situation is that many persons with visual impairment have become alienated from both the process and product of social research. In light of this, Oliver (1990: 3) states that "while this situation has been recognised in some parts of the academy and by some researchers, it remains true that government and funding bodies still require research to be churned out in the old disabling ways".

The main challenge with research approaches is that they do not confront the objective structures of oppression and despite personal intentions in many cases, visually impaired people are still positioned in oppressive and marginalised ways. It should be noted that failing to give visually impaired people positions, complete control and adequate resources through their own representative organisations, work environment or in their communities or their families, would lead visually impaired people to experiencing inferiority complex to those who are in control who, according to this study, are sighted people. The society represents visually impaired people as inferior by its actions, regardless of its intentions (Oliver et al., 2006). This was a significant factor in this study's theoretical framework as it allowed for participants to share their feelings and their experiences freely. The anti-oppressive theory is discussed in detail in chapter two.

1.10. Research methodology

In this study, the researcher explicated the study's research paradigm, design, as well as the methods of sampling, data collection and data analysis. A qualitative approach was used in conjunction with explorative, descriptive, and contextual designs. The study aimed to provide an opportunity for people with visual impairment to be directly involved in the research and to deliver findings guided by their experiences. According to Creswell (2003: 40), it aligns with the qualitative research goal of "wanting to empower individuals to share their stories, hear their voices, and minimise the power relationship that often exists between a researcher and the participants in a study". The research methodology is discussed in detail in chapter three. The study consisted of individual interviews and focus group discussions. The findings and analysis are discussed in chapter four and chapter five.

1.11. Limitations of the study

The following are acknowledged as limitations of the study:

a) The researcher is a visually impaired person who previously played a meaningful active role in the disability sector activities and is currently employed by the Department of Health. Hence, some of the participants felt that the researcher could assist them with their personal challenges with the Department of Health which were outside the scope of the research study. This challenge was overcome by the researcher emphasising the purpose and aim of the study. The researcher kept emphasising on the issue of confidentiality.

b) As a researcher is a social worker with visual impairment, respondents felt confident and willing to freely share their painful feelings and experiences which were the result of acquiring visual impairment. The researcher dealt with this challenge by referring the participants to the relevant professionals as per the agreement between the researcher and the affected participant.

c) The researcher was aware of her own subjectivity that could have been caused by her personal circumstances, being a visually impaired person. She therefore opted to pay more attention to her subject positioning in the study through self-management and self-monitoring which constituted an integral part of critical reflexivity.

d) Some of the participants were not trained in orientation and mobility and independent movement. They thus required a second person to accompany them to the interviewing venue or focus group discussion, which posed constraints in time arrangements for these interviews.

e) The sample size was relatively small in relation to the total number of visually impaired people in the district where the recruitment took place. However, this study used a qualitative paradigm which focuses on depth and description of the studied phenomenon as opposed to generalisability of the findings.

f) One of the limitations of the study was that the study was drawn from one district of KwaZulu-Natal which is uMkhanyakude District; hence it was not fully representative of visually impaired people from the other 10 districts of the KwaZulu-Natal Province. It cannot therefore be generalised to all visually impaired people of South Africa.

g) There is a paucity of research regarding rehabilitation for visually impaired people in the South African context. In order to address this situation, the researcher attempted to incorporate the research that was available into the study. The researcher also made extensive use of available research from other countries on the topic.

h) The sample size was relatively small in relation to the total number of visually impaired people in the district being researched. However, the researcher was supported by a qualitative approach which allows smaller samples to be researched.

The limitations of the current study are presented to facilitate future research projects that can address rehabilitation for visually impaired people in South Africa.

1.12. Significance of the study

The study would be able to contribute to the knowledge base in South African social work by applying an anti-oppressive framework to understanding the lived experiences and access issues of visually impaired people. It may be able to assist policy makers in recognising the gaps in policy and the experiences of blind and partially sighted people in accessing public rehabilitation services.

The study will contribute to the conceptual schemes for describing problems in rehabilitation of visually impaired people in order to develop rehabilitation policies, norms and standards and service delivery models. In addition, visually impaired people will be provided with the opportunity to contribute to the critique, design, implementation, monitoring and evaluation of rehabilitation policies and services. This research project will highlight the challenges that are there with regards to rehabilitation services to visually impaired people.

It may be possible to use the findings of the proposed study for the development of disability awareness-raising programmes so as to address the barriers faced by visually impaired people, i.e. access to physical environment, information and attitudinal barriers. Finally, the study aims to enable visually impaired people to acquire hope and optimism in changing their situation and take action on their own behalf.

1.13. Definition of terms

1.13.1. Disability

Disability is an umbrella term which includes those long-term physical, mental, intellectual, or sensory impairments, activity limitations or participation restrictions, taking into account environmental factors that interact with all these constructs. It can also be defined as a condition caused by an accident, trauma, genetics, or disease that may limit a person's mobility, hearing, vision, speech, or cognitive function. Disability is regarded as limiting, one is thought of as being incapacitated, and/or preventative by law (Blocksidge et al., 2003).

Throughout the dissertation the term 'disabled people' or 'people with disabilities' will be used in line with the preference of self-determination by persons with disabilities. It is the preferred term, for it asserts the value the person first and the disability then becomes merely an appendage (Oliver, 1990).

Notably, is the fact that disability is experienced by themselves who argue disability is the essential part of the self. Further using people with disabilities instead of 'people living with disabilities' is in line with the social model of disability. People with disabilities are demanding acceptance as they are not the medical labelling imposed by non-disabled professionals.

1.13.2. Visual impairment

Visual impairment can be defined as a functional limitation of the visual system and can manifest as reduced visual acuity or contrast sensitivity, visual field loss, photophobia, diplopia, visual distortion, visual perceptual difficulties, or any combination of these. Visual impairment stretches from moderate to severe impairment and from blindness with light perception to blindness with no light perception (Cole & Freeman, 2010).

In understanding visual impairment, the following definitions are applicable to this study. Visual impairment is a condition where glasses, lenses, or other low vision interventions do not assist to facilitate normal near vision (Willison, cited in Subrayen, 2011). Further, the Institute for Research in Extramural Medicine (2007: 63) defines visual impairment as "vision loss due to low vision or blindness that significantly limits visual capability". In addition, Padayachee-Naidoo (2005: 9) views visual impairment as "a generic term which covers a range of difficulties with vision and includes the following categories: blind, legally blind, partially sighted, low vision and cortically visually impaired". According to Sukhraj-Ely (2008: 45), a person is deemed to be "functionally blind when his /her visual senses cannot be used effectively". She further categorises visual impairment into functional blindness, education blindness and partially sighted.

All these definitions are located within the medical model framework of disability. The social model of disability would differentiate between impairment and disability. If we define visual impairment using the social model of disability, the focus would be on the barriers that limit a person with visual impairment to access other services beyond cure and welfare. It is in this context that the above definitions reflect that having visual impairment significantly affects what may be viewed as normal daily living and it limits the execution of daily activities.

Visual impairment is a category of disability where medical definitions could influence the way service provision is provided or how this group is viewed. Notably, all these definitions of visual impairment are located within the medical model framework and thus will influence how rehabilitation services are designed and provided.

Further, in terms of these definitions, other needs of persons with visual impairments are neglected. For example, Institute for Research in Extramural Medicine (2007) does not include the aspect of barriers experienced by persons with low vision or blindness. This limitation in this definition suggests therefore that intervention lies within the medical model definition which neglects other aspects of life. A more specific definition that would be reflective of experiences of people with visual impairment beyond the medical explanations is required.

1.13.3. Impairment

It is a perceived or actual feature in the person's body or functioning that may result in limitation or loss of activity or restricted participation of the person in society with a consequential difference of physiological and or psychological experience of life (White Paper on the Rights of Persons with Disabilities, 2015). It is any loss or abnormality of psychological, physiological, or anatomical structure or function (Oliver, 1990).

1.13.4. Rehabilitation

Rehabilitation refers to clinical and non-clinical training which provide the visually impaired with the skills to maintain a safe, active, and independent lifestyle (Taylor, 2005). It is a process aimed at enabling people with disabilities. Rehabilitation enables people with disabilities to reach and maintain their optimal functional levels by providing them with the tools they need to attain independence and self-determination (WHO, 2010).

Given the difficulties which result from being a visually impaired person within a society which barely caters for people with needs that differ from those of the majority, an attempt is required to facilitate their full integration into the society of the majority. One of the ways to facilitate this integration, can be viewed within the discourse of rehabilitation.

The Institute for Research in Extramural Medicine (2007: 64) states:

> Rehabilitation for visually impaired people is a professional form of rehabilitation with the aim of teaching people to adequately cope with their visual disabilities in daily life.

Marson (2003: 10) further notes that the aim of any rehabilitation programme which caters to the needs of blind and visually impaired persons must ultimately be to restore an individual to a level which will equip him/her to function in a relatively 'normal' way. Taylor (2005) asserts that rehabilitation is any activity that elevates individuals with disabilities from dependence to independence.

In this context, the function of rehabilitation is to enhance the client's self-confidence and self-image. Adjustment can only be achieved with the assistance of trained professionals and through structured rehabilitation programmes. It also assists individuals to develop personal confidence and skills for daily living through both professional and peer counselling as well as independence training to gain or regain self-esteem (Marson, 2003). Rehabilitation services could also assist people with visual impairment to adequately cope with their life challenges resulting from individual functional limitations, barriers in participation and discriminatory attitudes within the society.

The above literature reflects that rehabilitation includes a wide range of clinical therapy and non-clinical training to provide visually impaired people with the skills and tools to maintain a safe, active, and independent lifestyle. It should be noted that, while rehabilitation cannot restore lost sight, it can assist visually impaired people to maximise any remaining vision so that they can travel safely, take care of their needs, meet their career goals, participate in education and enjoy leisure activities (RNIB, 2009; Marson, 2003). Clearly, it is evident from the literature that rehabilitation plays a significant role in the lives of visually impaired people.

1.13.5. Independence

Independence is a state of being whereby available and adequate support services, assistive devices, and personal assistants to persons with all disabilities enable persons with disabilities to exercise choices, bear responsibility and participate fully in society (White paper on the Rights of Persons with Disabilities, 2015).

1.13.6. Assistive device

it is any device, product, equipment, or tool that is designed or adapted to enable persons with disabilities to participate in activities, tasks, or actions. These may include mobility devices such as white canes, crutches, etc. or sensory aids such as coloured lenses, magnifying glasses, etc., technology aids such as computers for alternate and augmentative communication, screen readers and texts in audio formats (White paper on the Rights of Persons with Disabilities, 2015; Assistive Devices Policy, 2014). It can also be defined as an item of equipment made specifically to help overcome a disability through the promotion of independence, in particular in the home or at work. Examples are teletypewriter, telephone amplifier, wooden block (to raise desk for a wheelchair user) and Braille printer (Blocksidge et al., 2003).

1.13.7. Access

Access in a broader sense is making forms and information accessible to people with visual or cognitive disabilities; making alarms and signals accessible to people who are deaf or hard of hearing; and making services such as health, education, and transport accessible to people with disabilities (Blocksidge et al., 2003).

1.13.8. Activities of daily living

Activities of daily living in the context of rehabilitation and independent living by disabled people, include dressing, making the bed, showering, shaving, combing hair, eating, making drinks and all other activities which will assist in enabling a person with a disability to function to the maximum of his or her capacity within the family and the community Blocksidge et al., 2003).

1.13.9. Orientation and mobility

Orientation and mobility a skill that helps a visually impaired person to picture in his mind where and what is his/her environment, his/her body awareness, his/her spatial development, and his/her physical development (Fish-Hudgson & Khumalo, 2015).

1.14. **Structure of dissertation**

The dissertation is structured as follows:

Chapter One: Introduction, orientation, and contextual framework of the study. This chapter introduces the topic, background and outline of research problem, the aims and objectives of the study, the questions the study aims to explore, the theoretical framework guiding the study, and definition of concepts.

Chapter Two: Theoretical framework and literature review. The theoretical framework guiding this study was briefly discussed above. However, the relevant literature, which broadens our understanding of the research and the topic under discussion, scales the extent of the problem and identifies the gaps in the lived experience and in the literature, is discussed.

Chapter Three: Research methodology. This chapter covers the research design and methodology utilised in the study. It includes sampling, population, data collection, and data analysis in relation to the research problems and objectives of the study.

Chapter Four: Analysis, findings, and discussion. This chapter presents and discusses the analysis of the data collected and the findings. Relevant literature is used to confirm and / or reject the findings.

Chapter Five: Conclusions and recommendations. This chapter deals with key perceptions and matters that arise out of the study and that form the basis of issues for consideration, with concluding remarks based on the key issues raised. It outlines the limitations of the study followed by the conclusion on the major findings of the study.

1.15. Conclusion

This chapter dealt with the background, rationale, aim and objectives of the study. These help to locate the study into the proper perspective. The chapter also defined some concepts that are critical in the field of rehabilitation for visually impaired people. It also highlighted some basic tenants for quality rehabilitation services.

The following chapter will deal in detail with what the literature reveals about both rehabilitation service and the theories underpinning them.

CHAPTER TWO

THEORETICAL FRAMEWORK AND LITERATURE REVIEW

2.1. Introduction

This chapter begins with presenting the conceptualisation of disability focusing on medical and social models of disability as encompassing theories on disabilities since they also refer to social model and medical model. The historical overview of visual impairment is examined under the following headings: the global prevalence, definition and causes and the prevention of visual impairment are presented.

As the current study focuses on rehabilitation services for visually impaired people, it is significant that a critical review of rehabilitation is discussed. The definition of rehabilitation, the categories of rehabilitation for visually impaired people which include medical, educational, vocational, training and psycho-social are also discussed. Legislative and policy frameworks that contribute to the experiences of visually impaired people accessing rehabilitation services and theories that underpin disabled people as a socially oppressed group are presented.

The chapter will also review the literature relating to disability and visual impairment from eastern and western countries and the African continent. South African literature also plays a significant role in locating the experiences of visually impaired people within the theoretical perspective.

2.2. Disability context

2.2.1. Definition of disability

The definition of disability is complex and there is no consensus on accurate definitions. In the South African context, there are various definitions aligned to different departments' competencies. For example, the health sector would define disability differently from the education sector, however, the study will look at some definitions as outlined below.

The White Paper on the Rights of Persons with Disabilities points out that "the struggle to define disability which accurately and realistically encompasses the lived experience of persons with disabilities is a historical one, characteristics of power dynamics, prejudice and social exclusion of those who do not belong" (White Paper on the Rights of Persons with Disabilities 2015: 15). Statistics South Africa (2011) looks at disability as a physical or mental handicap which has lasted for six months or more, or is expected to last at least six months, which prevents the person from carrying out daily activities independently, or from participating fully in educational, economic, or social activities.

The WHO International Classification of Impairment, Disability and Handicap (2001) views disability and impairment differently. Impairment is viewed in the context of health as any loss or abnormality of psychological, physiological, or anatomical structure or function. Disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (McKinney, 2013; Blocksidge, 2003). Disabled People's International (1982) looked at impairment as the functional limitation within the individual caused by physical, mental, or sensory impairment. Disability is also seen as the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others due to physical and social barriers' (Disabled People's International, 1982).

One may realise that the framework for each discourse is unique but they share the same perspective as they both view disability as a problem in need of remedy (Titchkosky, 2004). Further, traditionally, disability was perceived as the tragic problem of unfortunate individuals whereas now disability is often seen as a form of social oppression and social exclusion (Oliver & Barnes, 2006).

In view of this, disability is reflected as having various meanings such as that disabled persons do not understand their social status. For example, they do not know whether they are an object of curiosity, non-human, pity, patronised, sympathised with, rejected, praised for abilities, or avoided. On the other hand, the disability movement promotes the view that disability is a social construct wherein society creates barriers for people with impairments to participate fully in all aspects of life.

This study has adopted the definition of the Disabled People Movement which looks at disability as the social construct where disabled people are prevented from participating in societal activities due to various barriers that are created by the society. This is reflected by the National Primary Health Facilities Survey (2003) which reported that only twenty-four percent of health facilities were wheelchair accessible and twenty-eight percent had wheelchair accessible toilets. It should be realised that disabled people were and still are precluded from access to health including rehabilitation services due to various barriers such as physical, information, attitudinal and other forms of barriers.

2.2.2. Medical model

Within the medical model disabled people are defined by their impairments instead of their capabilities. Further, people with disabilities are viewed as needing cure and if it fails, they are channelled to alternative separate institutions. In this view people with disabilities need welfare and care and all other needs are neglected (Oliver, 1990; Finestone, 1960). The medical model was developed on the assumption that disability was considered as a problem of the individual that is directly caused by some health conditions, diseases, or injuries (Mdluli, 2012).

According to the medical model, the impairment is the root cause of any disadvantages experienced by persons with disabilities. In line with this model, treatment and/or cure are perceived as the only way to correct these disadvantages (Crow (2010), cited in Mdluli, 2012). Similarly, Mitra views medical intervention in the form of treatment and rehabilitation as the only intervention (Mitra, 2005: 7). Further, with the medical model, impairments are problems in body function or structure such as having a limb or organ of the body that does not function fully effectively. Impairments include physical, sensory, neurological, intellectual, mental, or any physiological long- or short-term impairment (WHO, 2006). It should be realised that disability and impairment are terms which were designed and provided by non-disabled people who had no idea about how it feels like to have a disability. In line with this approach, people with disabilities are excluded from the development of the terms or interventions that affect them directly. This approach increases the dependency of people with disabilities.

One may realise that the medical model of disability leads people with disabilities to be dependant and to be patronised due to their impairments. The Welfare model has been incorporated into the disability model which makes disabled people reliant on handouts without access to essential services such as rehabilitation.

2.2.3. Social model

This study concurs with the social model of disability which views disability as a social construct. That is, people with visual impairment are disabled by the fact of inaccessible information not by the fact of their loss of vision. This is a reflection that disability is not an attribute of the individuals, but a creation by the environment in which they live in (Mitra, 2005: 7). The Social model is addressing the fact that barriers are the main causes which prevent disabled people from access to services. For example, visually impaired people may wish to apply for a job in order to be independent but if the advertisement is not accessible to him or her, a visually impaired person would remain unemployed due to an information barrier. Another example, a deaf person may fail to access HIV counselling, not because of his/her will but due to the health institution which does not have a sign-language interpreter to interpret for him or her, or does not have a deaf HIV employee employed by the institution. A person in a wheelchair may qualify and apply to work and wish to work for a government institution of his or her choice. However, due to the inaccessibility of the environment he or she may not be considered for the position. According to the social model, the shortcomings of society compromise the capabilities of people with disabilities (Mdluli, 2012).

The model reflects that there are various forms of discriminations which disadvantage the disabled people and these forms of discrimination manifest in various ways such as physical environment, attitudinal, information and communication. The social model of disability is concerned with evaluating disabled people's skills, talents, and capabilities to be recognised by the society. The social model further views disability as a result of the limitations imposed on people with different impairments also by various forms of barriers such as attitudinal, environmental and information. This prevents their participation in society.

The focus of the social model definition is not on the impairment or the diagnosis of an individual but on how society prevents people with disabilities from participating in daily activities. The social model is limited to the environment and do not consider other aspects either of an individual or society. For example, people with visual impairment experience poverty more than sighted people. This fact cannot be accounted either under environmental, information and communication; or attitudinal barriers (Mdluli, 2012; Oliver et al., 2006). In support of this, Sen cited in (Mdluli 2012) points out that a disabled person may have more resources than one who is not disabled, but may not enjoy his or her salary because of expenses associated with his/her disability (such as higher medical costs, white cane, and other necessary assistive devices that may be required in his/her daily life.

2.2.4. International context of disability

There are currently over 600 million persons with disabilities throughout the world, of these, "180 million are children, 400 million live in developing countries and 80 million are in Africa" (Matsebula, 2003: 3). Matsebula also predicts that by the year 2025, the population of persons with disabilities would have risen to 900 million worldwide of which 650 million will be in developing countries (Matsebula, 2003). The prediction of the increased number of disabled people world-wide is an indication that disability is growing rapidly. It can be caused by injury, accidents, diseases, etc. and is therefore something that cannot be planned or applied for. However, disabled people are subjected to oppression and negative social attitudes which inevitably undermine their personhood and their status as full citizens (Lang, 2001). Generally, persons with disabilities are often marginalised and face difficulties because of their disabilities. Most have limited or no access to educational, employment and medical services. In addition, people with disabilities often experience economic, cultural, social prejudice and discrimination which consequently prevents them from obtaining a better quality of life (Ingstad, 1995). However, in developed countries policy and legislative frameworks have been improved to ensure human rights and the dignity of persons with disabilities. For example, the United States of America has in the 1990s developed the American Disability Act and the disability movement developed 'people first' language to address sociocultural attitudes (Rackley, 2015).

In 2006, the international disabled community introduced a human rights instrument that would guide the development of policies and legislation globally. This was termed the United Convention on the Rights of Persons with Disabilities (UNCRPD). This legislative framework contains guidelines on various aspects, including defining disability and protocols relating to disability. Within the UNCRPD, disability is viewed within the context of the social model and human rights frameworks. All these international tools are designed to assist in addressing barriers and challenges that make life difficult for disabled people to access vital services. It is also through these legislative instruments that disabled people would be able to advocate on their issues and raise disability awareness on issues pertaining to disability within the society. The attitude of disabled people towards their own disabilities, towards other disabled persons and towards the members of their society, as well as the attitude of society towards them are, determining factors for the development of their personalities and for their integration in society. This calls for society and people with disabilities to work as a collective in identifying the challenges people with disabilities experience; this requires the understanding and recognition of each other's unique experiences. Society must understand how disabled people experience disability in the way that they do, and disabled people also must attempt to understand how society is socialised to behave and treat disability in particular ways.

Disabled people therefore must be politically empowered to advocate for the removal of the barriers that hinder their full recognition in the society. This calls upon disabled people to demand to be accepted by the society in which they live as disability is part of their identity. In fact, Oliver argues:

> It is society that has to change not individuals and this change will come about as part of a process of political empowerment of disabled people as a group and not through social policies and programmes delivered by establishment politicians and policy makers nor through individualised treatments and interventions provided by the medical and para-medical professions (Oliver, 1990: 2).

The current situation around disability in South Africa reflects that people with disabilities face multiple forms of discrimination in various social spheres such as access to health care services, employment, and education (McKinney, 2013).

Furthermore, the South African Human Rights Commission (SAHRC 2013-2017) reflects the slow progress made by the South African government on matters pertaining to disability and the implementation of the Convention on the Rights of Persons with Disabilities (CRPD).

2.2.5. Review of disability and its status in South Africa

Statistics South Africa (2014) reflects that South Africa has a population of 51.8 million of which 7.5% over the age of five has a disability. Wegner and Rhoda note:

> This statistic on the national prevalence of disability should be interpreted with caution since psycho-social and neurological disabilities are not accounted for by Statistics South Africa" (Wegner & Rhoda, 2015: 1).

In South Africa, 38% of the population resides in rural areas, and 25% of the labour force is unemployed (The World Bank, 2014). At the time of the national census in 2011, more than a quarter (26.3%) of all poor people in South Africa resided in KwaZulu-Natal (KZN), most living below the per capita upper-bound poverty line of R620 per month (Statistics South Africa 2014). Disabled people are no exception in this as they are the most marginalised and vulnerable people relying on government disability grant which is R 1780.00 per month for their means of living. Some of them have families who are solely reliant on these grants and others are still young people with high expectations for their future.

Illiteracy and unemployment are a huge challenge of South Africa. Those who are fortunate enough to be employed are placed at lower paid jobs regardless of the tertiary qualifications they hold. This confirms Oliver's argument that disability is currently located within the individual model. This model sees disability as the problem within the individual. This means that the cause of the problem stems from the functional limitations and psychological losses (Oliver, 1990). Looking at the individual model, one may realise that disabled people are deprived most of the opportunities because of the assumption that they cannot perform most of the activities due to the nature of their disabilities. For example, children with disabilities from rural areas find it difficult to access education opportunities due to various forms of barriers including cultural barriers (Crow, 2000). Some of these cultural barriers include:

a) Performance of rituals to appeal for healing of impairment from the ancestors.

b) Ritual performances instructed by abathandazi (foretellers) who would indicate something wrong happened in the family which requires such rituals.

c) Asking for forgiveness rituals because of the act that caused the disability is believed to have been performed by a member of the family.

d) Process of healing in the belief that bewitchment was cast upon the family.

e) A process of healing of a child believed to be possessed by some evil spirits.

Disabled people do not deny their various forms of impairments. However, they look at their disabilities as being perpetuated by their own societies which create barriers that prevent them from access to better opportunities. Having realised that, disabled people adopted the social model which states clearly that it is not their individual limitations, of whatever kind, that cause the problem but society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organisation. Moreover, the consequences of this failure, does not simply and randomly fall on individuals but systematically upon disabled people as a group who experience this failure as institutionalised discrimination throughout society (Oliver, 1990).

In South Africa, people with disabilities continue to experience exclusion from the economy and education system (Moller, 2012*)*. Myths and stigma are some of the major barriers to the social inclusion of people with disabilities. For example, in certain areas of KwaZulu-Natal province people with albinism are kidnapped and killed because of the belief that their body parts can make better medication than that of ordinary people. Therefore, it is imperative that urgent attention should be paid to education and to promote equality and inclusion in the context of disability. Awareness campaigns and education on disability should be facilitated. This calls government to act urgently in bringing the promotional aspects of the Promotion of Equality and Prevention of Unfair Discrimination Act, 4 of 2000 (PEPUDA) into operation. This act tries to redress the imbalances of the past through promoting equality and to remove unfair discrimination of all groups including blacks, disability, and women. Visual impairment is no exception to this as it is also one of the categories that suffers discrimination and prejudice from all aspects of life.

2.3. Visual impairment: Background and status in the context of rehabilitation

2.3.1. Global context

The new global estimate of visual impairment released by the WHO in 2010 indicated that the number of people presenting with visual impairment was 285 million. Of these, 39 million were blind and 246 had low vision. In 2012, the WHO indicated that a large number of people with visual impairment were over the age of 50 years. In the African continent, 26.3 million had low vision and 5.9 million were blind people (Mabaso, 2012).

