FACTORS THAT INFLUENCE COMMUNITY INTEGRATION OF PERSONS WITH PHYSICAL DISABILITIES IN POST-CONFLICT BOSNIA AND HERZEGOVINA AS PERCEIVED BY PERSONS WITH DISABILITIES

by

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Abstract

**Rationale:** Due to the uniqueness of the conflict and post-conflict experience in Bosnia and Herzegovina and limited primary source research, it is unclear to what extent persons with physical disability participate in rehabilitation and other community services. It is uncertain whether persons with physical disability have access to available community programs and services and what role policy, environmental and attitudinal barriers play in community integration and social participation.

**Objective:** The purpose of this study was to understand and describe factors that influence community integration and social participation of persons with a physical disability in post-conflict Bosnia and Herzegovina.

**Methods:** A concurrent embedded mixed methods design was used. Three face to face interviews were conducted and thirteen participants completed written questionnaires adapted from *The “KIPA” Clear Direction Strategic Framework: Knowledge-Inclusion-Participation-Access* (Edmonds, 2003). Participants had physical disabilities and were recruited through Mojmilo Health Clinic, Centar Za Fizikalnu Theraiji I Rehabilitaciju Community Based Rehabilitation centre and the Clinical Centre University Hospital in Sarajevo, Bosnia and Herzegovina.

**Results:** The study identified challenges and barriers encountered when accessing rehabilitation, primary health care, education and other community services and programs. The data suggested that persons with a physical disability perceived that factors associated with knowledge, inclusion, participation, and access are very important to their quality of life. Government policy reform and assistance,
employment opportunities, attitudes and awareness, and community understanding emerged as critical factors of acceptance and integration.

**Conclusions:** The study revealed that a complex array of factors influenced the integration of persons living with a physical disability in post-conflict Bosnia and Herzegovina. Persons with disability indicated the need for individuals and disability groups to collectively advocate for all PWDs in order to voice their goals for integration and social participation. Knowledge, inclusion, participation, and access to health care, education, livelihood, attitude, social participation and advocacy emerged as intrinsic to the successful community integration of persons living with a physical disability.
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Elizabeth Richan, April 2011
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<td>Active Daily Living</td>
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<td>BiH</td>
<td>Bosnia and Herzegovina</td>
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<td>Community Based Rehabilitation</td>
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<td>International Labour Organization</td>
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<td>KIPA</td>
<td>Knowledge, Inclusion, Participation, Access</td>
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Chapter 1
INTRODUCTION

1.1 Background

According to World Health Organization (WHO) data it is estimated that approximately 650 million people worldwide (WHO, 2010) live with a disability, including an estimated 15 to 20% who live in poverty in developing countries (Elwan, 1999). These numbers indicate that over 20% of the world’s population is impacted by disability through family or other close social connections. Less than 2% have access to rehabilitation and less than five percent have access to education and employment (Edmonds, 2005a). Within regions of conflict this is particularly true as the numbers of persons with disability increases dramatically over a short period of time (Peat & Jalovcic, 2009). In these areas the need for rehabilitation services for persons with disabilities (PWD) explodes, often amid a collapsing health care system such as in the case of Bosnia and Herzegovina (BiH) (Map 1.1) during and after the war years of 1992 to 1995. “In 1992, the war broke out in BiH. This led to the breakdown of social order leading to chaos, victimization, injury, disability, isolation, starvation and death” (Edmonds, 2005a, p.295).

For the purposes of this study the term disability is defined by the WHO as: “a difficulty in functioning at the body, person, or societal levels, in one or more life domains, as experienced by an individual with a health condition in interaction with contextual factors” (WHO, 2010, p. 2). Additionally the term
community will be defined by the commonly understood usage of: a group of people living in a particular local area.

**Map 1.1: Bosnia and Herzegovina**

Prior to the war, persons with disability were treated in residential institutions, and access to physical rehabilitation was often located in hospitals and clinics in Croatia and Serbia. After the medical professionals determined that treatment was complete the individual was regularly sent to an institution (Hastie, 1997). With the country under siege, health and rehabilitation services were crippled and these traditional approaches were no longer viable. New strategies to treat the bourgeoning numbers of wounded and disabled civilians
were urgently needed and with the help of international stakeholders, including the International Centre for Community Based Rehabilitation (ICACBR), Queen’s University, community based rehabilitation (CBR) emerged as an appropriate service delivery model (Villeneuve, 2000).

Bosnia and Herzegovina is one of six Republics that make up former Yugoslavia. During the 3½ year conflict it was inevitable that the population of persons with disability, both military and civilian, would increase significantly. In conflict environments casualties from shelling, landmines, and sniping add to pre-existing numbers of persons with a disability. Estimates of war-related injuries in Bosnia and Herzegovina requiring physical rehabilitation ranged from 40,000 to 70,000. By the end of the war 12,296 persons with major disabilities had registered in the Federation of BiH (FBiH), one of two entities that make up Bosnia and Herzegovina. Among the 40,000 to 70,000 wounded it is estimated that approximately 50,000 children were injured and almost 25,000 of them were left with major injuries (Peat & Jalovcic, 2009). In the Republika Srpska (RS), BiH’s second entity, similar numbers existed, with an estimated 100,000 wounded, 50,000 severely (Edmonds, 2002).

Even more than before the war, access to rehabilitation for individuals with disability was of primary concern and ironically the destruction of the old system offered an opportunity for change (Hastie, 1997). Government leaders and stakeholders in primary health care (PHC) in BiH recognized the urgent need for changes to the traditional medically based system. With support of
international agencies and organizations, ways to provide an environment for PWD to access rehabilitation services was important. The ultimate goal was to create opportunities to integrate individuals with physical disabilities into the mainstream of the community. CBR became the model to support a shift in services from institutional care into a network of accessible, cost-effective community services (Villeneuve, 2000).

During the war, severe damage to the country’s infrastructure and devastation of health care services demanded creative and innovative thinking. According to the BiH Institute for Public Health, almost 65% of health care organizations were destroyed, 33 out of 80 ‘ambulanta’ clinics were destroyed, and 7 out of 38 Dom Zdravljas (houses of health) were damaged and deemed unusable (Peat et al., 1997). In order to accommodate the high demand for rehabilitation services, health care professionals including nurses, therapists, doctors and volunteers provided services in shelters, shops, and vacated buildings for the growing population of war-wounded. These professionals encouraged community members to assist them with the day-to-day care of patients in order to provide critical and timely care for the exploding population of persons with disability (Peat & Jalovcic, 2009). A community based rehabilitation approach to health care emerged. Professional and technical support in the delivery of educational programs was provided by ICACBR/Queen’s University with support from the Canadian International Development Agency (CIDA) and the WHO to help the overwhelmed health care workers and to ease the strain on the system (Villeneuve, 2000).
Three components of the new strategic health care plan were: orthopaedic and mental services in community and tertiary care hospitals, the establishment of regional community based prosthetics and orthotics centres, and the creation of a unit to oversee project implementation. The fourth and final component of the government’s strategic plan to rebuild the health care system was CBR. By the end of the war, community based rehabilitation, including the establishment of 60 CBR centres, had spread throughout the region. The World Bank provided $30 million USD to assist BiH in restructuring its health care system to “facilitate the reintegration of disabled people into economically productive and social lives in their communities by restoring and improving the quality and scope of rehabilitation services” (Edmonds, 2005a, p.296). The lead CBR component became the ICACBR/Queen’s University War Victims Rehabilitation Project and was supported by the Canadian Government through CIDA and the World Bank with $12 million USD (Peat & Jalovcic, 2009). The FBiH Ministry of Health was mandated to create a policy, legislation and management framework to develop CBR and with it integration strategies for persons with disabilities (Peat & Jalovcic, 2009). Opportunities for PWD to learn new skills enabling access to employment, education and other community and social services were built into the new framework and one of the main characteristics of the project was the participation of persons with disability in the decision making process (Edmonds, 2005a). This strategy created an atmosphere for change, promoting “the ‘social model’ approach to disability, which, rather than
obliging individual disabled people to change and adapt to an inaccessible society, aims to make society accessible to disabled people….[it] is essentially an approach and an attitude, rather than a prescriptive list of actions and interventions” (Hastie, 1997, p. 23).

1.2 Statement of the Problem

The new approach to primary health care in BiH brought into question whether all persons with a disability had equal access to rehabilitation services brought about through health care reform after the conflict. Did this new approach in fact provide opportunities for community integration and social participation for persons with disability after the war?

Research into the area of disability in BiH primarily focuses on physical and clinical rehabilitation with little emphasis on factors that influence community integration of persons with a disability (Edmonds, 2002). Moreover the majority of study focuses on landmine survivors and war-disabled outcomes (Peat, 2007). Other areas of research into persons with disability in BiH have been neglected or need further investigation. Areas including how disability affects educational opportunities and the impact of disability on other vulnerable groups such as women and children, and experiences of persons with a range of acquired and congenital disabilities seem to be ignored.

Because the conflict decimated the region’s infrastructure and economy, the need to rebuild was urgent and the demand for skilled labourers escalated
at the end of the war. Housing, industry, telecommunication systems, roads, bridges, water and power supplies were destroyed or damaged during the war (Mitchell, 2004) and employment for demobilized soldiers was given priority (Walsh, 2000). Does this also suggest that ex-soldiers were given priority to rehabilitation services in order to increase labour resources to rebuild the country? Is this an example of how a specific group of PWD were given special status that ultimately provided integration opportunities ahead of others? This example illustrates the need to understand what key factors played a role in the rehabilitation and integration of persons with a disability in post-conflict BiH.

With health care reform, employment and education for PWD became part of the new government strategy, but full community integration issues still existed. Physical and attitudinal barriers were major factors that PWD faced as challenges to integration. Lack of physical access to homes, schools, government and commercial buildings where services and daily-living activities occurred also had an impact on successful integration. Each kind of barrier influenced the level of independence that an individual had and their ability to lead a fulfilling and satisfying life.

1.3 Research Question

The researcher sought to answer the following question: What factors influence community integration of persons with disability in post-conflict Bosnia and Herzegovina as perceived by persons with disability?
1.4 Overview of Thesis

This thesis aims to uncover factors that influence community integration of persons with disability in post-conflict BiH as perceived by persons with disability. Chapter One is an introduction and background to the topic, and outlines the research question. Chapter Two provides an overview of the current literature related to factors that influence community integration of persons with disability in BiH. Chapter Three describes the research methodology which uses a concurrent embedded mixed methods design. In this chapter sampling, data collection and analysis for each part of the study are described, and the research question and rationale addressed. This chapter also includes measurement and data collection strategies, and implementation processes of the research. Chapter Four presents the results of the research, including descriptions of the individual experiences of three persons with a disability, as well as results from thirteen additional survey participants. Chapter Five brings together the findings of the research through a discussion and conclusion and implications for further research and programming.
Chapter 2

LITERATURE REVIEW

2.1 Process of Review

The goal of this literature review was to explore the factors that influence integration of persons with a physical disability into the social fabric of the community after the end of the 1992-1995 Bosnia and Herzegovina conflict.

This search of the literature led to questions including: how are PWD perceived within their community?; have post-conflict health care reforms had an impact on integration?; how are PWD affected by attitudinal barriers?; do PWD feel empowered to better their own lives?; and, how does culture impact integration of people living with a disability?

A review of the literature indicates significant gaps in understanding factors that have influenced social and community integration of persons with physical disability in BiH in the years since the 1992-1995 conflict. This chapter presents a summary of the literature which addresses the above questions.

2.1.1 Method

In conducting the literature review databases used included: CIRRIE, CINAHL, REHABDATA, PubMed, and EBSCOhost. Bosnia and Herzegovina and disability delimiters were used with key terms including: attitudes, barriers, conflict, empowerment, integration, inclusion, disabled, physical disability, war injured, rehabilitation, health care, health care reform, mainstreaming, social
participation, and community participation. The search included English language articles published between 1995 and 2010. Additionally, the search uncovered several additional sources not found in the initial search strategy in relevant article bibliographies. A combination of peer reviewed articles, books and “grey” literature were surveyed.

2.2 Initial Findings in the Literature

The preponderance of research literature focuses on the period during, and immediately following, the war, with less attention paid to the region since 2005. The topic of integration and factors influencing integration of persons with disability is not addressed consistently or in depth within the wider body of literature. While the majority of this research predates 2005, much of this work is still relevant, as it offers a baseline for activities that occurred during and in the immediate aftermath of the war. Research in post-conflict BiH is varied and focuses on a wide range of topics, including: international development (Edmonds, 2005a; Elwan, 1999; Handicap International, 2003), employment, economic impact and reconstruction (Foco, 2002b; Mitchell, 2004; Tzifakis & Tsardanidis, 2006), public policy and reform, and human rights (Bosnjak & Stubbs, 2007; Deets, 2006; Stokke, 2006), psychological rehabilitation and treatment (Adams, 2006; Avdibegovic et al., 2008; Jones, 2002; Kersten et al., 2000), children, education, and women (Hastie, 1997; Helms, 2003; Kasumagic, 2008; Rouse et al., 2000; Tsokova & Becirevic, 2009; Walsh, 2000), conflict and landmine victims (Eldar & Jelic, 2003; HI, 2003; Mitchell, 2004; Peat &
Jalovcic, 2009; Tabeau & Bijak, 2005) and, community based rehabilitation (Berry & Dalal, 1994; Edmonds, 2002, 2005a; Finkenflugel et al., 2005; ICACBR, 2000; Peat, 2007; Peat et al., 1997). This literature is meaningful when seeking to understand the context that PWDs lived in after the war; however, given the research on international development, health care reform, psychological rehabilitation, landmines, CBR, and education, there is very little attention paid to the questions and challenges of integration of PWDs. There is even less work that specifically focuses on the factors that influence PWDs’ social and community integration, and studies on the experiences of PWD in post-conflict environments are very few (dos Santos-Zingale & McColl, 2006).

The topics noted above offer an indication of the breadth of work addressed since the conflict ended, and although research in BiH crossed many disciplines, little work focused on factors that influence integration of PWD. While the following sections do not attempt to be a comprehensive study of each topic, they provide a cursory understanding of the issues related to physical disability and integration in the BiH environment.

2.3 Disability in Bosnia and Herzegovina

2.3.1 Background

The search revealed that national statistics on disability were not consistently maintained prior to the conflict, and during and after the war was often the first time that data collection occurred in any kind of a systematic way (Pevalin & Robson, 2007). Hastie’s work (1997) with Oxfam, noted that this
was a new area of work and there was little evaluation or analysis done to contribute to the agency’s learning. Disability was given low priority worldwide and did not have the same status as other health related issues for reasons including: deep-rooted culturally based prejudice, a clinical and medical approach rather than one of human rights, policy makers’ lack of direct contact with PWDs perpetuating lack of understanding, and lack of personnel with a disability working in development organizations (Hastie, 1997). This was no different in the BiH environment.

2.3.2 Prevalence of Disability

Although statistics on disability, injury, and general population data had not been recorded consistently (Handicap International, 2003), it is clear the war had a major impact on the demographic and health profile of the region. In 1991 the overall population of BiH registered just over 4.5 million and as of 2002 an official census had not yet been conducted in the postwar period; however, estimates suggest an overall population decline to between 2.9 to 3.97 million (Cain et al., 2002; Peat & Jalovec, 2009). Additionally, persons with disability make up approximately 10% of the overall population in FBiH with 6,119 children and 14,636 adults registered with the Social Welfare Department, including 5,000 with amputations, 750 with spinal cord injuries, 3,000 with lesions of peripheral nerves, 2,180 with traumatic brain injuries, and 10,150 fracture cases. Additionally, 2,280 amputations related to landmine accidents were recorded with the International Committee of the Red Cross (ICRC) between 1992 and 2003 including 4,824 landmine causalities (Handicap International, 2003; ICACBR,
Disabling injuries continued after the war as people returned to their communities where an average of 38 landmine accidents per month occurred in 1996 (Meier & Smith, 2002); however, an estimated additional 300 people were killed by landmines between 1996 and 1999 and 12,296 persons were identified as having major physical disabilities by war’s end (Meier & Smith, 2002; Peat & Jalovcic, 2009; Tabeau & Bijak, 2005). Gunshot wounds, landmines, grenades, rockets and artillery injuries made up 12% of all Emergency Department surgical patients in the city of Zenica alone from July 1994 to December 1995 (Lasseter et al., 1997). Estimates of between 40,000 and 70,000 of those injured required physical rehabilitation (Lasseter et al., 1997; Meier & Smith, 2002; Peat & Jalovcic, 2009). Similar statistics for the second BiH entity, the Republika Srpska (RS), have not been kept.

2.4 Rehabilitation and Health Care Reform

Social change is complex and a multitude of factors dictate the how, when, and why of transformation within a society, particularly one that has been fractured due to war. Societies in transition are often entrenched in traditional ways and do not have the knowledge or skills to improve quality of life for PWD or other vulnerable populations (Edmonds, 2005a). The United Nations World Programme of Action (WPA) Concerning Disabled Persons underscored the need for governments to take leadership in developing societies to facilitate change and improve quality of life for PWD (United Nations, 1982). With BiH restructuring government and health care reform, it was felt change would open new opportunities for the integration of PWD into daily community life. Hastie
extracts from L. Gilliam’s report to Oxfam, “As dreadful as the situation is, it presents an incredible opportunity for social change…and disabled people stand to benefit greatly…” (Hastie, 1997, p. 93). The path to inclusion and integration is often caused by a major upheaval in a society that can be the impetus for positive outcomes, and the concept of equal opportunity was new in Bosnia, “Perhaps the very social changes that occur in a time of conflict are actually conducive to the introduction of radical new ways of thinking” (Hastie, 1997, p. 93).

The war in BiH created an impetus for change due to devastation across sectors, including the health care system where ordinary citizens as well as health services were targeted (Edmonds, 2005a). It is estimated that 30% of health care facilities were destroyed or damaged and 30% of all health professionals were lost due to injury or migration (Handicap International, 2003). Rehabilitation was one area that saw major changes, not unlike in other countries in conflict situations, since wars create overwhelming casualties who often survive but who are severely disabled. Principles and practice of rehabilitation had to change to meet the needs of the injured due to the vast numbers and multiple types of care and treatment that were required (Edmonds, 2002; Eldar & Jelic, 2003; Lasseter et al., 1997; Tabeau & Bijak, 2005).

