

Title:

Access to health care services for people with disabilities in rural South Africa

Authors:

**Lisbet Grut, SINTEF Health Research;
Gubela Mji, Stellenbosch University;
Stine Hellum-Braathen, SINTEF Health Research;
Benedicte Ingstad, University of Oslo.**

Word count:

- Abstract: 247 words
- Main text (not including abstract and references): 4098 words
- All text (including abstract and references): 5080 words

Statement

Role of the funding source:

The study is funded by The research council of Norway according to the research programme Global Health. The funder has no other role in the project.

The authors' contribution:

All authors have participated in the field work/data collection, the analyses and the writing of the article.

Approvals:

The project is approved by the ethical committee of Stellenbosch University South Africa and the Norwegian Social Science Data Services - the body that approve all research in Norway that involve individual data.

Conflict of interest:

There are no conflicts of interest.

Abstract

Poor people with disabilities encounter several barriers when trying to access health services. The interplay between the many barriers influences the access to health services and maintains the difficult situation.

The study is based on in-depth interviews with people with disabilities and family members, and semi-structured interviews with health workers in Amathole district in the Eastern Cape, South Africa. A strategic sample was identified. The data analysis was contextual and interpretive.

Access to health services for people with disabilities that are living in a resource poor context is influenced by a combination of factors that creates barriers to accessing health services even when health services are in the area. Most significant factors are poverty, landscape and ecology, social forces of the past and the present, the health services system and the health workers' attitudes and lack of understanding.

When offering health services to people with disabilities that live in resource-poor settings, services should be based on the user's perspective by taking into consideration the needs and the resources and abilities of the family group. Rethinking the notion of access to health and rehabilitation services should transcend the narrow medical institutionalization of health professional's training and include a social vision in understanding and practice. Focusing on the perspective of the disabled person and the family requires models that integrate the skills of health professionals with the skills of disabled people and their family members. Such skills lie dormant at community level, and need to be recognized and utilized.

Access to health care services for people with disabilities in rural South Africa

South-east of Mthata, towards the rugged coast of the Indian Ocean, lies a beautiful landscape of steep hills and deep valleys. This is Amathole district in the Eastern Cape, South Africa. In the rainy season the hills are green, the fields yield their crops and the valley beds flow in rapid streams towards the ocean. When the rain is heavy it is almost impossible to get anywhere except on horseback. In the dry season everything turns yellow and barren. Narrow gravel roads, sometimes only walking trails, connect the clusters of roundavels and small houses that are mostly located on the hilltops and high mountain sides. This landscape, which seems so attractive to an outsider, represents a major barrier to the local inhabitants. It houses its problems of poverty and a suffering (Farmer, 2001) that do not only stem from the constraints created by the landscape but also by the politics of the past and present (Crais, 2002). When the ANC-led democratic government came to power in 1994, health policies were amongst the first policies to be given attention (Gray & Clarke, 2000). The new government focused on fundamental improvements in basic infrastructure, as well as poverty alleviation strategies. Funding was moved away from large sophisticated hospitals and towards primary health care (PHC) facilities. Despite these reforms, several researchers describe how access to health continues to elude the South African population (Barron & Roma-Readon, 2008). People with disabilities are among those who are struck the hardest (Ingstad & Whyte, 2007). Scattered around in more or less remote villages they depend to a large extent on the good will of family and friends.

In this paper we will focus on some of the barriers that poor people with disabilities encounter when trying to access health care services. We will show how

the interplay between the many barriers, created by poverty, landscape and local ecology, and social forces of the past and the present, influences the people's access to health care services and maintains the difficult situation.

Disability and health care services – a comprehensive approach

People with disabilities are a heterogeneous group with a wide range of abilities and needs. Even where disabilities are similar, contextual factors may vary. The African philosophy of *Ubuntu* is still used as an underpinning founding principle in dealing with day to day problems in the new republic of South Africa, the core concept being that “a person is a person through their relationship to others” (Boon, 1996; Van Niekerk, 2007). In this context the impacts of disability reach far beyond the disabled individual and affect the entire family, who become “the disabled family” (Ingstad, 1997).

Across the world, people with disabilities are likely to be poorer than the rest of the population (Elwan, 1999), and in a situation of general poverty the situation easily becomes critical. In accordance with recent thinking we understand poverty as a multi-dimensional concept which implies barriers in accessing substantial social services and institutions. In sub-Saharan African countries the basic necessities are found to be; cash income, medical care, food, clean water and cooking fuel (Mattes & Bratton, 2009). Understanding the relationship between disability and poverty requires a comprehensive approach to the study of people's living conditions (The World Bank, 2000). In addition to an understanding of access to the basic necessities, one must include human capabilities and how individuals can utilize these capabilities (Yeo, 2005).

In South Africa poverty is linked to past history where apartheid has played a major role (Crais, 2002), but also to the uneven distribution of wealth and welfare goods in today's situation. Poverty, however, is not only a question of suffering. It also has another side, that of the struggle by individuals and families to cope and make a life for themselves in spite of hardships.

People with disabilities have health and rehabilitation needs that require specialised services, and poverty contributes to the difficulty in accessing and utilizing health care services (Saloojee, Phohole, Saloojee, & Ijsselmuiden, 2007; Smith, Murray, Yousafzai, & Kasonka, 2004). There is also a need to understand that people base their decisions on a cultural belief system (e.g. disability seen as caused by witchcraft, ancestor's anger, break of taboo) as much as on modern knowledge of health, disease and treatment (Groce & Zola, 1993; Kleinman, 1980; Ross, 2008).

The study setting

Amathole district in the Eastern Cape, as one of the poorest, most highly populated and most neglected rural areas in South Africa, was one of the areas targeted for the new South Africa Government's healthcare reforms. Poor infrastructure exposes people residing in areas like Amathole district to a variety of health hazards. Lack of clean water and good sanitation combined with poor hygiene creates a number of health threats, including epilepsy, caused by the tapeworm *Taenia solium* usually found in fecally contaminated water and undercooked pork (Veary & Manoto, 2008). Other common health threats in the Amathole district are Tuberculosis and HIV/AIDS, diseases that go hand in hand with high burden and morbidity and people with disabilities are considered to be particularly vulnerable (Groce, Yousafzai, Dlamini, Zalud, & Wirz, 2006; Rohleder, Braathen, Swartz, & Eide, 2009). There are indications that people with disabilities living in rural settlements such as the study

area report lower health related quality of life than people in urban living (Jelsma, Maart, Eide, Ka'Toni, & Loeb, 2007). Disability prevalence figures in Amathole district are unknown. However, South Africa's official disability prevalence figures vary from 4% to 6.5%, or around 2.5 million people, and figures as high as 12% have been mentioned.

In the Amathole district, health and rehabilitation services are based at Madwaleni District Hospital, a rural 200-bed secondary hospital. Up to 2007, when rehabilitation services were introduced, the hospital paid no specific attention to disabled people. However, with the introduction of community health care services and their policy for health and rehabilitation, a professional rehabilitation team joined the hospital's medical team. This team started community and home visits to locate people with disabilities living in the area as well as disability and rehabilitation awareness raising programmes. Eight clinics have been built around Madwaleni District Hospital as a result of the implementation of PHC. Doctors and rehabilitation professionals visit on specific days. The clinics are nurse-driven and are staffed by community health workers (CHWs), who mainly are young people trained in basic home care skills and working as volunteers. Both the hospital and its eight clinics face the challenge of staff shortages, especially with regard to medical and rehabilitation professionals.

Seen in an African context South Africa has a well developed welfare system. Many mothers choose to give birth in hospital in order to get a birth certificate and health card; documents that are necessary to access social grants as child support grants as well as disability grants when a person is disabled. More than 1.3 million South Africans currently receive disability grants (Statistics South Africa, 2007), and in the Eastern Cape about 74% of people with disabilities receive such grants (Loeb, Eide, Jelsma, Ka'Toni, & Maart, 2008). In the face of widespread poverty, social grants have become the main means of existence for many families. While this money may prevent complete destitution for individuals and families, it is not enough to escape poverty completely (Surender, Ntshongwana, Noble, & Wright, 2007). It appears, however, that if disability grants are combined with other grants such as old age pensions and child support grants, these grants may provide rural households with sufficient amounts of money to prevent dire poverty (Hansen & Sait, in press).

Methods

The fieldwork was carried out in November 2008 in the Madwaleni Hospital catchment area. The study was conducted as a joint effort between social scientists from Norway and South Africa.

We carried out in-depth interviews with a strategic sample (Kvale, 1996) of 24 people with a disability and/or their family members. Informants were identified by the rehabilitation personnel at Madwaleni District Hospital, by health workers at the local health clinics, by local chiefs and by snow-balling among community members. The informants represented a variety of life situations, types of disabilities, ages, family conditions and settlements. Included in the sample were people with bodily, sensory and intellectual impairment of all ages. For children below 18 years and persons that could not speak for themselves, caretakers were interviewed as proxies. The interview guide was developed for similar studies in Yemen and Kenya (Grut & Ingstad, 2006), and was further developed to accommodate the South African setting. The interviews with the persons with disabilities and their families were done by two teams consisting of one Norwegian and one South African researcher in each team. The interviews were done in the informants' homes. The language used was the

informant's mother tongue, in most cases Xhosa, with a simultaneous translation into English. We also carried out six semi-structured interviews with professional health workers at Madwaleni District Hospital, and seven interviews with professionals and five with unskilled health workers in four of the eight health clinics; Two clinics that were well-staffed and two that were under-staffed according to the Madwaleni District Hospital rehabilitation team. These interviews have been used as supplement data. The notes that were taken during the interviews were transcribed and discussed among the team members every afternoon during the field work. The data analysis was contextual and interpretive (Denzin & Lincoln, 2005). The challenges that poor people with disabilities encounter when trying to access health care services were analysed as experiences interwoven in the informants' everyday life, knowledge and life history.

Ethics

Ethical clearance was obtained from ethical research committees in Norway and South Africa. Consent was obtained from all informants.

Findings

This study shows that access to health care services for people with disabilities that are living in a resource poor context is influenced by several factors. Looking upon each factor separately without understanding the connection between them can easily make us think that some of them are rather trivial. By taking a deeper look into the situation it is evident that many different elements appear together creating a situation with significant obstacles. The combination of the different factors creates barriers to accessing health care services even when there are health care services in the area. The most significant factors are:

- Poverty; understood as lack of money to buy goods and services
- Landscape and ecology, of which terrain and lack of transport are significant barriers
- Social forces of the past and the present, of which unemployment and labour migration, lack of knowledge of health and illness and how to keep a good health are major barriers
- The health care services system, of which lack of local health care services and the health workers' attitudes and lack of understanding are major barriers.

We will illustrate these findings through a case that comprises the principal findings of the study. The family in this case consists of an elderly couple and their disabled son; let us call him Mthunzi, who is in his thirties.

The story of Mthunzi

Tamara (which is a proxy name), an unskilled community health worker (CHW) told us about a patient she perceived to be particularly difficult. For the past three years she had provided regular visits to this family. She told us that the parents were neglecting their disabled son: *"They have never taken him to the clinic. They will not take him because they do not care if the patient lives or dies. They only take him to traditional healers"*. At one point she had sent the village headman to convince the parents to take him to the clinic and she has offered to bring him herself in a wheelbarrow, but the parents have refused. The family lives four hours walk on narrow gravel roads from the nearest health clinic, with steep paths to climb up and down. All visits by the CHW are done by foot as no car or public transport is

available in that area. Her tasks, as she sees it, are to advise the parents on how to care for their disabled son and encourage them to take him to the clinic to receive medication. She took us to see the family.

Mthunzi has epilepsy as well as physical and mental impairment. He was born at home and has never been registered for an ID card. Thus, he has no disability grant. He is the only son in the family and there are no other close relatives nearby. During the years the mother has stayed at home in order to run the household and take care of Mthunzi. The father has been away for long periods working in the mines in Johannesburg until he was injured some years ago. He has been unemployed since then. He has not received any compensation from the mining company. In the past the family had several cows and sheep which they have sold one by one in order to buy food. At the moment they have three sheep left. They have no access to safe drinking water or latrines, and there is no electricity in the area.

Mthunzi's parents say they have tried everything to help their son. He was a healthy child up to three years of age, when he got pains in his back and bones. The mother took him to Madwaleni District Hospital, which took a whole day by foot each way. He was hospitalised for a year and a half, and during this period he developed epilepsy. The parents do not know what the doctors at the hospital did to him neither do they know why he developed epilepsy. He was eventually discharged with epilepsy medication, but the medication did not eliminate the seizures, and they soon stopped going to the hospital for more tablets. When they took him to a traditional healer they were told that he had been bewitched by a close relative. This created a feeling of despair as they had a good relation to this relative. Shortly after, lightning struck their house. This encounter with misfortune raised a feeling of hopelessness, and they gave up seeking for a treatment for his condition.

Through the years without medication the epilepsy has worsened and Mthunzi has gradually developed mental and bodily disabilities. In the past few years he has had seizures five to six times a day. Because of his severe epilepsy the parents never leave him alone. Although he is not paralysed it is difficult for him to walk. He does not talk and spends most of his time sitting outside the hut. He seems not to understand much of what happens around him. He is big and strong and his parents are afraid of him. The only way to transport him to the clinic is by wheelbarrow but they avoid doing so because it is too far to walk and the hills are too steep for them to manage. Furthermore, when he is transported he will most likely have seizures, soil himself and be violent. This situation is embarrassing, laborious and frightening to them.

Discussion and analyses

Earlier studies have pointed to a number of factors that render health care services inaccessible for people with disabilities. These include unavailability and inaccessibility combined with financial constraints and ignorance of available services, inadequate and inaccessible transport and lack of visible improvement after therapy (Saloojee, Phohole, Saloojee, & Ijsselmuiden, 2007). Mthunzi's case illustrates how people with disabilities living in a resource-poor area experience a number of barriers associated with individual and societal poverty. People's choices and decisions must be understood within this context. The interaction of many negative factors creates difficult situations and prevents people from accessing health care services even when there are services available in the area.

Skilled health personnel are trained to relate to a set of guidelines and instructions within the frame of their training and job tasks. They seek to fulfil their

obligations as professionals (Abbott & Meerabeau, 1998). This colours their expectations to the patient of what is a reasonable way to handle a health problem. When health service users are non-compliant with the prescribed treatment or therapy, this study and previous studies have shown that health workers may conclude that the disabled person is neglected by the family and not properly cared for (Ingstad, 1997). This might be interpreted as shifting the blame to the 'victim' (Ingstad, 1995) and might be interpreted as lack of compassion from the health care provider. These types of perceptions serve both parties no good. The reasons for Mthunzi's parents not to take him to treatment are many. We need to look not only at the problems of the individual person with a disability in order to understand the rationale behind his situation, but at the whole care unit; "the disabled family" (Ingstad, 1997).

In Amathole district the terrain is obviously one of the main barriers to accessing and providing health care services. If there had been good roads and affordable public transport the terrain would not have represented a barrier. Public transport in the form of small pickups does exist, but poor people can rarely afford it. If they can afford it, public transport is only available on the main roads, which is a long walk for most people. Disabled people or sick people need to be accompanied, which implies paying extra. Wheelchairs are only exceptionally admitted, and only when charged extra. A person that does not behave in a socially acceptable manner will not be permitted in the pickup.

In principle health care is free for disabled people in South Africa, but this study shows that in reality there are substantial costs attached to accessing it. There are costs related to transport, sometimes medication, accommodation and food for the patient and accompanying family member. Like Mthunzi's father, many of the men in this area have to stay away from their families for long periods in order to find work. As unskilled and underpaid workers there is not much money to send home. Because of this the mother of a disabled child, or in even more cases; the grandmother, is likely to be alone with the daily household responsibilities. Because of the impoverished landscape (Crais, 2002) there is not much to grow and the families rarely can get an income from what they grow. People that are day workers lose the opportunity to get an income while they stay at the hospital or the health clinic. In a situation like this, there is not much money to spare for health care services.

Adding to this there is a general lack of health personnel in South Africa. This is even more pronounced in rural areas like Amathole district, as these areas are undesirable for qualified personnel in spite of governmental financial incitements. While there are skilled health professionals at the Madwaleni District Hospital and at the clinics, they do not have the capacity to work outside the health facilities. The home-based care programme is based on the use of community health workers who have very limited training and only very basic health care knowledge. As volunteers they are unpaid and they are not allowed to carry or prescribe medication. They receive instructions from health professionals high up in the hierarchy of the health system. From their subordinate placement it is not right to question these instructions.

On the other hand, the disabled people and their families in this study seek first and foremost to improve their life situations. In Mthunzi's case this implied improving his health by having the epileptic seizures stopped or reduced to a minimum, and the aggressive behaviour modified. The parents of Mthunzi had learned that the best way to avoid seizures were to leave him in peace and not take him away from home. As the community health workers were prohibited from bringing medication to the houses the home-based care services were unable to provide Mthunzi with the health care services he needed. Another way to support the

family could be by disability grants as this could strengthen the family's financial situation. However, disability grants are only obtainable for those who show up at the hospital and registered for a health card.

Similar to many of the informants in this study, the parents of Mthunzi saw little use in making the effort to bring him to the clinic for medication. The effort involved in moving him was not worth the gain of getting a medication that the parents had perceived as having no sustainable effect. In fact, the journey might cause them embarrassment and danger by him having a fit of rage and soiling himself. Given their situation, this non-compliance could be understood as a rational choice.

Many of our other informants had made similar assessments. The chance of receiving help from the health professionals was weighed against the money spent and the effort and social costs involved. Some informants did make the effort to get the clinic, only to find out that not much could be done, or they got explanations or instructions from the doctors that they could not understand or relate to.

Like the parents of Mthunzi many of the informants lacked knowledge on how to acquire and sustain good health as well as knowledge about training and rehabilitation. In particular they lacked knowledge on how medical treatment works. Those who had some knowledge often lacked the means to comply with it. For instance, some informants knew about the risk of epilepsy due to Tapeworm infections, but they had no access to bore hole water, neither did they or any of their neighbours keep the pigs fenced in, in order to prevent the water from being infected by the animals' droppings. Thus, the informants all too often had to choose between high costs - use of scarce money, effort and energy - weighed against their daily chores and responsibilities. These choices were made against a background of experience and knowledge on how to sustain and gain good health, expectations of a cure and how health, illness and (mis)fortune are understood within the cultural context.

The lack of compliance of people like Mthunzi's parents, faced with the double burden of poverty and caring for a multi-handicapped adult son, should be recognised and understood as a rational choice against a background of a social suffering with deep historic roots.

Conclusions

When offering health care services to people with disabilities that live in resource-poor settings, services should be based on the patient's perspective by taking into consideration the needs as well as the resources and abilities of the family group. Rethinking the notion of access to health and rehabilitation services in this rugged, under-resourced area, should also call for a need to transcend the narrow medical institutionalization of health professional's training and include a social vision in their understanding and practice. Further, in consistency with an extended health professional approach there is a need to develop the training and the tasks of the unskilled health workers.

The close link between disability and poverty cannot be underplayed and should be integrated with health policy and strategies. Future development of health care services should focus on bringing the services out to the disabled person and the families; with a stronger emphasise on mobile and home-based services. In cases where this is not possible there is a need to strengthen the transport facilities in order to bring the patient to the hospital.

Focusing on the perspective of the disabled person and the family requires looking for innovative models that integrate the skills of health professionals with the

skills of disabled people and their family members. Such skills lie dormant at community level, influenced strongly by the well established system of Ubuntu, and need to be recognized and utilized.

In South Africa it is expected that institutional structures such as health and rehabilitation services support and respond to policy implementation and health strategies. However, these objectives are difficult to achieve in a society where the majority of the population experience gross poverty and inequality. Problems affecting families from the poorest of the poor, such as disabled people, becomes enormous. When focusing solely on the limited resources in the health care services and the lack of compliance of the patient, there is a risk of letting the resources of the family and the community to lie dormant. A further question that deserve a critical examination is whether individual-based incitements such as disability grants serve as a substitute for inclusive work and education, and as a pretext for the authorities to do nothing about improving the infrastructures in the area, such as improving the roads, and providing safe drinking water and sanitation facilities.

References

- Abbott, P., & Meerabeau, L. (1998). *The sociology of the caring professions*. London: UCL Press.
- Barron, P., & Roma-Readon, J. (Eds.) (2008). *South African Health Review 2008*. Durban: Health Systems Trust.
- Boon, M. (1996). *The African way - The power of interactive leadership*. Johannesburg: Struik Publishers.
- Crais, C. (2002). *The politics of evil: Magic, state power, and the political imagination in South Africa*. Cambridge: Cambridge University Press.
- Denzin, N.K., & Lincoln, Y. S. (2005). *The Sage handbook of qualitative research*. Thousand Oaks, Calif.: Sage.
- Elwan, A. (1999). Poverty and disability: A survey of the literature. Washington DC: The World Bank Social Protection Unit.
- Farmer, P. (2001). *Infections and Inequalities: The modern plagues*. Berkeley, Calif.: University of California Press.
- Gray, A., & Clarke, E. (2000). *Critical choices for South African Society: Health and the Mbeki government*. Cape Town: Political Studies Department, Cape Town University, Institute for the Study of Public Policy.
- Groce, N.E., Yousafzai, A., Dlamini, P., Zalud, S., & Wirz, S. (2006). HIV/AIDS and disability: A pilot survey of HIV/AIDS knowledge among a deaf population in Swaziland. *International Journal of Rehabilitation Research*, 29(4), 319-324.
- Groce, N.E., & Zola, I.K. (1993). Multiculturalism, Chronic Illness, and Disability. *Pediatrics*, 91(5), 1048-1055.
- Grut, L., & Ingstad, B. (2006). Using qualitative methods in studying the link between disability and poverty. Developing a methodology and pilot testing in Kenya. Washington D C: The World Bank.
- Hansen, C., & Sait, W. (In press). "We also are disabled". Disability grants and poverty politics in rural South Africa. In B. Ingstad & A. H. Eide (Eds.), *Disability and poverty: A global challenge*. Oslo: The Policy Press.
- Ingstad, B. (1995). Mpho ya Modimo-A Gift from God: Perspectives on "Attitudes" towards Disabled People. In B. Ingstad & S.R. Whyte (Eds.), *Disability and Culture*, pp. 246-263. Berkeley: University of California Press
- Ingstad, B. (1997). *Community-based rehabilitation in Botswana: The myth of the hidden disabled*. Lewiston, N.Y.: Edwin Mellen Press.
- Ingstad, B., & Whyte, S. R. (2007). Disability connections. In B. Ingstad & S. R. Whyte (Eds.), *Disability in local and global worlds*, pp. 1-29. Berkeley: University of California Press.

Jelsma, J., Maart, S., Eide, A., Ka'Toni, M., & Loeb, M. (2007). The determinants of health-related quality of life in urban and rural isi-Xhosa-speaking people with disabilities. *International Journal of Rehabilitation Research*, 30(2), 119-126.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Thousand Oaks, Calif.: Sage.

Loeb, M., Eide, A.H., Jelsma, J., Ka'Toni, M., & Maart, S. (2008). Poverty and disability in Eastern and Western Cape Province, South Africa. *Disability & Society*, 23(4), 311-321.

Mattes, R., & Bratton, M. (2009). Poverty reduction, economic growth and democratization in Sub-Saharan Africa. In *AFROBAROMETER*, Briefing Papers: AFROBAROMETER

Rohleder, P., Braathen, S. H., Swartz, L., Eide, A.H. (2009). HIV/AIDS and disability in Southern Africa: A review of relevant literature *Disability and Rehabilitation*, 31(1), 51-59.

Ross, E. (2008). Traditional healing in South Africa: ethical implications for social work. *Social Work in Health Care*, 46(2), 15-33.

Saloojee, G., Phohole, M., Saloojee, H., & Ijsselmuiden, C. (2007). Unmet health, welfare and education needs of disabled children in an impoverished South African peri-urban township. *Child; care, health and development*, 33(3), 230-235.

Smith, E., Murray, S.F., Yousafzai, A.K., & Kasonka, L. (2004). Barriers to accessing safe motherhood and reproductive health services: the situation of women with disabilities in Lusaka, Zambia. *Disability and Rehabilitation*, 26(2), 121-127.

Statistics South Africa. Community survey (Revised version) 2007 (2007). www.statssa.gov.za

Surender, R., Ntshongwana, P., Noble, M., & Wright, G. (2007). *Employment and social security: A qualitative study of attitudes towards labour market and social grants*. Department of social development, RSA.

The World Bank (2000). *World development report - attacking poverty: overview*. Washington DC: The World Bank.

Van Niekerk, J. (2007). In defence of an autocentric account of *Ubuntu*. *South African Journal of Philosophy*, 26(4), 364-368.

Veary, C.M., & Manoto, S.N. (2008). Neurocysticercosis: a possible cause of epileptiform seizures in people residing in villages served by the Bethanie clinic in the North West Province of South Africa. *Journal of the South African Veterinary Association-Tydskrif Van Die Suid-Afrikaanse Veterinere Vereniging*, 79(2), 84-88.

Yeo, R. (2005). Disability, poverty and the new development agenda. Reducing poverty study: Disability KaR Knowledge and Research.