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Perceptions of Physiotherapists on Disability: Awareness and Health Promotion

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A Thesis submitted to the College of Health Sciences,

University of KwaZulu-Natal, in fulfilment of the requirements for the degree of **Master of Physiotherapy, Health Sciences**

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Ethical Clearance:

HSS/0264/017M

DECLARATION

I, JOAN PATHER, Student number 8830502, declare that,

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2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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DEDICATION

GOD

My first and foremost dedication is to my LORD AND SAVIOUR JESUS CHRIST for His grace and mercies and for making this possible for me: “I can do all things through Christ who strengthens me” Philippians 4:13

MY HUSBAND, MY DAUGHTER

“The price of success is hard work, dedication to the job at hand, and the determination that whether we win or lose, we have applied the best of ourselves to the task.”

Vince Lombardi

ACKNOWLEDGEMENTS

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My supervisors - thank you for your unwavering support and guidance through this journey. It was an amazing learning experience.

My colleagues, thank you for your participation, sacrifice and support in making the study a success. Without you, there would have been no study.

All of your support has allowed for my growth in learning. Thank you, thank you and May God richly reward you.

ABSTRACT

Background: The lack of effective accommodation and integration of people living with disabilities in the community raises the need for rehabilitation professionals such as physiotherapists to deliver disability awareness programmes. These programmes aim to reduce environmental and attitudinal barriers that exist in their communities. Limited information about the perceptions of physiotherapists in South Africa on disability awareness programmes is available.

Objectives: To explore perceptions of physiotherapists on disability awareness programmes as a health promotion strategy in public healthcare.

Method: Two focus group discussions were conducted with public healthcare physiotherapists employed at urban and rural facilities. Transcribed data were analysed using conventional content thematic analysis and described perceptions of participating physiotherapists on disability and disability awareness programmes targeting community awareness.

Results: The discussions revealed five major themes, namely, knowledge dearth consequence, personal factors, facilitators to disability awareness programmes, barriers to disability awareness programmes, and recommendations.

Conclusion: The need to address the barriers to disability awareness programmes is essential to advocate for disability issues that pose environmental and attitudinal barriers to access in all areas of society. Access to healthcare is hindered by lack of understanding and subsequent behaviour including stigmatisation of people with disabilities. Therefore, it is essential for rehabilitation professionals to offer comprehensive disability culturally sensitive awareness programmes to communities in order to influence attitudes and behaviour toward people with disabilities.

Keywords: disability. Disability awareness programmes, physiotherapists, public healthcare.

CONTENTS

LIST OF TABLES

ABBREVIATIONS

PLWD	Person/People living with disability
ICF	International classification of
DAP/s	function Disability awareness programme/s
KZN	KwaZulu-Natal
NRP	National rehabilitation policy
SA	South Africa
WHO	World Health Organisation
CCG	Community care giver
CRW	Community rehabilitation worker
CBR	Community based rehabilitation
PHC	Primary health care
HAMSOC	Health Education, Appropriate Media and Technology and Socio-cultural Sensitivity

OPERATIONAL DEFINITIONS

Disability: According to the National Council for Persons with Physical Disabilities in South Africa (NCPLWDSA) in 2006, Cabinet adopted the definition of disability as follows: “the loss or elimination of opportunities to take part in the life of the community equitably with others that is encountered by persons having physical, sensory, psychological, developmental, learning, neurological, or other impairments, which may be permanent, temporary, or episodic in nature, thereby causing activity limitations and participation restriction with the mainstream society” (Burger, & Burger, 2010).

Disability awareness: being mindful of disabilities and people living with disabilities by educating others to manage, communicate and work with them effectively (Langtree, 2010).

Knowledge of disability: refers to the understanding of disabilities including knowledge of the different types of disabilities, communication strategies for people with disability as well as legislative mandates and collaborative structures that are used in encounters with people living with disabilities (PLWD).

Attitudes toward disability: complex collection of beliefs, feelings, values and dispositions that characterise the way people think or feel about disability or people with disability.

Cultural Beliefs: Cultural beliefs define who people are, how they interact with the world and how they behave in certain situations and can be considered a combination of religious beliefs, socially accepted norms and traditions (Bailey, Erwin, & Belin, 2000; Omu, & Reynolds, 2012; Martin et. al.., 2007)

CHAPTER 1 – INTRODUCTION

1.1. Background

The World Health Organisation (WHO) defines disability according to the international classification of function disability and health (ICF) as a broad term that covers the impairments, activity limitations and participation restrictions of an individual. The ICF enhances the understanding of disability from that of a previous impairments based biomedical model to a model that integrates biological, social, psychological and cultural factors of disability. This framework allows for holistic assessment and management of people living with disabilities (PLWD) in his/her context taking into account environmental factors affecting the individual's health status. This model acknowledges that overcoming the challenges faced by PLWD requires address of social and environmental barriers not merely management of impairments related to body function or structure (WHO, 2001).

The reported prevalence of disability globally is estimated at approximately 1 billion people (WHO, 2011). Disability prevalence in South Africa, according to a census conducted in 2011, showed a population of 7.5% PLWD in SA and of these, 2.5% of were disabilities related to mobility and physical functioning (Stats SA, 2014). The association between poverty and ill health or disability has long been established (Elwan, 1999). Lower and middle-income countries are often disproportionately affected by disability. Furthermore, PLWD are far more likely to either be denied medical care, or offered sub-standard medical care (WHO, 2011).

Society in general is often less acquainted with the causes, burden or challenge of disability until they are directly affected by it personally or through the people around them (Masasa, Irwin-Carruthers, & Faure, 2005). As a result, perspectives regarding the causes and outcomes of disability are often informed and deeply rooted in spiritual and cultural beliefs as opposed to biological details. A lack of knowledge pertaining to causes of disability gives rise to social integration challenges for PLWD. Community members with inadequate understanding of disabilities may develop misinformed opinions of PLWD contributing to inappropriate attitudes and behaviour including demonstration of poor disability etiquette toward PLWD (National Disability Authority,

2007). PLWD often feel notably isolated and suffer discrimination and stigmatisation in their communities (Lusli et. al.., 2015). Additionally, the attitudes of health professionals toward PLWD is directly related to the level and quality of healthcare that they receive (WHO, 2011). These factors have been shown to directly reduce the health seeking behaviour of PLWD (Wegner, & Rhoda, 2015; Hussey, McLachlan, & Mji, 2017). A vicious cycle of shame, isolation and finally poorer health due to unmet health needs then ensues. For reasons like these, disability awareness promotion (DAP) is crucial to both PLWD and the public at large so that PLWD are recognized as valuable, contributory members of their societies and not marginalised due to environmental and attitudinal barriers.

South African legislature for rehabilitation are underpinned by the principles of primary healthcare (PHC) and community based rehabilitation (CBR). PHC was a movement initiated over three decades ago in an attempt to address the political, social and economic inequalities related to healthcare globally, with the aim of better health for all (WHO,1978). The essential features of this healthcare delivery system includes "accessibility, equity, social justice and protection, improved first contact with the healthcare system, decentralisation of the existing health system, without neglecting the quality of care on higher-level medical services". The PHC approach aims to lessen the burden on secondary and tertiary institutions and support people to manage their health conditions at a primary level, in the community (World health report, 2008). PHC includes the use of local people such as traditional healers and community health workers (WHO, 2008). The current delivery of healthcare in South Africa lacks translation of policy into practice. CBR is a model of service delivery that fits perfectly into the vision of PHC. CBR was initiated after the 1978 Alma Ata declaration on PHC as a strategy to improve access to rehabilitation services in resource poor settings. It is now a multi-sectorial approach aimed at social inclusion and equalising opportunities for all PLWD (WHO, 2010). The CBR matrix or strategy for CBR broadly summarises CBR in five categories of health, education, livelihood, social and empowerment for PLWD. This matrix provides a clear picture of the components to be included in CBR. CBR principles are further classified as participation, inclusion, sustainability and self-advocacy. While PHC and CBR are grounded in strong constructs, Mji et. al. (2013) commented on the current delivery and implementation of these models. The authors cited shortages of healthcare

workers, poorly balanced

allocation of resources and a predominantly curative-orientated health service and even at primary levels of care the major challenges to CBR principles being converted from policy to practice. In order to appropriate the ideals of PHC and CBR a team of health professionals is required. Physiotherapists are essential role players in the multidisciplinary team particularly in the context of PLWD. Physiotherapists are responsible for managing activity limitations and participation restrictions related to the patient's primary impairments. Health education and health promotion are embedded in physiotherapists' undergraduate training and are fundamental components to implementing CBR as part of fulfilling the goals of PHC (Bury, 2005).

1.2. Problem statement

Persons with Disabilities still face challenges with acceptance and accommodation in the community due to a lack of understanding of disability awareness issues and effective disability awareness strategies. There is a need for health professionals such as physiotherapists to advocate and implement disability awareness programmes that will accommodate the viewpoints and expectations of the community and people living with disability. The physiotherapist's knowledge, attitude and belief towards disabilities influences the manner in which they are able to promote disability awareness in the various communities. A lack of knowledge about disabilities, negative attitudes and poor accommodation of cultural and religious beliefs has unsuccessful outcomes for disability awareness promotion (Wegner, L., & Rhoda, A. 2015) (Eide, A. H., et. al., 2015). Physiotherapists' attitudes toward PLWD in community healthcare settings also influences the manner in which disability awareness is approached. Although many studies have investigated the knowledge, attitudes, beliefs and practises of health professionals towards disability (Culp, 2016; Gething, 1993; Badu, Opoku, & Appiah, 2016), fewer studies have explored the perceptions of healthcare professionals toward disability awareness strategies or programmes (Gething, 1993; Badu, Opoku, & Appiah, 2016) as health promotion strategies, and to the researchers knowledge, no studies have separately explored the perceptions of physiotherapists toward disability awareness programmes.

1.3. Research question

What are the perceptions of physiotherapists on disability awareness programmes in public healthcare institutions KwaZulu-Natal?

1.4. Aim

The primary aim of the study was to explore perceptions of physiotherapists on disability awareness programmes within public healthcare institutions in KwaZulu-Natal, South Africa in order to understand how these perspectives may influence the care offered to PLWD by physiotherapists in these settings.

1.5. Objectives

1.5.1. To explore physiotherapists' knowledge on disability awareness in KwaZulu-Natal.

1.5.2. To explore the facilitators to disability awareness programmes in the communities of KwaZulu-Natal.

1.5.3. To explore the barriers to disability awareness programmes in KwaZulu-Natal

1.5.4. To make recommendations for future physiotherapy practise in terms of educational development and training.

1.6. Significance

This study will provide information on the perceptions of physiotherapists towards disability and disability awareness programmes which may be useful to the Department of Health's physiotherapy bodies in the province, highlighting barriers, facilitators and recommendations for future disability awareness strategies.

The results of this study may also inform future undergraduate physiotherapy training and practise. The study will also influence barriers of participation in healthcare that exists in South African communities by mitigating against poor knowledge and attitude toward PLWD (Grut, L., Braathen, S. H., Mji, G., & Ingstad, B., 2012).