After the signing of the war-ending Dayton Agreement in 1995, the health system in BiH shifted responsibility to the entity level; RS and FBiH. This created a complex system where both entities issued legislation on health care and health insurance, with RS maintaining a centralized system and FBiH a
decentralized system, which were further shared with the ten cantons (geographical divisions resembling counties). Additionally, Brcko District became responsible for organizing and financing its own health care after its creation in 2000 (Handicap International, 2003). A complex power-sharing state emerged with international players contributing military and financial aid and monitoring local conflicts in various sectors. The crisis in the health field continued as reforms to improve stability in health care were regularly blocked by one of the vetoing groups. The result was a dysfunctional institutional approach to health care led by a weak central government and local institutions. The outcome was a civil society that barely functioned (Bosnjak & Stubbs, 2007; Deets, 2006; Edmonds, 2002; Foco, 2002a).

2.4.1 Models of Disability

There are four main recognized models of disability that provide a rationale for policies and programs when understanding and describing disability and development: charity, medical, social, and citizenship or right’s based (Handicap International & CBM, 2005; Marsala & Petretto, 2010). The charity model focuses on the person with a disability as a victim who is in need of lifelong pity and help. These PWDs are seen as disempowered and in need of being cared for and who should be grateful for those who provide for them (Marsala & Petretto, 2010). The medical model of disability is based on an institutional approach where clinical care and treatment are provided and seen as the best strategy for persons with disability (Handicap International & CBM, 2005). Prior to the war,
BiH was entrenched in a traditional medical model approach to health care. Persons with disability were passive consumers living in institutions dependent on State run disabled people’s organizations that followed State mandates (Edmonds, 2005a, 2005b; Peat & Jalovcic, 2009). Social needs of vulnerable populations were not a priority and institutional care was seen as the best solution. Users were expected to fit into existing services which were often far from their families and where care was provided in a paternalistic way (Bosnjak & Stubbs, 2007; Hastie, 1997). After the war the health care system could no longer meet the needs of PWDs who were in need of treatment and rehabilitation as facilities and health care professionals were decimated. If rehabilitation in health care reform was to be successful, it required a new approach and the government chose new options based on the social needs as well as the medical care of PWDs (Edmonds, 2002, 2005a; Meier & Smith, 2002). The social and citizenship models will be discussed in the section that follows.

2.4.2 Shift from Medical to Social and Citizenship Models of Disability in Health Care in Bosnia and Herzegovina

The social model approach to rehabilitation encompasses “the 3Ds” of social services reform: deinstitutionalization, diversification and decentralization (Bosnjak & Stubbs, 2007; Coleridge, 2000). The social model grew out of a movement led by PWDs in the 1970s and 1980s as a result of negative effects of the medical and charity models. PWDs felt low self esteem, isolated and marginalized (Edmonds, 2005a). Social model principles lessen the role of institutions and health professionals and advocate for a community and
independent living approach. The social model, unlike the medical model, tries to create an environment where the community is accessible to all individuals, and where the atmosphere is more about social participation and inclusion than medical intervention. Positive attitudes and an understanding of disability issues focusing on social, economic and environmental factors aim to allow PWDs to participate in decision making and leadership roles within the community (Edmonds, 2005b, Hastie, 1997; Peat, 1997a).

Harris and Enfield’s (2003) discussion on disability models describe the rights/citizenship model has having two key features: empowerment and accountability. Empowerment enables the participation of PWD as active stakeholders, while accountability obliges public institutions to apply rights and to manage successful implementation. After the war in BiH international commitment and financial support for policy reform, health care and rehabilitation services created an environment for positive change (Edmonds, 2005a; Hastie, 1997; Peat & Jalovcic, 2009). Deets (2006) argued this was only possible if the State created the environment to implement reform.

2.4.3 Community Based Rehabilitation (CBR)

Bosnia and Herzegovina embraced the idea of a new humanitarian assistance program adhering to the principles of the social and citizenship models which were initiated during the war for rehabilitation services. By 1996, the World Bank and the BiH Ministry of Health (FBiH) devised a programme made up of four components to reconstruct the national rehabilitation system. Their aim was to promote independence and integration of
PWDs into productive social and economic lives within the community. This was to be accomplished by improving rehabilitation services as part of reforming the health care system, and CBR was introduced as one of the four components to achieve this goal (Edmonds, 2002, 2005a; Eldar & Jelic, 2003; Hastie, 1997; ICACBR, 2006; Peat & Jalovcic, 2009; World Bank, 1996). Following the implementation of CBR programming in FBiH, the second entity, Republika Srpska (RS) Ministry of Health and Social Welfare approved CBR “into the strategic plan for reform and reconstruction of health system” (Peat & Jalovic, 2009, p. 26). Community Based Rehabilitation is:

…a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organizations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services. (International Labour Organization/United Nations Educational, Scientific and Cultural Organization/World Health Organization, 2004, p.2)

McColl and Paterson (1997) summarized the key concepts of CBR as: a community development approach; the partnership of PWD, their families and community; the philosophical importance of integration versus segregation of service delivery; and its multidisciplinary approach embedded in the health, education and social sectors. While the CBR strategy lays the foundation for community integration, “Community is a term with powerful positive characteristics” (Boyce & Lysack, 2000, p.54) and the challenge for CBR is in finding ways to integrate PWDs into their community. Debate arguing the merits of institutional versus community based services are often portrayed as exclusive
to one another; however, studies by Coleridge and Peat maintain they are 
complementary and both play a key role in the rehabilitation continuum 
(Appendix A) (Coleridge, 2000; Peat, 1997b). What has not been demonstrated 
in previous research is whether reform in BiH has been successful in its 
expectation that CBR would create an environment empowering PWDs’ access 
to social and community participation.

2.4.4 CBR in the BiH context

Community Based Rehabilitation A Peace Building Strategy (Peat et al., 1997), a 
foreign policy research paper, addressed the benefits of CBR as a key component of the 
peace building process in countries in conflict and those in transition. The authors argue 
that CBR is an important feature of partnership and community participation addressing 
goals in rehabilitation, training and community integration of PWDs. This approach is 
most effective in a community where contributions based on ability, at whatever level, 
are valued. Since 1976 WHO member countries have recognized CBR as an appropriate 
strategy that focuses on meeting PWDs basic needs while ensuring participation and 
inclusion and providing a better quality of life for people with disabilities and their 
families (Edmonds, 2005a; Lundgren-Lindquist & Nordholm, 1996; Peat & Jalovcic, 
2009). Program leaders agreed on the value of CBR but were concerned that there were 
inconsistencies in the CBR strategy leading to debate and dissension between different 
groups (Peat, 1997b). In order to bring understanding and consistency to this strategy, 
the WHO designed a CBR Matrix (WHO, 2010) (Appendix B) and guidelines with five
key components as intrinsic to the design of a CBR program: health, education, livelihood, social, and empowerment.

CBR provided the framework for BiH to maximize community participation and minimize use of health and social services resources. The goal in restructuring the national rehabilitation system after the war through the CBR strategy was to reintegrate PWDs into productive lives, both socially and economically (Pecar, 2006). With $12 million USD from the World Bank for CBR design and implementation, and technical assistance for capacity building supported by ICACBR/Queen’s University, BiH was poised to develop a rehabilitation system that would work to meet the needs of its population of persons with disabilities (Edmonds, 2002, 2005a, 2005b; ICACBR, 2006; Peat, 2007; Peat & Jalovcic, 2009).

How was CBR going to achieve this and provide opportunities for PWD integration? Scott (2002) argued that in theory CBR seemed like a worthwhile concept, but questioned how it worked in war torn and often chaotic communities. All persons, especially PWDs, had little access to the barely functioning health care facilities, and community clinics were initially established in make-shift shelters, empty shops, basements and other vacant buildings providing accessible rehabilitation services (Edmonds, 2002; Peat & Jalovcic, 2009). Health care professionals called on community volunteers to help with the day- to-day operations of the clinics. Dr. G. Cerkez of the Bosnian Ministry of Health, noted that out of the disorder, health professionals and local people worked together to take care of the community’s medical needs by setting up health care services (Scott, 2002). Following the war, the network of
CBR centres evolved into primary care facilities that provided the local population free, convenient, accessible rehabilitation services to help meet the demand of the large numbers of wounded requiring daily care. Between 1996 and 2000, 38 CBR Centres (Map 2.1) were established and by 2004 60 Centres were active (Edmonds, 2002, 2005a; Peat & Jalovic, 2009; Scott, 2002).

**Map 2.1: Initial 38 CBR Centre locations established in BiH**

Clinical and university education, teaching manuals, policy development, and management training programs were established and rehabilitation specialists began to influence community integration of PWD (Edmonds, 2005a). In its early stages, the CBR program relied on the leadership and
expertise of the ICACBR/Queen’s University team with support from the Canadian International Development Agency (CIDA). The initiative developed essential services for PWD and their families during and after the conflict and activities provided opportunities for local therapists, nurses, physicians and volunteers to advance their skills and increase their capacity. It also delivered community services to the large vulnerable population who were left isolated in their homes and unable to access health facilities and services.

One of the key features of the CBR approach is that it shifted the patient’s role from one that was passive to one where they became active and involved, empowered and became participants in the decision making process (Edmonds, 2002; ICACBR, 2006; Peat & Jalovcic, 2009). Through projects administered by ICACBR between 1997 and 2006, the development of CBR programs provided an environment for PWDs to access rehabilitation services, count on quality services, and participate in community life. CBR proved to be an appropriate strategy in BiH in helping to alleviate social and economic pressures by facilitating reintegration of war victims into their communities (Edmonds, 2005a; Peat & Jalovcic, 2009).

2.4.5 KIPA “Clear Direction” Framework

Edmonds’ work (2005b) introduced development organizations to a new framework which enabled administrators and officials to review policies and programs for PWDs. CBR and disability were the backbone of KIPA and adhered to concepts embedded in the citizenship model of disability. It was
designed around four outcomes: knowledge, inclusion, participation and access (KIPA), with additional strategies developed to advance full citizenship for PWDs. Edmonds argued that disability and poverty are intertwined and that barriers to inclusion and integration must be addressed in order for PWDs to become full participants in their community. Mainstreaming disability plays a pivotal role in development strategies and an extensive checklist in the KIPA framework guides users to assess strategies in programming and policy design. “The primary applications of the checklist are to identify the need for including people with disabilities in the CSP [country strategy and program] and to identify the extent to which their needs should be included in the planning of the country program or project” (Edmonds, 2005b, p. 43). This framework was the result of two studies; the first was work done in BiH evaluating the mainstreaming of CBR in the post-conflict reconstruction of the national rehabilitation system (Edmonds, 2002), and the second was a baseline assessment of inclusion of disability in World Bank activities led by D. Stienstra (Stienstra et al., 2002). The KIPA framework was utilized in the examination of issues of integrating disability into poverty reduction strategies in India, Cambodia, Sri Lanka and the Philippines (Edmonds, 2005b). The KIPA framework is one approach developed to guide local, national and international governments, agencies and organizations when establishing programmes for PWDs by incorporating knowledge, inclusion, participation and access strategies. CBR strategies in primary health care provide an approach for mainstreaming integration opportunities for disabled persons. An adaptation of
the KIPA framework will provide the basis in the data analysis process of this study when looking at integration factors in post-conflict BiH.

2.5 Community Participation and Disability

When doing research on factors of integration in BiH it is important to address the concept of community participation. By the 1970s it was evident that physician and hospital based programs worldwide were not meeting basic patient needs in Southern countries (Zakus & Lysack, 1998). Community participation as part of the WHO strategy on *Health Care for All by the Year 2000* assessed the strategy of community participation and its impact on the provision of health care. The authors argue there are factors and predisposing conditions that lead to participation in health. However, findings showed a number of factors made it difficult for community participation to be sustainable: 1) varied health initiatives using community participation as a strategy, 2) the complexity of the community participation process, and 3) what community participation really meant. The study revealed that to be effective, community participation needs to be accepted into the wider community’s consciousness with a clear commitment from health professionals.

Qualitative research conducted in post-conflict Sierra Leone (dos Santos-Zingale & McColl, 2006) sheds light on PWDs and community participation. This research examined attitudes and help that PWDs look for from international agencies and governments after an armed conflict using the ICF participation domains (WHO, 2001) as the working framework. The researchers designed a
Participation/Environment Matrix based on the ICF nine Participation and Activities Domains. Findings of the study showed six of the nine domains were represented in the matrix (D4, D5, D6, D7, D8, and D9). Four unexpected themes regarding PWD’s attitudes surfaced: the desire to live in a community of people with disabilities; the desire to be recognized as equal citizens and be given equal opportunities; the desire to become economically independent; and a high expectation of assistance. Support from peers, a feeling of belonging, acceptance and increased social participation were factors influencing PWDs desire to live in segregated communities rather than be integrated. PWDs also felt that as a segregated and unified body they had more influence to lobby for assistance from internal and external agencies. The results of this study revealed that environment and circumstance often determine that PWDs do not necessarily strive for inclusion and integration within their community.

Edmonds’ study (2005a), however argues that common to all disabled and non-disabled worldwide, is the wish to participate. The difference between those living in Western societies and those living in developing regions is that often communities do not know how to facilitate change to include the participation of PWD. Edmonds’ findings show this is a “significant development weakness in countries in transition” (p.307). How then do health care reforms in BiH address issues of community participation for PWDs?
2.5.1 Community Integration and Participation in Bosnia and Herzegovina

Edmonds’ research on mainstreaming CBR in BiH (2005a) utilized a multi-method participatory strategy which included a survey, questionnaire, interviews, focus group meetings and a presentation of results. A grounded theory approach to gain knowledge through inductive and abductive reasoning was used over three phases of the research period. The results revealed that PWDs were increasingly becoming active community members in the BiH post-conflict environment and the key factor in this change was that the needs of PWDs were, for the first time, being included as part of primary health care. This shift in health care strategy allowed for PWDs to have a voice and become part of the decision making process. Sixty per cent of respondents of the practitioner questionnaire felt that rehabilitation should include strategies for social and economic integration and should not only focus on function and mobility. Further results indicated that 67% of practitioners and 50% of PWDs felt that work opportunities would improve, and 72% (practitioners) and 89% (PWDs) felt their daily lives would improve by including CBR as a strategy.

Barriers to integration included mobility within the community, employment, school attendance and recreational opportunities and were key issues for independence. The study results illustrated that positive attitudes towards PWD changed through community participation and individuals with disability were more aware of the importance of maintaining their presence and working with associations, government, and NGOs. One study participant commented, “Associations of disabled people need to increase their profile, and participate at
the Cantonal level to fight for their position to make them aware of their needs, culture, education, health, social care and protection” (Edmonds, 2005a, p. 302).

The gradual shift in community integration led to the increasing participation of PWDs through their involvement in joint decision making, planning and evaluation; however, their participation in leadership roles was still lacking. Edmonds illustrated that PWD in BiH were still struggling to participate fully in their communities but that with the advancement of CBR strategies this was becoming more and more possible (Edmonds, 2005a).

2.6 Attitudes and Persons with Disability

2.6.1 Cultural Implications

One of the challenges of the literature examining attitudes and disability is that data become dated quickly and often what is reported as attitude-related and based on ethnic background is actually more relevant to poverty. Another challenge for researchers is Western bias in recording disability findings, because in many cultures the concept or word disability does not exist nor has consistent definition, making it difficult to analyze (Frey & Campbell, 2002). Berry and Dalal (1994) identified that among the many factors that affect PWDs, the most critical is that of beliefs and attitudes, and that understanding disability itself is a key first step in improving quality of life. They contend that the social and physical environment is a major factor affecting quality of life. Their research focused on four communities: one in Bangladesh, one in Canada, one in India and one in Indonesia and how culture impacted attitudes toward disability. Differences in terminology, religion, tradition, ethnicity, and caste are among the factors that influence
attitudes, and cultural factors should be incorporated into development strategies or they become unsustainable. This research did not delve into nuances in BiH, but findings addressing cultural beliefs and attitudes toward integration and community participation and the need to be flexible to the needs of each individual community are key commonalities (Berry & Dalal, 1994; Boyce & Lysack, 2000; Thomas & Thomas, 1998).

2.6.2 Media Influence

The 2006 Handicap International survey of Disability in the press: How disability and people with disabilities are depicted in print media in Bosnia and Herzegovina, Montenegro and Serbia (Adams, 2006) found that irresponsible journalism perpetuated discriminatory images of disabled persons. People with disabilities were repeatedly depicted as incapable and dependent with derogatory and negative stereotyping. The key data used in this study came from press clippings covering a one year period, 2006, with over 100,000 articles from BiH. The author noted four key trends: the use of inconsistent and offensive terminology; the voice of the disabled was absent with non-disabled persons being interviewed on disability related issues; reporting was framed in the medical model; and, lastly PWDs were depicted as other when categorizing groups (Adams, 2006). The author, however, found positive examples that countered these trends when journalists approached their story from a social model perspective and used disability activists as their source. This reporting was usually initiated by disability advocates who had successfully worked with the media to communicate their message. The HI report found that more work
needed to be done in the region to support disability groups and stressed the media could play a key role in influencing positive attitudes towards PWDs (Adams, 2006).

2.6.3 Attitudes, Rights and Barriers

As the war ended, pockets of PWDs emerged from isolation, found a voice and began to take responsibility for advancing PWDs’ rights in answer to specific needs. While communities began to address environmental and physical barriers, they also discovered that attitudinal barriers presented an even greater challenge to quality of life. “Negative reactions, stereotyping and misconception remain major stumbling blocks” (Peat, 1997a, p. 659) and groups such as Disabled People’s International (DPI) advocated for the adoption of policies that facilitated integration and inclusion of PWDs and their families. Negative attitudes regularly prevented people with disabilities from entering the workplace causing financial pressures on the individual, family and community creating a situation of dependency. Hastie’s findings (1997) revealed that integration in BiH was not achievable unless initial work in the community was done to counter negative attitudes that came with the old medical approach. If access challenges were alleviated, PWDs would have improved ability to contribute to the economy and create a better quality of life. Community programs, such as CBR, “emphasize the role of family and the community and promote the right of disabled people to live within their communities and participate fully in all aspects of life” (Peat, 1997a, p.658). By taking into
consideration, rights and attitudes, programmes in BiH, health care reform could
meet the needs of PWD and their families.

