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The Role of Occupational Therapy in Implementing Inclusive Education in a Residential Care Facility: A Case Study

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THE ROLE OF OCCUPATIONAL THERAPY IN IMPLEMENTING INCLUSIVE
EDUCATION IN A RESIDENTIAL CARE FACILITY: A CASE STUDY

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Erica Steinhoff

Lungisisa Indlela Village (LIV)

Advisor: Robin Joubert

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Abstract

South Africa has been in the process of implementing inclusive education since 1996, and recent research has emphasized that strong education support services are needed to achieve inclusive education. In order to better understand the role that occupational therapy plays in implementing inclusive education, I explored how occupational therapy intersects with the implementation of inclusive education at Lungisisa Indlela Village (LIV), a residential care facility for orphaned and vulnerable children with approximately 200 children in Verulam, South Africa.

I conducted a case study by engaging in participant observation in everyday activities around the village with the children, conducting informal interviews with the special needs class teacher, the occupational therapist, and the speech therapist, and observing the full-time occupational therapist in therapy sessions and her daily work routine over the course of three weeks.

Through my inquiry, I discovered that occupational therapy plays a large role in assisting disabled students and supporting teachers in inclusive classrooms, as well as determining which children may succeed in an inclusive classroom as opposed to a special needs class. The occupational therapist at LIV embraces the social model of disability which motivates her to look for ways to adapt each child's environment in order to make him or her successful in the classroom. Although LIV has not achieved full inclusion by the standards set by the South African government in the Education White Paper 6, it has created an inclusive community culture and attempts to provide all children with an equitable chance at receiving an education.

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Introduction

Research Question

The aim of this study is to attempt to explore how the occupational therapy services provided at Lungisisa Indlela Village (LIV)—a residential care facility for orphaned and vulnerable children with approximately 200 children in Verulam, South Africa—play a role in the institution’s implementation of inclusive education, and evaluate the effectiveness of LIV’s occupational therapy services in achieving the country’s goals for inclusive education. My objectives are: to observe the occupational therapist in her therapy activities to understand how occupational therapy is provided to the children and integrated into their education, to interview staff members to understand how they believe they are implementing inclusive education, to observe the children in the special needs class and mainstream classes to understand how the children with disabilities receive an education, and to research inclusive education policies in South Africa in order to compare the country’s goals with my findings from LIV.

I approached this exploration using a case study because I wanted to conduct an inquiry into the intersections between occupational therapy care and the implementation of inclusive education in South Africa, and due to the time constraint it was only appropriate to study one institution. Another consideration was that this institution is well-funded enough to have a full-time occupational therapist. Although their institution is unique, as a residential care facility and not merely a public school, their institution is based on a model for large-scale change, and they intend to replicate their model throughout South Africa. Their school is run similarly to an average primary school in South Africa, so lessons learnt from their model could potentially be applied to both other residential care facilities and public schools in the future; however, the conclusions from my case would have to be compared with other researchers’ case studies before

that generalization could occur. Thus, my ultimate aim for conducting this study is to add one case to the body of research related to this topic in South Africa, and possibly inspire more research to be conducted on this topic.

Therefore, I attempted to discover how LIV provides occupational therapy services to its children and creates an inclusive education system so that my findings could be compared to the goals of the policy on inclusive education and education support services in South Africa. This study is timely because the country is still struggling to achieve the goals of its inclusive education initiatives that were announced beginning in 1996.

Frequently Used Terms

LIV: Lungisisa Indlela Village

ESS: Education support services

OT: Occupational therapy

SIAS: National Strategy on Screening, Identification, Assessment and Support

Context

Literature Review

Education for the disabled in South Africa before 1994. In South Africa, disabled children have historically been largely excluded from receiving a proper education. During apartheid, schools were racially segregated, as well as segregated in terms of disability. Education was compulsory for white pupils, but not for learners of other races or for learners with disabilities (Department of Education, 2001). A severe disparity existed between the amount of support given to learners with disabilities based on their race; for example schools for white learners with disabilities were well-funded (Department of Education, 2001), whereas support services for learners with disabilities who attended schools for blacks were uncommon (Department of Education, 2001; Lomofsky & Lazarus, 2001) and few and far between.

Goals for inclusive education. Since democracy was established in South Africa in 1994 and there was a push for the government to provide services to all citizens on an equitable basis, there has been more concern for the provision of education for learners with disabilities. Similarly, at the time of the birth of democracy in South Africa, a general paradigm shift was beginning with the target of moving toward the Alma-Ata conference's definition of health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" and the declaration that "[health] is a fundamental human right;" (Declaration of the Alma-Ata, 1978, p. 1) This definition of health affirmed the idea that facing discrimination and being denied the right to an education is detrimental to one's holistic health. Thus, the development of an inclusive education system can be traced back to the founding document of South Africa's democracy, Section 29 (The Bill of Rights) of the *Constitution of the Republic of South Africa, Act No. 108 of 1996*, which states that everyone has the right to "a basic

education... which the State through reasonable measures must make progressively available and accessible.” It also states that the State may not discriminate directly or indirectly against anyone on one or more grounds, including disability (Republic of South Africa, 1996, p. 12).

Building on that declaration, in 2001 the Department of Education laid the framework for an inclusive education system in the Education White Paper 6: Special Needs Education: Building an Inclusive Education and Training System (Department of Education, 2001). This policy outlines the government’s goal for “a single, undivided education system for all learners,” including those with disabilities, and calls for a significant conceptual shift regarding the provision of support for learners who experience barriers to learning asserting that all children, youth, and adults have the potential to learn given the necessary support (Department of Education, 2001, p. 29-30). It advocates for an integrated system for all learners (i.e. no special and ordinary schools) through the use of a curriculum that is more flexible and suitable to the needs and abilities of learners, the development of district-based support teams to support teachers, and the training of teachers so that they have the skills to cope with more diverse classes (Muthukrishna & Schoeman, 2000).

One of the main strategies that the Department of Education has adopted to guide the implementation of the desired inclusive education outcomes outlined in the Education White Paper 6 is The National Strategy on Screening, Identification, Assessment and Support (SIAS). The SIAS was developed as a tool to assist educators in identifying and removing barriers to learning. In contrast to previous approaches to assessment that focused on health conditions and impairment, the “SIAS focuses on removing barriers to learning and development and moving towards the provision of appropriate support...[with] the aim of bringing the support to the learner, rather to taking the learner to the support” (Department of Education, 2011, p.10). The

SIAS strategy attempts to achieve that purpose through an “overhaul [of] the process of identifying, assessing and providing programs for all learners requiring additional support so as to enhance participation and inclusion” (Department of Education, 2001, p.7).

As mentioned, the SIAS process follows four stages of screening, identification, assessment, and support. The first stage focuses on creating a learner profile from information obtained on the learner’s background in order to understand his or her needs, as well as strengths and aspirations. The second stage involves identifying barriers to learning and development, and compiling an in-depth profile of the learner, ideally in consultation with the parents so that contextual factors that may impact on learning and development may be identified. The third stage involves assessing the learner’s support requirements. A review of the impact of the school and an analysis of its capacity to improve is conducted, as well as an identification of community resources. The fourth stage involves action planning, provisioning and monitoring the necessary additional support (Department of Education, 2008, p. 10-11). Following these four stages of the SIAS will ensure a comprehensive evaluation of the learner is completed before they are either mainstreamed or enrolled in a special needs school.

Current implementation of inclusive education. Today the South African government’s goals for inclusive education are far from being realized. The most recent census conducted on disability in South Africa found that approximately “110,300 learners with disabilities are attending ordinary public schools,” while “423 special needs schools nationwide are catering for approximately 105,000 learners.” There has been progress as the number of “full-service schools—schools that are equipped to support a range of disabilities—has grown from 30 in 2008-2009 to 513 in 2010-2011” (DSD, DWCPD, and UNICEF, 2012, p. 45) but

there is by no means “a single, undivided education system for all learners” in South Africa currently (Department of Education, 2001, p. 29-30).

Because of the legacy of severe disparities between citizens of different races and many families’ poor socioeconomic conditions, “learners [in general] are [commonly] faced with personal and environmental stressors that put them at risk for emotional, behavioural and academic difficulties” (Engelbrecht, Green & Naicker, 2003, p. 19). In educational contexts, socioeconomic-related factors contribute to high teacher to learner ratios, shortages of textbooks and other resources, and limited provision of school and district-based educational support (Muthukrishna, & Schoeman, 2000).

Learners with disabilities often face these challenges in an exacerbated manner, which has led to “up to 70% of children of school-going age with disabilities [being] out of school, and [children who do attend school attending] separate “special” schools for learners with disabilities” (Donohue & Bornman, 2014, pg. 1). Recent research has shown that “the implementation of [inclusive education] policies are hampered by the lack of teachers’ skills and knowledge in differentiating curriculum to address a wide range of learning needs” (Dalton, Mckenzie & Kahonde, 2012, p. 1), as well as “[a] general lack of support and resources and prevailing negative attitudes toward disability” (Bornman & Rose, 2010, pg. 7).

In terms of the provision of education support services, although there is a dearth of recent research on the availability and accessibility of these services across South Africa, a qualitative study of the experiences of educators in three primary schools in the Gauteng district in 2009 revealed that there is a serious lack of education support specialists in that area. According to Health Systems Trust, there are 1,313 registered occupational therapists in the public sector in South Africa, although an unknown number of those therapists are based in

schools (2015, n.p.). And although the exact numbers are unknown, there has been a reported increase in the number of occupational therapists working in mainstream schools in recent years in South Africa (Hargreaves, Nakhooda, Mottay & Subramoney, 2012, p. 1).

To support all learners, “district-based support teams ideally should include therapists, such as occupational therapists and speech therapists, along with counsellors and psychologists, and although provision is made for such posts they are not easily filled because positions are more attractive in the private sector” (Ladbrook, 2009, p. 54). As a result of the lack of sufficient education support specialists, “educators [sometimes] have to take on some of the work of paraprofessionals, namely remedial teachers, occupational therapists and counsellors” for which they are unqualified (Ladbrook, 2009, p. 126). “Educators [also] have reported that they feel their roles as educators are both onerous and very stressful due to lack of parenting and lack of parental responsibility to seek professional support such as speech therapists, occupational therapists, and psychologists as supplementary to the service of the educators” (Ladbrook, 2009, p. 123).

Social Model of Disability

The traditional approach to thinking about disability, from both the medical professional and the average individual’s perspective, involves viewing the disability “as a problem that exists in a person’s body,” (Goering, 2015, p. 134) which has been found to result in people with disabilities often reporting “feeling excluded, undervalued, pressured to fit a questionable norm, and treated as if they were globally incapacitated” (Goering, 2015, p. 134). In response to this, disability activists and scholars have introduced the social model of disability. The social model of disability recognizes an individual’s impairment and a possible need for medical treatment, but it also identifies disability as a “disadvantage that stems from a lack of fit between a person’s

body and its social environment,...and [is] caused by a contemporary social organization which takes no or little account of people who have physical impairments excluding them from participation in the mainstream of social activities” (Goering, 2015, p. 134-135). The social model of disability also promotes the idea that the formation of an identity inclusive of disability is a positive experience that can help to improve an individual’s psychological wellbeing and adaptability (Dunn & Burcaw, 2013).

The use of the social model of disability as a framework for changing an education system can move the system from one of “integrated education—[which follows the] medical model of disability and sees the child as a problem and demands that the child is changed, or rehabilitated, to fit the system”—to one of inclusive education—which enables the school and the education system as a whole to change in order to meet the individual needs of all learners” (Miles, 2000, n.p.) (See Appendices A & B for a visual depiction of common ways of thinking associated with integrated and inclusive education).

It is especially relevant for South African medical professionals and education authorities to embrace the social model of disability because it is based on the principles of social justice that the country has been trying to adopt since the birth of its democracy. The social model of disability sees that “disability is being enforced on disabled people in addition to their impairment by a repressive and discriminating social structure” (Meltz, Herman & Pillay, 2014, p. 2). It then attempts to challenge this marginalization and discrimination by “removing the disabling barriers produced by dominant social and cultural institutions... [and] deconstructing these barriers by aiding in understanding” (Meltz, Herman & Pillay, 2014, p. 2).

Therefore, the social model of disability also recognizes secondary conditions, which are commonly defined as “additional physical or mental conditions that occur as a result of a disability or illness” (Field, Jette, & Martin, 2006, p. 27). These conditions are often “highly preventable and exist on both the individual and environmental levels” (Field, et al., 2006, p. 27). The social model of disability attempts to prevent these secondary conditions with its attention to environmental factors and social constructs that can negatively impact a person compounding his or her already existent impairment.

This model is considered by some to be the primary principle upon which inclusive education should be founded (Winzer and Mazurek, 2009). An inclusive school should use the social model of disability to become “a place where each person belongs, is accepted, supports and is supported by his or her peers and other members of the school community in the course of having his or her educational needs met” (Sunday, Anderson, Flack, Fisher, Greenhough, Kendal & Shadwell, 2012, p. 2). Thus, education support services provided to learners should align with this model. Educators and education support specialists should be aware that when following this model the ultimate aim should be to take action to ensure that equity in education and freedom from discrimination are achieved (Johannessen, 2008).

Background on LIV

LIV is a residential care facility for orphaned and vulnerable children in Verulam, South Africa. The Village currently has 198 children but its 96 homes can house 600 children, and it hopes to eventually reach full capacity. LIV’s mission is to create change on a large scale in South Africa and its slogan is “rescue a child, restore a life, raise a leader, and release a star” (LIV, 2015, n.p.). The village is based on a foster model where the children are not legally

adopted by the mothers, but rather they are fostered by the organization. The children are referred to LIV by the Department of Social Welfare and placed at LIV on a Foster Care Court Order under the Children's Act of 2008. Each child is cared for by a Mama, along with up to 5 other children, in her own home, and a Mama may also raise one or two of her biological children in her home. The mothers are selected from a group of women recommended to LIV by local church and community leaders who believe the women have a passion for caring for orphaned and vulnerable children. They are then trained for six weeks with continuous counseling and training for three months once they join the village. Additionally, the homes are grouped together forming "clusters" to give the children an extra sense of community. LIV is a Christian organization that is funded by local government grants, corporate, and individual donations and corporate investments in LIV business—the wholly owned subsidiary of LIV that aims to provide sustainability for the village and create jobs for local community members (LIV, 2015, n.p.).

Methodology

Because I conducted this study as a case study, I collected all of my primary data at LIV from October 31st, 2015 -November 21st, 2015. I chose to conduct a case study because it allowed me to investigate this complex issue in a limited time period. The case study allowed me to "optimize [my] understanding [of the topic through the] pursuit [of] scholarly research questions [while] concentrating on experiential knowledge of the case and [paying] close attention to the influence of its social, political, and other contexts" (Stake, 2005, p. 444).

The case study site was selected by convenience, as I visited LIV during a field visit with the School for International Training and selected the site at that time. I informally interviewed and observed one occupational therapist, one speech therapist, and one special needs educator. I

also observed 30 children that I encountered during the three weeks that I was gathering data. My observations were based convenience sampling because I only observed children or staff members in areas that I was given access to. For example, I only observed children in therapy sessions, in select classrooms, and public spaces on the village. I was not given access to observe the children in their homes. Similarly, my interviewees were selected based on convenience sampling, as I interviewed the three professionals familiar with my topic that I was given access to interview. I was not given access to interview social workers, psychologists or Mamas. I spent most of my time observing the occupational therapist at LIV. I observed her from 8:00 a.m.-12:00 p.m. Monday through Friday while she assessed children, engaged in therapy sessions, completed administrative work and interacted with other LIV staff members.

I utilized participant observation by living and volunteering at the organization for three weeks. I attempted to establish rapport with the community in order to be accepted as a member of the community for the short time that I was there. I informally interacted with the children and staff by participating in activities, such as church services, sports practices and bible studies on the village on weeknights and weekends. I chose to engage in participant observation, because it has been shown to provide “opportunities for viewing or participating in unscheduled events,” “improve the quality of data collection and interpretation, and facilitate the development of new research questions or hypotheses” as compared to nonparticipant observation (Dewalt & Dewalt, 2002, p.8). My ability to observe informal or impromptu interactions the between staff members and children was key to my study because my topic is based understanding the holistic care of the children, meaning the actions that occurred outside of normal working hours were particularly relevant.

I chose to employ informal interviewing, as opposed to structured interviewing, because “unstructured interviews [are] a way to understand the complex behavior of people without imposing any *a priori* categorization, which might limit the field of inquiry” (Punch, 1998). Hence, I thought informal interviewing would be the best method for discovering the authentic challenges as well as the successes of the organization. I kept a running questionnaire of specific questions that I wanted to ask the staff members to ensure that I got sufficient information from my informal interviews (see Appendix E for a copy of my questionnaire).

My data collection was limited because although I observed a wide range of children, I did not have adequate time to closely follow any children throughout their entire daily routines so my observations clearly cannot produce deep insights into individual children’s experiences. Additionally my restricted access allowed me to only observe a small proportion of the LIV children causing me to miss some children’s experiences and limiting my findings. As a result, my findings by themselves are in no way representative of other facilities, residential care facilities or schools, in South Africa; my findings are only intrinsic and applicable in this case.

Moreover, because participant observation is an inherently subjective method of data collection, I had to spend time intentionally filtering out my personal bias from my observations. I took extensive field notes of my observations and informal interviews, and I kept a reflective journal to try to identify the biases in my observations and reflect on my own experiences. Through this reflection, I realized that while taking field notes I was biased towards believing that LIV is successful because I was observing first-hand the maximum effort and passion of the staff members who were trying to make LIV successful, and I didn’t want to believe that their efforts may be in vain. In the same way, I was conscious of the bias of the staff members and

volunteers who believe that LIV's model is the best model because they are dedicated to the organization and the Christian values that it attempts to embody.

I also had to be conscious of the language barrier because, at times the staff members and children would speak in IsiZulu that I could not understand, potentially causing me to miss negative interactions between them. Additionally, I had to take into account the fact that my presence may have influenced the findings because staff members may have intentionally distorted their actions and behavior in order to appear more successful or efficient than usual.

Lastly, I used the social model of support (based on the social model of disability mentioned above) as my conceptual framework for evaluating the effectiveness of the occupational therapy services at LIV in implementing inclusive education. I have selected this model because I found that many experts have agreed that it should be the foundation for implementing inclusive education. Additionally, it aligns with the government's goals for inclusive education in South Africa.

Ethics

In order to conduct this study, I adhered to strict ethical guidelines because I was working with vulnerable populations, orphans and minors. Additionally, because I was volunteering with and observing at LIV, I had to give consideration to the protections that LIV is entitled to as an organization. I discussed my role in the organization with the volunteer coordinator, and she gave me written permission to conduct and write a report on this study. She also gave me written permission to observe and interview the occupational therapist, the speech therapist, and the special needs teacher, as well as observe any activities that the children were involved in on the village. In addition to the volunteer coordinator's permission, I obtained informed consent from

each staff member that I observed and interviewed (see Appendix D for a blank copy of the informed consent form). The volunteer coordinator also confirmed that LIV did not want to bar publication or request anonymity in the report.

Additionally, whenever I observed a child's therapy session, I made sure that they were comfortable with my presence. Thus, I was very careful not to cause any harm or distress to the children with my presence. I also ensured that I did not mention any participant who wanted to remain anonymous in any written report, and I kept my collected data confidential by keeping all documentation related to this study on my computer under password protection. Similarly, before beginning this study, I obtained authorization from the School for International Training and a local Human Subjects Review Board to conduct this study (see Appendix C for the completed LRB action form).

I carefully chose my methods of data collection to ensure sensitivity by not being intrusive with my methods or questions asked during the informal interviews. I chose not to interview any children since the children at LIV are an especially vulnerable population, and there are strict laws concerning releasing information about children in residential care facilities. I also chose participant observation as my main method to avoid "othering" the children and staff members, because I was entering a space that they call home; I believe that using more formal research methods such as focus groups or surveys would put up a researcher-participant barrier and make the children and staff feel like subjects of research rather than just fellow human beings I am interested in learning about. Similarly, I chose informal interviewing because I thought it would be insensitive to ask questions about the children from the staff members in formal interviews because the staff members treat the children like they are their family members, and vice versa (the children call the staff "Auntie" or "Uncle"). I chose my questions

in my interviews very carefully to ensure that I was sensitive and not deceptive. Lastly, I did not use any form of inducement or reward to get information from my informants.

I believe that it was ethical for me to enter LIV, the space that many children and staff call home, in order to conduct this study because I significantly benefitted the organization while I was there. I tried to benefit the children with my presence in the organization, by being a positive presence in their therapy sessions and engaging with and entertaining them in my free time. Additionally, I benefitted the occupational therapist and social workers by assisting them with running and collecting kids from their classes and bringing them for therapy or counselling sessions. Likewise, I engaged in normal LIV volunteer duties, such as helping with Sunday school and planning games for the children on Saturdays.

The most ethically challenging part of this study was balancing the need to disclose the fact that I was making observations for a study, while not disrupting the normal activities and behaviors of the people I interacted with. In order avoid to being intrusive I only entered private spaces, such as the classrooms, when invited or serving a specific purpose such as assisting the occupational therapist. In addition, I tried to be completely open about my purpose for being there in my initial interactions with LIV community members, and I avoided making them uncomfortable by taking field notes only after leaving their presence. Furthermore, if someone asked me about my purpose in being there or my study, I was open and answered their questions with truthful and direct answers. In order to protect their privacy, I always offered them the chance to stop a discussion, withdraw from the process, or make any information confidential or anonymous at any time.

Primary Source Findings

Profile of the Therapy Department

LIV has a full-time occupational therapist, Ros Irving, who works from 8:00 a.m.-5:00 p.m. Monday through Friday and lives on the village. She is not paid by LIV, but rather she is sponsored by a private company that donates her salary annually. The same company also donated all of the equipment that she has in her therapy room which includes, but is not limited to: fine motor games, toy cars, hula-hoops, a ball pit, exercise balls, foam building blocks, swings, mirrors, and dry erase boards. Ros has been working full-time and living at LIV for two years, although she began volunteering at the organization a year before she joined the staff. Ros said that she wanted to work for LIV because she believes that LIV has the ability to transform a large number of children's lives through their unique model of care (R. Irving, personal communication, Nov. 11, 2015)

In the therapy department, there is also a part-time speech therapist, Jade Hodgkinson, who works two days a week from 8:00 a.m.-5:00 p.m. on Mondays and Thursdays. Jade has been working at LIV for six months. When she is not working at LIV, she works as a pediatric speech therapist in a private practice, as well as two public schools (J. Hodgkinson, personal communication, November. 7, 2015).

Profile of Disabled Children at LIV

There are at least 30 disabled children currently at LIV, including three children with severe cerebral palsy. The exact number of disabled children is unknown because many of the children have not been officially diagnosed with any specific condition, although most appear to have some sort of intellectual or physical disability. According to Ros, many of the children

are not diagnosed because the government did not want to pay for the medical tests to diagnose the children when they were in the government's care, and now that they are at LIV, there are too many of them for LIV to afford the genetic or blood tests that are necessary to diagnose most impairments or conditions. Of the children who have known diagnoses, there are children with Attention Deficit Hyperactivity Disorder (ADHD), autism, mild to severe cerebral palsy, hearing impairments and partial blindness (R. Irving, personal communication, Nov. 11, 2015).

Profile of Education System at LIV

There are 22 children in the special needs class at LIV. The special needs class is held in a classroom separate from, but adjacent to, the normal school building. The children in the special needs class range from age six to twelve years old, but their cognitive abilities appear to all be fairly equal. The special needs class teacher, Kate Hunt, said that her objective in the classroom is to increase their basic reading, writing, speaking, and math skills while also placing a large emphasis on teaching them English. Her secondary goals are to help them improve their gross and fine motor skills (K. Hunt, personal communication, November 3, 2015).

According to Kate, the children are placed in or graduate from her class based an annual assessment by herself, the social workers, the principal of the school, and the occupational and speech therapists. The assessment judges each child's progress in her class and their potential capacity to benefit from and engage well in another class in the school (K. Hunt, personal communication, November 5, 2015).

Profile of Occupational Therapy at LIV

Occupational therapy assessments. In order to determine which children require occupational therapy, Ros has assessed all 198 children on the village. She chose to assess every

child because she believes that the children at LIV have a high risk for developmental delays since many of them come from poor or abusive homes and have endured traumatic childhoods. Even though it has taken her almost two full years to be done with all of the assessments, by doing 3 to 4 assessments a week, she said that she is glad that she assessed every child because she feels that it is the only way to make sure that every single child receives the attention and, ultimately, the therapy they may need. By initially assessing every child she can determine a need for therapy before a severe developmental delay develops. She continues to assess each new child that joins the village as they arrive. When determining their need for therapy, she looks at not only their current ability but their capacity to improve because she knows that her therapy is a limited resource, and she wants to give therapy to the children who will be able to benefit the most from it (R. Irving, personal communication, Nov. 11, 2015).

Although she does not rely solely on teacher referrals, she does use teacher referrals to catch any issues in a child's development that may have come about since she initially assessed him or her. She tells the teachers to pay close attention to their children, and she makes them aware of what signs to look for in their children's development specific to their age group.

When assessing children, Ros looks at their ability to accomplish a list of tasks that allows her to assess their fine motor skills, (including pencil skills, motor control skills, bilateral skills and hand skills) gross motor skills, play skills, and their ability to accomplish activities of daily living. She also often completes pre-arrival assessments of children in order to understand the extra support systems that any given child may need and to ensure that LIV is prepared to provide that support before the child arrives. In one instance, I observed her assessing eight special needs children who were going to join the village in the coming months when the orphanage that they currently lived at was scheduled to close. During the pre-arrival assessments,

she took careful notice of each child's ability to perform the activities of daily living because she wanted to ensure that each child was placed with a mother who would be prepared and willing to assist the child every day in the necessary manner.

Additionally, Ros completes assessments of the children in order to evaluate their progress after having a block of therapy or to evaluate their progress in relation to an environmental change or a change in their medical care. For example, Ros assessed a child in the special needs class six months after she was placed in the class, and she assessed another child two months after she was placed on a new ADHD medication.

Free play. Ros places a large emphasis on allowing the children time to engage in free play. At the end of every session with a child, she gives them five to fifteen minutes to play with whatever game or toy they would like to play with. She said that she gives them this time dedicated to free play firstly because she wants "them to learn how to engage in free play since many of them come to LIV not understanding free play as a result of their traumatic childhoods" (Ros Irving, personal communication, November 15, 2015). Secondly, she wants the children to enjoy the therapy room so that they'll want to come back for their next therapy session. She explained that "self-initiated free play experiences are vital for the normal development of children" (Ros Irving, personal communication, November 15, 2015).

For the same reasons, she also brings the whole class of daycare children to the therapy room once a week for a session of free play. She gives the children no prompting or direction and allows them to decide which toys to play with, how to play with them and encourages them to use their imaginations to entertain themselves. She only supervises the sessions to mediate fights between the children. During the free play sessions, I observed most children engaging with the toys with some running from one toy to the next every several minutes, and I observed

only one child sitting alone and barely touching any toys. The few children who sat alone appeared to be confused about what toys to play with and how to play with them.

Ros has been giving these children this weekly free play session once a week for a six months, and she says that she has seen a great improvement in their abilities to engage in free play. She said that when she first started these sessions many of the children could not self-initiate free play, and they did not know what to do. They would either wonder around aimlessly without playing with any of the toys or simply sit alone.

Inter-sectoral Collaboration at LIV

Ros collaborates with staff members across the education and medical departments. She often collaborates with the psychologists and remedial specialists to ensure that children aren't being overloaded with therapy. For example, she recommended that one child may benefit from a further block of occupational therapy, but she did not want him to undergo that therapy at the same time as receiving one-on-one lessons from a remedial reading specialist. She also often refers children to medical professionals outside of LIV, such as behavioral optometrists, if the medical professionals at LIV are not able to properly fulfill the child's needs. She even takes on the role of calling for collaboration between other departments. In one instance, Ros initiated a meeting between a child's social worker, daycare teacher, psychologist, speech therapist, and Mama in order to talk about addressing violent behavior that the child was beginning to exhibit.

Combined speech and occupational therapy sessions. Every week the occupational therapist, Ros, and the speech therapist, Jade, run combined therapy sessions for the children in the daycare (ages 1 and 2) and the children in Grade RRR (ages 3 and 4). Each combined therapy session is one hour long and allows the children to interact with each other and the therapists

while they improve their speech and fine motor skills. Each therapy session usually involves the class collectively singing two speech therapy songs and playing two occupational therapy games used to improve their fine motor skills or tactile perception.

Both therapists agreed that it is beneficial to engage the children in combined therapy sessions because many of the interventions complement each other and the skills that are practiced during therapy overlap. For example, during a game used to improve tactile perception, Ros had the children name many different items that she placed in a bag; she then had them individually name the item that they intended to find, before having them reach into the bag and pull out the item based on tactile perception. When she had the children name the items, Jade would help them properly pronounce the items that they missed. The integration of speech and occupational therapy appeared to keep the children engaged in both intellectual and physical activity giving them a high level of stimulation (J. Hodgkinson, personal communication, November 13, 2015).

Therapist-teacher relationship. The occupational therapist spends about a third of her time assisting the teachers so that they can adapt the children's learning environment to fit their needs. She often meets with school teachers throughout the day whether formally or informally. She writes weekly reports about the children's progress in therapy and gives them to their teachers, their social workers, and the principal. The reports are intended to keep all relevant staff members updated on the child's progress and act as prompts for discussions with the teachers and other people concerned about the child's development. One morning I observed her walking from her office to the Early Childhood Development Center, and she stopped to talk with two teachers. She talked to one teacher about a child that has been having regular therapy sessions, and the first teacher described the improvements that she has observed in his

handwriting. The second teacher expressed a concern about a child who was having attention issues in class, and Ros suggested that they meet later in the week to discuss potential changes in the classroom environment that they could make to accommodate the child; this is a good characterization of a usual informal dialogue that Ros has with the teachers.

Additionally, Ros often goes to the special needs classroom in order to observe the children in their learning environment or support the teacher, Kate. During one class period, I observed Ros in the special needs classroom providing support to Kate. Ros noticed Kate having to repeatedly tell one child to sit with proper posture in her chair so that she can learn to write properly. Ros suggested to Kate that she could give her a weighted stuffed animal that she can use for proprioceptive purposes instead of a normal weighted lap bag, which the child is not interested in using.

Therapist-parent relationship. Although Ros does not usually give the Mamas direct instructions for how to support their children while she is doing therapy with them, she is a facilitator of change when it is brought to her attention that a Mama is caring for their child in a manner that could potentially inhibit his or her development. For example, it was once brought to Ros' attention by a social worker that a Mama was putting a disabled child in diapers one day and underwear another day while trying to toilet train her. The social worker asked Ros to explain to the Mama why it is harmful to her development to inconsistently put her in one or the other. After that conversation, Ros immediately went to the Mama and explained that the child may be getting confused as to when she has to use the toilet and when she doesn't, and that is why it is important that the Mama put her in underwear all of the time when she is attempting to toilet train her. However, Ros did not just leave the Mama with that instruction; she also explained that if she tried it for a significant period of time and toilet training the child seemed to

be impossible, then Ros would support her in determining whether or not the child could eventually achieve that skill. Ros assured the Mama that she would be there to support the Mama until they found an appropriate solution.

Similarly, in another instance, I observed a daycare worker telling Ros that she was concerned because a child with very poor vision wasn't wearing her glasses at school. The teacher had spoken to the Mama, and the Mama told her that the child had lost her glasses. Ros then went to the Mama to explain to her how important it is for her to look after the child's glasses and to discuss ways to ensure that the child does not lose them again.

Ros explained to me that she feels that it is necessary for her to intervene with the Mamas when issues such as those mentioned above arise, because she has the knowledge and credentials to explain to them exactly why it crucial for the child's development that they change their actions. Most importantly, she can also offer the Mamas solutions or ways to cope with the issues.

Secondary Source Findings

Transformation in South African Education Support Services

In 1996, South African policy, namely the South African Schools Act, made the provision of education support services (ESS)—defined as "... all human and other resources that provide support to individual learners and to all aspects of the education system" (Department of Education, 1997, p. 2)—mandatory. It stated that the government "... must, where reasonably practicable provide education for learners with special educational needs at ordinary public schools and provide relevant educational support services for such learners" (Republic of South Africa, 1996, p. 10). Then, in the Education White Paper 6, the government

emphasized the importance of strong ESS by saying that they are “the key to reducing barriers to learning within all education and training” (Department of Education, 2001, p. 28). At this time, the traditional model of delivering ESS in South Africa was being criticized by researchers in addition to politicians.

The commonly used model had been accused of failing the country because it had been “focused on the learner’s deficits and not educational needs and abilities” (Department of Education, 1997, p.20). In the Education White Paper 6 it was recommended that the country moves away from this medical intervention model and moves towards a “social model of support [based on the social model of disability], which doesn’t assume that the barriers to learning reside primarily within the learners themselves” (Struthers, 2005, p. 64) Some researchers agreed that this “paradigm shift for South African ESS was highly contextually relevant in the ‘African century’ (Mbeki, 2001, n.p.)” that the former President Mbeki was calling citizens to embrace at the time. (Hay, 2003, p. 136) This shift was relevant because it called for a movement away from a model that “had its origins in Eurocentric countries with a strong individual-focused ethos” and towards a model that aligns with the South African philosophy of Ubuntu, which challenges that individual focus. This “africanization” of ESS was deemed necessary because it “meant a specific focus would have to be placed on making education support services relevant and meaningful to many people who had been neglected in past ESS provision” (Hay, 2003, p. 136).

The Specific Role of Occupational Therapists in Inclusive Education

Occupational therapists, specifically, must play a central role in the transformation of ESS and the implementation of inclusive education in South Africa. Although there is a dearth of recent writing on this topic, since the beginning of the inclusive education movement in 1996 various authors have emphasized the fact that inclusive education will not succeed without adequate classroom (and beyond) support to learners experiencing barriers to learning (Stainback & Stainback, 1996; Swart, Pettipher, Engelbrecht, Eloff, Oswald, Ackerman & Prozesky, 2000) and that “inclusive education without adequate support is ‘inclusion by default’” (Hay, 2003, p. 1). Most experts also have continuously agreed that the specialist support needed to avoid “inclusion by default” is a team that includes a “speech therapist, a psychologist, an occupational therapist, as well as a remedial teacher who is prepared to provide the other teachers with in-service training” (Hornby, Atkinson & Howard, 1997, pg. 101).

Occupational therapists are an essential part of inclusive education, because “fully included learners require more occupational therapy support within the education setting” and they need occupational therapists to facilitate a student-environment fit that enables full participation, both academically and socially in their school setting (Sunday et. al, 2012, p. 3). Thus, one of the main roles that occupational therapists in an inclusive education environment most often adopt is one of a consultant for parents and teachers. It is especially important for occupational therapists to support teachers because educators should be the primary agents of change in the inclusive classroom. Occupational therapists should take on the role of empowering teachers to best meet the needs of all the learners in the classroom (Sunday, et. al., 2012). Consequently, it would be effective for occupational therapists to provide “education and training on how to adapt the classroom environment, how to modify teaching techniques and

how to access assistive devices so as to adjust and meet environmental demands” (Sunday, et. al., 2012, p. 3). All of these supportive activities would ideally “allow the teacher to experience and thus understand the disability of the child” (Sunday, et. al., 2012, p. 3), which is so valuable in an inclusive classroom.

Another major role of occupational therapists in inclusive education environments is the facilitator of collaboration between ESS professionals. Research has shown that “part of the [broader responsibilities] of the occupational therapist in developing the school as an organization is to facilitate communication [that is dynamic and collaborative] amongst [relevant] groups” (Sunday, et. al., 2012, p. 5). Although it is important to have the appropriate professionals present on the ESS team, if there is a lack of resources and the team is not complete there is an even more urgent need for clear and constant communication. An ESS team can compensate for lacking a member by placing an emphasis on coordination and communication. “The various roles represented in the team should be clearly defined and understood enabling easy and correct referral and treatment” (Sunday, et. al., 2012, p. 5). Whether or not an ESS team is sufficiently staffed, it is essential that this open line of communication exists between its members in order to provide the best comprehensive care possible to the learner.

Analysis

LIV’s Implementation of Inclusive Education

According to the Department of Education’s goals for inclusive education outlined in the Education White Paper 6, LIV has not achieved full inclusive education although it is making some successful efforts through its use of occupational therapy following the social model of

disability. In addition, LIV does provide all of its children with an education on an equitable basis, and foster an inclusive community culture.

Division of classrooms. LIV does provide formalized education to every child on the village, except for the three children with severe cerebral palsy. Although some children are educated in a special needs classroom separate from the children in the other classes of grades 1-9, the children were placed in the special needs class based on their capacity to learn and the limited resources of the school. Not all disabled children are in the special needs class, but those who need extreme repetition or extra instruction in order to learn a low-level curriculum are placed in the special needs class. At LIV, the biggest consideration when deciding whether or not to place a child in the special needs class is their ability to participate in the class without being disruptive to others and the capacity of the staff to give the child the extra support that they need. Some of the children in the special needs class that I observed may have been able to be mainstreamed into the inclusive classrooms, but they would require an individual education support specialist—to assist the teacher in adapting the classroom environment and curriculum for the child—which LIV does not have the funds to employ.

Integration of classrooms. Because LIV strives for “a single, undivided education system for all learners,” the staff members at LIV realize that the separation of the special needs class from the rest of the school isn’t ideal so they make a conscious effort to integrate the children in the special needs class with the learners in the rest of the school (Department of Education, 2001, p. 29). The children in the special needs class run on the same schedule as the rest of the school, so they join in assemblies together, take breaks together, and eat lunch together with the other learners. Additionally, the teachers try to facilitate social interaction between the children, so the classes sometimes combine for ‘specials’ classes such as music, art,

and sport. The three children with cerebral palsy are also integrated into the school through visits to the Early Childhood Development Center where they can socialize with the other children and be exposed to various stimuli outside of where they live. This integration of the classrooms appears to promote an overall inclusive community culture at LIV and prevent the children in the special needs class from feeling excluded or discriminated against in any major way.

Role of OT in Inclusive Education at LIV

Ros is deeply involved in the processes of enrolling, monitoring, and supporting all of the children with disabilities in the school. Although her services are a limited resource, she tries very hard to give each child who needs it equitable access to her services.

Implementation of the social model of support. Instead of simply providing the children with therapy to improve their skills, Ros spends a lot of her time looking for solutions to barriers to learning that reside in the children's environments, which aligns with the social model of support i.e., it is not our handicap that disables us but society's inability to accommodate us. Because of her collaboration with other therapists, support specialists, and teachers, she is able to take a holistic approach to each child's care. Each professional brings a different perspective of the child's past life experiences, current social ability, and academic ability in order to make best decisions for the provision of education support services for each child.

Because of the constant collaboration between all staff members involved in the children's schooling experience, LIV is able to move past the traditional system of "integrated education" and create a true "inclusive education" system, where the whole school shares the responsibility of helping to meet each individual learner's needs (Miles, 2000, n.p.). Ros prompts

regular conversations about the progress of the children receiving occupational therapy with her weekly written reports, but it is the teachers and social workers responsibility to bring up any potential issues in the behavior of children who aren't currently receiving occupational therapy.

Ros focuses on providing solutions or methods for coping with the environmental barriers to learning for each child when she counsels the Mamas and the teachers. She knows that the teacher should be the primary agent of change in the classroom, so she uses her knowledge to advise the teachers on how to change a child's physical environment in the classroom, or how to adjust a teaching technique or attitude to eliminate a barrier to learning for a specific child.

OT's role in prevention of secondary disabilities. Through her occupational therapy activities, Ros tries to foster "identities inclusive of disability," in children with impairments so that they are able to have a "positive experience" of their disability (Dunn & Burcaw, 2013). From as early an age as possible—starting whenever a child arrives at LIV or starting at daycare age—she tries to improve the children's skills and abilities so that they can physically compensate for their impairment by adapting their actions or behaviors. She also focuses on making them aware of their abilities rather than just focusing on their disabilities. She does this so that in the future they will be less likely to develop a "secondary disability," which might impact their later functioning in the school setting, the community, or the even the workplace.

One specific method of preventing "secondary disabilities" that she uses is encouraging the children to engage in sessions of self-initiated free play. She places an emphasis on giving the children opportunities to engage in free play because occupational therapy research has discovered that if "children with physical disabilities are deprived of the opportunity to regularly engage in free play, particular types of secondary disabilities—[such as increased dependence on others, decreased motivation, lack of assertiveness, poorly developed social skills in unstructured

situations, and lowered self-esteem]— are likely to result (Missiuna & Pollock, 1991, p.883).

When deciding which children free play sessions would be especially beneficial to she takes into account any past trauma they have experienced, recognizing the child's past social environment as a factor in their disability.

OT's role in assisting educators. Each child is individually evaluated using a process guided by the National Strategy on Screening, Identification, Assessment and Support (SIAS) before they are placed in a classroom; this ensures that they are assessed by a team of educators, social workers, the principal, the psychologist and the occupational therapist before they are placed in a specific class. Ros facilitates this process because the teachers do not necessarily have the time or expertise needed to collect and interpret all of the background information for each child. Even though the SIAS guidelines call for an in-depth profile of the learner to be compiled ideally in consultation with the parents, (Department of Education, 2008, p. 10-11) it appears that Ros has to step into the role of leading this process because the biological parents of the children are not involved, and the LIV Mamas do not know the children's past histories. The LIV staff are also limited in completing the full SIAS process because the only background information they have to analyze is the information provided to them by the government or other agency that used to foster the children.

OT's influence on Mamas. The relationship between the occupational therapist and the Mamas at LIV is unique to residential care facilities, and even more specifically the foster-care model of residential care. Ros appears to have a large influence on the way in which the Mamas care for the children. Ros can easily intervene in the children's care at home by being in almost a position of power over the Mamas due to the structure of the institution. Also, because of her close physical proximity to their homes, she can easily visit and observe the care the Mamas are

providing to the children at home. In an average public school in South Africa, the school-based occupational therapist would have little authority to influence the actions of the parents, unless he or she builds a relationship of trust and respect with them.

Limitations of LIV's Implementation of Inclusive Education

Although clear successes can be seen in LIV's implementation of inclusive education, if LIV truly embodied the vision detailed in the Education White Paper 6 it would not have a class specifically for special needs learners. Two key components of implementing inclusive education that are missing from LIV are specific teacher training and curriculum adaption. In order to place all of the students currently in the special needs class into the mainstream classes, the teachers would need training on how to adapt the curriculum in order to provide each individual child with the opportunity to learn at different levels. However, this is not the job of the occupational therapist, but rather an education expert or remedial teacher. Because LIV's school has a larger amount of disabled learners than the average South African public school, mainstreaming every disabled learner would put a large strain on the human resources of the institution and is simply not possible with their current amount of resources.

Conclusion

Through this study, I have discovered that occupational therapists have an important role to play in the implantation and implementation of inclusive education in South Africa. This role is exemplified through the efforts of the occupational therapist at LIV, Ros Irving. By embracing the social model of disability, she is able to address not only each child's impairment but the environmental barriers to learning that each child may face. Additionally, through her support of the educators and the Mamas at LIV she is able to promote proper comprehensive care free from discrimination for the children with disabilities in their classrooms, as well as their homes. Lastly, by acting as a facilitator of communication for the team of education support specialists and professionals across departments she ensures that the children are given comprehensive assessments, and that the best decisions are made for their general care, as well as their education.

In general, school-based occupational therapists in South Africa should shift their usual role in and approach to supporting children experiencing barriers to learning. They should embrace the social model of support and focus on adapting the environment of the child, as well as supporting the teachers and parents who are the main influencers of the child academically and socially. Educators have so far struggled to implement inclusive education in South Africa because of their lack of funding and lack of comprehensive support from education support specialists. However, if occupational therapists embrace their new role in implementing inclusive education, educators may begin to succeed, and the country may be able to move closer to its aim of having a "single, undivided education system [free from discrimination] for all learners". (Department of Education, 2001, p. 30).

Recommendations for Further Study

This study might be expanded upon by another student conducting an ISP at LIV guided by one or more of the following research questions:

- How could the specific model of collaboration between the education support specialists at LIV be improved?
- How are the therapy services provided at LIV influenced by the residential care setting?
- How effective is the model of the continuum of care provided to the children at LIV?
- How does the Christian belief system of the organization influence the health care provided to the children at LIV?

I believe LIV is a great organization for another student to study further because it is hoping to implement its model in another village near Johannesburg in the coming years, so the staff would gladly accept any research on their model that might help them to improve a certain aspect of the organization's model.

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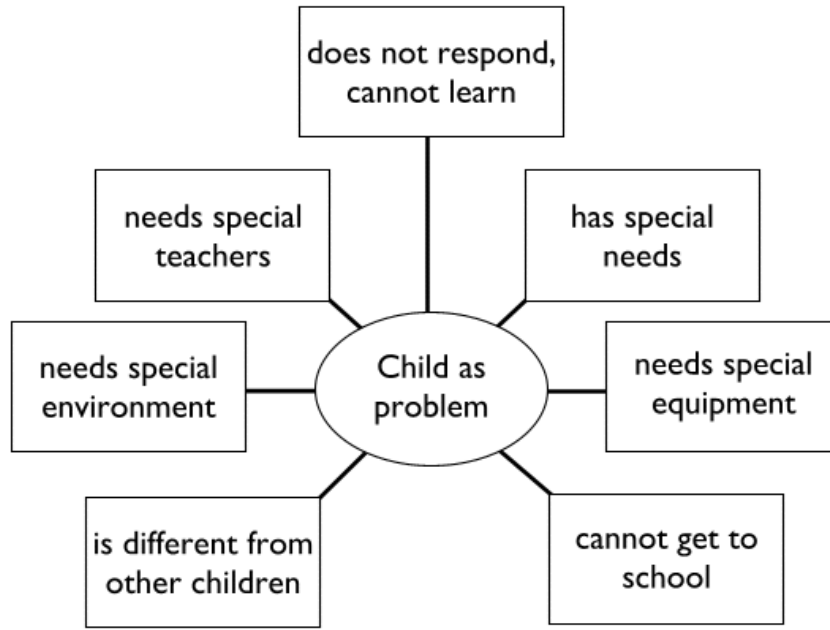
List of Primary Sources

- Ros Irving, LIV Village, occupational therapist, informal interview, Nov. 15th, 2015.
- Kate Hunt, LIV Village, special needs class teacher, informal interview, Nov. 3rd & 5th, 2015.
- Jade Hodgkinson, LIV Village, speech therapist, informal interview, Nov. 7th, 13th, 2015.
- Clive Bruzas, School for International Training, Lecture: *Heuristic Inquiry, case studies, and photovoice*, Oct. 6th, 2015.

Appendices

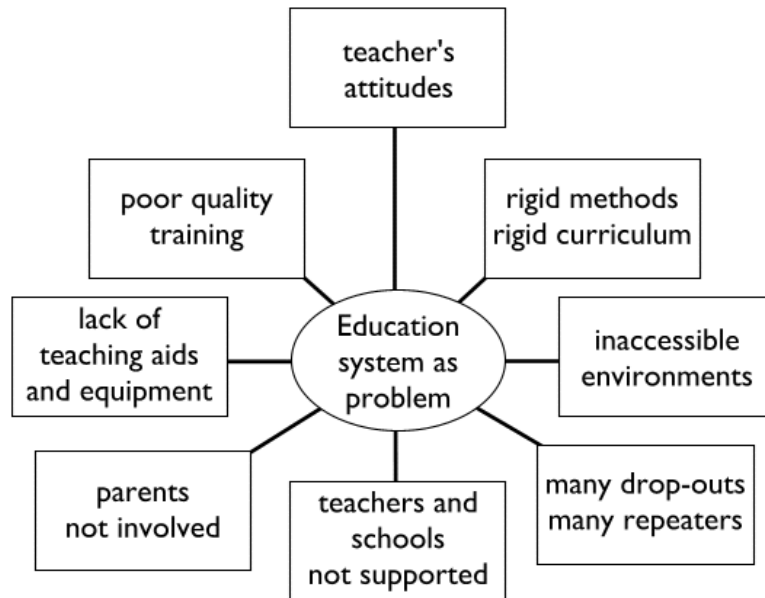
Appendix A: Model of Integrated Education (Miles, 2000)

Integrated Education



Appendix B: Model of Inclusive Education (Miles, 2000)



Inclusive Education



Appendix C: Completed LRB Action Form



**Human Subjects Review
LRB/IRB ACTION FORM**

<p>Name of Student: Erica Steinhoff The Continuum of Care Provided ISP Title: to children in an orphanage setting at LIV village: A case study Date Submitted: 30 October 2015</p> <p>Program: SFH Community Health</p> <p>Type of review: LRB</p> <p>Exempt <input type="checkbox"/> Expedited <input checked="" type="checkbox"/> Full <input type="checkbox"/></p> <p>No Interviews before memorandum is agreed.</p>	<p>Institution: World Learning Inc. IRB organization number: IORG0004408 IRB registration number: IRB00005219 Expires: 9 December 2017</p> <p>LRB members (print names): John McGladdery Clive Bruzas Francis O Brien</p> <p>LRB REVIEW BOARD ACTION:</p> <p><input checked="" type="checkbox"/> Approved as submitted <input type="checkbox"/> Approved pending changes <input type="checkbox"/> Requires full IRB review in Vermont <input type="checkbox"/> Disapproved</p> <p>LRB Chair Signature: John McGladdery  Date: 30 October 2015</p> <p></p>
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Form below for IRB Vermont use only:

Research requiring full IRB review. ACTION TAKEN:

___ approved as submitted ___ approved pending submission or revisions ___ disapproved

 IRB Chairperson's Signature

 Date

Appendix D: Blank Informed Consent Form

SIT Study Abroad

a program of World Learning



CONSENT FORM

1. Brief description of the purpose of this study

The purpose of this study is to... explore the ways in which the occupational therapy provided to children at LIV helps children with disabilities to be provided with equal education opportunities. I will be assisting the occupational therapist Monday through Friday and I will participate in other LIV village activities with the children on week nights and weekends. I will also be talking to the occupational therapist, speech therapist, and special needs class teacher to better understand how occupational therapy helps to implement an inclusive education system at LIV. I will use my observations and information gathered from interviews to write a report in which I will compare what I found at LIV Village to the policies for inclusive education set by the South African government.

Rights Notice

In an endeavor to uphold the ethical standards of all SIT ISP proposals, this study has been reviewed and approved by a Local Review Board or SIT Institutional Review Board. If at any time, you feel that you are at risk or exposed to unreasonable harm, you may terminate and stop the interview. Please take some time to carefully read the statements provided below.

- a. **Privacy** - all information you present in this interview may be recorded and safeguarded. If you do not want the information recorded, you need to let the interviewer know.
- b. **Anonymity** - all names in this study will be kept anonymous unless you choose otherwise.
- c. **Confidentiality** - all names will remain completely confidential and fully protected by the interviewer. By signing below, you give the interviewer full responsibility to uphold this contract and its contents. The interviewer will also sign a copy of this contract and give it to you.

I understand that I will receive no gift or direct benefit for participating in the study.

I confirm that the learner has given me the address of the nearest School for International Training Study Abroad Office should I wish to go there for information. (404 Cowey Park, Cowey Rd, Durban).

I know that if I have any questions or complaints about this study that I can contact anonymously, if I wish, the Director/s of the SIT South Africa Community Health Program (Zed McGladdery [0846834982](tel:0846834982)).

Participant's name printed

Your signature and date

Erica Steinhoff

erica steinhoff

Interviewer's name printed

Interviewer's signature and date

I can read English. (If not, but can read Zulu or Afrikaans, please supply). If participant cannot read, the onus is on the researcher to ensure that the quality of consent is nonetheless without reproach.

Appendix E: Beginning Questionnaire for Informal Interviews

Questions for occupational therapist:

- Can you describe the process of deciding if a child should receive occupational therapy?
- How do you observe children?
- How do you assess children?
- How do you monitor a child's progress when they are receiving occupational therapy?
- Who do you collaborate with when assessing children?
- How are you included in the implementation of inclusive education?
- What do you think is your role within the implementation of inclusive education?
- How do you think LIV is implementing inclusive education?
- Can you describe the process of deciding which class a child should be placed into?
- How do you evaluate a child's progress?
- What is your relationship with the special needs class teacher like?
- What is your relationship with the Mamas like?
- How often do you observe children in the special needs class?
- How often do you observe children in other classes?

Questions for speech therapist:

- How do you decide if a child needs speech therapy?
- How do you observe children?
- How do you assess children?
- Who do you collaborate with when assessing children?
- How are you included in the implementation of inclusive education?
- What do you think is your role within the implementation of inclusive education?
- How do you think LIV is implementing inclusive education?
- How do you evaluate a child's progress?
- What is your relationship with the special needs class teacher like?
- What is your relationship with the Mamas like?
- How often do you observe children in the special needs class?
- How often do you observe children in other classes?

Questions for special needs class teacher:

- How are you included in the implementation of inclusive education?
- What is your relationship with the occupational therapist like?
- What is your relationship with the speech therapist like?
- What do you think is your role within the implementation of inclusive education?
- How do you think LIV is implementing inclusive education?
- How do you evaluate each child's progress in your class?
- How do you decide if a child should leave your class?
- What do you do if a child in your class appears to be having problems learning in class?

- Do you collaborate with the Mamas when a child is having issues learning in class?