1.7. Overview of the manuscript

The manuscript adheres to the College of Health Sciences guidelines posted on the 20 August 2015 [Appendix 1]. This document guides the submission of the master's degree. The method of choice for submission for this study is "a thesis by manuscript". The candidate may have at least one paper as the prime author that has not yet been published but is in the form of a manuscript. This thesis is divided into four chapters.

Chapter 1:

This chapter introduces the study and the question that framed the aim and objectives

and the significance of the study. It also provides insight into the structure of the thesis in its entirety and describes the flow of the contents.

Chapter 2:
This chapter delves into the contemporary literature that assisted in contextualising the study.

Chapter 3:
This chapter is presented in its original form as submitted to the Journal: African Journal of Disability.
Pather J, Chetty V, Maddocks S, Chemane N, “Instead of just focusing on the people living with disabilities and the community. Let us also focus on ourselves working in the community”: Physiotherapists perceptions of Disability awareness programmes in KwaZulu-Natal. AJOD. 2017; in review.

Chapter 4:
This chapter concludes the manuscript by summarising the study findings and assessing whether the study objectives were met. It also includes limitations of the study and recommendations on how to take this work forward.

CHAPTER 2 - LITERATURE REVIEW

2.1. Disability awareness promotion

Disability awareness promotion is aimed at improving knowledge and acceptance of PLWD for the public including PLWD (Twible, & Henley, 2000). The hope is that educating people will improve their knowledge of the causes of disability and to advocate for the support PLWD require in order to be contributory members of society having equal opportunities to live satisfying lives. Additionally, the education is also aimed directly at PLWD so that they are empowered with knowledge regarding their rights and responsibilities toward maintaining and improving their health. Disability awareness although critical for the promotion of health and wellbeing of members of the community, must offer good practice by the cadre of rehabilitation professionals in healthcare to PLWD (Frantz, 2008; Rao, Sharmila, & Rishita, 2002). Physiotherapists who form part of the team of rehabilitation professionals are responsible for the optimisation of activity and physical function as well as integration of PLWD into communities (Frantz, 2008). In South Africa, physiotherapists study a four-year undergraduate degree, complete a mandatory community service year of practice and are governed by statutory requirements provided by the Health Professions of South Africa (HPCSA). They are regarded as essential healthcare providers for PLWD as they spend a lot of time interacting with the communities and patients and have an understanding of the factors affecting health in the community (Joseph, 2011). In addition physiotherapists can be consulted directly without medical referral (Cobbing et. al.., 2013; Diener, 2010), thus making them more accessible to individuals in the community. Therefore, it is integral for this cadre of professionals to demonstrate adequate knowledge and understanding of disabilities, display disability etiquette and positive attitudes toward PLWD (Joseph, 2011). Furthermore, they should be sensitive to religious and cultural beliefs of the community they serve (Wegner, & Rhoda, 2015) (Joseph, 2011).

2.2. Knowledge about disability amongst community members

Knowledge about disability among the public is critical to sensitise all people to the needs and challenges faced by PLWD so that they may be better accommodated by communities and more inclusively integrated into society. A mixed methods study by

Masasa (2005) investigated the knowledge, attitude and beliefs of caregivers of PLWD relating to disability among three cultural groups (white, coloured and black) in the Western Cape of South Africa. The results showed that participants of black ethnicity particularly, had far less exposure to disability awareness or knowledge about disability than white or coloured participants who had become acquainted with disability at an earlier age. Adequate knowledge and understanding of disabilities facilitate more positive attitudes toward PLWD (Joseph, 2011).

2.3. Knowledge of physiotherapists

Apart from the clinical knowledge of the conditions leading to disabilities, physiotherapists require extensive knowledge of the ICF principles, the CBR matrix, PHC and legislature that governs and protects PLWD in order to educate and promote disability awareness in the community. In addition, they must be knowledgeable about the use of appropriate communication skills.

The acquiring of knowledge by physiotherapists must be an ongoing process through continuing education programmes either formally or informally. A study by Sutherland and student teacher (2004) investigated the attitudes towards inclusion of children with disabilities in mainstream education based on knowledge vs experience in preservice and in-services educators. In-service educators were pragmatists whose attitude towards inclusion depended on their experience in the field of education. The preservice educators who was in the training phase of their career used the knowledge gained in their training to complete the surveys. The results showed that the preservice educators demonstrated more positive responses to the inclusion related topics such as knowledge of special education, positive effect of inclusion, teacher preparation programme, willingness to teach in inclusive classrooms, effective for student with disabilities, inclusion of special needs students and sufficient training. This study revealed that the positive response towards inclusion of children with disabilities in the classroom was based on their current learning in the teacher training programmes as they lacked experience at this stage. Comparatively the negativity demonstrated by the in-service educators was based on their experiences. This research thus confirmed that updated knowledge together with experience might have a positive influence on attitudes to PLWD. A further study by Raj & Thomas (2015) explored the effectiveness of training CBR personnel with regard to their knowledge on

multiple

disabilities. The training of the CBR workers in the study was aimed to be local and addressed the needs of the projects they serve. The results showed that there was an improvement in the knowledge outcomes after three monthly training interventions over a period of twelve months. This showed that conducting regular training as a part in continuing education is an important source for better outcome. Since South African physiotherapists are required to acquire continuous professional development (CPD) points as a requirement of the physiotherapy profession (HPCSA), such training and development programmes can be held within the context of the areas they service.

The implementation of ICF and CBR approaches to disabilities require that health professionals such as physiotherapists need to have a holistic understanding of disabilities i.e. they need to understand the diagnosis not only from a medical point, but the cause of the impairment, and limitations in activity experienced by the PLWD and the restrictions to active participation in the community (Masasa et. al.., 2005).

When communicating with PLWD and speaking about disabilities physiotherapists need to understand and apply the use of disability etiquette, i.e. the use of proper terminology and verbal and non-verbal language to avoid discrimination and offense to PLWD. The incorrect and in appropriate use of terminology and verbal and non-verbal language such as “disabled people” as compared to the term “People with Disabilities” generates feelings of social detachment between health professionals and PLWD (Culp, 2016). The correct use of PLWD indicates that they are regarded as people first, before their disability is indicated.

Communication strategies such as the use of direct communication with PLWD and the planning of communication means for persons with difficulties in communication is a skill that is essential in enabling effective communication with PLWD (Rathod, Alagsen, 2014; Shakespeare, & Kleine, 2013). Direct communication involves interacting with the PLWD directly and not only through carers, relatives or other representations. In order for physiotherapists to educate, advocate and collaborate in the community on disability issues they need to understand the current guiding national and international policies that help to overcome barriers faced by PLWD (Mji et. al.., 2013). The National Rehabilitation Policy (NRP) (DoH, 2000) promotes

community-based services and adopts the Primary Healthcare (PHC) approach to service delivery. This, however, has been very challenging to implement in South Africa (Kautzky, & Tollman, 2008; Mji et. al.., 2013). Among a combination of factors cited as the reason to the challenge was that health professionals still adopted a biomedical approach to service delivery (Kautzky, & Tollman, 2008.). This may have resulted from a lack of knowledge by healthcare workers regarding policy changes together with inadequate skills to

implement the PHC principles according to the biopsychosocial model (Mji et. al.., 2013).

2.4. Attitudes of community members toward PLWD

PLWD experience significant stigmatisation by society. In a recently published local newspaper article, the manager of a prominent physical activity facility indicted PLWD as seekers of 'special attention" (Zungu, & Mngadi, 2014). While these prejudices are often the result of ignorance leading to a lack of sensitivity toward the needs of PLWD, cultural influences also play a very critical role, shaping the views and attitudes of the community toward PLWD (Masasa et. al.., 2005). A study by Wegner and Rhoda (2015) exploring the influence of cultural beliefs on the utilisation of rehabilitation services in rural South Africa confirmed that cultural beliefs may enhance discrimination and stigmatisation against PLWD. The study found that community members saw PLWD as cursed and if they were unable to work, they were perceived as having little value in the society. Awareness of disability in the community helps improve attitudes and behaviour towards PLWD by curbing misunderstandings regarding disability causes and outcomes (Aiden, & McCarthy, 2014; Rao, Sharmila, & Rishita, 2002; Masasa et. al.., 2005). Disability awareness highlights the need to view PLWD as an integral part of society (Rao, Sharmila, & Rishita, 2002). Furthermore it enhances the health seeking behaviour of caregivers and PLWD themselves by making them knowledgeable in all areas of PLWD (World report on disability, 2011).

2.5. Attitudes of healthcare professionals toward PLWD

The attitudes of healthcare professionals, shapes society's attitude towards PLWD (Al-Abdulwahab, & Al-gain, 2003). Negative attitudes of health professionals towards PLWD may promote discriminatory behaviour toward PLWD by the community and a

cause lack of confidence and motivation by PLWD (Masasa, 2002). The WHO acknowledges disability as an issue pertaining to human rights, accepting that PLWD are usually more vulnerable, discriminated against and are often denied autonomy (Who global disability action plan 2014-2021). Healthcare professionals' perspectives influence policy decisions, allocation of healthcare and other resources, as well as employment opportunities for PLWD (Kirchman, 1987; Chamberlain, 1998; Walker, 1993). This places an onerous responsibility on healthcare professionals to be satisfactorily informed in order to appropriately advocate regarding best practise for PLWD.

Vincent-Onabajo and Malgwi, (2015) quantitatively examined the attitude of final year physiotherapy students in Nigerian universities toward PLWD. The study found that the overall attitude of the students was positive but the students held negative perceptions regarding the emotional capacity of PLWD. The study highlighted that negative attitudes about PLWD may be influenced through education and training as the findings revealed that issues relating to stigmatisation, discrimination and misconceptions about PLWD had not been sufficiently covered in undergraduate education. Factors such as experience and frequency of contact with PLWD, as well as professional supervised contact during undergraduate training have been found to have a positive impact on attitudes of students towards PLWD (Shakespeare, & Kleine, 2013; Satchidanand et. al.., 2012; Al-Abdulwahab,, & Al-gain, 2003). Gender differences have also been shown to influence health professionals' attitudes toward PLWD. A study by Satchidanand et. al.., (2012) highlighted gender based attitude disparities in therapists' toward PLWD, where female professionals displayed significantly more positive attitudes toward persons with physical disabilities than males, however, these findings were not supported in other similar studies (Al-Abdulwahab,, & Al-Gain, 2003; Al-Zahrani, 2012). In the study by Al-Abdulwahab, & Al-Gain, 2003 this difference could be attributed to the fact that the study was limited to a small sample size and there were only three healthcare disciplines in the study. Another study by Badu, Opoku, and Yaw Appiah, (2016), examined the perspective of people living with disabilities on health professionals' attitudes towards their healthcare in the Kumasi Metropolis in Ghana. The study adopted a quantitative method with a cross sectional design whereby PLWD were interviewed in a language of their choice and a questionnaire was completed. The study found that PLWD experienced discrimination in the form of delays in services delivery, the use of

derogatory remarks, the type of services accessed and the location of the services. Furthermore, they reported that healthcare providers were unfriendly and displayed a lack of time and discomfort when attending to PLWD. It was concluded that healthcare providers needed in-service training to update their knowledge on disability issues to improve their attitudes.