Hastie’s work (1997) in BiH submitted that one of the critical obstacles
for PWDs is that of facing prejudice and discrimination. Community planners,
architects, designers, and service-providers uncaringly create architectural and
institutional barriers and it is attitudes like these that create additional barriers
when working to establish relationships with PWD groups. Peat (1997a)
contended that disability stems from society’s inability to change to meet the
needs of a “(perceived) disability rather than from that person’s incapacity to
meet the requirements of the society” (p. 659). Additionally, by placing
responsibility within the community, a better understanding of the challenges
faced by PWDs would be realized. The most important impetus for attitudinal
change in BiH would come through education (Hastie, 1997; Peat, 1997a;
Tsokova & Becirevic, 2009).

2.6.4 Persons with Disability Perceptions of Impairment and Self

Perceptions of disability in BiH by PWD themselves is key to the
research in this study. It is important to hear the voice of PWD directly in order
for the researcher to describe and understand the challenges they face in their
daily lives. In Deal (2003), Disabled People’s Attitudes toward Other
Impairment Groups: a hierarchy of impairments, it is argued that disabled
groups do not identify themselves as a common group but as individual
impairment groups. He suggested this area requires more research in order to
gain a better understanding of whether impairment groups see themselves as united, as separate entities, or as not having a *disabled identity* at all. Deal’s study revealed that the informal hierarchy that exists within the disability community has created a pecking order and creates inequality within its own population. This hierarchical thinking leads to the fracturing that exists within the larger body of disability groups. He recommended impairment groups pull together for their common cause in seeking equality and reducing discrimination. This approach provides a united voice for effective strategies in creating a change in attitude for and within disabled and non-disabled people alike. Until recently attitude rating scales led researchers to try to measure attitudes towards PWDs; however, Deal argued that qualitative methodology be used to further study in order to reveal new research and information as a more “rounded, richer picture of disabled people’s attitudes” (p. 907). The author argued that PWDs and disability groups need to address their own prejudices before they can insist and count on a totally inclusive society. This research study will examine how PWDs perceive the impact they have using their own voice to improve their own quality of life and break down barriers.

Lundgren-Lindquist and Nordholm (1996) conducted a follow up study which explored the impact of CBR on the lives of persons with disability. Interviews (n=77) revealed how PWD perceived their quality of life (QOL) after CBR programming was initiated three years earlier in the village of Moshupa, Botswana. They divided their sample population into two groups: 15-59 years (adults) of age and those over 60 years (elderly). Their findings revealed that
60% of adults and 7% of the elderly group considered themselves to have better QOL; 24% of adults and 13% elderly considered that they had the same QOL; and 16% adults and 80% elderly perceived that they had worse QOL since the inception of the CBR initiative three years earlier. This data revealed that there were interesting differences in perceptions of those under and over 60 years of age and that elderly people may have a different viewpoint than younger individuals. It also appears to indicate that it cannot be assumed that all people believe their quality of life is better after CBR has been initiated in a community. It is of interest that this is one of the few studies where persons with disability themselves were asked for their perceptions of their quality of life, giving them a voice and the possibility of improved active daily living (ADL) strategies. There is no documented evidence that people in BiH feel their voice is heard and acted upon.

2.7 Summary of Literature Review

In summary, the literature revealed that a wide breath of research has been conducted in post-conflict BiH; however, research into the factors that influence social and community integration for persons with physical disabilities is minimal. Factors common to persons with disabilities create complexities for community integration and social participation, suggesting cultural factors, attitudes, and health care reform and restructuring all play an important role in how disability is perceived within society and how it impacts services and care for persons with a disability. The review revealed that minimal research has been conducted based on data collected from the disabled
population itself. Furthermore, there has been no recent research exploring community integration and social participation of PWD in BiH in the fifteen years since the end of the war. This research study examines how PWDs perceive the impact they have using their own voice to improve their own quality of life and break down barriers.

2.8 Study Rationale

By reviewing the literature it is evident that there is limited research addressing factors that influence social and community integration of persons with physical disabilities in BiH. This study explored factors influencing integration of PWD in BiH through questionnaires and personal interviews with persons with disabilities. Suggestions for enhancing opportunities for community and social integration for PWD were drawn from the data, and were considered, illustrated and discussed. The researcher interpreted the data in order to understand the factors that influence integration of the PWD population in post-conflict BiH and in so doing it is hoped that this study offers insight into how these factors affect social and community integration of PWD.
3.1 Research Design

This study was designed to investigate factors that influenced integration of persons with a physical disability in post-conflict BiH and how these factors impacted social and community participation. A mixed methods procedure involving a concurrent embedded design (Figure 3.1) was used. One data collection phase incorporating two simultaneously occurring research methods was implemented, associating both qualitative and quantitative forms of inquiry (Creswell, 2009). Qualitative and quantitative data collection methods were used as means to elicit information and serve as the basis for analysis. The primary qualitative method guided the study while the secondary, quantitative method provided a supporting role and is embedded within the primary data. Three face-to-face interviews and thirteen questionnaires were organized by the researcher and data collection occurred over a two week period. Qualitative data explored areas that were not easily defined and did not have a strong theoretical base and provided richness in the research that quantitative data alone could not provide. This mixed methods procedure encouraged an environment that determined issues defined by persons with a physical disability as they described and reflected on perceptions of their lived experiences. The data from the two methods were not mixed but remained side by side to provide the researcher with an overall perspective of the study problem. This chapter will first describe the qualitative method used, including participant selection,
inclusion/exclusion criteria, and analysis procedures. The same information regarding the quantitative data collection method follows.

**Figure 3.1: Study design using a concurrent embedded procedure**

![Diagram of study design using a concurrent embedded procedure]

### 3.1.1 Research Paradigm

The philosophical base of this research study stemmed from a pragmatic worldview or paradigm focusing on the research question, and utilized different approaches to help understand the problem. Mixed methods researchers do not follow a single philosophy or methodology, but draw freely from both qualitative and quantitative methods, allowing choices in techniques and procedures that best suit their purpose.

Unlike traditional qualitative and quantitative researchers who subscribe to a single
method of science or understanding, mixed methods approaches utilize multiple perspectives providing overall strength to the research and allowing a range of philosophical assumptions (Creswell, 2009).

3.2 Research Implementation Process

The research study implementation process was conducted over three phases.

3.2.1 Phase 1: Orientation Mission

Phase one took place from May 4th to 10th, 2007 in Sarajevo as a seven day scoping and orientation mission. At this time the researcher met with Dr. Mirsad Muftic, Director of CBR programs at the Mojmilo Health Clinic, Centar Za Fizikalnu Theraiji I Rehabilitaciju, an established Community Based Rehabilitation centre in Sarajevo. A copy of the Research Proposal was given to Dr. Muftic for discussion and reference. Permission to conduct research, logistics and selection of participants were discussed and agreed upon. Also attending was Dr. Malcolm Peat, Executive Director of ICACBR/Queen’s University. Several meetings with local translator, Ms. Sanela Sadikovic, were held to discuss the needs, logistics and timeline required to prepare for the data collection phase during the next visit. A letter of permission with approval to conduct research in the region was received by the researcher from Dr. Slobodan Trninic, Director Domova Zdravlija, Kanton Sarajevo (Appendix C) during the May 2007 scoping mission. A copy of the Research Proposal was also given to Dr. Trninic. No data collection took place during this phase of the study.
3.2.2 Phase 2: Research Instruments Review

The second phase of the research project took place in November 2007 when a review of the research instruments occurred. Three outside reviewers, including one person with a physical disability from BiH, one occupational therapist from BiH and one Canadian researcher reviewed the questionnaire and interview strategies. Their feedback was assessed and appropriate changes were made to the instruments. The researcher’s Advisory Committee also had the opportunity to review the research proposal and feedback was elicited and acted upon.

3.2.3 Phase 3: Data Collection Period

The third phase of the study was conducted in June 2008. During this phase a two week data collection period occurred in Sarajevo. The CBR in the Centar Za Fizikalnu Terapiju I Rehabilitaciju at Dom Zdravlja Mojmilo Novi Grad Saraj Polje-Sarajevo was chosen as the primary research site because of its past collaboration with ICACBR/Queen’s University, making it a convenient sampling site. The Clinical Centre University Sarajevo hospital, the secondary research site, was chosen as the location to conduct additional data collection, again due to previous partnerships between the researcher and local personnel.

During the research period the researcher maintained a log book to record all aspects of research procedures and processes including personal thoughts and reflections, observations, logistics, meetings, data collection procedures, data collection analysis, assessment and review of investigation and research methods.
3.3 Data Collection Strategy

Interviews formed the basis for the primary or qualitative component of data collection, and a questionnaire was used to elicit secondary quantitative data. Both qualitative and quantitative data were collected to address the same research question. The quantitative component of the study was designed to provide a more balanced perspective on the research question through gathering additional descriptive data from a broader sample of PWD. The primary research question guiding this inquiry was, *What factors influence community integration of persons with disability in post-conflict Bosnia and Herzegovina as perceived by persons with disability?* The researcher sought to answer the research question with the following sub-questions:

a. How do PWD in BiH perceive the current level of integration of PWD in their community?
b. Do PWD perceive some factors as more important to achieving integration than others?
c. What role do attitudes play in community integration?
d. What kinds of barriers to integration exist for PWDs?

3.3.1 Interviews

The researcher, with the aid of a local translator, conducted face-to-face interviews (n=3) with clients of the CBR centre from Centar Za Fizikalnu Terapiju i Rehabilitaciju in Sarajevo. These individuals acted as the primary participants of this study. A semi-structured interview adapted from the KIPA framework (Edmonds, 2003) was used to gather information to help understand the perceptions, personal experiences, and background of PWD, and helped to identify factors that influence social participation and community integration. The interviews targeted four key areas: knowledge,
inclusion, participation and access, and linked them to personal experiences and reflections of the participants.

3.3.1.1 Instrument

A semi structured interview (Appendix D) was developed by the researcher. The interview consisted of six demographic questions and six open ended questions adapted from the KIPA framework (Edmonds, 2003). A secondary set of questions was used to probe when the researcher felt additional discussion could enhance the richness of the data. Six additional questions were designed to use if time permitted. Interview questions were designed incorporating the four KIPA themes, and with the aid of a local translator, the researcher conducted interviews (n=3) and recorded the findings. Each interview took approximately sixty to seventy minutes, incorporating five to ten minutes for the researcher to establish a rapport with the interviewee. During the interview the researcher probed the participants when it was felt this would enhance the richness of the responses. During the interview process an audio tape recorder was used to record the proceedings for verification purposes. The translator acted as an assistant in communicating with the participants in terms of interview procedures and logistics. Simultaneous translation during the interviews occurred enabling the researcher to probe further as deemed necessary. The researcher took notes and recorded observations during the interviews.

3.3.1.2 Participant Selection

Recruitment for the interview component of the study took place during the researcher’s second trip to Sarajevo in June 2008. Purposeful sampling was used to locate
participants with physical disability and was based on recommendations made by Dr. M. Muftic, Director of the CBR center in the Mojmilo Health Clinic in Saraj Polje, the northwest area of the city of Sarajevo. Dr. Muftic made initial contact with the participants to seek participation willingness and availability. The researcher, with the help of the translator, then proceeded to set up logistics to conduct each interview. The sample size was predetermined (n=3) given the time and resource constraints of this phase of the study. Participation in the interview process was voluntary and participants were selected using inclusion/exclusion criteria, as follows.

Inclusion criteria for participation in the interview included the following: adult population (over 18 years of age), have accessed rehabilitation services at the CBR Saraj Polje Center at least three times over the previous six months, present a medically diagnosed physical disability for longer than 2 years, and have verbal communication. Including adult individuals who had received services at the CBR Centre provided the researcher access to participants who would have some prior knowledge of opportunities for rehabilitation and services for PWDs in Sarajevo, providing a knowledge baseline for social factors that enhance integration. By having lived with a physical disability for a period of two or more years, the participants would have personal experience with various community living situations, providing a valuable primary resource to the study. Exclusion criteria included potential participants who had a cognitive disability or hearing impairment, which would compromise the ability to participate in a verbal interview with oral translation. Based on the inclusion/exclusion criteria no participants were excluded from the study.
Upon completion of the sample group selection, the local translator set up times and locations to conduct the interviews. Prior to committing to the interview each participant was given a translated Letter of Information (Appendix E) outlining the study and interview process. Upon understanding the requirements of the interview and verbal agreement was given, each participant was asked to sign a Letter of Consent (Appendix F) which complied with the requirements of the Queen’s University, Research Ethics Board.

3.3.1.3 Data Analysis Process

A generic form of analysis was used as the basis for data analysis in this study. In this approach, Caelli, et al. (2003) describe the validity of the generic approach in qualitative research, suggesting that it “is not guided by an explicit or established set of philosophic assumptions in the form of one of the known qualitative methodologies” (p. 9). Creswell (2009) stated that the generic form of analysis is often seen where, “the researcher collects qualitative data, analyzes it for themes or perspectives, and reports on 4-5 themes” (p. 184). The researcher adhered to Creswell’s approach, which is interactive and interrelated and not strictly linear in style.

Following raw data collection, the researcher transcribed the English responses in preparation for analysis. Further preparation occurred by visually scanning the material, reviewing the transcripts, and typing the field notes. The data were read to get a general overview of the information and a period of reflection occurred for the researcher to get a sense of its overall meaning. Manual coding, sorting, and arranging data for each interview were performed by the researcher. Manual coding was performed as a result of
the small data sample, and the desire for the researcher to be as close to the raw data as possible. Each interview participant was assigned a numeric code to assure anonymity and confidentiality. The coding process generated a general description of the participants allowing the researcher to examine the data across interviews for common themes. Colour coding was used to identify and organize the data into four predetermined themes provided by the KIPA framework. Additionally, key words were identified, extracted and sorted based on the KIPA themes.

Scott (1997) used identification of key words to illustrate a method of sorting key words within text to show association through grouping to reveal commonalities and stereotypes. He indicated that procedures for grouping words were not refined and further research was needed with different types of text. Scott defined a key word as a “word which occurs with unusual frequency in a given text” (p.236). He identified three stages for identifying a key word: 1) a reference word list is developed containing types and frequencies of each word, 2) a similar list is developed based on the types of words that are to be found, and 3) each word in the individual word list is compared with the reference list. The researcher determined, for this study, if a word occurred two or more times it was considered “key”. Due to the small sample size, the researcher modified this method to extract key words from interview transcripts to seek commonalities and differences that apply to the KIPA themes. Particular attention was paid to commonalities pertaining to community integration and social participation factors. Emerging themes were cross referenced for insightful understanding of the data and the researcher determined that the information would be presented in a narrative format to convey the
findings. Interpreting the data was the final step in the analysis process and is explained later in this chapter.

### 3.3.2 Questionnaire

The researcher used a self-designed closed response questionnaire to elicit information to be used in a supportive role to the interview data. The design of the questionnaire was adapted from the KIPA framework (Edmonds, 2003). The questionnaire, like the face-to-face interviews, elicited data related to perception and personal experience related to factors that influence integration of PWD within the community. The questionnaire consisted of six demographic questions and twenty one closed ended topical questions.

#### 3.3.2.1 Instrument

A questionnaire (Appendix G) consisting of six demographic questions and twenty one closed questions was adapted from the *Disability Checklist on Integration of Disability-Relevant Programs, Projects, and Activities* using the KIPA framework (Edmonds, 2005b, p. 44-45). The questionnaire was translated from English into Bosnian by the local translator who was used throughout the course of this study.

#### 3.3.2.2 Participant Selection

Convenience and snowball sampling were used to identify participants with physical disability in Sarajevo to participate in the questionnaire component of the study. Sample size was not predetermined given the uncertainty of how many participants could
be recruited to complete the questionnaire during the data collection timeframe. Recruitment for the questionnaire component of the study took place during the researcher’s second trip to Sarajevo in June 2008. Participation in the questionnaire was voluntary and participants were selected using inclusion/exclusion criteria. With the assistance of the translator, the researcher invited fifteen PWDs to complete the questionnaire. Thirteen were completed and returned over a period of three days.

Inclusion criteria for participation in the questionnaire included the following: individuals who were adults over 18 years of age, have accessed rehabilitation services at the Clinical Center University Hospital Sarajevo at least three times over the previous six months, present with a medically diagnosed physical disability for longer than 2 years, and have verbal or written communication skills. Exclusion criteria included potential participants who had intellectual disability or hearing impairment which could compromise the ability of the translator and researcher to accurately communicate the goals and processes of the study. Similar to the interview inclusion/exclusion criteria, the questionnaire criteria was designed to include adult individuals who had received services at the Clinical Centre University Hospital in order to provide the researcher access to participants who would have some prior knowledge of opportunities for rehabilitation and services for PWDs in Sarajevo. This provided a knowledge baseline for social factors that enhance integration. By having lived with a physical disability for a period of two or more years, the participants would have personal experience with various ADL situations, again providing a valuable primary resource to the study. Based on the inclusion/exclusion criteria no participants were excluded from the study.
Upon completion of the questionnaire sample group selection, the local field assistant and translator distributed and collected the questionnaire sheets. Prior to committing to the questionnaire each participant was given a translated Letter of Information (Appendix H) outlining the study and interview process. Once questions were answered and verbal agreement was given, each participant was asked to sign a Letter of Consent (Appendix I) which complied with the requirements of the Queen’s University, Research Ethics Board.

3.3.2.3 Data Analysis Process

Upon completion of the questionnaires the researcher manually scored, ranked and reviewed the data. Each questionnaire was assigned a numerical code to provide participant anonymity and confidentiality. The questionnaire was ranked by totalling the numeric scores for each question based on the Importance Scale (Appendix J).

3.4 Critique of Data Collection Strategy

3.4.1 Strengths

The validity of the instruments developed for this study was enhanced through discussions with the local CBR Centre Director and other rehabilitation specialists. Collaboration with the developer of the KIPA framework was undertaken early in the study process to make each question selected as relevant as possible to the research objectives. Further credibility was achieved through accuracy and authenticity of data utilizing reflexivity, thereby holding the researcher accountable for biases, role and over-
involvement. Peer review was conducted with three impartial colleagues who discussed and reviewed the research questionnaire and interview questions.