The global estimate of blindness was 0.7% in 2000, and is expected to increase by 1% by 2020 if appropriate interventions are not implemented to eliminate the causes of avoidable or preventable blindness (Mabaso, 2012: 4). However, Frick and Foster (2003, in Mabaso, 2012) assert that the prevalence of blindness is expected to decrease to 0.3% by year 2020 if vision 2020 programmes are implemented successfully. Mabaso (2012: 5) further states that if health authorities and other stakeholders can identify the factors that influence the prevention of visual impairment and take appropriate action, the prevalence of visual impairment can be reduced.

The literature reflects that visually impaired people face the challenge of poorer social relationships as they cannot use non-verbal cues like eye contact, gestures, etc. (Carabellese et al., cited in Rackley 2015; Marson, 2003; Zalilem, 2002). This leads to visual impairment having a significant negative impact on people's lives as it is restricting leisure activities and the ability to work and live an independent life. It also affects other socio-economic factors including, access to business opportunities, internship and learnership programmes. For visually impaired people from the lowest socio-economic backgrounds accessing practical and emotional support can be extremely challenging. As a result, this can lead to social exclusion and may have a negative impact on their wellbeing (Rackley, 2015). Further, Williams views this as something which can also hinder their progression into education and securing meaningful employment (Williams, 1999).

Adolescents with sight loss are vulnerable to other mental health difficulties as well as depression (Rackley, 2015). It should be noted that mental health challenges and the emotional impact of having visual impairment have been observed to be pervasive across the lifespan of the person with visual impairment. However, the unique needs and experiences of adolescents with visual impairments are important to consider since young people may need to deal with multiple challenges which stem from the developmental stage of being in adolescence stage as well as having loss of sight (Rackley, 2015).

2.3.2. Understanding the South African context of visual impairment

Approximately 80% of the South African population is indigent, relying on public hospitals and clinics and this leaves only 20% of the population dependent on private health care (South African Optometrist 2005: 1). The South African Optometrist (2005) further reflects that the majority of the health care professionals are in private practice and this exacerbates the burden of care in public health care organisations which has to provide health care services to a large proportion of people with very limited staff and resources.

South Africa has a prevalence of 0.75% of blindness in the South African population and 80% of this population reside in rural areas (Prevention of Blindness in South Africa, 2002). It is to be noted that statistics South Africa (2012) report that approximately 1.10 million citizens in South Africa live with visual impairments while KwaZulu-Natal has the figure of 976 798. These figures show a high number of visual impaired in the province whilst uMkhanyakude District which is the main focus of this study has 49 289.

These figures raise questions relating to the availability of services, status of visually impaired people and other critical questions on their quality of life.

2.4. Understanding the causes of visual impairment

Visual impairment is a medical condition with psycho-social impact. Visual impairments are often caused by disease, accidents, trauma or a congenital or degenerative condition and cannot be improved by conventional means such as refractive correction, medication, or surgery (Mabaso, 2012). However, worldwide, incorrected refractive errors are the main causes of visual impairment cataracts which remain the leading cause of blindness in the middle- and low-income countries (WHO, 2012). This in part reflects inequalities in the provision and access to quality health care in different countries.

According to Lewellen and Cartwright, 2001, in Mabaso, 2012) the major causes of blindness in Africa are cataract, trachoma and glaucoma. Cataract can be cured through surgical operation while both trachoma and glaucoma can be treated if discovered at an early stage. Other causes of blindness include onchocerciasis or river blindness, vitamin A deficiency, diabetic retinopathy, and trauma. In developing countries, the causes of blindness mainly stem from medical conditions which at times are not treated. In developed countries, major causes of low vision stem from age-related macular degeneration that are difficult to prevent and difficult to manage (Mabaso, 2012). The prevalence of diabetes mellitus varies in different populations according to genetic predisposition and environmental risk factors, particularly diet (WHO, 2000). Mabaso (2012) and Oduntan et al. (2003) indicate that in many developed nations, diabetes mellitus (DM) is among the leading causes of visual impairment and blindness. As one of the complications of DM, diabetic retinopathy (DR) has been identified as the leading cause of new cases of visual impairment and blindness among adults aged between 20-74 years in developed countries (Mabaso, 2012).

The survey conducted amongst children attending schools for the blind showed corneal scarring to be a significant cause of blindness amongst rural African children (Department of Health, 2002). Corneal scarring may result from a combination of vitamin A deficiency, measles, secondary bacterial infection, and the use of harmful traditional medicines or ophthalmic neonatorum (Mabaso, 2012; Gilbert et al., 2001).

In South Africa, Oduntan et al. (2003) reflected that cataract is the most common cause of low vision in the central region of the Limpopo province and in many other African countries. There are also some myths and stereotypes that perpetuate narratives on the causes of visual impairment in the African context. Some of them are as follows.

2.4.1. Witchcraft

Witchcraft is regarded as one of the causes of visual impairment in the African community. Raines (1990) talks about the fear of witchcraft associated with traditional beliefs. This belief is particularly strong among those people who are not highly educated. For example, when impairments such as that of visual occur abruptly they tend to be associated with witchcraft even though they can simply be explained within the medical realms.

2.4.2. Ridiculing, imitating, or laughing at a disabled person

It is believed that it is wrong to ridicule, imitate or laugh at a disabled person. This might provoke the aggrieved party to curse the offender. In this case, three things could then happen

a) The cursed person would have a child with impairment.

b) An accident might befall the cursed person and one might be rendered disabled, or

c) Future generations of the cursed would be tainted, and this boils down to the notion of punishment.

2.4.3. Disregard of the ancestors

There is also a belief that if ancestors are neglected, disobeyed, or disregarded this could result in some form of punishment which, in some cases, may be in the form of a child with a disability. In order to avoid that punishment, an older person of the affected family has to ask forgiveness from the ancestors. This might be in a form of slaughtering a goat or a cow.

2.4.4. Caused by fate, the will of God

Causes of visual impairment can point to nothing other than just God's will. It might happen that God wants to reveal Himself through a visually impaired child. In order for that to happen, God uses the chosen family to fulfil his will. Ingstad (1995) notes that God's will is sometimes not seen as punishment, but more as a God's trust in the parents' ability to take care of a special child. This means that a visually impaired child can receive a higher rather than diminished status and is treated with affection because, after all, it is not the child's fault (Albrecht, 1999, Belay 2005).

2.5. Categories of rehabilitation for visually impaired people

Bhagotra et al. (2008: 49) categorises rehabilitation for visually impaired people in four categories: medical, training and psycho-social, educational, and vocational rehabilitation and these are discussed below.

2.5.1. Medical rehabilitation

Medical rehabilitation is often an entry point for early detection and diagnosis of visual impairment. Medical rehabilitation includes early identification of visual impairment and timely management which can be medical or surgical (Bhagotra et al., 2008: 49).

Low vision services form part of medical rehabilitation and persons with low vision are able to benefit from low vision assistive devices. These assistive devices assist visually impaired people to benefit from their residual useful vision. There are two types of low vision assistive devices, i.e. optical which includes handheld and standing magnifying devices, reading lenses, microscopic lenses, etc. and non-optical which includes large print books, typewriters, computers with jaws, etc.

Medical rehabilitation also includes assessment of the functional levels of different senses of a diagnosed person with a visual impairment. The WHO (2012) indicates that approximately 87% of visually impaired people reside in developing countries. Important to note is that eye care specialists are based in major cities and towns thus excluding people from rural areas who require eye care services like cataract surgery from accessing these services. The estimation is that the number of eye care providers per million populations in the richest countries may be nine times more than in the poorest countries (Oduntan et al., 2003).

Most practising optometrists and ophthalmologists in South Africa are either in private practice or in urban areas (Naidoo, 2007). One of the reasons is that the previous South African government's health policies did not include the posts for optometrists at state or district hospitals (Mabaso, 2012).

As the study explores the experiences of visually impaired people in accessing rehabilitation services at uMkhanyakude District, a deep rural area in KwaZulu-Natal, it is clear that the district is also affected. Most practising optometrists and ophthalmologists are mainly based in private practise and urban areas in South Africa, and thus people with visual impairment from rural areas may find it difficult to access eye care services. Naidoo (2007) confirms that these practitioners only serve a small portion of the population who can afford health care services with the majority dependent on the public sector for eye care services. There are about 70 ophthalmologists, 5 ophthalmic medical officers, 74 optometrists and 65 ophthalmic nurses in the public sector serving about 38 million people who are dependent on the public sector. This ultimately creates a major burden for the public sector. This is the true reflection of structural inequalities between the rich and the poor as the poor find it difficult to access essential eye care services like the urban people due to the unavailability of required eye care specialists. Anti-oppressive practise theory is to provide more appropriate services by responding to clients' needs regardless of their social status (Mullally, 2010).

The above scenario reflects the tip of the iceberg as it does not reflect the other areas of medical rehabilitation, including the aspects of access, affordability and availability of these services. Furthermore, the research available excludes other areas of medical rehabilitation, such as functional level assessment of senses, cognitive abilities, etc.

The rehabilitation research available in South Africa focuses on two medical professions, that is, optometrists and ophthalmologists to the exclusion of occupational therapists, social workers, psychologists and audiologists. The rehabilitation scope of service including social work, psychology, orientation and mobility generally do not form part of rehabilitation for visual impairment research. Social work profession is essential to medical rehabilitation as the diagnosis is done within the health care setting. Social workers are required to enable people acquiring visual impairment to regain hope in changing their situation and take action on their own behalf.

2.5.2. Access to educational rehabilitation

The previous section indicated that rehabilitation for visually impaired people consists of different facets. Educational rehabilitation assists visual impaired people with self-development. It entails the provision of educational services which meet the needs of visually impaired people. These services are located in the residential 'special' schools for the blind furnished with facilities of braille education system (Bhagotra et al., 2008: 49). Furthermore, in these special schools, educational materials in alternative reading formats such as braille and large print are available to accommodate the learning requirements of visually impaired learners.

Adequate training and education are essential to securing employment in any country. Marson (2003) states that for many blind and visually impaired persons, education provides the only medium through which upward mobility can be achieved. Through education, visually impaired people can access better employment opportunities. International Labour Organisation (2007) also puts forward that people with disabilities require education in order to access decent employment opportunities. Furthermore, many others a higher education degree is a prerequisite for many higher-paying jobs.

However, visually impaired people find it difficult to achieve upward mobility as they cannot be accommodated fully by the education system (Sukhraj-Ely, 2008). This is due to the specialised equipment and diverse resources that are required by a visually impaired person. Several writers have alluded to the fact that special equipment used by visually impaired people need extra money to cover the cost of equipment like tape recorders, braille equipment, making it difficult for them to reach higher levels of education (Marson, 2003). In addition, visually impaired people require special individual attention inside and outside the learning environment as they require both teaching and non-teaching staff. For example, orientation and mobility practitioners are required to assist learners with familiarising them with the school environment. In relation to this fact, the education of the visually impaired child goes beyond the curriculum to education on orientation and mobility, activities of daily living, reading, and writing of braille and sensory and tactile development to enable them to create perceptions of various phenomena and to cope with every day of practicalities.

From the researcher's perspective, visually impaired people also need individual attention from a multidisciplinary team which include educators, social workers, orientation and mobility practitioners, occupational therapists, community rehabilitation workers and other relevant professionals. The multidisciplinary team that provides the required support to visually impaired learners in the field of educational rehabilitation must have proper expertise and suitable qualifications to render effective and quality services. The lack of adequate diverse skills and expertise of various professionals contribute to the marginalisation of visually impaired people.

Looking at the historical overview of education, one may realise that prior to 1994, the provision of education for people with disabilities was recognised and supported by religious organisations. Most of the schools for visually impaired children were built by religious churches, non-governmental organisations, and charity organisations. History shows that the quality of education received by non-white learners was solely dependent on wealthy businesspeople, religious and charity organisations instead of the state. In addition, both internationally and in South Africa, disabled children were the last group of learners to be identified and considered for education and schooling (Sukhraj-Ely, 2008**)**. In the sphere of education, African disabled persons endured three-fold segregation in that they divided on the grounds of race, they were also kept separate from mainstream learners and were further separated from each other according to their particular disabilities.

The current status of the South African educational rehabilitation is facing major challenges because of the number of teachers who do not have knowledge of braille nor the expertise for teaching visually impaired learners. These challenges began to emerge after the cancellation of specialist diplomas in special needs education at teacher training colleges and universities in South Africa (Fish-Hodgson & Khumalo, 2015). It should be noted that many schools try to provide support to teachers with the required training by using other teachers who know braille. This is not enough nor consistent as this not an accredited training. As a result, many educators who are teaching braille-using learners can themselves not read braille with sufficient competence or confidence to provide learners with quality education.

Out of 22 schools, 17 have no access to any textbooks in the CAPS curriculum at all. To date, the Department of Education itself has neither funded nor produced any textbooks for the CAPS curriculum (Fish-Hodgson et al., 2015). Visually impaired people from uMkhanyakude district are no exception in this as they have no choice but to leave their homes as the district does not have schools for visually impaired people. This poses a challenge to parents who have to send their children to another district as some of them have financial challenges and are not in a position to pay for the travelling costs and accommodation fees. As a result, many people with visual impairment stay at home and are denied the opportunity of receiving a formal education. Those visually impaired learners who are fortunate enough to access education are denied bonding opportunities with their parents. Many children drop out as they find it difficult to progress in such an environment.

2.5.3. Vocational rehabilitation

In the foregoing section of this chapter, some of the factors relating to education for visually impaired people were examined. It should be noted that a natural progression from education and training is vocational rehabilitation. This is the continuous and coordinated process of rehabilitation which involves the provision of vocational services, vocational guidance, vocational training, and selective placement, designed to enable a disabled person to secure and retain suitable employment (International Labour Office, 1973).

The National Council on Disability (2007) noted that the employment and earnings gaps faced by people with disabilities are a result of a gap in education. One may concur with the above statement when looking at a number of visually impaired people who didn't have opportunities to access education due to the limited schools for visually impaired people in South Africa, especially in rural areas of KwaZulu-Natal province. If visually impaired people are fortunate to attend schools, some of them experience challenges of the age limit in the education system. A huge number of them are not employed and those who have been able to access education and employment are placed in lower paid jobs regardless of what qualifications they have. For example, a visually impaired person holding a master's degree would be employed as a telecom operator. Further, most visually impaired graduates are either in sheltered employment with very low earnings or internships, if they are lucky.

If training and education is essential in securing jobs, it is vital to ensure that it is inclusive to afford people with disabilities access to quality education and vocational rehabilitation. There is a dearth of information relating to visually impaired people's access to vocational rehabilitation. In part, this could be due to the fact that visually impaired people were and still are viewed as people who are not capable of being employed. However, vocational rehabilitation helps visually impaired people to earn their livelihood and live as useful citizens (Bhagotra et al., 2008). Moreover, it is through vocational rehabilitation that the status and autonomy of visually impaired people can be improved and secured. The International Labour Organisation Conference held in 1983, also recognised the importance of vocational rehabilitation and the following aspect was included in their definition of vocational rehabilitation, "to enable a disabled person to secure, retain and advance in suitable employment, and thereby to further such person's integration or re-integration into society" (International Labour Organisation, 1983: 93). It includes medical, psychological, social and occupational activities aimed at re-establishing disabled, sick or injured people with previous work history, their working capacity and prerequisites for returning to the labour market, and entry into the labour force (International Labour Organisation, 1983).

Looking at the above statement, one can view vocational rehabilitation as a tool which is designed to maximise work participation of people with disabilities and promote their full integration and participation in society. Notwithstanding this, the best rehabilitative efforts are useless when opportunities for employment are not available to facilitate the blind person taking his position in the community (Finestone, 1960, cited in Marson, 2003). Literature shows that there is a clear and direct link between the education children receive and their entry into employment prospects (WHO, 2011). According to the National Council on Disability (2007), education has a significant effect on employment opportunities for people with disabilities. In 2004, the Commission for Employment Equity (CEE) stated that only approximately one percent of the total South African workforce was made up of people with disabilities (McKinney 2013; Department of Labour, 2004). In view of the above, it is clear that vocational rehabilitation is the only process of restoring individuals with visual impairment to the maximum usefulness of which he is capable physically, mentally and vocationally.

The rationale for rehabilitation is the principle that in an organised society each member should have a right to an opportunity to work for a living and to make some contribution to the development of the society. One may argue that as part of career development, vocational rehabilitation is a way of helping persons with visual impairment overcome the disabling conditions involved with visual impairment. It involves building new lives.

2.5.4. Training and psycho-social rehabilitation

The training and psycho-social rehabilitation is categorised into two facets, that is, on the one hand the training aspect and on the other hand the psycho-social aspect. These will be discussed below.

2.5.4.1. *Psycho-social rehabilitation*

The literature reflects that visual impairment is one of the disabling conditions which evoke strong emotional reactions in the affected individual as well as their significant others. This might be a spouse, friends, partners, or children (Ross et al., 2010; Lewis & Rosenblum, 1977). In respect of the above, it must be noted that every member of society grows up with some life expectations, like marriage, giving birth to a child, finding a satisfying job and so on. In all these expectations and fantasies, disability does not feature anywhere. Literature also reflects that in the course of anticipating, for example, the birth of a child, parents may fantasise about who or what the child will be for them (Ross et al., 2010). As disability does not form part of fantasies and dreams, it becomes the great 'spoiler' of dreams when disability like visual impairment occurs. The age of onset of visual impairment can have a significant effect on the affective development of individuals and it results in stigmatisation by society which has a great impact on an individual with visual impairment.

The word stigma refers to social disapproval due a person's characteristics, beliefs, or behaviours, which are against what is generally considered 'normal', and can be economic, political, cultural, or social. Goffman (1963: 3) defined stigma as a "highly discrediting attribute" (The word "attribute" can cover different issues: race, ethnicity, appearance. It can also be applied to visual impairment, the subject of this section). Stigma is characterised by a lack of knowledge about disability, fear, prejudice, and discrimination. Stigma is also the result of false ideas that people have when they describe someone they see as 'different'. People are stigmatised when a word, phrase or category that is judgmental, and which can lead to unfair treatment, is utilised. This happens because people do not know or understand a person's differences.

In view of this, stigma often separates visually impaired people from the rest of their families and communities, leaving them feeling alone, depressed, and devastated. Stigma comes in many forms. It can be simple and direct like a negative word directed at an affected person. It can also be hidden, like when a person thinks one cannot do his or her job. Visually impaired people experience stigma from family and friends or from strangers and even sometimes from different professionals including medical and social work professionals. The stigmatisation of people with visual impairment is not new. For centuries people with visual impairment have long been viewed as not part of the norm. To this day the stigmatisation of people with visual impairment can lead to people being discriminated against in daily life, being denied access to rehabilitation services, employment, education, being over-protected or being treated unfairly. It is seen right across the country regardless of differences in culture and context.

Consistently, the evidence points towards strongly negative attitudes towards people with visual impairment, including the use of negative terms and language towards and about them. Negative attitudes are not only found among the general public and media, but even among disability service professionals. These and other elements of stigma increase social distance and lead to social exclusion. Individuals with disabilities themselves and family members who feel stigmatised often experience increased emotional distress and social isolation (Angermyer et al., 2003). Visually impaired people internalise the values of dominant groups of society and develop a negative self-image, which constitutes internalised oppression.

Stigmatization can make some disabled people feel devalued, useless, and disempowered and it also prevents them from building confidence and having self-respect. Goffman (1963) distinguishes between individuals whose stigmatised characteristics are immediately apparent to others (the discredited) and those whose stigmatised characteristics are invisible (the discreditable). For the discreditable, the issue of public perception of severity and permanence is often irrelevant to initial encounters. For such individuals, however, whether and when to disclose the presence of the disability can be problematic (Goffman 1963). The sighted majority tends to maintain a certain social distance, often treating the visually impaired people as outsiders. Many sighted people feel uncomfortable in the presence of visually impaired individuals. They find it very difficult to accept and mingle with the visually impaired people as they do with other people, and this leads to the visually impaired people being forced either to associate only with each other or become socially isolated. They are frequently marginalised: physically, psychologically, and socially.

This means that for a person who has been sighted, being blind or experiencing visual impairment can be a devastating experience which affects the physical, emotional, and psychological functioning of the individual (Marson, 2003). Further, this can lead to a loss of visual functioning resulting in the loss of confidence in his or her ability to conduct everyday tasks in life and to perform in a job. The feelings of inadequacy and anxiety, combined with insecurity and frustration within the visually impaired person, may result in withdrawal, introversion, aggressiveness etc., (RNIB, 2009). Society's attitudes and behaviour towards visually impaired people determines whether their negative feelings, behaviours and personality maladjustments would take hold.

2.5.4.2. *Intervention strategies*

To address the above effects on the people with visual impairment, several strategies have been proposed in the literature and are discussed below.

a) **Middle step-down facility.** A middle step-down facility which could be hospital-based during the time of diagnosis is required as the facility which assists in bridging the gap between formal diagnosis and the commencement of community-based rehabilitation. It must have well- trained social workers and psychologists who can assist in providing counselling to visually impaired people and helping them with coping mechanisms and strategies. A basic introduction to low vision, preparation for rehabilitation skills training and familiarising visually impaired people with the required assistive devices can be done within the middle step-down facility. Facilitation should be undertaken by appropriately trained and experienced practitioners who are: social workers, ophthalmologists, optometrists, ophthalmic nurses, psychologists, orientation and mobility practitioners, occupational therapists, audiologists, and community-based rehabilitation workers.

b) **Support groups.** It is difficult for visually impaired people to seek support from professionals like orientation and mobility practitioners and occupational therapists, considering the need for help if their loss of vision has not been dealt with. An establishment of a well-structured support group for people with recent visual impairment can be a hugely rewarding experience and positive intervention strategy (RNIB, 2009). This intervention strategy could be an effective communication strategy for providing visually impaired people with the information on coping with visual impairment. It can also provide demonstrations on using different types of assistive devices.

People's social needs and experiences encompass social relationships and support networks that play a crucial part in their wellbeing. In relation to this, Wang and Boerner (2008) assert that these are of particular importance in helping the adaptation process when dealing with a chronic sensory impairment. It should be noted that reactions to a sensory loss, especially sight may be viewed as manifesting the same reactions to bereavement. People appear to pine for the loss of vision, lamenting that they can no longer do certain activities they used to do, e.g. driving, reading, etc., (Douglas et al., 2006). This situation of the grieving process could manifest in anxiety and fearfulness and even develop into depression. When rehabilitation is not offered, this depression can escalate. RNIB (2009) asserts that loss of sight and the process of learning to adapt is likely to impact upon the social relationships and personal perceptions an individual has of him/herself.

Most of the literature on disability state that when visual impairment occurs after marriage the effects on the family are disruptive (Marson, 2003). In view of this, a well-structured peer support system for carers and family members is one of the intervention strategies which should be established. This could assist family members to come into terms with their own changed circumstances. This intervention strategy could also contribute in helping family members or carers to understand how to support their family member to benefit from rehabilitation services and to achieve their desired outcomes. These intervention models would afford people with recent visual impairment opportunities to talk openly about their concerns and address them in a safe and supportive environment conducive to healing and growth. It could also provide visually impaired people with an opportunity to spend some time over a period of weeks conducting their self-assessment and identifying the outcomes and what they would like to achieve.

2.5.4.3. *Training: Independence, orientation and mobility, and activities of daily living*

a) **Orientation and mobility.** Visually impaired individuals need to have a good and efficient training in the use of their remaining senses so that they acquire some amount of independence in their mobility (Bhagotra et al., 2008). The loss of sight has to be compensated for by use of the senses of hearing, touch and smell. These sensory stimuli enable visually impaired people to orient themselves better within the environment and instil a greater level of confidence in visually impaired people regarding their mobility (Bhagotra et al., 2008).

Orientation is the ability to recognise and establish a position in relation to the environment (Ballemans et al., 2011). In support of this view, orientation is viewed as the process of using all available senses to establish one’s position and relationship with objects in one’s physical environments (Fish-Hodgson et al., 2015). It assists the visually impaired person to understand where she/he is and where she or he wants to go. It also helps them with the ability to perform simple daily tasks, for example, catching taxis, making phone calls, navigating new and familiar and unfamiliar physical environments safely and effectively, like cooking and dressing.

To perform the above-mentioned tasks, a visually impaired person has to depend upon his or her remaining senses to be able to move around freely. The senses of touch, hearing, taste, kinaesthetic and smell can assist him or her to recognise his or her position and identify obstacles in the environment. Mobility is the "physical ability to move in an orderly, efficient and safe manner through the environment" (Ballemans et al., 2011: 881). In addition, it is the ability to move around the environment safely, independently, and efficiently. The level of independence in mobility can help visually impaired people to develop self-esteem and obtain employment.

b) **Significance of orientation and mobility.** Orientation and mobility are essential for the full development of the visually impaired people, and viewed as the autonomy of visually impaired persons which enables them to become oriented to their environment and facilitates their mobility and travel (Marson, 2003; Fish-Hodgson et al., 2015).

The provision of orientation and mobility training assists visually impaired people with the ability to move in and around their environment. It also enables them to enhance their understanding of the concepts and give them more self-confidence, which may result in increased self-esteem and also lead to personal development. It is through orientation and mobility that a visually impaired person is able to picture his or her physical environment. Orientation and mobility can assist persons with visual impairment to visit the grocery shop, temples, houses of their relatives, neighbours, and friends. This would also enable them to develop personal relations. The extent of social interaction would be enhanced further if the individual with visual impairment is able to utilise the public transport and visit other places including cities and towns (Fish-Hodgson et al., 2015; RNIB 2009).

c) **Principles in the training of mobility and rehabilitation.** Lynch et al. (2011) provides six important principles in the training of mobility and rehabilitation. These principles include:

> Use of individualised approach in training. This principle reflects the fact that visually impaired people are trained as individuals not in groups. The person responsible for the training focusses on one visually impaired person.
>
> The training is goal directed or goal oriented. The training for the visually impaired person has specific goals to be achieved by both the trainer and the trainee to make the training beneficial to the individual.
>
> The training is based on individual needs and interests. The person with visual impairment is provided with an opportunity to choose what she/he would like to be trained on based on his/her interests and needs.
>
> The training is based on individual abilities and potentials. This principle refers to the training where an individual receives training based on his/her potential or abilities to carryout particular activities. The training should be carried out in a natural setting. In this principle, it is clearly stated that the training of a visually impaired person should be carried out in an environment where the trainee resides, works or attends school. This will assist the trainee to use the knowledge and skills to carry out his/her day to day activities in life. When the skill is learnt in a place with which the trainee is familiar, a more positive impact is made on the life of the trainee and he/she will become productive, independent, and self-reliant.
>
> The training should be functional. The training should be able to improve the quality and life situation of the visually impaired person.

