

WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT

Impact Assessment of Disability Programmes Provided by Non- Governmental Organisations Funded by the Western Cape Department of Social Development

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1. ACRONYMS AND TERMINOLOGY

AIDS	Acquired Immune Deficiency Syndrome
CC&DW	Creative Consulting and Development Works
CBR	Community-based Rehabilitation
CRPD	Convention on the Rights of Persons with Disabilities
CBT	Community-based Treatment
DAR	Dial-a-Ride
DPSA	Disabled People South Africa
DSD	Department of Social Development
DPO	Disabled People Organisation
DR-TB	Drug Resistant Tuberculosis
DTI	Department of Trade and Industry
FAS	Foetal Alcohol Syndrome
HIV	Human Immunodeficiency Syndrome
HSRC	Human Sciences Research Council
FAMSA	Family and Marriage Society of South Africa
ILO	International Labour Organisation
IDDC	International Disability and Development Consortium
INDS	Integrated National Disability Strategy
IPDS	Integrated Provincial Disability Strategy
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MDG	Millennium Development Goals
NGO	Non-Governmental Organisation
NPO	Not for Profit Organisation
NQF	National Qualifications Framework
SASSA	South African Social Security Agency
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation
WHO	World Health Organisation

Definition of “Persons with Disabilities”

Persons with Disabilities are classified by the United Nations Convention as *“including those who have long-term physical, mental, intellectual or sensory which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”*¹

The Convention further defines several terms relevant to the disability sector as follows²:

- Communication: this can include languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology
- Language: includes spoken and signed language and other forms of non-spoken language
- Discrimination on the basis of disability: means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial or reasonable accommodation
- Reasonable accommodation: means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with Disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.
- Universal design: means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialised design. Universal design shall not exclude assistive devices for particular groups of Persons with Disabilities where this is needed.

¹ <http://www.un.org/disabilities/convention/conventionfull.shtml>

² <http://www.un.org/disabilities/convention/conventionfull.shtml>

2. EXECUTIVE SUMMARY

2.1 Report overview

The Department of Social Development (DSD) in the Western Cape provides financial resources to non-governmental organisations (NGOs) to implement programmes that will help DSD to achieve their strategic objective for the sub-programme for Persons with Disabilities which is to ensure “*the provision of integrated programmes and services to Persons with Disabilities and families*” (Department of Social Development, 2011, p. 31). These services aim to promote the rights, well-being and socio-economic empowerment of Persons with Disabilities, and their families in the Province.

This evaluation considers the impact of the DSD-funded NGOs disability programmes in order to assess whether the programmes are effective in achieving their stated objectives. The focus of this evaluation was on the organisations, their staff and their beneficiaries. Fifteen organisations were selected for the evaluation and all types of disability were reviewed except for programmes addressing mental illness, because the organisation that focuses on mental health that was selected for inclusion in the evaluation did not consent to participate in the evaluation.

The report begins with an introduction providing a background and overview of the international and South African context. This is followed by the evaluation methodology. The main findings and discussion are then presented covering six broad themes. The final section looks at the conclusion and recommendations with respect to the findings. Tools that assisted in the evaluation such as informed consent forms and interview guides form the appendices section.

2.2 Summary of key findings and recommendations

Findings

1. Impact of services delivered to Persons with Disabilities, their caregivers/ families and communities

Context of beneficiary support

The evaluation found that beneficiaries, including Persons with Disabilities and their caregivers, remain vulnerable because there are very few resources provided to them beyond that of NGOs. This is further exacerbated by the finding that there is a lack of information about the extent of the need for services which highlights that there could be many people who are unable to access the services they need.

Despite the high levels of vulnerability reported, beneficiaries including Persons with Disabilities, their caregivers and representatives from community organisations cited the

enormous value of the services of the NGOs. Beneficiaries said that the NGOs evaluated offered services that are provided by a very limited number of NGOs.

Nature of NGO support to beneficiaries

All fifteen organisations that participated in this evaluation were funded to provide;

- Awareness and prevention programmes,
- Early intervention programmes, and
- Reintegration programmes.

Statutory services, which included the provision of residential care, were provided by two organisations under this review.

Early intervention programmes, which include the provision psychosocial support, account for the majority of services provided. This closely aligns to DSDs mandate and strategy, which is to support and improve the social functioning of Persons with Disabilities. Much of the support provided by NGOS was very practical in nature, responding to the high level of needs of Persons with Disabilities and their families.

2. Accessibility of services

Accessibility of services was evaluated by assessing the availability of services, affordability of services and the acceptability of services.

Availability of services

Transport services are available to Persons with Disabilities, however they are mostly available to those who live in the Metro. Transport mentioned by beneficiaries includes Dial a Ride, MyCiti bus services, and this is augmented by transport services provided by more than half the NGOs, who are able to provide transport to beneficiaries.

All of the NGO offices were found to be adapted in order to facilitate physical accessibility of service users. Most of the NGOs services were found to be in the Metro with some extending their services beyond to Eden and the West Coast Districts. Networking was found to be an important way of closing service delivery gaps amongst stakeholders, and is a factor in ensuring accessibility to different types of services. The evaluation found that there was effective networking amongst organisations, particularly in the Metro, and this is further facilitated through the Western Cape Network on Disability. It was difficult to accurately establish how easily accessible information is about NGO services for Persons with Disabilities because the evaluators spoke to beneficiaries already accessing the NGO. Therefore it is important for NGOs to continuously assess how they are sharing information about their services in order to facilitate access.

Affordability of services

Public transport services in the Metro were found to be affordable, with rural areas still spending substantial funds on travel. NGOs however reported that the costs associated with vehicle maintenance were high which had the potential to disrupt their service.

Enormous value is associated with home adaptations and assistive devices to ensure that Persons with Disabilities can be as independent as possible; however for most families the costs associated with improving accessibility within the home remains completely unaffordable.

Acceptability of services

Whilst transport for Persons with Disability in the Metro is becoming more available and affordable, communication remains a barrier in using public transport and other public services, as staff are unable to communicate appropriately.

3. Relevance and appropriateness of services

The evaluation found that there was a high demand for NGO services and high levels of satisfaction from the beneficiaries including Persons with Disabilities and their caregivers. A major finding is that organisations did not seem to know the extent of the need for their services, which makes it challenging to assess real coverage. Furthermore, the service may be acceptable to beneficiaries receiving the service, but if the organisations are only reaching a small percentage of beneficiaries then perhaps their service could be more relevant and appropriate if it was offered differently and was able to reach more beneficiaries. Additional information regarding the gaps in services and coverage of services is essential to inform planning.

Many of the NGOs reported that they have not completed a formal needs assessment, but through their work felt attuned to the needs of beneficiaries. NGOs believed that their services were relevant to beneficiaries. Whilst NGOs should undertake a formal needs assessment, other methods can be used to ensure that organisations have a good understanding of the needs of their beneficiaries. For example, Persons with Disabilities can be represented within the governance structure of the NGO and NGOs can attend networking meetings. DSD would also benefit from having a regular needs assessment to inform their strategic direction.

Many NGOs said that they did not have funds to commission external evaluations. This further highlights the gaps in information that are undermining the ability of NGOs to be properly informed about the needs of beneficiaries, and the impact NGOs are having on the lives of their service users.

Whilst DSD predominantly focus on the provision of psychosocial support to Persons with Disabilities and their caregivers, evaluation respondents believed that more could be done to prevent disability.

The evaluation found that as a result of the high levels of need and vulnerability of beneficiaries, that respondents found that it can be a challenge to establish what services are appropriate and relevant. Greater work between DSD, NGOs and other partners is

needed to ensure that minimum service standards are developed to appropriately guide those involved in service delivery to ensure equitable access to services.

DSD and NGO partners cited their particular concern with regard to the underservicing of Persons with Disabilities in rural areas of the Western Cape. There is agreement that it is not simply a case of scaling up what is available in the Metro but that understanding the needs of diverse rural communities and appropriate planning was necessary towards ensuring services are available and appropriate.

The evaluation found that there is an overwhelming need for a coordinated multi-sectoral response to ensure that the diverse and ongoing needs of Persons with Disabilities are met, to ensure their full participation in communities. Once again, the response to the needs of rural and metro beneficiaries should not be a 'one size fits all' approach.

Evaluation participants recognised the huge costs associated with caring for some beneficiaries and that there was a need to explore different models of care that were cost-effective and sustainable such as respite care and support in the home.

4. Extent to which the services provide value for money

The evaluation observed NGOs responding to different and multiple types of disabilities. The vast majority of beneficiaries cannot afford to pay for services and service delivery is costly. NGOs cited that their key cost drivers include transport, staff and the provision of assistive devices. NGOs are extremely dependent on DSD for funds and their service offering was under threat if any administrative delays impacted on the delay in the transfer of funds.

5. Extent to which interventions contribute to social change and improved social functioning of beneficiaries

NGOs provided life skills activities to Persons with Disabilities to help them become more independent. Such services could include self-care, as well as orientation and mobility training.

Organisations recognised the enormous value but the challenge of securing employment for Persons with Disabilities. It was highlighted that there is a place for protective workshops to provide opportunities for people with certain types or severities of impairment but that protective workshops need to try to procure contracts from the open market so as to be sustainable. Providing support to Persons with Disabilities to enter the formal job market was seen as critical towards achieving real integration for the disability sector.

6. Social impact of services in changing the community attitude/ social attitude towards Persons with Disabilities and in the reduction of stigma and social exclusion

High levels of stigma continue to be a social barrier for Persons with Disabilities particularly those with severe forms of disability. Targeted awareness was seen as important, but resource intensive, form of addressing stigma but also creating a deep understanding of different types of disability. Targeting particular groups, such as potential employers was

recognised as an important step towards breaking down barriers and improving opportunities for Persons with Disabilities.

Advocacy was recognised as an important and ongoing activity to raise awareness of discrimination faced by Persons with Disabilities in accessing services. This could be undertaken by NGOs themselves and/ or by empowered beneficiaries.

General awareness raising was undertaken by many organisations as part of their mandate with particular emphasis on the commemoration of certain days. This was not their primary focus and organisations cited that it was hard to measure the impact of such activities.

7. Promising practices

Beneficiaries cited the provision of support groups as an effective methodology, as they were able access psychosocial support. Furthermore the delivery of targeted awareness programmes was recognised as a more effective method of ensuring that the correct audience was targeted with messages that were appropriate and relevant. Finally, the evaluators recognised the value of DSD and NGOs further exploring community based interventions as it ensures that Persons with Disabilities and their caregivers are identified and appropriately supported in their own community.

Recommendations

NGOs

1. NGOs to continue to provide information, awareness and psychosocial support to Persons with Disabilities and those in the microsystem to empower them with knowledge, skills that will create an enabling environment for Persons with Disabilities. As far as possible, Persons with Disabilities should be integrated to participate in all aspects of home and community life.
2. NGOs to explore different models of support to communities to ensure that Persons with Disabilities are identified and linked to community services.
3. NGOs to continue to implement programmes and campaigns that effectively reduce the stigma associated with disability in different community contexts.
4. Persons with Disabilities to provide advisory support via their participation on Boards and other structures so as to appropriately advise organisations about the needs of beneficiaries.
5. NGOs to continue to offer comprehensive reintegration programmes particularly those aimed towards enabling Persons with Disability to enter a workplace that is a supportive and enabling environment conducive to their employment.
6. NGOs to advocate to local business / organisations to be compliant and employ Persons with Disabilities.
7. NGOs to mobilise resources to undertake needs assessments, and improve their capacity to implement monitoring and evaluation systems.

DSD in partnership with other government departments and NGOs

8. Particular focus to be given to the needs of Persons with Disabilities and their caregivers in rural areas to ensure they are provided with appropriate support.
9. The Western Cape Network on Disability to be properly resourced and supported to engage with, and represent its membership.
10. DSD and its NGO partners to pilot different models of care that could be cost effective and could lead to replication of services and enable services to go to scale.
11. DSD with other government departments and non-governmental partners to mobilise a sustained multi-sectoral effort to;
 - a. Ensure a comprehensive gap analysis is undertaken to identify where the disability sector currently is in terms of service delivery versus where it should be.
 - b. Undertake sectoral planning, ensuring that strategies are designed and implemented that respond to the gap analysis and provide clear direction with regard to strategies and priorities focused on prevention, early intervention, statutory/ residential care and reintegration programmes. Furthermore, services need to be:
 - i. Sustainable, for example, in providing support for the purchase of assistive devices, continued support for the maintenance of such services is critical. This is also true for the purchase of vehicles.
 - ii. Comprehensive, for example they need to fill all the accessibility criteria, ensuring they are available, affordable and acceptable to Persons with Disabilities.
12. Design minimum standards for services for Persons with Disabilities where these are not already in place. For example, home adaptations, the provision of assistive devices, and the provision of rehabilitation services.
13. Design and appropriately resource a monitoring, evaluation and research framework, that produces information to further inform planning.
14. Develop and implement an advocacy campaign to mobilise additional partners to become actively involved in ensuring that the rights of Persons with Disabilities are upheld. For example, the private sector becoming an active employer of Persons with Disabilities, or providing contracts to protective workshops to ensure they are sustained.

3. INTRODUCTION

3.1 Background and overview of the international context

3.1.1 Global statistics for prevalence of disability

As reported in the World Health Organisation (WHO) Community-based Rehabilitation (CBR) Guidelines (2010, p.18), globally:

- *Approximately 10% of the world's population lives with a disability.*
- *People with Disabilities constitute the world's largest minority.*
- *An estimated 80% of People with Disabilities live in developing countries.*
- *An estimated 15 to 20% of the world's poorest people are disabled.*
- *No rehabilitation services are available to People with Disabilities in 62 countries.*
- *Only 5 to 15% of People with Disabilities can access assistive devices in the developing world.*
- *Children with disabilities are much less likely to attend school than others. For example, in Malawi and the Republic of Tanzania, the probability of children never having attended school is doubled if they have disabilities.*
- *People with Disabilities tend to experience higher unemployment and have lower earnings than People without Disabilities.*

3.1.2 United Nations Convention on the Rights of Persons with Disabilities

In 2006, the United Nations (UN) adopted the Convention on the Rights of Persons with Disabilities (CRPD). The purpose of the CRPD is *"to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all Persons with Disabilities, and to promote respect for their inherent dignity"* (United Nations, 2006). The CRPD outlines the range of different rights ranging from; *"civil, cultural, political, social, and economic rights of Persons with Disabilities"* (United Nations, 2006). The principles of the UN CRPD (2006) are;

- *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons,*
- *Non-discrimination,*
- *Full and effective participation and inclusion in society,*
- *Respect for difference and acceptance of Persons with Disabilities as part of human diversity and humanity,*
- *Equality of opportunity,*
- *Accessibility,*
- *Equality between men and women, and*
- *Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.*

3.1.3 Brief overview of disability, development and poverty

The WHO (2011) recognise that disability is a development issue, because of its strong link to poverty. Sen (2009) in the World Report on Disability (2011) states that “*disability may increase the risk of poverty, and poverty may increase the risk of disability*”. Evidence shows that Persons with Disabilities and their families are “*more likely to experience economic and social disadvantage than those without disability*”. This can occur because disability can affect Persons with Disabilities’ access to primary, secondary and tertiary education, as well as their ability to procure employment. Furthermore, Persons with Disabilities require financial resources so as to meet their basic needs.

The onset of disability may lead to the worsening of social and economic well being and poverty through a multitude of channels, including the adverse impact on education, employment, earnings, and increased expenditures related to disability (Jenkins and Rigg, 2003 in WHO, 2011). For example (WHO, 2011, p. 10);

- *Children with disabilities are less likely to attend school, which reduces their for human capital formation. Furthermore they face reduced employment opportunities and decreased productivity in adulthood [Filmer (2008), Mete (2005), Burchardt (2005)].*
- *Persons with Disability are more likely to be unemployed and generally earn less even when they are employed [Burchardt (2005), Organisation for Economic Co-operation and Development (2010), Houtenville et al (2009), Contreras et al (2006), Coleridge (2005), Mitra (2011)]. Both employment and income outcomes appear to worsen with the severity of the disability [Grammenos (2003), Emmett (2006)]. It is harder for Persons with Disabilities to benefit from development and escape from poverty (Thomas, 2005) due to discrimination in employment, limited access to transport, and lack of access to resources to promote self-employment and livelihood activities (Coleridge, 2005).*
- *Persons with Disabilities may have extra costs resulting from disability, such as costs associated with medical care or assistive devices, or the need for personal support and assistance – and thus often require more resources to achieve the same outcomes as non-disabled people. Because of higher costs, Persons with Disabilities and their households are likely to be poorer than non-disabled people with similar incomes [Zaidi et al (2005), Braithwaite et al (2009) and Cullinan et al (2010)].*
- *Households with a disabled member are more likely to experience material hardship – including food insecurity, poor housing, lack of access to safe water and sanitation, and inadequate access to health care [Van Brakel (2006), Mitra et al (2011), Beresford (2008), Loeb et al (2004), Eide et al (2006), Eide et al (2006)].*

Whilst disability may increase the likelihood of poverty, poverty may also increase the risk of disability. The World Report on Disability (WHO, 2011, p.10) highlights this point, stating “*a study of 56 developing countries found that the poor experienced worse health than the better off (Gwatkin, 2007). Poverty may lead to the onset of a health condition associated with disability including through: low birth weight, malnutrition [Maternal and child under nutrition, (2008), United Nations Children’s Fund (2008)] lack of clean water or adequate sanitation, unsafe work and living conditions, and injuries [WHO (2008), Emerson (2006),*

Emerson et al (2006), Rauh et al (2008)]. Poverty may increase the likelihood that a person with an existing health condition becomes disabled, for example, by an inaccessible environment or lack of access to appropriate health and rehabilitation services (Peters et al, 2008).

In South Africa research by Dube (2005, p.6) shows that *“approximately 71.7 per cent of the non-disabled population live in households where the average annual per capita income is below R10, 000 (US\$1,518) and where the maximum educational level is below Standard 10. This compares to 79.4 per cent in the same group of disabled people. A possible conclusion from these results is that disability increases the chance of living in extreme poverty by approximately 10 per cent. A disabled person with no education has a 60 per cent likelihood of being in the lowest income category, versus 44 per cent for people with no disability.”*

The World Report on Disability (WHO, 2011, p.12) highlights that *“despite the widely acknowledged interconnection between disability and poverty, efforts to promote development and poverty reduction have not always adequately included disability, for example disability is not explicitly mentioned in the eight Millennium Development Goals (MDGs). Therefore in November 2009, the Sixty-fourth UN General Assembly adopted a resolution; ‘Realizing the Millennium Development Goals for Persons with Disabilities.’³*

Furthermore the World Report on Disability (WHO, 2011, p.12) calls for;

- *Disability to be a higher priority,*
- *Successful initiatives to be scaled up,*
- *A more coherent response, and*
- *Persons with Disabilities to be included in development efforts, both as beneficiaries and in the design, implementation, and monitoring of interventions (Kett et al, 2009).*

3.1.4 Community-Based Rehabilitation

Community-Based Rehabilitation (CBR) *“focuses on enhancing the quality of life for Persons with Disabilities and their families, meeting basic needs and ensuring inclusion and participation. CBR was initiated in the mid-1980s but has evolved to become a multi-sectoral strategy that empowers Persons with Disabilities to access and benefit from education, employment, health and social services. CBR is implemented through the combined efforts of Persons with Disabilities, their families, organisations and communities, relevant government and non-government health, education, vocational, social and other services.”⁴*

In 2004 CBR was repositioned, as a result of a paper by the International Labour Organisation (ILO), United Nations Educational, Scientific and Cultural Organisation

³ Resolution: (A/RES/64/131) (15)

⁴ Accessed from <http://www.who.int/disabilities/cbr/en> on 21 August 2013.

(UNESCO) and WHO. CBR was seen as a strategy for rehabilitation, equalisation of opportunity, poverty reduction and social inclusion of Persons with Disabilities (in WHO, 2010). The goals of CBR are to ensure the benefits of the CRPD reach the majority by;⁵

- *Supporting Persons with disabilities to maximise their physical and mental abilities, to access regular services and opportunities, and to become active contributors to the community and society at large,*
- *Activating communities to promote and protect the human rights of Persons with Disabilities for example by removing barriers to participation, and*
- *Facilitating capacity building, empowerment and community mobilisation of Persons with Disabilities and their families.*

The CBR Guidelines (WHO, 2010, p. 11 and 12) join the development and human rights aspects of disability and they;

1. *Provide guidance on how to develop and strengthen CBR programmes,*
2. *Promote the need for inclusive development for Persons with Disabilities in the mainstream health, education, social, and employment sectors,*
3. *Emphasise the need to promote the empowerment of Persons with Disabilities and their family members, and*
4. *Position CBR as a tool that countries can use to implement the CRPD through the provision of practical tools.*

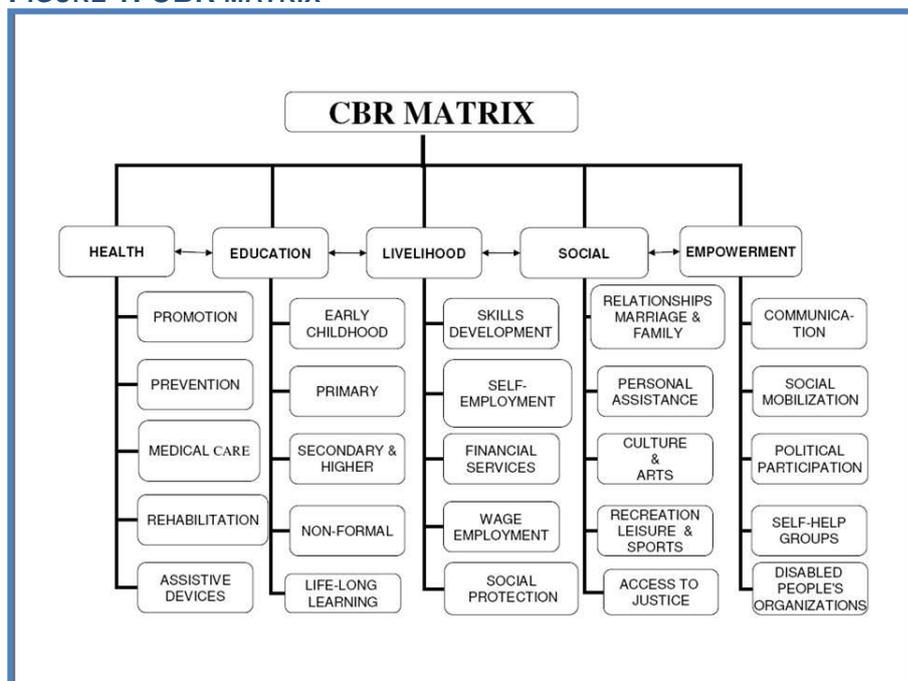
In response to point 2 in the above box, the CBR approach of mainstreaming the rights of Persons with Disabilities in the development agenda is seen as “a way to achieve equality for Persons with Disabilities” [United Nations (2008) in WHO (2010)]. The UK Department for International Development (2000) in WHO (2010, p.20) says that “to enable Persons with Disabilities to contribute to creating opportunities, share in the benefits of development, and participate in decision-making, a twin-track approach may be required. A twin-track approach ensures that (i) disability issues are actively considered in mainstream development work, and (ii) more focused or targeted activities for Persons with Disabilities are implemented where necessary.”

CBR has “evolved into a broader multisectoral development strategy. To reflect this evolution, a matrix was developed in 2004 to provide a common framework for CBR programmes (See Figure 1 below). The matrix consists of five key components – the health, education, livelihood, social and empowerment components. Within each component there are five elements. The first four components relate to key development sectors, reflecting the multisectoral focus of CBR. The final component relates to the empowerment of Persons

⁵ Accessed from <http://www.who.int/disabilities/cbr/activities/en/> on 21 August 2013.

with Disabilities, their families and communities, which is fundamental for ensuring access to each development sector and improving the quality of life and enjoyment of human rights for Persons with Disabilities.” (WHO, 2010, p. 24).

FIGURE 1: CBR MATRIX

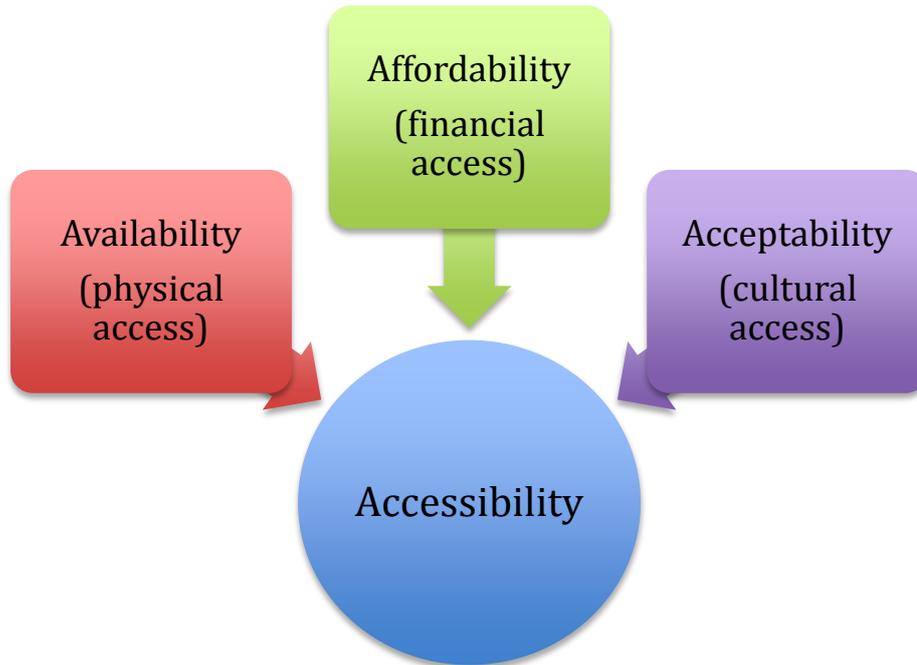


Whilst CBR is recognised to be a useful tool, as are many other programmes by national governments or national and international NGOs, the “*systematic removal of barriers and social development has not occurred, and disability still is often considered in the medical component of development*” (WHO, 2010, p. 12).

3.1.5 Understanding accessibility

A paper by McIntyre, Thiede and Birch (2009) define access to health care as “*the empowerment of an individual to use health care and as a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households and communities. These dimensions of access are identified as; availability, affordability and acceptability (See Figure 2 below), through which access can be evaluated directly instead of focusing on utilisation of care as a proxy for access.*”

FIGURE 2: DIMENSIONS OF ACCEPTABILITY



Whilst the definition by McIntyre et al (2009) assesses access to the health care context specifically, this conceptual framework is useful when adapted to understand the opportunities and constraints that persons with disabilities face when trying to access a range of different services.

The paper goes on to further highlight that: *“Although each dimension is distinct and focuses on a set of clearly distinguishable issues, it is the interaction between the dimensions that determines access. For example, the effect of improving the geographic distribution of providers (availability) on individual empowerment is dependent on or influenced by whether the services of the providers are affordable (e.g., the mean travel time to providers might be less but provider fees may have increased) and acceptable (the providers may not be consistent with the cultural expectations of the population).”*

This thorough analysis of the dimensions of accessibility provide a useful lens the disability sector.

3.2 Background and overview of the South African context

3.2.1 Prevalence of disability in South Africa

Statistics on the prevalence of disability in South Africa have been poorly reported. The most recent census survey completed in 2011 in South Africa unfortunately does not give a precise breakdown of prevalence. The Community Survey conducted by Statistics South Africa (2007) reports prevalence as follows:

TABLE 1: PROPORTION OF DISABLED SOUTH AFRICANS⁶

Census 1996	Census 2001
2 657 713	2 255 982
6.5%	5%

Table 2 below provides a detailed breakdown of disability across population group and gender (Stats SA, 2007).

TABLE 2: DISABLED SOUTH AFRICANS BY POPULATION GROUP AND GENDER (2007)

Population group	Disabled			Percentage disabled		
	Male	Female	Total	Male	Female	Total
Black African	797 254	728 497	1 525 751	2.1%	1.9%	4.0%
Coloured	95 064	88 224	183 288	2.2%	2.0%	4.2%
Indian or Asian	29 268	27 928	57 196	2.4%	2.2%	4.6%
White	78 972	71 011	149 984	1.7%	1.5%	3.2%
Total	1 000 558	915 661	1 916 219	2.1%	1.9%	4.0%

Table 2 above shows that the population group, which makes up the largest percentage of the disabled population, are Indian or Asian people, with 4.6%. The least prevalent population group with a disability is among white people with 3.2%. Additionally, more males have reported disability than females at 2.1% to 1.9%.

⁶ Please note that the Community Survey (2007) data is excluded as this was a sampled assessment.

TABLE 3: DISABLED POPULATION DISTRIBUTION PER PROVINCE AND TYPE OF DISABILITY [(FROM 2007, STATS SA (2007))]

Type of disability	Eastern Cape	Free State	Gauteng	KwaZulu-Natal	Limpopo	Mpumalanga	Northern Cape	North West	Western Cape	Total
Seeing	36 556	19 105	43 196	46 815	35 664	18 437	7 721	24 957	17 334	249 786
Hearing	35 539	9 709	28 889	40 832	18 747	12 986	4 398	14 693	14 604	180 397
Communicating	16 030	6 445	14 678	21 600	9 830	7 020	1 944	6 027	7 491	91 065
Physical	130 079	61 861	124 848	188 128	65 642	54 068	24 595	46 318	74 233	769 772
Intellectual	24 131	8 181	22 609	24 857	15 585	8 122	3 983	7 265	14 107	128 841
Emotional	71 949	22 487	56 075	90 468	36 768	25 183	9 633	30 214	30 840	373 617
Multiple disabilities	17 907	9 083	17 545	24 663	9 138	7 516	5 243	10 462	21 183	122 741
Total disabled	332 191	136 871	307 840	437 363	191 374	133 332	57 517	139 936	179 792	1916 219
Total population	6527 747	2 773 059	10451714	10259230	5238286	3 643 435	1058 060	3271 948	5278 585	48502064
Percentage disabled	5.1%	4.9%	2.9%	4.3%	3.7%	3.7%	5.4%	4.3%	3.4%	4%

Table 1.3 shows that the Northern Cape and Eastern Cape have the highest percentage of disabled people within the country with 5.4% and 5.1% respectively. Specifically, the Western Cape has the second lowest percentage of disabled people at 3.4%, with only Gauteng having a smaller percentage at 2.9%. Nationally, physical disability accounts for the majority of disabilities with 40% of people with Disabilities experiencing physical disability. This is followed by emotional (19%) and visual impairment (13%). In the Western Cape, 41% of Persons with Disabilities experience physical disability, followed by emotional disability (17%) and 12% experience multiple Disabilities.

3.2.2 South Africa's policy environment

South Africa has the Integrated National Disability Strategy White Paper, 1997 (INDS). The White Paper “represents the government's thinking about what it can contribute to the development of disabled people and to the promotion and protection of their rights” (INDS, 1997). The vision of the INDS (1997, p. 5) “is a society for all. This means that there must be an integration of disability issues in all government development strategies, planning and programmes. There must be an integrated and coordinated management system for planning, implementation and monitoring at all spheres of government. And, to complement the process, there must be capacity building and wide public education”.

The Department of Social Development (DSD) has a “Policy on Disability” (undated) that guides the response to the needs of Persons with Disabilities and outlines DSDs responsibilities. The Policy (undated, p. 19-23) provides a set of principles that seek to promote the following;

- *Right to self-representation*
- *Accessibility*
- *Support system*
- *Self respect and self-sufficiency*
- *Access to appropriate services*
- *Social integration*
- *Enhanced inter-sectoral collaboration*
- *Equitable resource allocation*
- *Inclusion*
- *Batho pele principles*

Under this policy, DSD is responsible to provide and be involved in; social grants, personal assistance services, social support services, community development, community based services, social integration, advocacy, and rehabilitation. DSD's secondary role, as defined in the policy, is to ensure; the provision of transport, provision of assistive devices, promotion of employment opportunities, facilitation for inclusive education processes, the provision of medical rehabilitation and to ensure the economic empowerment to Persons with Disabilities.

Other national government departments have policies addressing disability. To name a few;

- The Department of Health (2000). National Rehabilitation Policy.
- The Department of Education (2001). Education White Paper 6: Special Needs Education.
- The Department of Health and Education (2011). National School Health Policy and Implementation Guidelines.

- The Department of Labour. Code of good practice on the Employment of Persons with Disabilities. Part of the Employment Equity Act No 55 of 1998.

Dube (2005, p.39) in a study on the role and effectiveness of disability legislation in South Africa, concluded that *“Departments within the social services spectrum play an important role in the development of Persons with Disabilities, and their programmes therefore are an essential requirement, more specifically for children with disabilities. The physical, psychological, social and economic development of Persons with Disabilities is largely dependent on the services and programmes provided within these departments.”*

He further noted that there is a *“positive policy environment in South Africa, and that this presents unique opportunities for disabled persons to address issues such as: poverty alleviation, high levels of unemployment, education of children and youth with disabilities, improved access to social security and assistive devices as well as access to housing, public health services and transport.”* (Dube, 2005, p. 39) However he cautions that the implementation of policy is undermined by the lack of budgetary allocations especially with regard to the IPDS.

3.2.3 Social grants

Individuals older than 18 years of age are entitled to apply for a disability grant of a maximum amount of R1 260 per month⁷, if they are not able to work due to mental or physical disability. There are two main types of disability grants;

- temporary, given to individuals whose disability lasts between six months and a year, and
- permanent disability, which is provided for a year.

According to The Community Survey (StatsSA, 2007), the disability grant is the third most frequent grant given to South Africans (third out of seven). Moreover, 10.6% of all grants are disability grants.

3.2.4 Disability Charter of South Africa

To complement the policies of government, Disabled People South Africa (DPSA) developed the Disability Rights Charter of South Africa (1992). This Charter addresses the rights of disabled people and promotes the right to; non-discrimination, self-representation, health and rehabilitation, education, employment, sport and recreation, social security, housing, transport, the built environment, independent living, communication, participation in social life, prevention, positive action and the enforcement of the charter. The charter further recognises the rights of disabled children and disabled women.

⁷ Western Cape Government Website. Accessed online at http://www.services.gov.za/services/content/Home/ServicesForPeople/Socialbenefits/disabilitygrant/en_ZA

3.3 Addressing the needs of Persons with Disability in the Western Cape

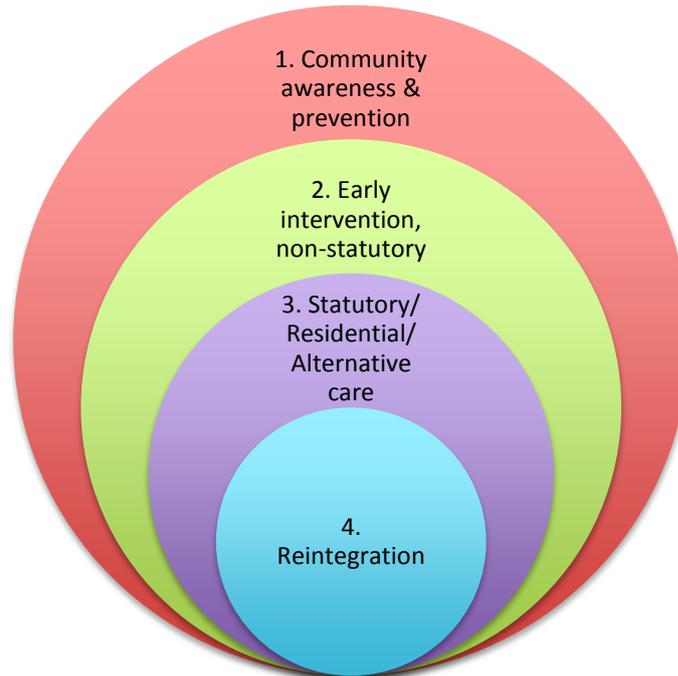
The Provincial Government of the Western Cape is committed to implementing integrated programmes and services that facilitate the well-being and socio-economic empowerment of Persons with Disabilities and their families.

In the Western Cape, a provincial version of the INDS, termed the Integrated Provincial Disability Strategy (IPDS) was developed in 2001 in an attempt to address disability issues from an intersectoral perspective and looks at integration of disability issues into the line functions for different government departments. Ten government departments committed to the IPDS; Economic Affairs, Education, Health, Housing, Justice, Labour, Social Services, Local Government, Sport and Transport (Province of the Western Cape, 2001).

3.3.1 Strategy of the Department of Social Development

The Western Cape DSDs' commitment to Persons with Disabilities is reflected in the Provincial Strategic Objective 8 namely: Social Inclusion and Poverty Reduction. The 'Services to Persons with Disabilities' falls within DSDs' Sub-Programme in the Directorate of Special Programmes. The strategic objective of this programme is *"the provision of integrated programmes and services to people with Disabilities and families. These services are aimed at the promotion of the rights, well-being and socio-economic empowerment of Persons with Disabilities, and their families in the Provinces, reaching 24 900 people by March 2015"* (DSD, 2011, p. 31) Such services are provided in accordance with the four levels of the Integrated Service Delivery Model (DSD, undated).

FIGURE 3: INTEGRATED SERVICE DELIVERY MODEL



The DSD has seven key foci. This speaks to the strategic thrust of the programme. The seven foci are listed, as follows:⁸

1. *The expansion of services into rural areas.*
2. *All Persons with Disabilities and their families will have access to developmental social welfare services.*
3. *Protective workshops are transformed and supported to create socio-economic opportunities by providing a diverse service baskets ranging from social services, promoting skills development, entrepreneurship and exposure to the world of work.*
4. *Persons with Disabilities should be fully empowered, and some candidates will graduate from protective workshops to more open economic empowerment opportunities and the broader economy.*
5. *The mainstreaming of disability issues across all departmental programmes and activities.*
6. *Early intervention and support programmes targeting children with disabilities, families, parents and caregivers.*
7. *Expand community programmes such as day care programmes for Persons with Disabilities under the age of 18.*

The DSD has formed strategic partnerships with a range of key role players to assist in the delivery of appropriate services for Persons with Disabilities. The following table (DSD, 2011, p. 31) shows these strategic partnerships:

⁸ Western Cape Governmental website.

TABLE 4: DSD STRATEGIC PARTNERSHIPS

Strategic Partnerships	Area of collaboration
Persons with Disabilities, their families/ caregivers, communities (beneficiaries)	Awareness and advocacy programmes
Non Governmental Organisations (NGO) / Disabled People Organisations (DPO)	Service delivery arm, rendering developmental social welfare services across four levels of intervention
Department of Health, Department of Basic Education, Department of Trade and Industry (DTI)	Primary strategic partners on Social Development mandate: Residential Care and Protective Workshop Services
Other DSD Programmes and six regional offices	Promoting disability mainstreaming

As seen in Table 4 this evaluation will focus on the second area of strategic partnerships – particularly NGOs and DPOs. DSD recognise the value and importance of the programmes being delivered by NGOs to beneficiaries and recognise the huge need they are responding to. NGOs that receive funding from the DSD to provide services to people with Disabilities are funded to implement the following;

- Awareness and educational programmes regarding the rights and needs of persons with disabilities in order to reduce stigma and social exclusion,
- Provision of psychosocial support programmes,
- Reintegration services to assist persons with disabilities to function optimally in society,
- Capacity building to organisations providing services in the disability sector.

In response, DSD have increased funding for NGOs in this sector from approximately R47 million in 2008 to R86, 395 000 in 2013. This increase in funds has allowed DSD to increase the number of organisations they are able to fund, and also give inflation related increases to existing partners of six per cent. Currently there are 147 partner organisations funded by DSD in the Western Cape. Whilst DSD has insight into the costs associated with residential care, protective workshops and other services, DSD are planning to improve the quality of their costing information to improve their decision-making, relating to budgetary planning and disbursement decisions.

3.3.2 Targets achieved by Western Cape DSD

With the introduction of new performance indicators, DSD mainly has information on estimated performance and targets. However, from targets, one can see the Department aims to increase the number of Persons with Disabilities and their families reached, whom they access through awareness, educational and social empowerment programmes.



TABLE 5: DSD PERFORMANCE NON-FINANCIAL DATA⁹

Performance indicator	Audited/Actual performance			Estimated performance 2011/12	Medium-term targets		
	08/09	09/10	10/11		12/13	13/14	14/15
Sector performance indicators							
No. of Persons with Disabilities in funded residential facilities managed by NPOs.	1 315	1 346	1 366	1 380	1 265	1 265	1 265
No. of Persons with Disabilities accessing services in funded protective workshops managed by NPOs.	2 425	2 400	2 549	2 523	2 625	2 625	2 625
No. of funded protective workshops for Persons with Disabilities managed by NPOs (annual targets).	43	46	43	43	46	46	46
No. of funded residential facilities for Persons with Disabilities managed by NPOs (annual targets).	31	33	33	33	31	31	31
No. of clients benefitting from government social work services.				New indicator	300	350	400
No. of clients benefitting from funded NPO social work services.				New indicator	23222	24070	24500
Provincial performance indicator							
No. of adult Persons with Disabilities benefitting from six funded community based day care programmes.				New indicator	180	220	250
No. of youth peer support counsellors trained from the youth				New indicator	20	30	40

⁹ Amended table from Department of Social Development. *Annual Performance Plan 2012-2013*.

with Disabilities empowerment and support programmes implemented.							
No. of children with Disabilities benefitting from the eight funded day care services implemented.				New indicator	327	500	550
No. of families with deaf infants: 0-3 years, benefitting from early intervention and support programme implemented.				New indicator	85	100	100
No. of caregivers in day care centres benefitting from capacity building and support programmes implemented.				New indicator	20	30	50

4. EVALUATION METHODOLOGY

4.1 Evaluation aims and objectives

This evaluation assessed the impact of the disability programmes offered by service providers, whom DSD provide funding to, in order to assess whether the programmes are effective in achieving their stated objectives. Additionally, the assessment identified elements of emerging promising practices in the field of disability programmes. The evaluation centred around six areas of impact as identified in the Terms of Reference of this project shown in Table 6 below:

TABLE 6: EVALUATION QUESTIONS

Area of impact	Evaluation question
Impact 1: The impact of the service on individuals and their caregivers / families and communities.	1. What changes are Persons with Disabilities and caregivers or families / communities experiencing through the services of NGOs?
Impact 2: The accessibility of services.	2. How accessible are the services to individuals and caregivers or families affected by disability in terms of geographical distance, cost to get to NGO and mobility to get into and around the building?
Impact 3: The relevance and appropriateness of the services (i.e. does the service provided meet the needs of the affected persons).	3. How relevant and appropriate are the services offered to the needs of Persons with Disabilities and caregivers or families?
Impact 4: The extent to which the service provides value for money.	4. How do Persons with Disabilities and caregivers or families value the services provided by NGOs? 5. Are NGOs delivering services as per their agreement with the DSD? 6. Are services delivered efficiently? 7. Did the NGO achieve its outcomes? 8. What are the key cost drivers of NGO programmes?
Impact 5: The extent to which interventions contribute to social change and improved	9. Are beneficiaries (Persons with

social functioning of beneficiaries (i.e in terms of social integration and inclusion, as well as empowerment and participation of Persons with Disabilities).	Disabilities and caregivers or families) more socially integrated, included and independent?
Impact 6: The social impact of services in terms of changing community attitude / social attitude towards Persons with Disabilities and the reduction of stigma and social exclusion.	<p>10. What activities have NGOs undertaken within the community to improve attitudes towards Persons with Disabilities?</p> <p>11. What impact do NGOs believe they have had on societal levels of awareness, attitude and stigmatisation of disabled persons?</p> <p>12. How do NGOs measure this change?</p>

The evaluation has resulted in a report that provides;

- The compilation of a comprehensive assessment report, as well as executive summary for DSD.
- Findings and recommendations regarding promising practices, as well as highlighting areas where interventions need to be strengthened, and
- Recommendations regarding resource requirements of Programmes.

4.2 Data collection

Creative Consulting and Development Works (CC&DW) used a mixed-method design for this evaluation. Combining both qualitative and quantitative data collection techniques, our team aimed to achieve the aforementioned evaluation outcomes. These outcomes were accomplished through a methodological framework that incorporated a desktop review, collection and analysis of routine data, semi-structured interviews and site observations.

Participants were carefully selected on the basis of their potential to contribute to the evaluation outcomes, with the aim of ensuring that a sufficiently diverse range of perspectives and expertise was taken into account from different levels within the organisations.

All sampled organisations had their activities evaluated and one fieldwork team comprising of two evaluators each visited the organisations.¹⁰ One of the evaluators was a registered

¹⁰ In cases where study participants are Xhosa or Afrikaans-speaking, fieldworkers with the relevant language proficiency conducted the research.

social worker and was present during all site visits. A fieldwork period of one day was allocated per organisation. During this period, data was collected using the methods outlined in Table 7.

The focus of the evaluation was on the six areas of impact, as outlined in Table 6 above. The working methods and approaches of the selected organisations differed substantially; therefore they required a diversified evaluation methodology.

TABLE 7: OVERVIEW OF DATA COLLECTION METHODS

Method	Details	Data Type by Source
Desktop Review	<ul style="list-style-type: none"> (i) DSD's internal documents e.g. contracts between the Department and the organisation that outlines the agreed programme's progress reports, monitoring and evaluation plans, meeting minutes, and other relevant documents. (ii) Domestic and international Disability policy and programme documents describing the range of services. (iii) Documentation and studies related to Disability Programmes. 	Quantitative Qualitative
Routine Data Collection	<ul style="list-style-type: none"> (i) Outcomes and results furnished by project sites. (ii) Organisational documents and routine statistics. 	Quantitative
Semi-structured Interviews	<p>Donor:</p> <ul style="list-style-type: none"> (i) DSD Disability Programme Manager <p>Key Informants:</p> <ul style="list-style-type: none"> (ii) Specialised disability organisations/ informants <p>NGO:</p> <ul style="list-style-type: none"> (iii) Centre Director (iv) Centre Programme Manager/ Staff <p>Beneficiaries:</p> <ul style="list-style-type: none"> (v) Persons with Disabilities (utilising the services of NGOs) (vi) Caregivers / Parents / Family members of 	Qualitative

	<p>Persons with Disability (utilising the services of NGOs)</p> <p>(vii) Community level interviews of representatives from schools, primary healthcare clinics, other referral services.</p>	
Site Observation	Evaluators assessed the accessibility and appropriateness of the NGO facilities	Quantitative

Figure 2 below shows a breakdown of the evaluation approach, and illustrates CC&DWs chosen methodological approach with its relevant target groups.

FIGURE 4: EVALUATION APPROACH

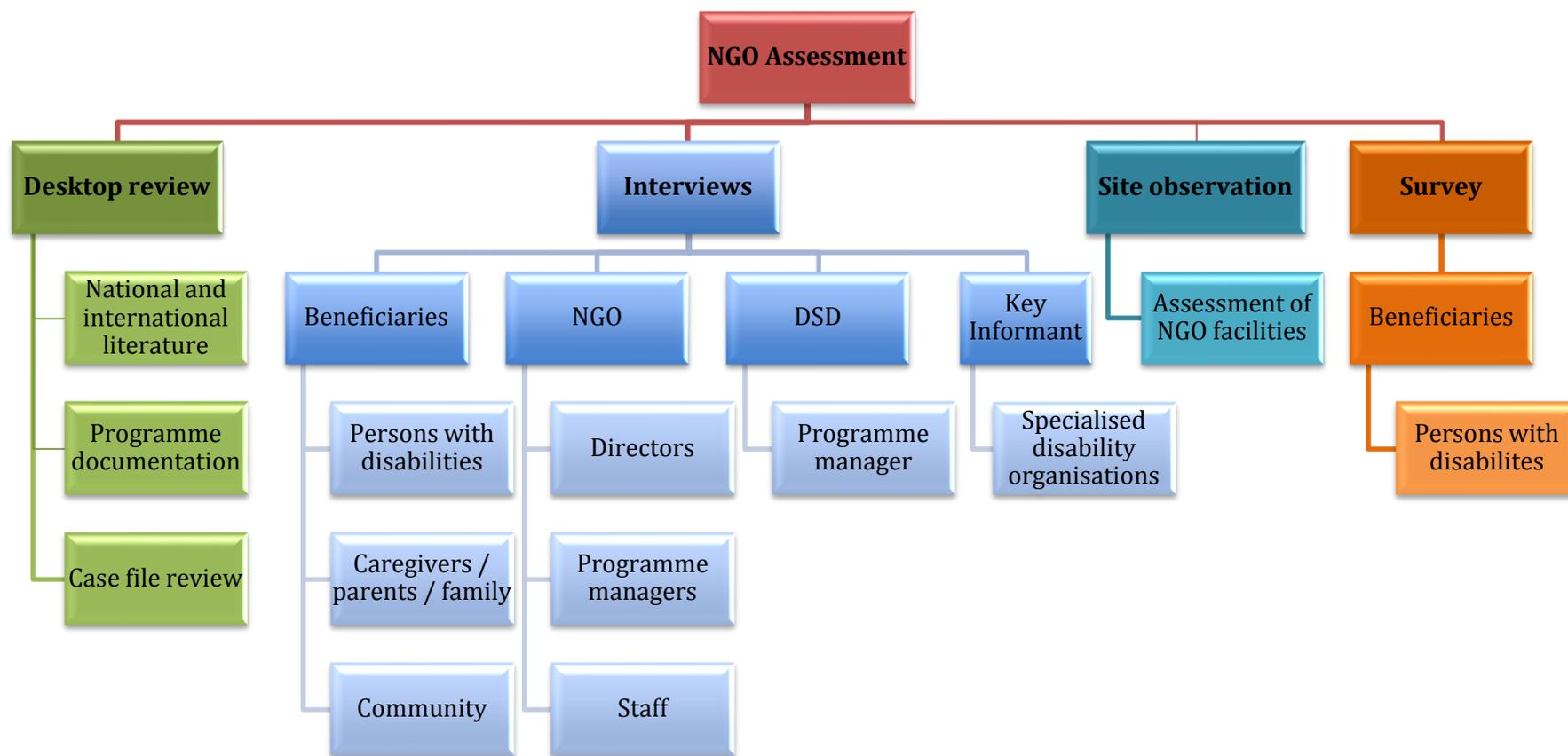


Table 8 below indicates how the CC&DW evaluation team addressed the relevant evaluation questions proposed in Table 6 and the evaluation approach in Figure 2.

TABLE 8: CC&DW APPROACH TO ADDRESSING THE EVALUATION QUESTIONS

Evaluation question	Type of investigation	Evaluation Instrument
1. What changes are Persons with Disabilities and caregivers or families / communities experiencing through the services of NGOs?	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
		Interview schedule for community representatives.
2. How accessible are the services to individuals and caregivers or families affected by disability?	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
		Interview schedule with NGO Director/ Programme Manager.
	Interviews	Participation questionnaire administered to Persons with Disabilities.
	Site observation	Site observation.
3. How relevant and appropriate are the services offered to Persons with Disabilities and caregivers or families? i.e. Does the service provided meet the needs of the affected persons?	Desktop review	Analysis framework aligned to national and international standards of services according to disability.
	Literature	Analysis framework aligned to national and international standards of services according to disability.
	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
		Interview schedule with NGO Director/ Programme Manager.
4. How do Persons with Disabilities and caregivers or families value the services provided by NGOs?	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
5. Are NGOs delivering	Interviews	Interview schedule for Persons with

services as promised? 6. Have resources been used in the best way? 7. Did the NGO achieve its outcomes?		Disabilities.
	Desktop review	Proposed outputs compared to actual outputs Case file review.
	Interview	Interview schedule with NGO staff.
8. Are beneficiaries (Persons with Disabilities and caregivers or families) more socially integrated, included and empowered?	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
9. What impact have NGOs had on societal levels of awareness, attitude and stigmatisation of disabled persons? i.e. What effect has the NGO had on the community in terms of its attitude and behaviour towards Persons with Disabilities?	Interviews	Interview schedule for Persons with Disabilities.
		Interview schedule for caregivers / parents / family members.
		Interview schedule for community representatives.

4.3 Sampling

Fifteen organisations were identified by DSD for inclusion in the evaluation. The selection of services for the evaluation were informed by the following factors:

- Type of disability
- Nature of service
- Funding period (2008/09; 2009/10, 2010/11)

In the current financial year, 2013/2014, DSD provide funding to 147 NGOs to provide services to Persons with Disabilities. Therefore the sample size of NGOs in this evaluation is approximately ten percent. The identified organisations provide services to Persons with Disabilities with diverse needs and in diverse areas of the Western Cape. Whilst many organisations were based in the Metro, their services extended further afield. See Table 9 below.

TABLE 9: LIST OF SAMPLED FACILITIES

Organisation	Type of Disability
Organisation 1	Multiple Disability
Organisation 2	Physical Disability
Organisation 3	Hearing Disability
Organisation 4	Hearing Disability
Organisation 5	Intellectual Disability
Organisation 6	Hearing Disability
Organisation 7	Physical Disability
Organisation 8	Physical Disability
Organisation 9	Intellectual Disability
Organisation 10	Visual Disability
Organisation 11	Visual Disability
Organisation 12	Physical Disability
Organisation 13	Physical Disability
Organisation 14	Intellectual Disability
Organisation 15	Hearing Disability

Twenty per cent of the organisations (three) visited were based outside of the Metro. Thirty-three per cent of organisations (five) provide services to people with physical disabilities. Twenty seven per cent of organisations (four) provide services to people who are hearing impaired. Twenty per cent of organisations (three) provided services to people with an intellectual disability. Thirteen per cent of organisations (two) provided services to people with visual impairment. One organisation provided services to people who have physical, intellectual, hearing and/ or visual disability.

4.4 Data collection

Ethical approval was received from the Western Cape DSD prior to the commencement of any fieldwork. This enabled CC&DW to sensitively collect data from study participants.

The data collection tools were piloted at the beginning of the fieldwork process. This allowed the evaluators to pre-test the tools to ensure that; the questions were correctly pitched, the tools collected the correct information, the questions flowed smoothly, and that the tools were completed within the allocated time. Data collected in the pilot contributed towards the overall evaluation data.

Following the pilot, the tools were adjusted. The fieldwork team was then trained prior to the commencement of the fieldwork.

4.4.1 Semi-structured interviews

Prior to the interview commencing, all semi-structured interview participants were required to provide their consent for the interview by signing two copies of the Informed Consent Form (See Appendix 1: *Informed Consent Form*), one retained by the interview participant and one by the evaluator. Participation was voluntary and the information shared will remain anonymous.

Where evaluation participants were 18 years and under, parents/ guardians were required to sign an informed consent form (See Appendix 2: *Informed Consent Form for Dependents to Participate in Evaluation*).

The interviews were recorded on a Dictaphone for record-keeping purposes and will only be shared amongst the research team. Semi-structured interview guides were used to steer the conversation.

DSD official

One key informant interview (See Appendix 3: *Key Informant Interview Guide for Donor Level Staff*) was conducted with a representative from the Provincial DSD to understand the Departments' strategy in support of Persons with Disabilities, to assess the relationship between DSD and respective NGOs and to understand the reporting practices between NGOs and DSD, as well as the functioning of NGOs.

Key informants

Evaluators conducted two interviews with stakeholders who held positions in organisations that had a perspective of the disability sector as a whole in the Western Cape. See Appendix 4: *Key Informant Interview Guide for Sectoral Representatives*.

Community key informant interviews

The evaluation team, with assistance from the organisations listed in Table 9, identified key stakeholders in the community whom the organisations networked with (See Appendix 5: *Key Informant Interview Guide for Community Informants*). Twelve interviews were conducted either face-to-face, and in cases where this was not possible, telephonically. Community key informants represented two hospitals, one clinic, four schools (five educators interviewed), three non-governmental organisations (NGOs) and a children's home.

NGO staff interviews

The evaluation team interviewed key personnel at the NGOs, including directors and programme managers (27 interviews). See Appendix 6: *Key Informant Interview Guide for NGO Managers*. Thirty-two programme staff were interviewed, see Appendix 7: *Key Informant Interview Guide for Programme Staff*. The aim of these interviews was to ascertain the strengths and challenges the organisation faces and draw key promising practices for other organisations.

Persons with Disabilities

Thirty-four semi-structured interview was held with selected service users at each organisation during site visits (See Appendix 8: Key Informant Interview Guide for Persons with Disabilities). The evaluators tried to ensure that beneficiaries were randomly selected, to ensure that organisations were not selecting beneficiaries that would report favourably on their service. Whilst the majority were randomly selected, this was not always practical. Beneficiaries were selected according to how long they have been accessing the services of the NGOs. The selection criteria were based on stratified sampling, where beneficiaries were selected from present strata naturally found within the population. The main strata used to select beneficiaries included gender, and stage of their interaction with the NGO. The following criteria were identified:

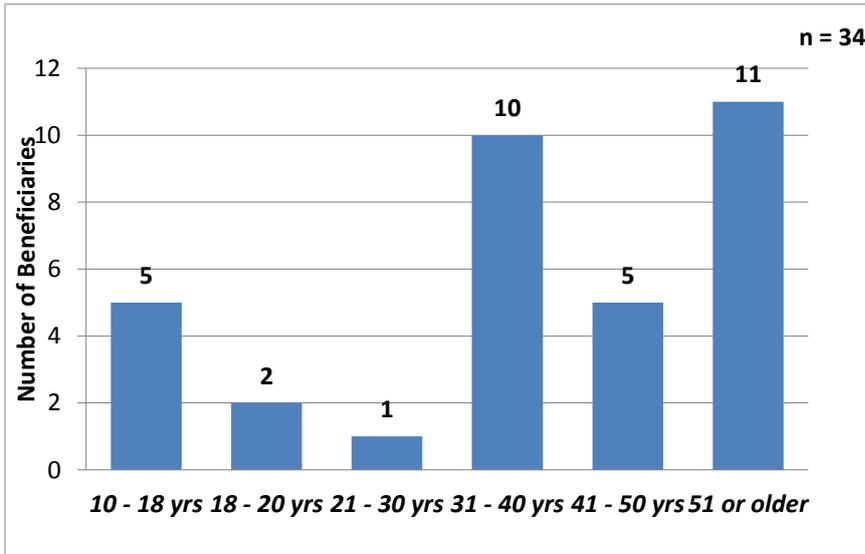
TABLE 10: SAMPLING STRATA

Strata	Variables
Gender	Male Female
Stage of interaction	Beneficiaries who have been with the NGO for under 3 months Beneficiaries who have been with the NGO for 3 or more months

The CC&DW social worker conducted the interviews with beneficiaries; however sign language interpretation assistance was needed for the evaluators when they interviewed persons with hearing disabilities. The interview aimed to address key evaluation questions and gain deeper insight into the beneficiaries experience with the NGO.

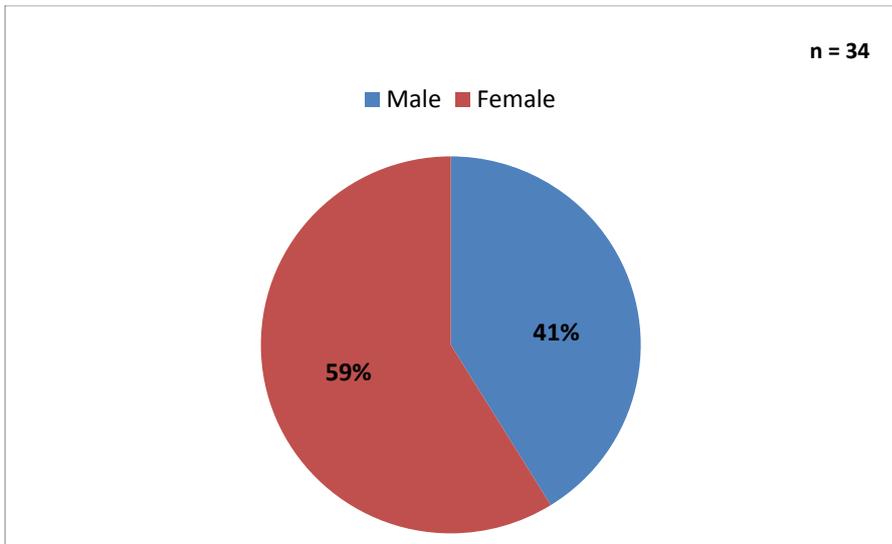
A total of 34 beneficiaries were interviewed. Figure 5 below shows that majority of beneficiaries who were interviewed (11) were in the age group 51 years and older. The second largest group of respondents (10) were between the ages of 31-40 years.

FIGURE 5: AGE DISTRIBUTION OF BENEFICIARIES



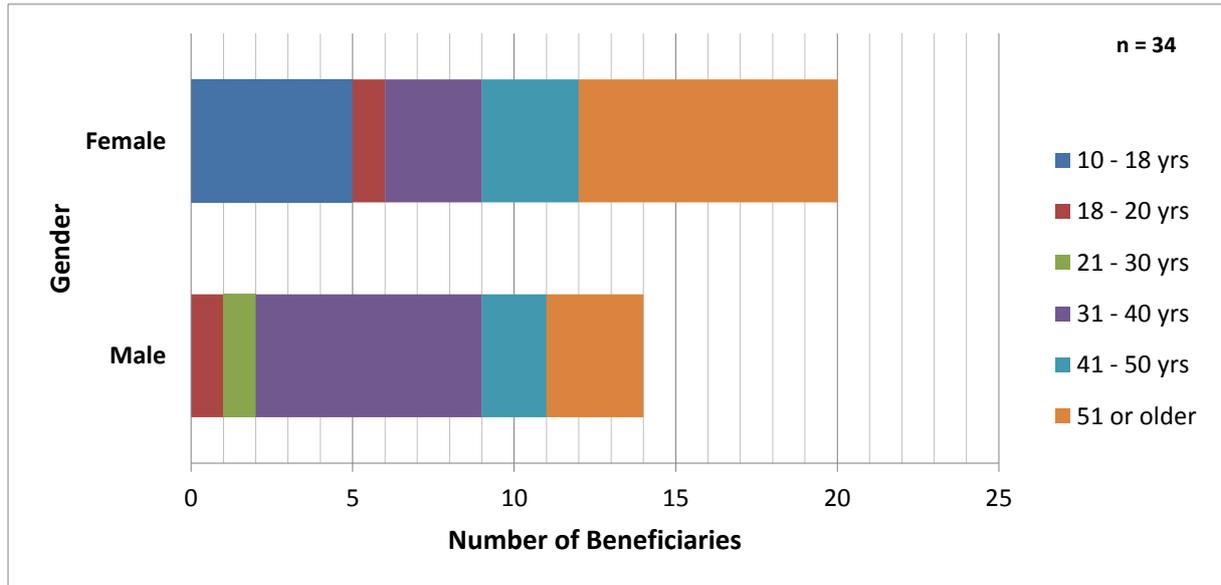
With regard to the gender distribution of the beneficiaries (See Figure 5 below), 59% of the beneficiaries interviewed were female and 41% male.

FIGURE 6: GENDER DISTRIBUTION OF BENEFICIARIES



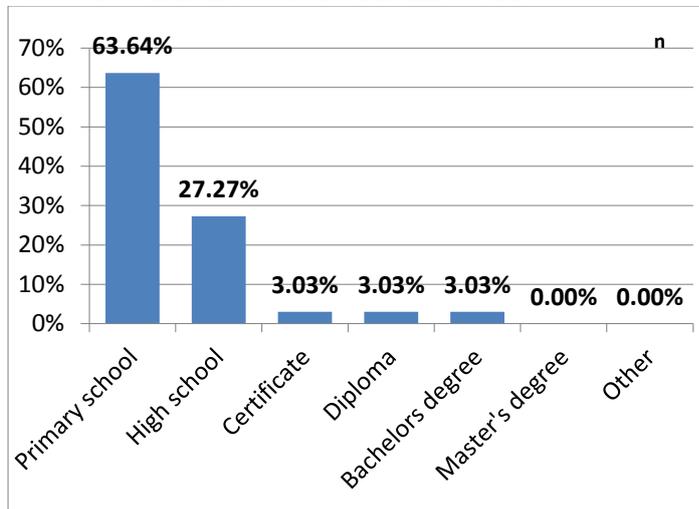
When we compare age group and gender (Figure 6 below), it shows that in the age category 10-18 years, there were only female respondents. The largest age category of female respondents was 51 years and older. The majority of the male participants were in the age category 31-40 years.

FIGURE 7: AGE PER GENDER DISTRIBUTION OF BENEFICIARIES



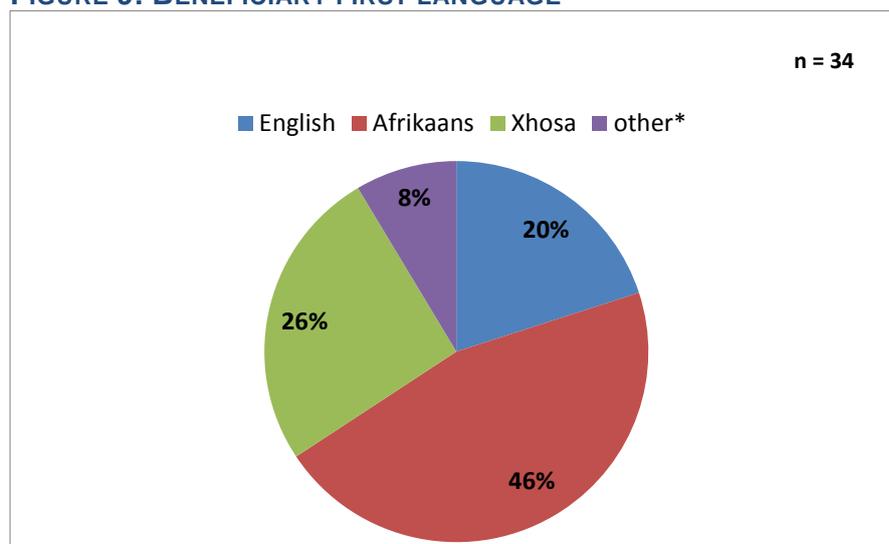
As shown in Figure 7, all beneficiaries had completed primary school. Sixty-four per cent of beneficiaries had only completed primary school but had not completed secondary school. Those who had started secondary school but not completed Grade 12 are counted in the primary school group, as the evaluation sought to understand the respondent’s highest level of education completed. Three per cent of beneficiaries had a certificate, diploma or bachelors degree.

FIGURE 8: BENEFICIARIES LEVEL OF EDUCATION



Finally, as shown in Figure 8, almost half of the beneficiaries (46%) interviewed spoke Afrikaans as their first language, with Xhosa (26%) and English (20%) following. One beneficiary was a foreign national, and beneficiaries who were hearing impaired recognised sign language as their first language.

FIGURE 9: BENEFICIARY FIRST LANGUAGE



*Other languages included two Sign Language and one French & Swahili speaker

Caregivers, parents or family members of Persons with Disabilities

Ten semi-structured interviews were held with caregivers / parents / family members of Persons with Disabilities who have been using the services of NGOs for less than three months and for more than three months (See Appendix 9: *Key Informant Interview Guide for Caregivers*). The CC&DW social worker conducted the interview. The interviews aimed to address key evaluation questions and gain deeper insight into the beneficiaries experience with the NGO. In three organisations, where Persons with Disabilities had an intellectual disability, caregivers were interviewed. Therefore the quantitative data reflects those beneficiaries that have physical, hearing, sight and/ or multiple disabilities.

Table 11 indicates the total number of fieldwork interviews undertaken during the evaluation:

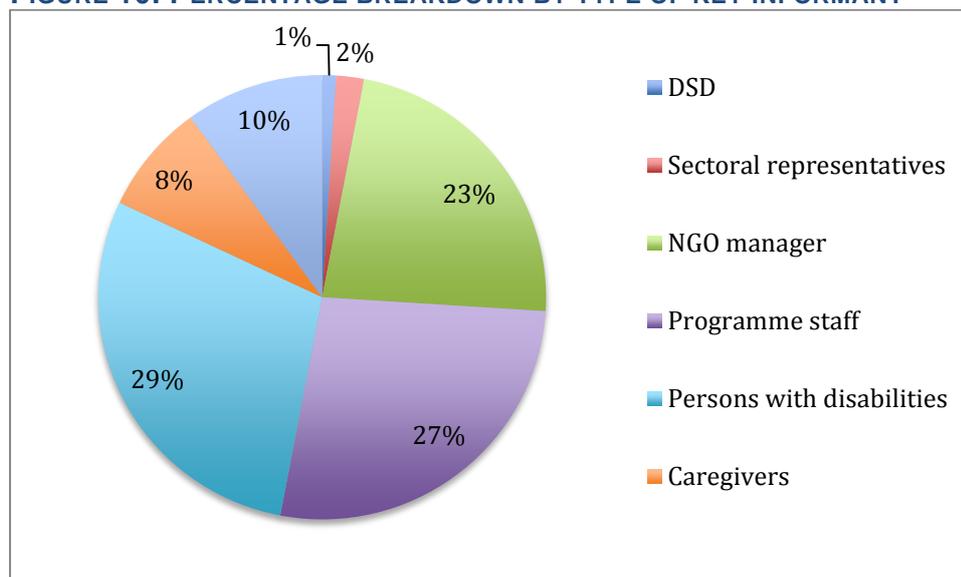
TABLE 11: NUMBER OF INTERVIEWS HELD

Organisation	Manager	Programme Staff	Persons with Disability	Caregiver	Community key informant
Organisation 1	2	3	4	0	1
Organisation 2	2	0	0	0	0
Organisation 3	2	4	1	1	2
Organisation 4	2	4	4	0	1
Organisation 5	2	0	0	4	0
Organisation 6	3	0	3	0	1
Organisation 7	2	2	3	1	1
Organisation 8	2	4	4	0	0
Organisation 9	1	2	0	2	1
Organisation 10	2	3	4	0	1

Organisation 11	1	1	3	0	1
Organisation 12	1	2	3	0	1
Organisation 13	2	4	2	1	0
Organisation 14	2	3	0	0	1
Organisation 15	1	1	3	1	1
TOTAL	27	32	34	10	12

Figure 9 provides a breakdown of the 118 interviews held as part of this evaluation. The highest percentage of interviews reflects Persons with Disabilities, followed by the two categories of NGO staff.

FIGURE 10: PERCENTAGE BREAKDOWN BY TYPE OF KEY INFORMANT



4.4.2 Case file reviews

As an additional way to triangulate data, beneficiaries were asked for their permission for the social worker to review their file. Space was allocated on the consent form where permission could be indicated. Nineteen beneficiaries from six organisations provided their consent and their case files were reviewed.

4.5 Data quality, management and analysis

4.5.1 Data quality

A number of methods were used to ensure the reliability and validity of the data collected and of the conclusions reached:

- Random stratified sampling of beneficiaries ensured that a broad range of perspectives were included in the study.

- The research team received a client list from each NGO to ensure random stratified sampling was done.
- Team members consulted with DSD particularly during the design and initial planning of the evaluation to ensure that all the relevant variables, issues, and stakeholders were identified.
- The interview guides with the NGO staff, beneficiaries and community key informants were piloted to ensure that the questions flowed well and captured the relevant data.
- Data collection tools were mostly semi-structured. Findings were gathered through note-taking by the interviewer and recorded for back-up purposes.
- Preliminary findings were presented to DSD in a draft report. Following an initial round of feedback, the CC&DW team presented the findings and recommendations to members of the DSD project reference team. This provided an opportunity for detailed feedback, and for additional information to be incorporated before a final draft was prepared.

4.5.2 Data management and analysis

Qualitative data from the interviews was coded and analysed thematically. All interviews conducted were not transcribed, but reports were generated that captured the key points. All interviews were recorded on a dictaphone for reporting purposes. The limited amount of quantitative data was coded and analysed using Excel.

During data analysis ‘triangulation’ between various sources and kinds of data was used. Findings from the qualitative data (semi-structured interviews) were compared with quantitative findings (structured survey questionnaire, routine data collection) in order to ensure validity and reliability.

4.6 Ethical considerations

Prior to the commencement of any fieldwork, ethical approval was sought through the Research Ethics Committee of the Western Cape DSD. This ensured that CC&DW conformed to standard ethical practices during the course of the evaluation. Good ethical practice was observed via the following processes:

- All client case files were assessed by the CC&DW team social worker.
- All participants were encouraged to participate on a voluntary basis. Participants were informed of what the information provided was for and how it would be used. They were informed that they were free to not answer questions and that this would not lead to any negative consequences for them or their organisation. Participants were told that their anonymity would be protected in that no comments in the report are linked to any names. Participants were also free to withdraw from the data collection process at any time without any negative consequences. Evaluation findings have not been linked to the names of specific organisations during data analysis and report writing.

- It was the duty of the social worker to report any neglect or abuse, and our social worker was held to these standards during interviews and case file reviews.
- If during an interview, it became clear that the beneficiary or care giver would benefit from a service that is known to the interviewer or social worker, those individuals would ensure that information about the service was given to the beneficiary or care giver. In addition, should any participant have needed debriefing after the interview, CC&DW fieldworkers were able to refer the participant to the Family and Marriage Society of South Africa (FAMSA), or the participant could have referred themselves, using the FAMSA contact details in the informed consent form (See Appendix 1).
- All participants were required to sign an informed consent form (See Appendix 1). Where telephonic interviews were held, verbal consent was obtained and recorded.
- Interview guides were adapted to ensure all respondents clearly understand questions.
- The evaluation team ensured that special needs of participants were catered for to ensure the evaluator and respondent were able to communicate clearly through use of facilitating resources including:
 - the use of sign language interpreters or advocates.
 - the verbal consent for blind participants.
- Should a third party (caregiver) be part of the interview for need of translation, they were required to sign a confidentiality agreement.

4.7 Limitations of the evaluation

1. Data collection was limited to one day per organisation. Whilst the evaluation team tried to be as efficient as possible, they had to ensure that sufficient time was given to ensure that the beneficiaries understood the informed consent form and the questions posed. At many organisations, this was a time consuming process and impacted on the number of beneficiaries who could be interviewed.
2. The organisations selected for the evaluation covered most categories of disability however the organisation that was focusing on mental illness declined to participate in the evaluation and was therefore not included. Therefore mental illness, as a category of disability, is not reflected in this report.
3. As described above, the evaluation team used random sampling to select beneficiaries. The evaluation team requested a list of names of beneficiaries and selected beneficiaries to be included in the evaluation. The challenge with this sampling method is that it did not always result in high quality interviews because the evaluators chose beneficiaries randomly.
4. Different challenges were experienced whilst interviewing Persons with Disabilities. The social worker did her best to accommodate the needs of beneficiaries and ensure the interview went as smoothly as possible. Challenges experienced include;

- Some beneficiaries had a very short attention span, which limited the length and depth of the discussion.
 - Some beneficiaries did not understand the type of sign language used by the sign language interpreter.
 - Some organisations who are primarily working with people who are hearing impaired, had beneficiaries who have multiple disabilities. For instance, one beneficiary who was hearing impaired, was also unable to speak and had sight impairment. Communication was therefore limited as the interpreter had to write on the beneficiaries' hand, which was extremely time consuming, and also open to miscommunication.
5. Due to the anonymous nature of the evaluation, it is difficult to be very specific in the findings and discussion, as this will undermine the commitment the evaluators made to DSD and to the evaluation participants to protect their anonymity.

5. EVALUATION FINDINGS

5.1 Impact of services delivered to Persons with Disabilities, their caregivers/families & communities

5.1.1 Context of beneficiary support

The evaluation found that much of the support provided by NGOs made a positive and immediate impact on the lives of Persons with Disabilities and their caregivers. One director said;

“The majority of our clients have no support systems in the community. We are their only support system.”

This quotation is very important as it represents an overwhelming finding of the evaluation that points to the high levels of vulnerability of Persons with Disabilities with regard to their realising their human rights. This vulnerability extends to the caregivers of Persons with Disabilities, as they often find themselves with very few resources to adequately support the person they are supporting. Therefore the DSD-funded NGO services are a critical resource to beneficiaries and the community.

However, it also highlights that beyond the DSD-funded NGOs and public sector services designated for Persons with Disabilities, that there is a lack of integrated services in the broader community to adequately support Persons with Disabilities and/ or their caregivers. Whilst it is hoped that this situation will shift as disability becomes integrated into different service platforms, a stronger impetus is needed to ensure that advocacy, strategic thinking and proper planning is undertaken to ensure that services can be sufficiently resourced to provide appropriate services to Persons with Disabilities.

Interviews with key stakeholders in the community highlighted the important services that the DSD-funded NGOs provide to support the work of hospitals, clinics and schools in appropriately supporting Persons with Disabilities. The support by DSD-funded NGOs included; providing support in sign language translation, enabling children to visit their parents over weekends, providing outings for Persons with Disabilities into the community, providing and/ maintaining assistance devices, and the provision of residential care. One of the key stakeholders, an educational psychologist, was asked, “Do you see the need for what X NGO are doing?” She replied;

“I don’t know what would happen if they (the NGO) were not there. If they are not here our work would be useless.”

Another stakeholder said;

Yes, there is a need for institutions such as them as there aren't many institutions specifically dedicated to meet the special need of persons with hearing disability.

5.1.2 Nature of support by NGOs to beneficiaries

The evaluators reviewed the 15 organisations' Transfer Payment Agreements (TPAs). Funding is provided against across all of the four levels of intervention of DSD's Integrated Service Delivery Model (See Figure 2 above). The TPA review found the following:

- Fifteen out of 15 of the organisations are funded for awareness and prevention programmes,
- Fifteen out of 15 organisations are funded for early intervention programmes,
- Two organisations have been funded for a statutory programme, and
- Fifteen out of 15 organisations are funded for reintegration programmes.

Awareness and prevention programmes

There are many different types of disabilities, and these disabilities can emerge at different stages of a person's life - a disability may be;

- Congenital which means that it is present from birth, or
- Acquired which means that it occurs during a person's lifetime either as a result of an accident, genetics or disease.

Disabilities can be classified as long-term, recurring or progressive in nature. As a result of the diversity of needs that emerge as a result of disabilities, there is an ongoing and very high need for organisations to provide awareness, education and support to Persons with Disabilities, their caregivers and the community.

DSD's ISDM (undated, p. 25-26) says that prevention services include; *"promoting the inclusion and mainstreaming of Persons with Disabilities, the rights of Persons with Disabilities, awareness of disability issues, and the accessibility of services, community and public resources; the prevention of discrimination against Persons with Disabilities; programmes for the early identification of genetic disorders and awareness regarding the prevention of the transmission of genetic disorders; life-skills and capacity- building programmes; and skills development services."*

Awareness and prevention programmes offered by NGOs in this evaluation were well aligned to the ISDM and covered a range of programme areas and targeted different groups.

- Awareness and information campaigns targeting Persons with Disabilities. For example, some programmes targeted the deaf community and organisations would provide awareness and information about different topics such as HIV and AIDS, substance abuse, leadership, abuse, violence, and even baby care.
- Awareness and information programmes targeting caregivers in order to improve their knowledge and understanding about a specific type of certain disabilities so as to improve the quality of care towards Persons with Disabilities.
- Awareness programmes for professionals to improve their understanding and knowledge of specific disabilities, and gain insight about emerging therapeutic methods new communication methodologies.
- General awareness programmes to the community to raise awareness about disability or about a very specific disability to improve people's knowledge, attitudes and practices. Some used commemorative days to highlight specific disabilities, others targeted schools and other community based institutions

The evaluators noted the diversity of awareness programmes in terms of whom they targeted, some were very specific and targeted Persons with Disabilities, caregivers or professionals. Other awareness programmes were targeted towards the general population. Whilst general awareness and prevention programmes in the community have their place, it is challenging to monitor and evaluate what the real impact of these programmes is beyond a very general level of awareness. Most often more targeted awareness programmes see greater impact because they are responding to a direct need of the beneficiary.

It is encouraging to note that prevention and awareness programmes are focused on Persons with Disabilities, and not just caregivers and the larger community. It is critical that relevant information such as HIV and AIDS and substance abuse is being made accessible by DSD-funded NGOs, as these activities acknowledge the real need of Persons with Disabilities for this information. To note, *“South Africa’s HIV epidemic is generalised among the population, but a subset of groups is at particularly higher risk for HIV transmission. The Human Sciences Research Council (HSRC) defines most-at-risk populations (MARPs) as those groups that have higher than average HIV prevalence when compared to the general population. At-risk populations are among the most marginalised and most likely to be stigmatised. In addition, resources and national HIV-prevention campaigns are not necessarily geared to their specific HIV prevention, treatment and care needs. In South Africa, the HSRC defines Persons with Disabilities as MARPS.”*¹¹

In recognition of the vast and ongoing need for awareness and prevention programmes in the Western Cape, DSD and their NGO partners need to strategise about;

- i. The high prevalent disabilities that can be prevented in the Western Cape. For example motor vehicle accidents and foetal alcohol syndrome,
- ii. The most effective methodologies for preventing these types of disability, and
- iii. The most relevant target audience/s.

Early intervention programmes

DSD’s responsibilities are focused on improving the lives of Persons with Disabilities from a social perspective and within the context of the family through the provision of psychosocial support. Therefore early intervention programmes were delivered in a variety of ways:

¹¹ Accessed from http://www.cdc.gov/globalhealth/countries/southafrica/what/at_risk.htm on 21 August 2013.

- Developmental support and therapeutic services to ensure early detection of disabilities, for example hearing impairment as well as ongoing assessments for Persons with Disabilities.
- Provision of counselling and psychosocial support to Persons with Disabilities and/ or their caregivers including referrals to appropriate services. Counselling could have been provided one on one, via support groups, peer counselling, family counselling and telephonic support. This service could include home visits.
- Stimulation groups for Persons with Disabilities.
- Skills development focus – empowerment of young persons with disabilities, social and life skills programmes for Persons with Disabilities, vocational training and preparing young Persons with Disabilities for independence.

Many organisations provide psychosocial support by offering support groups and/ or counselling to Persons with Disabilities and/ or their caregivers to help them cope with their emotional needs that arise from living with a disability or caring for someone with a disability. Furthermore, the support assisted people to acknowledge and accept the different and multiple losses associated with disability. The length and type of support differed across the different types of disabilities, with some programmes being very structured and time specific and others being more long-term.

Support groups were reported by beneficiaries to be a very useful practice. They were highly valued as spaces for sharing and members of the support groups reported that they felt less isolated as they could interact in an environment where people faced similar challenges. Beneficiaries could be Persons with Disabilities, caregivers and/ or parents/ family members. It was highlighted that caregivers often found caring for a Persons with Disabilities to be a lonely and stigmatised experience. Support groups ranged from being highly structured to others that were less structured. With regard to impact, one manager said;

“It is difficult to measure concretely, because you’re dealing with emotions and things you can’t physically see, but the feedback from parents, they are in tears because there is finally someone who is listening to them.”

Beneficiaries reported that they don’t believe that other service users (Persons with Disabilities and their caregivers) properly recognise the value of a support group. They felt that the psychosocial support they received provided a space for them to vent their frustration. One beneficiary said,

“People don’t understand the constraints of disability.”

Another beneficiary said,

“A lot of us sit at home, your family feels you are a nuisance. Here (at the organisation) you can talk about your problem with others, instead of sitting at home.”

Fifty per cent (six) of the organisations were funded to offer programmes only in the Metro, three organisations had good coverage of the Western Cape and two offered programmes that were offered from a small town but targeted a broader community and one offered programmes in the metro with limited reach to other areas just beyond the Metro.

The evaluators noted that the majority of the more specialised psychosocial support services were offered exclusively in the Metro and that in more rural communities access to general counselling and support was available to beneficiaries.

Statutory programmes

Two NGOs provided residential care for Persons with Disabilities, specifically those with hearing and intellectual impairment.

Reintegration programmes

DSD funded reintegration programmes mostly related to employment opportunities for Persons with Disabilities. Services ranged from;

- Career path support and identifying relevant training opportunities.
- Developing a Curriculum Vitae (CV) and providing support in finding employment.
- Lifeskills programmes for Persons with Disabilities who are joining the open employment market.
- Entrepreneurial workshops to encourage Persons with Disabilities to pursue self-employment.
- Assessment of Persons with Disabilities within and entering a protective workshop for appropriate placement.

In general, the disability sector provides a range of services to support the education and/or employment needs of their service users. Access to education offers children with disabilities the opportunity to be intellectually and economically empowered and they are able to interact socially. With regard to education, children are either in mainstream school, or they attend specialised schools that cater for their specific needs. Whilst DSD does fund access to basic education, some of the DSD-funded NGOs offered social support to Persons with Disabilities and/ or their caregivers, within a school environment.

With regard to employment, the trend internationally and locally is towards mainstreaming and integrating Persons with Disabilities into the open job market and moving away from protective workshops. This is discussed later in this report however it is important to note that DSD are funding organisations to support Persons with Disabilities to explore new and innovative approaches towards employment. One NGO manager said;

“Protective workshops are not sustainable, though there is a place for it because not everyone can enter the open labour market but we are looking at how can we upscale and differently skill Persons with Disabilities. One is through starting cooperatives and to get them (Persons with Disabilities) placed in the open labour market.”

Organisations appear to have had limited success in trying to place Persons With Disabilities in the open labour market. It is very labour intensive for organisations because their staff have to prepare the groundwork prior to making a placement, to identify suitable companies, prepare the company about what they can expect, orientate the company to the needs of the Persons with Disability and to anticipate potential problems that many arise. Once the candidate has been placed, the organisation has to provide support to the placement to ensure it goes smoothly and ensure that the placement is sustained. Whilst this is a resource intensive process it is certainly a well-received service by Persons with Disabilities looking for employment as it creates a more supportive environment for job seekers and ensures their right to employment, as described in the Disability Rights Charter is realised.

The nature of the work of protective workshops is shifting towards trying to source contracts from the open market thereby ensuring that the protective workshops are getting an income, and being sustainable. This is discussed in more depth in the sections to follow.

Employment provides an opportunity for Persons with Disabilities to earn a salary and builds the independence, confidence and skills of Persons with Disabilities. This is illustrated in the following story shared by a staff member:

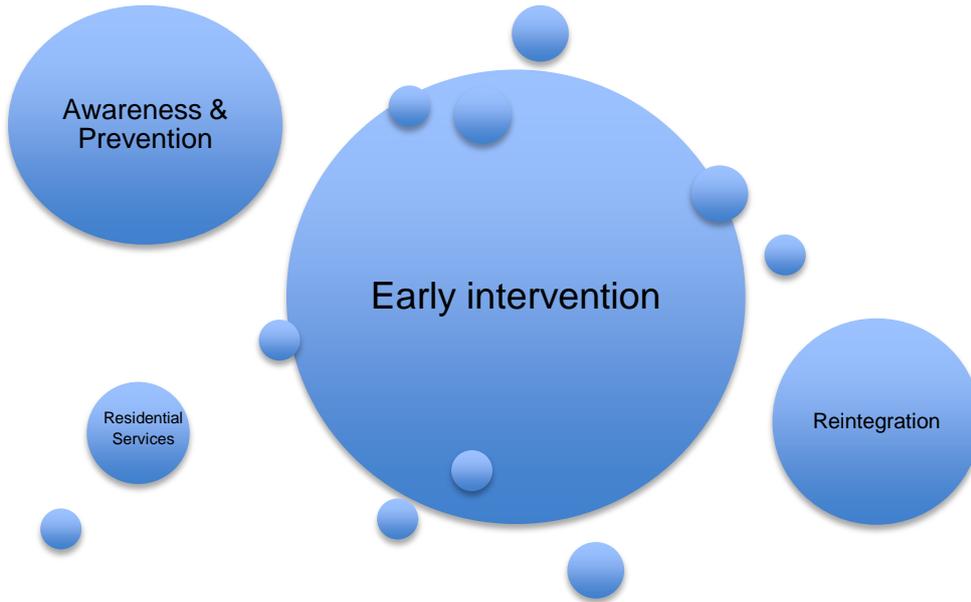
One organisation was able to place 60 people with hearing impairments at a large retailer to pack shelves in stores.

“15 of those placed qualified to do training on NQF (National Qualifications Framework) level 2. Ten people are still in the programme - it is amazing to see how they have grown and developed. It is unbelievable to see how they apply what they have learned and you can how they have been empowered. They do an English course, which is for many of them their third language and many of them were able to do a presentation in English, and write a letter in English.”

The reason is unclear why the other 45 people were not afforded the same training opportunity, however in sharing the story the DSD-funded NGO was thrilled with the changes they had seen in the ten candidates who have managed to stay on the training.

In summary, it is clear that most NGOs are funded towards awareness and prevention, early intervention and reintegration, with a particular emphasis on early intervention which is the delivery of psycho social support to Persons with Disabilities and their caregivers. Figure 10 is not based on the financial resource allocation, but rather on the level of effort that the evaluators have assessed via the TPAs.

FIGURE 11: OVERVIEW OF NGO ACTIVITIES FUNDED BY DSD



5.2 Accessibility of services

As shown in Figure 2 earlier in the report, accessibility has been said to include availability, affordability and acceptability. It is important to review accessibility through these multiple lenses in order to firstly see whether a service is available, then to see whether it is affordable. If it is available and affordable, it is important to review whether the service is acceptable to Persons with Disabilities. This provides a comprehensive review of the overall accessibility of the service.

5.2.1 Availability

Transport

Fifty-three per cent (eight) of the organisations interviewed, which includes the three non-metro organisations, had access to their own vehicles, which was a huge advantage. These vehicles are a critical resource as organisations use transport for different reasons; transporting children to day care centres, adults to protective workshops and for social workers or outreach workers to undertake visits especially to Persons with Disabilities, who are unable to travel as a result of their disability.

Dial-a-ride (DAR), a public transport service for Persons with Disabilities is a project funded by the City of Cape Town and the Provincial Administration of the Western Cape and the National Department of Transport. To date, the Western Cape is the only province that provides this service in South Africa.

It is offered to people with visual impairment or a physical disability residing in the City of Cape Town. According to DAR, their service is not available for; *“people who are able to board and/or alight from mainstream public transport, mentally handicapped and/or challenged individuals i.e. those with diminished intellectual capacity which may affect their ability to travel independently, those living in old-age homes and/or care centres unless formally employed, those with disabilities wanting to be transported for purposes other than work, such as social or medical reasons etc., scholars and students/learners and passengers making private trips.”*¹²

Service users who qualify for DAR phone and book the service and DAR organise a suitable vehicle to come to their home to collect them and take them to school, work or a health facility.¹³ Beneficiaries who use DAR reported that it fills a huge gap with regard to transport and is a benefit to them. However, they also reported that the service was inadequate, with the transport arriving late, sometimes even arriving on a different day to that which the service was booked.

¹² Information retrieved from <https://www.capetown.gov.za/en/Transport/Pages/AboutDialaRide.aspx> on 22 August 2013.

¹³ <https://www.capetown.gov.za/en/Transport/Pages/AboutDialaRide.aspx>

The new MyCiti bus service was cited by beneficiaries as a positive new transport service, because it introduced and integrated different facilities to ensure it is universally accessible for people who are hearing and/ or visually impaired, as well as people in wheelchairs. Presently, the service is offered on limited routes in the metro and for many beneficiaries, they said that they still need assistance to get to the bus stop.

Physical access

Site observations of the NGOs by the evaluators and as discussed during interviews with staff and beneficiaries indicated that, where it was necessary, adaptations to the physical space of the organisation had been made and the buildings were accessible to all users. Accessibility mostly referred to the installation of ramps, wider entrances and passages, as well as access to ablution facilities.

Networking

Strong networking across organisations can close gaps in service delivery and ensure that service users can access services.

The relationship between DSD-funded NGOs and other services indicates that community services can refer their clients and/or draw on the expertise of DSD-funded NGOs where necessary. Due to the small evaluation sample, this finding cannot be generalised across the Western Cape, but rather shows the importance and benefits of functional referral services.

In some instances the stakeholders highlighted the specialist nature of the services provided by the DSD-funded NGOs and that not many other organisations offered such services. It would seem from the interviews with community stakeholders that different models of work already exist:

TABLE 12: MODELS FOR REFERRALS

Model 1: Specialist support services	Model 2: Additional support services
Community Need: Specialist skills in situations where the type of disability is rare.	Community need: Additional services offered by NGOs to community organisations that provide ongoing services to Persons with Disabilities (children and adults). For example; providing education or health services.
Rationale: Since the nature of the support required by the community organisations is very ad hoc, it is more cost effective to outsource the support required to a specialist NGO. Specialist NGOs would need to make their expertise and services known and be accessible in the case of a referral.	Rationale: The resources of community organisations are limited to their core business. Therefore they are unable to provide other important services such as providing and maintaining assistive devices, facilitating outings for children, or parent visits.
Support required: Dedicated NGOs that can provide specialist expertise and resources when needed.	Support required: NGOs to provide appropriate services to community organisations to help them provide services to Persons with Disabilities and their families.



	This will enable the community organisation to extend their service offering by providing additional services. For example, outreach support and counseling.
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Additional services requested by community stakeholders included more psycho-social support as well as job skills training. Key stakeholders also reported that they felt that the services of funded NGOs were not accessible to everyone, and that there was a need to expand. Stakeholders recognised that the limited financial resources would hinder this expansion process, but still felt that expansion was necessary.

Improved networking in rural areas appears to be another area where greater attention is needed because of the relative abundance of resources in the metro.

Many of the organisations belong to the Western Cape Network on Disability which provides a platform for organisations addressing different disabilities to network, share ideas, challenges and progress in the sector. Beyond this network, organisations reported that they are working with other organisations both inside and outside the disability sector to ensure the smooth running of their programmes.

Information

Information about services needs to be made available to Persons with Disabilities and/ or their caregiver. If information cannot be accessed, the service user cannot benefit from the service on offer. Organisations are encouraged to carefully consider how and where they share information about the services they offer.

5.2.2 Affordability

Transport

Most organisations were primarily based in the Cape Town metro and some had satellite services in other parts of the Western Cape. Organisations cited the expense, especially for people from rural areas, to pay for transport to access their services. One manager said a client had to use half of their disability grant to pay for transport. These costs are also high because most adults and children with disabilities cannot travel independently and some cannot make use of public transport.

Whilst many organisations had their own vehicles, organisations reported the high cost of maintaining their fleet vehicles. Expenses such as money for fuel and other mechanical problems associated with the vehicles drive up the costs of maintenance. As such the implication of disruptions of the use of the vehicles by organisations to transport the beneficiaries is significant. This sentiment was captured by one of the beneficiaries;

“If the transport is broken then they can’t help.”

DAR “is a heavily subsidized service, and the cost to the passenger is equivalent to the mainstream public transport fare on that particular route”.¹⁴ The MyCiti bus service charges the same fares to all people to use their bus service depending on their preferred route.

Physical access

On the whole, beneficiaries said that whilst the organisations were well equipped and adapted for their needs, that adaptations to their homes was limited due to the costs associated with making these adaptations. However there are some exceptions. When asked to recall a story of Most Significant Change, one organisation said they had provided a significant amount of funds to improve the accessibility of their service users;

“We installed a lift in one of the flats in the Cape Flats for one of the persons living on the third floor.”

Whilst improvements are being made to ensure that organisations are more easily accessible, Persons with Disabilities cannot realise proper independence if their local environment, including their home and local community resources (clinics, churches, schools, shops, pavements etc), is not suitably adapted. This remains an ongoing challenge for the sector.

5.2.3 Acceptability

Communication

Appropriate forms of communication when using public transport remained the biggest obstacle cited by beneficiaries and organisations preventing accessing services. One manager at an NGO, who is hearing impaired, said that accessing public transport was a major obstacle for her;

“I would sometimes find myself in the wrong taxi because I would write down where I would like to be and then I would be lost. I would say ‘no, this is where I wanted to be’, then there is the communication again. Some of the drivers are good, but some are very rude and they would just drop you off wherever you are. Even with the train, it is a problem. When the train gets stuck and announcements are made we can’t hear if there is a change of train/platform or what is going on.

The busses are okay, but it is expensive and that is why most of us opt for the train or taxi. With planes as well, if you travel by plane, maybe there is something happening in the sky and the pilot makes an announcement you don’t know what is going on, or when they turn around and go back, you don’t know what is going on. You get scared sometimes.”

This example clearly shows that the service is available and affordable to the service user, but it is not acceptable to her, which limits the accessibility of the service to her.

¹⁴ Information retrieved from <https://www.capetown.gov.za/en/Transport/Pages/AboutDialaRide.aspx> on 22 August 2013.

Beneficiaries also said that they were trying to access services such as the South African Social Security Agency (SASSA) for their disability grant, health facilities, police station, banks, court etc. Once they were physically able to get to the service, they then faced constraints regarding communication. For example, for people with a hearing impairment, no interpreters are available. Many organisations recognised this constraint and organisations physically visited different service providers to educate them on the needs of Persons with Disabilities. One organisation said;

“We go to places like the traffic department and explain to them how they have to handle the situation when they encounter a deaf person.”

People who have a sight impairment, intellectual impairment or mental illness face similar, but different constraints. Constraints regarding poor accessibility due to communication resulted in delays in accessing services and sometimes this could have prevented further disabilities, as problems would have been identified and addressed earlier.

5.3 Relevance and appropriateness of the services

The evaluation acknowledges the strengths of the existing programmes and appreciates the experience and commitment that the NGO staff have towards offering high quality services. However, there are some areas in which DSD and organisations they fund could strengthen their programme.

5.3.1 Demand for services

Overall, beneficiaries reported that they were very grateful for the service they were receiving from the NGO they interact with. Evaluators noted however that beneficiaries had little choice in where they went for services due to the poor availability of services. Furthermore, many beneficiaries' lack of exposure to any other alternatives meant that their expectations may have been fairly low. Caution is therefore needed in judging quality of services according to users' responses.

Whilst the work of organisations is clearly very well received and the feedback reflects well on the NGOs providing the service, it appeared to the evaluators that beneficiaries were so vulnerable due to the general lack of services for Persons with Disabilities that they would be fairly easily satisfied. Client satisfaction should therefore not necessarily be the only indicator reflecting on the quality of service.

The evaluators found it challenging to assess the demand for the organisations' service. Whilst most organisations were metro-based, most of them were also servicing communities beyond the metro via satellite services. Organisations cited that there was a high demand for their services, and many had waiting lists. It was not clear how many people are unable to access their services. One director said;

“We are offering services to the extent that we can afford it. Where are the people we don't know about? How do they live and how are we going to get to them? There are many ways to do it but how are you going to afford it?”

This quote indicates that there is a great need to gather information that will help to answer these questions with regard to the demand for services in the whole province. Strategies by NGOs and DSD, such as a gap analysis, needs assessment and strategic planning could be used to assist in programme planning.

Whilst NGOs recognised the continuous need for their services, they strongly indicated that they have resource constraints that prevent their programmes from scaling up and having greater reach. NGOs did not seem to express much innovation with regard to identifying strategies to increase accessibility to their services. This finding should be tempered against the fact that organisations can decide on their own mandate and the extent to which they can provide services across a larger geographical region and/ or to a larger group of beneficiaries.

5.3.2 Formal needs assessment

According to Rossi, Lipsey, & Freeman (2004, p.54), a formal needs assessment “assesses the nature, magnitude, and distribution of social problems; the extent to which there is a need for intervention; and the implications of these circumstances for the design of the intervention.”

It therefore forms a crucial component of any programme in order gain a comprehensive understanding of the structural challenges facing communities, how these are interlinked and at what point of intervention a programme can be most effective.

Organisations said that they believed that the range of services they offered were extremely relevant to the needs of beneficiaries. However, when organisations were asked whether they had undertaken a formal needs assessment, many said they had not, but through their work, they feel attuned to the needs of their beneficiaries. Whilst their experience in the field is both commendable and would provide anecdotal evidence of need, it is still very important for organisations to undertake a needs assessment at least every two years to ensure the organisation is relevant and responding to needs of its beneficiaries, and have a clear understanding where the gaps in service delivery remain so that appropriate strategies are put in place to address gaps.

Being better attuned to the needs of beneficiaries can also be accomplished by appointing Persons with Disabilities into the governance and staff structures of organisations, improving M&E systems and consulting with service users about decisions regarding service provision.

At a higher level, it appears that information is needed to inform the strategic thinking of DSD as to the gaps in services for Persons with Disabilities and ensure that the services procured by NGOs are meeting the needs of service users, and covering the whole province in a equitable manner.

5.3.3 External evaluation

Another mechanism for establishing programme relevance is for organisations to commission an external evaluation. When organisations were asked whether their programme has been independently evaluated, all of the organisations said that they do not have the financial resources for such a task.

5.3.4 Focus on prevention

Respondents felt that more needs to be done to prevent the cause of disability and thereby reduce the prevalence of disability. Furthermore, more needs to be done to raise awareness about how disability can be prevented. For example, raise awareness about Foetal Alcohol Syndrome (FAS), highlight the potential side effects of treatment for Drug Resistant Tuberculosis (DR-TB) that causes permanent hearing loss, enforce health and safety in the workplace to prevent accidents and try to prevent road accidents. Through improved multi-sectoral collaboration, other stakeholders could play a lead role in the realm of prevention.

5.3.5 Types and standards of different services

With greater strategic information at their disposal, organisations would be able to clearly assess the appropriateness of their services.

One organisation said they have a huge need for wheelchairs, especially motorised wheelchairs, as these allow Persons with Disabilities to be more independent. A staff member of an organisation that had been able to provide such a service said the following;

“We gave motorised wheelchairs to two men who have never had motorised wheelchairs before and they appreciated it a lot because they were now able to do things for themselves again and didn’t have to be that dependent on other people.”

Whilst this is a major accomplishment, one challenge that organisations could face is how to make decisions that are cost-effective and may benefit more people. This could impact on whether their services are in fact relevant and appropriate to the broader community as opposed to one or two people. DSD in partnership with NGOs and other government departments could consider developing an agreed set of minimum standards for different categories of disability. This will help guide the sector as to what services need to be made available.

5.3.6 Underservicing Persons with Disabilities in areas beyond the Metropole

DSD indicated a particular concern with regard to ensuring coverage of services to rural areas and said that they are in the process of exploring different service delivery models. They recognise that in speaking about rural areas, more information is needed about needs of different rural contexts. For example the needs in small towns versus the need on farms with services offered could range from limited to non-existent.

DSD-funded NGOs expressed the same concern for rural communities, but said that simply scaling up existing services is not yet viable because; the burden of this disability may be prevalent but low, and establishing offices that are satellite offices of larger organisations in other parts of the Western Cape is very resource heavy, with travel being a major cost driver. Therefore NGOs acknowledge that other solutions need to be identified.

The opportunity to initially identify Persons with Disabilities often sits at health facilities. The development of functional referral procedures between the Department of Health and DSD could help to ensure that appropriate assessments are undertaken and that community health workers, community development workers and NGOs provide appropriate support. This will contribute towards ensuring that local stakeholders are accountable to one another, that the needs of Persons with Disability are being addressed, and it ensure that communities are able to adequately care for Persons with Disability in their own community. Whilst there is a place for specialised residential institutions many Persons with Disabilities are best cared for by their own family.

Furthermore, where needed additional capacity can be built in communities. Disability organisations that do very specialised work with specific disorders or disabilities could partner with existing NGOs in rural districts to help NGOs to identify Persons with Disabilities, and be trained to provide the necessary support to Persons with Disabilities and where necessary, refer the client for further help. Depending on the nature of the support, rural organisations would need to be resourced to provide the service.

5.3.7 Multi-sectoral response and the continuum of care

The nature of the interventions in the disability sector tend to be resource intensive and long-term, because most disabilities tend to be permanent in nature. DSD are responsible for ensuring that the social aspects of a beneficiary's life are sufficiently supportive to improve their quality of life during their different life stages.

It is noted that no specific legislation currently in place in South Africa that mandates government departments to provide services to Persons with Disabilities. It is unclear from the evaluation how well the CBR approach is understood by organisations and or the public sector partners. Whilst the IPDS is an attempt by the sector in the Western Cape to indicate areas of responsibility, it is unclear how this translates into a coordinated and sustained effort by partners.

Perhaps if the sector followed the CBR approach they would approach their work differently, would leverage from one another's resources and have a shared service delivery strategy.

Furthermore, due to the long-term nature of many interventions, high levels of need and the low base of resources, organisations need to be thinking about their own approaches in terms of sustainability, growing their resource base, and the extent to which organisations are capacitating their beneficiaries to exit their service so that they are able to provide a service to new beneficiaries. Ultimately an approach that promotes inclusion and mainstreaming should reduce NGO workloads, as other partners become involved and assist in carrying the burden.

An approach towards locating services in the community could ease their load. This could require additional thinking about how they differently deliver a service. One innovative model that is starting to be implemented is the Isibindi Model.¹⁵

¹⁵ Accessed from <http://www.naccw.org.za/isibindi/index.html> on 30 October 2013.

The Isibindi Model

“The Isibindi Model was designed by the National Association of Child Care Workers, and is implemented in over 55 sites in eight provinces - by over 40 partner organisations in South Africa. It responds holistically to the needs of children, youth and families who are vulnerable and at-risk. Unemployed community members are screened, selected, trained and deployed as child and youth care workers servicing families in their own communities. They work under the mentorship of experienced social service professionals, blending practical household support tasks with care and development opportunities. The model has a disability component because the increased incidence of disability linked to the HIV and AIDS pandemic spurred the development of a screening and assessment program where children are provided with access to remedial therapy and (where possible) assistive devices.”

5.3.8 Exploring different models of care

Many organisations work with beneficiaries to help Persons with Disabilities become independent adults. Whilst an independent lifestyle is the goal, for some Persons with Disabilities, their needs are far greater and they require ongoing support to ensure they are able to enjoy a good quality of life. In this instance, residential care facilities and protective workshops provide much needed support, however the constraint of these organisations is that they are full to capacity. This is a huge challenge for organisations as they have nowhere to refer beneficiaries to. DSD and its partner organisations have therefore begun exploring other models of care to provide less resource intensive support, such as respite care (day only and overnight) for caregivers caring for adults and children with disabilities. Another model of care, which could be less resource intensive, is to provide carer support and training, as well as home adaptations.

5.4 Extent to which DSD-funded NGO programmes provide value for money

Historically, DSD and many NGOs in the disability sector and beyond, have followed the social welfare model. More recently there is a move to augment this with a model that focuses on community development.

Currently most beneficiaries receive free services from NGOs because NGOs report that beneficiaries don't have enough money to pay for the services being rendered. Many beneficiaries meet the means test threshold to receive the disability grant.

5.4.1 Key cost drivers

As already discussed, transport is the most commonly cited cost driver associated with programme delivery. Another cost driver is staff. Many of the NGOs employ social workers. DSD subsidise these posts by 75% and NGOs are expected to find additional sources of funds to top up the salary. However many NGOs cannot afford to top up the salary, which results in staff earning low salaries and this affects staff turnover and morale. This is a huge challenge because of the skills shortage of people who have experience in working in this sector.

Some NGOs report that their clients require costly equipment such as wheel chairs, oxygen and ventilators, cough assisters and hospital mattresses to prevent them from getting seriously ill. This can be prohibitively expensive and is out of reach to most organisations and beneficiaries unless they are able to raise funds through a specific fundraising initiative. One visually impaired beneficiary said;

"In 2008 I applied for a Perkins braille machine. The price was between R20 000 - R26 000. I called this office and they said there is one machine, R1 600. I didn't have the money, and the organisation did not have the money also, and I prayed. One person called from Rotary, so the Rotary Club sponsored me. With the tax it was R1 800."

Another common request is for computer assistance programmes and other computer assistance devices help Persons with Disabilities to communicate and to work.

5.4.2 Administration of TPAs

NGOs reported that they are compliant to the stipulations of their TPA, but find it frustrating that there are often delays in receiving their annual TPAs on time and this affects the flow of funds, with delays undermining service delivery. Many organisations do not have other sources of income that can provide a buffer between contractual periods between NGOs and DSD.

Reporting by organisations to DSD tend to be at the output level, with additional reporting focused on key programme highlights and challenges. DSD head office are now responsible for monitoring and reporting, and they monitor the progress of NGOs via progress reports,

site visits and use a risk-based approach that helps them prioritise NGOs that may need closer monitoring to ensure they are complying with the conditions of the TPA. Organisations were compliant with DSDs monitoring requirements, however many of them did not take their monitoring and evaluation further, saying that they don't have the resources to conduct independent evaluations.

5.5 Extent to which interventions contribute to social change and improved social functioning of beneficiaries

5.5.1 Skills development

Some services provided by organisations tried to appropriately improve the social functioning of their beneficiaries. Many organisations that provided services to people with physical, visual or hearing impairment offered life skills training in areas such as shopping and independent self-care, so that Persons with Disabilities could independently care for themselves. One beneficiary who is visually impaired described the need she felt for this kind of service:

“To be dependent on others, it is frustrating. For example, when I want to eat something at home, if no one leaves me some food, I have to wait until the first one comes home - it could be hours.”

One of the organisations working with people who are visually impaired, provides orientation and mobility training. The programme manager explained the approach;

“We aim to build their confidence to move around inside and outside the house. We give them pre-cane skills to be able to walk indoors without any assistance. They then learn the diagonal cane technique where they learn use of the cane inside the building, instead of using his/her arms he uses the cane. They then learn the two-point touch cane technique; touch left and right to identify obstructions in the way and they then go outside using the above technique where they learn to cross the street, listen to the traffic, rely on the sense of hearing and they learn the buttons of the robots - when they hear the sound of the robot they know to cross the street. Where there are no-button robots they use the parallel cross technique.”

One beneficiary who is visually impaired said;

“I started coming here this year, I couldn’t come last year, my granny didn’t have money. The social worker at Site B clinic told me about organisation 10, and they have done good things. They encourage us to go back to school, they are doing a good job for us, taught me Braille and I am still learning cooking skills and how to clean the house, how to do things myself.”

5.5.2 Access to employment

Whilst beneficiaries saw the enormous value of learning to live more independently, they repeatedly cited that their biggest challenge was unemployment and that they needed more opportunities to be economically empowered.

On a positive note, many organisations involved in the evaluation are currently staffed by Persons with Disabilities, which is an important move towards ensuring that NGOs are

mainstreaming disability themselves. One manager said that employment has provided one of their staff with a disability with an opportunity to live more independently;

“About five years ago he started working here. He is earning a salary. He bought his own car. Six months ago he got his learners, three months ago he got his licence. Previously, the bus had to fetch him at his home and bring him here and depending on the traffic he was late. Now, he has his own car, he drives here by himself, parks it at the back and come into the office.”

Historically it was thought that Persons with Disabilities would not be able to enter the open labour market and therefore protective workshops were designed to provide an employment opportunity for Persons with Disabilities. Today however, protective workshops are condemned by the United Nations CRPD, because they serve to segregate Persons with Disabilities from mainstream society rather than facilitate inclusion. In response to this concern, DSD has developed the Transformation of Protective Workshops Policies. They have identified an organisation to train protective workshops, self-help groups and entrepreneurs with disabilities in this policy in order to make the policy more practical and ensure that protective workshops are DSD compliant. As a result of the improved functioning of protective workshops, protective workshops are able to obtain contract work from the private sector and can charge appropriately for their services and increase the pay to people working in the protective workshops. One manager described this shift :

“Protective workshops are now trying to get work from the open labour market in order to sustain the protective workshop and to provide some sort of employment, protective employment to Persons with Disabilities. We are trying to transform the protective workshops by becoming more relevant. We try and do this by establishing a cooperative perhaps, or by establishing them as social enterprises.”

Although controversial, protective workshops continue to offer opportunities for Persons with Disabilities’ to develop new skills, including social skills. A staff member at a protective workshop described the impact on one service user:

“The woman was very shy when she started working here. When she started working here she could not speak, now she speaks to us. She can dress herself and chooses what she wants to wear.”

Another staff member said;

“Previously the tendency was to do things for the deaf, now we focus on empowering them with assistance. For example, one of our clients, when I met her she would never come to my office on her own, she would always bring her husband with. Now she has the confidence to go to places by herself because she has an input in her own life.”

5.6 Social impact of services in changing the community attitude/ social attitude towards Persons with Disabilities and in the reduction of stigma and social exclusion

Stigma can be described as “a powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons” (Alonzo et al., 1995).

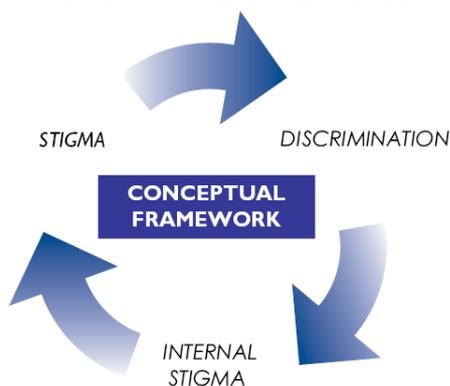
5.6.1 Stigma associated with disability

Many barriers such as widespread ignorance, fear and stereotypes have caused Persons with Disabilities to be unfairly discriminated against in society, particularly those with severe disability associated with physical, mental or intellectual disability.

Figure 11 below depicts the relationships among stigma, discrimination, and internal stigma, as it is understood in the context of understanding HIV stigma. The evaluators would argue that the same conceptual framework could be used to understand stigma, discrimination and internal stigma related to disability.

To understand Figure 12, differences (such as disability) are noted and labelled; these differences are then given a negative attribute, called stigma, and a distinction is made between those who have the negative attribute and those who do not. The person with the negative attribute is seen as having a lower status, and then discriminated against (Link and Phelan, 2001). Experiences of discrimination—such as blame, rejection, intimidation, name-calling, exclusion, isolation, and name-calling—may then lead to internal stigma, which reinforces and legitimises societal stigma (Morrison, 2006).

FIGURE 12: CONCEPTUAL FRAMEWORK



Beneficiaries and service providers believe that stigma associated with disability was still prevalent. Some respondents felt that until you have experienced disability personally, or with someone close to you, that you will not understand it. A manager said that there is a lack of insight and ignorance by health workers of the constraints of living with a disability.

Organisations who participated in this evaluation reported a range of different ways that they try and address stigma and discrimination so as to improve the quality of life of Persons with Disability. Mostly such interventions focus on awareness raising, information sharing and sensitization training programmes so that there is a better understanding of disability. There were a few organisations which stated that they provided support to Persons with Disabilities to help improve their self-image and self-perception, because they recognised that this was important. Whilst they did not say it explicitly, what they are focused on is the reduction of internal stigma.

Whilst information sharing is important, other activities are also important. For example; advocacy against instances of discrimination, improving the policy environment to ensure that the rights of Persons with Disabilities are protected, ensuring there is a multi-sectoral approach towards addressing the needs of the disability sector as well as research that indicates whether there has been any improvement in the quality of life of Persons with Disability.

5.6.2 Targeted awareness

One of the organisations actively target companies to educate and raise awareness about the needs of Persons with Disabilities. This work supports Persons with Disabilities, as well as companies, as it helps companies to comply with the Employment Equity Act (EEA) No. 55 of 1998. They assist companies to understand the different needs of Persons with Disabilities and guides them as to how to reasonably accommodate a Person with a Disability. The EEA No. 55 of 1998 states that reasonable accommodation includes but is not limited to;

- Adapting existing facilities to make them accessible,
- Adapting existing equipment or acquiring new equipment including computer hardware and software,
- Re-organising workstations,
- Changing training and assessment materials and systems,
- Restructuring jobs so that non-essential functions are re-assigned,
- Adjusting working time and leave, and
- Providing specialised supervision, training and support in the workplace.

5.6.3 Advocacy

Some organisations provided direct support to beneficiaries who are stigmatised and / or discriminated against because of their disability, which most often takes the form of being denied a service. Different managers said the following:

“We try to raise awareness at places like the police station and clinics to give people equal access to these services. There is a lot of stigmatisation in these organisations. We are trying to build a relationship with those organisations and raise awareness there but it is taking a long time.”

“Our clients will talk to us about an institution where they experienced discrimination and the treatment they are getting and then we make an appointment with that institution and talk to them about the complaint and report back to the person who made the complaint.”

It is important that organisations advocate for the rights of their beneficiaries, however where possible organisations should capacitate their beneficiaries to address discrimination themselves. This approach will also help live up to the motto *“Nothing About Us, Without Us.”* This motto relies on this principle of participation, and it has been used by Disabled Peoples Organisations throughout the years as part of a movement to achieve the full participation and equalization of opportunities for, by and with Persons with Disabilities.

5.6.4 Involving Persons with Disabilities to promote their own rights

Some programme staff indicated that they followed an empowerment approach;

“I want them to be able to walk around without feeling stigmatised and even if they are stigmatised they should feel that they have the right to be here regardless of the stigmatisation.”

“One of the people came to me and told me: ‘You know, what you are teaching us is really making a difference. I now know that I have rights. I am going to go and tell my family that I am 50 and they should treat me like an adult. I am not a child’.”

Whilst self-representation is important, the evaluators recognise that, due to the severity of some peoples disability, that not all Persons with Disabilities are able to represent themselves.

5.6.5 Awareness-raising

Many organisations reported that they made use of the media to spread information and awareness about specific disabilities. If the organisation was affiliated to a provincial or national organisation, the higher office would take responsibility for these campaigns. Radio was the most commonly cited medium for sharing information, followed by pamphlets, posters, social media and websites. Opportunities for awareness-raising was mostly organised around the designated day/ month allocated for that specific disability, for example World Sight Day on 10 October 2013.

Awareness-raising took the form of prevention, early intervention and education about the disability. On the whole, organisations said that they did not spend as much time on these

activities as they would like to, as they allocated more time towards service delivery directly to their beneficiaries.

Whilst organisations reported that community awareness-raising was important, they found it difficult to measure the impact of these campaigns. Some organisations reported an increase in telephonic enquiries to their office and used this as a proxy indicator of the effect of their campaign.

5.7 Promising practices emerging from the evaluation

Some examples of emerging promising practice have already been noted in above findings, but are briefly highlighted below:

5.7.1 *Support groups*

Psychosocial support groups were mentioned by beneficiaries as being an effective form of support. It is well documented that support groups are an effective methodology in helping Persons with Disabilities and/ or their caregiver to have a space to share their successes and challenges amongst a group of people who have the same or similar conditions. In South Africa, most support groups are held in person, however in other countries, some support groups are held online, for those who live in rural areas or are unable to travel. Internet support groups may either have a chat format or a virtual format, which would be more resource intensive as the member would need an internet connection and a web camera.

5.7.2 *Targeted awareness campaigns*

Targeted awareness campaigns are seen to be an effective way of raising awareness and sharing information that is relevant to the user. Such campaigns have clearly defined goals, provide relevant and specific information in an appropriate manner (newspaper, community radio, giving a talk) and language, and have a specific target audience. Whilst the organisation may want to target 'the community' it is important to break down the community into different audiences for example, schools, business executives, health workers, faith based organisations etc. These campaigns will more easily allow organisations to see the impact of their work in ensuring that there is an improvement in the lives of Persons with Disabilities.

5.7.3 *Community based intervention models*

The Isibindi Model was shared as one example of how programmes can more easily identify and better reach Persons with Disabilities. It appears from the evaluation that NGOs could consider other models of work that could help them extend their reach, in a way that is both effective and cost effective. Caring for Persons with Disability in the community is not only cost effective but is also often preferred by the Person with Disability. Whilst care in the community is not always appropriate, because of the severity of a disability, residential care or institutional care at special schools can further isolate children when they return to their homes as the interventions that help improve their communications at their institution are not always well understood in their home, making communication a huge barrier.

6. CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The evaluation found that economic and social barriers continue to prevent Persons with Disabilities from being able to fully participate in society, therefore making many of them extremely vulnerable and marginalised.

The evaluation of the work of NGOs shows their deep understanding of different types of disabilities, the valuable services they are delivering and the huge commitment they have towards the disability sector.

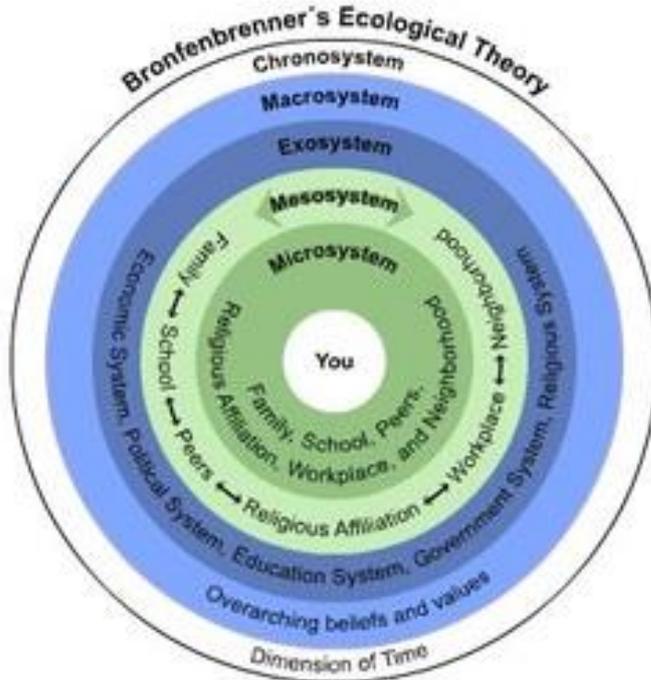
However, it appears that many gaps in information and services exist. Having a greater understanding of; the prevalence of disability in the province, the coverage of services to Persons with Disability in the province, the needs of Persons with Disabilities and the capacity of organisations to deliver services (government and non-government) are important steps towards ensuring the development of coherent strategies towards effective programme implementation.

Whilst the Western Cape Network on Disability is an active and valuable organisation for the sector, it appears that a greater, and coordinated multi-sectoral response is needed to leverage additional resources to enable Persons with Disabilities to fully participate in society.

6.2 Recommendations

The recommendations from this evaluation have been organised against Bronfenbrenner's Ecological Systems Theory, as depicted in Figure 13 below (Santrock, 2007). Ecological Systems Theory holds that development reflects the influence of several environmental systems, and it identifies five environmental systems: micro system, mesosystem, exosystem, macrosystem and chronosystem. For the purposes of the recommendations, we will look at the key levels where the disability sector can actively respond which will have a positive impact on the macrosystem and chronosystem.

FIGURE 13: BRONFENBRENNER'S ECOLOGICAL SYSTEMS THEORY



The **micro system** is “the setting in which the individual lives. These contexts include the person's family, peers, school, and neighborhood. It is in the micro system that the most direct interactions with social agents take place; with parents, peers, and teachers, for example. The individual is not a passive recipient of experiences in these settings, but someone who helps to construct the settings.” (Santrock, 2007)

Recommendations:

1. NGOs to continue to provide information, awareness and psychosocial support to Persons with Disabilities and those in the microsystem to empower them with knowledge, skills that will create an enabling environment for Persons with Disabilities. As far as possible, Persons with Disabilities should be integrated to participate in all aspects of home and community life.
2. NGOs to explore different models of support to communities to ensure that Persons with Disabilities are identified and linked to community services.

The **mesosystem** refers to “relations between microsystems or connections between contexts. Examples are the relation of family experiences to school experiences, school experiences to church experiences, and family experiences to peer experiences” (Santrock, 2007).

Recommendations:



3. NGOs to continue to implement programmes and campaigns that break down the stigma associated with disability in different community contexts.
4. NGOs to continue to offer comprehensive reintegration programmes particularly those aimed enabling Persons with Disability to enter a workplace that is a supportive and enabling environment conducive to their employment.
5. NGOs to advocate to local business / organisations to be compliant and employ Persons with Disabilities.
6. Particular focus to be given to the needs of Persons with Disabilities and their caregivers in rural areas to ensure they are provided with appropriate support.

The **exosystem** involves “links between a social setting in which the individual does not have an active role and the individual's immediate context” (Santrock, 2007).

Recommendations:

7. Persons with Disabilities to provide advisory support via their participation on Boards and other structures so as to appropriately advise organisations.
8. The Western Cape Network on Disability to be properly resourced and supported to engage with, and represent its membership.
9. DSD and its NGO partners to pilot different models of care that could be cost effective and could lead to replication of services and enable services to go to scale.

DSD with other government departments and non-governmental partners to mobilise a sustained multi-sectoral effort to;

10. Ensure a comprehensive gap analysis is undertaken to identify where the disability sector currently is in terms of service delivery versus where it should be.
11. Undertake sectoral planning, ensuring that strategies are designed and implemented that respond to the gap analysis and provide clear direction with regard to strategies and priorities focused on prevention, early intervention, statutory/ residential care and reintegration programmes. Furthermore, services need to be:
 - a. Sustainable, for example, in providing support for the purchase of assistive devices, continued support for the maintenance of such services is critical. This is also true for the purchase of vehicles.
 - b. Comprehensive, for example they need to fill all the accessibility criteria, ensuring they are available, affordable and acceptable to Persons with Disabilities.



12. Design minimum standards for services for Persons with Disabilities where these are not already in place. For example, home adaptations, the provision of assistive devices, the provision of rehabilitation services.
13. Design and appropriately resource a monitoring, evaluation and research framework, that produces information to further inform planning.
14. Develop and implement an advocacy campaign to mobilise additional partners to become actively involved in ensuring that the rights of Persons with Disabilities are upheld. For example, the private sector becoming an active employer of Persons with Disabilities, or providing contracts to protective workshops to ensure they are sustained.

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APPENDIX 1: INFORMED CONSENT FORM TO PARTICIPATE IN EVALUATION

CONSENT TO PARTICIPATE IN EVALUATION

Impact Assessment of Disability Programmes Provided by non-governmental organisations in the Western Cape

You are being asked to participate in an impact assessment of disability programmes provided by non-governmental organisations in the Western Cape. The evaluation will be conducted by Creative Consulting & Development Works on behalf of the Western Cape Department of Social Development. You have been selected as a participant in this evaluation because you have relevant knowledge and information about the programme, and your experience and opinions about the programme may provide valuable information.

PURPOSE OF THE STUDY

This evaluation aims to explore the thoughts, perceptions, and experiences of individuals with regards to the disability programmes provided by non-governmental organisations in the Western Cape. This will enable us to make suggestions regarding future programme improvements.

PROCEDURES

If you volunteer to participate in this evaluation, we will ask you to do the following things:

You will respond to a series of questions regarding your perceptions of the programme. These questions will come in the form of a key informant interview or survey questionnaire.

If you feel uncomfortable about discussing these perceptions, feel free not to participate or to decline to answer any specific questions. If you are taking part in an interview, you will be asked for your permission to record on an audiotape the answers you provide. The interview will last between sixty and ninety minutes. Please tell the interviewer facilitating your interview if you have any time constraints or if you need to leave at any time.

POTENTIAL RISKS AND DISCOMFORTS

Speaking about your experiences of the programme may be uncomfortable if it reminds you of painful experiences or highlights difficulties you are currently facing. If at any time you feel you do not want to answer a particular question, please tell the interviewer and you will not be asked to answer. You are free to decline to answer any question that you do not want to answer.

If you feel distressed/upset at the end of the interview, please tell the interviewer and he/she will arrange an appropriate form of support/counselling for you.

Cape Town	Worcester	Knysna
Main office: Observatory 021 447 7951	Contact number 023 347 5231	Contact number 044 382 5129
Satellite offices: Dunoon 021 556 1945 Factreton 021 593 8074 Elsie's River 021 946 4744 Khayelitsha 021 361 9098 Mitchell's Plain 021 372 0022 Tygerberg 021 946 4744	Address 83 Tulbach Street Worcester 6850	Address Court Square, 21 Spring Street, Knysna, 6571

PAYMENT FOR PARTICIPATION

You will receive no payment for participating in this evaluation.

CONFIDENTIALITY

Any information that is obtained in connection with this evaluation and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of removal of identifying information from records. The collected data will be made available only to the main evaluators. The interview will be recorded by means of Dictaphone to ensure accuracy of capturing your answers and responses to questions and for the evaluators reference during analysis. The recorded (audio) interviews will be made available only to evaluators and the subjects of the interviews. Your name will never be linked with your responses during data analysis and reporting.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this evaluation or not. If you volunteer to be in this evaluation, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the evaluation.

CASE FILES

Creative Consulting and Development Works would like to access your case files held with the organisation. In order to review your case file, we need written permission from you to access these confidential documents. The documents requested will be reviewed only by our social worker, who will keep you identity anonymous and confidential. In addition, any sensitive information will be screened. Any information will only be summarised.

If you consent to us accessing your case files please initial the following block



You can choose if you want to participate in the evaluation only by answering the questions and not letting us access your case files. If you do not want to us to access your case file, but would still like to take part in the evaluation, do not initial the box.

IDENTIFICATION OF EVALUATORS

If you have any questions or concerns about the evaluation, please feel free to contact Susannah Clarke telephonically on 021 448 2058 or via email: Susannah@developmentworks.co.za.

RIGHTS OF EVALUATION SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this evaluation. If you have concerns about the evaluation, its risks and benefits or about your rights as an evaluation participant in this evaluation, you may contact the secretariat of the Department of Social Development's Research Ethics Committee, Ms. Petro Brink telephonically on 021 483 4512, or via email: Petro.Brink@pgwc.gov.za.

SIGNATURE OF EVALUATION SUBJECT

I hereby consent voluntarily to participate in this study. I have been given a copy of this form.

Name of Subject/Participant

Signature of Subject / Participant

Date



APPENDIX 2: INFORMED CONSENT FORM FOR DEPENDENTS TO PARTICIPATE IN EVALUATION

CONSENT TO PARTICIPATE IN EVALUATION

Impact Assessment of Disability Programmes Provided by non-governmental organisations in the Western Cape

Your child/ dependant is being asked to participate in an impact evaluation of disability programmes provided by non-governmental organisations in the Western Cape. The evaluation is being conducted by Creative Consulting & Development Works on behalf of the Western Cape DSD. Your child/ dependant has been selected as a possible participant in this evaluation because he/ she has relevant knowledge and information about their programme, and his/ her experiences with and opinions about the programme may provide valuable information.

PURPOSE OF THE STUDY

This evaluation aims to explore the thoughts, perceptions, and experiences of individuals with regards to the disability programmes provided by non-governmental organisations in the Western Cape. This will enable us to make suggestions regarding future programme improvements.

PROCEDURES

If your child/ dependant volunteers to participate in this evaluation, we will ask him/ her to do the following things:

He/ she would be expected to respond to a series of questions regarding their experience of the programme. These questions will come in the form of a survey questionnaire.

If he/she feels uncomfortable about discussing these perceptions, they must feel free not to participate or to decline to answer any specific questions. Your child/ dependant's answers may be recorded using a recording device with their prior permission. The interview / questionnaire will last about 30 minutes. Please inform your child/ dependant to tell the evaluator if he/she has any time constraints or if they need to leave at any time.

POTENTIAL RISKS AND DISCOMFORTS

Your child/ dependant may find speaking about their experiences with the treatment programme to be uncomfortable. If at any time your child/ dependant does not want to answer a particular question, they may tell the researcher that they do not want to and they will not be asked to answer. They are free to decline to answer any question that they do not want to.

If your child/ dependant feels distressed/upset at the end of the interview, please tell him/ her to tell the interviewer and he/she will arrange an appropriate form of support/counselling for them free of charge.

PAYMENT FOR PARTICIPATION

You and your child/ dependant will receive no payment for participating in this evaluation.

CONFIDENTIALITY

Any information that is obtained in connection with this evaluation and that can be identified with your child/ dependant will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of removal of identifying information from records. The collected data will be made available only to the main evaluators. The interview will be recorded by means of Dictaphone to ensure accuracy of capturing answers and responses to questions and for the evaluators reference during analysis. The recorded (audio) interviews will be made available only to the evaluators and the subjects of the interviews. The name of your child/ dependant will never be linked with responses during data analysis and reporting.

PARTICIPATION AND WITHDRAWAL

Your child/ dependant can choose whether to participate in this study or not. If your child/ dependant volunteers to be in this study, they may withdraw at any time without consequences of any kind. Your child may also refuse to answer any questions they do not want to answer and still remain in the study.

CASE FILES

Creative Consulting and Development Works would like to access your case files held with the organisation. In order to review your case file, we need written permission from you to access these confidential documents. The documents requested will be reviewed only by our social worker, who will keep you identity anonymous and confidential. In addition, any sensitive information will be screened. Any information will only be summarized.

If you consent to us accessing your case files please initial the following block

You can choose if you want to participate in the evaluation only by answering the questions and not letting us access your case files. If you do not want to us to access your case file, but would still like to take part in the evaluation, do not initial the box.

IDENTIFICATION OF EVALUATORS

If you have any questions or concerns about the evaluation, please feel free to contact Susannah Clarke telephonically on 021 448 2058 or via email:

Susannah@developmentworks.co.za.

RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue your child / dependant's participation without penalty. You are not waiving any legal claims, rights or remedies because of your child's participation in this evaluation. If you have concerns about the evaluation, its risks and benefits or about your rights as a research participant in this evaluation, you may contact the secretariat of the Department of Social Development's Research Ethics Committee, Ms. Petro Brink telephonically on 021 483 4512 or via email: Petro.Brink@pgwc.gov.za.

SIGNATURE OF PARENT / GUARDIAN

I hereby give consent to allow my child / dependant,
_____, to voluntarily participate in this
evaluation. I have been given a copy of this form.

Name of Parent/Guardian

Date

Signature of Parent / Guardian

APPENDIX 3: KEY INFORMANT INTERVIEW GUIDE FOR DONOR LEVEL STAFF - DSD

1. DSD Objectives

1. What are the key objectives for DSD's services to Persons with Disabilities sub-programmes?
2. What programme is in place to reach these objectives?

2. Partnerships

1. What are the general practices around partnerships between NGOs in this sector? [probe: in terms of capacity development, sharing resources, sharing ideas, funding]
 - 2.1.1. Is this a close community? – Are NGOs servicing Persons with Disabilities working closely together?
 - 2.1.1.1. Why?
 - 2.1.1.2. How?
2. What have been the benefits of NGOs forming partnerships within their communities?
3. Have all NGOs had the same success in forming partnerships?
4. What recommendations does the DSD have in terms of partnerships between NGOs?

3. Communication

1. What is the nature of communication between the NGOs and the DSD and vice-versa?

4. Finances

1. What is the DSD budget for funding NGOs in the disability sector?
2. DSD only has so much money, how does this affected funding distribution?
 - 4.2.1. How do you decide who to fund?
3. Of the funds that are distributed:

- 4.3.1. What types of disabilities need the most funding? (for example; types of disability programmes include epilepsy, muscular dystrophy, down syndrome, blindness, deafness, mental disability, autism, TB and general)
- 4.3.2. Is it based on the size of the problem?
- 4.3.3. What types of interventions need the most funding? (types of interventions include: awareness, prevention, early intervention, statutory, reintegration)
- 4. What have been the key successes in terms of accessing funds for NGOs?
- 5. What have been the key challenges in terms of accessing funds for NGOs?
- 6. What recommendations does the DSD have to improve funding and allocation to NGOs?

5. Programme delivery

- 1. How do you think the funded NGOs meet the needs of service users in the sector?
- 2. How would you describe the quality of the services that are provided to service users by NGOs?
 - 5.2.1. Maybe if you could think of an example of best quality service and one where you have identified challenges in service delivery?
- 3. How well do you think the NGOs deal with innovation in their programmes?
 - 5.3.1. Could you give us an example of instances where NGOs came up with innovative solutions?

6. Most Significant Change

- 1. Do you feel there has been a change in the lives of Persons with Disabilities in the Western Cape? Give reasons.
 - 6.1.1. Can you think of an example from a funded NGO which demonstrates this change?
- 2. Do you feel there has been a change in the types of programmes implemented by NGOs? Give reasons.
 - 6.2.1. Can you think of an example from an NGO which demonstrates this change?
- 3. Do you feel there has been a change in the way that the sector operates? Give reasons.
 - 6.3.1. Can you think of an example which demonstrates this change?

7. M&E

1. How do DSD measure the programme results?
 - 7.1.1. What indicators do you use to measure progress?
 - 7.1.2. What sources of evidence do you use?
 - 7.1.3. Are your indicators selected according to the industry norms?

8. Overall assessment

1. In terms of overall functioning:
 - 8.1.1. What have been the key successes of NGOs?
 - 8.1.1.1. Can you think of an example that illustrates these successes?
 - 8.1.2. What have been the key challenges for NGOs?
 - 8.1.2.1. Can you think of an example that illustrates these challenges?
2. What recommendations does the DSD have to improve the overall functioning of NGOs?
3. What do you feel the sector, and specifically the NGOs, should focus their efforts on to improve the services offered and delivered to Persons with Disabilities?

APPENDIX 4: KEY INFORMANT INTERVIEW GUIDE FOR SECTORAL INTERVIEWS

1. Overview and Objectives

- Please introduce yourself and your role?
- What are the key objectives of your organisation with regard to Persons with Disabilities?
- What programme of support/ strategy is in place to reach these objectives?

2. Partnerships

- In your opinion, how strong are the partnerships between (1) NGOs, (2) NGOs and government, and (3) government departments in this sector? Please provide examples of partnerships?
- What have you observed to be the benefits of partnerships within this sector?
- What recommendations do you have in terms of promoting future partnerships?

3. Programme delivery

- How well do you think the NGO sector meets the needs of service users (Persons with Disabilities and their caregivers) in the sector?
- How would you describe the quality of the services that are provided to service users by NGOs?
 - Can you provide an example of best quality service and one where you have identified challenges in service delivery?
- How well do you think the NGOs deal with innovation in their programmes?
 - Could you give an example of instances where NGOs came up with innovative solutions?

4. Most Significant Change

- Do you feel there has been a change in the lives of Persons with Disabilities in the Western Cape? Give reasons.
- Do you feel there has been a change in the types of programmes implemented by NGOs? Give reasons.
- Do you feel there has been a change in the way that the sector operates? Give reasons.

5. Overall assessment

- In terms of overall functioning:
 - What have been the key successes of NGOs?
 - Can you think of an example that illustrates these successes?
 - What have been the key challenges for NGOs?
 - Can you think of an example that illustrates these challenges?
- What recommendations do you have to improve the overall functioning of NGOs?
- What do you feel the sector, and specifically the NGOs, should focus their efforts on to improve the services offered and delivered to Persons with Disabilities?
- In your opinion, how strong are the partnerships between (1) NGOs, (2) NGOs and government, and (3) government departments in this sector? Please provide examples of partnerships?
- What have you observed to be the benefits of partnerships within this sector?
- What recommendations do you have in terms of promoting future partnerships?

6. Programme delivery

- How well do you think the NGO sector meets the needs of service users (Persons with Disabilities and their caregivers) in the sector?
- How would you describe the quality of the services that are provided to service users by NGOs?
 - Can you provide an example of best quality service and one where you have identified challenges in service delivery?
- How well do you think the NGOs deal with innovation in their programmes?
 - Could you give an example of instances where NGOs came up with innovative solutions?

7. Most Significant Change

- Do you feel there has been a change in the lives of Persons with Disabilities in the Western Cape? Give reasons.
- Do you feel there has been a change in the types of programmes implemented by NGOs? Give reasons.
- Do you feel there has been a change in the way that the sector operates? Give reasons.

8. Overall assessment

- In terms of overall functioning:
 - What have been the key successes of NGOs?
 - Can you think of an example that illustrates these successes?
 - What have been the key challenges for NGOs?
 - Can you think of an example that illustrates these challenges?
- What recommendations do you have to improve the overall functioning of NGOs?
- What do you feel the sector, and specifically the NGOs, should focus their efforts on to improve the services offered and delivered to Persons with Disabilities?

APPENDIX 5: INTERVIEW SCHEDULE FOR COMMUNITY REPRESENTATIVES

1. PERSONAL

- 1.1. What role(s) do you perform within the community?
- 1.2. Which groups within the community do you feel best able to represent? Why?
- 1.3. Which groups would you perhaps not know as much about?
- 1.4. How would you explain to someone what “disability” means?
- 1.5. What do you know about people with...[relevant impairment] [look for indications of training]

2. NGO

- 2.1. What do you know about x NGO? What dealings have you had with them?
- 2.2. What reports have you heard about their work?
- 2.3. Do you see the need for what they are doing?
- 2.4. Are there other services you feel they should also cover?
How relevant and appropriate are the services offered to Persons with Disabilities and caregivers or families? i.e. Does the service provided meet the needs of the affected persons?

3. SOCIETY

- 3.1. What do you think it's like for Persons with Disabilities in this community? (probe – how are they treated)
- 3.2. Do you feel your community understands people with Disabilities and the challenges they face better?
 - Are people more aware of what disability means and what challenges Persons with Disabilities face?
- 3.3. Has the attitude within your community changed towards Persons with Disabilities? If yes, how?
- 3.4. Do you feel that the community stigmatises Persons with Disabilities less? i.e. Please give examples.
 - Do you feel people judge people based on their disabilities? [probe for example]
 - Do people treat Persons with Disabilities unfairly because on their disability? [probe for example]
 - Do people discriminate against Persons with Disability? [probe for example]

4. FOR CLINICS

- 4.1. How often do you see Persons with Disabilities in the clinic? (NB include mental health)
- 4.2. Are they assisted by family or a caregiver?
- 4.3. Do you think Persons with Disabilities are more supported now than in the past? Please explain.
- 4.4. When you think about your clinic in particular – has there been a change in experience of the Persons with Disabilities?
- 4.5. Are you aware of the xxx NGO and its work in the community?
- 4.6. What are the greatest challenges for Persons with Disabilities in the community (related to health)?
- 4.7. Do you think the needs of Persons with Disabilities are being addressed? (by government and by NGOs?)

5. FOR SCHOOLS

- 5.1. Are there children with disabilities in your school?
- 5.2. What do you think is their experience (classroom and playground) or your school? (Probe: general challenges and enablers) .
- 5.3. What challenges do you as a school face with regards children with disabilities?
 - 5.3.1. Check awareness of inclusive education policy
- 5.4. What are the greatest challenges for Persons with Disabilities in the community (related to education)?
- 5.5. Have there been improvements in terms of educating Persons with Disabilities?
- 5.6. Do you think the needs of Persons with Disabilities are being addressed? (by government and by NGOs?)
- 5.7. When you think about your school in particular – has there been a change in the school experience for children with disabilities?
 - 5.7.1. What kind of a change do you see?
 - 5.7.2. Do you see more people / children with Disabilities staying in school?
 - 5.7.3. Are people / children with Disabilities being assisted more in terms of getting an education?
- 5.8. How do you think people / children with Disabilities are being treated differently compared to 5 years ago?

APPENDIX 6: KEY INFORMANT INTERVIEW GUIDE FOR MANAGEMENT LEVEL STAFF

1. Introductory

- 1.1. How long has the programme existed?
- 1.2. What are the objectives of the organisation?
- 1.3. Could you explain and describe the activities of your programme?
- 1.4. Who decides what is done in the programme? [Probe: long standing, based on certain theoretical models or approaches – if so then which]

2. Needs

- 1.5. Have you done a needs assessment within your community? Provide evidence.
- 1.6. Have you included service users in the needs assessment?
- 1.7. How do you get feedback from Persons with Disabilities or clients regarding their needs?
- 1.8. How do you know you are addressing your clients needs?

2. Accessibility

- 2.1. How far do your clients usually travel to get to use your services? [Probe for distance, time and cost]
- 2.2. How have you made your building most accessible for Persons with Disabilities? [Probe for access to / entrance and mobility around / inside the building]
- 2.3. What are the challenges of ensuring accessibility?
- 2.4. How do potential service users get to know about your organisations? (Probe for flyers, posters, referrals?)
- 2.5. Is there a high demand for your services?
 - 2.5.1. How are you managing this?
 - 2.5.2. What are the constraints or enabling factors that enable you to have a greater reach? [Probe for geographic, need, funding/resource]

3. NGO – change for Persons with Disabilities

- 3.1. How does your organisation enable Persons with Disabilities to participate more in community life? (either through improved capacity OR access to opportunities)
- 3.2. In what ways do you [partner with other community stakeholders to] promote inclusion of Persons with Disabilities in mainstream activities, [Probe for school, employment, etc]?
- 3.3. How do you empower Persons with Disabilities,
 - 3.3.1. To do what?
 - 3.3.2. What evidence can you show that this happens? [empowerment should result in behavioural change]
- 3.4. Do you include Persons with Disabilities in the running of the organisation?
 - 3.4.1. If yes, how do you include Persons with Disabilities in the running of your organisation?
 - 3.4.2. If no, what are the constraints?

4. Finances (Value for Money)

- 4.1. What are your biggest cost drivers? (Probe for staff, travel, facility, maintenance, rent)
- 4.2. In terms of fundraising, what line items are the hardest to fund or find funding for?
- 4.3. How do you try and keep costs down?
 - 4.3.1. What are the challenges?

5. Partnerships

- 5.1. What kind of partnerships do you have within your community (geographic and or disability specific community) and with which organisations?
 - 5.1.1. What is the benefit of partnerships?
 - 5.1.2. What is the challenge of partnerships?

6. Overall

- 6.1. Can you give us an example of the most significant change you have seen for your clients?

APPENDIX 7: KEY INFORMANT INTERVIEW GUIDE FOR PROGRAMME LEVEL STAFF

1. Introductory

- 1.1. What are the key objectives of your organisations programme?
- 1.2. How long has the programme existed?
- 1.3. Could you explain and describe that activities of your programme?

Awareness intervention

- 1.3.1. If the NGO offers an Awareness Intervention Programme, please can you briefly describe it.

Prevention Intervention

- 1.3.2. If the NGO offers a Prevention Intervention Programme, please can you briefly describe it.

Early Intervention

- 1.3.3. If the NGO offers an Early Intervention Programme, please can you briefly describe it.

Reintegration Intervention

- 1.3.4. If the NGO offers a Reintegration Intervention Programme, please can you briefly describe it

- 1.4. Who decides on what activities are undertaken in the programme?

2. Needs

- 2.1. What are the services you see most clients utilising? i.e. What are the greatest needs of clients that the NGO meets?
- 2.2. Are there services that clients ask you for assistance with that your NGO does not offer at the moment? i.e. are there needs the NGO is not meeting?
- 2.3. Are you able to give feedback to your managers about the needs of clients that are not being addressed?
- 2.4. Are there any services currently being offered you feel are unnecessary or not utilised as much by clients?

3. Accessibility

- 3.1. How far do your clients usually travel to get to use your services? [Probe for distance, time and cost]

- 3.2. How have you made your building most accessible for Persons with Disabilities?
[Probe for access to / entrance and mobility around / inside the building]
- 3.3. What are the challenges of ensuring accessibility?
- 3.4. How do potential service users get to know about your organisations? (Probe for flyers, posters, referrals?)
- 3.5. What is the demand for your services?
 - 3.5.1. How are you managing this?

4. NGO – change for Persons with Disabilities

- 4.1. How does your organisation enable Persons with Disabilities to participate more in community life? (either through improved capacity OR access to opportunities)
- 4.2. In what ways do you [partner with other community stakeholders to] promote inclusion of Persons with Disabilities in mainstream activities, [Probe for school, employment, etc]?
- 4.3. How do you empower Persons with Disabilities,
 - 4.3.1. To do what?
 - 4.3.2. What evidence can you show that this happens? [empowerment should result in behavioural change]
- 4.4. How do you include Persons with Disabilities in the running of your organisation?
 - 4.4.1. What are the challenges?

5. Finances (Value for Money)

- 5.1. What do you think are the most important things to spend money on that your NGO does?
- 5.2. What do you think is less important – that the NGO could do less of (or save money on)?

6. Partnerships

- 6.1. What kind of partnerships do you have within your community (geographic and or disability specific community) and with which organisations?
 - 6.1.1. What is the benefit of partnerships?
 - 6.1.2. What is the challenge of partnerships?

7. Overall

7.1. Can you give us an example of the most significant change you have seen for your clients as a result of your programme?

APPENDIX 8: INTERVIEW SCHEDULE FOR PERSONS WITH DISABILITIES

1. BIOGRAPHICAL DETAILS

Organisation (1-15): _____

Beneficiary (1-4) _____

My age is	10-18
	18-20
	21-30
	31-40
	41-50
	51 or older

Gender	Male
	Female

I have completed (selected highest level)	Primary school
	High school
	Certificate
	Diploma
	Bachelor's degree
	Master's Degree
Other, please specify	

My home language is	English
	Afrikaans
	IsiXhosa
	Other, please specify.....

2. PERSONAL

- 2.1. What type of impairment /disability do you have?
- 2.2. How long have you had this disability?
- 2.3. What are the main challenges you face on a day to day basis? [include probe items here e.g. health, mobility/ getting around, having friends/a social life, being accepted, personal safety...BUT start with open question so that people aren't led by suggestions]

3. NGO / NPO

- 3.1. Tell me about how you came to be involved with [NPO].
[probe for when, how found out, how access process worked, how long they struggled with a need before accessing etc]
- 3.2. What activities have you been/are you now involved in at this NPO? How do these help you? [These may have changed over time – get comments on why and how?]
- 3.3. Is it easy for you to use the NPO's services –
[probe questions]
 - Are the times convenient for you?
 - Is it easy to get to the NGO?
 - How far did you have to travel to get here? [Probe for time and distance]
 - How much did it cost you to get here?
 - How easy is it for you to get into and around the building?
 - Does it require a lot of effort from your caregiver to go there?
- 3.4. You told me earlier your biggest challenges in life are [refer to 1.3.]. How does the organisation help to meet these needs OR what were the needs that they do meet for you – were these also major challenges before? [find out if the needs being met are major ones]
- 3.5. What challenges do they not assist you with? What else do you feel you need assistance with? What is not being done?
- 3.6. What are the best things about the NPO?
- 3.7. Do you have any ideas on how they could improve what they do?
- 3.8. We all know every organisation only has so much time/staff/resources/money. Do you think this NPO is making the best use of what they have? Would you prefer that they used their resources for other things instead, e.g. [refer to suggestions from 2.4. as labelled above]?
- 3.9. How would your life be different if the service wasn't here?

4. QUALITY OF LIFE

- 4.1. What differences (good and maybe not-so-good) do you think [NPO] has made in your life and in that of your caregiver/ parent/ family member, since you started going there? Think of concrete examples.
- 4.2. How has [NPO] changed your life?
- 4.3. Are you able to (as much as your peers)
 - Visit friends?
 - Take care of yourself?
 - Move around your house and your neighbourhood?
 - Meet new people?
 - Start or keep a long-term relationship?
- 4.4. Do you feel
 - You are respected?
 - Your opinion counts at home?
 - You have the equal job opportunities as your peers?

5. SOCIETY

- 5.1. What is it like to be a person with [impairment] [OR to care for a person with...] in this community? Do you feel as if people understand you?
- 5.2. Do you feel your community understands you and the challenges you face better?
 - Are people more aware of what disability means and what challenges Persons with Disabilities face?
- 5.3. Has the attitude within your community changed towards Persons with Disabilities?
 - How? Could you give an example?
- 5.4. Do you think [NPO] has had a role in changing this at all? [e.g. compare how it was before and now]
 - How have they done this?
 - Do you think they've reached the whole community, or just some people?

6. OTHER

- 6.1. Do you have anything else you would like to share?

APPENDIX 9: INTERVIEW SCHEDULE FOR CAREGIVERS OF PERSONS WITH DISABILITIES

1. PERSONAL

- 1.1. What type of impairment /disability does the person you care for have?
- 1.2. How long have they had this disability?
- 1.3. What are the main challenges s/he, and you as caregiver face in living your lives?
[include probe items here e.g. health, getting around, having friends/a social life, being accepted, personal safety...BUT start with open question so that people aren't led by suggestions]

2. NGO / NPO

- 2.1. Tell me about how you came to be involved with [NPO].
[Probe for when, how found out, how access process worked, how long they struggled with a need before accessing etc]
- 2.2. What activities have you been/are you now involved in at this NPO? How do these help you? [These may have changed over time – get comments on why and how?]
- 2.3. Is it easy for you to use the NPO's services – [probe questions]
 - Are the times convenient?
 - Is it easy to get to the NGO?
 - How far did you have to travel to get here? [Probe for time and distance]
 - How much did it cost you to get here?
 - How easy is it for you to get into and around the building?
 - Does it require a lot of effort from you to go there?, etc
- 2.4. You told me earlier your biggest challenges in life are [refer to 1.3.]. How does the organisation help to meet these needs OR what were the needs that they do meet for you – were these also major challenges before? [find out if the needs being met are major ones]
- 2.5. What challenges do they not assist you with? What else do you feel you need assistance with? What is not being done?
- 2.6. What are the best things about the NPO?
- 2.7. Do you have any ideas on how they could improve what they do?
- 2.8. We all know every organisation only has so much time/staff/resources/money. Do you think this NPO is making the best use of what they have? Would you prefer that they used their resources for other things instead, e.g. [refer to suggestions from 2.4. as labelled above]?
- 2.9. How would your lives be different if the service wasn't here?



3. QUALITY OF LIFE

- 3.1. What differences (good and maybe not-so-good) do you think [NPO] has made in your life and in that of your child/family member, since you started going there?
Think of concrete examples.
- 3.2. How has [NPO] changed your life as a caregiver for [name]?
[probe for]
 - Understanding of disabled Persons and what kind of support they need?
 - New skills to support or care for disabled persons?
 - More confidence in caring for child or persons with disability?
- 3.3. Do you feel that [NPO] has addressed your needs as a caregiver/parent/spouse as well? How?

4. SOCIETY

- 4.1. What is it like to be a caregiver for a Person with Disabilities in this community? Do you feel as if people understand you?
- 4.2. Do you think [NPO] has had a role in changing this at all? [e.g. compare how it was before and now] How have they done this? Do you think they've reached the whole community, or just some people?

5. OTHER

- 5.1. Do you have anything else you would like to share?