Trustworthiness was based on soundness of the research established reflecting on its credibility, neutrality, applicability and consistency (Creswell, 2009). The study aimed to reflect the reality of the experience of PWD and provided participants with the opportunity to review the researcher’s interpretation of the data. Member checking occurred via electronic communication with the assistance of the local translator, whereby the documenting of data collected was reviewed by participants to ensure it represented an accurate account of their experience. This alleviated any evidence of researcher bias. Triangulation was established by using PWD populations from two different health centres and by using both qualitative and quantitative methods of inquiry. Rigour was reflected through the researcher’s analytical log where she recorded thoughts and events that took place during the research process. Rich and descriptive quotes by the participants provided findings that were transferable to another situation. Field notes were taken by the researcher to enhance the findings of the questionnaire and interviews. Audio tape recording was utilized during the interviews for verification and clarity purposes.

3.4.2 Assumptions and Limitations

3.4.2.1 Assumptions

The successful completion of this research project was based on a number of assumptions. One assumption was that recruited participants had at least some awareness of factors that influence integration of disabled people in their community in BiH. A
second assumption was that the participants would provide a large enough sample to merit data analysis, discussion and conclusions. A third assumption was that the small sample group of the study would provide a sufficiently broad and unbiased overview of the situation on which to draw preliminary conclusions. Lastly, it was assumed that an accurate transfer of responses during the interview would occur during simultaneous translation.

3.4.2.2 Limitations

Six limitations with the research study were identified. The first limitation was the short time frame for the data collection phase. Due to restricted resources, a longer in-depth study period was not feasible. The researcher provided personal resources for the study, limiting the length of time for field research which would have allowed for a larger population base for the study.

A second limitation was created by parameters that determined the participant pool. The local translator was available after 16:30h which may have negated the involvement of some willing participants who were only available during daytime hours. The prescribed hours may have created bias based on a population available during restricted hours.

A third limitation was the scope of the sample group. The research was limited to a small group of persons with physical disability and included the perspectives of only PWD's on their experiences of community integration. Broader, undetermined studies could also include family members, educators and rehabilitation specialists made up of physical therapists, nurses and physicians. This approach could provide a wider range of
participants who might offer additional perspectives and further understanding of factors that influence integration issues within the community.

A fourth limitation was that the data were only representative of what the participants chose to share with the researcher, who was a foreign investigator from another culture. This may also have influenced the types of information shared based on underlying political concerns. The participants may also have felt uncomfortable disclosing certain aspects of their experience.

A fifth limitation was the possibility of participant bias emerging as a result of being recipients of care at the CBR Center and the University Clinical Center. Participants may have felt obligated to convey only favourable statements regarding services they received.

A final limitation in the research was that the data collection was restricted to an established urban population. A more diverse data sample would have been revealed if participants from rural environments were also included, reflecting the rural experience, including access to services. The urban perspective of this study may not fully reflect the situation of all PWD in BiH.

3.5. Ethics

Participants received letters of invitation to participate in the study. After participant agreement, letters of consent prior to participation were reviewed and signed. Every effort was made to ensure that anonymity was maintained through a coding process optimizing complete transparency.
Approval for research was acquired from Dr. M. Muftic, Director of the Community Based Rehabilitation Centre Saraj Polje- Sarajevo, prior to the research period. An additional letter of approval was received from Dr. Slobodan Trninic Director of the Domova Zdravlja, the wider health region of Sarajevo. Draft Questionnaires, Interview questions and supporting Guides, along with the draft research proposal were submitted to the Queen’s University Research and Ethics Board for approval in November 2007. Approval was granted on November 16th, 2007. The final proposal and full application were submitted to Queen’s Research Ethics Board in April 2008 and final approval was received in May 2008 (Appendix K). Translated explanatory Letters of the Research and Letters of Consent were distributed in person by the principal researcher and local translator at the outset of the data collection period. The risks and benefits of involvement in this study were thoroughly explained to participants and they were allowed to withdraw from the study at any time without question. There were no inherent risks that participants needed to be aware of. Time demands on the participants were estimated to be sixty minutes for the interview sessions and twenty minutes for the questionnaire.

Confidentiality and security of data were the responsibility of the principal researcher. Hardcopy and electronic data were stored in a locked filing cabinet at 154 Albert St., Queen’s University, Kingston, Canada. Hard drive data were password protected and research participants were provided with numeric codes to protect their identities. The document linking numeric codes and identities was maintained in hardcopy in the secure location.
Chapter 4

RESULTS

Results obtained from the research data are presented in this chapter. First, results from the qualitative or interview component are discussed, including participant profiles and participant perceptions of community integration and social participation based on their experiences as individuals living with a physical disability in post-conflict Bosnia and Herzegovina. This is followed by a discussion of the quantitative results, including demographic characteristics and findings regarding factors that influence community integration and social participation based on questionnaire responses.

4.1 Qualitative Findings

4.1.1 Participation

Face to face interviews were conducted with three participants recruited through convenience sampling through the principal researcher’s contacts with the Director of one CBR Centre in Novi Grad Sarajevo. The participants were residents of Sarajevo, Bosnia and Herzegovina who had lived with a physical disability for two or more years. Gift certificates to a local bookshop were given to each interviewee as a thank you for their participation. A local translator provided simultaneous translation for each interview.

4.1.2 Participant Profiles

The interviews revealed commonalities and differences in their perceptions of integration of those living with a physical disability. Two of the participants were more
articulate and expanded on their thoughts more easily. Both of these individuals were male and both were employed fulltime. The unemployed female answered the questions posed by the researcher but needed probing to expand on her responses. This probing prompted additional discussion about her experiences as a person living with a physical disability. The participants’ names throughout this study are pseudonyms used to provide anonymity to protect confidentiality of each interviewee.

Participant one, Azra, was a 59 year old female with secondary school education. In September 2002 she suffered a stroke and had no hand function and very limited use of her legs. With assistance, she used a wheelchair fulltime for mobility. She reported that she only feels emotionally strong with the help of her husband and daughter. She lived in an apartment in Sarajevo with her husband and had limited opportunity to leave her living accommodations and can only do so with the assistance of her husband or adult daughter. She was unemployed. She liked to bake at home especially when her daughter came to visit. Azra lost her son during the conflict and received rehabilitation services through military benefits she received due to his death. She visited the Domova Zdravlija CBR Centre several times a month for physical rehabilitation services. During the interview Azra was friendly and pleasant and was open and willing to discuss her situation although often became emotional and tearful when talking about her son and her own health status. She was a member of the Sarajevo Association of Paraplegics.

Participant two, Basir, was a 50 year old male who acquired his disability in 1992 as a result of the war. He considered himself a war victim. He had a lower limb amputation, used a prosthesis and walked with a minor limp but had no overall mobility issues. He drove and owns a car. He regularly visited the Domova Zdravlija CBR Centre
Participant three, Duran, was a 47 year old male who was born with cerebral palsy. He walked unassisted but with some difficulty. His speech was also affected by his condition. He visited the Domova Zdravija in Sarajevo regularly for physical therapy services. He had a college education. Duran was employed fulltime as the President of the Association of Persons with Cerebral Palsy of Canton Sarajevo. He was a resident of Sarajevo and was not married. He credited his mental and emotional strength to his parents and their motivating attitude in encouraging him to reach his potential. As a teenager, with his parent’s help, he realized his disability would not be cured so he stopped hoping and waiting for medical intervention to help him. This became a turning point in his life and he dedicated himself to living up to his potential despite his disability. Duran felt his purpose in life was to help others reach their potential and advocated for persons with disability to lead purposeful and meaningful lives.
4.1.3 Terminology Reflected in the Context of KIPA

The interview was designed with questions related to four themes adapted from the KIPA framework: Knowledge, Inclusion, Participation and Access. In this section the researcher placed the participants’ own words into the KIPA themes providing preliminary insight into perceptions that PWD have of community integration and social participation factors. This allowed the researcher to synthesize responses systematically for further analysis. Fifty three relevant key terms emerged from the interviews with 38 fitting into one of the four themes based on researcher sorting.

An additional fifteen terms emerged that were relevant and crosscut all themes based on researcher key word sorting. They were not, however, specific to a particular theme, but contributed to the overall richness of the data (Table 4.1). This sorting scheme provided an additional opportunity for researcher synthesis and reflection on PWDs’ perspectives of their experience of living with a disability.

**Table 4.1: Terminology relevant across KIPA themes and crosscutting terms**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Inclusion</th>
<th>Participation</th>
<th>Access</th>
<th>Crosscutting Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate</td>
<td>Acceptance</td>
<td>Barriers</td>
<td>Access</td>
<td>Change</td>
</tr>
<tr>
<td>Approach</td>
<td>Attitude</td>
<td>Community</td>
<td>Challenge</td>
<td>Courage</td>
</tr>
<tr>
<td>Connections</td>
<td>Equality/equal</td>
<td>Disability/disabled</td>
<td>Environment</td>
<td>Enemy</td>
</tr>
<tr>
<td>Contribute</td>
<td>Inclusion</td>
<td>Employment</td>
<td>Government</td>
<td>Fight</td>
</tr>
<tr>
<td>Education/school</td>
<td>Integration</td>
<td>Function</td>
<td>Health care</td>
<td>Future</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Involv</td>
<td>Institution</td>
<td>Hierarchy</td>
<td>Goals</td>
</tr>
<tr>
<td>Leadership</td>
<td>Isolation</td>
<td>Needs</td>
<td>Opportunity</td>
<td>Help</td>
</tr>
<tr>
<td>Understanding</td>
<td>Society</td>
<td>Participation</td>
<td>Rehabilitation</td>
<td>Jealous</td>
</tr>
<tr>
<td></td>
<td>Support</td>
<td>Programs</td>
<td>Services</td>
<td>Money</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social welfare</td>
<td>Transportation</td>
<td>Negative</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Pity</td>
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<td>Shame</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Spirituality</td>
</tr>
</tbody>
</table>
The first grouping of words fell within the *knowledge* theme based on researcher sorting. These terms were related to knowledge because they illustrated a relationship or association between the theme and the words of each interview. By using terms such as “advocate” and “leadership” the participants’ language suggests they recognized there is a relationship between knowledge and community integration. For example, in order to provide leadership an individual needs a certain level of knowledge to advocate on behalf of his or her peers. The same sorting principle applied to each of the remaining themes. An example of how the *inclusion* word cluster was connected was that for integration to be accepted in society, attitudes had to be addressed. The *participation* theme focused on words that incorporate ideas that related to individuals becoming an active member of their community and factors that may or may not hinder their participation. Terms such as “barriers”, “employment” and “social programs” each play a role in the degree to which an individual was able to participate in community life. The fourth KIPA theme included terms such as “services”, “government” and “rehabilitation” reflecting language that targets possible avenues for PWDs to access community programs.

Finally, as noted above, the crosscutting terms were not associated with a specific theme, but convey expressions of emotion or uncategorized words, that can be applied within any of the KIPA themes adding another level of richness to the data. Examples of this were, how the crosscutting term “rights” might interact with the themes; without *knowledge* of disability and *rights* it would be difficult for a PWD to advocate on their own or others’ behalf; without an awareness of their *rights* it might be difficult for a PWD to understand that activities and programs should be *inclusive*; an understanding of the *rights* of PWDs could provide strength and courage to *participate* in community
events; and, without knowing their rights PWDs may be denied access to services that they are entitled to.

4.1.4 Key Findings and the KIPA Context: Interviews

The participants were consistent in their belief that knowledge is critical for understanding their rights and opportunities for community integration. Knowledge of rights, education, leadership, and community connections emerged as factors to social participation and integration. Basir expressed that some PWDs were more aware than others of their rights, “I am knowledgeable of my rights but most disabled are not and it is very different for them. If everyone knew what they are entitled to or what they should be entitled to it would easier for all of us (Basir).” This suggested that the level of knowledge that PWDs have can have a major impact on how PWDs live, what services they receive, or what kinds of programs might be available to them.

The participants described education as a key to understanding and changing attitudes both from the wider community’s perspective as well as within PWDs themselves. An understanding of the challenges PWDs face was verbalized by the participants. One commented that, “More understanding is needed. We need everyone to understand about us. If no one understands we cannot have change and we will not be part of our city. Our families are good but we want to be part of the activities outside too (Basir).” Azra described the relationship between education and attitudes:

“Education is important and would help in understanding challenges of people with disabilities. One approach is not enough. If people had education about us then they would have a good attitude about us. Right now most people have bad attitude. During the war aid was better. Help was easier to get and it was an important privilege before. People cared about you. Now people pity me and that is hard. Most of the time I feel alone because no one understands how it feels to
live in a wheelchair. I don’t have my old friends anymore because they do not know how to help me and are busy with their lives. People need to understand and if they knew what to do and had education about people in wheelchairs it would be better (Azra).

Azra also described the link between financial resources and education, stating, “The government has money to give schools but they don’t care (Azra).” Duran described how a shortage of money for education was regarded by another group of PWDs:

“More money is needed for education and teachers. Government is slowly working for inclusion in education. Many teachers are not helpful and schools are inaccessible. Children are allowed to go to school, they have the right to go, but the schools do not have ramps and they cannot go into the buildings. If more money was given to schools and teachers disabled people could learn and be able to get jobs and look after themselves. If schools worked on teaching children about disability then they would grow up to be more accepting and helping for people (Duran).”

Strong leadership in decision making on behalf of disabled groups was described as being critical in order for government and community groups to change attitudes. Participants described how government needs more knowledge in order to provide education and employment opportunities.

“The government should know more and if the people in charge knew more about us they would give us better treatment. It is up to us to give the government knowledge about us. Even when some of us are lucky to have jobs there are poor leaders at work. If people had knowledge about who we are our country would treat us disabled better. Now there is a spiritual emptiness in the country. There is less belief, less religions. I am spiritually rich because of my disability. It is because I have knowledge of the real world and what hardships people have to live. I want people in charge to know this. This would make our country better (Basir).”

This statement suggested that there is self-awareness, at least among some PWDs, that they need to be more active in advocating for themselves, especially with community leaders and government officials. Taking leadership roles within community groups and
organizations would provide an opportunity for knowledge transfer, and efforts could be initiated to eliminate the status quo where those in power dictate how PWDs live. Taking responsibility for providing knowledge, and promoting and changing community attitudes and education, would increase opportunities for PWD to participate in a wider range of work and social activities supported by community members. Traditionally, PWDs are silent community members whose voice is never heard. However, with efforts to restructure health care since the end of the war, there appeared to be a gradual transition from passive consumers to knowledgeable advocates among a new generation of PWD. Basir suggested the need for this kind of movement, but also that there was much work to be done before reaching this kind of goal. The impetus for advocacy and responsibility appear to stem from a sense of despair and resentment of being regulated by powers that lack knowledge and understanding.

Similarly, Duran indicated how leadership and knowledge played a role within disability groups. He described that disability groups were divided on how to come together under one homogeneous organization for advocating for all PWDs:

“There is a hierarchy in disabled groups. There needs to be one large group to talk for all groups. This is starting but there is so much fighting about who should be the leader and everyone wants their own disability to be the most important, the one that should be at the top. We cannot get anywhere like this (Duran)”.

Azra revealed how she felt about disability groups and the role they play in community integration. Disability groups are trying to educate through organizations and passing on knowledge; however, there are barriers even among themselves within various disability groups. Like Basir, Azra expressed a feeling of frustration and despair:

“I am a member of the Association of Paraplegics but it is better for me to be quiet because I know my comments will not do anything. There are about five or six of us that feel this way and we call ourselves the ‘hopeless fighters’. We are
helpless even in the group that is supposed to help us because of the hierarchy. If we listen to each other we can work together and make it better in Sarajevo for all us in our situation (Azra)”.

Basir described his leadership role and how he felt it impacted the integration of PWDs:

“I understand what the needs are so I can help others as President of the Association. So many people have no heart, no understanding, so if I can help I feel I am obliged to help and I am happy to take that role. I want to contribute to my community, to give back to my parents. It will take people with disabilities to show everyone else, the government, the schools, the shop keepers, the children, everyone else will see what we are capable of and will see us as a people of our society (Basir)”.

Being able to navigate the system to get what was needed, and having the knowledge of who to go to, emerged as key in order to receive necessary services, “If you want to get good rehabilitation you need to know who to go to, who has connections. This is important if you want the best help. You have to have the right connections if you know what I mean. If you do not know about where to go you cannot get the best help that you can (Duran)”.

Azra also described the difficult process required to receive rehabilitation services:

“It is a complicated process to get a slip of paper from a doctor. Only the doctor can get you to the private spa which is the best rehabilitation. Before the war anyone could go there to get help. Now you have to have a connection with a doctor and pay and it is too much money for most people. It is only good for rich people now and the rest of us cannot go. Even if we get a paper from the doctor it is hard to go there. You have to have a car and so it is impossible so we don’t try anymore. There are long waiting times for rehabilitation or you can go to the private spa. The [CBR] Centre is the best we can do and it is good too but the spa has more help and it is nice to go outside the city sometimes (Azra)”.
Inclusion was the next KIPA theme that participants responded to during the interview process. They expressed the view that attitudes were negative and they needed to change before PWD could feel included in their community. They wanted to be treated equally and felt that barriers in society were a critical problem. There has been some government movement for integration although implementing policies has been slow and there was lack of support in the workplace for those who were employed. The interviews revealed that persons with disability needed to set their own goals and needed to accept their own disability. Attitude, equality and barriers were common topics described by the participants when responding to questions about inclusion.

The participants indicated that community attitudes were negative toward PWDs and created a stigma, “Attitude is negative and one of pity. The attitude of the community must change for us to be included. There is no change in attitude since the war (Azra)”. The other participants echoed Azra’s statement, “Attitudes are very negative and we cannot be in our society and be included if we have so many who are negative about us. Since the war there has been a change in attitudes, but it worse now than right after the war” (Basir); and, “Attitudes play a big role in the community. We have negative attitudes in Sarajevo and until this finds a change we will not be able to be a part of everyone else (Duran)”.