The above principles reflect that, in order for the training to be implemented, a number of resources are required to make the training feasible. Various adaptive techniques and other resources that are offered by science and technology have made it possible for visually impaired people to become integral members of the society (Seesurun, 2015). Visually impaired people receive their full independence through the training which they receive, using different techniques and resources.

The previous sections of this study explicitly indicate that a visually impaired person who does not acquire good orientation and mobility skills is restricted in the amount, diversity, and spontaneity of social encounters (Zilalem, 2002). The inability to move around affects the self-identity of the visually impaired person. It affects the psychological, economical, emotional, physical, and social characteristics of the individual. It would limit their knowledge of the world around them and would also restrict their exposure to the environment (Fish-Hodgson et al., 2015;). Stone (Priestley, 2011) alludes to the fact that an inability of the visually impaired person to travel around freely has devastating effects on the individual's self-concept. Most people with visual impairment remain confined to their homes and live solitary lives. They depend upon the convenience and favour of others for their daily activities, movement and participating in social activities (Seesurun, 2015; RNIB, 2009; Zelalem, 2002).

2.5.4.4. *Training on daily living skills*

Available information from literature reveals that visual impairment in our communities result in helplessness and dependence on other people (Lynch et al., 2011). In order to reduce the dependence of visually impaired people, training in daily living activities is important. Daily living skills include and are defined by the literature as: self-care, home living, communication, socialisation, travel, shopping, money management, leisure skills, eating, using toilet, taking medicines, maintaining body hygiene (Seesurrun, 2015; Bhagotra et al., 2008).

Daily living skills are also critical for the wellbeing and self-concept of visually impaired people (Zalalem, 2002). If visually impaired people are restricted or overprotected by their relatives, families, or professionals, it may result in dependence and low self-esteem. It should be noted that visually impaired people should be invited to assist in a wide range of activities, like sighted people. This could help visually impaired people to feel more fully integrated in the community and accepted by their peers.

2.5.4.5. *Assistive devices in the training process*

Assistive devices play a major role in the life of persons with disabilities, including people with visual impairment. Government policies, blind person's organisations' budgets, and a significant number of the literature agree on the usefulness of assistive devices and assistive technology towards quality of life for persons with visual impairment.

The KZN Standardisation Guidelines of Assistive Devices (2013: 3) defines assistive devices as "any devices and ergonomic solution capable of reducing the disability experienced by an individual". It enables individuals with disabilities to participate on equal terms with their counterparts. If visually impaired people are to attain their rights and responsibilities and participate in society as equal citizens, they must have access to affordable, quality, and appropriate devices.

The rehabilitation policy further indicates that assistive devices should include those that promote independence of a person; contribute to functional independence of a disabled person in society; facilitate communication for disabled people; and improve the quality of life of disabled people (National Rehabilitation Policy, 2013). A device must be specific to the client and individual needs of a client.

Providing appropriate assistive devices to persons with visual impairment not only enhances functional independence but also begins a process of opening up to a world of employment, social life, and/or education.

a) **Categories of assistive devices.** According to KZN Standardisation Assistive Devices guidelines (2013) assistive devices are categorised as follows:

    i. Mobility devices. These include white canes, symbol canes and guide dogs.

    ii. Communication devices. These include braille frames, braille machines, adapted computers, braille slates, braille note-takers.

    iii. Visual devices. These include spectacles, sun glasses, magnifying glasses, telescopes, hard contact lenses, lenticular lenses, binoculars.

Activities of daily living devices which include among others liquid level indicators, needle threads, medication dispensers, signature guides, etc.

b) **Benefits of assistive devices.** Various literature and policies such as National Rehabilitation Policy, 2008; KwaZulu-Natal Rehabilitation Policy, 2013; KZN Guidelines on Assistive devices, 2014, White paper on the Rights of Persons with Disabilities, 2015; Taylor, 2000; Marson, 2003,) indicate the following benefits:

i. Enhancement of the rehabilitation process.

ii. Promotes independence and quality of life to persons with visual impairments.

iii. Ensures a free and appropriate education.

iv. Improves effectiveness of educational interventions and academic achievements.

v. A white cane plays an important role to the lives of visually impaired people. It enables them to negotiate their environment.

vi. Assists users to become more productive members of their communities.

In view of the above advantages, assistive devices must be available to support visually impaired people in improving their independence and quality of life.

2.6. Policy and legislative framework on disability

The Constitution of South Africa, Act 108 of 1996 explicitly prohibits unfair discrimination by the state or any person directly or indirectly based on disability, amongst other grounds. It further states that all South Africans are equal before the law and that equality includes full and equal enjoyment of all rights and freedoms.

Hill (cited in Sukhraj-Ely, 2008) states that policies are not formulated and implemented in a vacuum. They involve various actors, organisations, institutions, bureaucrats, and members of the public. Section 2 of the Constitution provides for the human rights of all citizens including visually impaired people. These rights include that of freedom of movement, access to rehabilitation services as well as education and training. The Constitution as the supreme law of the land provides the framework for policy direction and service delivery. It is therefore implied that in terms of equality, Clause (Section 9) of the Constitution, people with visual impairment are no exception in accessing and enjoying the freedoms enshrined in the Constitution. Policies developed and service delivery programmes must incorporate aspects pertaining to visual impairment.

The discussion of the above rehabilitation categories reflects that in order for rehabilitation of visually impaired people to be successful, the multidisciplinary approach team is recommended of which social work profession forms part of it. Social work profession may play a significant role in the formation of identity for an an individual who has acquired visual impairment. The intervention of social workers may assist in moving clients who have acquired visual impairment from being placed in the position of accepting, accommodating, or rejecting the inferior status by the privileged group. It should be noted that in all rehabilitation categories discussed above there is a minimal role of social work profession in rehabilitation for visually impaired people. It is therefore crucial to have social workers who will be able to address social divisions and structural inequalities in order for visually impaired people to access rehabilitation as other groups.

2.6.1. International legislations

Globally, the United Nations (UN) introduced the Standard Rules on the equalisation of opportunities for Persons with Disabilities. Clause 3 of the Standard Rules specifies the point of rehabilitation services to people with disabilities in order for them to reach and sustain their optimal level of independence and function (United Nations 1993). Furthermore, the WHO (2005) requests states to strengthen national rehabilitation services in line with the UN Standard Rules on the Equalisation of opportunities for Persons with Disabilities. In addition, the UN Convention on the Rights of Persons with Disabilities (2006) Article 26 outlines the measures state parties should undertake to ensure that people with disabilities are able to access health, services, and rehabilitation.

These measures include peer support to enable persons with disabilities to attain and maintain their maximum independence, full physical, sensory, mental, social, and vocational ability, as well as full inclusion and participation in all aspects of life. In addition, Article 26 states that services must begin at the earliest possible stage, should be based on multidisciplinary assessment of individual needs and strengths, and ought to include provision of assistive devices and technologies.

The International Classification of Functioning Disability and Health (2000), has been developed as a way of understanding the complex interaction between features of the biological, psychological, cultural, and social factors of disability (WHO, cited in Mji et al., 2013). The International Classification of Functioning Disability and Health (ICF) is also seen to be relevant to the professional areas of rehabilitation and public health.

The WHO (2011) developed the Vision 2020 strategy which calls for the participation of local eye healthcare experts and planners in its implementation. It encourages increased awareness about public health concepts in eye care and the formation of committees to assess local needs, develop national action plans and facilitate their implementation, monitoring and periodic assessment. Included in the Vision 2020 strategy are interventions for preventing avoidable visual loss.

In addition, member states including South Africa are encouraged to integrate eye care services into national healthcare systems. The Vision 2020 strategy focuses on the following:

a) Increasing political and professional commitment to the prevention of visual impairment;

b) Increasing the provision of high quality, sustainable eye care;

c) Increasing public awareness and use of eye healthcare services; and

d) Encouraging the commitment and support of non-governmental organisations and private sectors.

2.6.2. National legislations

The reforms of 1994 in South Africa and the introduction of the constitutional democracy have necessitated adjustments to existing government policies and legislation and the development of new ones. In the area of disability, the launch of an integrated National Disability Strategy in 1997 saw a change in the inclusion and integration of disability in policy and legislative frameworks.

The Integrated National Disability Strategy influenced the South African public service towards a paradigm shift in how disability is viewed. It was influential in the enhancement of disability legislation and a call for change in the structure and implementation of rehabilitation services. The Integrated National Disability Strategy was based on the UN Standard Rules for the Equalisation of Opportunities for Persons with Disabilities which shaped the foundation for the national rehabilitation policies (Department of Health, 2000; Department of Social Development, 2010). The National Department of Health Rehabilitation Policy (2000) aims to improve accessibility to all rehabilitation services in order to facilitate the realisation of every citizen's constitutional right to have access to healthcare services. The policy (in line with UN Standard Rules) should serve as a vehicle to bring about equalisation of opportunities and enhance human rights for persons with disabilities. The Department of Social Development National Rehabilitation Policy (2010) focusses on the areas of social, psycho-social, and community-based rehabilitation. Its emphasis is on access to services and empowerment of persons with disabilities.

The National Department of Health realised the gaps in National Rehabilitation Policy and thus developed the Framework and Strategy for Disability and Rehabilitation Services in South Africa. The policy signals the Department of Health's full commitment to addressing the health concerns of people with disabilities. It embraces the human rights culture outlined in the UN Convention on the Rights of Persons with Disabilities. In addition, the White paper on the Rights of Persons with Disabilities was approved by the Cabinet in 2015. This policy is in line with the UN Convention on the Rights of Persons with Disabilities and is the extension of the White Paper on an Integrated National Disability Strategy (1997).

2.6.3. Provincial legislations

The KwaZulu-Natal (KZN) Department of Health in 2008 developed the provincial rehabilitation policy. All these policies recognise that many people with disabilities in South Africa are excluded from mainstream society and prevented from accessing fundamental social, political, and economic rights and opportunities. These policies also realise that the exclusion experienced by persons with disabilities and their families is the result of a range of factors, such as exclusionary barriers in society and a weak and discriminatory legislative framework, which has failed to protect the rights of persons with disabilities enshrined in the Constitution of South Africa.

The KwaZulu-Natal rehabilitation policy focuses on primary, secondary, and tertiary prevention of disability. Although the policy aims to improve the quality of life of persons with disabilities in general, it lacks the vision to respond effectively to rehabilitation needs for visually impaired people. The KwaZulu-Natal Rehabilitation policy (2008) presents the vision of "achieving optimum quality of life for persons with disabilities and those at risk as well as their families" in KwaZulu-Natal. It envisages accomplishing this vision through: improving accessibility of services, monitoring policy implementation, providing assistive devices and raising awareness in disability prevention. All these services do not include aspects of empowerment through counselling, skills in safe movement in the environment, activities of daily living, adjustment to social life, and other services that impact greatly on the quality of life of visually impaired people.

Despite the success in the prevention and control of avoidable blindness and low vision in the KwaZulu-Natal province, considerable challenges remain for the implementation of training and psycho-social rehabilitation services for visually impaired people.

2.7. Theory that underpins disabled people as a socially oppressed group

As disabled people form part of social divisions that experience imposition from superior groups, they form part of a group that requires paradigm shifts from oppressive relations. Therefore, the study is guided by anti-oppressive theory (Dominelli, 2002; Mullaly, 2010).

Mji et al. (2013) argues that the discourse of rehabilitation has been underpinned by the changing theoretical and socio-political understandings of disability. This in turn has influenced the various international and national health and disability policies and legislations that oversee the implementation of rehabilitation practice. Rehabilitation services can be analysed within a particular framework. The theoretical frameworks used by different researchers pertaining to disability-related services, including rehabilitation, all relate to interaction and how disability is viewed within society. Some of the important theories or models forming the basis for disability studies are human rights, medical and social models of disability, as well as social oppression theories. The theories discussed below are in line with the anti-oppressive theory in the context of disability:

2.7.1. Medical/individual model of disability

Since the rise of scientific medicine in the eighteenth century, disability in industrialised countries has largely been understood in terms of health and illness, and viewed as a problem of an individual (Barnes et al., 2007: 233-246). Hosking (2008: 11) views the medical model as the model that “sees disability as an inherent characteristic of a person arising from an objectively identified impairment of the mind or body”.

Obosi (2010) asserts that the disability movement views this model as viewing disabled people in terms of their impairments and as passive, helpless, tragic victims and not as ordinary human beings with potential. In support of this Mji (2008) argues that in South Africa the healthcare services still reside in a medical model approach whereby people with disabilities still play a passive role.

Visual impairment is also one of the categories of disability which is defined either by using the medical model or bio-psycho-social models. According to the individual/medical model of disability, people are disabled by their impairments, and it is the role of medicine and psychology to restore them to ‘normality’ (Oliver, 2010). In view of this, the problem of visual impairment is thus located within the impaired individual. The provision of rehabilitation, in this view, is to eliminate or return impaired bodies to societal normality (Simmons et al., 2008).

One may argue that the notion of power is firmly in the hands of health professionals whilst people with visual impairment play a passive, subordinate role. In support of this, Mji (2013) reflects that a clear distinction needs to be made between disability, impairment, and ill-health. Visual impairment is a long-term characteristic of an individual that affects a person’s functioning and/or appearance. Ill-health is the short-term or long-term consequence of disease or sickness (Mji, 2013; Oliver, 2010). Visually impaired people have an impairment not ill-health, therefore they cannot be considered to be disabled.

2.7.2. Social model of disability

In opposition to the medical approach, alternative approaches are required for rehabilitation services that look beyond the disabled body. In line with the above, the disability movement proposed the social model of disability towards the end of the nineteenth century which helps to locate disability within society. The social model of disability removes the barriers that persons with disabilities encounter in various aspects of life.

In the twentieth century the disability movements such as Disabled People International, South African Federation of Disabled People, and Disabled People South Africa redefined disability as a form of oppression on a par with racism and sexism (Mji, 2008). The disabled people criticised the medical model and its failure to recognise disabled people as the experts on their own situation (Oliver, cited in Barnes et al., 2007). The social model of disability emerged as it recognises the capabilities of disabled people and focusses on the societal construct of disability. During the late 1980s in South Africa people with disabilities began to rise up and challenged rehabilitation professionals to work with the disability rights movement (Mji, 2008). One of the main criticisms of the medical approach is that it places sole responsibility for change upon the individual and pays little attention to the barriers that hinder the full social integration of people with disabilities.

The social model is based on the principles that disability is a social construct, not the inevitable consequence of impairment; Disability is best characterised as a complex interrelationship between impairment, individual responses to impairment, and the social environment; and that the social disadvantage experienced by disabled people is caused by physical, institutional, communication and attitudinal barriers (Shakespeare et al., 2002; Barnes, 2012).

The social model assists people in being able to identify factors that cause oppression and discrimination. It also helps disabled people to choose to work towards doing something about them. It should be noted that the social model is not trying to change a person or cure the individual impairment but it offers solutions that can help to remove societal barriers which prevent visually impaired people from performing their daily activities.

2.7.3. Anti-Oppressive Practice theory (AOP)

Anti-oppressive practice theory provides an important approach towards identifying experiences of visually impaired people and analysing their situations in the context of existing oppression and access to services. The question is whether the AOP is upheld alongside social model of disability and rehabilitation services. Through examination of the rehabilitation practice models, key social models of disability principles are shown to reinforce anti-oppressive theory's worthiness for analysing rehabilitation services accessed by visually impaired people.

Until now, the voices of disabled people have been suppressed and their feelings unarticulated, often remaining unheard and unrecognised by members of dominant groups. In the context of the proposed study, these groups consist of non-disabled persons who have the power to make decisions on behalf of disabled persons. For example, those in charge of the provision of rehabilitation services to visually impaired persons overlook their opinions and their voices. The non-disabled groups (members of the dominant group) find it difficult to respond to the needs of visually impaired people, resulting in a vicious cycle of oppression. Hence, the anti-oppressive theory has emerged to challenge the underlying assumptions of the medical/individual model of disability (Shakespeare et al., 2002).

2.7.3.1. *Oppression in the context of visual impairment*

Disability theory can arguably be best located and understood through the use of the concept of oppression. This is because people with disabilities are excluded on a regular basis from all aspects of life due to various barriers. This is in line with Strier's (2006: 5) definition of social oppression as "the systemic subordination of specific social groups through institutionalised use of unjust power and authority". Oppression is a phenomenon of power in which relations between people and groups are experienced in terms of domination and subordination, superiority, and control (Lang, 2001). Because oppression refers to the way societies are structured and the way people relate to the context of these structures, oppression is far more than just "the exercise of power in a tyrannical manner, the cruel treatment of subjects and the imposition of unjust burdens" (Shorter Oxford English Dictionary, cited in Dominelli, 2002: 7). Dominelli (2002: 47) further states that, "exclusionary processes and oppressive dynamics are linked to identity formation in all its complexities".

Beatson (2003: 4) views oppression as "the infliction on others of one or more of the following: physical pain, emotional distress, neglect, exclusion, denigration and powerlessness. Consequently, people who are subjected to oppression tend to internalise the experience of inferiority which further contributes to their experience of 'voicelessness' and the silencing of their feelings (Subrayen, 2011).

2.7.3.2. *Identity and visual impairment*

Kidd (cited in Murugai, 2009:1) defines identity as, "the condition of being a person and the process by which we become a person, that is, how we are constituted as subjects". Further, Weeks (1990: 88, in Shakespeare) views identity as "about belonging, about what you have in common with some other people and what differentiates you from others. At its most basic, it gives you a sense of personal location, the stable core to your individuality". Disability identity can be viewed in the context of how disabled people narrate their stories and having the similar space to tell those stories with an audience which will listen to them. It is also about recognising differences. It is important to note that identity can be structured upon shared experiences. There are fixed identities of persons with disabilities and also the self plays a significant role in the formation of identity. Important to note is that persons with disabilities' identities have been enforced over time by regulatory regimes, embodied in societal prejudices.

It should be noted that identity or self-concept is developed through a fundamental sense of who people are as individuals, distinct from others. This identity is constantly modified according to how people organise and derive meaning from their experiences. Regarding this, Bowman et al. (2011: 55) asserts that "the outcome of this process has been described as producing a self with two complementary aspects; the "I" (my internal messages about my experience) and the "Me" (the messages I get about how others experience me). Messages about the "I" emanate in words generated in our minds, and the words communicated by others about us create the "me". This distinction becomes important when an "other" sees visually impaired persons very differently than they see themselves.

An oppressed person may experience low self-esteem, develop a negative self-concept and a poor self-image, which undermines the discovery of true self-identity. This can result in the development of a false consciousness, which means they believe that they are less capable than others (Dominelli, 2002; Bulhan et al., cited in Mullaly, 2010).

The oppressive mechanisms of societal structures are embedded in ideas and attitudes of non-disabled persons who often regard people with visual impairment as different from, and less acceptable than, members of the dominant group (Subrayen, 2011). Visually impaired people experience oppression when decisions are made and their activities selected and constrained, without their voices being heard, by non-disabled decision makers. Oppressive relationships emerge, when strategic leadership does not facilitate the inclusion of visually impaired people and other oppressed groups when apportioning power, resources, and more specifically the provision of rehabilitation services (Dominelli, 2002).

In short, anti-oppressive theory is relevant to this study in that it addresses the oppression of visually impaired people. The study has afforded members of this group the opportunity to voice their experiences regarding access to rehabilitation services, which the researcher regards as key to their ‘independent living’ aspirations.

2.8. Conclusion

This chapter offered an overview of visual impairment, its causes and possible prevention of it. It also provided an understanding of rehabilitation for visually impaired people and its various categories. The chapter also included an explanation of international, national, and local legislation as it impacts on the disability context and process. Theories that underpin disabled people as a socially oppressed group were presented.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter outlines the methodological approach which was utilised in conducting the research study. It focuses on the research approach, the research design and sampling strategy. It provides an in-depth discussion and analysis of the results from the interviews of visually impaired people from uMkhanyakude district KwaZulu-Natal. The ethical considerations and limitations of the study are presented.

3.2. Research paradigm

Researching visual impairment in a rural community dictated an approach which recognised the context in which visual impairment is experienced. Since this study focused on the experiences of visually impaired people in attempting to access rehabilitation services in the province of KwaZulu-Natal, uMkhanyakude District, the qualitative approach was deemed most suitable. The researcher focused on meanings, given by persons with visual impairment, to their situation, experiences and the researchers' understanding of the context. A qualitative methodology was therefore relevant and most appropriate to this study as Polit and Beck (2004: 16) also suggests that it "emphasises the dynamic, holistic and individual aspects of the human experience, and captures those experiences in their entirety, within the context of those experiencing them".

Furthermore, Padgett (2004: 3) asserts that "qualitative research offers an approach that is both complementary to, and transcendent of, conventional scientific inquiry". The qualitative method also facilitates the study of issues in depth, without imposing pre-existing notions on the research setting (Patton, 2002).

It is considered to be the most appropriate manner of discovering or uncovering the perceptions about access to rehabilitation by visually impaired people themselves. It was crucial in this study to elicit the personal views from visually impaired people themselves, as this study hopes to contribute to the planning and implementation of an all-inclusive rehabilitation services for visually impaired people. Any investigation into rehabilitation services must initially acknowledge that visual impairment is a distinct and unique disability, and any question about how visual impaired people may regard access to rehabilitation would reveal and portray new insight that can contribute to existing scientific discourse about rehabilitation and its implementation.

3.3. Research design

Creswell (2013) views research design as comprising the detailed plans and procedures for collecting data. Research design outlines pertinent steps in conducting the study, including sampling techniques and size, data collection tools, data handling, data analysis, and presentation of findings. Babbie et al., (2006: 87) states, "the most common designs for research are: explorative, descriptive and contextual research designs". This study was qualitative in nature and employed an explorative and descriptive design to explore the experiences of visually impaired people in accessing rehabilitation services at uMkhanyakude District, a rural area in KwaZulu-Natal province.

The researcher's aim was to focus on and uncover how the participants make sense of their own world, using their own perceptions, understanding, and experiences (Cebekhulu, 2016). In support Babbie et al., (2006: 80) assert "studies that are of an exploratory nature usually lead to getting to know what is happening and understanding the journey of these happenings". This design afforded the researcher the chance to explore and understand the experiences and challenges of visually impaired people in accessing rehabilitation services. Furthermore, the exploratory design was particularly appropriate to the study as it generated new insights, enabled the researcher to discover new ideas and contributed new knowledge to the field of social work with visually impaired persons (Babbie et al., 2006: 80). According to Steyn (2016) an exploratory design was crucial for this type of study as it ensured that rich descriptions of phenomena are produced and that they merge after carefully selecting participants. Babbie et al., (2013: 43) maintains that exploratory design is conducted for three purposes:

a) To test the feasibility of undertaking a more extensive study.

b) To develop the methods to be employed in any subsequent study.

c) To satisfy the researcher’s curiosity and desire for better understanding.

The latter purpose as noted by Babbie (2013) was applicable in the present study as the aim was to generate a more comprehensive understanding of the real challenges confronted by visually impaired people when faced with the reality of losing one’s eye sight and when accessing rehabilitation services.

A descriptive design was also utilised. The purpose of descriptive research is to provide an accurate description of the situation under study. This researcher aimed to provide a picture of visually impaired people’s situation as it naturally occurred (Burns et al., 2001). Also, Polit and Beck (2006: 498) describe the main objective of descriptive research as the accurate portrayal of the characteristics of persons, situations, or groups, and/or the frequency with which certain phenomena occur. Similarly, Streubert et al., 1999) and Carpenter (cited in Mabuda 2009: 5) maintain that “descriptive research involves direct exploration, analysis and description of the particular phenomena, as free as possible from unexplained presuppositions, aiming at maximum intuitive presentation”. Therefore, this study employed a descriptive design to document the experiences and perceptions of visually impaired people in their context by attempting to understand their perceptions and feelings in accessing rehabilitation services. This was to ensure that participants’ actual meanings were optimally captured. The researcher also used interviewing techniques such as probing, paraphrasing and summarising to enhance detailed descriptions of experiences.

The context of participants was considered by including both totally blind and partially sighted individuals from differing circumstances. As Babbie et al., (2006: 272) explain, “the context has to do with events, actions and processes in which the participants of the research are involved”. The participants provided different meanings of phenomena such as rehabilitation and visual impairment, as well as how they perceive access to rehabilitation, given the context of their social world. Participants presented diverse realities and offered suggestions for the Department of Health on visual impairment.

In summary, combining descriptive, exploratory, and contextual designs assisted and permitted the researcher to comprehensively implement the stated objectives of the study. In addition, the combination and integration of the designs allowed for the “authenticity of the study's findings” (Polit et al., 2001: 216).

3.4. Research sample

Burns and Grove (2001: 213) describe population as “all the elements that meet the criteria for inclusion in a study”. Polit and Beck (2004: 50) add that it is the “aggregate or totality of those conforming to a set of specifications”. As indicated in chapter one, the sample was selected from the uMkhanyakude District as opposed to the entire province of KwaZulu-Natal. The study used purposeful sampling and sampled participants with visual impairment as they would be able to engage with the specific concepts and the explorative nature of the study as they may have personal experience with them. Sampled participants were therefore visually impaired and resided within the district of uMkhanyakude. Initially, and as part of the preparatory process for data collection, the study was discussed with the programme manager of Disability and Rehabilitation programme (KZN Department of Health) where the researcher is employed. A meeting was proposed and convened with the core group members comprising of colleagues at work including the programme manager, disability advisor, assistant director (physiotherapist), researcher assistant, the district rehabilitation coordinator, and the chairperson of the district disability forum. Three consecutive meetings were held where the following aspects of the data collection process were discussed: finding the participants who met the criteria for inclusion (this afforded the core group members to suggest suitable names), identifying and inviting the participants to participate in the study.