A study by Dorji and Solomon (2009) investigated the impact of attitudes of physicians and nurses in Bhutan towards PLWD. It was the first of such a study conducted in Bhutan amongst health professionals and it was found that the Bhutanese physicians and nurses demonstrated less positive attitudes towards PLWD when compared to their counterparts in other western countries. This was attributed to a lack of experience with rehabilitation of PLWD and cultural differences between the eastern and western countries. Most of the doctors were trained outside of their country, thus adopted the western principles of training which was not well received in the context of the Bhutanese population. The doctors however had better attitudes to PLWD than the nurses that was attributed to them acquiring knowledge of rehabilitation in training.

2.6. Beliefs about disability

Masasa et. al. (2005) meaningfully highlighted the disparity in the beliefs of caregivers of children born with disabilities among white, black and coloured caregivers in the Western Cape. Participants of black ethnicity mostly emphasised that disability was a result of a curse, witchcraft or a consequence for bad behaviour. On the contrary participants from the white and coloured community felt that their children's disability resulted from their own poor health-related decisions for example omitting important childhood vaccinations or as an act of God since he trusted them with the "blessing" of a disabled child. This stark contrast in beliefs provides good evidence for the need for health education and promotion which could be provided by DAP's. The same study (Masasa et. al.., 2005) encouraged health professionals to advocate for and implement DAP's accommodating viewpoints of caregivers. The study also revealed the necessity of disability awareness programmes to highlight causes and prevention of disability in the perinatal period as knowledge about the causes of disabilities in babies was particularly lacking. The result of this lack of

knowledge was that mothers from sub-economic areas were less likely to attend antenatal clinic check-ups.

In order to optimise management of PLWD a team of healthcare professionals is often required. Good collaboration between team members is critical for co-ordination and continuation of care for PLWD (Maddocks et. al.., 2017; Chetty, & Maharaj, 2013). Bruner et. al. (2011) explored the collaboration of an interdisciplinary healthcare team serving an underprivileged community in America. The results of this study emphasised the need for cultural sensitivity training among staff members in the team to accommodate patients of varying beliefs and cultures. The study further suggested that the ethnicity of staff members in health facilities should match the demographic of the people that they are serving. However, this may not be feasible in the South African context due to the diversity and spread of the population. By confining the healthcare workers to their ethnical areas would violate their rights to choose their areas of work. Masasa (2005) supported these findings concluding that health professionals ought to be trained in matters regarding culture sensitivity and respect for the value systems and beliefs of their patients. This gap should be addressed at undergraduate level to ensure that healthcare workers are made aware to cultural sensitivity from the beginning of their professions. The recent introduction (2017) of decentralised training (DCT) by the University of KwaZulu-Natal of fourth year students aims to encourage training of physiotherapists in rural settings, thus exposing them to a variety of socio-cultural factors of healthcare.

A qualitative study by Wegner, and Rhoda, (2015), explored the cultural beliefs that affect the utilisation of rehabilitation services in a rural community in South Africa from the therapists' perspective. The physiotherapists identified factors of cultural beliefs such as cause of a disease, stigma and community perception of a person's worth as factors preventing the utilisation of rehabilitation services. At the same time, other factors of cultural beliefs such as patients' conviction regarding the efficacy, continuity and quality of rehabilitation hampered the continuation of rehabilitation. These negative findings in the study indicated that it is imperative that healthcare providers possess skills of cultural awareness and competence in order to deliver the most appropriate service that fulfils the needs of the community. A further qualitative study by Alqahtani (2015) explored the views and beliefs of stroke survivors in Saudi Arabia via semi- structured interviews. The results showed that cultural beliefs

predominated as the cause for the stroke during interviews, and lifestyle, behavioural and cultural interventions were cited as coping strategies of the individuals living with stroke. The study concluded that health professionals who are trained differently from their patients need to possess cultural competency in order to manage the cultural beliefs of patients undergoing rehabilitation.

The diversity of religious and cultural beliefs impacts on the manner in which the community will receive the information given, the home programmes advised on and interaction with PLWD in the community. Hence it is essential for physiotherapists to gain the confidence and participation of the community members by engaging the traditional healers and involving PLWD themselves in the awareness programmes (Masasa et. al.., 2005; Mji et.al., 2013).

Disability awareness programmes should be underpinned by the ICF in order to help physiotherapists and other healthcare professionals, PLWD and community members view disability and its impact on the individual in their context. The ICF, based on the bio-psychosocial model of functioning and disability, includes the interaction between an individual and all other related factors in the individuals set of circumstances. The ICF integrates the physical, psychological, emotional, environmental and social aspects of daily functioning.

A study by Rhoda, Waggie, Filies, and Frantz (2016) reported on the use of the conceptual frameworks of the ICF and CBR matrix in identifying the needs of the community and thereby planning interventions to address the needs by a group of Interprofessional students. It was found that the students were able to identify limitations that went beyond impairments such as environmental barriers, lack of skills and social interactions that could be addressed in a collaborative manner through various programmes. The study by Kostanjsek (2011) further, informs about the adoption of the ICF to document and code functional status information in line with conceptual framework that was agreed upon by the world health organisation. The ICF can be used in a multipurpose manner and in a variety of settings. It can be used for health and disability data collection, compilation and analysis; policy development and service provision. This was evident in a study by Good (2011) which reflected on the use of ICF in Ireland. The case study highlighted the following four effects of the use of ICF in the framework of National Disability Survey (NDS) in Ireland – (a) the NDS

was able to allow for a wider range of disabilities to be incorporated into the survey; (b) the environmental factors included in the survey were policy relevant; (c) barriers and facilitators were embodied in the survey and (d) a focus on research ethics was encouraged in the survey.

CHAPTER 3 – ARTICLE IN REVIEW

3.1. Introduction

In this chapter, the article as submitted to the African Journal of Disability is included. The article summarises the findings from the focus group discussions conducted with two groups of physiotherapists employed at rural and urban settings. The paper aimed to explore the perceptions of physiotherapists on disability awareness programmes as a health promotion strategy in public healthcare. Ten physiotherapists where included in the study. The questions focused perceptions on disability awareness programmes. Ethical clearance of the study was obtained from the University of KwaZulu-Natal – Reference Number HSS/0264/017M [Appendix 2]

3.2. Publication details

Title: Physiotherapists perceptions of Disability awareness programmes in KwaZulu-Natal.

Journal: African Journal of Disability

Volume: in review

Number: in review

Pages: in review

Journal Details: Peer reviewed (blinded)

Listed with Department of Higher Education & Training (DoHET)

Impact Factor: No impact factor was found

Refer to table of statistics

Table 4.1: Statistics for African Journal of Disability

Year	Sessions	Users	Page views
2011	936	405	4326
2012	5111	2527	34285
2013	11339	7771	47768
2014	18831	13536	67411

Year: 2017

3.3.1. African Journal of Disability

AJOD, the official journal of CRS, AfriNEAD and CEDRES, introduce and discuss issues and experiences relating to and supporting the act of better understanding the interfaces between disability, poverty and practices of exclusion and marginalisation. Its articles yield new insight into established human development practices, evaluate new educational techniques and disability research, examine current cultural and social discrimination, and bring serious critical analysis on problems shared across the African continent. Emphasis is on all aspects of disability particularly in the developing African context. This includes, amongst others: disability studies as an emerging field of public health enquiry, rehabilitation, including vocational and community-based rehabilitation, community development and medical issues related to disability and poverty, disability-related stigma and discrimination, inclusive education, legal, policy, human rights and advocacy issues related to disability the role of arts and media in relation to disability, disability as part of global Sustainable Development Goals transformation agendas, disability and postcolonial issues, globalisation and cultural change in relation to disability, environmental and climate-

related issues linked to disability, disability, diversity and intersections of identity, disability and the promotion of human development.

3.3.2. Publication Record

The article was submitted on the 27 November 2017. The article is now in review.

3.3.3. Contribution Record

The candidate developed the protocol for her masters in physiotherapy at the University of KwaZulu-Natal. Three academic staff members supervised the study.

3.4. SUMMARY OF FINDINGS

The need to address the barriers to disability awareness programmes is essential to advocate for disability issues that pose environmental and attitudinal barriers to access in society for PLWD. Access to healthcare is hindered by lack of understanding and subsequent behaviour including stigmatisation of people living with disabilities. Therefore, it is essential for rehabilitation professionals to offer comprehensive disability, culturally sensitive awareness programmes to communities in order to influence attitudes and knowledge.

3.5. AJOD South African Family Practice Journal

Title: Physiotherapists perceptions of Disability awareness programmes in KwaZulu-Natal.

Abstract

Background: Disability awareness programmes are essential for rehabilitation professionals such as physiotherapists to provide understanding of disability, influence of environmental and attitudinal societal barriers. There is paucity on perceptions of physiotherapists on disability awareness programmes in a South African context.

Objectives: To explore perceptions of physiotherapists on disability awareness programmes as a health promotion strategy in public healthcare.

Method: Two focus group discussions were conducted with public healthcare physiotherapists employed at urban and rural facilities. Transcribed data were analysed using content thematic analysis and described perceptions of participating physiotherapists on disability and disability awareness programmes targeting community awareness.

Results: The discussions revealed five major themes, namely, knowledge dearth consequence, personal factors, facilitators to disability awareness programmes, barriers to disability awareness programmes, and recommendations.

Conclusion: The need to address the barriers to disability awareness programmes is essential to advocate for disability issues that pose environmental and attitudinal barriers to access in society in all areas. Access to healthcare is hindered by lack of understanding and subsequent behaviour including stigmatisation of people with disabilities. Therefore, it is essential for rehabilitation professionals to offer comprehensive disability and culturally sensitive awareness programmes to communities in order to influence attitudes and knowledge towards PLWD.

Keywords: disability. Disability awareness programmes, physiotherapists, public healthcare.

Introduction

Disability awareness is critical for the promotion of health and wellbeing and offering of good practice by the cadre of rehabilitation professionals in healthcare to people living with disabilities (PLWD) (Frantz 2008; Rao et. 2002). The concept is focused on providing knowledge and understanding of disabilities to the communities being served by various health professionals (Culp 2016). Disability awareness programmes could provide necessary information surrounding PLWD in order to curb misunderstandings that often create social and environmental exclusion barriers (Gupta & Singhal 2004; Masasa et. al.. 2005). In order to understand disability and subsequently disability awareness for purposes of this paper, we use the international classification of functioning, disability and health (ICF) (WHO 2001). The understanding of disability through the ICF framework stems from a bio-psychosocial standpoint which factors in activity limitations and participation restrictions from a holistic view i.e. it takes into account the physiological, environmental and psychosocial aspects of the individual when managing PLWD (Mlenzana et. al.. 2013; Masasa et. al.. 2005). Members of the multidisciplinary team of healthcare professionals caring for PLWD can offer disability awareness programmes within health promotion strategies (Rao et. al.. 2002).

Physiotherapists who form part of the team are rehabilitation professionals who are responsible for the optimisation of physical function and activity as well as integration of PLWD into communities (Frantz 2008). In South Africa, physiotherapists study a four- year undergraduate degree, complete a mandatory community service year of practice and are governed by statutory requirements provided by the Health Professions of South Africa (HPCSA). Disability awareness programmes are core to the responsibilities of a physiotherapist (Fricke 2005). Therefore, it is integral for this group of professionals to demonstrate adequate knowledge and understanding of disabilities, disability etiquette and to display positive attitudes toward PLWD (Joseph 2011). Furthermore, they should be sensitive to religious and cultural beliefs of the community they serve so that they do not infringe on their religious and cultural practices (Wegner & Rhoda 2015). In order for disability awareness programmes to be successful, programmes must be measured for effectiveness (Frantz 2008). This has been a problem in that there is a lack of indicators to measure outcomes of disability awareness programmes conducted by physiotherapists (Frantz 2008).

The primary aim of the study was to explore perceptions of physiotherapists on disability awareness programmes within public healthcare institutions in KwaZulu-Natal, South Africa in order to understand how these perspectives may influence the care offered to PLWD by physiotherapists in these settings.

METHODOLOGY

Design

The research adopted an explorative, descriptive qualitative design (Creswell et. al.. 2007) to understand in depth the perspectives of physiotherapists toward disability awareness and health promotion and to gain insight into the ways in which such programmes are monitored in KwaZulu-Natal. The primary method of enquiry used in in this study was focus group discussions (FGD's) (Hennink 2013). FGD's channel interactional discussions to express the details of complex experiences and rationalisations behind individuals' actions, beliefs and attitudes (Powell & Single 1996).

Setting

The study was conducted in the province of KwaZulu-Natal. The population of KZN is diverse in culture, language, race and ethnicity (Grut et. al.. 2012). KZN is the only province in South Africa where a monarchy provided for in the constitution (Certification of the Constitution of the province of KwaZulu-Natal 1996), one in which strong cultural influences in the community are upheld. Most communities in KZN are still disadvantaged regarding access to resources and still maintain strong ethnic and cultural views toward health and rehabilitation (Wegner & Rhoda 2015).

Participants

The study population included physiotherapists employed by the department of health in public sector facilities across both urban and rural settings in KZN. Only qualified physiotherapists, currently registered with the Health Professionals Council of South Africa (HPCSA) for the years 2017-2018 and practising in KZN province were included in the study. The study participants were drawn from the results of a quantitative knowledge, attitude and belief (KAB) study undertaken by the researcher with the same population. Purposive maximum variation sampling was used to identify participants from the KAB quantitative results. Eligible candidates were invited to participate in the study telephonically or via email. Although ten participants were

initially recruited for each focus group discussion, the final sample included two groups of five participants each from the EThekwini, Ugu and King Chetshwayo districts of KZN. One FGD comprised of physiotherapists working in the rural setting and the other represented physiotherapists working in the urban setting. Pseudonyms are used when referring to physiotherapists in discussion of findings.

Data collection procedure

Two separate focus groups for physiotherapists working in urban and rural settings were conducted. A flexible focus group guideline was developed (Powell & Single 1996) adapted from the literature and piloted among three physiotherapists in academia (Carey 1995). Thereafter, recommendations and modifications were applied to the guide prior to its use. The FGD's were conducted in English. A dictaphone and notebook were used to record participants' verbal and non-verbal responses. In each discussion a facilitator, research assistant and moderator were present. Member checking was conducted with participants during and after the discussions to ensure that the participant responses were accurately interpreted in order to enhance trustworthiness of the data (Guba 1981). Each discussion lasted approximately an hour long.

Data Analysis

The FGD's was transcribed verbatim by a trained research assistant. The transcriptions were read and re-read in order to familiarise the researcher with the data and gain a full understanding of the content. Thematic analysis (Boyatzis 1998) was then used to identify, analyse and discuss emergent themes. Data was coded to identify common concepts discussed by the participants. Codes were then grouped into categories, analysed into sub-themes and finally broader themes were identified. These themes were discussed and debated with two individuals viz. the moderator and an expert in qualitative research until consensus was reached. This process aimed to enhance the study's trustworthiness and rigor (Creswell et. al.. 2007).

Ethical considerations

Ethical approval was obtained from Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal (UKZN) and the KZN Department of

Health. All participants were recruited on a voluntary basis and informed of their right to withdraw from the study at any time. Signed informed consent was obtained from participants after the nature and purpose of the study was explained both verbally and in writing. Participants' anonymity was preserved by coding of the data. Only the researcher, supervisors and research assistant have access to the raw data that has been electronically stored and password protected ensuring participant's confidentiality.

Findings and Discussion

Two of the ten participants were male. Only one participant had less than five years of work experience in South Africa. There was an equal distribution of participants from the rural and urban public sector setting. Table 1 reflects the demographic characteristics of the participating physiotherapists.

Table 1: Demographic characteristics of the participating physiotherapists

AGE (YRS)	**n=10**
21-25	0
26-30	2
31-35	4
36-40	2
>40	2
GENDER	**n=10**
Male	2
Female	8
RACE	**n=10**
Black	4
Coloured	1
Indian	4
White	1
NO. OF YEARS WORKING	**n=10**
0-5	1
6-10	4
>10	5
SETTING	**n=10**
Public sector - Rural	5
Public sector - Urban	5

Five major themes emerged from the two focus group discussions, namely, knowledge dearth, personal influences, facilitators to disability awareness programmes, barriers to disability awareness programmes, and recommendations. The themes, sub-themes and participants' quotes are reflected in Table 2 below.

Table 2: Themes, sub-themes and illustrative quotes

Knowledge dearth consequence	
Sub-theme	*Quotes*
Physiotherapists understanding	*"Because of lot of it comes from what society believes and what society grew-up being told, even us we didn't engage or interact with children with disability until we were professionals."* Vani (urban physiotherapist)
Community interpretation	*"….there are certain terms that are given to disabled people that are derogatory that when you analyse the meaning, it is an insult. They come from the lack of understanding of disability and for example 'umuntu ono isishawa' a person with albinism, isishawa. In other words, a person has been hit or punished."* Dumi (rural physiotherapist) *" people believe that its witchcraft or curse on people who have been bad"* Enhle (rural physiotherapist)
Healthcare staff knowledge	*"I happen to sit in the Complaints Committee of the Hospital and the complaints that are coming from the people with disability, the offenses committed by the so called people that should be understanding what disability is, it amazes me"* Bianca (urban physiotherapist)
Stigmatisation	*"People are going to lose their jobs simply because they don't understand what disability is, they discriminate against disability, people are going to lose their jobs."* John (rural physiotherapist)
Personal Factors	
Sub-theme	*Quotes*
Self-reflection	*"Instead of just focusing on the people living with disabilities and the community. Let us also focus on ourselves working in the community. Because a lot of people they might know what disability is but they might not understand it."* Candice (urban physiotherapist)
Self-motivated	*"It goes back to your personality, what kind of a person are you? If you are a person that would go all the way just to help people, until that person gets better, then that is the drive behind the awareness campaigns."* Enhle (rural physiotherapist)
Compassion	*"…once you see what people are going through and the pain of a mother says that even her in-laws are treating her this bad because they do not understand. That drives me to create awareness"* Santhuri (urban physiotherapist)

Fulfilment	*"Then you see that person walking into your department (following disability awareness intervention) that is a positive reinforcement for me and it is a personal experience."* Amy (rural physiotherapist)
Experience	*"It is exposure, it is experience. With experience you will know how to deal with an emotional disabled person."* Bianca (urban physiotherapist) *"Yes, generally you would think that the older you get, the more knowledge and experience you get so that informs you better about the situation."* Santhuri (urban physiotherapist)
Facilitators to Disability Awareness Programmes	
Sub-theme	*Quotes*
Involvement of People with disabilities	*"So possible people who present with impairments can tell the community "I am deaf but I can still communicate with you for example."* Amy (rural physiotherapist) *"Finding key people in communities that you would engage with and part of those key people should be people with disability themselves."* Enhle (rural physiotherapist)
Disability forums	*"The area which I come from what works in our community is having disability forums in the community. Members are chosen by the community of the persons who are disabled so that they can propagate awareness."* Candice (urban physiotherapist) *"We have that relationship, with the Disability Forum. They people out there who are aware of it."* Bianca (urban physiotherapist)
Barriers to Disability Awareness Programmes	
Sub-theme	*Quotes*
Facility infrastructure	*"So we are not looking at disability further than the hospital, unless you are in a rural setting and you are rostered to go out."* Santhuri (urban physiotherapist) *"I think all the therapist are comfortable where they are, and I think people don't want to move from their comfort zone and try to go to the community, it is trying to motivate them make them to realise how important it is to reach out to go out there even in a in a urban setting because I think like the rural physiotherapists are-very proactive with that, but the urban ones, oh well…this is where we are."* Candice (urban physiotherapist)
Resource limitations	*"I think the services are asked to provide in institutions makes the impact on what we can do. Our priority in a hospital is in-patients and acute care. So now with the situations as it is, very limited posts are vacant and you can fill them. So you just have to prioritise those services."* Enhle (rural physiotherapist)

	"But going out and doing it, is something we hardly do and I am not giving excuses but the issue of resources in some Hospitals, when you out, you close the department." Bianca (urban physiotherapist) *"The current situation does not allow us to take the services to take it to where we want to take it."* Sheila (urban physiotherapist)
Environmental systems	*"In the country we haven't done enough research about disability, it's all based on the Western Knowledge. But the content of the Western Civilisation or countries it is different from the African Context."* Thobani (rural physiotherapist) *"I think that gender would influence it depending on who you are. If you go to certain rural areas, you cannot address traditional leadership if you are a female… And you are only allowed to speak when spoken to in some areas."* Enhle (rural physiotherapist)
Lack of Intersectoral engagement	*"So out here in our district we know that we don't have the interaction with the disability community….. Yes they exist, but it almost seem as if they want to function independently as much as we've had meetings with them also…But neither do they invite us"* Dumi (rural physiotherapist) *"We are aware of the traditional healers, but we don't involve them in our programmes … We do not include it (traditional healer) in our material, you know the knowledge of it. We just put everything that is pertaining to physio or any other rehab in the material that we use"* Vani (urban physiotherapist)
Lack of multidisciplinary collaboration	*"If you are talking about disability, attitudes of physiotherapists, I think that it is a bigger thing than that. I think it is the attitudes of the entire health team. ….. A lot of us may even understand disability and what our role is in disability, but we are not able to exercise it, because the control system by the doctor he is always ready to send anybody home, is not giving you the chance to even do anything."* John (rural physiotherapist) *"But I think that the awareness of disability and how it impacts on a person's life and everything that goes afterwards … needs to be done with the medical profession in our settings….doctors feels that he treats the patient and he gives the medication and the patient must go and that is the end of story."* Vani (urban physiotherapist)
Recommendations	
Sub-theme	*Quotes*

Task-shifting	*"I know that at one stage they (referring to Department of Health) used to have the CBR (referring to Community Based Rehabilitation) workers. It is something that we need to do again. Because it is specific to rehab"* Thobani (rural physiotherapist) *"So we have to educate Community caregivers (CCGs), if we can't physically go to the community, we can educate them on disability and programmes then we can filter to the houses that cannot come, because of transport and costs"* Dumi (rural physiotherapist)
Improved stakeholder involvement	*"Whilst we are running awareness and everything that there are key people that are usually left behind that I think should be in the forefront: we have the traditional leaders, the traditional healers, we have the religious leaders…"* Enhle (rural physiotherapist) *"As much as we would like to advocate for disability issues, there needs to be buy-in by the disability community."* Amy (rural physiotherapist) *"Consultation is very important…engaging…… representation not only from the communities but also from government sectors like the Department of Labour, the Department of Transport, Social Development, Health, Education. There is lot of issues that need to be addressed."* John (rural physiotherapist)
Materials and media	*"The posters, students create posters and sometimes they do research on the topic"* Dumi (rural physiotherapist) *"Through the media; whether it is Television or Radio…there's got to be some awareness that goes through media."* *People talk what they see on TV and/or listen to on Radio and take it as it is."* Thobani (rural physiotherapist) *"Educational pamphlets for various topics such as disability awareness….in English and IsiZulu."* Bianca (urban physiotherapist) *"Research articles, the internet…"* Santhuri (urban physiotherapist) *"..we using some the SASP materials, we make our own posters,"* Sheila (urban physiotherapist)
Innovative ideas	*"I think that something like a sketch or a drama, because sometimes if you just go there and tell them the theory, you are just wasting your time. It's better to put in practical so that they can see."* Enhle (rural physiotherapist)
Education sharing	*"We can also communicate via churches we can ask them that we are going to teach the Christians about the disabilities and maybe the schools can also come…… They still need to be taught about disability."* John (rural physiotherapist) *"I think it is the sharing of knowledge among the public at large. In a form of education; teaching people about disability, what disability is and how to manage people with disability at home, school or the work place."* Vani (urban physiotherapist)

Curriculum review	*"So it is important to teach the family, even the care giver that this is how you treat a disabled person."* Sheila (urban physiotherapist) *"So when we are talking about the curriculum be it for nurses, physiotherapistsor even doctors, is it the Medical model, as the medical model is disease based. So if I am born with Spinal Bifida they approach it medically should interact with social inclusion."* Dumi (rural physiotherapist) *"I am thinking that the DCT (referring to local physiotherapy placement in rural settings) if anything, will provide much better exposure to our students anyway. So when you are talking about education, their skills and training out, there will be a better exposure to disability."* Bianca (urban physiotherapist)

Knowledge Dearth Consequence

The overarching theme of knowledge dearth consequence included the subthemes physiotherapists understanding, community interpretation, healthcare staff knowledge and stigmatisation. Some physiotherapists verbalised that their experiences and exposure during their formative years influenced their knowledge and their current practice. A study by Masasa (2005) demonstrated that caregivers of PLWD displayed varying knowledge of disabilities depending on their level of exposure to PLWD in earlier years. Although the groups were heterogeneous, similarity is identified in the influence of previous exposure on knowledge of disability. All the physiotherapists in our study corroborated that the multidisciplinary healthcare team lacked knowledge they believed was critical to disability awareness issues. Badu, et. al. (2016) found that doctors and nurses in Bhutan portrayed a less positive attitude towards PLWD and were not at ease with disability and rehabilitation issues due to a lack of knowledge of these matters. The theme around knowledge is reflective of the influence it could have on the rehabilitation framework including awareness programmes offered to PLWD by the team of professionals within multidisciplinary teams.

Physiotherapists also felt that the communities they served believed in myths such as disability being a punishment or witchcraft. Several studies corroborate that cultural beliefs contribute to health seeking and participatory behaviour and these beliefs can leave PLWD and their families feeling marginalised and stigmatised within the communities they reside in (Hussey et. al.. 2017; Massasa 2005; Wegner & Rhoda 2015). This also highlights the need for qualified physiotherapists to collaborate with communities in developing the disability awareness strategies taking into account cultural sensitivity and community beliefs. The success of health promotion programmes such as disability awareness strategic programmes is dependent on the relevance to cultural beliefs embedded in communities (MacLachlan 2006). This necessitates that healthcare professionals such as physiotherapists reflect cultural awareness and competence (Wegner & Rhoda 2015) when implementing disability awareness programmes or offering rehabilitation within the communities they serve. In a study with health science students Robey et. al.., (2013) reflected that cultural competency is best acquired by students' exposure to PLWD within their cultural contexts which will consequently acquaint them with the daily needs and realities of PLWD (Robey et. al.. 2013). Furthermore, rehabilitation and programme outcomes

are

influenced by the cultural beliefs held by PLWD, families and communities and could lead to lack of engagement if not incorporated into the approach (Wegner & Rhoda 2015; Grut et. al.. 2012). Physiotherapists believed that stigma around disability still seems to plaque awareness and was thought to be career threatening especially when such practices are demonstrated by the team responsible for offering comprehensive rehabilitative care to PLWD

Personal Factors

The second major theme personal factors encompassed self-reflection, self-motivation, compassion, fulfilment and experience of physiotherapists. Physiotherapists believed that self-reflection is important to really understand disability issues. They also felt that motivation was key to giving the best as a practitioner. Personal fulfilment in providing holistic care was also mentioned as a contributor to including awareness in practice as well as experience as a clinician. In a study by Cobbing et. al. (2017) the perceptions of community healthcare workers were explored following their implementation of a home-based rehabilitation programme for people with HIV living with disabilities. Participants reported feeling a sense of self-worth and empowerment in offering care to PLWD. Twible & Henley (2000) indicated that personal characteristics of healthcare professionals such as creativity, perseverance, patience and diplomacy when working with PLWD in the community contributed toward the development and success of practice. In work by Jain et. al. (2009) findings suggested that the ability of health professionals to deliver quality client care corresponds with levels of job satisfaction. Similarly physiotherapists in our discussions felt fulfilment when impacting communities through awareness programmes.

Facilitators to Disability Awareness Programmes

The theme facilitators to disability awareness programmes included the sub-themes involvement of people living with disabilities and disability forums. The physiotherapists echoed that disability awareness programmes necessitate involvement of PLWD in their experience. According to Mji et. al. (2013) the legislature guiding South African

rehabilitation discourse necessitates the full involvement of PLWD in all levels of care offered. Some physiotherapists verbalised that their service communities have disability forums that has representation of community members that allows for advocacy in disability awareness strategies. Several studies highlight the need to involve PLWD, their families and communities when offering rehabilitation or health initiative programmes in a health promotion approach (Mji et. al.. 2013). Often the voices of these crucial role players are omitted and this leads to poor uptake of health awareness initiatives (Kautzky &Tollman 2008; Naledi et. al.. 2011; Mji et. al.. 2013).

Barriers to Disability Awareness Programmes

The overarching theme barriers to disability awareness programmes incorporated the sub-themes of facility infrastructure, resource limitations, environmental systems, lack of intersectoral engagement and lack of multidisciplinary collaboration. Some of the physiotherapists believed that the hospital structure and the historical functioning of how “things were done” dictated the levels of involvement in such community outreach strategies like disability awareness programmes. Resource limitations such as staff shortage was also believed to influence the implementation of disability awareness programmes. Staff shortage and resource limitations is reflected in several studies as a hindrance to optimal care offered to PLWD (Chetty 2015; Ned et. al.. 2017). The health systems in South Africa is inequitable in that the majority of the population access public healthcare from overburdened facilities and this adds strain on healthcare professionals servicing these care facilities (Chetty 2015; Cobbing et. al.. 2013; Naledi et. al.. 2011; Ned et. al.. 2017).

A therapist believed that the country’s context had an impact on disability awareness and believed that issues were still based on western knowledge. In Owusu-Ansah and Mji (2013) paper, the authors stimulate awareness around African indigenous knowledge centred on research. The authors support the therapist in this study in expressing that a shift from western methodologies and adoption of a more “Afrocentric” method is crucial to develop our research centred on PLWD. The inclusion of culturally sensitive approaches in for example disability awareness programmes offered by rehabilitation professionals will allow for improved participation and acceptance by PLWD and communities. Ned et. al. (2017) agree

that indigenous health knowledge lies inactive

within communities we serve. Some physiotherapists felt a lack of intersectoral collaboration between the community, disability sector and healthcare as an inhibitor to optimal healthcare and rehabilitation. Ned et. al. (2017) also believed that gaps in intersectoral collaboration contributed to the flaws in South African healthcare systems. This study was conducted in the Province of Eastern Cape in South Africa. Hussey et. al. (2017) revealed that PLWD and representatives of PLWD in their enquiry in a South African context, felt that the government sectors do-not function cohesively and this has contributed to political barriers to the optimal implementation of the United Nations Convention on the Rights of Persons with Disabilities in the country. Furthermore, participants in Hussey's study felt that there was a lack of consultation of PLWD and community leaders by political leaders. A physiotherapist in our study believed that Traditional healers were omitted from their approach to disability awareness and in the programme development. Traditional healers and religious leaders are vital avenues to create pathways for communication, discussion and dissemination of information, as they are highly esteemed and respected members of the community (Masasa et. al.. 2005). Ned et. al. (2017) present narrative on obligatory legislative commitments made to integrate traditional healers into South African healthcare systems since 2013, yet a gap is still evident in translating policies into practice.

On a meso-system level the lack of multidisciplinary collaboration was debilitating health systems and in turn affecting disability awareness issues. The teamwork approach is essential to optimise care and a lack of knowledge will inadvertently affect the challenges experienced by PLWD that would need input from the multidisciplinary team. (Chetty & Maharaj 2013). Chetty and Maharaj (2013) in their work on collaboration of healthcare professionals believed that partnership between the multidisciplinary team as well as knowledge of the role of team members is crucial in the care offered. Maddocks et. al. (2017) in an exploration into collaboration between doctors and physiotherapists in the rehabilitation of people living with HIV experiencing disabilities believed that cohesive partnership between healthcare professionals would influence the care offered. Participants in our study reported that they were often not included in the clinical decision making process for patients who were in-patients in facilities of higher levels of care, especially regarding readiness for discharge. Collaborative decision making for PLWD involving multidisciplinary and multisectoral engagement amongst all role players is critical for

improved outcomes of these patients and this positively influences care offered to PLWD (Bruner et. al.. 2011).

Recommendations

Finally, the recommendations offered by physiotherapists included task-shifting, improved stakeholder involvement, materials and media, innovative ideas, education sharing and curriculum review. Some physiotherapists believed that community rehabilitation or midlevel workers could assist with staffing issues and offer respite to overburdened facilities. (Chetty 2015). Lay personnel offer rehabilitation and care to PLWD under supervision of qualified health professionals. (Luruli et. al.. 2016) This is often termed task shifting and is an advocated approach in similar contexts. (Chetty 2015; Cobbing et. al.. 2017; Ned et. al.. 2017) Empowering PLWD in this approach would offer further respite as a strategy that would provide a further platform for advocacy and integration of issues and societal barriers faced in communities. (Ned et. al.. 2017; Grut et. al.. 2012).). A therapist in our study believed that the task-shifting approach will offer continuity of care into the home of the individuals living with disability (Cobbing et. al.. 2017). A study by Cobbing et. al. (2017) in a similar context using a task-shifting home based rehabilitation intervention protocol proved to be beneficial to PLWD's as well as the community healthcare trained personnel. The authors of this study believe that this involvement will improve the disability awareness strategies as the contextual factors and community knowledge will also become an imperative.

All the physiotherapists agreed that collaborative stakeholder and intersectoral involvement was critical to addressing disability issues. Collaborative approaches to rehabilitation has the potential to offer seamless care to PLWD (Bruner et. al.. 2011; Chetty & Maharaj 2013; Maddocks et. al.. 2017; Ned et. al.. 2017). Greater effort needs to be made to overcome professional hierarchy and to encourage an inter-professional, collaborative approach that considers participation of all team members in clinical decision-making. (Chetty & Maharaj 2013; Maddocks et. al.. 2017) Multidisciplinary team work places the patient and his/her needs as the focal point of interest while mutual respect, power, goals and partnerships are shared among team members (Bruner et. al.. 2011; Gerdes et. al.. 2001). In this study, the team can be actively involved in implementing the awareness programmes as well as the development of the most effective strategies in collaboration with PLWD and community leaders.

A few physiotherapists verbalised that materials and media could offer creative interventions to disability programmes. An effective disability awareness programme

should have

clear objectives and focus on a particular audience with the choice of media that matches the needs of the multicultural and multilingual society (Hugo & Smit 1999). The Health Education, Appropriate Media and Technology and Socio-cultural Sensitivity (HAMSOC) model offers some direction to assist with the planning and drawing up of messages for disability awareness promotion within a multicultural setting and should be applied by physiotherapists (Hugo & Smit 1999). Additional sources from government sectors, non-governmental organisations and peers is also believed to be a good source of information (Twible & Henley 2000). These sources of information should be accompanied by collaborative information sharing from PLWD and community key players (Grut et. al.. 2012) which allow for guidance by the contextual and social issues of the community rather than just prevailing impairments of PLWD in order to promote holistic health and wellness (Ned et. al.. 2017).Another therapist believed that innovative platforms should be created to in order capture the attention of the communities. Education of communities on various fora was also felt to be an avenue to alleviate the lack of knowledge. Schools, religious facilities and gatherings were thought of as opportune platforms for education sharing. Furthermore the undergraduate programmes offered to healthcare professionals was suggested by participating physiotherapists as an ideal setting to influence the future multidisciplinary team on disability issues and awareness. Many studies in South Africa focused on care offered to PLWD recommended the need to review undergraduate programmes and service training approaches in order to facilitate appropriate clinical training that addresses the need of the communities served in South Africa (Mji et. al.. 2013; Ned et. al.. 2017; Twible & Henley 2000).

Conclusion

The South African healthcare system is burdened by the inequality of public versus private sector needs. (Chetty 2015; Hatcher et. al.. 2014; Kautzky &Tollman 2008). The large number of people accessing care in the public sector are often plagued by poverty and lack of access to basic needs such as water, sanitation and food (Naledi et. al.. 2011). The focus is on disease management with little attention paid to prevention strategies such as disability awareness programmes. This study provided insight into the perceptions of physiotherapists toward disability awareness programmes and highlighted the facilitators and barriers to the implementation of

these programmes as well as recommendations for future delivery of programmes in a South African healthcare setting. Participants perceived poor knowledge about disabilities and disability awareness programmes among healthcare workers and community members as a significant contributor to the gap that exists in implementation of disability awareness programmes. The lack of knowledge was believed to contribute to stigmatisation. Personal factors such as self-reflection, self-motivated, compassion, fulfilment and experience of physiotherapists was believed to influence involvement in awareness programmes. Involvement of people living with disabilities and disability forums was necessary for the successful implementation of disability awareness strategies. Barriers to disability awareness programmes included facility infrastructure, resource limitations, environmental systems, lack of intersectoral engagement and lack of multidisciplinary collaboration. Physiotherapists believed that task-shifting and improved stakeholder involvement is crucial for successful practice in terms of disability awareness. The attitude and perceptions of family and the community toward PLWD has great potential to add to the environmental barriers to society. Disability awareness programmes offered by physiotherapists has the potential of reducing barriers by raising awareness into disability issues. (Gupta & Singhal 2004)

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CHAPTER 4 - CONCLUSION AND FUTURE RECOMMENDATIONS

This chapter concludes the thesis through a summary of the findings in line with the objectives of the study that were set out in the introductory chapter. It also includes limitations of the study and the way forward.

4.1. General Conclusion

This study has fulfilled its primary aim of exploring the perceptions of physiotherapists towards disability awareness programmes within public healthcare institutions in KwaZulu-Natal, South Africa. Furthermore, the objectives of the thesis were met that was to explore physiotherapists' knowledge on disability awareness in KwaZulu-Natal, to explore the facilitators to disability awareness programmes in the communities, to explore the barriers to disability awareness programmes in the same setting and to make recommendations for future physiotherapy practise.

Physiotherapists indicated that their experiences and exposure during their formative years influenced their general current knowledge and practice. They raised limited access to training and development as reasons for their lack of knowledge resulting in poor outcomes in approaches to DAP. Most participants lacked indigenous knowledge regarding community-based rehabilitation due to undergraduate training that was based predominantly on western perspectives. Participants in the study reported that healthcare staff and other members of the multidisciplinary team lacked knowledge about disabilities and disability awareness programmes, thus resulting in discrimination and stigmatisation of PLWD. According to the focus group discussion (FGD) in the study the participants indicated that physiotherapists also lacked knowledge in disability etiquette and communication skills resulting in misinterpretation by the community and vice versa.

The study identified that personal factors influenced attitudes of physiotherapists towards PLWD. Self- reflection was an important factor for physiotherapists to adopt in order to understand disability issues from the perspective of the PLWD and not from their own self. Self-motivation was another key factor influencing attitudes of physiotherapists to PLWD and promotion of disability awareness. Physiotherapists give their best as a practitioner when self- motivated. Health professionals

experienced a sense of personal fulfilment and job satisfaction when they are able to deliver quality and holistic client care. Professional attributes such as creativity, perseverance, patience and diplomacy when working with PLWD were also found to influence attitudes of health professionals towards DAPs.

Physiotherapists also felt that the communities they served believed in myths such as disability being a punishment or witchcraft (Wegner & Rhoda, 2015). This highlights the need for qualified physiotherapists to collaborate with communities in developing the disability awareness strategies taking into account for cultural sensitivity and community beliefs. The success of health promotion programmes such as disability awareness strategic programmes is dependent on the relevance to cultural beliefs embedded in communities (MacLachlan, 2006). This necessitates that healthcare professionals such as physiotherapists reflect cultural awareness and competence when implementing disability awareness programmes or offering rehabilitation within the communities they serve to prevent cultural imposition according to Wegner, & Rhoda, (2015). Furthermore, rehabilitation and programme outcomes are influenced by cultural beliefs held by PLWD, families and communities and could lead to lack of engagement if not incorporated into the approach (Wegner, & Rhoda, 2015; Grut et. al.., 2012).

Physiotherapists that participated in the study believed that stigma around disability still seems to plague awareness and was thought to be career threatening especially when such practices are demonstrated by the team responsible for offering comprehensive rehabilitative care to PLWD. It was also found that traditional healers were omitted from their approach to disability awareness and in the current way by which disability awareness programmes are implemented. Traditional healers and religious leaders are vital avenues to create pathways for communication, discussion and dissemination of information, as they are highly esteemed and respected members of the community (Masasa et. al.., 2005).

The study found that there was a lack of structure with regards to DAP in the public sector with some institutions being compliant whilst others were not. There many barriers to disability awareness programmes including facility infrastructure, resource limitations, environmental systems, lack of intersectoral engagement and lack of

multidisciplinary collaboration. There was also a misconception that DAPs were only to be conducted in the rural communities; hence, most physiotherapists in urban communities were not actively involved in DAPs resulting in a gap in service provision in this area. Most DAPs were undertaken in the form of talks, presentations and the materials used included posters, and information pamphlets with information sourced from research through article reviews, internet, and physiotherapy organisations etc.

4.2. Summary

This study provided insight into the perceptions of physiotherapists toward disability awareness programmes and highlighted the facilitators and barriers to the implementation of these programmes as well as recommendations for future delivery of programmes in a South African healthcare setting. The knowledge dearth perceived by the participants was attributed to the lack of ongoing continuing education in disability issues and poor knowledge of communication skills that leads to misinterpretations of the needs of PLWD. Participants perceived poor knowledge about disabilities and disability awareness among healthcare workers and community members as a significant contributor to the gap that exists in implementation of disability awareness programmes. The lack of knowledge was believed to contribute to stigmatisation. Attitudes of physiotherapists were influenced by personal factors such as self-reflection, self-motivated, compassion, fulfilment and experience of physiotherapists that was believed to influence involvement in awareness programmes. Involvement of people living with disabilities and disability forums together with traditional and religious leaders was deemed necessary for the successful implementation of disability awareness strategies. Barriers to disability awareness programmes included facility infrastructure, resource limitations, environmental systems, lack of intersectoral engagement and lack of multidisciplinary collaboration. Participants believed that task- shifting, improved stakeholder involvement, education sharing and curriculum review were crucial recommendations for successful practice in terms of disability awareness. Innovative ideas and the appropriate use of materials and media were recommendations made regarding the presentation of successful DAPs that will appeal to various sectors of the community.

4.3. Limitations

The study sample was small. Difficulties were experienced in trying to set up focus

group discussions at a central meeting point convenient to all participants, as the province is geographically extensive. Generalisability of study results is not recommended due to the study approach.

4.4. Recommendations

The following is recommended from the outcome of the study;

- The CBR approach needs strengthening by improving communication strategies between training of healthcare professionals and the public health system. Hospital managers and supervisors of rehabilitation personnel must be alerted to the CBR approach in order to support the physiotherapists with provision of resources for disability awareness promotion.
- In order to assist with the dearth of rehabilitation professionals in KwaZulu-Natal task shifting to the midlevel workers should be encouraged to access a greater number of PLWD in the community.
- Review of curriculum to include cultural competency skills.
- Continuous professional development programmes to improve knowledge and skills in disability etiquette, legislation and ICF framework within the CBR for postgraduate physiotherapists.
- It proposes that further exploration should be done concerning the standardisation of disability awareness programmes and development of monitoring structures to evaluate the effectiveness of such programmes.
- Standardisation and monitoring of DAPs to be conducted by the disability and rehabilitation component of the KwaZulu-Natal Department of Health

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GUIDELINES FOR PRESENTATION OF MASTERS AND PHD DISSERTATIONS/THESES BY RESEARCH

1. Purpose

The purpose of this document is to provide guidance to students and supervisors on how to prepare a dissertation/thesis for Masters by Research and PhD degrees using the manuscript or publication format..

2. Introduction

These guidelines must be read together with the College of Health Sciences (CHS) Handbook as well as the Jacobs documents on examination policies and procedures for PhD degrees. The rules on thesis format are based on modification of point 1 of the definition of terms section in the Jacobs document. In this section a thesis is defined as *"the supervised research component of all PhD degrees, whether by supervised research only, or coursework and research, or by papers that are either published or in manuscript form (the supervised research component of the PhD degree by paper(s) comprises the introduction, literature review, account of the methodology, selection of manuscripts, and conclusion)."* A dissertation is defined as "*the supervised research component of all Masters degrees, whether by supervised research only, or coursework and research, or by papers that are either published or in manuscript form (the supervised research component of the Masters degree by paper(s) comprises the introduction, literature review, account of the methodology, selection of manuscripts, and conclusion*)."

2.1 PhD thesis

In the CHS Handbook the rules for a PhD thesis are not in one place; they are stated in DR8 a i & ii, DR9 c and CHS 16. DR8 a i & ii and direct that a thesis be presented in the standard format together with one published paper or an unpublished manuscript that has been submitted to an accredited journal, arising from the doctoral research. CHS16 (thesis by publications states that the thesis may comprise of at least three published papers or in press in accredited journals; such papers must have the student as the prime author. The same CHS16 provides for a thesis by manuscripts that may have at least 3 papers with the student as the prime author that have not yet been published but are in the form of manuscripts; at least two of such papers must constitute original research. In both cases (thesis by publications and manuscripts), there must be introductory and concluding integrative material sections.

The standard type thesis is being phased out in many African countries in favour of the other options that originate from the Scandinavian countries. While this format ensures that all details of the work done for the doctoral degree are captured and thoroughly interrogated, they often remain as grey literature which is mainly useful to other students, usually within the same university, although with digitization of theses, such work may become more accessible beyond the source university. Apart from the risk of losing good work because of it not being on the public domain, as students rarely publish such work after graduating, this approach denies the college additional productivity units (PUs) emanating from publications.

The thesis by publication encourages students to publish key aspects of their doctoral research as they will not graduate if the papers are not published or in press. This approach ensures that the work of the student enters the public domain before the thesis is examined, providing the examiner with some assurance of prior peer review. The thesis must constitute a full study of the magnitude expected of a PhD with the papers providing a sound thread or storyline. Furthermore, the college maximizes the students' work as PUs are awarded for the papers as well as for graduating. However, this approach may negatively affect throughput and frustrate students as

they cannot graduate unless all the papers are published or in press, in addition to the synthesis chapter demonstrating the story line of the thesis.

The option of a thesis by manuscripts ensures that students make efforts to start publishing. The risk of not passing because of failure to publish all papers (as in the thesis by publication) does not exist under this option. However, the PUs emanating from publications from the doctoral work are not guaranteed as the submitted papers may eventually be rejected. Thus there is a possibility of the doctoral work remaining on the university library shelves as is the case for the standard thesis format. The standard thesis does have the advantage that more details of the doctoral work are usually included.

In view of the above, the best option for the college is that of a thesis by publication. However, in the interim, the attractive option is that of thesis by manuscripts, as it provides the possibility of publication without putting the student at risk of delayed graduation when some of the manuscripts are not published/accepted, which also disadvantages the college in terms of PU earnings. The standard thesis option should ultimately be phased out for the stated reasons and students are not encouraged to present their theses in that format. Consequently this document does not describe the standard thesis.

2.2 MSc dissertation

The rules on presentation of MSc dissertations are presented in CR13 (course work), CHS 14 (course work) and MR9 (research) in the CHS Handbook. CR13 c and MR9 c direct that a dissertation "may comprise one or more papers of which the student is the prime author, published or in press in peer-reviewed journals approved by the relevant college academic affairs board or in manuscripts written in a paper format, accompanied by introductory and concluding integrative material." Such a dissertation should include a detailed description of the student's own distinct contribution to the papers. Both CHS14 and CR13 specify that reviews and other types of papers in addition to original research paper/s may be included, provided they are on the same topic.

3 *Length of thesis and dissertation by word count*

Table 1 provides a guide of the length of a thesis or dissertation by word count excluding preliminary pages and annexes.

Table 1: Thesis length by word count

Sections	PhD		Masters	
	Minimum	Maximum	Minimum	Maximum
Introduction	2700	2700	2000	2000
Chapters	10000	25000	6000	11000
Synthesis	2000	2000	1700	1700
Bridging	300	300	300	300
Total	15000	30000	10000	15000

4. Intention to submit

A written intention to submit a thesis or dissertation should be submitted to the appropriate postgraduate office with endorsement of the supervisor at least three months before the actual date of submission which should be before November if the student intends to graduate in the following year. The actual submission will under normal circumstances require approval of the supervisor.

5. Format for theses/dissertation

There is little variation in the actual format of the PhD thesis and Masters dissertation for the various types described above. The box below summarise the outline of a thesis/dissertation for the thesis by manuscripts and thesis by publications.

Box 1: Outline of thesis

Preliminary pages

i. Title page
ii. Preface and Declaration
iii. Dedication
iv. Acknowledgements
v. Table of contents
vi. List of figures, tables and acronyms (separately presented)
vii. Abstract

Main Text

1. Chapter 1: Introduction
   Introduction including literature review
   Research questions and/or objectives
   Brief overview of general methodology including study design
2. Chapter 2
   First manuscript/publication
3. Chapter 3
   Second manuscript/publication
4. Chapter n
   Final manuscript/publication
5. Chapter n+1: Synthesis
   Synthesis
   Conclusions
   Recommendations
6. References Appendices

NB. Between the manuscripts or publications there must be a 1 page (maximum) bridging text to demonstrate the link between them

6. Details for thesis/dissertation subheadings

This section summarizes what is expected under each subheading shown in Boxes 1 and indicates where there might be variations between a Masters Dissertation and PhD Thesis.

6.1 Title Page

The officially approved title that is concise (Fewest words that adequately describe the contents of the thesis/dissertation – usually 15 or fewer words) is presented at the top. This should be followed by the candidate's name in a new line. At the bottom the thesis statement should be presented. The thesis statement may be stated as "*Submitted in fulfillment of the requirements for the degree of _____ in the School of_____, University of KwaZulu-Natal"* for a PhD/Masters by Research thesis. In the case of a Masters Dissertation it should be stated as "Submitted as the dissertation component in partial fulfilment (% stated) for the degree of_____in the School of _____, University of KwaZulu-Natal". For both Masters and PhD the date of submission must be stated.

6.2 Preface (Optional)

The preface merely states the reason (motivating factors) why the study was conducted without getting into details of what was investigated.

6.3 Declaration

This must be structured as follows:

I, Dr/Mr_____, declare as follows:

1. That the work described in this thesis has not been submitted to UKZN or other tertiary institution for purposes of obtaining an academic qualification, whether by myself or any other party.

   Where a colleague has indeed prepared a thesis based on related work essentially derived from the same project, this must be stated here, accompanied by the name, the degree for which submitted, the University, the year submitted (or in preparation) and a concise description of the work covered by that thesis such that the examiner can be assured that a single body of work is not being used to justify more than one degree.

2. That my contribution to the project was as follows:
   This is followed by a concise description of the candidate's personal involvement in and contribution to the project, in sufficient detail that the examiner is in no doubt as to the extent of their contribution.

3. That the contributions of others to the project were as follows:
   This is followed by a list of all others who contributed intellectually to the project, each accompanied by a concise description of their contribution. This does not include people who ordinarily would be "acknowledged" as opposed to considered for authorship.

4. Signed_____Date_____

6.4 Dedication

This is an optional section. Should it be included it must be very brief merely indicating to whom the work is dedicated. Avoid anything too flowery

6.5 Acknowledgements

This section acknowledges all individuals, groups of people or institutions that the candidate feels indebted to for the support they rendered. The funding source for the work should also be acknowledged.

6.6 Table of contents
Table of contents must be inserted after the preliminary sections and must capture all major sections of the thesis at the various levels (primary, secondary, tertiary subheadings). It should be electronically generated and should be able to take the reader to specific headings in the thesis.

6.7 Lists of figures, tables and acronyms
These lists must be presented separately. All titles of figures presented in the thesis/dissertation must be listed indicating on what page they appear. Similarly for tables the titles must be presented indicating on what page they appear. In the case of acronyms, the acronym is stated and all the words describing the acronym are presented. Only key acronyms should be stated. In some cases they may not be listed as long as full text is presented whenever the acronym is used for the first time.

6.8 Abstract
The abstract should summarize the thesis mainly stating the purpose of the study, highlights of chapters and the new knowledge contributed by the thesis. The abstract must be approved by the supervisor of the thesis and should not be more than 350 words in length.

6.9 Introduction
The introductory chapter for both types of thesis is similar. The section should include literature review and have the following information. Headings are used as appropriate and need not correspond exactly to the following.

i. Background and the context of the study
ii. Description of the core research problem and its significance
iii. A comprehensive, critical, coherent overview of the relevant literature leading to clearly defined knowledge gaps
iv. A coherent problem statement highlighting the nature and magnitude of the problem, the discrepancy, knowledge gaps therein and possible factors influencing the problem.
v. Clear and SMART research questions, objectives and hypothesis and/or theoretical framework
vi. A conceptual framework (optional)
vii. Description of the study area and general methodology *(in a standard thesis this should be a stand-alone section)*
viii. Layout of the thesis (thesis structure) indicating what chapters are presented in the thesis and how they address the objectives.

6.10 Literature review
This section is subsumed in the introduction within the stipulated word count for a thesis or dissertation.

6.11 Methodology
A standalone section is not needed as the methods are adequately described in each manuscript/publication.

6.12 Data chapters/manuscripts/publications
The full published paper or manuscript submitted for publication should be presented as published or submitted to the journal. The actual published paper should be scanned and inserted

in the chapter. There should be a separator page between chapters that has text linking the previous chapter to the next and providing details of the next manuscript/publication indicating publication status.

6.13 General discussion/Synthesis chapter

This is a general discussion that demonstrates the logical thread that runs across the various manuscripts/publications (synthesis). There should be no doubt that the manuscripts/publications complement each other and address the original objectives stated in the general introduction of the thesis. The general discussion/synthesis chapter should end with a conclusion and recommendations where necessary.

6.14 References

Only references cited in the introduction and synthesis chapters should be listed as all other references should be within the manuscripts presented under data chapters.

6.15 Annexes

All information (questionnaires, diagrams, ethics certificates, etc) considered important but not essential for inclusion in the actual thesis is put in this section as reference material. In addition papers that emanated from the work but not directly contributing to the thesis may be included.

7. Thesis formatting

For standardisation of thesis the following formatting specifications should be followed.

7.1 Font

Times New Roman 11pt should be used throughout the thesis. However, major headings may be made bigger (12pt) but using the same font type

7.2 Paper size and margins

A4 (297 x 210 mm) should be used and in the final thesis both sides of the paper should be used. However, the loose bound copy submitted for examination should be printed on only one side. The recommended margins are 30mm for all the left, right, top and bottom margins.

7.3 Line spacing

The copy submitted for examination should have 1.5 line spacing but the final copy should have single line spacing. Paragraphs should be separated by a blank line. Published or submitted manuscripts should remain in their original format in all aspects as they are inserted in their published format in appropriate places.

7.4 Headings

A consistent numbering system and captions should be maintained with first level being in CAPS and centred, second level being **normal bold** font and third level being ***italics bold***. If there is need for 4th level it should be *normal italics*.

7.7 Pagination

Page numbers should be centred at the bottom of the page. All preliminary pages should be numbered in lower case Roman numerals and subsequent pages should be numbered as indicated in the Box The title page should not be numbered.

The body of the thesis (chapter 1 onwards) should be numbered consecutively with Arabic numerals. The numbers should continue consecutively from the introduction through the through the publications or submitted manuscripts and subsequent sections. The published papers will therefore bear two numbers: a set specific to the manuscript (it is recommended to place these in the upper right hand corner) or published paper, as well as the consecutive numbers belonging to the thesis as a whole. Care must be taken to distinguish these in terms of position and font.

7.8 Referencing

Supervisors have the freedom to decide the type of citation of references but there must be consistency. This is mainly applicable to the standard type of thesis. In the case of thesis by manuscripts or publications, individual papers will maintain the reference system of the journal but the supervisor can decide on the type of referencing for the introductory and synthesis chapters.

8. Final thesis submission

The thesis should be submitted for examination in a loose bound form accompanied by a PDF copy. After the examination process the final version PDF copy of the thesis must be submitted to PG office for onward submission to the library. It is not a requirement to submit a copy fully bound in leather cloth or similar material.

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

02 June 2017

Ms Joan Pather (8830502)
School of Health Sciences
Westville Campus

Dear Ms Pather,

Protocol reference number: HSS/0264/017M
Project title: Knowledge, Attitude and Beliefs (KAB) of physiotherapists on Disability: Awareness and Health Promotion

Approval Notification – Expedited Application

With regards to your response received on **25** May 2017 to our letter of 28 April 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

[redacted]

.....
Dr Shenuka Singh (Chair)

/ms

cc Supervisor: Dr V Chetty, S Lawler & N Chemane
cc. Academic Leader Research: Professor Johan van Heerden
cc. School Administrator: Ms P Nene

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
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DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: **HRKM190/17**
KZ_2017RP14_118

24 May 2017

Dear Mrs J Pather
(University of KwaZulu-Natal)

Subject: Approval of a Research Proposal

1. The research proposal titled **'KNOWLEDGE, ATTITUDES AND BELIEFS (KAB) OF PHYSIOTHERAPISTS ON DISABILITY: AWARENESS AND HEALTH PROMOTION'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at selected facilities at KZN-DoH.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facility before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]

Chairperson, Health Research Committee
Date: 26/05/17

University of KwaZulu Natal

Date: 07 March 2017

Dear Colleague

My name is Joan Pather, a Masters in Physiotherapy (M. Physiotherapy) student at the University of KwaZulu Natal (WESTVILLE Campus). My contact details are as follows:
Telephone no: Cell: 0823330629 or (031) 5787959
email:joanpather@gmail.com or manopather@telkomsa.net
I am pursuing my research as a dissertation in completing my master's program.

My research topic is Knowledge, Attitude and Beliefs (KAB) of physiotherapistsregarding their role in Disability Awareness Promotion in KwaZulu Natal Province, South Africa. The PhysiotherapistsKAB towards disabilities influences the manner in which they are able to promote disability awareness in the various communities. A lack of updated knowledge about disabilities, negative attitudes and poor understanding and accommodation of cultural and religious beliefs has unsuccessful outcomes to disability awareness promotion.
Previous studies have indicated that there is a need for health professionals such as Physiotherapiststo advocate and implement disability awareness programmes that will accommodate the viewpoints and expectations of the community.
These studies have also concluded that Physiotherapistslack knowledge on causes and prevention of disabilities, on legislation that govern and protect PLWD, and on the necessary communication skills when engaging with PLWD and the community they live in.
The differing attitudes of Physiotherapiststo PLWD in their communities, also influences the manner in which disability awareness is promoted. Some studies found that factors as age, sex and experience can influence attitudes portrayed by the Physiotherapists. The cultural and religious attributes that Physiotherapistspossess can be imposed on the community through awareness programmes; hence, it is necessary for Physiotherapiststo be sensitive of their own beliefs and the beliefs of the community in order to effectively promote disability awareness.
There is limited studies done to ascertain whether the KAB held by Physiotherapistsis adequate in the promotion of disability awareness in the community.

In view of the above, I would like to conduct a study in KwaZulu Natal province to test the knowledge, attitudes and beliefs of qualified and registered Physiotherapists.
You are being invited to consider participating in a study that involves research using a mixed method approach.
The aim of the study is to investigate Physiotherapists' knowledge, attitude and beliefs on disability in awareness promotion.

The study is expected to enrol all Physiotherapistsin KZN that are registered with HPCSA. A questionnaire will be issued to all registered Physiotherapistsin KZN electronically and in hard copies to those without email addresses. Thereafter two focus group discussions, with a maximum of eight people per group will be held. The focus group discussions will be held at the sites with settings of Public sector Physiotherapistsin rural, public sector

Physiotherapistsin urban and private sector Physiotherapistsin urban. Selection of the exact sites will be dependent on participants from the different settings.

A questionnaire and an informed consent and consent form will be issued in determining the study. The questionnaire contains of four sections:
Section A: Demographic data
Section B: Knowledge on Disabilities
Section C: Attitude towards Disabilities
Section D: Beliefs about Disabilities

The duration of your participation if you choose to enrol and remain in the study is expected to be 2 years. The study is self-funded.

The participants will require about 20 minutes to complete the questionnaire and about 60 minutes to participate in the focus group discussions. Venues for the focus group discussions will be arranged at the convenience of all participants of the group.

I hope that the outcome of the study will assist in developing professional development activities to enhance knowledge, skills and competencies in dealing with the community about disability awareness programmes. It will also assist in reviewing of Physiotherapy curriculum.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions, you may contact:
The researcher, Joan Pather
Tel: 0823330629 or 031 5787959
Email: joanpather@gmail.com or manopather@telkomsa.net
or
The UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary and participants may withdraw participation at any point and that in the event of refusal/withdrawal of participation the participants will not incur any penalty.

The cost of transport to the venue for the focus group discussion may be the only cost incurred.

All the information you provide is considered completely confidential. Your name will not appear in thesis or report resulting from this study.

Thank you for your participation

Yours faithfully

Joan Pather
Principal Investigator
M. Physiotherapy
Student no: 8830502

I_____(Name) have been informed about the study entitled Knowledge, Attitude and Beliefs (KAB) of physiotherapistson Disability: Awareness and Health Promotion by Joan Pather.

I understand the purpose and procedures of the study as detailed in the information provided to me.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without consequences.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at tel: Cell 0823330629 or (031) 5787959 or email: joanpather@gmail.com or manopather@telkomsa.net

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

I do understand that in the completion of the electronic questionnaire, I hereby provide consent to participate in the study .

Audio-record my focus group discussion YES / NO

Video-record my focus group discussion YES / NO

_____ _____
Signature of Participant **Date**

_____ _____
Signature of Witness (Where applicable) **Date**

_____ _____
Signature of Translator (Where applicable) **Date**

FOCUS GROUP GUIDE

Q1. What is your understanding of disability?

Probes

- . ICF
- . Persons having physical, sensory, psychological, developmental, learning, neurological, or other impairments, which may be permanent, temporary, or episodic in nature, thereby causing activity limitations and participation restriction with the mainstream society"

REF: "Further studies by Merten, Pomeranz, King, Moorhouse, and Wynn (2015) found that PLWD are not getting preventative cancer screening as often as people without disabilities due to individual (low intellectual capacity, depression), interpersonal (strength of support systems, provider communication, lack of information, lack of provider training), and environmental barriers (transportation, inaccessible buildings and screening equipment). If Physiotherapistsare able to identify and understand these barriers that PLWD face in the community, they can set in motion appropriate programmes to educate the various sectors of the community and advocate for PLWD.
Although the curricula for teaching and training of Physiotherapistswas reviewed to include the ICF in assessment and treatment programmes, a lot more is to be done to enhance skills and competencies of the professional to identify issues and rights of people living with disabilities to avoid unnecessary discrimination against them (Badu et. al.., 2016)**.** "

Q2. From your experience what would help communities discuss disabilities more openly?

Probes

- Education about disabilities
- Positive attitudes and confidence of physiotherapist in discussions about disability issues

REF: "positive attitudes of health professionals reflect a desire to be nice, helpful and to treat a person with disability in an equal manner and can be used to encourage nondisabled people with no contact or experience with disability, to treat a PLWD in a genuine, warm and accepting manner, as health professionals are usually respected and welcomed by society (Al Al-Abdulwahab, & Al-gain, 2003). There has been mixed outcomes of various studies done. Culp, AG. (2016) reported on reviews in their study that a greater number of college students had negative attitudes towards PLWD, whilst other studies reported that health professionals have friendly attitudes towards PLWD. Some studies have indicated that experience working with PLWD influences the Physiotherapistsattitudes in a positive manner (Al Al-Abdulwahab, & Al-gain, 2003)."

Q3. What do you think would make is easier for communities to have more open dialogue on disability issues?

Probes

Support from people e.g. physiotherapistswho understand disability issues and the rights of PLWD (People with disabilities)

Appropriate communication e.g. use of proper terminology, use of communication assistive devices, mother tongue, translators etc.

REF: "In order for the community to embrace and accept the disability awareness being taught, the information provided must be in a language and medium that they are familiar with and in formats accessible to people with sensory impairments (Rathod V.J., Alagsen J., 2014). Often information pamphlets are not in the mother tongue language or in lay terms that the community understands or the content of information may infringe on their cultural and religious beliefs. Research shows that failure to communicate in appropriate formats leads to problems with compliance to home programmes, taking of medications etc. and attendance to medical appointments because of information not being presented in an easily understandable manner (The Lancet, Vol. 374, 2009). The failure to communicate effectively with disabled people not only wastes time and human resources, but also potentially causes delays in diagnoses and treatment for PLWD (The Lancet, Vol. 374, 2009).

The use of interpreters when doing awareness and health promotion programmes is contentious as it can have adverse effects especially if the information being interpreted is not acceptable to the interpreter and does consider cross cultural differences when engaging in health issues Wegner, L. & Rhoda, A., 2015 stated that Physiotherapistsfelt that since some of them made use of translators from the community, who would change what they said to fit the cultural context, the quality of their rehabilitation services was negatively impacted on as they felt that, they could not educate or counsel patients sufficiently. Hence the value of using formally trained interpreters in cross cultural encounters is encouraged by Campinha-Bacote (2002)(as cited by Wegner, Rhoda, & Wegner, 2012)"

1.

Q5. How often is disability awareness promotion conducted by your institution in the community?

Probes

- As per rostered programme conducted weekly, monthly, quarterly etc.
- As per special awareness days e.g. International day of the Disability, Stroke awareness etc.
- Upon request from various sectors e.g. Schools, factories etc.

Q6. Describe the sectors of the community that are addressed?

Probes

- Schools, Industries, Senior citizens, recreational clubs

Q7. What materials do you use to develop your disability awareness programme?

Probes

- Legislative documents e.g. Acts and policies

- Clinical knowledge, Physiotherapy curriculum
- Information from various sectors of the community e.g. industries, sport and recreational, education etc.
- Religious and cultural practises

Q8. What is the source of the materials you use to guide your education sessions?

Probes

- Government departments
- Community members
- Universities
- Online research

Q9. What do you think is the best communication channel that is likely to be effective in reaching the majority of disability change targets in your community?

Probes

- Use of social media e.g. television, Facebook, you tube etc.
- Talks and presentations
- Role plays e.g. a day in the life of a PLWD
- Information pamphlets

Q10. How is feedback from the disability awareness programmes monitored and evaluated?

Probes

- Questionnaires are completed by audience
- Reviews conducted in the community
- Analysis of feedback forms from the audience.
- Interviews of PLWD to assess impact of programmes

Q11. How do you think that age, gender or experience influences ones attitude to disability awareness promotion?

Probes

- Age – older, greater understanding, patience, perseverance
- Gender – females more empathetic, patient but can be too sympathetic sometimes to the detriment of PLWD
- Experience – greater confidence in handling disability issues