Participants stated that both their own feelings of equality, as well as being treated as an equal by the community, were primary objectives when discussing inclusion. They expressed that being treated as an equal to able bodied community members is essential in order for successful integration. The desire to be treated as an equal was a cause for frustration. Azra expressed her own sense of equality, and how she and other PWDs were
capable of participating in many activities in their community, but getting this across to
others was difficult:

“I feel equal to others. I want to be equal to others. I have to be. I feel I am equal but
others do not feel I am equal though…. I only feel equal when I am at home. I want to
be included outside my home too. Some human rights have helped to start a process
but it is slow and society is a big problem (Azra)”.

Basir reiterated these thoughts of equality and inequality and described his
experience of trying to be included and have all PWDs included in community activities
and employment:

“There has been a psychological change but there is no real integration or inclusion-
none, none! There is negative energy between people now. NGOs tried to start human
rights and change but for example dogs for the blind are not allowed anywhere so no
rights were really started and places have very few rights so we cannot be included
anywhere. Another example is where I used to work. The future was not good at
work when the leaders at the top changed and I had no good support at work from my
Board or the NGOs so I quit. We need many ways, many people, many approaches,
equality is meaningless with only one approach. Another big problem is that there is
no equality among us, among the disabled, so until we are one group we will never
get anywhere (Basir)”.

Alternatively, Basir described a different viewpoint in that change is taking place. He
described a situation where the government is moving toward change and working to
integrate PWDs into the community:

“The government is working for inclusion in education especially intellectual
disabilities. There is still a long way to go to reach Western standards but it is a
beginning. There has been some change in Sarajevo with the Health Ministry and the
city, they are supporting us better. Most though feel isolated and feel the government
is the enemy. We need to be able to fight for change within the government for
opportunities. We cannot forget who we are and where we came from, we cannot
forget the disabled. I do not want to forget this but it is hard. I want to take my son to
the monument in Srebrenica but I still do not have enough courage to go. We all need
the courage to fight for an equal place. So I can do things and go places and it is
getting better but we still need courage (Basir)”.
Barriers were another topic that the participants focused on when describing integration, and community and social participation. Differences and commonalities illustrated the diverse thinking that exists among PWDs. Bazir commented that both attitudinal as well as physical barriers created difficulties to becoming full community members. He suggested PWDs should take responsibility for changing attitudes and advocating for changes to their physical environment:

“Attitudes are a barrier for us. Even with people thinking like this we have to set our own goals and work toward them. This will help with this barrier. It will be hard but we have to do it…. Buildings like schools and shops, even government buildings have barriers like no ramps. I used to work at the US Embassy so I had to go everyday. They had concrete blocks all around the front of the embassy and I had to go all the way around them. It was not right so I told them that it was hard for people to get in but they did not do anything about it (Basir).”

Duran described a different experience when talking about barriers. He illustrated barriers can be overcome by taking personal responsibility for inclusion in community activities and the need to rise above the stigma. He shared his story of his journey in finding the best way for him to make a difference working for and with other PWDs:

“There are no barriers in the community except myself! I go to movies and I participate in everything even though I cannot walk very well. When I turned 16 I realized I was not going to get better so I set goals for myself and I feel successful because I set the goals and worked toward them. I studied Law and wanted to work with a company but decided instead my spot was to work with the disabled people because I understand our needs. This is how I became the President of the CP Association. So there are no barriers for me (Duran).”

He acknowledged, however, that barriers come in different forms for PWDs, “Money is a major barrier for everything: rehab, education, transportation, and health care. Family attitudes are also barriers. Many families feel shame and hide us in their house because they cannot accept the disability (Duran).” Azra also expressed financial resources as a
barrier to integration and independence, “I would like to go to the private spa but it is too much money so money is a problem for me too so I cannot do that (Azra)”.

Duran described however, that changes were beginning in Sarajevo, and programs and services were being implemented but many PWDs were not aware of what was available:

“There have been some changes especially at Sarajevo canton. The Minister of Health in Canton Sarajevo and the city of Sarajevo are supporting the Association better. Lately they have been giving money to the Association to find physical therapists to do rehab in homes and CBR centres. Also anyone older than 16 is getting money from the city. Physicians are including more physical therapy in their treatment for CP and every two months more members get included in this treatment. This treatment helps people participate more in activities because they will be able to move around better. It is a bit hard to become a member of the Association. You have to get a letter from [Dr] Muftic to be referred and you have to fill out two forms—one from before the war and one for after the war. All the outpatient clinics were destroyed in the war but the spa was rebuilt but really only for tourists because they pay a lot of money to the government to go there and the government wants to make money. The tourists pay about 1000 km per week. We are trying to get more people working too. Now the Association has 315 members but only 15 are employed. We have to work harder for everyone to be able to find jobs to participate in everyday life. Many disabled people do not know about the different associations in Sarajevo (Duran).”

Despite knowing what barriers create difficulties for integration, such as environmental, and lack of financial or family support, it appears challenges remain for PWDs to overcome obstacles for integration.

Participation was the third KIPA theme that study participants responded to. The participants expressed above they felt the need for family support, more programs and more money. Basir expressed awareness that many people in the wider community did not want to see PWDs integrated because they have become a negative reminder of the war. Azra indicated that little progress for social participation and integration was being made because it was not a priority with the government and community leaders and they
did not listen to those who advocated for people with physical disabilities. She also described the feeling of isolation she felt because she could not participate in community activities and events, “There are no programs to participate in so I stay home and bake cakes when my daughter visits me. I try to do as much as I can at home to keep busy. I cannot go out without my husband or daughter so I cannot go out much (Azra)”.

Duran described how children’s participation in school is affected by their disability, “Schools are open to children with disabilities but they cannot participate because teachers do not help. The teachers do not want disabled children in their classrooms so they can legally go to school but they are denied participation in different ways (Duran)”.

This statement indicates there appears to be discrimination and prejudice within the education system, creating an obstacle to participation. It reinforces the frustration among persons with disability, that a stigma remains and participation through programs and services are controlled by non-disabled society members. Children are placed in a situation where on the exterior participation in school programming seems to be available; however, the practical application of obtaining education is dictated by teacher attitudes and whether or not children with disabilities are accepted. Duran seems to have indicated that if there are indeed policies in place to require schools to enrol disabled children they are not accepted nor enforced.

Similar descriptions were depicted by Basir when he discussed his experience when trying to participate in day-to-day activities, “The community has no understanding or interest unless it benefits them and not the disabled and people are jealous of me and think I get special treatment. The community will not solve our problem (Basir)”. Basir appears to be resigned to his perceptions that the community is unwilling to assist or
accept him, and indicates that society has no interest in supporting the needs of PWDs.
The community was depicted in some instances as uncaring and resentful of any specific
services that PWDs may receive. Basir’s comments reinforced a sense of stigma and
negative attitudes, and this had an impact on his ability to participate in community
activities.

_Access_ was the fourth and final theme of KIPA. Participants described physical and
attitudinal barriers that deny them access to the broader community. As already
articulated, regular rehabilitation services were difficult to access, as were other activities
and programs housed in facilities such as schools, shops and government offices.
Transportation was a challenge and hinder PWDs from travelling to activities,
employment, activities and events in the city. “I cannot be involved in any groups in the
city because they are not accessible. I cannot take a train to get to any programs that I
might be interested in (Azra)”. Azra also described the difficulty in getting access to
rehabilitation, “There is a long long wait for rehabilitation services. I can get it because
my son was killed in the war, not because of who I am and because I have a disability.
The government does not care about me (Azra)”. Azra’s comments indicated a feeling
isolation and frustration in not being able to be more active in programs that interested
her and that she would have liked to be involved in.

Basir expressed how lack of access was also a problem for him, and he focused on the
government and how its lack of interest in PWDs divided disabled and the non-disabled
groups:

“There must be change in the government to provide change and opportunity. They
need to give money to the city so that people can access hospitals and programs but
people in the government do not care. People go into the government to get rich and
not to help the people. The war opened doors for friends but it also opened doors for
enemies. So we can get access we have to be able to have non-disabled people help us because it is a fight that does not stop. We feel the government is our enemy (Basir)

Similarly, Duran described how the lack of coordinated policy within government regulations was an obstacle to accessing programs and services. He discriminated between the different government priorities and how it affected the people:

“The government has no understanding. It does not care about disabled people, it only cares about money. This is its priority. Before the war a disabled person could go to rehabilitation at a clinic or the spa three to four times per year but now I can go once a year for twenty-one days but I have to pay. I cannot pay, no one can pay! Even if I could pay the money I cannot access it because there is no transportation there. In the winter the government will pay for the rehabilitation service but I have to pay for room and board and I cannot pay! I cannot do this. If people had a job maybe they could pay but getting a job is not easy. In the city there is one accessible train but it stops at 4 pm so that means life must stop at 4 pm (Duran)

This sentiment was also illustrated by Basir, who described how the issue of financial resources and support from outside agencies played a role in services provided. It suggested that outside agencies, rather than his own government, have more interest in providing assistance to programs for PWDs:

“The government should be more knowledgeable but people go into the government because they want to become rich-not to help people. In this case access to money was a priority for the government but a lot of that money went to the government and not to the people who needed it. I started working at the Centre for the Blind and made it the largest in the Balkans and it made a lot of money. We were able to get aid money from Norway, Sweden and Germany but most of the money went to the government. We were getting help from NGOs but not from our own government (Basir)

4.1.5 Summary of Qualitative Findings

In summary, the findings from the qualitative phase of the study indicated that there was a high level of consistency in the views of the three individuals that were interviewed. The themes of knowledge, inclusion, participation and access provided a guide to understanding the experiences of the participants. The findings suggest that
knowledge is critical to people with and without disabilities, as well as government and
civilian groups, and provides a key to unlock attitudinal barriers and negative feelings
toward PWDs. Gaining knowledge through education would provide an understanding of
rights, leadership and how connections play a role in creating a better quality of life for
all PWDs. Inclusion topics that emerged as priorities were rooted in the concepts of
attitudes, equality and barriers. Each one of these played a role in how and whether
PWDs are integrated into the social fabric and welcoming environment within their
community. Participation in daily living activities and events were dependent on such
things as money, courage, and barriers. These topics were regarded as roadblocks for
PWDs to be able to be active members of their society. Access to integration
opportunities appeared to be reliant on the government, transportation, and money. The
government determined what and how financial resources were funnelled into different
PWD groups and services including among others, transportation, rehabilitation services,
and social programs.

4.2 Quantitative Findings

4.2.1 Participation

Thirteen adult participants gave signed consent and reviewed the information
letter prior to responding to the questionnaire. The participants were rehabilitation
patients of the Clinical Centre, University Hospital in Sarajevo, Bosnia and Herzegovina
and all had lived with physical disabilities for two or more years. Each participant
received a gift certificate to a local bookshop as a thank you for their participation in the
study. A local translator assisted with the distribution and collection of the questionnaire forms.

4.2.2 Participant Demographics

The study sample was varied in terms of age, sex, length of disability, and of those who had acquired a disability at birth as well as later in life. The length of disability categories were determined to reflect different stages that a PWD would encounter over the course of a lifetime, including birth, pre-school, childhood, and beyond childhood. Demographic characteristics are shown in Table 4.2 and indicate that none of the respondents was educated beyond the secondary school level, with the majority being unemployed.

Table 4.2: General demographics of study participants: questionnaire

<table>
<thead>
<tr>
<th></th>
<th>N=13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years)</strong></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>56</td>
</tr>
<tr>
<td>Range</td>
<td>34-69</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
</tr>
<tr>
<td><strong>Level of Education</strong></td>
<td></td>
</tr>
<tr>
<td>Primary School</td>
<td>5</td>
</tr>
<tr>
<td>Secondary School</td>
<td>8</td>
</tr>
<tr>
<td>Some College/University</td>
<td>0</td>
</tr>
<tr>
<td>Completed College/University</td>
<td>0</td>
</tr>
<tr>
<td>Graduate School</td>
<td>0</td>
</tr>
<tr>
<td>Professional Degree</td>
<td>0</td>
</tr>
<tr>
<td><strong>Length of Time with Disability (years)</strong></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>20</td>
</tr>
<tr>
<td>Since Birth</td>
<td>3</td>
</tr>
<tr>
<td>1-5</td>
<td>3</td>
</tr>
</tbody>
</table>
Additional demographic characteristics for male and female participants in the study are identified in Table 4.3 and include education, length of time with disability, and employment status.

Table 4.3: Education, length of time and employment status characteristics of study participants

<table>
<thead>
<tr>
<th></th>
<th>Male (n=6)</th>
<th>Female (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary School</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Secondary School</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Length of Time with Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5 yrs</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>6-10 yrs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11-15 yrs</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>16+ yrs</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Part-time employed</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Full-time employed</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
4.2.3 Key Findings and the KIPA Context: Questionnaire

The questionnaire responses were based on an importance scale that included five ratings: very important, important, moderately important, of little importance, and unimportant. The questions were adapted from the KIPA framework and were grouped into its four themes: knowledge, inclusion, participation and access. No inferential statistical analysis was conducted due to the small sample size.

The first grouping of questions focused on knowledge and five different areas of life including: programs, government representation, decision making, rights and services, and awareness of rehabilitation opportunities (Table 4.4). The responses indicated that programs, government representation, decision making, rights and services, and awareness of rehabilitation opportunities were viewed to be “very important”, with a minority of respondents rating them as “important”, and none seeing any category as “moderately important”, “of little importance”, or “unimportant”. In order to get a sense of the relative importance of the different items to the participants, the ratings were converted to numerical totals by assigning a weight and averaged to find a mean rating; “very important” = 5, “important”= 4, “moderately important”= 3, “of little importance”= 2, “unimportant”= 1, and “missing data”= 0 (Appendix J). This method was used in each subsequent section. Of note is there were no circumstances of “missing data” found in the participant response items.

Although all items in the area of knowledge were viewed as important, the item average ratings were used to get a general sense of which were more valued. The items were ranked in terms of the calculated mean ratings. Using this ranking as a general
gauge of strength and opinion, the items most highly ranked were *rights and services* and *awareness of rehabilitation opportunities*, both with a mean rating of 4.92.

Table 4.4: Participant questionnaire ratings for importance of *Knowledge* in 5 different areas of life

<table>
<thead>
<tr>
<th>Area</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately important</th>
<th>Of little importance</th>
<th>Unimportant</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rights and Services</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Awareness of Rehabilitation Opportunities</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Programs</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.85</td>
</tr>
<tr>
<td>Decision Making</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.85</td>
</tr>
<tr>
<td>Government Representation</td>
<td>9</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.69</td>
</tr>
</tbody>
</table>

The second grouping of questions focussed on *inclusion* and five different areas of life including *school integration, attitudes, community resources, government policy*, and a *welcoming community* (Table 4.5). The responses indicated that *attitudes* and *school integration* received lower ratings than the other three areas. Although the majority of items in the area of *inclusion* were viewed as important, in order to get a general sense of which items overall were most highly rated, the items most highly ranked were *government policy* and *a welcoming community*, both with a mean rating of 4.92.
The third grouping of questions focussed on participation and five different areas of life including gender equality, family and community integration, family participation, limitations and barriers, and education goals (Table 4.6). The responses indicated that the majority saw gender equality, family and community integration, family participation, limitations and barriers, and education goals to be “very important”, with a minority rating them as “important”, “moderately important” or “unimportant”. The items most highly ranked were gender equality and limitations and barriers, both with a mean rating of 4.92. This grouping of questions showed a broader range of response items, with four out of five categories being selected.
The fourth and final grouping of questions focussed on *access* and six different areas of life including *access to programs, to technology, to services, to home, to work,* and *to community* (Table 4.7). The responses indicated that the majority pointed to access to programs, technology, services, home, work and the community to be “very important”. The majority of items in this area were viewed as important, with *programs* and *work* as the most highly ranked, both with a mean rating of 4.92.

**Table 4.6: Participant questionnaire ratings for importance of Participation in 5 different areas of life**

<table>
<thead>
<tr>
<th>Area</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately important</th>
<th>Of little importance</th>
<th>Unimportant</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender Equality</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Limitations/Barriers</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Family/Community Integration</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.77</td>
</tr>
<tr>
<td>Family Participation</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4.54</td>
</tr>
<tr>
<td>Education Goals</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4.46</td>
</tr>
</tbody>
</table>

**Table 4.7: Participant questionnaire ratings for importance of Access in 6 different areas of life**

<table>
<thead>
<tr>
<th>Area</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately important</th>
<th>Of little importance</th>
<th>Unimportant</th>
<th>Mean Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programs</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Work</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.92</td>
</tr>
<tr>
<td>Community</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.85</td>
</tr>
<tr>
<td>Services</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.85</td>
</tr>
<tr>
<td>Home</td>
<td>11</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.85</td>
</tr>
<tr>
<td>Technology</td>
<td>10</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4.38</td>
</tr>
</tbody>
</table>
4.2.4 Summary of Quantitative Findings

Results from the questionnaire data demonstrated that perceptions of persons with physical disability showed a high level of perceived importance relative to KIPA themes in all major life areas. Similarities were found in topics related to knowledge, inclusion, participation, and access - the four KIPA themes. Responses indicated that gender, employment status, length of disability, or level of education did not play a role in differences or similarities of choices, as the majority of respondents in each demographic group rated all areas within the themes as “very important”.
Chapter 5

DISCUSSION

5.1 Discussion of Findings

Although the sample size was small, there was strong consistency in views expressed in both the qualitative and quantitative portions of the study. The results showed the multiple interactions between environment and personal factors including health, education, livelihood, social and empowerment factors (WHO, 2001). The study findings showed consistency with the WHO’s CBR Matrix, which gives a visual representation of CBR elements (WHO, 2010). The components of the Matrix consist of principles intended to be transferred into concrete ways of working within community activities. The results of the study indicated an adherence to CBR principles, whereby the participants’ responses coincided with elements of the Matrix. Components such as advocacy, rehabilitation, non-formal learning (knowledge), and employment were evident in participant responses and show the relationship between what the participants perceive as necessary for satisfactory quality of life and theoretical principles.

The three face to face interviews provided rich data for the researcher to build a profile of the key issues described by the interviewees. The thirteen questionnaires provided supporting documentation to garner further understanding of the perceptions of persons living with a disability in BiH after the war. The topics raised were varied and covered a wide range of subjects including knowledge, inclusion, participation and access, with additional discussion focussing on rehabilitation, education, employment,
recreation, communication, services, programs, disabled people’s organizations, relationships, and government.