A letter of invitation was sent to the potential participants and explained the background to the research study and invited participation.[1] The invitation was faxed, emailed and/or hand delivered by the researcher. The letters were translated into isiZulu and converted into braille and large print. The objectives and ethical considerations of the study were explained in the letter. The adherence to ethical protocols and concerns in sampling was a priority for the researcher as suggested by Marlow et al. (2005: 158). The researcher emphasised how the voices of the visually impaired would mutually benefit the research field, the disability movement and health organisations as it would contribute towards improved service delivery (Marlow et al., 2011: 155).

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[1] See Annexure 1.

The researcher worked very closely with both the disability and rehabilitation district coordinator from the Department of Health and the disability coordinator of uMkhanyakude District municipality as both of them work very closely with disabled people of the district under study. Such collaborative involvement of key persons who “best know the needs” of the sample population, is suggested by Babbie et al., (2013: 173).

The researcher requested the contact details of visually impaired people of the district under study and she received approximately twenty visually impaired people’s contact details who accessed rehabilitation services. Thus, twenty visually impaired people who reside in uMkhanyakude district showed interest in the study and were invited and from the 20 initially invited to participate, ten consented to participate.

Burns and Grove (2003: 234) define eligibility criteria as, “a list of characteristics that are required for the membership in the target population”. For this study the criteria for selection was sample size consisted of ten visually impaired people who were interviewed individually. They were between the ages of 18 and 35.

There were six males and four females. In terms of blindness there were six partially sighted and four totally blind individuals. The causes of their blindness included various illnesses, accidents, congenital conditions and different illnesses, bewitchment, and unknown causes. It also included those who were born with visual impairment and those who acquired it later in life. Participants were from a wide variety of educational and socio-economic backgrounds, some employed and others were unemployed.

3.5. Sampling methods

Polit and Beck (2004: 731) viewed sampling as:

> The process of selecting a portion of the population that conforms to a designated set of specifications to be studied. It is a subset of a population selected to participate in the study.

Neuman et al., (2011: 241) asserts, “the logic of the qualitative sample is to sample particular aspects/features of the social world”. For this study non-probability sampling was utilised, which consists of four sampling methods namely: convenience, purposive, snowball and quota sampling methods. In non-probability sampling, researchers use their judgements to select the subjects to be included in the study based on their knowledge of the phenomenon (Parahoo, 2006: 223).

According to Creswell (2003: 185) purposive sampling refers to "selection of sites or participants that will best help the researcher understand the problem and the research question, they must be willing to reflect on and share this knowledge". Mabuda, (2009: 14) also suggests that, "purposive sampling requires selecting participants who are knowledgeable about the issue in question, because of their sheer involvement in and experience of the situation". This method of sampling was appropriate for the study because the researcher had to select the participants with specific knowledge about the studied phenomenon. Visually impaired people who participated in the study had experience of visual impairment and had an understanding of their area and were also willing to share their knowledge of accessing rehabilitation services in their district.

The researcher previously observed during various disability events held at uMkhanyakude districts that visually impaired people constantly complained about accessing rehabilitation services in their district, which became one issue that motivated the study. Furthermore, the participants were identified and accessed through the researcher's present social work caseload since the researcher is a social worker by profession thus sometimes puts her in a good position to observe that most of the visually impaired people are neglected in accessing rehabilitation services. As an employee of the Department of Health (DoH), the researcher is also able to observe that the Department of Health has a number of visually impaired people who experience challenges from accessing rehabilitation services from the Department of Health.

The researcher also realised that these challenges are not known by the Department as visually impaired people are marginalised and not empowered enough to voice their distress with the Department. This also motivated the study as the researcher strongly believes that social work should provide the opportunity for clients to raise their concerns in order for them to live a meaningful life.

His section discusses the process of data collection and suggests how participation in groups facilitates the process of sharing and generates a powerful cathartic experience. Hence, in this study individual interviews were conducted first, and the same participants were invited to participate in a focus group discussion thereafter.

In exploring the experiences of visually impaired people in accessing rehabilitation services, two methods of data collection were used with the same group of participants, i.e. semi-structured individual interviews and focus group discussions. Mullaly (2010) asserts that in anti-oppressive social work, individual and group work are both necessary, and that it is important for individual interventions to precede the group intervention.

The main reason for this is that according to Mullaly (2010: 225):

> A common experience of oppressed persons upon joining a group is to feel overwhelmed and lack the confidence to speak out. For this reason, many people feel the need for some kind of personal development to build up self-esteem and confidence before participating in a group.

Individual interventions serve to explore identity issues in a safe space, as well as building the strength and confidence to express difficult emotions. On the other hand, a group context facilitates the joint and conscious exploration of the social causes of people’s predicaments, and of the ways in which these could change.

3.6. Researcher preparation

As the researcher became involved in the study, she was aware of her position as an outsider to the community of visually impaired people at uMkhanyakude District. Hence, a concerted effort was made to acquaint herself with the community within a different relationship dynamic to that of a client/professional relationship. On several occasions, the researcher conducted community work to monitor the service delivery, as an employee of the Department of Health and as a social worker, which afforded the researcher an opportunity to build a rapport with the wider groups and to establish a common ground for understanding. The same logic can be applied to conducting research and collecting data from oppressed people. Social work as a profession promotes evidence-based practice as a central concept that informs interventions.

3.6.1. The pilot study

The pilot study was conducted in 2016 for the period of two weeks.

Monette et al. (2010: 94) define a pilot study as a small-scale, “trial run” of all the procedures planned for use in the main study. One data collection instrument, the individual interview guide, was piloted for this study.

To pilot the individual interview guide, three interviews were held with three participants who met the selection criteria to participate in the actual study. In the following paragraph, the process of how the pilot was conducted and the lessons learnt will be described.

The questions from the interview guide were confirmed as appropriate by the participants. The researcher observed that the participants were eager to talk and it became evident that some interviews would probably take longer than the one and a half hours anticipated. It was specifically the question on how the participants acquired blindness and the feelings about their blindness that elicited a longer response. With participants who became emotional during the interview the researcher employed her social work skills to calm the participants before offering them an opportunity for further counselling and assistance. Monette et al. (2011) also promote the importance of offering the participants an opportunity to debrief post-participation of the study.

The recordings from the pilot individual discussions were transcribed and incorporated with all other findings in the subsequent chapter. The participants did not understand how research is conducted, for example, they had perceptions that they were expected to provide correct answers. The participants were also scared to participate as they thought that their real names were going to be reflected in the study results.

From the pilot, consisting of individual interviews, it was ascertained that the questions were appropriate and some participants required clarity to ensure that they were giving “correct answers” and so it was reiterated that they should speak directly from their subjective experiences as there are no wrong answers. They were also reassured that their real names were not going to be mentioned in the study.

The lessons learnt confirmed that the pilot study did ensure that the main investigation itself will be worthwhile and can give an indication of which mistakes to avoid and which provisions to make for the actual study.

3.6.1.1. *Semi-structured individual interviews*

The individual interviews were semi-structured as Patton (1990) asserts that participants are more likely to express their viewpoints in a relatively openly designed interview situation. It also allows participants the freedom to digress and introduce their own issues during the interviews. The demographic details were initially captured. The research topic and open-ended questions were introduced which allowed for spontaneous expressions in answering questions, as well as probing by the interviewer where necessary. The interviews were conducted face-to-face in isiZulu as it was the preferred language for all the participants. Each interview was approximately one hour and thirty minutes, with ten participants who were interviewed individually and were also included in the focus group discussion. Interviews were conducted in different and conducive venues that were consensually agreed upon.

3.6.1.2. *Focus group discussion*

The second phase of data collection consisted of a focus group discussion to which all 10 participants in the individual interviews were invited and eight of them agreed to participate. The two participants were university students and they were busy preparing for their examinations during the data collection period, therefore they did not participate.

This phase was informed by the pilot session held earlier in the data collection process.

The focus group is a special qualitative research technique in which people are informally interviewed in a group discussion setting (Neuman, 2011). Babbie et al. (2007) view the focus group as a space where people get together and create meaning among them around a specific topic. They further assert:

> Focus groups bring those aspects of the topic that researchers may not have anticipated and that may not have emerged in individual interviews" (Babbie et al., 2007: 297).

The rationale for choosing focus group discussion for this study was to obtain different perspective on subjective experiences of accessing rehabilitation services (Monette et al., 2011). Also, to clarify unclear questions towards greater understanding of their experiences, to explore further levels of meanings that emanated from the individual interviews, and to observe non-verbal communication. Furthermore, the focus group assisted the researcher to gaining in-depth and comprehensive understanding of the issues and situations pertaining to rehabilitation for visually impaired people. The researcher was also able to generate and collect information on how group members perceived and experienced access to rehabilitation services. Perceptions, feelings, and attitudes were identified through the group members' interaction. Holloway and Wheeler (2002), assert that in focus group discussions, researchers interview participants with common characteristics or experience for the purpose of eliciting ideas, thoughts and perceptions about specific topics or certain issues linked to an area of interest.

There was a total of one focus group, approximately two hours long, and facilitated in isiZulu as this was the language of the participants. The focus group consisted of eight members - four females and four males. The researcher ensured participants were met in a more conducive environment so as to meet the participant's needs. As arranged in the pilot, all logistics were replicated in the session. Participants actively participated in the discussion. As noted by Monette et al. (2011) the researcher facilitated the flow of responses; developed incrementally from general to specific questions; clarified questions and adhered to the principles that govern group dynamics.

Both individual and focus group discussions were audio-recorded with the permission of the participants and notes were taken, as suggested by Monette et al. (2011) who reiterate that these audio-recordings are used for analysis that informs the conclusions and recommendations for evidence-based practice in social work. It also frees the researcher from focussing on her note-taking to concentrating on discussions and participants. The translation (from isiZulu to English) of all interviews and focus group discussion was thereafter completed. The process of translation is discussed further in the section under trustworthiness.

3.7. Data analysis

The data collection process began by listening to participants' verbal descriptions, followed by reading and re-reading the written responses and verbatim transcriptions in order to make sense of participants' input as data.

Data analysis involves organising, providing structure and eliciting meaning from the information collected. Many writers on research agree that analysis of qualitative data is an active and interactive process. Hatch (2002: 148) states that data analysis is a "systematic search for meaning". In this study, thematic analysis was used for the data analysis. (Mabuda, 2009; Polit et al., 2001; Babbie et al., 2006).

The researcher considered the following during data analysis process: scanning of data where the raw data was transcribed, arranged, and organised for analysis. This was for the purposes of scanning for incomplete, inaccurate, and inconsistent and irrelevant data in order to organise data into relevant categories. Data was organised into a manageable format or into groups in terms of descriptions, common words, phrases, themes, or patterns into information that was categorised according to smaller relevant pockets of information. Tabulation was the best format for re-presenting the data in ways that provided meaningful summaries and interpretations, and by selecting quotations, from the responses to questions posed in both individual and focus group interviews.

The researcher also followed the steps recommended by Creswell (2003) when she transcribed verbatim all the audio-recorded responses to the semi-structured interviews and focus group discussion. The researcher listened to the audiotapes, read and re-read all the transcriptions. The process was followed for the body of data, then significant statements pertaining to the participants' experiences were extracted, a list of topics was compiled and similar topics were clustered together. The most descriptive words for the topics were assigned and turned into categories. Topics that were related were grouped together. The topics that were not similar were also clustered together. Statements were thereafter organised into themes. Themes were used to provide full description of the participants' experiences.

3.8. Validity and reliability

Lincoln and Guba (1985) argue that when we look at trustworthiness of a study, we use criteria of credibility, transferability, confirmability, and dependability hence the research focused at the participants residing at uMkhanyakude District with visual impairment. The researcher motivated the study by using credibility, transferability, confirmability, and dependability that validate the findings of the study.

3.8.1. Credibility

Credibility relates to the trustworthiness of findings in qualitative research studies. It is demonstrated when participants recognise the reported research findings as their own experiences (Mabuda 2009: 20). Furthermore, credibility should relate to the degree of confidence in the findings of the research, or how believable the findings are. DeVos et al. (2005, p. 346) alluded to the fact that "believability is made easier when the researcher provides a rich, thick description regarding the setting, participants' procedures and interaction". The researcher tape recorded, transcribed, and translated all the interviews into English. The researcher was responsible for taking notes during the interviews to ensure that everything was captured effectively.

In order for the researcher to be able to gather enough data and respond to the research questions, the researcher allowed participants enough time to respond to the questions and to ask for clarity where it was required. Participants had sufficient time to elaborate on their experiences. Further, to ensure credibility, the most appropriate participants were selected using purposive sampling.

The tape-recorded data gave detailed information which was crucial for transcribing and rechecking purposes. In view of this, Terre Blanche et al. (2006) assert that credibility can be ensured by reflecting the participants' original voices. Three participants from the individual interviews and three from the focus group discussions were requested to reconfirm the translated transcripts to minimise misunderstanding. The pilot study also assisted with generating the appropriate answers to the research questions and confirmed the relevancy of the questions listed in the interview schedule to the study.

The data was collected by both semi-structured and focus group interviews to get in-depth information regarding visually impaired people's access to rehabilitation services. This was done through the interaction between the researcher and visually impaired people from uMkhanyakude District where the researcher studied their perceptions, feelings, and experiences on accessing rehabilitation services. This also ensured credibility of the study as the information was gathered directly from the affected people.

3.8.2. Dependability

According to Lincoln and Guba (1985: 316), "there can be no credibility without dependability". Dependability is a state where the study findings can be replicated if undertaken with similar participants in a similar context. It is determined by the consistency of the research process as indicated by Robinson et al. (2002). If the study is repeated with the same or similar participants within the same context, the findings should be similar (Babbie et al., 2006).

In this study, the researcher asked some of the participants to check that she had documented and interpreted their interviews dependably. Furthermore, dependability was also achieved by interviewing individuals with visual impairment from uMkhanyakude District using similar interview schedule to answer the research questions.

3.8.3. Confirmability

Confirmability refers to the data representing the information participants provided. The study did not have biases or subjectivity and the findings will represent the participant's voices (Polit et al., 2010). Terre Blanche et al., (2006) view confirmability as the degree to which the findings and conclusions of a study are true to the research objectives instead of the values and biases of the researcher. The researcher was able to confirm that the findings of the study was supported by literature from prevalent studies and also returned to the participants to discuss the conclusions made and double checked whether there were contradictory themes to those that were initially identified. Some of the participants from both the individual and focus group were requested to confirm the credibility of the description.

3.9. Ethical considerations

Ethics refers to the quality of research procedures with regard to their adherence to professional, legal, and social obligations to the research participants. It is the branch of philosophy that deals with morality and acting within agreed parameters of what is considered fair, just and/or ‘right’ or ‘wrong’ (Polit et al., 2004). Moreover, Marlow and Boone (2011) emphasise that, in evidence-based practice, it is imperative that social workers abide by the specific ethical research considerations stipulated by the governing social work council. As this research involves human participants, it was therefore necessary that the following ethical principles were adhered to.

3.9.1. Gatekeepers

The researcher started by presenting her research proposal to the higher degrees research committee of University of KwaZulu-Natal and committed to comply with the stated ethical rules.

In order for the researcher to access the participants, the researcher secured permission from the District municipality, local municipalities and tribal authorities of five clan-lead areas (izigodi) to conduct the research study in their areas of jurisdiction.

The researcher approached the disability coordinator of uMkhanyakude District who introduced the researcher to the tribal authorities where the research proposal was presented. The aim of the research, objectives and research methodology were explained to the district coordinator and the chiefs. All of them were satisfied and granted the permission for the research to be conducted.

3.9.2. Informed consent

The researcher was aware that participants had a right to know that they taking part in a research study and that they had to give their consent. All participants were required to sign a written informed consent document. The document indicated the purpose and objectives of the study. The document also stipulated that participation was on a voluntary basis and that any participant could withdraw at any time. Their consent to audio taping the focus group discussion was also included.[2]

3.9.3. Right to self-determination

The right to self-determination as based on the ethical principle of respect for a person. This means that all participants must be provided with adequate information regarding the research and they must be capable of comprehending the information. The objectives of the study were explained to the participants, and they had the power of free choice, enabling them to consent voluntarily to participate in research, decline participation or withdraw during the data collection process without any penalty. Participants who could not read or write braille and those who were illiterate were orally informed.

3.9.4. Confidentiality

Confidentiality refers to the researcher's management of private information shared by the participants, which must not be shared with others without the authorisation of the participants. The researcher ensured and guarded against unauthorised access to the data, and that the research data was only available to the researcher and the supervisor. The researcher ensured privacy in all personal matters arising from information gleaned from the participants, including expressions of feelings, beliefs, attitudes, and opinions. Both research assistants and co-participants signed a confidentiality agreement. The researcher ensured that no one was able to identify any participant in the data collection documents or research report. Pseudonyms were used throughout the study. Participants were assigned identification numbers which were utilised throughout the study and no identifying information was entered into computer files (Mabuda, 2009).

3.9.5. No harm

The principle of no harm was adopted. It was ensured that research should cause no harm to the participants either physically or psychologically (Parahoo, 2006). The researcher did not harm the participants in anyway and those who were affected by the questioning where referred to relevant departments for further assistance. The platform for ventilation and support was

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[2] See Annexures.

created by the researcher. The researcher is a practising social worker who is equipped to assess and debrief traumatised clients therefore participants who experienced trauma were assessed, debriefed, and referred to a qualified counsellor. Arrangements and agreement on the referral procedure between the researcher and counsellor were made prior to the commencement of the fieldwork. However, the researcher did not encounter any challenges throughout the whole research process.

3.9.6. Freedom to withdraw

The participants are not required to provide the researcher with notice of their withdrawal and they are not expected to give explanations for their withdrawal (Oliver, 2003). The participants have to be made aware that withdrawal from the research will not have a detrimental impact on him or her (Cebekhulu, 2016). The researcher informed the participants about their right to withdraw in the event of their not feeling comfortable continuing with the interview, without any prejudice from the researcher (Oliver, 2003; Cebekhulu, 2016). The researcher therefore tried not to impose her position as a social worker on the participants. Everything was transparent and the participants were clearly informed about their rights.

3.9.7. Researcher's bias and subjectivity

The researcher is a visually impaired person who sometimes has gone through the same painful experiences as the participants. There were times when participants shared similar experiences to the researcher's past experiences. The researcher found it helpful to share with them that she also went through those experiences and how she overcame them. However, the researcher was aware of her own subjectivity which could have been caused by her personal experiences and her impairment. The researcher tried by all means not to allow that; instead she focused more on the subject of the study and continuously engaged in self-monitoring and self-reflection.

3.10. Conclusion

This chapter described the research methodology that was employed to conduct the study. The data instruments employed were semi-structured and focus group discussion interviews. The data collected was analysed using thematic analysis. Non-probability, purposive sampling was used to select participants. The chapter concluded with a brief discussion on the ethical considerations to ensure that the participants were ethically and morally protected and the principles of confidentiality, no harm, self-determination, and human dignity prevailed through the entire data collection process.

CHAPTER FOUR

EXPERIENCES OF VISUALLY IMPAIRED PEOPLE ON ACCESSING REHABILITATION SERVICES

4.1. Introduction

This chapter focuses on the findings generated through the analysis of the data collected. The data was analysed through themes identified within the data as they relate to the research framework, literature, and objectives of the study. The chapter includes analysis and discussion of themes that emerged. The chapter is divided into two sections: the first describes the biographical and the demographic characteristics of the participants; the second section focuses on unpacking and analysing the themes that emerged from the narratives of the participants. The narratives of the participants are italicised and indented. Pseudonyms were used to protect confidentiality and anonymity of the study participants. This chapter concludes with a summary of the analysis.

4.2. Summary of participants' profiles

In this section, the profiles and additional information is presented to contribute to a deeper understanding of experiences of visually impaired people in accessing rehabilitation. In addition, an overview of individual participant profiles is presented to contextualise the participants' voices in the area of rehabilitation. This information is provided to assist the reader to gain some knowledge and understanding of the importance of rehabilitation to a person who is either born with or acquires visual impairment later in life. It is important to note that participants' real names are not used when representing their voices.

Table 4.1.

Summary of participants' profiles

Number of females with visual impairment: 4 **Number of males with visual impairment: 6**	**Profile of participants with visual impairment**	**Experiences of participants with visual impairment in accessing rehabilitation services**
Female participants: 4	The ages of participants range between 18 and 35.	All participants could not accept their visual loss.
	Three of the participants are partial sighted and one was born with visual impairment.	All participants were still searching for their self-identity.
	One participant was able to access education from special schools outside of the uMkhanyakude District.	Four participants experience neglect in accessing information on visual loss and rehabilitation services.
	Three of the participants accessed their primary education from mainstream school at uMkhanyakude district.	Four participants delayed in accessing relevant health services and support because of traditional and cultural beliefs.
	Four participants experienced challenges in accessing assistive devices for visually impaired people.	One participant is employed and three are unemployed.
	One participant who was born blind can use braille, whilst the remaining three cannot use braille as the medium of reading and writing.	Four participants never received counselling on their visual loss resulting to their experiencing loneliness, depression.
	Three participants are currently registered with adult centre whilst one is registered with tertiary institution.	Four participants experienced challenges in accessing orientation and mobility services and thus experience total dependence.

	Four participants cannot move around safely and independently.	All participants' family members never received counselling and support regarding visual impairment resulting in experiences of non-acceptance and affected visually impaired people experiencing marginalisation and isolation.
	Four participants who acquired visual impairment later in life were diagnosed with their visual impairment without either counselling nor referred to a support group.	All participants do not participate in either hospital structures or rehabilitation and disability forums thus they, as visually impaired people, experience suppression of their voices and exclusion from society.
Male participants: 6	The ages of participants range between 18 and 30.	All participants could not accept their visual loss.
	Four of the participants are partial sighted and two were born with visual impairment.	All participants were still searching for their self-identity.
	Four participants received their education from mainstream school within the uMkhanyakude district, whilst two of the participants accessed their primary education from a special school outside of the uMkhanyakude district.	Six participants experience neglect in accessing information on visual loss and rehabilitation services.
	Six participants experienced challenges in accessing assistive devices for visually impaired people.	Six participants delayed in accessing relevant health services and support because of traditional and cultural beliefs.
	Two participants who were born blind can use braille, whilst four use large print.	Two participants are employed and four are unemployed.
	Four participants are currently registered with an adult centre, whilst two are registered with a tertiary institution.	Six participants never received counselling on their visual loss resulting to their experiencing loneliness, depression.

	One participant can move around with sighted guide skills and five participants cannot move around safely and independently.	Six participants experienced challenges in accessing orientation and mobility services and thus experienced total dependence.
	Six participants who acquired visual impairment later in life were diagnosed with their visual impairment without either counselling nor referred to a support group.	All participants' family members never received counselling and support regarding visual impairment resulting in experiences of non-acceptance and affected visually impaired people experiencing marginalisation and isolation.
		All participants do not participate in either hospital structures or rehabilitation and disability forums; hence, as visually impaired people, they each experience suppression of their voices and exclusion from society.

4.3. Individual profiles of the participants

The profiles in this section illustrate the background of the participants.

Table 4.2.

Participant 1

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
1	Female	Partial sighted	Registered with UNISA	Youth	None

4.3.1. Participant 1

Participant 1 is in her mid-thirties, and learnt of her blindness only in her mid-twenties. Her understanding of what led to her impairment is linked to witchcraft and reports that her blindness occurred abruptly as a direct result of witchcraft by a neighbour. She reports that being visually impaired has posed not only physical challenges for her as she is a wife and a mother but also has affected the whole family as well. She also states that her children have become a mockery and continue to be ridiculed by other children and feels disrespected by the community which is challenging as she is a community worker.

Table 4.3.

Participant 2

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
2	Female	Blind	Grade 12	Youth	None

4.3.2. Participant 2

She is a 24-year old and unmarried mother of one child. She reported that she has been visually impaired since birth. She also reported that her visual impairment is genetic as her mother and her elder sister are both blind. She is in the process of completing Grade 12 and enthusiastic about fulfilling her dreams but discouraged as her district does not provide rehabilitation services for people with visual impairment. The lack of rehabilitation services contributes to her dependency on those who are sighted, a situation she is dissatisfied with.

Table 4.4.

Participant 3

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
3	Female	Partial sighted	Grade 11	Youth	None

4.3.3. Participant 3

The participant is a 21-year old woman who acquired her visual impairment in 2011 while she was chopping wood. It commenced initially with one eye and the second one was thereafter also affected. Visual impairment was devastating to her as she was a Grade 11 learner. She reported that her world changed completely since 2011. The treatment she experienced at school was ghastly and horrifying, where she spent most of her days in tears. Much changed after being referred to the School for the Blind by the ophthalmologist from the hospital she attended. During the time of the interview, she was completing Grade 12 and aspiring to study journalism. Her mother, a single parent with three children, is the only person employed in their home. She hopes to contribute financially to their household income in the future. Her dream was to see uMkhanyakude District being able to understand issues of blindness.

Table 4.5.

Participant 4

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
4	Female	Partial sighted	Grade 12	Youth	None

4.3.4. Participant 4

The participant is 20 years old, completed her Grade 12 and continued with her tertiary studies. She reported that she acquired visual impairment at the age of 15 after experiencing a terrible headache. As the youngest in her family, life became difficult as she was often confined indoors. She saw her home as a prison as she was staying indoors for the whole day. Her mother was able to find an organisation in another district which assisted her. This brought immediate relief for her.

Table 4.6.

Participant 5

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
5	Male	Partial sighted	Grade 12	Youth	None

4.3.5. Participant 5

The participant reported that he completed Grade 12 with the aim of graduating from a university, and subsequently finding employment. He is a partially sighted person and acquired blindness in 2014 while he was in Grade 10. He lives with his parents and his two sisters and is the only person with a disability in his family. He wants to access rehabilitation services to regain a sense of independence as it currently frustrates him to depend on other people at all times.

Table 4.7.

Participant 6

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
6	Male	Bind	Grade 9	Youth	None

4.3.6. Participant 6

This participant reported that he has been blind since 2012 while in Grade 9. Another learner stabbed him in his left eye and the right eye was also affected. He resides with his mother and two sisters. Visual impairment was hugely devastating for him and his family and he could not accept that his sight was gone forever. He felt as if every part of him had fallen apart. The participant had to discontinue his schooling as he was in a school for sighted learners and could not cope with the attitude of his peers and his educators.

Table 4.8.

Participant 7

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
7	Male	Blind	University degree	Youth	None

4.3.7. Participant 7

This participant is a 28-year old. He holds a degree in Social Science. He acquired visual impairment when he was five years old as a result of dreadful headaches. He completed both primary and secondary education at a school for visually impaired learners. During his primary education, he tried to read like sighted people but it was difficult for him and was thereafter introduced to braille alphabets. This improved his life substantially and he was able to write and read his own notes independently. The participant experienced several barriers while completing his studies but he succeeded in completing his degree. It was difficult for him to access the required rehabilitation services for visually impaired people such as basic living skills.

Table 4.9.

Participant 8

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
8	Male	Partial sighted	Grade 11	Youth	None

4.3.8. Participant 8

He is 32 years old and acquired visual impairment in Grade 11. His visual impairment was as a result of a gun shot by a friend during a fight at school. It was difficult to accept visual impairment as he was 16 years old at that time. He thought that it was the end of this world. He spent most of his time crying for the whole day when the doctors told him that they did everything to restore his sight but everything failed. Upon his discharge from the hospital he returned home where he stayed for two years. He received assistance to access a school for visually impaired people, from other visually impaired individuals.

Table 4.10.

Participant 9

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
9	Male	Partial sighted	University degree	Youth	None

4.3.9. Participant 9

The participant is 32 years old and is partially sighted. His visual impairment was due to meningitis. He reported that he was in Grade 10 when he became sick with a headache. He was writing his test at school when the exercise book just turned white. It was another moment for him as everything was white. The teacher who was responsible for his test shouted at him as he thought he was becoming naughty. He reported that the visual impairment was difficult to navigate, especially since his parents believed that his visual impairment was as a result of witchcraft. He was taken to the traditional healers but with little results, eventually his parents took him to the hospital where the diagnosis was made.

Table 4.11.

Participant 10

No. of Participant	Male / Female	Type of impairment	Educational qualification	Youth / Adult	Accessing rehabilitation
10	Male	Partial sighted	Grade 9	Youth	None

4.3.10. Participant 10

This participant is also from the uMkhanyakude District. He became visually impaired in 2014 while completing Grade 9. The participant recalled that he was watching a world soccer tournament on television when his sight disappeared. His life was very difficult as he could not cope with visual impairment. He also reported that to access rehabilitation services was a challenged for him. He did not receive counselling and he spent most of his time in tears. He reported that it would be much better to have a school for the visually impaired people in his district.

4.4. Themes from the findings

The following table shows the themes that emanated from analysing the data from the transcriptions of both the individual interviews and focus group discussions. Various sub-themes also emerged, aligned to each of the main themes, as listed in the subsection.

Table 4.12.

Themes

Objective	Theme	Sub-themes
To explore feelings and reactions of visually impaired people in relation to these experiences.	1. Distress associated with the loss of sight.	1.1. Shock and confusion. 1.2. Emotional turmoil. 1.3. Coping with reactions from families and community. 1.4. Sense of losing identity.
To explore the experiences of people with visual impairments when trying to access rehabilitation services (including the provision of assistive devices).	2. Factors that contribute to poor rehabilitation of people with visual impairment.	2.1. Cultural beliefs as a hindrance to seeking healthcare timeously. 2.2. Lack of access to information. 2.3. Negative societal attitudes. 2.4. Lack of access to assistive devices.
To explore how people with visual impairments articulate their own rehabilitation needs.	3. The rehabilitation needs of people with visual impairment.	3.1. Access to hospital and comprehensive rehabilitation team intervention. 3.2. Access to counselling services. 3.3. Support from non-governmental and blind people's organisations for the visually impaired. 3.4. Access to orientation and mobility training. 3.5. Access to interventions to assist with activities of daily living.
To examine visually impaired people's involvement in the overall development, implementation, monitoring and evaluation of rehabilitation services.	4. Self-representation of people with visual impairment.	4.1. Sense of powerlessness. 4.2. Lack of participation.

4.4.1. Distress associated with the loss of sight

From the narratives, the participants experienced difficulties in coping with visual impairment and loss. The limited knowledge on how to confront and manage visual loss or impairment at the onset resulted into long-term negative implications. The initial experiences were characterised by the denial of visual loss which also delayed seeking medical intervention in accessing rehabilitation services. Denial was also noted by the study conducted by Subrayen (2017) on hearing loss. Acquiring visual impairment results in confronting challenges of personal development which includes community life, employment, and education (Shahnasarian, 2001). Evidently, from the narratives, there was lack of self-actualisation which led to poor self-image and a negative self-concept. This influenced their feelings of inadequate fulfilment and under achievement. This theme therefore captures the experiences of the participants shortly after the onset of the visual impairment. Three sub-themes are discussed: Loss and confusion, emotional turmoil, and a sense of losing personal identity.

The findings indicated that sight loss has a devastating effect on the self and the family. Furthermore, lack of access to rehabilitation services aggravates the impact further if there is no access to rehabilitation services. In addition, the stigma most participants experienced from their communities, families as well as their significant others was paralysing.

4.4.1.1. *Shock and confusion*

Visual impairment can be the full blow to the personality and is not necessarily easily overcome. It is not only the loss of sight as perceptual inhibition but the psychological feelings of loss that impact on the ability to deal with life (Harsh, 1998). Further, visual impairment is one element amongst others that can lead to inner conflict and self-doubt. A sense of confusion, shock, and loss was a dominant subtheme among the participants. For most participants, acquiring visual impairment was confusing which resulted in disbelief and sometimes self-doubt.

> *I kept on scratching my eyes hoping that I could be able to remove the itching which was inside my eyes. They were very itchy. The more I kept on scratching them, then my sight deteriorated (P1).*

> *I couldn't believe it as it started with one eye. I used to sit alone trying to pour water inside my eye with the hope of washing it and hoping that my sight would come back but everything got whiter and whiter. It was difficult to share what*

> *I experienced with my mother at that time because it was something that was unbelievable to me (P6).*

> *I was sitting on the sofa watching television when everything started. I tried to stand up and went to my bedroom because I couldn't believe the drama of that day. I sat on my bed and started to scratch my eyes trying to remove something that I didn't know (P7).*

The individual interview narratives reflect that individuals react differently to trauma. An experience such as the loss of vision is one of the traumatic experiences that could bring a wide spectrum of negative experiences and stress. For most participants, the participants and those around them were not socially and psychologically ready to cope with the conditions of acquiring visual impairment. It is also noted that the onset of visual impairment was accompanied by a complex series of shocks to the participants and to everyone around them. The experiences shared by the participants reflect that people, even with the same visual condition, may be affected differently, and an individual's vision may fluctuate from morning to evening, and from day today (Morrow, 2015).

The disbelief and sense of loss was reflected during the focus group discussion.

> *When you first experience visual impairment, it is like there is something on your eyes and you try to scratch your eyes with the hope of removing it. Sometimes you feel like washing them with the soap (Focus group discussion).*

For participants whose visual loss was sudden, the experience was even more confusing and traumatic.

> *It is really confusing – you sleep being full sighted and you wake up the following day being blind and you see everything becomes white (P3).*

> *You keep on touching yourself trying to find out if is it still you or someone else (P8).*

The person with visual impairment who considers himself stigmatised due to his disability condition may be more vulnerable to anxiety than a non-disabled person. High levels of anxiety may reduce his ability to cope realistically with his environment and he may tend to react impulsively, compulsively, and rigidly (Mitra 2005). In support of this view, Van Meygaarden et al. (2005) sees visual impairment as not only a blow to the eyes only but also a blow to one's self-image and one's very being. This participant affirms that, beyond the felt confusion, articulating, and clarifying the feelings and sharing the experience was equally challenging.

> *I became very confused because I found it hard to speak about it. I had no one to talk to (P6).*
>
> *It is not easy to share this with your family as it is something that you also don't believe (P9).*

The above participants' responses reflect that acquiring visual impairment may lead the affected individual to develop anger, defensiveness and helplessness which may restrict his activity and maintain his low level of aspiration. Visual impairment is usually the result of some trauma or disease; however, its impact may take many forms. The first effects are often physical pain, limitation of mobility, disorientation, confusion, uncertainty and a disruption of roles and patterns of social interaction (Kurawa, 2010).

4.4.1.2. *Emotional turmoil*

Emotionally, vision loss is like other major life changes such that people acquiring vision loss may experience guilt, fear, anxiety, rationalisation, and isolation (Morrow, 2015). Lamoureux and Pasudovs assert that common features of all the depressive disorders are the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function (2011: 195). In view of this, the loss of vision evokes strong emotional reactions in the affected individual. It also affects others in his or her environment, such as parents, spouses, partners, children, or grandparents (Morrow, 2015). Participants from the focus group discussion regarded losing sight as very difficult, trying, and challenging times. For some, visual impairment involves a grief process with feelings of sadness and anger being dominant. Sadness can be viewed as feelings of emptiness, despair, yearnings, or deep loneliness (Cebekhulu, 2015). A sense of helplessness and hopelessness was evident among the participants as they were engulfed in intense emotions of sadness and helplessness.

> *When the doctor told me that there was nothing that could be done regarding my sight, I cried and tried to commit suicide several times (P10).*
>
> *I couldn't even be able to separate between day and night. Everything was quiet (P7).*
>
> *The day that I will never forget is when the doctor told me and my family member that there was nothing to be done to assist me with my sight. I asked him what next to be done and he told me that he didn't have any idea. I cried bitterly not knowing what to do. My family member also cried (P6).*

The Royal National Institute for the Blind (2009) also points out that if the information on available support and rehabilitation services is not properly handled, visually impaired people may experience shock and become more vulnerable and may end up taking inappropriate decisions, such as committing suicide (RNIB, 2009).

This was also confirmed by one participant from the individual interviews when expressing:

> *During the diagnosis of my visual impairment, I preferred to be dead than to live in a strange world which I couldn't understand and the only way to do that was to commit suicide (P3).*

Sometimes feelings of frustrations were aggravated by how participants were introduced to the world of visual impairment.

> *What irritated me was the way that one of the staff members treated me in the clinic. The staff member just put hands on my head and started to pray. This was very frustrating because I wanted the solution of where to go and what to do about my visual impairment (P4).*

In support of the above, the research conducted by the Thomas Pocklington Trust in UK, interviewees reported leaving eye clinics with limited information and understanding of their condition and the support available for them (Douglas et al., 2005).

Participants from the focus group also noted that vision loss commenced with denial or disbelief and thus results to feelings of sadness.

> *Visual impairment is devastating. It is very difficult to accept when you are told that your sight won't be perfect anymore (Focus group discussion).*

In the study conducted by the Royal National institute for the blind (RNIB) in UK similar mental health issues were noted by the participants as they reflected lack of emotional support during acquiring of visual impairment (RNIB, 2009). In view of this, one might realise that, when visual impairment is acquired, affected people appear to pine for the loss of vision as they cannot perform some of the tasks they used to perform before they become visual impairment. Failure to perform these tasks manifests into anxiety and tearfulness (Douglas et al., 2005). This may result in ongoing depression if not well attended by designated professionals such as social workers, psychologists, and other relevant rehabilitation professionals.

4.4.1.3. *Coping with reactions from families and community*

Many consider family as a concept made up or occurring in many different ways: married couples, single parents, step-parents, blended, adopted parents/children, heterosexual or homosexual families etc. An individual's physical, emotional, and psychological development occurs within the family environment. Thus, the family remains the primary unit for providing physical, emotional, and social support of the visually impaired person (Bambara, 2010). The family is also a social institution where individuals should embrace unconditional love, gain empathy, learn respect and self-regulation (White Paper on the Rights of Persons with Disabilities, 2015). These qualities enable individuals to engage positively at work, school, and in society in general. In view of this, the family serves as a major source of interpersonal influences which affect what visual impairment means to the visually impaired person, what a person with visual impairment does with it, and the eventual outcome of plans made jointly with the visually impaired person.

Individual and focus group interviews reflected that when visual impairment occurs in the family, division, conflict, and blame is experienced.

> *It is difficult because you find that your family members start to blame each other about who is the cause of your visual impairment (P 2).*

> *There is lots of debates within the family. They don't know how to treat you and sometimes you come to a state where you feel that you are a real burden (P3).*

Van Mergaarden et al (2005: 74) also alludes to the above when stating that "when visual impairment occurs the entire family begins an adaptive struggle to regain equilibrium". Initial diagnosis of visual impairment may cause stress to the family and thus the visual impairment of one may change the lifestyles of family members and this results to family members experiencing several phases of adjustment including shock, denial, mourning, withdrawal, succumbing, depression, coping and self-acceptance (Bambara, 2010). At times, families would blame each other and at other times, even God would be blamed for the trauma.

The diverse reactions which reflected the trauma and stress they had experienced was difficult for the researcher and participants to observe as they shared these during the focus group discussion.

> *It is not an easy thing as you as an affected member of the family and you expect them to comfort you but only to find that they also cry as if someone has died (Focus group discussion).*

A number of focus group participants also viewed visual impairment is as a result of punishment or almighty intervention.

> *You know if you are visually impaired, people always assume that something wrong has been done by your family. You would hear them praying saying that if there is something wrong that this family has done God must forgive the family (Focus group discussion).*

Some of the responses from family members illustrated some lack of knowledge about appropriate ways of responding to someone's experience with visual impairment and these were oppressive to the participants. For example, some of the family members kept the participants indoors and they did not want them to be seen by the community members, especially during the first weeks of the incident, whilst some were excluded from attending family functions thus further contributing to social isolation:

> *My relatives were telling my family that they must not take me to family occasions till the solution to my visual impairment was discovered. The only time when I was taken out was when visiting the hospital or the traditional healer (P5).*

One of the responses to the individual interviews reflected:

> *My experience is that when there are functions in my family I am now excluded from the discussions. Before I became visually impaired, I was consulted as other children but life is not like before, it has completely changed (P7).*

Similarly, in a study undertaken at the University of KwaZulu-Natal by Subrayen (2011), participants on this study also expressed a sense of exclusion and humiliation by their family members. Whilst families may have restricted the movement of participants as a form of protection, considering that they were not trained on how best to support them to lead their lives independently, it led to isolation. Being prevented from being involved in daily chores and tasks was paralysing, as the participants reflected:

> *Sometimes we didn't go out because our family members didn't know how to guide us and they had a fear of hurting us (Focus group discussion).*
>
> *You are like a dead person. You are not allowed to touch a stove or wash dishes as they are scared that you might hurt yourself. Sometimes they even bath you (P4).*

This is a clear indication that people fail to understand that visual impairment and illness are not the same thing and should not be conflated (Barnes, 1992). In addition to the isolation, the monotony of their confined daily activities is a huge challenge which excludes the visually impaired from actively participating in social life, and it becomes oppressive.

> *Life becomes very difficult because you sleep for the whole day and the only time that you wake up is when it is time to bath and time to eat when food is ready (P 6).*

These responses concur with other studies showing that overprotection by parents, despite the intention of caring, becomes restricting and oppressive to those with visual impairment. Little knowledge on how and when family members could help them leaves individuals struggling for independence (Royal Institute for the Blind, 2009). Creating dependency removes the ability to make individual decisions and affects exercising the right of choice. Furthermore, visually impaired people who strive to seek employment, education, and to start and maintain families can be negatively affected by overprotective friends, family, and relatives. In view of that, concerns over safety result in family members placing limits on the activities which can cause conflicts and affect their relationships (Thomas Pocklington Trust, 2008).

The findings here reflect that families found it difficult to accept and cope with these experiences which cause confusion and frustration to both the affected participants and their families.

> *Our families do not allow us to be independent. We are always treated as children. It is difficult to go out and look for work or to find a tertiary institution (P8).*

The participants felt that a disability grant is the only thing that makes them visible to their families. They are only regarded as significant on the disability grant day. This is reflected by the following quotations from the individual interviews:

> *My disability grant is what represents me in the family. What I am trying to say my disability grant is more important than me (P6).*
>
> *I don't have any decision on what is going to happen with my disability grant. I am only told that it is going to pay school fees for my brothers and sisters (P5).*
>
> *My disability grant is a curse because it creates bad relationship between me and my family. I cannot enjoy it. It is used to buy groceries and to buy clothes for my siblings (P4).*

Another participant from the individual interviews also stated that:

> *It is difficult to be a woman with visual impairment because both society and family members think that we need to be locked inside the house. When you fall pregnant, you will be ridiculed and be told that you are a burden and you also bring another burden (P1).*

Participants felt that visual impairment results in exclusion from the decision making for their lives. They mentioned that decisions of what would happen to them were taken by their parents and professionals in their absence. Focus group participants lamented:

> *It is better to be a child because parents do sometimes tell their children of what is going to happen to them. If you can't see you are like a parcel. They take you and put you wherever they think is fine for them (Focus group discussion).*

Some members of the focus group discussion added that when one is the eldest son in the family, he is not given a chance of burning incense and talking to the ancestors on behalf of the family.

The treatment received by visually impaired participants may be regarded as marginalising as their voices, contributions, and even their very existence, are ignored and suppressed (Subreyen, 2011). The state of confusion experienced by families potentially has other ramifications such as their need to call for support from non-governmental organisations (RNIB, 2009). In the district where the study was conducted, the unavailability of disabled people's organisations and non-governmental organisations contributed to this social gap in families and community. Families or significant others are unaware of their right to demand services and how best to exercise their rights to access services on behalf of family members with visual impairment. In addition, all participants reflected that their families had not been offered support to help them understand how to manage a family member with visual impairment.

4.4.1.4. *Sense of losing identity*

Identity is described as the empirically verifiable aspect of the self-concept that arises through social interaction (Darling, 2013). In the case of individuals who acquired visual impairment later in life, a dominant aspect of their new sense of identity is that of shame, emerging as a result of interactions with their family members and society who sometimes stigmatise visually impaired people who internalise the stigma (Seesurun, 2015).

The words uttered to visually impaired people and the actions towards them by the dominant group of sighted people impacts negatively the self-identity of visually impaired people. This contributes to the loss of self-identity and self-esteem. Moreover, the loss of self-identity can thus lead to an internalisation of the dominant group's stereotyped and 'inferior-causing' images of subordinate populations (Mullally, 2010: 84). Therefore, an identity shift was a shared narrative among the participants. This change of identity is not the experience that is unique to people who have visual impairment. In fact, Bowman et al. (2011: 55) argues that identify change and development is a life-long process that is affected by experiences among the disabled people. The outcome of this process has been described as producing a self with two complementary aspects; the internal messages about one's experience and the messages one gets about how others experience him/her.

> *You sometimes get people who tell you directly that you are no longer a complete person. Sometimes when parents count their children you are the last person to be counted and sometimes you are not remembered at all. You find that people always feel pity for you for being visually impaired (Focus group discussion).*

A participant in the individual interviews elaborated on this:

> *People who contribute a lot to our loss of self-esteem are sighted people. You know they always remind you that you cannot see. We don't remind them about their shortcomings. Why are we constantly reminded? (P1).*

One may notice that whenever a major change or loss in life is experienced, self-esteem is temporarily diminished (Morrow, 2015). When actions and messages are internalised by the affected individuals, loss of hope and self-image are experienced but looking for services which might empower them as individuals with visual impairment does not happen. In focus group discussions, participants felt that, when visual impairment is acquired, the self of the visual impaired person disappeared due to the low status given to them by sighted people.

> *When acquiring visual impairment, you are no longer yourself. You are being disregarded by everyone. This happens at home, within your family and in the community (Focus group discussion).*

One of the participants in the individual interviews noted that:

> *Being visually impaired leads to hopelessness as no one respects you like a complete human being. People don't seem to have trust to someone who is visually impaired (P2).*

These findings are consistent with research undertaken by Subrayen (2011), showing that society defines what is abnormal and normal, and disability is given 'abnormal' status. The researcher concurs with Subrayen (2011) as she views the state not as 'abnormal' but as the loss of self-identity for visually impaired people. In support of this, participants felt that visual impairment is the worst disability amongst other types of disabilities. They regarded the sense of sight as the most important sense in a human being's body. They believed that once you lose the sense of sight you lose everything including yourself:

> *I am no longer myself. I was not like this. I am another person who is completely different from the old one who was the sighted one (P3).*
>
> *When I was full sighted, I used to play soccer and watch television but now everything has changed. I am talking about the real me not the dead one (P 8).*
>
> *When I look at me or touch myself, I am a new person who needs to be redefined (P9).*

The focus group discussion reached consensus on the issue of feeling inferior:

> *Having visual impairment makes one to be inferior. You are scared even to raise your opinion because of the treatment that you receive from sighted people. It is even worse if the situation is still new. It is like you go back to early childhood stages (Focus group discussion).*

Participants revealed that none of their relatives showed interest in their education when they lost their sight. They reported that always being reminded of their visual impairment is "their daily bread" and this leads to their feeling useless. This was reflected by the responses, for example:

> *When mentioning the issue of going back to school, you are always being questioned about how because you can't see. This is very painful and it makes you to feel useless (Focus group discussion).*

Adapting to the society of the dominant group was reported as key to participants' survival:

> *The difficulty is that visual impairment makes you to revisit your decisions. You don't pursue the career that you always dreamed about when you were sighted. You have to change and maybe follow your second choice or sometimes take what is available (P5).*

Mullally supports the participants' concerns when stating that "the group identity of the subordinate group is defined or socially constructed by the dominant groups and subordinate group members have no say in this definition or construction (Mullally, 2010: 74). The notion is thus that the person with visual impairment should adapt to society, not that society should make allowances for the visually impaired person. This raises feelings of frustration, anger, restriction, and a fear of being perceived as incompetent.

4.4.2. Factors that contribute to poor rehabilitation of people with visual impairment

Seeking help after the onset of visual impairment is key in helping the affected individual and his/her family understand how to manage this new condition. However, it is important to ensure that the process of supporting the affected individual does not overlook the self-development of the individual. Cultural beliefs and beliefs in witchcraft influence help-seeking behaviour and the type of support families seek. In fact, Maart (2007) points out that attitudes, practices, and ideologies of society affect decisions people make in relation to their health.

4.4.2.1. *Cultural beliefs as a hindrance to seeking healthcare services timeously*

The way people treat persons with visual impairment relates to the culture of the society. The culture of the society therefore has an impact on the attitude of that society towards persons with visual impairment which affects their way of treatment and behaviour (Zilalem 2002). Carol et al. (cited in Wegner & Rhoda 2015) view culture as something which plays a central role in health-related behaviours. In this study, participants reported that cultural groups have different views and perceptions about the causes of different types of disabilities. People's perceptions about disability and its etiology influence how and where people seek services to help them understand and manage visual impairment. Whilst the existing literature links culture to how health is perceived, in this study cultural beliefs did seem to affect how and where health was accessed, when seeking health from hospitals and clinics was delayed:

> *My family believed that my visual impairment was as a result of the ancestral anger. They went to the traditional healer who told them that the ancestors were very angry and something like slaughtering a hen was required. My parents bought it and slaughtered it. The problem was worse as I just became totally blind instead of partially sighted. My father and my mother went back to the same traditional healer and he told them that the hen was too small and the goat was required. They slaughter the goat and there was no difference. After consulting different traditional healers with no success, I was then taken to the hospital and that was where the proper diagnosis and referral were done (P6).*

> *My extended family believed that my visual impairment was as the result of the traditional wedding which was not done by my parents. They thought that my father didn't pay everything for my mother before they got married and the ancestors were angry about that. My parents tried to rectify everything that was not done well but it couldn't help (P8).*

Ngubane (cited in Masasa, 2002) concurs with the participants when she indicates that disability is believed to be served by the ancestors to descendants who fail to perform traditional rituals. This cultural belief can also be found in the Sotho culture where the in-laws of the young married woman slaughter a sheep if the woman is pregnant with her first baby. The pregnant woman has to wear the skin of that sheep throughout the pregnancy. If the woman delivers a disabled child, they believe that those rituals were not followed properly and thus resulted in the anger of the ancestors which led to the birth of the disabled child (Masasa, 2002).

> *What is irritating is that during the process of making things right with the ancestors you as a visually impaired person are made to believe that your sight will be restored and only to find that you remain the same. I was made to believe that if my father burnt the saints and talk to our ancestors my sight was going to come back (P4).*

> *It is very painful because during the process you are expected to sleep without bathing or something washing your eyes with the blood of the slaughtered animal with the hope that sight will be restored (P3).*

Regan et al. (2003: 434), note that, "Differences in meaning or emphasis across cultures can result in a shared misunderstanding of signals, preferences and perceptions". Some societies, communities or families may believe that if a pregnant woman has seen and laughed at a disabled person the ancestors will curse her by giving her a disabled child. This is confirmed by some members of the focus group discussion who pointed out:

> *Sometimes you or your parents are blamed that your visual impairment is as a result of laughing at someone who had a disability (Focus group discussion).*

In support of this, Barnes (2001: 2) views 'culture' as "generally used to refer to an overarching set of values and norms associated with a particular group, community, nation or society". It should be noted that these shared values and norms are dynamic, changing as a result of experiences of life and interaction with others. For example, Sullivan et al. (2000) note that typically, individuals from a common ethnic group share cultural practices and pass them from one generation to another. Beliefs are rooted within culture and also differ from society to society and are passed from generation to generation within a culture. These beliefs can create delays in health-seeking behaviours. Consequently, most of the participants recommended that culture and belief systems should not interfere with the process of rehabilitation services as such factors may cause the experience or sense of marginalisation and disempowerment in visually impaired people.

Among the various ethnic groups of Southern Africa there are some cultures that believe that disability is caused by witchcraft or is sent by the ancestors if one has failed to follow the traditional rituals (Masasa, 2002). Beliefs in witchcraft were cited as a barrier to accessing rehabilitation services and this was reflected in the focus group and individual interviews. The disability survey conducted by the Department of Health in 2002 reflects that 3% of the population mentioned witchcraft as the cause of disability (DoH., 2002). Despite being a barrier, a number of the participants appeared to belief that their visual impairment resulted from witchcraft**.**

> *If my exercise book wasn't borrowed by my friend, I wouldn't have lost my sight. My parents wasted lots of time and money trying to find traditional healers who could help with my visual impairment and accessing services like attending eye*

> *hospital or clinic, accessing schools for visually impaired people were not easy as my family believed that this was an evil spirit (P5).*

Gilbert et al (2001: 4) concur with the above in that visual impairment at times is attributed to evil spirits and not treatable by physical human beings. One of the participants shared that to access rehabilitation services was not easy as her family believed that the visual impairment was as a result of witchcraft. They even pointed out the neighbours whom they thought were the cause of her visual impairment:

> *What is painful is that even today my family doesn't get along with that family (P3).*

Another participant also alluded to the fact that the issue of witchcraft is painful for both the affected individual, community, and the family:

> *You know this witchcraft issue causes boundaries between the immediate family, extended family and the community members. The problem is that once the sangoma mentions that the person who has done that is within the family member and describes the physical characteristics of that person, the affected family members start to identify the person. This was what happened to me. The sangoma told us that the person who bewitched me was around my area and that person was light in complexion, not tall and fat. How many people are like that in my family but my family members pointed out a person and they were confident (P4).*

One of the participants, echoing similar sentiments stated the following:

> *It is difficult when the diagnosis is not yet confirmed because belief in witchcraft plays a major role and this delays the process of rehabilitation services (P2).*

Focus group discussion participants also viewed witchcraft as a barrier in accessing rehabilitation services since the affected individual has to go through the healing process of taking the prescribed medication from the traditional healer.

> *You have to wait for both your family and the traditional healer to complete the healing process (Focus group discussion).*

The participants further reflected that this process might take a long time depending on the instruction of both the family and the traditional healer, meanwhile they use the medicinal herbs from the traditional healers which they cannot combine with the western medicine.

> *It is a long process which prevents us from accessing a useful service. You don't have power to convince your family because they don't regard you as someone who can come with a tangible opinion (P1).*

Individual and focus group discussions indicate that disability has been seen as a result of witchcraft, devil, evil spirits, and supernatural powers (Higgins, 1992). Culture, witchcraft, and other factors were reflected as barriers which hindered access to rehabilitation services by the participants. Whilst culture was viewed as a way of life and an important part of their identity, some objected to its being used as a hindrance from accessing essential health services. Different people hold different views about visual impairment as some may believe that it is due to supernatural powers and witchcraft, or that it is produced by the saints or ancestors while others may believe that it is a gift or curse from God. They also believe that if disability occurs, they are singled out by God for the role because of their past kindness to a relative or a neighbour who was disabled (Groce et al., 1993).

Even when looking at visually impaired people's experiences within the context of Christianity there are misconceptions around disability, broadly shared, internalised, and accepted, promoting exclusive attitudes. It is through these misconceptions that one finds most of visually impaired people being excluded from access to rehabilitation services as people would consider them sinners or incomplete and deny them the opportunity of participating from essential services.

4.4.2.2. *Access to information*

The provision of educational information that could assist the persons with visual impairment with knowledge such as training in daily activities, orientation, and mobility, as well as support groups should be the focus of government initiatives. Participants reflected that the lack of information on rehabilitation services for visually impaired people is a major barrier which prevents them from accessing rehabilitation services. According to the participants, information has to be available in various formats such as braille, audio, electronic and large print. The participants stressed that what needs to be considered is the fact that visually impaired people are not homogeneous therefore different people prefer to access information in the way that is suitable to their needs. Some participants mentioned the following:

> *It is very difficult to grasp the concept of visual impairment at an early stage you need to be given information about what does it mean to be visually impaired (P10).*
>
> *One might not understand the difficulty that one goes through when one is being diagnosed with visual impairment and no information is given to you. I think that to be linked up with the organisation which might help you can be a relief (P7).*
>
> *I used to hear people saying that information is power and I only started to realise it when I needed it and couldn't find it. I just wanted to find a school for visually impaired people but to have that information took two years (P6).*

All the participants felt that at least the information has to be available in all government departments as their districts do not have non-governmental organisations for visually impaired people. The lack of resources for visually impaired people was shared in both the focus group and individual interviews. Participants from the focus group also shared the feeling that their district doesn't have resources for visually impaired people. They have to find information from other districts which is very difficult for them as they come from the very poor background.

> *Our district doesn't have information on visual impairment especially when it comes to rehabilitation services. We are being referred to other districts (Focus group discussion).*

Visually impaired people are not disabled by the functional limitations of their impairments but by the external barriers that prevent their full participation in the societies in which they live (Oliver et al., 2010). These barriers create more dependence for people with visual impairment as they are unable to move freely and access information as they wish. This results in their being viewed as sick which aligns with the medical approach. It is through this societal perception that visually impaired people end up feeling unheard and inferior.

4.4.2.3. *Societal attitudes*

Participants view distorted and negative attitudes towards visually impaired people as the main barrier which prevents them from accessing rehabilitation services. These can be manifested in various ways through the treatment by members of the society or professionals from the public sector such as clinics. The majority of the participants noted that people tended to have assumptions about visually impaired people being incapable of functioning independently and such assumptions and judgments can be discouraging.

> *I am a very active person I like to do things on my own but when I lost my sight it was very difficult as most of the people including government officials viewed me as not capable of doing anything. Whenever I tried to touch something like trying to find things like enquiring about furthering my studies, I was told that a visually impaired person cannot read or write. Sometimes you are questioned about how are you going to study as you cannot see? (P1).*

> *I would have been able to get my social work degree if my relatives didn't discourage me telling me that a visually impaired person won't be a social worker (P3).*

> *I had an experience which I don't think that I will ever forget. I went to the hospital to request the doctor to fill in the form which was required by the university. The nurse took me to the chair which was in front of the doctor and the doctor instructed the nurse to bring my sister and let her to sit on that chair. The doctor let me to sit on a chair which was far from her. Whenever she needed to know something, she would ask my sister not me and my sister didn't have answers. I was very traumatised as I thought that the doctor thought that I was going to infect her with my visual impairment (P8).*

> *I went to the hospital as my child was not well. The doctor looked at my child and prescribed the medicine for my child. I went to the other department where I found a nurse who was instructed to explain everything to me. Unfortunately, one of the containers with the treatment fell down. I started to look for it but I couldn't find it. When I requested the nurse to help me, she shouted at me telling*

> *me that I was able to see the man but I can't find the container. I asked if my husband is equal to the container and she shouted at me and told me that I was rude. She didn't help me till I was assisted by another patient (P1).*

This reflects non-verbal and verbal cues from professionals which reflect negative stereotypes. In support of what is reflected by the participants, several writers point out some health professionals may hold negative, stereotyped attitudes due to their exposure to disabled persons requiring treatment, rather than seeing them as healthy individuals leading independent lives within the community. It should be noted that attitudes of health professionals towards disabled persons reflect those of the broader society that is, predominantly negative and stereotyping (Watermeyer, 2006; Rackley, 2015).

A number of participants in the focus group also noted that:

> *You know at the government institutions nobody has time for disabled people. They ridicule you and tell you that there is nothing that you can do and it is the barrier to rehabilitation services (Focus group discussion).*

Looking at the participants' views, one may acknowledge that a person's sense of identity is dependent on the manner it is perceived by others. Most of the participants from the focus group discussion alluded to the fact that in society visually impaired people are seen as incomplete people. They mentioned that when people greet them, they speak to their relatives instead of greeting them directly. They also felt that their confidentiality rights are being infringed by the health practitioners as their illnesses are always discussed with their relatives.

> *Visually impaired people do not have the right to privacy (Focus group discussion).*

Participants from the individual interviews shared more experiences:

> *People do not understand visual impairment; they just talk about you as if you don't exist. If I go with my sister people would ask questions like who buys clothes for her? Who helps her with dressing up? It is like they are talking about a one-month child (P4).*

> *In my area the huge challenge that we have as visually impaired people is that when we try to be independent by using public transport, the drivers would want the cell phone numbers of our family members as they think that we won't be able to give them directions. When you give them one of your family member's cell phone number, the driver would then demand extra payment because he has done a favour for you by taking you in his mode of transport (P3).*

Societal attitudes seem to be one of the main barriers to the development of visually impaired people (Seesurun, 2015). Society does not consider that impairment is part of being human. However, disabled people do need feedback about everything that affects them. Feedback allows for the control and organisation of actions and behaviour, and provides checks on how visually impaired people adapt and live, based on constant feedback from the community, family, and friends. Raising rehabilitation awareness in rural societies could address some of the challenges that prevent visually impaired people from accessing rehabilitation services. It also allows for exploration of the effects of impairment as obstacles and this is done through interactions between visually impaired people and the society (Murugami, 2002).

4.4.2.4. *Lack of access to assistive devices*

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) dictates for the provision of quality health services including provision of assistive devices to persons with disabilities. Furthermore, the National Department of Health (NDOH, 2003) developed guidelines on standardisation of provision of assistive devices.

Considering the above, KwaZulu-Natal Department of Health has also developed provincial standardised guidelines for provision of assistive devices and for direction to specialists, disabled people and their families and all stakeholders involved in provision of assistive devices to persons with disabilities. An assistive device is defined as any item, piece of equipment or product, whether acquired commercially, modified, or customised, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities (Provincial Standardised Guidelines on provision of Assistive Devices in KwaZulu-Natal, 2013). Examples of assistive devices for visually impaired people are: liquid level indicators, money markers, medicine dispensers, signature guides, white canes, etc. These assistive devices enhance the independence of visually impaired people and contribute tremendously to their participation. Participants alluded to the fact that it is very difficult to participate in the community activities like education, daily activities, and employment if visually impaired people are not provided with the required assistive device. Participants from the focus group discussion stated:

> *When one is provided with proper assistive devices, he or she gain self-esteem and self-independence (Focus group discussion).*

All participants from individual interviews viewed provision of assistive devices as freedom from bondage and slavery. What the participants said is echoed by the Provincial Standardised Guidelines on Provision of Assistive devices in KwaZulu-Natal (2013) in its definition of assistive devices where assistive devices are defined as enabling individuals with disabilities to participate on equal terms with their counterparts. However, both individual and focus group interviews reflected that in the district where the study was conducted, provision of assistive devices for the visually impaired people is not a priority. They all stated that the only assistive devices that are distributed and prioritised are wheelchairs, crutches, and other assistive devices for physically disabled people. What is reflected by the participants is not in line with what is stated in Provincial standardised Guidelines on Provision of Assistive Devices (2013) that an assistive device must be specific to the impairment and individual needs of client. One of the participants from the individual interviews mentioned:

> *I did receive eye spectacles but they are broken and I do not have money to get the new ones as they are expensive for me as I am only relying on my disability grant (P1).*

What is reiterated by this participant is against the vision of the Department of Health which calls for accessible, affordable, appropriate, and quality disability and rehabilitation services throughout the course of life (Frame work and Strategy for Disability and Rehabilitation Services in South Africa, 2015).

Another participant echoed similar views:

> *To get a white cane you have to contact South African National Council for the Blind which also requires lots of money as one has to phone first and order it.*

> *It is hard to do that if you only rely on your disability grant and come from the deep rural area like myself (P4).*

The white cane is one of the assistive devices which speeds up the adjustment process to visual impairment. One can argue that it serves as an identifier of a visually impaired person to the sighted people. Omvig (2005) also confirms this when viewing the white cane as a symbol of independence. If white canes and other assistive devices for visually impaired people are crucial as stated above, they have to be equally issued like all other assistive devices by the relevant government departments.

Participants from the focus group discussion expressed that they find it difficult to be independent without being provided with the proper assistive devices.

> *We think that an awareness raising on assistive devices for us is crucial in our district as the government officials seem not to understand about them. If the department of health can assist by conducting awareness raising both on issues pertaining visual impairment and the role of assistive devices on the lives of visually impaired people, provision of assistive devices can be well implemented in our district (Focus group discussion).*

One of the participants from individual interviews shared the difficulties associated with the lack of independence:

> *I am not able to feel the difference between R100.00 and R200.00 and sometimes my relatives give me 10.00 instead of R200.00. It is really heart breaking when you discover it later (P3).*

A participant from the individual interviews shared the importance of independent living in minimising oppression:

> *It is important to be trained in identifying money because it is easy for your relatives to take an advantage of you (P5).*

A focus group member noted that:

> *The other challenge is when you are using public transport and you cannot tell the difference between paper notes. Passengers take advantage of you (Focus group discussion).*

Both individuals and the focus group felt that what is required is proper disability sensitisation training for community members and government officials. The Framework and Strategy for Disability and Rehabilitation Services in South Africa (FSDR, 2015) concurs with this sentiment when acknowledging that the lack of awareness, knowledge, and training among healthcare providers, regarding the challenges, needs and rights of persons with disabilities, result in poor care and disempowerment. The national healthcare 'free health' policy also points out that any indigent disabled person is entitled to free assistive devices, including maintenance/repair, as long as one meets the set criteria.

In view of the above, it is clear that visually impaired people are entitled to receive assistive devices depending on their needs and requirements. The White Paper on the rights of persons with disabilities supports the above when stipulating that universal design shall not exclude assistive devices for a particular group of persons with disabilities where this is needed. The researcher feels that the visually impaired is a grouping which has been marginalised and excluded regarding the provision of assistive devices and therefore should be prioritised when assistive devices are provided, depending on the need and the assistive device required by the visually impaired person. The data suggests that very little progress has been made for visually impaired people to access rehabilitation services. The themes identified in the data reflect that most of the services are not available in the district where the research was conducted. It was further felt that some government officials were not sensitive to the needs of the participants and therefore education is required.

4.4.3. The rehabilitation needs for visually impaired persons

Ideas on the rehabilitation services that are required in the district were mentioned by the participants. Amongst others, were the following: counselling services, non-governmental organisations, and blind people's organisations.

A diagnosis of sight loss in later life can be a trigger for depression (Horowitz et al., 2000). Findings suggest that the initial experience of vision loss can contribute to depression and that higher levels of depression have been associated with the recent onset of visual impairment (RNIB 2009). Hence counselling would be a major factor in rehabilitation.

4.4.3.1. *Access to counselling services and support groups*

Counselling is professional assistance given by a counsellor to an individual or group of individuals who are either able or disabled for the purpose of understanding their conflicting areas of life better, detecting alternative solutions to problems and living a fulfilled life. Counselling could further assist in helping people to cope with difficult life situations. This is confirmed by Ross et al. (2010) when looking at the aim of counselling as to improve the quality of life of people and to help them to cope more effectively with the problems of living. It is worth noting that counsellors working with people with visual impairment must be empathic in order to be able to perceive accurately and sensitively the client's feelings and to communicate that understanding to the clients. This is evidenced by the participants, from individual interviews, expressing that counselling is crucial to visually impaired people immediately after the diagnosis. However, this seems not to be implemented as participants from both individual interviews and focus group discussions felt that eyecare health institutions are not functioning well in that regard as they indicated that none of them received counselling after diagnosis.

> *I didn't receive counselling services. I was only told that I won't be able to see again (P2).*
>
> *I don't have a picture of counselling services. There was no one who told me what to expect and I don't even remember talking to a social worker while I was still in the hospital (P4).*
>
> *I think counselling is a good thing and we need it to be implemented in our government institutions, especially the department of health as it is the entry point of diagnosis but that does not happen (P10).*

The focus group also alluded to the fact that counselling is important but none of them received such service after diagnosis. The focus group participants expressed their painful experiences of not receiving counselling when visual impairment is acquired.

> *The world is strange and unusual. Your need someone to take you by the hand and walk with you in this difficult and painful journey but only to find that you are all by yourself (Focus group discussion).*

Counselling facilitates meaningful understanding of the self and environment as it results in the establishment and/or clarification of goals and values for future behaviour. Participants from the individual interviews noted that awareness raising and sensitisation on disability is required for counsellors who, like social workers, will provide counselling to visually impaired people. They mentioned that this would help in dealing with the issue of 'us versus them' thinking.

> *Sighted people do not see any value to us. We have experienced this when visiting government institutions. We need counselling to be well implemented in our district (P9).*

Focus group participants noted the following:

> *Negative treatment leads to anger and frustrations. The only way to deal with this situation is to receive counselling which will be facilitated by the professional person without any judgement (Focus group discussion).*

Supporting what is noted by the participants, from both individual and focus group discussions, many writers and practitioners agree that counselling gives the client a n opportunity to explore, discover and clarify ways of living meaningfully towards greater well-being. It enhances the ability of the client to cope with life conditions that are not easy to change (Horowitz et al., 2000; Ross et al., 2010; Uba, 2009).

There were times where the participants felt that their rights were not recognised by the professionals in the health institutions:

> *The patient's rights are not respected in the health institutions as we are sometimes told in front of our parents that our sight will be affected for the rest of our lives without given a proper counselling (P9).*

According to the participants this is very hurtful as the news should be told directly to the affected person. They felt that respect does not apply to the visually impaired person. Authors like Hanson et al. (2007) agree with the above, stating that hospitals and eye clinics do not always recognise such feelings and offer only limited counselling, if any, and little information about community support services. The previous statements strongly imply the need for a counselling service that does not discriminate, exclude or prejudice visually impaired people. Participants from both individual and focus group look for an empathic person who can walk with them from the beginning of their journey till the end of it. The counsellor must continuously check if their understanding of what the client is sharing is a true reflection of what is perceived by the client (Steyn, 2016). Further, it should be noted that counselling is the only significant practice that can enhance the client's ability to make appropriate life decisions in a situation of visual impairment. One may realise that if counselling can be facilitated at the onset of visual impairment, visually impaired people would be skilled to develop the ability to set realistic goals for themselves and improve their total being.

Improved access to both professional and peer support groups would help to address the needs of individuals experiencing visual impairment (Hanson et al., 2007). These services should be viewed as the process of reducing feelings of depression, anxiety, and stress, and encouraging resolutions to be more confident and independent across all age groups. Also, improving the environment in which the visually impaired persons live can enhance the mental attitude of those persons, and as they learn to cope, social relationships will gain strength. It should be noted that the support provided should not only focus on educating individuals directly affected, but their friends and families too. All participants expressed their sadness at the ignorance of health institutions after diagnosis. They felt that being told that one has lost his or her sight is not an easy thing. One needs to be provided with proper guidance and support.

> *You need to be linked up with other visually impaired people like you and only to find that you are being thrown into the dark world that you have never experienced before (Focus group discussion).*

Individual interview participants responded that they were not referred to any support group. Some mentioned that this interview was the first time they had heard that one can become a member of a support group.

> *I haven't been part of any support group and it is my first time to hear about it (P2).*

> *I wish I heard about it immediately when I acquired visual impairment may be my life wouldn't be like this (P5).*

One member of the focus group noted that she only became aware of the support group when she was at school in another district. She explained to the other group members the importance of the support group:

> *I got the opportunity of understanding and accepting myself when I joined the support group. I started to realise that I am still a complete human being and that there were other visually impaired people who experience challenges like myself when they acquired visual impairment (Focus group discussion).*

In view of that, the researcher felt that what is shared by the participant illustrates the importance of a professional support group that provides a safe space to communicate with like-minded people and provide personal and social support to alleviate feelings of isolation. Most participants from the focus group reflected the need of such a service as they indicated that they had issues that they would like to share with other people who have the same experiences as them.

> *We feel that it is important to find other people with similar experiences like ours better than being alone in a new dark world (Focus group discussion).*

The researcher concurs with the above as one may notice that the level of visual impairment challenges across all age groups varies and the needs and experiences will be diverse.

4.4.3.2. *Access to hospital comprehensive rehabilitation team intervention*

The challenges experienced by visually impaired people calls for comprehensive rehabilitation which integrates the client's physical, psychological, and social well-being. This kind of rehabilitation cannot be provided by one specific profession rather it requires a multidisciplinary approach based on teamwork. Clearly there is no multidisciplinary team in existing health institutions hence participants find it difficult to access comprehensive rehabilitation services. This results in multifaceted challenges including non-acceptance of visual impairment, family neglect, lack of independence and so on (Zungu, 1993; RNIB, 2009; Mabaso, 2012).

Participants expressed their views on the unavailability of a multidisciplinary health team in the health institutions.

> *It is very difficult to be told that you have permanently lost your sight and being left like that. Nobody tells you the possible options. The doctor told me that my sight was not going to be restored, that means that I will be visually impaired for the rest of my life. I couldn't understand that and I asked the nurse who was assisting with the interpretation of what was the meaning of that? She said you won't be able to see. I cried and stand up and go (P1).*

> *It would be better if hospitals have referral systems. We need to be referred to people who will be able to make us understand the meaning of the situation that we are facing regarding our new life situations (P5).*

> *What is painful is when the doctors tell you that there is nothing that could be done except receiving disability grant. Sometimes you are told that there is nothing that you can do. I think that they are taking decisions for us without referring you to the social worker (P3).*

The multidisciplinary team's function is to consult with the client on everything that it does and to put the client's interest first. It is not allowed to decide for the client. It should be noted that the multidisciplinary team's communication is vital when dealing with the visually impaired person's rehabilitation especially if the visually impaired person is still admitted in to the health institution. Ross et al. (2010: 7) point out that "without effective and consistent communication, the functioning of the team may become disjointed, contradictory and harmful to the patient or community".

> *My experience with the health institutions is that they do not work together after diagnosis. It would be much better if doctors especially the eye doctors can refer you to the social workers and the social workers refer you to the psychologists after the sad news (P8).*

Most of the participants in the individual interviews view the health institution as the place for operation and diagnosis of visually impaired people. Focus group participants alluded to the fact that health institutions must have the step-down facility for rehabilitation which will include at least an occupational therapist, social worker, psychologist, audiologist, orientation and mobility practitioner and community rehabilitation worker:

> *It might be better if the hospitals can have the appropriate team like social workers, psychologists, orientation, and mobility practitioners who are well trained in dealing with visually impaired people (Focus group discussion).*

A number of participants felt that multidisciplinary team approach is very significant as it might bring respect and dignity to the visually impaired people. According to the participants' views working together with the multi-disciplinary team might reduce the burden of disability grant provision to the visually impaired by the state. Commitment is very significant to the team members that are working with visually impaired clients within the health institution setting. Looking at the participants' responses, it is noted that team work in existing health institutions does not function properly.

4.4.3.3. *Support from non-governmental and blind people's organisations for visually impaired people*

According to the participants, the district does not have non-governmental nor blind people's organisations for visually impaired people. These types of organisations play a pivotal role in bridging the gap where government services are not provided. In the country there are a number of blind people's organisations focusing on different areas of visual impairment conditions, retina, glaucoma, etc. The South African Council for the blind is an umbrella body of more than 120 member-organisations throughout South Africa. It is further constituted of nine provincial structures in various provinces of South Africa of which KwaZulu-Natal is one of them. It should be noted that the KwaZulu-Natal province does have the member-organisations for and of visually impaired people. All these organisations are based in urban areas of the province which makes it difficult for visually impaired people who reside in rural areas to access them.

Focus group discussion participants pointed out that the lack of availability of the non-governmental and blind people's organisations in the district makes them feel overlooked, invisible in the society. According to these participants, the availability of the non-governmental and blind people's organisations would help to create training opportunities for them as visually impaired people in the district. 100% of the individual interviews considered non-governmental and blind people's organisations as advocacy organisations. They felt that their issues are not taken into consideration because they do not have these non-governmental and blind people's organisations. Participant from the individual interviews stated:

> *You know there're not even a preschool or a school for visually impaired children. Children with visual impairment have to leave their homes and parents and travel five hours to look for education. This is not fair for these children; we need somebody to advocate on our behalf and that can be done through the NGO or BPO (P7).*

This was confirmed by other participants from the individual interviews who mentioned that:

> *To find an NGO or a BPO one has to travel something like 4 to 5 hours because we do not have one in our district (P5).*
>
> *We don't know each other because we don't have an NGO with social workers who can call us and assist us with empowerment programmes (P8).*

It is therefore crucial for the district to have non-governmental or blind people's organisations which would provide support to visually impaired people as one of the responsibilities of social workers is to engage in the lived experiences of the vulnerable, oppressed and disadvantaged people whose lives are characterised by poverty, deprivation and social exclusion (Subrayen, 2011). This view is supported by the focus group discussion which alluded to the fact that in their district there is no NGO or BPO to assist them with rehabilitation services.

> *It is difficult here; we don't have any support from our government regarding rehabilitation services for us as visually impaired people and also there is no non-governmental or blind people's organisations to assist us in accessing rehabilitation services. We have to go to other districts to have access to rehabilitation services. Infect, we are voiceless, powerless and we feel like there is no one who cares about us (Focus group discussion).*

The White Paper on the rights of persons with disabilities views Disabled People's Organisations (DPOs) as very significant as they support the development of persons with disabilities by providing them with a common platform to exchange and share their experiences and build a common voice (White Paper on the rights of persons with disabilities 2015: 9).

Both individual and focus group interviews report feelings of marginalisation, exclusion and oppression by the government which does not regard them as equal to other disabilities. The call for social work is to empower, liberate and institute social change of and for the oppressed, vulnerable masses including persons with visual impairment (Subrayen, 2011). It is through both non-governmental and disabled people's organisations that the visually impaired would be able to access information on disability, understand their rights as citizens of South Africa and become aware of existing services and relevant facilities. The formation of the non-governmental and disabled people's organisations could contribute a great deal to the creation of a new identity for people with visual impairment.

4.4.3.4. *Access to orientation and mobility services*

'Orientation and mobility' training involves developing skills that assists visually impaired persons to move around in the environment freely and independently (Seesurrun, 2015; Fish-Hodgson, 2012; Marson, 2003). The onset of visual impairment limits movement of the visual impaired person which means becoming dependent upon others to perform tasks previously carried out by him alone. Consequently, by asking for or demanding so much assistance he is transformed into a helpless object of ridicule (Kuruwa, 2010). Visual impairment impacts upon visually impaired people's daily activities, their social relationships, and their sense of self. Thus, training in different areas of life is highly significant and desirable to individuals with visual impairment. That is where training in orientation and mobility plays a significant role in the lives of people with visual impairment. This kind of support should commence at the time of the onset of sight loss. Areas of life where training would be valued include the following: use of the white cane, sighted guide, sensory awareness, etc. For the training to be well executed, an orientation and mobility practitioner who is a specialist in this field is required. In South Africa there is a shortage of orientation and mobility practitioners; the reason being that their significance is only being recognised by the non-governmental organisations which employ them. Non-governmental organisations provide training and psycho-social rehabilitation services for visually impaired people in South Africa with limited funding from donors.

The participants reported difficulty in accessing rehabilitation services because these were available only in distant locations, and dependence on family members to take them to the facilities was a challenge since, at times, there was no one available. This perpetuated further dependence and contributed to their exclusion from participating in societal activities. Participants reported orientation and mobility training as one of the sensitive but crucial issues as they felt that their right to independence is being infringed.

> *I want to be able to walk around without any assistance. I don't have any right to privacy because I always have to ask by brothers or sisters if I want to go to town. It is very painful because it depends on their availability (P10).*

> *This thing of dependence is very painful because it requires me to have extra money to pay for the person who accompanies me (P5).*

Another participant from the individual interviews expressed her frustration about her dependence on people around her:

> *It makes me to always curse the day which made me like this. You know I cannot move anywhere without my mother or my relatives. Sometimes my mother has to ask someone else to take me to the pay point. If I was trained in orientation and mobility, I wouldn't be like this. I have seen so many blind people moving around without being helped (P3).*

> *Being unable to move around reminds me every day that I am not myself. I think that the government doesn't care about us because if it does care about us we would have an orientation and mobility practitioner to teach us how to move around (P6).*

For many, independence means that the visually impaired person is autonomous and has the opportunity to take care of himself or herself to the best of her ability, without constant help from others. However, without assistive devices, the focus group participants pointed out:

> *It is very difficult even to use a white cane because we are not allowed to use it without being trained. This makes it difficult for the drivers to recognise us*

> *when walking on the roads because we just walk without white canes (Focus group discussion).*

> *Orientation and mobility training can assist with sighted guide skills. What is happening now is that even if I walk with my friends, they just drag me than using appropriate sighted guide skills which is embarrassing to me (P7).*

> *If you are not independent, you won't be able to have a wife of your choice because you cannot propose a girl with your relatives around you. They just choose for you and sometimes discourage you to choose a girl that you feel she is suitable for you (P9).*

Visual impairment affects one's ability to perform tasks that require independence in challenging settings (e.g. moving along crowded city streets, negotiating stairwells) or the use of peripheral vision (e.g. driving). Most participants from the focus group felt that orientation and mobility training should be the state's responsibility. They felt that it is their right to be independent and the government should employ orientation and mobility practitioners in the government departments to assist them. According to the participants from both the individual and the focus group discussions this could reduce the burden from the state as visually impaired people would be able to access employment if they were trained in orientation and mobility. However, this is not the case as society restricts their opportunities to participate in mainstream economic and social activities rendering them more or less dependent (Oliver et al., 2010).

Participants also reported experiences of loneliness which are the result of not being able to access training in orientation and mobility. The researcher concurs with the participants as she views orientation and mobility training as an inherent requirement of rehabilitation services for visually impaired people and if it is not offered the visually impaired person may face the consequences of loneliness and dependence which may lead to depression and stressful situations for the visually impaired person. In the focus group, participants vocalised their experiences of being confined in one place as the result of not accessing rehabilitation services.

> *It is very difficult to be left alone behind closed doors. You don't have anyone to talk to. The only thing that you listen to is the radio (Focus group discussion).*

> *Loneliness makes one to have negative thoughts like ending your life. It makes one to realise that he or she is useless (Individual Interview).*

Participants from the focus group also reported that:

> *Visual impairment is difficult because you lose your friends. You know that is where one realises that it is true that when days are dark friends are few. You become very lonely. There is no one who is prepared to share anything with you (Focus group discussion).*

Some participants from the individual interviews mentioned that they missed television programmes.

> *Listening and watching is not the same. Sometimes you feel like watching your favourite programmes but there is nothing that you can do as you will not restore your sight (Focus group discussion).*

Training in orientation was seen as a solution for the participants as they would be able to visit their friends and do shopping on their own. Participants also felt that their friends and relatives find it boring to sit and share stories with them. They further expressed that the only solution to loneliness is access to rehabilitation services such as orientation and mobility, activities of daily living and educational rehabilitation services.

4.4.3.5. *Access to interventions to assist with activities of daily living*

Activities of daily living are basic activities that comprise everything included in human life. These are daily activities performed by human beings from the moment they wake up till they go to sleep (Marson, 2003; Taylor, 2005). A large number of these activities are learnt by observation and imitation which makes life difficult for visually impaired people as they cannot observe and imitate by watching other people. Research has shown that loss of sight is associated with difficulties in performing basic activities of daily living which reduce the welfare state of the individual (RNIB, 2009; Seesurun, 2015).

Participants were found to experience high levels of difficulty in cooking, mobility, as well as personal care compared to their sighted peers. Focus group participants noted that the most challenging household tasks when acquiring sight loss are preparing meals and household cleaning.

> *The most difficult thing is being unable to make yourself a cup of tea, just a cup of tea (Focus group discussion).*

RNIB's "Lost vision report" found that almost half of people experiencing sight loss cannot cook for themselves. Individual interviews confirmed this:

> *Sometimes it is good to eat food that you have cooked for yourself than always eating other people's food (P1).*
>
> *What I sometimes hate is to eat cold food as I cannot warm it myself (Individual Interview) (P3).*

This emphasises how crucial it is that visually impaired people gain independence. However, depending on the severity of the vision loss differing but specific assistance devices are required. Meanwhile, the general responses to vision loss increase the risk of people being put into managed care, rather than attempts being made to help them make transitions to adapting to living in a sighted environment in their own home. The interviews revealed that support in small tasks like making tea are valued services which require an individual to be able to perform them by her or himself rather than someone else taking over all household tasks (Thomas Pocklington Trust, 2000; RNIB, 2009). Assistance which allows the individual to remain in control and assert independence provides positive support is favoured to avoid overprotective, negative support. Labelling of containers, prescribed medication, cleaning products may improve the quality life of individuals with visual impairment.

Focus group discussions expressed the feelings that training them as affected individuals alone and living behind their families would be meaningless services. They felt that services like these have to be extended to their families so that they could be able to support them:

> *Our family members also have to attend training on activities of daily living so that they can support us (Focus group discussion).*

One hundred percent of the participants also felt that training on activities of daily living is crucial when one becomes visually impaired. They mentioned that visual impairment does not only affect individuals but also impacts on family members as well. Focus group participants further pointed out:

> *Sitting at home and doing nothing for the whole day is not healthy. It makes one to think negatively and start to curse God (Focus group discussion).*

Participants from the individual interviews said:

> *I hate it when they leave me alone and put everything that they think that I will need. You don't know the time; you only think by listening to the different sounds of the birds and other animals like cows (P7).*
>
> *Drinking cold tea is not nice. It is very important to be trained on how to cook and clean the house (P6).*

A participant from the individual group revealed that:

> *My experience is that of being left with children and expected to look after them. It is painful because you find that the family has gone to the wedding or family party and you are left behind with children and you don't know how to feed them. I also think that training on daily activities is the best but we do not have any one to offer that training in our district (P5).*

Through activities of daily living, visually impaired people are able to be self-sufficient in all functional activities and be socially integrated. They may be able to reduce dependence from the caregivers. However, the findings suggest that very little progress has been made for visually impaired people to access rehabilitation services. The themes identified reflect that most of the services are not available in the district where the research was conducted. It was further felt that some government officials were not sensitive to the needs of the participants and therefore education is required.

4.4.4. Self-representation of people with visual impairment

The general practise in society's representation of people with disability can be characterised as one of being hidden away or put on display. Considering this, self-representations have become a powerful weapon of the disability rights and culture movement. Despite the significance of the voices of visually impaired people and their self-representation to improve the well-being of their lives, little research in South Africa has been undertaken to understand the voices of people with visual impairment. This includes their perceptions of themselves, what they seek to achieve as the beneficiaries of services to explore the self-representation of people with visual impairments, their voices and gap in policy and access to rehabilitation services.

The aspect of self- representation is reflected in the White Paper on the Rights of Persons with Disabilities' (WRPD) Strategic Pillar 6 (2015: 91). It asserts that the representative voice of persons with disabilities is "being able to take decisions that affect one's standard of living – where to go to school, where you live, with whom you live, who you form relationships with, where you work and what you do – is an unknown concept for many persons with disabilities". This is in line with other relevant views. United Convention on the Rights of Persons with Disabilities articles 4, 29 and 33 locate the representative voice of persons with disabilities in the context of human rights. The UNCRPD aims not only to ensure people with disabilities human rights, it also recognises that a part of having full human rights is to participate in decision making with regard to one's own affairs. In fact, one of the key changes that the UNCRPD brings with it is that it treats disabled people as subjects capable of making decisions regarding their own lives and not as objects to be managed or cared for. It is important to note that the recognition of the right to be in charge of one's own life and affairs draws on Articles 12 and 19 of the UNCRPD (2007), which lays the foundation for actualising the right to make decisions regarding one's own life and to effective inclusion in society.

In terms of rehabilitation specifically, the National Department of Health (NDOH) introduced the Framework and Strategy for Disability and Rehabilitation (2015) drawing from articles 25 and 26 of the UNCRPD. Some of the key principles in disability and rehabilitation are self-representation (UNCRPD, 2007; FSDR, 2015; WPRPD, 2015). Self-representation ensures that the voices of persons with disabilities are acknowledged in different aspects of life, including government, traditional, religious, cultural, and political structures. The White Paper on the Rights of persons with disabilities (WRPD, 2015: 12) views self-representation as "the practice of people being able to articulate their own issues by themselves and for themselves and it refers to people being enabled and allowed to have their own voice in issues that relate to their specific needs and circumstances".

4.4.4.1. *Sense of powerlessness*

Despite the UNCRPD and other policies, participants from both individual and focus group asserted that there is lack of awareness on governmental policies and this leads to them being powerlessness in decision making. This powerlessness prohibits these people from accessing opportunities to develop and exercise status-building skills. This was well articulated by the participants when they felt that they are not treated equal to other groups as opportunities and life chances are not available to them.

> *I don't know how to express your views as a visually impaired person in our country because if you try to talk openly about your dissatisfaction on service delivery, non-disabled people say that you are rude (P8).*

> *When I was a sighted person, I used to enjoy life. I attended the school of my choice and I had a right of choosing a profession of my choice. It is now difficult as I am now a visually impaired person. I only rely on the decisions of other people (P2).*

Focus group discussions also highlighted the fact that opportunities of employment to visually impaired people are not available and their voices on issues of education are not heard by anyone:

> *There is no school for visually impaired in our district. We have learnt to be separated from our parents from early childhood and you cannot challenge it (Focus group discussion).*

Individual interviews noted that visually impaired people are not employed in either lower or higher positions.

> *You have to go to other provinces and districts to be employed. Visual impairment is seen as a scurry thing here. No one is prepared to take a risk of employing someone with visual impairment and we don't have any voice on policies pertaining education and employment (P6).*

It should be noted that it is necessary to have the right to choose to be able to actualise the right to participate actively in political life at all levels, including in policy making (Keys 2017).

Furthermore, the rights stated in Articles 12 and 19 are fundamental for the active participation of visually impaired people in policy and decision making that affects them.

In view of this, participants demonstrated the position held by them as visually impaired people in service delivery and decision making as an indication that visually impaired people have to take orders from the various dominant structures without challenging them and implement them as required. Further, participants reflected that there is no self-representation in both government structures and their families. They are forced by the inadequate resources to leave their homes in order to access services. Their voices are being suppressed by various structures. Participants felt that people with visual impairment must also enjoy equal opportunities, like all other groups.

> *It is very difficult to be blind because you do not have a right to stay where you want. If you want training on certain things pertaining to your independence, you are forced to live your family (P1).*

This study found that living in rural areas poses challenges for people with visual impairment as they are left out of rural development strategies and programmes, which results in their exclusion from initiatives and marginalisation in community decision making. Further, policies for disability inclusion do not always exist and where they do exist, they are not implemented. The significance of full and active participation by marginalised groups in the policy making process has been recognised by many, including Priestley (2016).

Participants from the focus group discussions indicated that:

> *It is very difficult to have a voice in any societal developments whilst regarded as nothing. We say that because we are extremely excluded from things like RDP housing, agricultural programmes, and other community programmes but we are told that this is the country for all people (Focus group discussion).*

According to the participants, visually impaired people are taken for granted in their district:

> *We are voicelessness people and those who are not disabled are the ones who have a voice on our services (P10).*

The above quotations reflect the oppression that is experienced by the visually impaired people from the oppressors who are non-disabled people. This is demonstrated by blocking visually impaired people from opportunities for self-development and from certain rights that the dominant group takes for granted (Mullally, 2010).

4.4.4.2. *Lack of participation*

All the participants further felt that visually impaired people do not have a voice in rehabilitation services development. They indicated that services like vocational and educational rehabilitation services do not accommodate them as they are designed to suit sighted people. RNIB (2009) asserts this by viewing the ability to see as being taken for granted by many people. All participants alluded to the fact that it is difficult to have a voice while living in an environment which is more suited to sighted people and full of visual cues. According to the participants, this calls for visually impaired people to adapt and live in the world which is designed for sighted people. One participant from individual interviews concurs with the above by pointing out that:

> *Rehabilitation for visually impaired people is not an issue in our district because sighted people do not understand it and they don't implement policies. This is confirmed by the lack of awareness raising on policies pertaining visual impairment (P2).*
>
> *I know that there are government policies that deal specifically with disability issues but I cannot access them because they are not in an accessible format. How can you have a voice in something that you cannot even read? It would be much better if they are written in braille or large print (P4).*
>
> *Sometimes one must accept and adapt to the world of sighted people because there is no one to listen to you (P5).*
>
> *It is even difficult to share your thoughts on the governmental policies as we are not consulted when they are developed. We have heard that they are there but we don't know them. We only heard of them when researchers come to our district and after that we are being left like that. We are not informed about the outcomes of those research programmes. We are only important when they*

> *need to conduct their research about us. It is difficult to be visually impaired (Focus group discussion).*
>
> *We as visually impaired people do not have any voice on the delivery of rehabilitation services. I have heard that there are policies on rehabilitation, employment, education but I haven't seen them. This means that somebody just think on our behalf and decide for us (P7).*

This is consistent with Young's finding that society's structures and norms are a reflection of existing power relations that were created and defined by dominant groups to maintain the status quo. In order to change visually impaired people's position of oppression, they themselves must be part of the political structure, engage in setting the agenda and defining the issues, and redefining the concepts that relate to their lives as per the anti-oppressive theory. It is therefore necessary that visually impaired people themselves participate in policymaking to change laws and policies that do not reflect their experiences (Keys, 2017).

The participants felt that society fails to treat them as functioning individuals. They stressed that losing sight should not change the way people with visual impairment should be treated. Watermeyer et al (2006, p. 1) concur that "the story of disability in our country (South Africa) is a story of social oppression". Worth noting is that throughout the discussions, all the remarks left participants feeling personally insulted, humiliated, demotivated, and disempowered. Experiences shared by participants left them feeling as if it was part of being impaired to be handled and treated like that and that too contributed in them seeking no further support or services.

The researcher concluded that awareness raising on disability services, government policies and empowerment programmes are key to independence especially of those disabled people from rural areas. Thus, self-representation and political voice are among the key strategies to ensure that people with visual impairment are able to develop the ability to depend on themselves in order to meet their own needs.

The researcher therefore strongly believes that visually impaired people need to be empowered to rely on their own efforts, abilities rather than those imposed on them by sighted people. Visually impaired people must be enabled to articulate their needs and issues in all services like all other groups without being marginalised or discriminated against. It is their right to have access to rehabilitation services in order to enjoy independence and full participation in various structural activities.

4.5. Conclusion

The data analysis and findings from the research participants clearly indicated that rehabilitation services for visually impaired people in uMkhanyakude district are not fully implemented. The three aspects of rehabilitation namely: training and psycho-social, educational and vocational are non-existent. This poses a challenge in the experiences of visually impaired people as they have to travel long distances to access these services. This has some negative implications for their self-development and they remain stuck in a high poverty level. Furthermore, the dominant structures including government, community and families contributed to participant's experiences of not accessing rehabilitation services in their district.

Various barriers including culture, attitude, information, and traditional beliefs remain the major stumbling blocks to both accessing rehabilitation and development of visually impaired people. Both international and national disability policies advocate for self-representation of persons with disabilities. However, the study shows that people with visual impairment do not have a voice in all aspects including policy decision making, implementation monitoring and evaluation. Both individual interviews and focus group discussions point to the belief that rehabilitation is one of the tools which could assist them to regain the lost physical and mental functions (Marson, 2003; Taylor, 2005; RNIB, 2009; Kurawa, 2010).

CHAPTER FIVE

CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

5.1. Introduction

In this final chapter, the researcher presents a summary of the major themes analysed from the interviews. Insights were generated from narratives of the visually impaired participants' experiences and perceptions within the uMkhanyakude rural district of KwaZulu-Natal in South Africa. The chapter also explores limitations of the study and makes recommendations for the generation of future studies but most of all on policies and practices in some dire need of amendment and alteration so as to better cater for visually impaired people.

5.2. Findings and conclusions

The Department of Health does have rehabilitation policies. The Framework and Strategy for Disability and Rehabilitation (2015) serves to guide implementation of rehabilitation services in South Africa. These policies are located within a human rights framework that draws attention to the inclusion of all persons with disabilities in rehabilitation services. The findings of this study find that visually impaired people of uMkhanyakude district experience severe challenges in accessing rehabilitation services. These findings answer the research question posed regarding the experiences of visually impaired people when trying to access rehabilitation services (including the provision of assistive devices). The conclusions reached, from participants' perspectives, relate to the fact that a lack of access to these essential services had a short- and long-term negative impact which resulted in: challenges in coping with visual impairment, due to the limited knowledge on how to cope and manage visual loss; denial and failure to accept the new identity which is associated with visual impairment; inner conflict and self-doubt.

The question on the feelings and reactions of visually impaired people was clearly answered through the responses of participants. From the findings, the participants could not identify themselves as contributing productively and meaningfully to society and their families. At times visually impaired people face oppressive situations imposed on them by the dominant group – sighted people. This makes them feel oppressed and isolated. These fragmented experiences also leave them feeling uncertain, without alternatives and incapable of acting to change their situation. This scenario points to an approach that identifies or implies disability as a state of passivity, personal tragedy and dependency which is unacceptable to participants (Dominelli, 2002; Finestone, 2006).

In exploring visually impaired people's views on the currently available rehabilitation services, the study found that access to health institutions by visually impaired remains a serious challenge as their families prioritise traditional medicine over western medicine. Moreover, the traditional healing was the preferred choice whenever visually impaired people required a remedy for visual impairment. Traditional healing comprised the involvement of traditional healers who took responsibility to try and resolve visual impairment problems by giving them solutions to their visual impairment.

It further emanated that families of visually impaired people trusted the traditional healers in treatment settings. The traditional healer's remedies ranged from prescription of medicinal herbs, potions, prayer and the invocation of ancestors and spirits (Dookran, 2016). Visually impaired people were motivated to use traditional healing methods and herbs because these were believed to be solutions to their problems, as resolved by the traditional healers. However, all participants appeared to support the idea that western and traditional healing must be done concurrently for the success of rehabilitation services. Thus, the study concludes that traditional ways of healing can be a challenge in accessing rehabilitation services if it is not integrated into the comprehensive rehabilitation system.

The question on the experiences of visually impaired people when trying to access rehabilitation services, the study revealed that the lack of rehabilitation services in different districts where the participants resided created a significant gap in the provision of services for people with visually impairment. Furthermore, the study revealed that participants had to travel long distances to access these services which separated them from their families. Evidently, such lack of services in the district denies visually impaired people access to education for example and impacts on their socio-economic position. For example, they commonly must use their disability grants on which many people are dependent for survival. They therefore must choose between sending a visually impaired child to access very distant services and to access family basic needs, such as food.

Undoubtedly, a visually impaired person undertakes rehabilitation within the context of his own and his family's values, attitudes, and behaviour as well as those of the larger society. It is therefore significant that families and society should support people who require rehabilitation. The participant in the rehabilitation process is in actual fact actively engaged in adjustment and adaptation process that permits him/her to become increasingly independent of those around them. Thus, the visually impaired person must re-adjust to a new set of resources, change old patterns of social interaction, and modify the cultural norms that guide the process to fit the new circumstances.

It should be noted that for most visually impaired individuals in this study, their independence and maximum physical functioning are the goals of the rehabilitation process. These goals are determined and interpreted in the light of their resources, their own and others' expectations, and their environment. It seems the success of the rehabilitation in uMkhanyakude district is contingent upon the changing of family and societal values and goals, the identification of problems that hinder access to rehabilitation services, an accurate assessment of resources for visually impaired, and the modification of societal and family behaviour (Albrecht, 1976).

In response on the question of access to the provision of assistive devices, the study discovered that all participants do not access assistive devices which invariably makes it problematic for them to access other services such as employment, education, and health services. This also impedes them from travelling to places such as churches, shops and visiting friends which further isolates them and hinders socialisation. In addition, the related factor is the provision of assistive devices which emerged as a singular factor from this study. The participants revealed feelings of exclusion and discrimination in the issuing of assistive devices. They viewed the provision of assistive devices as being issued to physically disabled people which they regard as bias on the part of the Department of Health.

The conclusion is that assistive devices play a significant role in the life of people with visual impairment (KZN Assistive Devices Guidelines, 2014). In chapter two of this dissertation the literature reflected that assistive devices improve the quality of life of disabled people and create independence which enables visually impaired people to participate in gainful employment. The study has also revealed that with the provision of required assistive device, a visually impaired person can become independent and be able to attend educational institutions as well as performing activities of daily living without depending on his or her family members (Fish-Hodgson et al., 2014; Seesurrun, 2015).

In relation to articulation of rehabilitation needs by the participants, the study found that non-provision of rehabilitation services to visually impaired people results in their being confined to one place on a daily basis because of dependence to other people who in many cases are not available to assist. The study reflects that due to the nature of disability which caused dependency, participants are separated from other people which results into marginalisation. This confirms the notion that if an individual or group does not have the stated 'desirable' characteristics, they become socially excluded and subjected to marginalisation. This results in experiences of loss of self-esteem, loss of self-confidence, feelings of inferiority as well as feelings of loneliness (Bhagotra et al., 2008; Marson, 2003).

The lack of rehabilitation services such as orientation and mobility are not offered in health facilities at the time of diagnosis in the district. The conclusion drawn from the study was that if orientation and mobility training is not provided at the earliest possible time, one or more of the following may be experienced: fear of the unknown, loneliness, depression, anger, and frustration (Bhagotra et al., 2008). The objective of rehabilitation stresses the importance of considering rehabilitation services at the onset of visual impairment, since it does not only affect the person who has acquired it, but it also has a negative impact on his/her families. The situation is aggravated if families are not provided with counselling on how to cope with the new situation at the onset of visual impairment; thus, resulting in families being in denial of the impairment of their children which could lead to visually impaired people being subjected to negative treatment or overprotection by their families. This can manifest in emotional and economic abuse. In some instances, participants reflected that they were kept indoors and not allowed to go outside if family members were to go to work. This is what Subrayen (2011) views as the root of social exclusion which is deeply embedded in the family structure.

Some of the participants revealed that they were voiceless when it comes to the utilisation of their disability grants as their families took advantage of their visual impairment and utilised it for their family purposes instead of rehabilitation services. The researcher regards this as an internal oppression of visually impaired people. The researcher argues that if families of visually impaired people do not form part of rehabilitation services at the onset of visual impairment, this may result in the rejection of visually impaired persons.

The study concludes that family is a major contributing factor to successful rehabilitation (Zilalem 2002; Taylor 2005). However, the lack of knowledge on rehabilitation services by families was determined as a stumbling block in achieving the goal of rehabilitation. The researcher noted from the participants' responses that rehabilitation and treatment efforts are conditioned to a large extent by the support the visually impaired person receives from their family. In view of this, the attitude of the family is largely responsible for the success or failure of rehabilitation efforts. The significance of the family during the rehabilitation process has been widely noted by the participants but this is not the case as families prefer other methods such as traditional practices (as evidenced in chapter 4) to using public rehabilitation services. This results in painful experiences as people who acquired visual loss end up facing irrevocable visual loss, and find it difficult to accept major lifestyle changes. It is concluded that families who are overprotective, highly anxious and/or who encourage dependent behaviours may prevent total rehabilitation or impede rehabilitation success. Furthermore, the researcher therefore concludes that rehabilitation can be impaired by lack of knowledge, attitudes, and behaviour of the family within which a visually impaired person lives.

On the other hand, families who communicate attitudes of essential worth to the rehabilitation client help to stabilise the self-concept, foster a positive attitude toward the future, and facilitate maintenance of rehabilitation gains. The research concludes that families can be a major asset or liability in any attempt at rehabilitation processes (Marson 2003; Seesurrun 2015). The research findings also indicate that the rehabilitation needs of visually impaired people are not fulfilled in uMkhanyakude district. There are no specific resources there either to address aspects of visual impairment or to integrate rehabilitation services for visually impaired people. These range from non-availability of disabled people's organisations, specifically trained social workers to provide services for visually impaired people, or any other structure that may impact the quality of life of a visually impaired person. There is not even a single special school for visually impaired children and thus they must travel to other districts in order to access education (Fish-Hodgson et al., 2012).

The challenge is that even those visually impaired children fortunate to access education far from their homes are also negatively impacted in various aspects of their lives. The study further revealed that visually impaired people do not access counselling and other psycho-social rehabilitation services. Lack of access to counselling is more common in individuals who are diagnosed with visual impairment later in life. Often, they are just left alone after the diagnosis and this exacerbates frustration, neglect, and exclusion. Therefore, it is imperative that society priorities counselling services specifically for those who become visually impaired later in life. Therapeutic and educational interventions can develop much needed self-esteem and help build assertiveness and negotiation skills (Cebekhulu 2016).

The research question on visually impaired people's views on the improvement of rehabilitation services reflected poor participation and involvement of visual impaired persons in key structures affecting their lives such as governing bodies, ward committees or any community structure and this has had a negative impact on people who are visual impaired. Lack of participation contributes to poor integration in society as well as in families. Moreover, no, or poor participation in policy development further infringes upon the rights of visual impaired persons and marginalises them. Resulting in their not being seen as equal to other South African citizens as articulated in section 9 of the South African constitution, referred to as the equality clause. It can be concluded that the way society views disability contributes immensely to the marginalisation and exclusion of the visually impaired in all the structures. This poses a severe challenge in promoting the self-representation of persons with visual impairment. Ultimately, the lack of access to information in formats legible to people with visual impaired further isolates them and it weakens their voice. This may have an impact on their self-representation in policy development, implementation, monitoring and evaluation. Ultimately, the lack of information contributes to the neglect of visually impaired people.

5. 3. Limitations

All research is subject to limitations and this study is no exception. The following are some of the study's limitations:

Since the study was conducted in a South African deep rural district, there were no comparative studies in rehabilitation for visually impaired people that are underpinned by indigenous African rehabilitation philosophy. Most of the studies available are Eurocentric and do not include indigenous African ways to cater for persons with visual impairment. This factor could have shaped different outcomes and experiences in relation to the focus of the study.

Another limitation arises from the fact that most participants have acquired visual impairment later in life with no counselling or rehabilitation services. This could limit the inputs on both experiences of rehabilitation and understanding of rehabilitation needs. The voices of visually impaired people who have received proper rehabilitation could have produced different results. This research study was constrained to visually impaired people from uMkhanyakude district.

A further challenge noted is that, due to the nature of the participants' impairment and lack of rehabilitation, all participants found it difficult to effectively participate in both individual and focus group interviews. This runs a risk of a dominant position between the researcher as the primary data collection instrument and the participants during data generation. In view of this, the visually impaired researcher with experience and knowledge of disability scenarios came into this research study with an insider perspective of participants and developed mechanisms to facilitate dialogue.

5.4. Recommendations

The following are three major recommendations drawn from the results of the interviews and the interactions with visually impaired participants from uMkhanyakude District:

a) Recommendations to improve services for visually impaired people.

b) Recommendations for social work practice.

c) Recommendation for further research.

5.4.1. To improve services for people with visual impairment

In addressing the inaccessibility of rehabilitation services of visually impaired people in uMkhanyakude district, healthcare professionals must be capacitated to understand the rehabilitation needs for visually impaired people. This will assist with developing and implementing clear referral pathways. Healthcare workers must understand that assistive devices play a central role in rehabilitation and the life of a person with a visual impairment.

It is thus critical that the public service must develop an improved assistive devise policy. In the policy, the Department of Health budgeting and procurement plan must include assistive devices for all visually impaired people. Furthermore, the budget must include the training aspect as well as the maintenance and servicing of assistive devices as part of the assistive devices policy implementation.

All participants noted that there is very poor access to rehabilitation services. In order to address the rehabilitation needs articulated by the participants, the development and utilisation of referral guidelines must be published for all professionals including doctors. The referral guidelines will assist the doctors and other professionals to work as a team, have database of where to refer the patient and there will be a continuum of care. Furthermore, the government must strengthen and facilitate intra- and inter-collaborations between all role players in the field of rehabilitation, and step-down facilities must be developed and a dedicated multidisciplinary team approach in each district hospital must be implemented. To improve access to information, compilation of an accessible and uncomplicated information-pack must be prepared and unified across all service providers in a range of preferred formats. This information-packs must be in accessible formats which will be provided to the diagnosed person with visual loss, his caregivers, and parents. In addition, the information-pack prepared should be updated and the stated measures put in place. Once services have improved and healthcare works are more equipped to deal with visually impaired people then visually impaired people can begin to build a more content representation of their ‘self’.

5.4.2. Improvement of social work practices by the public sector

Giving birth to a child with a visual impairment and/or acquiring visual impairment later in life evoke intense emotional feelings. In order to address the effects of giving birth to a child with a visual impairment or being diagnosed with a visual impairment, social work practices need to change and that change is largely influenced by government policies and regulations. Therefore, for social work practices to improve, the following suggestions need to be critically considered:

a) Government to include rehabilitation services in its organogram and develop professional norms and standards.

b) Universities to develop rehabilitation in post-graduate modules of social work, occupational therapy, optometry, psychology, and ophthalmology.

c) Proper referral and counselling after diagnosis by a relevant professional social worker who has been trained and understands the field of visual impairment and rehabilitation.

d) The Department of Health and Social Development must develop and conduct family adjustment programmes.

e) The establishment and management of support groups for and of visually impaired people and parents must be prioritised. Support groups will help both parents of visually impaired people and visually impaired people themselves to share their painful experiences and find the way of moving on with their lives.

f) Antenatal care services should include information on visual impairment to parents attending these services to prepare them for the eventuality of giving birth to a child with a visual impairment.

g) Additional social workers and psychologists must be employed to meet the Overwhelming need for disability counselling. Moreover, creative ways of using disability counselling skills could enable social workers to reach a wider band of visually impaired people. Moreover, to increase the relevance of disability counselling in South Africa, it is recommended that social workers receive the appropriate training from universities on disability counselling including the empowerment of families who have an individual with visual impairment.

5.5. Future research

As this was an exploratory study, future research is required to further examine different experiences of visually impaired people. In view of this study being conducted only in uMkhanyakude District, generalisation of the findings is not possible. Furthermore, a comparative analysis with other districts is not feasible. A more representative sample with diverse racial profiles is recommended for comparative analysis on the basis of race.

In addition, development of research approaches that take into cognisance the disempowered disabled groups who are not able to participate effectively in research processes, and to build research skills to facilitate dialogues with visually impaired people who are not used to speak for themselves. Further research is required for policy development, monitoring and evaluation processes and to develop instruments for improved clinical guidelines, norms, and standards. Future research should create dialogues which will unpack what constitute rehabilitation services in South Africa are required. Furthermore, research is also needed in the hope that the government will review its policies to include issues of visual impairment and the Department of Health will budget for the implementation of framework Strategy, Disability and Rehabilitation. This could be well implemented if the Department of Health will consider funding the employment of multidisciplinary approach professionals such as social workers, occupational therapists, and orientation and mobility practitioners in health facilities. Since a number of rehabilitation and disability policies do not explicitly include issues of visual impairment, important changes are required in that regard and so the more research is done in this area the more awareness will be brought about on issues of visually impaired people.

5.6. Concluding remarks

Increasing personal contact with visually impaired people by supporting them to access rehabilitation services, health, education, employment, and social activities on an equal footing with everyone else may prove to be the most important and equitable of interventions. This can be done through reviewing rehabilitation and disability policies and tackling the obstacles that prevent visually impaired people from accessing appropriate rehabilitation services and participating in social and cultural life. As more visually impaired people participate in all aspects of mainstream life, the more the general population would become increasingly informed and abandon stereotypes based on ignorance. Thus, one would expect that integration of visually impaired people in rehabilitation services would continue to grow and be prioritised within the public sector.

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ANNEXURES

ANNEXURE A

INFORMATION LETTER AND CONSENT FORM FOR PROSPECTIVE PARTICIPANTS[3]

Consent Letter

Dear ……………………………………………

My name is Mrs Bawinile Albertina Mdunyelwa and I am currently a registered Masters student at the University of KwaZulu-Natal (Howard College Campus). I am doing a research on the experiences of visually impaired people in accessing rehabilitation services in uMkhanyakude District in KwaZulu-Natal and would like to invite you to be part of the study. This would require you to participate in an individual interview of about an hour. Thereafter, you would participate in a focus group discussion together with other visually impaired persons. This discussion would also take about an hour. Please note that:

- Your involvement in this study is entirely voluntary, and should you agree to participate, you would be allowed to withdraw at any time. Also, there are no rewards for participating. So whichever way you decide, your relationship with me as your social worker in the KZN: Department of Health will not be affected in any way.

- You might find some of the questions I would be asking emotionally trying. Therefore, you would be free not to answer any question that could make you feel uncomfortable.

- A tape recorder would be used to capture the information shared. This is to ensure that it is correctly captured. This information would only be used for research purposes, would be kept completely confidential and destroyed after five years. Neither your name nor other personal details, contact or physical address would appear in my research reports.

- To participate in the focus group discussion, you would have to commit to keeping the information shared by other participants as confidential as I would be keeping yours.

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[3] This document is translated into isiZulu below.

- Should you have any further questions concerning this study and your role in it, you may contact me any time at 033 785 2116, or 071 308 3824. You may also speak to my research supervisor, Ms D Holscher at 031-260 3165, or 082 950 1414.

If you are willing to participate in this study, please sign the attached consent form.

Sincerely,

…………………………………………………..

Mrs Bawinile Albertina Mdunyelwa

Isicelo semvume

Igama lami nginguNkosikazi Bawinile Albertina Mdunyelwa, ngingumfundi wasNyuvesi yakwZulu-Natal eHoward College. Ngenza ucwaningo ngokubuyiselwa emalungelweni kwabantu abakhubazeke ngokungaboni emehlweni esifundeni saseMkhanyakude esifundazweni sakwaZulu-Natali. Ngithanda ukukumema ukuba ubambe iqhaza kulolucwaningo. Ukubamba kwakho iqhaza kuzodingeka ukuba uphendule imibuzo isikhathi esingangehora. Emuva kwalokho ungaphinde ubambe iqhaza ngokuhlanganyela nabanye ekuphenduleni imibuzo isikhathi esingangehora. Sicela wazi ukuthi ukubamba kwakho iqhaza kulolucwaningo kungukuzinikela ngokungaphoqwa. Uma uvuma ukuzibandakanya kulolucwaningo ungakwazi futhi ukuphuma uma ungasafisi ukuzibandakanya noma yinini. Akukhonzuzo ezotholakala ngokubamba iqhaza kulolucwaningo. Noma yikuphi uzokunquma mayelana nalolucwaningo ngeke kubuqede ubudlelwano phakathi kwakho nami njengosonhlalakahle womnyango wezempilo.

Eminye imibuzo engizoyibuza kungase kwenzeke ukuthi ingakuphathi kahle, ngakho-ke ukhululekile ukuthi ungayiphenduli imibuzo oyizwayo ukuthi ayehli kahle. Isiqophamazwi sizosetshenziswa ukuqopha lonke ulwazi esizoxoxa ngalo. Lokhu sizobe sikwenzela ukuhlolisisa ukuthi lonke ulwazi luqoqwe kahle. Lolulwazi luzosetshenziselwa lolucwaningo kuphela, luzogcinwa luyimfihlo luyobe selucishwa emva kweminyaka emihlanu. Igama lakho noma imininingwane yakho, izinombolo zakho zezingcingo noma amakheli akho eleposi noma lalapho ohlala khona ngeke kuvele kulolucwaningo.

Ukubamba iqhaza ekuhlanganyeleni nabanye abangaboni emehlweni kuzodingeka ukuthi uvume ukungakhiphi noma yiluphi ulwazi okuyoxoxwa ngalo kulowomhlangano. Lokhu ngiyocela ukuthi ukwenze njengoba nami ngizokwenza njalo ngengizokuxoxa nawe.

Uma unemibuzo ngalolucwaningo nangeqhaza ozolibamba kulona, ungangithinta ku 031 785 2116 noma 071 3083824. Ungakhuluma futhi nomeluleki wami kulolucwaningo unkosazana D. Holscher ku 031 260 3165 noma 082 950 1414.

Uma ufisa ukubamba iqhaza kulolucwaningo ngicela usayine lelifomu lesivumelwano elilandelayo.

Ngiyabonga

……………………………………………………..

Bawinile Mdunyelwa (Nkz)

ANNEXURE B

INFORMED CONSENT FORM[4]

I ………………………………………………………. have read / have been read the information about Mrs Bawinile Albertina Mdunyelwa's study on the experiences of visually impaired people in accessing rehabilitation services in uMkhanyakude District in kwaZulu-Natal. I understand the explanations of it given to me verbally. I have had my questions concerning the study answered and understand that:

- My involvement in this study is entirely voluntary, and I will receive no rewards for participating. I will be free to withdraw from the study at any time.
- My decision on whether or not to participate in, or withdraw from the study will not in any way affect my relationship with Mrs Mdunyelwa as a social worker in the KZN: Department of Health.
- Some of the questions I will be asked may be emotionally trying. I understand that I do not have to answer any question that makes me feel uncomfortable.
- A tape recorder will be used to record the interview and focus group discussion. The recorded information will only be used for research purposes, will be kept completely confidential and destroyed after five years. Neither my name nor other personal details, contact or physical address will appear in Mrs Mdunyelwa's research reports.
- I will treat the information shared by other participants in the focus group confidential. This means I will not share any information, opinions, or feelings with anyone outside of the group.

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[4] This document is translated into isiZulu below.

- I am welcome to contact Mrs Mdunyelwa or her research supervisor, Ms Holscher, regarding any questions that I may have in relation to the study or my participation in it.

Signature:…………………………… Date: ……………………………………

Ifomu lesivumelwano lokuzibandakanya ocwaningweni

Mina …………………………………… Ngilifundile noma ngifundelwe lonke ulwazi ngocwaningo olwenziwa unkosikazi Bawinile Albertina Mdunyelwa ngezimvo zabantu abangaboni ekutholakaleni kosizo lohlelo lokubuyiselwa emalungelweni esifundeni saseMkhanyakude esifundazweni sakwaZulu-Natal. Ngiyayiqonda incazelo engiyinikeziwe. Imibuzo ebengizayo ngocwaningo iphendulekile futhi ngiyaqonda ukuthi

- Ukuzibandakanya kwami kulolucwaningo kungukuzinikela, futhi akukho nzuzo eyotholakala ngokuzibandakanya. Ngikhululekile ukuthi ngingaqhubeki nokuzibandakanya noma ngasiphi isikhathi.

- Isinqumo sami sokungazibandakanyi noma sokuyeka ukuqhubeka nocwaningo ngeke kukbuthinte ubudlelwane bami nonkosikazi Mdunyelwa njengosonhlalakahle emnyangweni wezempilo esifundazweni sakwaZulu-Natali.

- Eminye imibuzo ezobuzwa izozwela. Ngiyaqonda ukuthi angiphoqelekile ukuphendula noma imiphi imibuzo engingazizwa kahle ngayo.

- Lokukuxoxisana kuzoqoshwa ngesiqophamazwi. Ulwazi oluqoshiwe luyosetshenziselwa izinhloso zocwaningo kuphela, luyogcinwa luyimfihlo bese luyashatshalaliswa emuva kweminyaka emihlanu. Akuyukuvezwa igama lami noma imininingwane yami, kubandakanya imininingwane yokuxhumana ikheli lalangihlala khona emibikweni yocwaningo lukankosikazi Mdunyelwa.

- Ulwazi oluyobe lucotshelelwa wozakwethu eqenjini lokuxoxisana ngiyoligcina luyimfihlo. Kusho ukuthi ngeke ngixoxele muntu nganoma iluphi ulwazi, imibono Kanye nemizwa ongeyona ingxenye yaleliqembu.

- Ngivumelekile ukuxhumana nonkosikazi Mdunyelwa noma umeluleki kwezocwaningo uNkosikazi Holscher mayelana nanoma yimiphi imibuzo engingaba nayo ngokubandakanyeka kulolucwaningo.

Ukusayina: ………………………… Usuku: …………………………….

ANNEXURE C

CONFIDENTIALITY AGREEMENT FOR RESEARCH ASSISTANT

I, Ms Boniswa Mkhize am going to assist Mrs Bawinile Albertina Mdunyelwa with her study on the experiences of visually impaired people in accessing rehabilitation services in uMkhanyakude District in KwaZulu-Natal. This role requires my participation in individual interviews and focus group discussions with visually impaired persons. My signature below indicates my commitment to keep all the information confidential that I may come to know in this role, including any of the participants' personal details and other facts, as well as their perceptions, opinions, and feelings.

Signature: …………………………… Date: ………………………………………

ANNEXURE D

GATEKEEPER LETTER AND CONSENT FORM FOR INDUNA[5]

P.O. Box 2862

Pietermaritzburg

3200

[Date]

Your Majesty,

RE: PERMISSION TO CONDUCT A RESEARCH STUDY AT INGWAVUMA AREA (MKHANYAKUDE DISTRICT)

My name is Mrs. Bawinile Albertina Mdunyelwa and I am currently a registered Masters student at the University of KwaZulu Natal (Howard College Campus). I am doing a research on the experiences of visually impaired people in accessing rehabilitation services in uMkhanyakude District, KwaZulu-Natal. I am seeking permission to conduct research on visually impaired people at the aforementioned area. This study is conducted with an intention of contributing to the existing body of knowledge regarding the experiences of visually impaired people in their families and communities. Participants will be required to attend an individual interview and a focus group discussion. The research finding will provide key recommendations which I hope will contribute to improving access to rehabilitation services among visually impaired people from uMkhanyakude District, KwaZulu-Natal.

To show your willingness to grant me the authority to conduct this study, I kindly request that you sign the form which is attached to this letter.

Yours sincerely,

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[5] This document is translated into isiZulu below.

……………………………………………………….

Mrs Bawinile Albertina Mdunyelwa

P.O. Box 2862
Pietermaritzburg
3200
[Date]

Ndabezitha

ISICELO SEMVUME YOKWENZA UCWANINGO ENDAWENI YASENGWAVUMA ESIFUNDENI SASEMKHANYAKUDE.

Igama lami ngingunkosikazi Bawinile Albertina Mdunyelwa. Ngingumfundi eNyuvesi yakwaZulu-Natal eHoward College ngenza ucwaningo lokubuyiselwa emalungelweni kubantu abangaboni emehlweni esifundeni saseMkhanyakude kwaZulu-Natal. Ngicela imvume yokwenza ucwaningo kubantu abangaboni kulendawo ebalulwe ngenhla. Lolucwaningo lwenziwa ngenhloso yokwengeza kokwenzekayo emndenini nasempakathini yabantu abangaboni. Abazobamba iqhaza bazolindeleka ukuthi babambe iqhaza ekuphenduleni imibuzo ngabodwana, kanye nasekuhlanganyeleni nabanye. Okuyotholakala ocwaningweni kuyoletha izincomo engethemba ukuthi ziyokwenza umehluko ekwakheni izimpilo zabantu abangaboni bakwazi nokuzimela.

Ukukhombisa ukuthi uyavuma ukuthi ngenze ucwaningo, ngicela uNdabezitha angisayinele lelifomu elitholakala kulencwadi.

………………………………………………….

UBawinile Albertina Mdunyelwa

ANNEXURE E

INDIVIDUAL INTERVIEWS SCHEDULE[6]

Consent Form

I, the undersigned ………………………………………………………………………… granted authority to Mrs Bawinile Albertina Mdunyelwa to undertake a research study on experiences of visually impaired people at uMkhanyakude District, KwaZulu Natal. I am aware that the research involves interviews and group discussions with visually impaired persons at my vicinity. I am aware of the steps that will be taken to ensure confidentiality of my people. I am aware that the data will be used to produce written reports and that these will not contain any identifying information about my people. I acknowledge that I gave my consent willingly and without being influenced to do so by the researcher or any other person.

Signature: …………………………………… Date: ……………………………

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[6] This document is translated into isiZulu below.

Mina

………………………………………………………………………………………………………

Nginikela imvume ku Nkosikazi Bawinile Albertina Mdunyelwa ukuba enze ucwaningo ngezimpilo zabantu abangaboni emehlweni mayelana nokubuyiselwa emalungelweni abo esifundeni saseMkhanyakude endaweni yasengwavuma. Ngiyaqonda ukuthi icwaningo luzothinta ukuxoxisana okujulile endaweni yami. Ngiyaqonda ngezigaba zokuqinikesisa ukuphepha kwabantu bendawo yami. Ngiyazi ukuthi ulwazi oluzotholokala luzosetshenziswelwa ukubhala imibiko ezoshicilelwa okunye ulwazi aluzukidicilela phansi abantu bami. Ngiyaqonda ukuthi imvume ngiyanilela ngayo ngaphandle kwengcindezi yomcwaningi noma omunye umuntu.

……………………………   …………………….

Ukusayina kweNkosi

1. **Age.**

2. **Education.**

   a. Primary education (Main stream, LSEN)

   b. Secondary education (LSEN, Main Stream)

3. **Visual impairment.**

   a. Totally blind

   b. Partially sighted

   c. Born blind

   d. Acquired visual impairment late in life

4. **Information.**

In what format do you access your information?

a. Braille

b. Large print

c. Sighted print

d. Electronic

e. Audio recording

Experiences of visual impaired people in accessing rehabilitation services.

1. Discuss your experiences in accessing rehabilitation services in your district?

2. Discuss your experiences in the provision of assistive devices by the department of Health in your district?

3. How do your family members support you in accessing rehabilitation services?

Feelings and reactions of visually impaired people in accessing rehabilitation services.

1. Comment on the provision of rehabilitation services by the government and non-governmental organisations in your district?

2. How do you as the visually impaired people feel about the implementation of rehabilitation services in your district?

Articulation of rehabilitation needs by visually impaired people.

1. Comment on the contribution made by visually impaired people in the provision of rehabilitation services in your district?

2. What rehabilitation needs required in your district?

Exploration of visually impaired people's views and involvement on the available rehabilitation services.

1. Comment on your involvement in community structures?

2. How is your participation in disability and rehabilitation forums?

3. Explain your views on visually impaired people's involvement on the current rehabilitation services in your district?

4. How is your collaboration with government department in relation to rehabilitation services?

5. What support do you get from the non-governmental organisations for visually impaired people in your district?

Recommendations.

How can rehabilitation services for visually impaired people be improved in your district?

ANNEXURE F

VISUALLY IMPAIRED PEOPLE FOCUS GROUP GUIDE

My name is Bawinile and I am the social work Masters student from the University of KwaZulu-Natal. I am going to facilitate this focus group about experiences of visually impaired people in accessing rehabilitation services in uMkhanyakude District. We will introduce ourselves, then we will get started.

Our group is going to be discussing the provision of rehabilitation services for visually impaired people in the district. I am currently working for the department of Health (Disability and Rehabilitation Programme). Everything you say here is confidential. Your name will not be used in any reports or materials. I do tape record the groups so that I can go back and review the tapes while I am writing the report. After I am done, the recordings will be kept in a safe custody and deleted after five years.

In order for the recording to work it's important that we each speak one at a time, and that you speak up at least as loudly as I'm speaking now.

If you have a cell phone with you, now would be a good time to turn that off so that we will not be interrupted, and I will go ahead and do that too.

I need to hear from everyone at least once and I would like to have everybody's opinion on all the major issues that come up. If I call on you to ask your opinion it is not because I want to put you on the spot, I just want to make sure everyone's opinion is heard. In the same way, if I interrupt you or cut you off, please do not be offended, I do not mean to be rude, I just have a list of questions and issues to get through and I need to get them all in.

The reason we have a focus group with a lot of different people in it, is that we want to get a range of opinions. If you agree with what someone else says, I would like to hear that because it is important to know that more than one person thinks that way. We do not have to come to an agreement though, and if you disagree with what someone else thinks, I would like to hear that too. What I am looking for is an idea of the range of opinions.

To start out the group, I would like for us to introduce ourselves. If you would tell us your name, how long you have lived in uMkhanyakude district and when did you lose sight.

First, I would like to discuss some of the issues facing the Visually Impaired community today. Please think about what you believe the top three issues are, and then we will discuss.

What examples have you thought of in relation to visually impaired people's experiences in the community?

Is that a common or uncommon situation?

What services exist?

What needs go beyond existing services?

Disabling barriers.

Let us talk about barriers we experience in community.

1. Information: Do you think that information to visually impaired people is accessible? Can you provide some examples of accessible or inaccessible?

2. Environmental/physical: Do you consider your district as physically accessible to visually impaired people? Can you give examples of places/buildings that you find difficult to access, including low cost government subsidised houses?

3. Attitudes: Can we talk about the attitudes of society towards visually impaired people. Are the attitudes of the society similar or different to that of the government officials? How are the attitudes of our families after discovering sight loss? How do we feel about the attitudes in general? Is there anything that can be done to address attitudes? Who do you think should do that?

4. Financial barriers: Are there any challenges that we encounter in relation to finances? What are those challenges? Is there a way to remedy the situation?

5. Relationships: Are we involved in any relationships? Can you tell us about the relationships you are in? How is it like? Does it have any challenges? What constitutes those challenges?

Visually impaired people's needs.

Purpose: Understand gaps in services, visually impaired people request that are not realistic or any challenges adapting existing services to visually impaired people's needs and wants.

My next question is related, but it is a little different. What are the top 3 rehabilitation services provided in the district for visually impaired people?

How are these similar to the top issues, and how are they different?

Educational rehabilitation.

Purpose: Understand attitudes and beliefs regarding educational rehabilitation.

Let us talk about education and the public schools. What are your thoughts about educational rehabilitation?

What are your thoughts about educational rehabilitation and how it assists visually impaired people?

Who amongst you have received educational rehabilitation?

Where did you receive it?

Was it satisfactory?

What gaps are there in the educational rehabilitation service offered?

What needs to be improved?

Training and psycho-social rehabilitation.

What are your thoughts about educational rehabilitation and how it assists visually impaired people?

Who amongst you have received training and psycho social rehabilitation?

What did it entail?

Where did you receive it?

Was it satisfactory?

What gaps are there in the training and psycho social rehabilitation service offered?

What needs to be improved?

What do they do well?

What gaps are there in the services they offer?

What services need to be improved?

Medical rehabilitation.

Who amongst you have received medical rehabilitation?

How old were you when you receive medical rehabilitation?

Which clinic, hospital, community health centre did you receive it?

Who referred you for medical rehabilitation?

What was the reason for being referred to the medical rehabilitation?

What did it entail?

Was it satisfactory?

What gaps are there in the medical rehabilitation service offered?

What needs to be improved?

Vocational rehabilitation.

What type of skills did you receive in vocational rehabilitation?

When did you receive that training?

After receiving it what happened?

Do vocational rehabilitation skills assist you in any manner?

Can you tell us how does it assist?

Are there any challenges or gaps in the provision of vocational rehabilitation services?

How can these challenges be resolved?

Community rehabilitation providers.

Purpose: Explore relationships with CRPs, (perceptions of quality of services).

Next, let us talk about community rehabilitation providers.

How would you describe the services provided to visually impaired people through community rehabilitation workers? I am not asking what specific services they provide; I am asking you to describe the way they provide services.

Please think about 3 words that come to mind, and then we will discuss them.

Probe for:

a. Quality of services
b. Comprehensiveness
c. Flexibility motivation

What do you think are the primary concerns facing individuals who are visually impaired over the next five (5) years?

What could the government do to improve its services?

That is all the questions I have for you today. Thank for participating.

<<Ends>>