As discussed earlier in this study, CBR is a community development strategy that provides disabled people, their families and communities, appropriate health, social services and education (International Labour Organization/United Nations Educational, Scientific and Cultural Organization/World Health Organization, 2004). This strategy incorporates important concepts including, “…the community development approach; the partnership of disabled people and their families with their community; the philosophical importance of integration versus segregation of service delivery; the multidisciplinary nature of CBR, enriched by the three fields of health, education and social service” (McColl & Paterson, 1997, p. 298). The situation in BiH is an example of where CBR and traditional health care intersect. Sixty CBR centres have been established across the country and are providing quality rehabilitation services to PWDs. Initially the CBR strategy was implemented in FBiH, followed by RS after approval by the RS Ministry of Health and Social Welfare. CBR became the strategic plan for health care reform and the implementation of health care reform (Peat & Jalovcic, 2009). It is evident the CBR Centres continue to provide important services in a health care system still trying to recover and restructure from the impact of the war.

The qualitative data were critical to gaining an appreciation for how PWDs feel about their health status and their place in the community. Interviews were conducted to elicit a depth of information that statistical data alone could not provide. “It is also suggested that qualitative research methodology… may give a more rounded, richer picture of disabled people’s attitudes” (Deal, 2003, p. 907). Key word identification
(Scott, 1997) emerged as a means to sort and organize participants’ perceptions through terms related to each of the guiding themes. The participants were consistent in their views on knowledge, believing that without education in many forms for themselves as well as others, PWDs would have a difficult time finding opportunities for community integration and social participation. Other terms that were deemed to fall under the knowledge theme included, among others, advocate, leadership and contribute. Terms of inclusion focussed on attitudes, equality, integration and society. Participation included such terms as barriers, employment, programs and community. Access encompassed terms including challenge, hierarchy, rehabilitation and transportation. Commonalities and differences were reflected relative to the KIPA framework as expressed during the interview. Results across the KIPA themes indicated the participants highly ranked elements that would provide improved quality of life to the broader population of PWDs, rather than focussing on items that would benefit individual needs. For example, two elements from each of the four KIPA themes, knowledge (K), inclusion (I), participation (P), and access (A), emerged as very important to the participants: rights and services (K), rehabilitation opportunities (K), government policy (I), a welcoming community (I), gender equality (P), limitations and barriers (P), programs (A), and work opportunities (A) each scored 4.92, falling under “very important” rating. At the opposite end of the rankings, participant responses indicated that government representation (K), school integration (I), education goals (P), and access to technology (A) were of least importance based on a visual inspection of the mean ratings. These findings may be the result of participants who were of an age where these elements were not seen as having a major impact on their current living situation; for example, whether government
representation would influence policy change on behalf of all PWD; where they were beyond school age therefore school integration and educational goals were no longer a priority for them; and where access to technology is not seen as being a part of their basic living needs. The overall results address the indicators within the KIPA framework by reflecting the participants’ perceptions of the level of importance and the need for a wide range of programs and services, but the researcher was disappointed that the responses did not highlight any key area(s) as more critical than others to focus on. The responses indicated that there appear to be a continued need to strengthen and improve programs, services, and policies across every area and sector before community integration and social participation can fully occur.

While there was natural overlap between themes, the researcher suggests a more structured strategy be utilized in order to maximize community understanding and acceptance for successful integration. In this regard, through reflection, the researcher proposes that integration strategies may have a structured progressive approach with a specific implementation order: Knowledge, Access, Participation and Inclusion.

The four KIPA themes overlap and intersect with each other and cannot act as isolated concepts. This in itself is not a unique discovery; however, the question is how to make the elements of the KIPA themes practical and meaningful, and structure them in a way for stakeholders to design a progressive strategy for community integration. The researcher proposes organizing the approach of program implementation, and to order the themes to have a progression from knowledge to access, access to participation, and finally, from participation to inclusion. By following this strategy, a logical progression for implementation of a practical approach to integration for PWDs would occur.
Knowledge acquisition is the first step toward integration, and the researcher suggests it is the basis for understanding the who, what, where, why and how of manoeuvring through the complexities of government policy and community organizations. With an awareness of policy and rights, for example, PWDs would have the foundation for engaging in discussion with those in power, and in decision making on their own behalf. Organized bodies have formed and “advocacy groups have risen from the basic need of disabled people to make informed decisions about issues affecting their lives. They are a response to the traditional medical approach, which neglects the involvement of people with disabilities in the decision making process” (Peat, 1997a, p. 658).

The researcher suggests that the second step in the progressive strategy toward integration is that of access. Backed with knowledge, PWDs would have confidence to have a stronger voice when advocating for attitudinal and environmental barriers to be eliminated, and therefore, providing wider access to the community. For example, access to transportation, employment opportunities, technology, and education are necessary for PWDs to become active productive members of the community.

The third step, participation, establishes the mechanism for PWDs to become active members of society, contributing to, and feeling part of the community. By being able to fully participate in programs, services and other community activities persons with disability can begin to achieve a sense of equality through integration.

Finally, the fourth and last step in the progressive strategy to integration is that of inclusion. Inclusion can be achieved following the groundwork which has been laid by the first three steps. As the interview participants revealed, and the questionnaire
respondents indicated, this is not an easy journey and a myriad of complex elements must be overcome before integration can occur. Once PWDs have acquired knowledge, obtained access, and are participating members of the community, they can then feel the positive impact of integration. Although it is proposed that there is a clear linear pathway to integration, there remains constant interaction between each of these elements. For example, as an individual becomes more included in the community, their knowledge and access grows allowing for easier and more open participation, thus progressively increasing integration. The specific pattern and processes of community integration for PWD should be empirically observed and assessed to provide clearer understanding of this complex process.

5.2 Limitations Associated with the Research Study

Although every effort was made to minimize methodological limitations in this study, a number of limitations have been identified with respect to the data collection period, recruitment, scope of sample group, geographical restrictions of participants and peer review.

One of the limitations associated with this study is the short data collection period. All data were collected within a 10 day period due to the resources available to the researcher. This period included recruitment, scheduling, face to face interviews, distribution and collection of questionnaires. This timeframe restricted the number of participants that could be involved in the study. A longer data collection period would have allowed for a larger participant sample providing a broader cross section of participants.
This study utilized a small sample of convenience based on self-selection and recommendations made by the Director of the CBR centre. The participants of this study all met the inclusion and exclusion criteria; however, the recruitment procedure may have eliminated a number of additional participants who would have added supplementary data. The participant group met the sampling guidelines recommended by Sandelowski (2000) for a qualitative descriptive study by using cases that are information-rich for the purposes of the study. It may have been beneficial to use random or purposeful sampling to obtain participants from outside the hospital and CBR centre environment who many have been able to provide additional richness to the study.

Another limitation was that the scope of the sample group was restricted to persons with disabilities. Personal bias based on participants’ perceptions provided only one perspective on community integration. A broader study, including additional participants, family members, therapists, physicians, government officials, children and other community members, would have provided a more in depth understanding, and a wider range of perceptions of the lived experiences of persons with disability.

Geographical restrictions were also a limitation of the research. All participants were residents of Sarajevo, a major urban city in Bosnia and Herzegovina. In order to gain a full understanding of the perspectives of persons with disability on integration in BiH, a wider geographical area would have been included if enough time and resources were available. Residents from rural areas would bring another dimension to the data.

A fifth limitation in this study was related to the reality that the principal researcher was solely responsible for all phases of the data analysis. A number of methods were used to ensure trustworthiness, including member checking, peer review,
rich description of quotes, logging field notes, and triangulation; however, the study would be have been strengthened if a team of researchers were available to verify the findings.

5.3 Implications for Research

Limited literature was discovered relating to the integration of persons with disability in Bosnia and Herzegovina since the end of the war. Research associated with disability focussed primarily on medical intervention (Lasseter & Galijasevic, 1997), policy reform (Deets, 2006; Foco, 2002b), psychosocial matters (Avdibegovic et al., 2008), war related injuries and the rehabilitation of soldiers (Meier & Smith, 2002; Mitchell, 2004) and education (Rouse et al., 2000). These topics are worthwhile of themselves, but restrict the broader problem of the vast numbers of the population with physical disabilities in the region.

With the BiH health care system still under transition, it is a critical time for all associated with primary health care to be represented at the table. This includes persons with disabilities. Participants in this study strongly, yet eloquently, voiced their concerns over challenges associated with access to programs and services. They voiced the belief that the government is denying the financial resources required to provide for an accessible environment, whether it is ramps for schools, transportation services or allowing Seeing Eye dogs to enter public places.

One participant described feelings of isolation and dependency on others to care for her. She expressed feelings of hopelessness and could not find allies even within the leadership of the disability group she belonged to. She felt abandoned by her government
who gave her access to rehabilitation and health benefits because of the death of her son during the war and not because of who she was. While much progress has been made to serve those with disabilities, there remains work to do to integrate PWDs into the community. This is especially true for those who are undereducated or unemployed, and feelings of frustration, dependency and despair continue to exist.

It is important to note, however, that not all persons with disability had the same feelings of isolation and dependency. Two of the interview participants were employed fulltime, were mobile and had opportunities to socialize in the wider community. However, they voiced similar feelings of resentment toward the government for not providing necessary funding to create opportunities for programs and services for the disabled population. While some participants felt their situation would not get any better, others were more optimistic about the long term outcomes for PWDs in BiH. They were active in their work to try to make change for the benefit of all.

An article by dos Santos-Zingale and McColl (2006), related to developing countries and their work in Sierra Leone, provide an example of another post-conflict country working on the social participation of their disabled population. Community developers and rehabilitation practitioners can learn from each other about how to best work with disabled groups, governments and communities to create accessible yet reasonable accommodations. While it may not be feasible on a large scale, networking through technology can provide an accessible platform for discussion and problem solving. By communicating electronically with like minded community developers, rehabilitation practitioners, researchers, project leaders, and other stakeholders, strategies for addressing complex issues related to persons with disabilities in post-conflict and
rebuilding environments can be acted upon to mutually benefit those across cultures and geographic boundaries.

5.4 Implications of Results

The results of this study illustrate that persons with a physical disability believe their voice is not being heard by the decision makers and those in power positions, within the health care system in Bosnia and Herzegovina, specifically in Sarajevo where the participants reside. The participants of this study indicated they have much to contribute to their community but are not given the opportunity to participate due to the low priority they are given in the health system. Additionally they report that their community is not providing programs and services that they need in order to have active fulfilling lives at home, at work and in the community. They see their quality of life as demoralizing and frustrating, and this population often feels isolated without hope for a better future. The majority of participants indicate that all areas of knowledge, inclusion, participation, and access are very important in their lives. By examining the data it is evident the four KIPA themes are factors to understanding the complexities of the lives of persons living with a physical disability.

5.5 Areas for Future Research

This study based primarily in qualitative description (Sandelowski, 2000; Thorne et al., 1997) with a non statistical quantitative element, attempted to shed light on community integration of persons with physical disabilities in post-conflict Bosnia and Herzegovina, as perceived by those living with a disability. This is a topical area that has
not been previously studied. The qualitative phase of this study was intended to explore experiences of persons living with a disability in their community to try to gain a better understanding of factors that influence their daily lives. The quantitative phase was designed to act as supporting material and to enhance the qualitative data.

As follow up to this study, it would be valuable to conduct a similar study with a second group of participants to examine commonalities and differences between the initial data collection period represented in this study and the follow up period. Additionally, it would be beneficial for future research to explore: 1) policy change within the government and the impact it has on persons with disability, 2) a larger population of PWDs in a wider region of the country to gain further insight and a broader understanding of factors that influence integration, and 3) a broader range of participant voices, including community members, health professionals, and family members to gain additional information on how others perceive persons with disability living and working within the community.

5.6 Conclusions

This study is the first known to examine the perceptions of persons living with a physical disability in post-conflict Bosnia and Herzegovina, as perceived by the PWDs themselves. Based on the limited sample, this study indicated that post-conflict reforms within the health care system in BiH do not appear to meet a vast array of needs that PWDs described as important to their quality of life. PWDs indicated the need to provide their own leadership, and for those in leadership positions within different disability groups to come together to create one homogeneous group that can advocate for all
PWDs and goals for integration and social participation. Persons with disabilities continue to feel isolated and appear to have limited options for integration.

An analysis of the situation of disabled persons has to be carved out within the context of different levels of economic and social development and different cultures. Along with government assistance, policy regulation and community support, it appears the responsibility for changing attitudes and conditions leading to integration, ultimately rests within persons with disabilities themselves. The continued development, enhancement and expansion of existing CBR programs would provide a guidance and structure for ongoing improvement to daily living conditions for PWDs in BiH. Persons with disability continue to seek a voice and to set realistic goals for strengthening their situation by providing a mechanism for advocacy for community integration and social participation. A unified advocacy body would provide a single voice when meeting with decision and policy makers and when trying to secure resources and financial support for services and programming.

Despite a wide range of disabilities and priorities, persons with disabilities weave a common thread. They want to be treated equally in all aspects of daily living alongside their non-disabled peers. Knowledge, access, participation and inclusion are interrelated and overlap, however, for the community to accept and integrate PWDs, education is a critical path to understanding and support. Change and opportunities in education, livelihood, attitudinal change, social participation and advocacy emerged as factors to the successful community integration of PWDs. With knowledge across sectors, the key to accessibility will open doors for participation and provide for inclusion, integration and the best quality of life available to those living with disabilities.
References


APPENDIX A

<-- THE REHABILITATION CONTINUUM -->

Institutional Based Rehabilitation ↔ Community Based Rehabilitation

<table>
<thead>
<tr>
<th>Acute Care/ services</th>
<th>Outreach programme</th>
<th>Home Care services</th>
<th>Social services</th>
<th>Community workers</th>
<th>Volunteers</th>
<th>Family/ caregiver</th>
<th>PWD</th>
</tr>
</thead>
</table>

(Adapted from Peat, 1997b)
APPENDIX B

CBR MATRIX

HEALTH
- PROMOTION
- PREVENTION
- MEDICAL CARE
- REHABILITATION
- ASSISTIVE DEVICES

EDUCATION
- EARLY CHILDHOOD
- PRIMARY
- SECONDARY & HIGHER
- NON-FORMAL
- LIFE-LONG LEARNING

LIVELIHOOD
- SKILLS DEVELOPMENT
- SELF-EMPLOYMENT
- FINANCIAL SERVICES
- WAGE EMPLOYMENT
- SOCIAL PROTECTION

SOCIAL
- RELATIONSHIPS MARRIAGE & FAMILY
- PERSONAL ASSISTANCE
- CULTURE & ARTS
- RECREATION LEISURE & SPORTS
- ACCESS TO JUSTICE

EMPOWERMENT
- COMMUNICATION
- SOCIAL MOBILIZATION
- POLITICAL PARTICIPATION
- SELF-HELP GROUPS
- DISABLED PEOPLE'S ORGANIZATIONS

(WHO, 2010)
Dear Dr Malcolm Peat,
concerning your letter from May 6th, we would like to inform you that we agree to the visit of
Ms. Elisabeth Richan, a Queens University Masters student and her cooperation with Dr Mirsad Muftic
regarding her research project and the study of 20 patients (interviewing 3 of them) in our CBR
center.

Best regards,
Prim.dr. Slobodan Trninæ, General Manager
Public Institution Medical Center of the Sarajevo Canton (Javna ustanova Dom zdravlja Kantona
Sarajevo)
Dr. Slobodan Trninić  
Director of Domova Zdravlja, Canton Sarajevo  
May 6th, 2007

Dear Dr. Slobodan Trninić

I am writing to you on behalf of the School of Rehabilitation Therapy, Faculty of Health Sciences and the International Centre for the Advancement of Community Based Rehabilitation, Queens University, Kingston, Canada.

As you know Queens University has participated for over ten years in the development of community Based Rehabilitation in BiH. This has been an important program for Queens and for Canada. The objective of writing to You is to request your approval for Elizabeth Richan, a Queens University Masters student to collaborate with Dr. Mirsad Muftić and the CBR staff in a research project. The project protocol abstract is attached to this request. The research which is proposed would require Elizabeth Richan to have access to a maximum of 20 patients in the CBR and data would be collected using a questionnaire which will be provided to you in advance. In addition an interview could be conducted to a maximum of 6 of the same patient population. The objective of the research is to demonstrate the value of CBR and we appreciate this opportunity of the continuation of our collaboration.

If this proposal is acceptable to You I would request that I receive from you a short letter of approval following which we will make the appropriate arrangements with Dr. Muftić and the CBR staff for the implementation of the research project.

I appreciate your consideration of this request.

Sincerely

Dr. Malcolm Peat  
Executive Director  
The International Centre for the Advancement of Community Based Rehabilitation (ICACBR)  
154 Albert Street, Queen’s University, Kingston, Ontario, Canada K7L 3N6  
Tel: (613) 533-6881 Fax: (613) 533-6882  
Email: icacbr@post.queensu.ca Web-site: http://meds.queensu.ca/icacbr/  

Cc Dr Mirsad Muftić
Poštovani Dr. Slobodan Trninić

Pišem Vam u ime Škole za rehabilitaciju, Fakulteta medicinskih nauka i Međunarodnog centra za unapređenje rehabilitacije u zajednici, Queens univerziteta, Kingston, Kanada

Kao što Vam je sigurno poznato od ranije Queens Univerzitet je učestvovao više od deset godina u razvoju rehabilitacije u zajednici u BiH. Ovo je bio veoma značajan program za Queens i za Kanadu. Svrha ovog pisma jeste molba kojom Vam se želimo obratiti za dozvolu za Elizabeth Richan studenticu postdiplomskog studija Queens Univerziteta za saradnju sa Dr. Mirsadom Muftićem i CBR osobljem pri istraživačkom projektu. Sažetak istraživačkog projekta šaljemo Vam u prilog. Istraživački projekat bi obuhvatio 20 pacijenata, iz CBR-a, koji bi ispunili upitnik i maksimalno šest pacijenata iz iste grupe sa kojima bi bio obavljen intervju. Upitnik bi Vam bio dostavljen prije početka istraživanja. Cilj istraživanja jeste demonstracija vrijednosti CBR sistema. Veoma cijenimo ovu mogućnost nastavka naše saradnje.

Ukoliko udovoljite našoj molbi, bili bi Vam zahvali da dobijemo veoma kratko pismo saglasnosti, na osnovu kojeg bi smo dogovorili sve detalje predstojeće saradnje sa Dr Muftićem i osobljem CBR-a povodom istraživačkog projekta. Unaprijed Vam se zahvaljujemo što ste našu molbu uzeli u razmatranje.

S poštovanjem

Dr Malcolm Peat
Izvršni direktor
Međunarodni centar za unapređenje rehabilitacije u zajednici
Profesor Fakulteta medicinskih nauka
Queens Univerzitet Kingston, Kanada

Prosljedimo i Dr Mirsadu Muftiću
June 01, 2008

Interview

You have been asked to participate in this interview because you are a person with a
disability and have completed the questionnaire for the research study *Factors that
Influence Community Integration of Persons with Physical Disabilities in Post-
Conflict Bosnia and Herzegovina as Perceived by Persons with Disabilities*. In the
questionnaire you indicated that you place high importance on issues related to
persons with a disability. Minimal research has been conducted on attitudes toward
persons with disability and their experiences in family and community life. This
interview is a preliminary way of learning more about how you perceive community
attitudes toward integration. There are no “right or wrong” answers. The purpose of
this interview is to gather information from you about your experiences in family and
community life in order that we may gain insight into the attitudes towards integration
of persons with disability.

For transparency and verification purposes this interview will be audio-recorded.

### A. Background Information *(Gathering of basic demographic information)*

<p>| | |</p>
<table>
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</table>
| 1. | Birth date: | _____/___/___  
(year/month/date) |
| 2. | Gender: | ___F   ___M |
| 3. | Level of education: | Primary school____  
Secondary school _____  
Some college/university ____  
Completed College/university ____  
Graduate Studies ____  
Professional Degree ____ |
| 4. | When did you acquire your disability? | ______ |
| 5. | Number of visits to CBR Centre within the past six months: | 0-2 ____  
3 or more ____ |
| 6. | Employment: | Not employed ____  
Part time ____  
Full time ____ |
B. Interview: The following questions are about your experiences with factors that may influence community integration for PWD.

7. What are the most difficult challenges or barriers you have faced as a person with a disability? (School, work, health care services, activities with family and friends, other?)

8. Do you feel you are able to do everything you would like in your community? (School, work, shopping, being with friends and family, other?) If not, could you tell me why not?

9. Do attitudes of others play a role in the level of integration you have? (Explain)

10. Do you feel equal to others? (Explain)

11. What is the most important thing your community could do to integrate you better in your community? (Give examples)

12. Is there anything else you would like to say that would be important in understanding factors that influence integration of persons with disability?

Additional Questions:

13. Do you have a role in your community in terms of policy and legislation change for persons with disability? Or for those without a disability?

14. Do you know of persons with disability role models that you can go to for assistance or advice?

15. Are there opportunities for you to plan and implement programs for persons with disability? If so, have you participated?

16. Do you think it is important for non disabled persons to understand the challenges of persons with disability?

17. Do you have a say in directing processes or changing activities if you feel your rights and needs are not being met? (In what situation(s)?)

18. Are you satisfied with your level of participation in your family and community life? (Please expand)
01 Juni, 2008

Intervju

Zamoljeni ste da ucestvujute u ovom intervjuu jer ste osoba sa onesposobljenjem i ispunili ste upitnik za istrazivanje Faktori koji uticu na integraciju osoba sa onesposobljenjem u poslijeratnom periodu, percipirano od strane osoba sa onesposobljenjem. U upitniku ste naznacili da pridajete veliku vaznost faktorima koji se odnose napitanja osoba sa onesposobljenjem. Veoma je malo istrazivanja provedeno koja se bave faktorima i njihovim iskustvima u porodicnom i zivotu sa rijateljima. Ovaj intervju predstavlja preliminarni nacin dobijanja vise cinjenica o tome kako vi vidite faktore koji se odnose na integraciju u zajednicu osoba sa onesposobljenjem. Nema “ispravnih i pogresnih” odgovora. Svrha ovog intervju jeste prikupiti informacije o vasem iskustvu o porodicnom zivotu i zivotu u zajednici sa ciljem upoznavanja sa faktorima koji uticu na integraciju osoba sa onesposobljenjem.

U svrhe transparentnosti i validizacije ovaj intervju ce biti i audio sniman.

A. Osnovne informacije (Prikupljanje osnovnih demografskih informacija)

1. Datum rodjenja: _____/___/___
   (godina/mjesec/datum)

2. Pol: _____ F _____ M

3. Nivo edukacije:
   Osnovna skola_____  Srednja skola_____  Visa skola ______
   Koledz/Univerzitet_____  Magisteriji/Doktorati _____

4. Od kada imate onesposobljenje? ____________

5. Broj posjeta CBR Centru posljednjih sest mjeseci:
   0-2 _____  3 ili vise _____

6. Zaposlenje: ________________

   Nezaposlen _____
   Pola radnog vremena _____
   Puno radon vrijeme _____
B. **Intervju: Slijedeca pitanja vezana su za vase iskustvo sa faktorima koji mogu uticati na integraciju osoba sa onesposobljenjem u zajednicu.**

7. Koji su najtezi izazovi I barijere sa kojima se susrecete kao osoba sa onesposobljenjem? (Skola, posao, medicinske usluge, aktivnosti sa porodicom I prijateljima, ostalo?)

8. Osjecate li da biste mogli uraditi sve sto biste zeljeli u svojoj zajednici? (Skola, work, kupovina, biti sa vasom porodicom I prijateljima, ostalo?) Ukoliko ne, mozete li objasniti zasto?

9. Da li stavovi drugih uticaju na vas nivo integracije u zajednici? (Objasnite)

10. Da li se osjecate jednakim sa ostalima? (Objasni)

11. Sta je to najvaznije sto bi zajednica mogla uciniti za vasu bolju integraciju u zajednicu? (Dajte primjere)

12. Postoji li jos nesto sto bi ste dodali a sto je vazno za razumijevanje faktora koji uticu na integraciju osoba sa onesposobljenjem?

**Dodatna pitanja:**

13. Da li imate ulogu u vasoj zajednici u promjenama polica I zakona za osobe sa onesposobljenjem? Ili za osobe bez onesposobljenja?

14. Poznajete li osobu sa onesposobljenjem koja bi Vam mogla biti uzor I kojoj bi ste se obratili ukoliko vam treba pomoc ili savjet?

15. Postoje li mogucnosti za Vas za planiranje I implementaciju programa za osobe sa onesposobljenjem? Ukoliko postoje da li ste ukljuceni u to?

16. Da li smatrate da je vazno da osobe bez onesposobljenja razumiju izazove sa kojima se susrecu osobe sa onesposobljenjem?

17. Da li ste se nasli u situaciji ili nekoj aktivnosti gdje ste imali osjecaj da vase potrebe nisu zadovoljene? (U kakvim situacijama?)

18. Da li ste zadovoljni nivoom vaseg ucesca u vasoj porodici I zivotu u zajednici? (Molimo objasnite)
June 01, 2008

RE: Letter of Information (Interview)

Dear Potential Interview Participant,

I am a Master’s Rehabilitation Science student at Queen’s University Canada, and I will be conducting a study entitled “Factors that Influence Community Integration of Persons with Physical Disabilities in Post-Conflict Bosnia and Herzegovina as Perceived by Persons with Disabilities”. The purpose of this study is to investigate the impact of community attitudes toward persons with disabilities and whether attitudes influence integration within the region. It is hoped that the information gathered from this study will assist in understanding how attitudes impact integration and to identify possible areas for enhancing services and opportunities for persons with disability.

You are being invited to participate in this study because you have utilized rehabilitation services during the past six months. You are being asked to participate in an audio-taped forty-five minute interview related to your experiences pertaining to your knowledge, inclusion, participation and access within your community.

If you choose to participate in the interview, please sign the attached consent form. All information shared by you will be kept confidential and secure and the interview responses will only be available to the primary researcher and her advisor. Your name will not be associated with your answers and although the information obtained from this study may be published in journals or presented at conferences, your anonymity is assured. You can refuse to answer any questions and your participation in this study is entirely voluntary and you may withdraw at any time without consequences.

There are no foreseeable risks associated with your participation in this study. While you may not directly benefit from taking part in this study, the responses received from you during this interview will be used to further explore the issue of integration of persons with a disability in the community. If you are interested in the outcomes of the study, you may request a one-page summary from the primary researcher.

Should you have any questions regarding this study at any time you may contact:

Principal Researcher, Elizabeth Richan
(+1-613-533-6881, richanb@queensu.ca)

Research Advisor, Dr. Rosemary Lysaght
(+1-613-533-2134, lysaght@queensu.ca)

Director, Associate Dean, School of Rehabilitation Therapy, Faculty of Health Sciences,
Dr. Elsie Culham (+1-613-533-6727, culhame@post.queensu.ca), or

Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals
Research Ethics Board (+1-613-533-6081).

Thank you for considering this invitation to participate in this study. If you choose to participate, please read, sign and return the attached consent form.

Sincerely,

Elizabeth Richan, Principal Researcher
RE: Pismo informacija (Intervju)

Dragi potencijalni ucesnice u istrazivanju,

Ja sam student postdiplomskog studija rehabilitacionih nauka na Queen’s Univerzitetu u Kanadi, i provodim istrazivanje pod nazivom **Faktori koji uticaj na integrciju osoba sa onesposobljenjem u poslijeratnom periodu, percipirano od strane osoba sa onesposobljenjem.**

Svrha ove studije jeste da se istraže faktori koji uticaju na integraciju osoba sa onesposobljenjem u BiH. Nadamo se da ace informacije prikupljene pomocu ovog istrazivanja pomoci pri razumijevanju razlicitih faktora koji uticaju na integraciju u zajednicu i identifikaciji mogucih oblasti kojima bi se usluge mogle ojacati i prilikama osoba sa onesposobljenjem.

Pozvani ste da ucestvujete u ovom istrazivanju jer ste koristili rehabilitacione usluge u proteklih sest mjeseci. Ukoliko ste saglasni da ucescete u ovom istrazivanju, zamoli cemo Vas da popunite dvadesetominutni upitnik koji pokazuje vaznost koju za Vas predstavljaju razliciti aspekti zivota u zajednici. To je povezano sa oblastima kao sto su znanje, uključenost, ucesce i pristup.

Ukoliko se odlucite ucestvovati u ovom istrazivanju molim Vas da potpisete pismo saglasnosti u prilogu. Popunjene upitnike molim Vas vratite Elizabeth Richan ili Saneli Sadikovic.

Sve informacije koje dobijemo putem ovog intervjuva cuvace se kao povjerljive. Odgovore iz upitnika vidjete samo prevodioc, istrazivac i savjetnik istrazivaca. Vase ime nece biti povezano sa odgovorima i ako se neki podaci objave u nekom casopisu strucnog karaktera anonimnost vam je 100% zagarantovana. Mozete odbiti da odgovorite za razlete istrazivanja mozezatraziti jednu stranicu sazetka od istrazivaca.

Glavni istrazivac, Elizabeth Richan
(+1-613-533-6881, rihanb@queensu.ca)

Savjetnik istrazivaca, Dr. Rosemary Lysaght
(+1-613-533-2134, lysaght@queensu.ca)

Direktor, Zamjenik dekana, Skola za rehabilitaciju, Fakultet Zdravstvenih studija,,
Dr. Elsie Culham
(+1-613-533-6727, culhame@post.queensu.ca)

Ili Predsjednika, Queen’s University Zdravstveni studiji i Istrazivacki eticki odbor univerzitetske bolnice
Dr. A. Clark
(+1-613-533-6081)

Hvala Vam sto ste uzeli u razmatranje ovaj pozic za ucesce u istrazivanju. Ukoliko se odlucite na ucesce u istrazivanju molimo Vas procijete, potpisite i ratite slijedece dokumente saglasnosti.

S postovanjem,

Elizabeth Richan, Principal Researcher
June 01, 2008

RE: LETTER OF CONSENT (Interview)

Dear Potential Interview Participant,

If you are willing to participate in the study, “Factors that Influence Community Integration of Persons with Physical Disabilities in Post-Conflict Bosnia and Herzegovina as Perceived by Persons with Disabilities” as described in the letter of information on the previous page, please sign in the appropriate space below.

If you have any questions prior to giving consent, feel free to contact:

Principal Researcher, Elizabeth Richan (+1-613-533-6881, richanb@queensu.ca)  Research Advisor, Dr. Rosemary Lysaght (+1-613-533-2134, lysaght@queensu.ca)

Director, Associate Dean, School of Rehabilitation Therapy, Faculty of Health Sciences, Dr. Elsie Culham (+1-613-533-6727, culhame@post.queensu.ca), or

Dr. Albert Clark, Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (+1-613-533-6081).

Your participation in this study is voluntary and you do not have to answer any questions you do not wish to answer. Further, you may withdraw from this study at any time without pressure or consequence.

*********

I have read the description of this research study and retained a copy for my records. My questions have been answered, and I understand that my participation is voluntary, that I may withdraw at any time, that the information I provide will be treated as confidential and that my identity will be protected. Further, I understand that there are no foreseeable risks associated with this study.

I, ____________________, voluntarily agree to participate in the above-named study.

(your name here)

Please check (✓) the appropriate box

☐ I agree to participate in the interview

_________ (your signature)        _______________Date
Draži potencijalni učesnice u istraživanju,

Ukoliko ste saglasni da učestvujete u istraživanju Faktori koji utiču na integraciju osoba sa onesposobljenjem u poslijeratnom periodu, percipirano od strane osoba sa onesposobljenjem. kao što je opisano u pismu sa informacijama na prethodnoj stranici, molimo Vas potpisite na predvidjenim mjestima i ratite jednu kopiju ovog pisma i formulare saglasnosti u zatvorenoj koverti Elizabeth Richan ili Saneli Sadikovic u CBR Centru.

Uvijek možete kontaktirati:

Glavni istraživac, Elizabeth Richan Savjetnik istraživaca, Dr. Rosemary Lysaght
(+1-613-533-6881, richanb@queensu.ca) (+1-613-533-2134, lysaght@queensu.ca)

Direktor, Zamjenik dekana, Skola za rehabilitaciju, Fakultet Zdravstvenih studija,, Dr. Elsie Culham
(+1-613-533-6727 culhame@post.queensu.ca), ili

Predsjednika, Queen's University Zdravstveni studiji i Istraživacki etički odbor univerzitetske bolnice Dr. A. Clark
(+1-613-533-6081)

Vase učesce u ovom istraživanju je na dobrovoljnoj osnovi i nemorate odgovoriti ni na jedno pitanje na koje nezelite odgovoriti. Takođe možete odustati sa ovog istraživanja u bilo kojem trenutku bez ikakvih posljedica ili pritiska.

*********

Procitao/la sam opis ovog istraživanja i jednu kopiju zadražao za sebe. Dobio/la sam odgovore na svoja pitanja, Shavtio/la sam da je moje učesce dobrovoljno, da mogu odustati u bilo kojem trenutku, d ače se moji odgovori i informacije tretirati kao povjerljive ida će moj identitet biti zasican.. Razumio/la sam da nepostoji nikakav rizik vezano za ovu studiju.

Ja, ____________________, dobrovoljno pristajem da učestvujem u ovoj studiji.

(vase ime)

Stavite (✓) u odgovarajuću kockicu

 Slazem se da učestvujem u intervjuu

(vas potpis) ___________________ Datum ________________
Questionnaire

You have been asked to participate in this questionnaire because you have utilized rehabilitation services at a Sarajevo CBR Centre during the past six months. Minimal research has been conducted on attitudes toward persons with disability and their experiences in family and community life in Bosnia and Herzegovina. This interview is a preliminary way of learning more about how you perceive your experiences. There are no “right or wrong” answers. The purpose of this questionnaire is to determine the level of importance you place on different aspects of your family and community life. In so doing we will gain an overview of different perceptions towards persons with disability and their opportunity to be integrated into their community.

A. **Background Information** *(Gathering of basic demographic information)*

1. Birth date: _____/___/____ (year/month/date)
2. Gender: _____F   _____M
3. Level of education:
   - Primary school _____
   - Secondary school _____
   - Some college/university _____
   - Completed college/university _____
   - Graduate Studies _____
   - Professional Degree _____

4. When did you acquire your disability? ______
5. Number of visits to CBR Centre within the past six months:
   - 0-2 _____
   - 3 or more _____

6. Employment: Not employed _____
   - Part time _____
   - Full time _____

B. The next section will ask you to think about the *level of importance* you place on your Knowledge, Inclusion, Participation and Access that you may or may not have encountered or experienced in the community. For each question, I want you think about *how important it is for you* based on your personal experiences as a person with a disability. Please mark an “x” in one of the five columns reflecting the level of important you place based on your own feelings.
# Factors of Community Integration of Persons with Disability in Post-conflict Bosnia and Herzegovina as Perceived by Persons with Disability

**Questionnaire**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately Important</th>
<th>Of Little Importance</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. there are programs designed specifically for women and/or children with disabilities?</td>
<td></td>
<td></td>
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<tr>
<td>2. that a person with disability is a government representative?</td>
<td></td>
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<tr>
<td>3. the role that persons with disability have in decision-making within community activities? (i.e., advocacy groups)</td>
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<tr>
<td>4. the rights and services for persons with abilities?</td>
<td></td>
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<tr>
<td>5. that persons with a disability are aware of all rehabilitation, health, education and social services available to them?</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately Important</th>
<th>Of Little Importance</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. local schools/colleges/universities integrate children/youth with disabilities into regular classrooms?</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>7. attitudes toward disability are addressed in all education and government sectors?</td>
<td></td>
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<tr>
<td>8. community groups provide services and community resources for person with disability?</td>
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<tr>
<td>9. legislators make conscious decisions to include persons with disabilities into policies and programs?</td>
<td></td>
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<tr>
<td>10. your community is welcoming to persons with a disability?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Participation</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately Important</th>
<th>Of Little Importance</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. there is equality in service provision between men, women and children?</td>
<td></td>
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</tr>
<tr>
<td>12. you are integrated into family and community life as much as you would like?</td>
<td></td>
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</tr>
<tr>
<td>13. your family participates in community programs or services with you?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>14. programs that you are interested in participating in, are not available to you because of transportation, financial, time or other limitations?</td>
<td></td>
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<tr>
<td>15. you are able to participate in the education system to reach your goals?</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access</th>
<th>Very Important</th>
<th>Important</th>
<th>Moderately Important</th>
<th>Of Little Importance</th>
<th>Unimportant</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. you have access to rehabilitation programs, information and services that you require when you need them?</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>17. you have access to technology/computers on a regular basis?</td>
<td></td>
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<tr>
<td>18. you have access to services you need in order to reach your potential in school or employment?</td>
<td></td>
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</tr>
<tr>
<td>19. your home environment is accessible and meeting your needs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20. your workplace environment is accessible and meeting your needs?</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. local shops and community buildings are accessible and meeting your needs?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Adapted from Edmonds *KIPA Framework*

Thank you for your time in completing this questionnaire.
Zamoljeni ste da učestvujete u ovom upitniku jer ste koristili usluge rehabilitacije u zadnjih 6 mjeseci. Veoma je malo istraživanja provedeno koja se bave faktorima i njihovim iskustvima u porodicnom i životu sa prijateljima u BiH. Ovaj upitnik predstavlja preliminarni nacin dobijanja vise cinjenica o tome kako vi vidite faktore koji se odnose na integraciju u zajednicu osoba sa onesposobljenjem. Nema “ispravnih i pogresnih” odgovora. Svrha ovog upitnika jeste prikupiti informacije o vasem iskustvu o porodnom životu i životu u zajednici sa ciljem upoznavanja sa faktorima koji uticu na integraciju osoba sa onesposobljenjem.

A. Demografske informacije

1. Datum rodjenja: ___/___/___ (godina/mjesec/datum)
2. Pola: ___Z ___M
3. Nivo edukacije: Osnovna škola___
   Srednja___
   Visa škola___
   Koledž/Univerzitet___
   Magistarski/Doktorati___
4. Od kada imate onesposobljenje? ____________________
5. Broj posjeta CBR u zadnjih sest mjeseci:
   0-2 ___
   3 ili vise ___
6. Posao: __________ Nezaposlen ___
   Pola radnog vremena ___
   Puno radno vrijeme ___

B. Slijedeći dio trazi od vas misljenje o tome koliko vaznosti pridajete faktorima koji mogu uticati na integraciju unutar zajednice. Za svako pitanje razmislite koliko vam je vazno zasnovano na vlastitom iskustvu kao osobe sa onesposobljenjem. Stavite “✓” u red koji po vama najbolje opisuje kako se vi osjecate vezano za svako pitanje.
**Upitnik**

*Faktori koji utiču na integrciju osoba sa onesposobljenjem u poslijeratnom periodu, percipirano od strane osoba sa onesposobljenjem.*

<table>
<thead>
<tr>
<th>Znanje</th>
<th>Veoma vazo</th>
<th>Vazno</th>
<th>Srednje vazo</th>
<th>Malo vazo</th>
<th>Nevazno</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. da postoje programi dizajnirani posebno za osobe sa onesposobljenjem?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2. da li postoji clan u vladajućim strukturama koji ima onesposobljenje?</td>
<td></td>
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</tr>
<tr>
<td>3. ulogama koje можете imati pri donosjenju odluka u društvenim aktivnostima? (pr. Grupe koje zastupaju)</td>
<td></td>
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<tr>
<td>4. o pravima osoba sa onesposobljenjem?</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>5. o rehabilitaciji, zdravlju, edukaciji i drugim uslugama koje se vam dostupne?</td>
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</tr>
</tbody>
</table>

| Uključivanje                                                          |            |       |              |           |         |
| 6. skole/univerziteti uključuju osobe sa onesposobljenjem u redovnu nastavu? |            |       |              |           |         |
| 7. da se potencira vaznost stavova prema osobama sa onesposobljenjem u edukaciji i vladajućem sektoru? |            |       |              |           |         |
| 8. da grupe u zajednici obezbjedjuju i pružaju usluge za osobu sa onesposobljenjem? |            |       |              |           |         |
| 9. zakonodavci donose odluke uključujući osobe sa onesposobljenjem u polici promjene? |            |       |              |           |         |
| 10. da je vasa zajednica otvorena za osobe sa onesposobljenjem?        |            |       |              |           |         |

| Ucesce                                                               |            |       |              |           |         |
| 11 da postoji kvalitet u uslugama za osobe sa onesposobljenjem?       |            |       |              |           |         |
| 12. da ste učestvujete u porodici i društvu onoliko koliko zelite?    |            |       |              |           |         |
| 13. da vasa porodica učestvuje u programima u zajednici zajedno sa vama? |            |       |              |           |         |
| 14. programi vam nisu dostupni zbog transporta, finansija ili problema sa količinom vremena? |            |       |              |           |         |
| 15. umogućnosti da učestvujete u edukacionom sistemu kako bi ste dostigli svoje ciljeve? |            |       |              |           |         |

| Pristup                                                               |            |       |              |           |         |
| 16. imate brz pristup rehabilitacionim programima i informacijama?    |            |       |              |           |         |
| 17. imate pristup tehnologiji/kompjuterima?                           |            |       |              |           |         |
| 18. imate pristup uslugama koje vam pomazu da dosegnete vase potencijale u skoli in a poslu? |            |       |              |           |         |
| 19. je vasa okruženje na poslu i kod kuće pristupacno?               |            |       |              |           |         |
| 20. su ulice i drotoari pristupacni za kretanje?                      |            |       |              |           |         |
| 21. su prodavnice i ostale zgrade u zajednici pristupacne?            |            |       |              |           |         |

*Adaptirano iz KIPA Framework (2003)*

Hvala
June 01, 2008

Letter of Information (Questionnaire)

Dear Potential Questionnaire Participant,

I am a Master’s Rehabilitation Science student at Queen’s University Canada, and I will be conducting a study entitled “Factors that Influence Community Integration of Persons with Physical Disabilities in Post-Conflict Bosnia and Herzegovina as Perceived by Persons with Disabilities”. The purpose of this study is to investigate the impact of community attitudes toward persons with disabilities and whether attitudes influence integration within the region. It is hoped that the information gathered from this study will assist in understanding how attitudes impact integration and to identify possible areas for enhancing services and opportunities for persons with disability.

You are being invited to participate in this study because you have utilized rehabilitation services during the past six months. If you agree to take part in this study, you will be asked to complete a twenty-minute written questionnaire that addresses the importance you place on different aspects of community living including themes associated with knowledge, inclusion, participation and access. If you choose to participate in the questionnaire, please sign the consent form attached. Upon completion of the questionnaire please return the form to Elizabeth Richan or Sanela Sadikovic.

All information shared by you will be kept confidential and secure. The questionnaire responses will only be available to the primary researcher and her advisor. Your name will not be associated with your answers and although the information obtained from this study may be published in journals or presented at conferences, your anonymity is assured. You can refuse to answer any questions and your participation in this study is entirely voluntary, and you may withdraw at any time without consequences.

There are no foreseeable risks associated with your participation in this study. While you may not directly benefit from taking part in this study the responses received from participants will assist in identifying common experiences of persons with disability in community and family life. If you are interested in the outcomes of the study, you may request a one-page summary from the primary researcher.

At any time you may contact:
Principal Researcher, Elizabeth Richan (+1-613-533-6881, richanb@queensu.ca)  
Research Advisor, Dr. Rosemary Lysaght (+1-613-533-2134, lysaght@queensu.ca)

Director, Associate Dean, School of Rehabilitation Therapy, Faculty of Health Sciences, Dr. Elsie Culham (+1-613-533-6727, culhame@post.queensu.ca), or Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board Chair Dr. A. Clark (+1-613-533-6081).

Thank you for considering this invitation to participate in this study. If you choose to participate, please read, sign and return the attached consent form.

Sincerely,

Elizabeth Richan, Principal Researcher
01. Juni, 2008

Pismo sa informacijama (Upitnik)

Dragi potencijalni učesnici studije,

Ja sam student postdiplomskog studija rehabilitacionih nauka na Queen’s Univerzitetu u Kanadi, i provodim istraživanje pod nazivom Faktori koji uticu na integraciju osoba sa onesposobljenjem u posljednjem periodu, percipirano od strane osoba sa onesposobljenjem. Srh ove studije jeste da se istraže faktori koji uticu na integraciju osoba sa onesposobljenjem u BiH. Nadamo se da će informacije prikupljene pomoću ovog istraživanja pomoći pri razumijevanju različitih faktora koji uticu na integraciju u zajednicu i identifikaciji mogućih oblasti kojima bi se usluge mogle prilagoditi odlikom osoba sa onesposobljenjem.

Pozvani ste da učestvujete u ovom istraživanju jer ste koristili rehabilitacione usluge u proteklih sest mjeseci. Ukoliko ste saglasni da učestvujete u ovom istraživanju, molimo Vas da popunite dvadesetominutni upitnik koji pokazuje važnost koju za Vas predstavljaju različiti aspekti zivota u zajednici. To je povezano sa oblastima kao što su znanje, uključenost, učesce i pristup. Ukoliko se odlučite učestvovati u ovom istraživanju molimo Vas da potpisete pismo saglasnosti u prilogu. Popunjene upitnike molim Vas vratiti Elizabeth Richan ili Saneli Sadikovic.

Sve informacije koje dobijemo putem ovog intervjuja cuvace se kao povjerljive. Ukoliko ste saglasni da učestvujete u ovom istraživanju, molimo Vas da potpisate pismo saglasnosti u prilogu. Popunjene upitnike molim Vas vratiti Elizabeth Richan ili Saneli Sadikovic.

Sve informacije koje dobijamo putem ovog intervjuja cuvace se kao povjerljive. Ukoliko ste saglasni da učestvujete u ovom istraživanju, molimo Vas da potpisate pismo saglasnosti u prilogu. Popunjene upitnike molim Vas vratiti Elizabeth Richan ili Saneli Sadikovic.

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U bilo koje doba obavijestite:

Glavni istraživač, Elizabeth Richan (+1-613-533-6881, richanb@queensu.ca) Savjetnik istraživača, Dr. Rosemary Lysaght (+1-613-533-2134, lysaght@queensu.ca)

Direktor, Zamjenik dekana, Skola za rehabilitaciju, Fakultet Zdravstvenih studija, Dr. Elsie Culham (+1-613-533-6727, culhame@post.queensu.ca), ili Predsjednika, Queen’s University Zdravstveni studiji i Istraživački etički odbor univerzitetske bolnice Dr. A. Clark (+1-613-533-6081).

Hvala Vam sto ste uzeli u razmatranje ovaj pozic za učesce u istraživanju. Ukoliko se odlučite na učesce u istraživanju molimo Vas procijenite, potpisite i vratile slijedeće dokumente saglasnosti.

S postovanjem,

[Podpisanje]

Elizabeth Richan, Glavni istrivac
LETTER OF CONSENT (Questionnaire)

Dear Potential Questionnaire Participant,

If you are willing to participate in the study “Factors that Influence Community Integration of Persons with Physical Disabilities in Post-Conflict Bosnia-Herzegovina as Perceived by Persons with Disabilities”, as described in the letter of information on the previous page, please sign in the appropriate space, and return one copy of this letter and signed consent in the enclosed envelope to Elizabeth Richan or Sanela Sadikovic at the CBR Centre.

At any time you may contact:

Principal Researcher, Elizabeth Richan     Research Advisor, Dr. Rosemary Lysaght
(+1-613-533-6881, richanb@queensu.ca)     (+1-613-533-2134, lysaght@queensu.ca)

Director, Associate Dean, School of Rehabilitation Therapy, Faculty of Health Sciences,
Dr. Elsie Culham     (+1-613-533-6727 culhame@post.queensu.ca), or

Chair, Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board
Dr. A. Clark     (+1-613-533-6081)

Your participation in this study is voluntary and you do not have to answer any questions you do not wish to answer. Also, you may withdraw from this study at any time without pressure or consequence.

*********

I have read the description of this research study and retained a copy for my records. My questions have been answered, and I understand that my participation is voluntary, that I may withdraw at any time, that the information I provide will be treated as confidential and that my identity will be protected. Further, I understand that there are no foreseeable risks associated with this study.

I, ____________________, voluntarily agree to participate in the above-named study.

(please check the appropriate box)

I agree to participate in the written questionnaire

(Your name here)

(Your signature) ___________________________     Date ___________________________

112
01. Juna, 2008

PISMO SAGLASNOSTI (Upitnik)

Dragi potencijalni učesnice u istraživanju,

U koliko ste saglasni da učestvujete u istraživanju Faktori koji utiču na integriciju osoba sa onesposobljenjem u poslijeratnom periodu, percipirano od strane osoba sa onesposobljenjem., kao što je opisano u pismu sa informacijama na prethodnoj stranici, molimo Vas potpisite na predviđenim mjestima i ratite jednu kopiju ovog pisma i formulare saglasnosti u zatvorenoj koverti Elizabeth Richan ili Saneli Sadikovic u CBR Centru.

Uvijek mozete kontaktirati:

Glavni istraživac, Elizabeth Richan  Savjetnik istraživaca, Dr. Rosemary Lysaght
(+1-613-533-6881, richanb@queensu.ca)  (+1-613-533-2134, lysaght@queensu.ca)

Direktor, Zamjenik dekana, Skola za rehabilitaciju, Fakultet Zdravstvenih studija,, Dr. Elsie Culham  (+1-613-533-6727 culhame@post.queensu.ca), ili

Predsjednika, Queen’s University Zdravstveni studiji i Istrazivacki eticki odbor univerzitske bolnice Dr. A. Clark (+1-613-533-6081)

Vase učesce u ovom istraživanju je na dobrovoljnoj osnovi i nemorate odgovoriti ni na jedno pitanje na koje nezelite odgovoriti. Takodje možete odustati sa ovog istraživanja u bilo kojem trenutku bez ikakvih posljedica ili pritiska.

******

Procitao/la sam opis ovog istraživanja i jednu kopiju zadrazao za sebe. Dobio/la sam odgovore na svoja pitanja, Shavtio/la sam da je moje ucesce dobrovoljno, da mogu odustati u bilo kojem trenutku, d ace se moi odgovori i informacije tretirati kao povjerljive id a ce moj identitet biti zasticen.. Razumio/la sam da nepostoji nikakav rizik vezano za ovu studiju.

Ja, ____________, dobrovoljno pristajem da učestvujem u ovoj studiji.

(vase ime)

Kasnije u toku sedmice zamolit cemo vas da učestvujete u intervjuu koji je nastavak istraživanja. Ukoliko zelite da učestvujete molimovas napisite broj telefona na koji vos mozemo kontaktirati da ugovorimo termin intervjuu. Intervju ce trajati od prilike jedan sat. Hvala Vam

Broj telefona: ________________________________

Molimo Vas obiljezite (✓) odgovarajuci kockicu

❑ Slazem se da učestvujem u pisanom upitniku

(Vas potpis)                              (Datum)
APPENDIX J

IMPORTANCE SCALE

Questions were based on the four KIPA themes of Knowledge, Inclusion, Participation and Access and were used to extrapolate factors that influence community integration of PWD. The questionnaire that was developed utilized a five point Importance Scale based on the following five choices of importance.

<table>
<thead>
<tr>
<th>Importance</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Important</td>
<td>5</td>
</tr>
<tr>
<td>Important</td>
<td>4</td>
</tr>
<tr>
<td>Moderately Important</td>
<td>3</td>
</tr>
<tr>
<td>Little Importance</td>
<td>2</td>
</tr>
<tr>
<td>Unimportant</td>
<td>1</td>
</tr>
</tbody>
</table>

The researcher processed the questionnaire responses based on the following scoring system values:

<table>
<thead>
<tr>
<th>Importance</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Important</td>
<td>5</td>
</tr>
<tr>
<td>Important</td>
<td>4</td>
</tr>
<tr>
<td>Moderately Important</td>
<td>3</td>
</tr>
<tr>
<td>Little Importance</td>
<td>2</td>
</tr>
<tr>
<td>Unimportant</td>
<td>1</td>
</tr>
<tr>
<td>Missing Data</td>
<td>0</td>
</tr>
</tbody>
</table>

A high score represented an indicator of greater value and suggested the significance that participants placed on that particular factor of community integration. The translator also acted as an assistant in communicating with participants in terms of logistics and in distribution and collection of questionnaires. The questionnaires took approximately fifteen to twenty minutes to complete.
APPENDIX K
RESEARCH ETHICS BOARD PERMISSION TO CONDUCT RESEARCH LETTERS

QUEEN'S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

May 5, 2008

Ms. Elizabeth Richam
International Centre for the Advancement of Community Based Rehabilitation
154 Albert Street
Queen's University

Dear Ms. Richam,

Study Title: Factors Influencing the Community Integration of Persons with Disability in Post-Conflict Bosnia and Herzegovina as Perceived by Persons with Physical Disability
Co-Investigators: Dr. Rosemary Lyons

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol, questionnaires and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair's signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

➤ Reporting of Amendments: If there are any changes to your study (e.g. consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval (see http://www.queensu.ca/rep/eth.htm).

➤ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➤ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➤ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair's signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

[Signature]
Chair, Research Ethics Board

Date: May 5, 2008

Study Code: REH-136-08

➤ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete.

SHIPPED MAY 06 2008
November 16, 2007

Mr. Elizabeth Richman
School of Rehabilitation Therapy
Louise D. Aaron Building
Queen’s University

Dear Mr. Richman

Study Title: The impact of community attitudes on the integration of persons with a disability in post-conflict Bosnia and Herzegovina
Co-Investigators: Dr. Margaret Jamieson

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair’s signature below. This approval will be reported to the Research Ethics Board. Please attend carefully to the following list of ethics requirements you must fulfill over the course of your study:

➢ Reporting of Amendments: If there are any changes to your study (e.g., consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval (see http://www.queensu.ca/vpr/reb.htm).

➢ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➢ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➢ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair’s signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

[Signature]
Chair, Research Ethics Board

[Signature]
Date

Study Code: REH-420-07

➢ Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete.