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Challenges and barriers regarding access to the Disability Grant: experiences of persons with Physical Disabilities residing in Soweto, Johannesburg

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Challenges and Barriers regarding access to the Disability Grant: Experiences of Persons with Physical Disabilities residing in Soweto, Johannesburg.

A research report presented to

The Department of Social Work

School of Human and Community Development

Faculty of Humanities

University of the Witwatersrand

In partial fulfilment of the requirements

For the Degree of Masters in the field of Social Development

By

Nkhensani Baloyi

November 2020

DECLARATION

I hereby declare that this report is my own unaided work and that assistance obtained has been only in the form of professional guidance and supervision, that either it nor any part of this report has previously been submitted to any other university for any degree save to the one with which I am presently registered as a student; that the information used in this report has been obtained by me while working under the Department of Social Work at the University of the Witwatersrand; and that all references used have been acknowledged and appropriately cited.

Signature: **Date:** 23 November 2020



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ABSTRACT

The Constitution of the Republic of South Africa Act No. 108 of 1996 recognizes the right of social security under Section 27, 1c. The South African Social Security Agency (SASSA) is mandated by the Social Assistance Act No. 13 of 2004 to deliver three main duties: administration, management, and payment of social grants, including the Disability Grant (DG). While more research has been conducted, focusing on the administration, management, and payment of the Child Support Grant and the Old Age Grant, the DG received the least attention, specifically focusing on persons with physical disabilities. It is from these viewpoints that this study explored the challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. A qualitative approach employing a case study design was used in this study. A non-probability, purposive sampling technique was used to sample twelve participants between the ages of twenty-one to forty-four years old. A semi-structured interview guide was used as a research tool, and in-depth, one-on-one interviews were adopted as a method of data collection. The data were analysed using thematic analysis, following the six steps as outlined by Braun and Clarke, 2012. The findings of this study were conceptualised through the bio-psycho-social model of disability. These findings revealed that physically disabled persons experienced challenges and barriers regarding access to the DG. The challenges identified included difficulties in denial or self-denial, unstable family conditions, limited access to medical assessment, shortages of finances, as well as stigma and discrimination. The barriers identified ranged from physical organisational and attitudinal barriers. While intervention from social workers was reported as an important strategy to minimise these challenges and barriers regarding access to the DG, a call was reported for social workers to escalate their interventions by educating communities and families about the implications of having a disability. Programmatic interventions in the Disability sector could also include the SASSA to adopt a multidisciplinary team focus relating to the DG's qualifying requirements. The study might contribute to additional knowledge on enhancing programmatic interventions done by both the public and the private sectors in a bid to improve access to the DG for persons with physical disabilities in low-income communities.

KEYWORDS: Challenges, Barriers, Experience, Persons with physical disabilities, Access, Disability Grant (DG), Social Security.

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LIST OF ACRONYMS USED IN THE STUDY

ANC	African National Congress
CSG	Child Support Grant
DG	Disability Grant
DHET	Department of Higher Education and Training
DSD	Department of Social Development
DSPD	Division for Social Policy and Development
CSG	Child Support Grant
FCG	Foster Care Grant
ICF	International Classification of Functioning, Disability, and Health
JOCOD	Johannesburg Council for the Disabled
OAG	Old Age Grant
PWD	Persons with Disabilities
SASSA	South African Social Security Agency
Stats SA	Statistics South Africa
UNCRPD	United Nations Convention of the Rights of Persons with Disabilities
WPRPD	White Paper on the Rights of Persons with Disabilities
WVG	War Veterans Grant
WHO	World Health Organisation

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

The purpose of this study was to explore the challenges and barriers experienced by persons with physical disabilities regarding access to the Disability Grant (DG) in Soweto, Johannesburg. The DG is a form of social security. Social security in South Africa is the biggest government's initiative in addressing poverty alleviation and income security among individuals like the elderly, persons with disabilities (PWD) and children who cannot contribute to in the employment sector (Hancock & McKenzie, 2017; Kaseke, 2010; Samson, MacQuene, Ingrid & van Niekerk, 2005; Woolard, Harttgen & Klasen, 2010). The right to social security is represented in Section 27 of the Constitution of South African, which says that "everyone has the right to have access to social security including, appropriate social assistance for those who unable to support themselves and their dependents" (Constitution of the Republic of South Africa, 1996, p.171). The right to social security is therefore, without question, non-negotiable.

Social grants are a paramount strategy for social assistance as they are means-tested or income-tested and are financed through the government's tax revenue system collected on a national basis (Kaseke, 2010; Taylor & Triegaardt, 2018; Woolard, Harttgen, & Klasen 2010). These grants consist of the Disability Grant (DG), Care Dependency Grant (CDG), Child Support Grant (CSG), Foster Care Grant (FCG), Old Age Grant (OAG), War Veterans Grant (WVG), Grant-in-Aid, and social relief of distress (National Treasury, 2020). The OAG, the CSG, and DG are the largest sub-programmes in social assistance coverage. The grants account for 3.6 million, 12.7 million, and 1 million beneficiaries, respectively (The National Treasury, 2020).

Social grants are nothing new and have existed in the country for decades. Historically, before the transition from apartheid to a democratic African National Congress (ANC) government in 1994, social grants have been primarily targeted for the disadvantaged white and coloured populations (Samson et al., 2005). The OAP was the first social grant rendered to the predominately poor white and coloured in 1928. In 1937, the DG was extended within the same racial discrimination against the black population in the country. Statistically, in the 1980s, the Native Affairs Department estimated that at about 367 000 blacks were eligible for both the OAP and DG, but only 197 000 of these beneficiaries received the grants (Devereux, 2001). This figure provides evidence of how

the apartheid government enhanced socio-economic exclusions regarding social assistance based on race and income testing.

In 1994, the ANC government was elected, and its mandate was to advocate and work against the apartheid government's fragmented system and advance inclusion for the previously marginalised and racially discriminated black populations to social assistance benefits (Samson et al., 2005). From 2001, in addressing the 'poor white problem', social grants were made available to all races, including blacks and Indians (Taylor & Triegaardt, 2018). Several Committees and civil society organizations advocated for the ANC government to mitigate all forms of racial exclusions and abolish the income testing in social assistance coverage. The Lund Committee, Chikane Committee, and Taylor Committee (Devereux, 2001; Joseph, 2012; Lund, 2001; Taylor, 2002) stand to be the most recognised civil society servants for the inclusion of black people in social assistance programmes. The purpose of the Committees was to redress all inequalities and advocate or argue for the inclusion of all eligible beneficiaries irrespective of their income, race, gender, ethnicity, or class.

Before 2006, South Africa did not have a specialised and dedicated department to administer, manage and distribute cash transfers to eligible beneficiaries (Joseph, 2012). Provincial governments in the Western Cape, Gauteng, Limpopo, Northern Cape, Mpumalanga, North West, Free State, Eastern Cape, and Kwazulu-Natal performed these duties on their own. Without a dedicated and specialised department, several challenges to accessing social grants were found such as fraudulent grants, corruption, exclusion of eligible beneficiaries, and beneficiaries not receiving all the payments especially individuals living in low-income and disadvantaged communities (Hancock & McKenzie, 2017; Mitra, 2010; Sekele, 2017).

In considering the advocacy from the above-mentioned Committees, the government enacted the Social Assistance Act No. 13 of 2004 to promote planning, administration, management, and dispensation of social grants to all eligible beneficiaries in the country (van Dijk & Mokgala, 2014). To ensure the proper implementation the Social Assistance Act in 2006, a dedicated division of the SASSA was established on April the 1st in 2006 as a national department mandated by the SASSA Act No. 9 of 2004 (Woolard et al., 2010). Its primary duties are to deliver comprehensive social security services on behalf of the nine SA provinces. SASSA is subsequently

managed and monitored by the National Department of Social Development (DSD) and in terms of the Social Assistance Act No. 13 of 2004.

Scholars such as Hancock & McKenzie (2017), Johannesmeier (2007), Parodi & Sciulli (2019), Rohwerder, (2018) and the WHO (2011) have been involved in considering that PWD are most vulnerable to stigmatisation and discrimination, poor socio-economic outcomes, and experience barriers such as physical, attitudinal, organisational, socio-economic or technological to accessing support services when compared to persons without disabilities. The findings of this study were conceptualised through the bio-psycho-social model of disability by George L. Engel and Jon Romano from the University of Rochester (Wade & Haligan, 2017). The purpose of using this model was to begin to understand the interaction of the biological, psychological, and social factors that might have hindered access to the DG. This chapter will, therefore, focus on the general introduction of the study by outlining the statement of the problem and rationale for the study, brief background of the study, definition of key concepts, brief description of the research methodology, limitations of the study, and end with the organisation of the report.

1.2 Statement of the problem and rationale for the study

The DG is the only social grant programme for the working-age population with all forms of disabilities, who are unable to take care of themselves, who are without a basic income and are not financially independent (Mitra, 2010; SASSA 2017/2018). As with the other social grants, the DG is managed and monitored by the DSD, whose mandate is to oversee the SASSA on behalf of the nine official SA provinces (SASSA, 2018/2019). The DG is awarded according to two sub-programmes; temporary and permanent (Kidd et al., 2018; Mitra, 2010). The temporary DG is dedicated to beneficiaries with a disability that will hinder them from participating in the employment sector for less than 6-12 months. The permanent DG, in contrast, is dedicated to beneficiaries who are unable to work for more than twelve months and extends until a beneficiary becomes eligibility for the OAP.

Apart from physical accessibility barriers, (Hancock & McKenzie, 2017; Johannesmeier, 2007; Mitra, 2010; Penn & Penn, 2015), found that persons with physical disabilities from rural communities use the grant to meet their own necessary needs such as water, food, electricity, healthcare, and indigenous financial policies such as stokvels or funeral covers. Due to the extra

costs of navigating through their lives, the DG is consequently inadequate to comprehensively cater for the necessary needs of persons with physical disabilities (Mont & Nguven, 2011).

The DG was envisaged to contribute to the reduction of poverty rates for individuals residing in disadvantaged communities. However, in recent year, much attention has been paid to the CSG and the OAP (Dijk & Mokgala, 2014; Kidd et al., 2018), with limited attention paid to the dispensation of the DG. Since the CSG and OAP eligibility requirements are straight forward, there have been barriers in the administration and management of social grants to PWD, especially for those with physical disabilities (Kidd et al., 2018; Jelsma et al., 2008; Johannesmeier, 2007).

The other barriers noted are that, despite the legislation and policy frameworks, SASSA still depends on the DSD for policy formulation and accountability (Kidd et al., 2018). It was further revealed by Statistics South Africa (2011) that political pressures affect the processes and procedures of the DG administration by the SASSA. To a large extent, unnecessarily high rates of rejected disability applications are reported, and these rejections lead to increased rates of poverty among persons living with disabilities in rural areas (Mont & Nguven, 2011). While there has been an increased awareness in the area of disability accessibility to the DG, (East, 2012; Johannsmeier, 2007; Joseph, 2012; Mpinda, 2012; Penn & Penn, 2015; Sibanda, 2012; Sekele, 2017), there is a gap in recent studies focusing on a similar topic specifically in low-income communities such as Soweto, Johannesburg. The management and administration of the DG is currently changing and new trends or a nuanced approach in the topic should be updated both in theory and practice. Altogether, while more research attention has been given to persons with physical disabilities experiences of barriers to health-care access in South Africa and abroad (Alkawai & Alwayyedb, 2017; Vergunst, Swartz, Msi, MacLachlan & Mannan, 2015), there seems to be a gap in terms of research studies that pay attention to the challenges regarding access to the DG by persons with physical disabilities living in Soweto's low-income communities.

The interest of the study emerged due to the researcher’s interest in the disability sector. Historically, civil society organisations such as the Anglican Archbishop of Cape Town, Ndungane, Njongokulu, the Black Sash, Chikane, Lund, Taylor Committees and many others have advocated for PWD to be considered in the management and dispensation of the DG (Joseph, 2012; Samson et al., 2005). Some of these organisations gave PWD in rural communities a voice to share their experiences regarding access to the DG. The findings were presented to the government and

subsequently, these findings actioned the government to improve the DG's uptake. As a social worker, currently working in an inclusive education non-governmental organisation (NGO), there is a lesson to learn from these organisations in the hope of assisting the DSD in its efforts to providing prominent social assistance programmes to persons with physical disabilities. Firstly, the findings from this study will hopefully contribute to additional knowledge on enhancing programmatic interventions done by both the public and the private sectors in a bid to improve access to the DG by persons with physical disabilities in Soweto. Secondly, the study might also inform practice through social worker's intervention to educate communities and families about the implications of having a disability. Thirdly, the study will hopefully create contributions to existing knowledge in the Disability sector. Lastly, the study might create awareness for the SASSA to adopt a multidisciplinary focus relating to the DG's qualifying requirements.

1.3 Brief background of the study

The study was conducted in Soweto, Johannesburg. Soweto is an acronym for South West Townships located in the City of Johannesburg Metropolitan Municipality in Gauteng, South Africa. Since Soweto is broad, the participants were then sampled at the Johannesburg School of the Disabled (JOCOD). JOCOD is in Peshawar Street Ext 11 in Lenasia, South of Soweto (Figure 1.1). Soweto is mostly characterised by low-middle income households. Hancock and McKenzie (2017) state that households living with PWD often earn less compared to households living without PWD, particularly those from low-middle income communities. Fortunately, there is an increasing consideration to include disability-related matters with socio-economic factors or poverty reduction programmes so that economic loss can be achieved (Hanass-Hancock, & Mitra, 2016; Mont & Nguven, 2011; Sekele, 2017).



Figure 1.1 JOCODs location

1.4 Definition of key concepts

1.4.1 Challenges

The Cambridge Dictionary (2020) defines a challenge as a condition of being faced with something that requires determination to be achieved effectively. A challenge in this context refers to the difficulties or obstacles faced by persons with physical disabilities regarding their access to the DG in Soweto, Johannesburg. Through data analysis, the challenges experienced differed from one participant to another concerning their access to the DG.

1.4.2 Barriers

A barrier is a concept that addresses accessibility (DHET, 2018). This means that understanding the challenges of accessibility leads to addressing barriers successfully. Barriers, therefore, refer to the removal of obstacles that hinder PWD from accessing basic services (DHET, 2018). Patel (2015) notes that access to basic services consists of accessing jobs, education, medical care, and housing in a sustainable manner. Yakobi (2013) identified five main barriers to accessibility for PWD. First, attitudinal barriers, these are negative attitudes perpetuated in society that hinder PWD from believing in themselves or thriving to participate equally with others. Stigmatisation and discrimination are at the forefront of these barriers in such a manner that people in society tend to judge or ignore a person with a disability (Rohwerder, 2018). Secondly, organisational barriers refer to policies, practices, power dynamics that unfairly discriminate against PWD. For example, poorly defined coordination mechanisms or budgeted programmes for PWD can be an organizational barrier. Thirdly, physical barriers refer to the inaccessibility of buildings and structures due to the design of a building. The inaccessibility to a ramp at the SASSA offices, a clinic or hospital is one example of a physical barrier. Fourthly, information or communication barriers exist when sensory disabilities such as hearing or seeing are not considered to both sending and receiving information. For this study, the DHET's (2018) definition of a barrier was used while drawing on the types of barriers as classified by Yakobi (2013).

1.4.3 Experience

The concept of 'experience' is dominant in qualitative research studies (Daher, Carréet, Jaramillo, Olivares, & Tomicic, 2017; Hall & Harvey, 2018). Daher et al. (2017) define an experience concerning a person's understanding, choices, opinions and how these factors contribute to the world around them. By using a hermeneutic method by Dreyfus (1991), an individual's

understanding of the social and cultural world influences how that individual thinks about his or her world. Hannes and Macaitis (2012) goes beyond the Dreyfus explanation, linking experience to a personal-meaning-making process. His definition includes language expressions about the environment around that individual. A commonality in all the three definitions is that a person's experience is affected by his or her world. The world or environment, as a result, may mean the society or community of friends or family that an individual interacts with. This world or environment plays a paramount role in the understanding, views, choices, and opinions of an individual. The WHO (2011, p. 4) confirms this definition relating to PWD, and argues that, "a person's environment has a huge impact on the experience and extent of disability." For this study, all the three above mentioned definitions were used throughout the study due to their commonalities.

1.4.4 Persons with physical disabilities

A person with a physical disability emanates from the definitions of disability. Disability is then defined in different ways by different authors from their respective theoretical perspectives. In this study, disability will be defined according to the WHO (2011). A variety of models such as the medical model and the social model will be used to define disability. The Employment Equity Act's definition of disability is also important as the DG is dedicated for the working-age populations who are unable to work and are not financially dependent.

The WHO (2011) refers to disability as a multidimensional term and broad in scope. Disability is also an umbrella term for the different forms of disabilities such as physical, mental, sensory, intellectual, visual, or neurological. The WHO (2011) thus explains disability in terms of the International Classification of Functioning, Disability, and Health (ICF), assessing the three main inter-related categories, impairments, activity restrictions, and participation restrictions.

- ***Impairments*** are difficulties encountered in the functioning of the body, such as loss of vision, memory, or paralysis.
- ***Activity restrictions*** are challenges in the coordination of body activities, such as hearing, problem-solving, walking or eating.
- ***Participation restrictions*** are difficulties that hinder PWD in fully participating in every life activity on an equal basis with persons without disabilities, such as facing exclusion in

the labour market, church, or taking part in political decisions in the mainstream community life.

Disability then refers to challenges encountered in all or any of the three inter-related categories. The environment is considered when defining disability in this context. The degree of the person's disability plays a vital role in the ability to interact with the environment. (WHO, 2011). Similarly, Bindawas and Vennu (2018, p. 4) defines "a person with a disability as a person who suffers disability caused by genetic and environmental factors which resulted in a physical or mental impairment that makes it challenging to successfully carry out business or physical and mental activities which might be carried out by healthy persons".

The Diagnostic and Statistical Manual of Mental Disorders (DSM–5) identifies three degrees of severity forms of disability, namely mild, moderate to severe (WHO, 2016). Persons with mild disabilities are delayed in everyday social activities. Their self-care needs minimal support. They are also capable of learning practical life skills, which enable them to participate in mainstream social life. Persons with a moderate disability can practice self-care, learn practical skills, and participate independently in the mainstream community. Their self-care needs moderate supervision by families or caregivers. Severe disability combines both mild to moderate disabilities. Individuals are often delayed in all areas of development and cannot participate in mainstream society on their own. Supervision by a family member or caregiver is important and to a large extent, these individuals are closely supervised in special needs medical settings.

Disability is also defined according to a variety of models; medical, and social models of disability. Farre and Rapley (2017) state that the medical model defines disability as an illness that originates from the individual. The aim of this model is treatment and rehabilitation (Seligman & Darling, 2007). The model states that treatment should be solved, and often fails to consider the various factors leading to disability, such as environmental factors (WHO, 2016). The limitation of this model is that it blames the victim for their disability, without assessing the person's life.

The social model, on the other hand, recognises the limitation of the medical model which does not consider environmental factors as fundamental when defining disability (Rimmerman, 2013). This model argues that disability is caused by the way in which society is organised, rather than by a person's impairment or biological factors such as gender, sex, or age. This type of definition leads to a more inclusive measure of disability and much higher disability prevalence estimates.

The key element of the social model concerns equality by exploring ways of removing organisational barriers, negative attitudes, and social exclusion for PWD. "When barriers are removed, PWD can be independent and equal in society, with choice and control over their own lives" (DHET, 2018, p. 19).

According to the Employment Equity Act No. 55 of 1998 in South Africa, PWD are referred to as those with long-term mental, physical, visual, emotional, cognitive or neurological disabilities which hinders them from fully participating in the labour market on an equal basis with others (DHET, 2018).

It is observed that indeed, there is no single definition of disability. DHET (2018) suggests that there are common elements in the definitions of disability. Impairment is the first element, whereby disability is apparent due to difficulties in body functions. Secondly, activity limitations or barriers to accessibility are present which hinders full and equal participation. Thirdly, unequal participation due to stigma and discrimination. The WHO's (2011) definition of disability was therefore used throughout the presentation of this report.

1.4.5 Access

As previously noted in the definition of a barrier, accessibility refers to the removal of barriers that might hinder PWD to fully participate and benefit from welfare services on an equal basis with others (Taylor & Triegaardt, 2018). According to the DHET (2018), access refers to the removal of physical, attitudinal, organizational, technological, political, cultural, and other barriers that prevent PWD from using services that are available to others without disabilities. For example, physical barriers refer to a person using crutches to walk and enters a building without ramps or an elevator. In the same light, access is an integrated approach that views inclusivity as a key principle of developing barrier-free access in mainstream society (Taylor & Triegaardt, 2018).

Access originates from the social development principle of universalism (Midgley, 2009; Midgley & Pawar, 2014). Social development proponents on universalism believe that a collaborative effort to bring about social improvements in social welfare is important for all without the discrimination of their race, class, gender, sexuality, or place of birth. Taylor and Triegaardt (2018) provides that universalism means that welfare benefits should be available to all citizens as a social right. Thus, universalism means that the right of all citizens in a country would qualify for social grants despite

their income and be secured against any unforeseeable circumstances leading to income insecurity. For this study, DHET's (2018) definition of access was used.

1.4.6 Disability Grant

The DG is the only social grant made available to the working-age population with all forms of disabilities ranging from the ages of 18-59 years (SASSA, 2017/2018). Mitra (2010) states that the DG is made available to these individuals who are unable to take care of themselves, who are without a basic income and are not financially independent.

The DG is also the only programme that uses two eligibility assessment criteria: a work disability test and a means test (Mitra, 2010). A work disability test assesses whether a person can work or not and to what extent is that person unable to work. A means tests, in contrast, screens whether an individual is eligible for social assistance by assessing whether a household earns an income beyond the minimum wage of R3500 per month. A work-test is administered because this grant is dedicated to beneficiaries classified as working-age populations and should be screened to check reasons for the inability to work. A means-test falls under the vertical redistributive policy to social welfare (Taylor & Triegaardt, 2018). This means that the government has put measures in place such as social grants to redistribute income from those who have more resources to those who have less.

1.4.7 Social security

Social security is defined in many ways by different policies, Acts, and authors. For instance, the White Paper for Social Welfare (1997) defines social security as policies that are contributory and non-contributory socio-economic protection measures to mitigate income loss, unemployment, maternity, and injury on duty or disability. Two objectives of social security are identified by (Woolard et al., 2010), as (1) to reduce poverty among individuals who cannot work for themselves and are not financially dependent on their families such as children, PWD and the elderly and (2), to restore economic development through the Growth Domestic Product (GDP) by ensuring that nutrition, employment, education, and health needs are met. Although improvements have been made to mitigate socio-economic loss in the country, poverty and employment rates are still high in SA. Statistics South Africa (2019) found that at about 13.8 billion people are living in extreme poverty and 29% of the working-age population is unemployed. Since the DG is dedicated to the working-age population with a disability, the DG is subsequently another source of income.

Similarly, to the White Paper of 1997, the International Labour Organisation (ILO, 2014) defines social security as mechanisms of governmental measures put in place to ensure that socio-economic relief is made available to individuals who are exposed to sickness, maternity, work injury, unemployment, old age, disability or injury. Authors such as Patel (2015), Kaseke (2010) and Woolard et al. (2010) have also provided consistent definitions of what social security means. Overall, social security is a long-term governmental investment to socio-economically protect the poor population against falling into poverty. For this study, all the above-mentioned definitions were used.

1.5 Overview of the research approach, design, and methodology

The study employed a qualitative research approach to explore the thick descriptions of the challenges and barriers experiences by persons with physical disabilities regarding their access to the DG in Soweto, Johannesburg. A case study design was used for this study. JOCOD was used as a case of study to explore the stories, opinions, and views from participants with a physical disability accessing the DG. JOCOD renders services to persons with all types of disabilities in Soweto and its surrounding areas, and it is focused on providing a protective workshop. This organisation offers services for the application process of the DG, which then served as an appropriate location to explore the participant's experiences regarding the DG's access. Purposive sampling was used to sample twelve participants with a physical disability (using the 2011 WHO definition of disability). This study used a semi-structured interview guide as a research tool. The method of data collection applied was in-depth, one-on-one interviews. With permission from the participants, an audio-tape recorder was also used to assist in transcribing the verbatim interviews chronologically (Appendix D). Based on the themes that emerged, the data collected was analysed using Braun and Clarke's (2012) thematic analysis process.

1.6 Limitations of the study

1.6.1 Sample selection

Similarly, to most qualitative studies, the sample size was limited to twelve participants with a physical disability residing in the Soweto community. This sample was therefore not presentative of the overall population in Soweto, Johannesburg. Since qualitative studies adopt smaller samples in their studies, research findings cannot be contextualised from one location to another. (Padgett,

2016). However, the aim of this qualitative research was not to generalize the research findings, but to have the research findings to apply to the geographical area the study took place.

1.6.2 Language barriers

The semi-structured interview guide was written in English, while some of the interviews were collected in Zulu, Tswana, and Tsonga. Chronological transcriptions were often limited as the researcher is not a first language Zulu and Tswana speaker. Fortunately, the researcher is a first language Tsonga speaker with an added advantage of conversational proficiency in Zulu and Tswana. This advantage has assisted with probing, translating, and transcribing from those languages to English. In a cross-language qualitative research study Squires (2009) found that failure to address language barriers in data collection, disadvantages the trustworthiness of the data. Reflection and summarisation skills were also helpful in reducing researcher bias.

1.7 Overview of subsequent chapters

1.7.1 Chapter One: Introduction to the study

This chapter stated the introduction to the study through several sub-headings; statement of the study and rationale for the study; definition of key concepts, an overview of the research approach, design and methodology; limitations of the study; and overview of the subsequent chapters.

1.7.2 Chapter Two: Literature Review and Theoretical Framework underpinning the study

This chapter focused on the literature review and theoretical framework underpinning the study. The following sub-headings were outlined; an overview of PWD, understanding of social security, legislative and policy frameworks regarding DG's access, theoretical framework underpinning the study, and the literature review.

1.7.3 Chapter Three: Research Methodology

This chapter focused on the research methodology used to conduct and analyse the findings of the study. Several sub-headings are outlined; research questions, aim, and objectives; research approach and design; population, sample, and sampling procedures; research instrument; methods of data collection and data analysis; ethical considerations; and trustworthiness.

1.7.4 Chapter Four: Presentation and discussion of the findings

This chapter provided the presentation and discussion of data collected. Participants' demographic information was analysed using descriptive statistics, while thematic analysis was used to analyse

the qualitative data to record themes relevant to the research. The study findings were discussed in relation to the objectives of the study. Participants' verbatim responses, and empirical evidence were used to illustrate the themes.

1.7.5 Chapter five: Main findings, conclusions, and recommendations

This study explored the challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. This chapter, therefore, provided a summary of the main findings, conclusions, and recommendations from the study.

1.8 Conclusion

This chapter focused on the brief background and introduction of the study. Research in the sector of Disability should be holistic to the inclusion of persons with physical disabilities living in low income communities. While the OAG and the CSG received more attention in previous studies, the DG is equally important. The next chapter will, therefore, provide more detailed information of the study through the literature review and theoretical framework underpinning the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK UNDERPINNING THE STUDY

2.1 Introduction

The purpose of this study was to explore the challenges and barriers experienced by persons with physical disabilities regarding access to the Disability Grant (DG) in Soweto, Johannesburg. Authors such as (Johannsmeier, 2007; Mpinda, 2012; Penn & Penn, 2015; Rohwerder, 2018; Sibanda, 2012) found that persons with physical disabilities are at an increased risk of experiencing the DG's accessibility challenges such as difficulties in accepting the disability, unstable family conditions, limited access to medical assessment, shortages of finances, as well as stigma and discrimination. Accessibility barriers to the DG range from physical, attitudinal, organisational, and language barriers. Given these challenges and barriers to the DG's accessibility, there is limited research conducted to add to this body of knowledge in the Disability sector. This chapter will therefore focus on the literature review and the theoretical framework to guide the primary aim of the research study. The chapter will focus on the following sections: theoretical framework underpinning the study; an overview of PWD globally, regionally and locally; understanding social security historically; legislative and policy frameworks regarding access to the DG; challenges and barriers experienced by PWD regarding access to the DG; social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG.

2.2 Persons with disabilities: An overview

2.2.1 Global overview

The estimated global ratio of PWD makes up to 15% of the world's population (WHO, 2011). Of this global estimate, one billion is faced with significant forms of disabilities classified by the International Classification of Functioning, Disability and Health (ICF) such as hearing, communication, seeing, walking, cognition, and self-care. It is estimated that the number of PWD will increase globally due to population growth, chronic health conditions, aging, workplace-related incidents, motor vehicle accidents, and violence (Bindawas & Vennu, 2018; WHO, 2011).

2.2.2 Regional overview

According to the Organisation for Economic Cooperation Development (OECD) countries, 40% of PWD do not have jobs compared to 75% without disabilities. Bindawas and Vennu (2018) state that the statistics generated concerning PWD is limited globally, which impedes on the reliability and validity of disability measures.

While the global estimate of disability makes up to 15% of the population, studies state that the regional prevalence of disability varies from one country to another, accounting of 1% to 30% worldwide(Mitra, & Sambamoorthi, 2014; Bindawas & Vennu, 2018). Using the Demographic and Health Surveys (DHS) with 49 countries of the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), the differing results of disability varies due to several factors. These factors include how different countries define disability, the methodology used for data collection, sample size and other generic factors such as gender, level of education, employment, personal factors, or location (Thompson, 2017).

2.2.3 Local overview

Census (2011) estimates 7.5% of the national prevalence for PWD in South Africa. This percentage is not representative of the 15% world population for PWD because under-reporting of disability is a continuous methodological limitation observed in different studies (Bindawas & Vennu, 2018; Census, 2011; Kidd et al., 2018; WHO, 2011). The national disability percentage is demarcated provincially with the Northern Cape and Free State having higher proportions of disability (11%), and least in Gauteng (5.3%) and Western Cape (5.4%) respectively (Census, 2011).

Statistics South Africa (2017) used the General Household Survey (2016) to measure disability. The findings showed that women (50.5%) were more disabled as compared to men (4.7%). The results, of course, are dependent on the location and sample selection; concluding that they do not represent the entire population of PWD in each province. According to population groups, blacks have the highest proportion of disability (7.8%), followed by whites (6.5%), Indians or coloureds (6.2%), and other (5.2%) respectively. As shown in previous studies in the disability sector, disability is positively correlated with age (Mitra, 2010). This correlation implies that disability deteriorates across the lifespan.

2.3 Understanding social security

2.3.1 History of social assistance in South Africa

This section briefly outlines the historical context of social assistance in South Africa.

History of social assistance before 1994

During apartheid, social assistance programmes were discriminative based on race, gender, and disability (Joseph, 2012). Samson et al. (2005) state that the OAP was the first grant to be introduced in 1928, which were targeted to the poor white and coloured populations. Social grants were fragmented in nature and the black population was significantly excluded from these benefits (van Dijk & Mokgala, 2014). In addressing the 'poor white' problem, the OAP was subjected to a means-test and an age criterion of 65 years and above (Joseph, 2012).

The Department of Social Welfare was established to work with social grants in 1933 (Joseph, 2012). Apart from the establishment of this department, operational challenges were apparent whereby black people were still excluded from the social assistance programmes. It was only in 1937 that the DG was extended to persons with disabilities on the same racial basis, favouring white and coloured people in exclusion of black people (Samson et al., 2005). For instance, even the initial Blind Persons Act of 1936 excluded black people from the DG. In 1943, the social assistance coverage of the OAP was 40% for whites, 56% for coloureds and as a low as 4% for blacks respectively (Devereux, 2001). This grant only focused on social relief and the OAP for persons with visual disabilities. The grants were also subjected to a means-test. According to Joseph (2012), social relief included temporary food packages and funds that were only targeted to the white and coloured population.

The DG Act of 1968 provided for the payment of DGs to persons with severe physical and mental disabilities (Dixon, 1968). The de-racialisation of social assistance programmes has developed from the late 1970s (Patel, 2015). Equality based on race, to include all racial populations grew rapidly during the 1970s. Fiscal policies covered more black people as compared to white people- at 5 times more than white people (Triegaardt & Patel, 2005). In 1992, the Social Assistance Act finally did remove all racial discriminatory practices in social grants (Woolard et al., 2010) by including all races also blacks and Indians. This inclusion was made possible due to the advocacy of several Committees and civil society organisations explained below.

History of social assistance after 1994

In 1994, a newly anti-apartheid democratic party, the ANC was elected and to date, the ANC is the ruling party in the country. The mandate of the ANC is to advocate and work against the apartheid fragmented system and promote social assistance inclusion for all its citizenry (Samson et al., 2005). As previously indicated, several Committees and civil society organisations advocated for the ANC government to do away will all forms of discrimination in social assistance coverage. The Lund Committee (1996), Chikane Committee (1996), and Taylor Committee (1999) stand to be the most recognised civil servants who advocated for the inclusion of black people in social assistance programmes. These committees will be elaborated on below.

The Lund Committee

This Committee was established in 1996 with a primary focus on reviewing policies and administration of the State Maintenance Grant-which is now known as the Child Support Grant (Lund, 2001). Major loopholes that this Committee has found were that the CSG was only targeted at traditional nuclear families whereas many other different forms of families existed in the country such as female-headed and single-headed families (Lund, 2001). Joseph (2012) argues that the CSG was also awarded to fewer black African women in favour of white African women. These loopholes necessitated the paradigm shift. At the time, only R100 was paid to nuclear families with a maximum of 6 children per household. Some of the recommendations made by the Committee were that the CDG and the FCG grants must not be removed while the CSG provisions are extended to the other forms of families.

The Committee faced challenges to convince the government due to limited fiscal expenditures in the CSG. The CSG recommendations were later amended to include children over the age of 18 years and the link to the grant to the primary caregiver (Kabeer, 2008). To date, the benefits of the CSG are widely recognised taking the highest proportion in social assistance expenditure covering 12.7 million children in the country (National Treasury Report, 2020).

The Chikane Committee

The Chikane Committee was established in the same year as the Lund Committee. Its mandate was to review the entire social security system, including all social grants sub-programmes. This Committee recommended for a dedicated, specialised Department of Social Security to manage

and administer social assistance programmes (Triegaardt & Patel, 2005). The purpose was to redress all inequalities and inclusion of all eligible beneficiaries irrespective of their race. The recommendations proposed were reviewed by the government and they then found several challenges in establishing a dedicated and specialised department of social security. The main challenges were high costs, constitutional difficulties, payments of each individual and other policy changes. In addition, the Committee highlighted other barriers to obtain or access social grants such as long queues at pay points, delays of payments, and lack of water, shelter and/or sanitation at the pay-points.

The Taylor Committee

The final committee was the Taylor. The call for this committee was the removal of the income-test with replacement for the basic income grant. However, such recommendations were not adhered to by the government due to limited funds (Reddy & Sokomani, 2008; Taylor, 2002). The income-test is widely used today to allocate funds accordingly. In addition to the Taylor Committee, a task team of civil societies and labour unions were also appointed in 2000 to review the Social Assistance Act No. 59 of 1992, especially for the DG assessments. For instance, the Anglican Archbishop of Cape Town, Ndungane, Njongokulu, the Black Sash, General Secretary of the Labour Union Federation, Zwelenzima Vavi, and many others were part of the task team to advocate for equal rights to social security (Kidd et al., 2018).

The establishment of the SASSA

In considering the advocacy from the above-mentioned Committees, the government enacted the Social Assistance Act No. 13 of 2004 to promote planning, administration, management, and dispensation of social grants to all eligible beneficiaries in the country (van Dijk & Mokgala, 2014). Its primary duties are to deliver comprehensive social security services on behalf of the nine SA provinces. SASSA is subsequently managed and monitored by the DSD by the National DSD and in terms of the Social Assistance Act No. 13 of 2004.

There is a specific process followed from grant application and grant approval (Sekele, 2017). The SASSA uses the SOCPEN data management system to capture the grant applications electronically. Screening is the first step whereby the required documentations are submitted. The front-line staff check if those documents are accompanied by affidavits, medical reports, IDs, proof

of assets or income and then register the applicant to start the application process. For the DG, applicants are then booked for medical assessments. The SASSA uses a Disability Management Model by an internal medical practitioner to screen and assess eligible beneficiaries of the DG (Kidd et al., 2018). Applicants are sent back if they do not submit the required documents during screening. Attesting is the second step that requires the completion of the application form. The form and documents are captured on SOCPEN. Quality assurance step checks whether the documents submitted align with the legislative frameworks and whether these documents are correctly captured on SOCPEN. Finally, the verification step verifies the information captured on SOCPEN. SOCPEN either rejects or approves the DG.

Since the establishment of the SASSA and its data management system, SOCPEN, this agency has faced operational challenges in managing and administrating social grants (Mitra, 2010; Sekele, 2017). These challenges and limitations range from the fact that most application forms are still captured manually, misplacement of applications, incorrect capturing of applications, lack of attention to detail, or duplication of data storing (Joseph, 2012; Kidd et al., 2018; Sekele, 2017). Given the history of social assistance in South Africa, the following section will focus on the form of social security guiding the study (social assistance).

2.3.2 Forms of social security

The Social Assistance Act No. 13 of 2004 makes provision for the administration, management, and payment of social grants to individuals falling into poverty. Thus, social assistance specialises in social grants. These grants consist of the CSG, FCG, CDG, OAP, DG, WVG, Grant-in-Aid, and social relief of distress (The National Treasury, 2020). The SASSA Act No. 9 of 2004 is the dedicated agency to administer, manage and pay for social grants nationally and provincially. Social grants are subject to the two main administrative eligibility criteria, such as a cash transfer and means-test. Cash transfers are provided in the form of cash payable to eligible individuals who face an increased threat to falling into poverty (Joseph, 2012). Cash transfers are financed through the government's tax revenue system collected on a national basis (Kaseke, 2010). SASSA administers cash transfers to various banking systems and pay-points where payments are received. Means-test, on the other hand, states that an evaluation of income and assets of the applicant is conducted to assess whether the person is eligible for a social grant or not. Taylor and Triegaardt

(2018) show that means testing or screening of an income ensures that governments spend is targeted at those in dire need and that funds are distributed accordingly.

Social grants are therefore made available, not only for the use of basic needs but to reduce poverty and plan for second order-effects such as medical care and to promote social development. Even though there is resistance in Sub-Saharan African countries such as Zimbabwe in establishing social assistance, these countries fear that social grants could result in dependency rather than in employment participation (Mpinda, 2014). There is also fear that social grants could threaten free healthcare and basic education services as well as the long-term fiscal policies in sustaining the grants. South Africa is, therefore, a unique country because of the way the country manages social assistance.

The DG is the only social grant programme for the working-age population with all forms of disabilities, who are unable to take care of themselves, who are without a basic income and are not financially independent (Mitra, 2010; SASSA 2017/2018). The current threshold of the DG is R1, 860 (National Treasury Report, 2020). The DG is subjected to a medical assessment (Kidd et al., 2018). SASSA employs internal doctors to conduct these assessments. After the assessments are done, the grant will go under review or verification.

To qualify for the DG, applicants must meet the following requirements:

(i) A South African citizen or refugee
(ii) Aged between 18 to 59 years old
(iii) Undergo medical assessments, and
(iv) Provide evidence of previous medical records

2.4 Legislative and policy frameworks regarding DG access

The following sections will focus on the legislative and policy frameworks regarding the DG's access.

2.4.1 The Constitution of the Republic of South Africa of 1996

Section 27, 1c of the Constitution sets forth the right to social security to individuals who are unable to take care of themselves are not financially dependent on their families (Republic of South Africa, 1996). The Constitution, therefore, has a state obligation to provide for the coverage of

social security or provide alternatives within its available resources to ensure that those who are not eligible are covered.

2.4.2 The White Paper for Social Welfare (1997)

The White Paper for Social Welfare (WPSW,1997) stands to be the most recognised policy framework for the provision of comprehensive social security arising from the Constitution. The principle of universalism grants social security as a right (Taylor & Triegaardt, 2018). Patel (2015, p.19) states that "universalism refers to the right of all citizens in a country to universal coverage and access to welfare services and benefits such as income security, medical care, education, and housing on an ongoing basis."

The paper provides that the SASSA and DSD are responsible for the following in relation to social security (WPSW, 1997):

- Coordinating a variety of responsibilities in between national, provincial and private departments to ensure that social security is made available to poor populations;
- Plan, draft, consult, write-up and share national policies in relation to improving social assistance;
- Develop standards of social services in ensuring that social welfare is met as well as;
- Ensure that governance, financing, and accounting are promoted.

2.4.3 White Paper on the Rights of Persons with Disabilities (WPRPD, 2016)

The DSD has amended the WPSW (1997) to the White Paper on the Rights of Persons with Disabilities (WPRPD, 2016). Principle 1 under WPRPD provides that barriers to access and participation should be removed, adding the issue of disability which runs throughout the Constitution and it protects against discrimination for PWD. The following sections will focus on the literature reviewed regarding challenges and barriers as well as social support for persons with physical disabilities concerning access to the DG.

2.4.4 The South African Social Security Agency Act No. 9 of 2004

The SASSA ensures three main objectives, such as administration, management, and payment of social grants to eligible beneficiaries nationally and provincially. Reddy and Sokomani (2008) argue that the SASSA is a dedicated and specialised agency to ensure that these objectives are met according to the Social Assistance Act No. 13 of 2004. SASSA is subsequently managed and

monitored by the DSD by the National DSD and in terms of the Social Assistance Act No. 13 of 2004.

2.4.5 The Social Assistance Act No. 13 of 2004

This Act legislates how the SASSA should executive its objectives of social grants to applicants and beneficiaries. Woolard et al. (2010) stated that the eligibility criteria of social grants are outlined to ensure that minimum requirements are determined for the delivery of social assistance. This Act is an important strategy to mitigate fraud and regulating the payment of social grants to protect the right of social security for all (Van Rensburg & Horsten, 2004).

2.4.6 United Nations Convention of the Rights of Persons with Disabilities, UNCRPD (2008)

The UNCRPD was first signed with the South African Parliament on 30th of March 2007 and re-signed on 30th of November 2007 (DHET, 2018). The UNCRPD recognises a national effort to empowering and coordinating structures to support PWD. It also recognised South Africa's commitment to designing and structuring equitable social services to PWD. All forms of attitudinal barriers such as stigmatisation and discrimination are prohibited to promote the necessary needs for PWD in the disability sector. This Convention is consistent with the Promotion of Administrative Justice Act Non. 3 of 2000, which states that the SASSA, for example, should show written reasons why a certain decision was taken, such as why a grant application was rejected (Joseph, 2012).

2.5 Theoretical framework underpinning the study

Theoretical frameworks are research-based explanations and organised ideas from different scholars that help to clarify and inform the questions we ask. Research into the area of disability has drawn on a variety of theoretical frameworks and the current study is specifically guided by the bio-psycho-social model as outlined in the following sections of the report.

2.5.1 Bio-psycho-social model

The bio-psycho-social model of disability emerged in 1997 by George L. Engel and Jon Romano from the University of Rochester (Wade & Haligan, 2017). This model implies that disability should be viewed neither as purely medical nor purely social (WHO, 2011). The model incorporates three elements in its definition- implying that biological factors (sex or gender) interact with psychological factors (motivation or self-esteem), and social factors (culture, attitudes) rather than working in isolation with the environment (Farre & Rapley, 2017). It is

concerned with issues of inclusion (facilitation) and exclusion (barriers to accessing basic services, in the case of this study, access to the DG). This framework relates to the study because social problems should be understood from the individual to the broader social, political, psychological, and environmental factors. The model is essential as it guides practitioners to understand where social problems originate from other than blaming the victim of their disability. For example, exclusions to the DG would be minimal if all the multidisciplinary teams were extensively included in the grant's assessments. The teams would include social workers, doctors, nurses, occupational therapists, or physiotherapist who are trained to work with PWD.

The bio-psycho-social model was developed to oppose the traditional model of disability. According to Farre and Rapley (2017), the traditional model defines disability as an illness that originates from the individual. The aim of this model is focused on treatment and rehabilitation (Seligman & Darling, 2007). The traditional model states that treatment should be solved, and often fails to consider the various factors leading to disability, such as environmental factors. The limitation of this model is that it blames the victim for their disability, without assessing the person's life (Wade & Haligan, 2017). The bio-psycho-social model, on the other hand, recognises the limitation of the traditional model by considering environmental factors when defining disability (WHO, 2011). Environmental factors could include policies, practices, systems, settings, support, and technology which might hinder access to the DG. The key element of the bio-psycho-social model is equality by exploring ways of removing organisational barriers, negative attitudes, and social exclusion for PWD. In a facilitative environment, persons with physical disabilities might still be able to equally participate and ask for help during the application process. However, in an environment whereby there are a lot of barriers to accessing the DG, persons with physical disabilities might feel isolated and ashamed to ask for help and start the application process. Stigma and discrimination hinder PWD from accessing essential services such as healthcare, education, employment, or social services (Rohwerder, 2018). "When barriers are removed, PWD can be independent and equal in society, with choice and control over their own lives" (DHET, 2018, p. 19). Lastly, this model is applicable to the study because it considers environmental factors when working with PWD.

2.6 Literature Review

Scholars such as Hancock and McKenzie (2017), Johannesmeier (2007), Mitra (2010), Mpinda (2014), Parodi and Sciulli (2019), Penn and Penn (2015), Sekele (2017), Sibanda (2012), and WHO (2011) have been involved in considering that PWD is most vulnerable to experiencing challenges and barriers to accessing essential service than persons without disabilities. These challenges and barriers experienced range from attitudinal, physical, organizational, socio-economic, or information technology which serves to further marginalise and isolate PWD from full participation in mainstream society. To a large extent, social assistance such as the dispensation of the DG has been a poverty alleviation strategy for persons with all forms of disabilities for many years. What is missing from these studies is the challenges and barriers experienced by persons with physical disabilities regarding access to the DG, particularly in Soweto, Johannesburg. That is, the disability sector should keep abreast to new information and knowledge both in theory and practice to inform rigorous recommendations and interventions among groups with physical disabilities, particularly in low-middle income communities. The following section will present the main challenges and barriers, as well as the social support services experienced by persons with physical disabilities regarding access to the DG.

2.6.1 Challenges and barriers

The challenges and barriers range from physical, attitudinal, organisational and communication.

2.6.1.1 Physical challenges and barriers

Physical barriers to accessing the DG for persons with physical disabilities have been reported in many studies, particularly in rural communities (Jelsma et al., 2008; Johannsmeier, 2007; Sekele, 2017). Physical barriers refer to the inaccessibility of buildings and structures that are not disability friendly for PWD. For instance, Jelsma et al. (2008) conducted a quantitative study by comparing two groups (that is, those who receive the grant and those without the grant) in rural and urban communities of the Eastern Cape and Western Cape. The sample included 244 participants from rural communities and 61 participants from urban communities ranging from the ages of 18 years and above. The mode of transportation used was a major barrier reported by participants not receiving the grant (n=110). The results revealed that transportation was inaccessible in the rural communities which were undeveloped, poor roads and muddy during raining weather. No

significant difference was found for participants in urban areas as they had access to disabled-friendly transportation with well-developed tarred roads.

Johannsmeier (2007) found consistent results using a qualitative study with 46 participants from 8 rural and urban communities of the Kwazulu-Natal province (KZN). The study focused on the socio-economic factors regarding access to the DG for persons with physical, visual, and hearing disabilities. Transportation costs, especially for persons with a physical disability, emerged as a theme. The results showed that public transport was inaccessible to collect the payment from the community pay-points. Participants using wheelchairs and crutches further reported that steps of a bus or taxi were too high, and the cost of private cars was disproportionally high. Jelsma et al. (2008) state that having a physical disability appeared to be a financial disadvantage for participants living in rural communities. Physical barriers to accessing services consisting of public transport and access to buildings were also found in Sekele's (2015) qualitative study in the rural context of the Limpopo province. Overall, the grant happened to be the sole income for PWD, and extra transportation costs were deemed to be a barrier to the DG's accessibility.

2.6.1.2 Attitudinal challenges and barriers

Attitudinal barriers such as stigma and discrimination faced by persons with physical disabilities in accessing the grant have been reported by (Parodi & Sciulli, 2019; Rohwerder, 2018; Vergunst et al., 2015). Attitudinal barriers such as stigmatisation and discrimination have been widely researched in the disability sector's accessibility of the DG. Attitudinal barriers are negative attitudes perpetuated in society that hinder PWD from believing in themselves or thriving to participate equally with others (Rohwerder, 2018). Stigmatisation and discrimination are at the forefront of these barriers in such a way that persons without disabilities often judge, label, and ignore a person with a disability. Using a longitudinal study conducted from secondary data of the European Union Statistics on Income and Living Conditions in Italy, with more than 100 000 households living with a person with a disability, several results were found (Parodi & Sciulli, 2019). These authors found that social exclusion emanates from stigmatisation and discrimination perpetrated in mainstream society. Those who were severely disabled experienced exclusion by 2.5% in the communities they lived in. 20% of these individuals were primarily dependent on their family members for daily activities and survival which perpetuated an escape from being socially excluded. Disabled persons were also dependent on state provisions such as social grants and

subsequently limited their participation in employment and education. The strength of this study was the inclusion of households living with a PWD. The findings are indicative of the fact that social exclusion perpetuated by stigmatisation and discrimination is a worldwide concern and there is a need for policies to consider the socio-economic effects of households living with a severely disabled person.

Rohwerder (2018) on the other hand-reviewed literature from the Division for Social Policy and Development (DSPD) in Sub-Saharan African counties to understand the causes of disability stigma and their socio-economic consequences for PWD. The stigma of being disabled prevented PWD from accessing essential services such as healthcare, education, employment, and other services. Firstly, cultural, and religious practices led to the stigmatisation of PWD in regional countries such as Uganda, Zambia, Nigeria and Kenya (Aley, 2016; Mostert, 2016). Misconceptions of disability were found to be caused by ancestral spirits by PWD in Uganda and Zambia, while Nigeria found that disability is caused by a generational curse. Uganda participants also revealed that disability was a curse from the mother's side of the family rather than the father's side of the family, while witchcraft and magic were found in Kenya. In Nepal, Parnes et al. (2013) found that punishment from God resulted in a disability. Mostert (2016) found that parents or caregivers caring for a child with a disability were found to restrict the person with a disability to participate in the community's activities. Surveys conducted in Cameroon, Uganda, Zambia, Senegal, and Ethiopia concluded that 38% of these parents or caregivers were found to hide away their children to prevent them from being stigmatised. This view led to the prevention of participating in society and benefiting from social welfare. Parents or caregivers also reported that they were ashamed of their child living with a disability. According to Rohwerder (2018), persons with severe and mental disabilities were more stigmatised than persons with physical or sensory disabilities. Lack of knowledge and understanding of the causes of disability is a major factor experienced by PWD in their communities. Educating the family and community interventions to concientize them about stigma were major recommendations made by Rohwerder (2018).

In South Africa, Penn and Penn (2015) conducted a qualitative study to explore the barriers experienced by PWD regarding policy and service delivery implementation in 12 poverty-stricken communities of the Mpumalanga province. The sample comprised of 30 participants with equal gender characteristics (15 women and 15 men ranging from the ages of 19 to 83 years). Of the

participants, 16 of these participants had physical disabilities, while others had cognitive, sensory, and multiple disabilities. Only 21 of the 30 se participants were beneficiaries of the DG and others depended on their families for financial support. Discrimination and social exclusion emanated as themes from the study with 14 participants reporting feelings of isolation and six 6 participants reporting barriers to accessing information. The other themes emerged were organisational barriers to accessing identity documents for the application of the DG and barriers to accessing the DG after obtaining identify documents. The strength of this study was the focus on stigmatisation and discrimination while looking at the barriers experienced by persons with physical disabilities regarding access to the DG in low-income communities. This strength, therefore, grants the study to be applicable and transferable to the current study conducted in Soweto, Johannesburg.

2.6.1.3 Organisational challenges and barriers

Organisational barriers manifest at SASSA regarding medical assessments needed for persons with physical disabilities to be awarded the grant (Kidd et al., 2018; Mitra, 2010; Tumbo, 2008). This means that to qualify for the grant, individuals should have a medical report confirming their degree of disability (SASSA, 2017/2018). For instance, SASSA works with internal medical doctors who use the Guidelines for the Medical Assessment of Disability for Social Assistance (Kidd et al., 2018). To a large extent, doctors assess whether an individual has a mild, moderate, or severe disability using the prescribed guidelines. Mitra (2010) found that such medical guidelines further raise exclusions from the DG, particularly for persons with mild disabilities. The medical model would agree with this approach for doctors to conduct a medical assessment because the model favours reason based on biological grounds such as genetics or physiology (Seligman & Darling, 2007).

Tumbo (2008) conducted a qualitative study using interviews to explore the factors influencing a doctor's medical assessment of applicants regarding the DG. The sample consisted of 5 doctors working in a public hospital in the Limpopo province. The results showed that doctors were frustrated as medical assessments regarding the DG did not have a clear guideline. Medical clearance was dependent on the mood of the doctor and assessments of disability were often subjective. Attitudinal barriers such as the community's misconception about disability and the grant influenced whether doctors approved or disapproved applications. The researcher is aware that this study is old, however, the study is still applicable to the current challenges faced by PWD

in accessing medical reports required to accessing the DG. Kidd et al. (2018) found that applicants need to undergo two medical assessments before starting DG's application process. First, applicants should have a referral letter from an external doctor employed by the state before starting the application process and secondly, undergo the SASSA's internal medical assessment process. Navigating access to the DG is time-consuming and financially expensive particularly for persons living in rural communities.

Mitra (2010) additionally found exclusionary errors for both the work disability of the individual and the income test of the household. Using self-reports and standard measures of the socio-economic status (SES) of the household, Mitra (2010) found that households without the grant were more excluded as they lived in disadvantaged communities without welfare services, hospitals, and clinics. Financial constraints are higher for them compared to households with the grant. Furthermore, the South African medical system is largely private while medical reports for the DG's applicants should come from a doctor employed by the government (Kidd et a., 2018). The Department of Health (DoH) faces challenges in the employment of more doctors because of financial constraints. Even when doctors are employed in the public sector, they lack the necessary training regarding the DG's assessment and approval. The barriers are not only residing in the societal stigmatisation and discrimination, but also in the government's way of managing the DG's accessibility. Kidd et al. (2018) argue that exclusionary errors based on the work disability of the individual should be given the attention of policymakers because it is unfair, discriminative, and punitive.

The other barriers noted are that, despite the legislation and policy frameworks, the SASSA still depends on the DSD for policy formulation and accountability. It was further revealed by Statistics South Africa (2011) that political pressures affect the processes and procedures of the DG administration by the SASSA. To a large extent, an unnecessarily high rate of rejected disability applications is reported, and these rejections contribute to the high rates of poverty among persons living with disabilities in rural areas (Mont & Nguven, 2011).

The SASSA has best practices and measures put in place to assist beneficiaries with accessibility, management, and payment of social grants. However, there are still more organisational barriers when it comes to its operation (Sekele, 2017). The SASSA officers are expected to conduct not more than 40 assessments per day and only spend at least 10 minutes for each consultation (Kidd

et al., 2018). Joseph (2012) found that front-line staff at SASSA capture more than 30 applications per day. Using questionnaires with front-line staff at the SASSA offices in the rural Northern and Western Cape provinces, 100% of the participants indicated that applications get misplaced or lost after processing. The reasons behind this challenge was the lack of office space, poor capturing system, too many applications per day, a lack of staff accountability and poor filling system. The consequence of these barriers that applicants are required to start the application process from the onset while still lacking financial resources or transportation in rural areas to do so. Given that physical disability is a long-term condition (WHO, 2004), the limited time spent for assessment raises other communication barriers, such as language barriers for PWD (Jelsma, et al. 2008; Kidd et al., 2018). In many indigenous languages, there is a lack of language translations for a range of cognitive and mental conditions, which makes communication even more problematic. Mental illness is, for example, often referred to as being 'sick in the head.'

The SASSA has an appeal system put in place when grants applications are rejected (Sekele, 2017). This author showed that most of the appeals are related to the DG (94-96%), raising more barriers or challenges to the DG's accessibility. Applicants for the DG must undergo medical assessments, consisting of work disability and a means-test of the household while the CSG, OAP, and FCG requirements are straightforward (van Dijk & Mokgala, 2014). Kidd et al. (2018) found that only 23% of the DG's payment contribute to the household income, such as the household reported to be running out of money and covering disability-related costs during the application process. Even when the grant is received, Johannsmeier (2007) reported that participants with disabilities use the money for essential household expenditures such as funeral covers, food, clothes, school fees, water, or electricity. Social grants in South Africa aims to protect individuals from income loss, but there is a gap in studies revealing that income is limited for households living with PWD (Hancock & McKenzie, 2017; Kidd et al., 2018; Johannsmeier, 2007). Using descriptive statistics from the General Household Survey of persons with all types of disabilities ranging from 15 to 59 years old, several results have been shown. Hancock and McKenzie (2017) stated that applicants with mild disabilities such as concertation, remembering, intellectual, mental health, autism were less likely to access the DG. This had implications on the household expenditure with 25% of these households experiencing hunger over time. Ideally, disability grants assessments should adopt a nuanced approach that is targeted to reduce exclusions for those who are worth deserving.

2.6.1.4 Communication challenges and barriers

The barriers to communication was related to the language used during medical assessments. Taking language barriers into context, Jelsma et al. (2008), using an IsiXhosa version of the ICF has assisted with language translation during data collection. The authors used questionnaires administered to 244 rural and 61 urban participants. On a 0-100 Point-Likert scale, the participants were able to provide rigorous results of the 5 domains of functional impairments: mobility, self-care, usual activities, pain, anxiety, or depression ranging from sensory, cognitive, or physical disabilities. Penn and Penn (2015) also conducted narratives in SiSwati by employing a first language SiSwati speaker. The strength of the results calls for the induction of language translators when conducting disability assessments. This recommendation is consistent with Article 2 of the UNCRPD (2008) which states that communication should be free of barriers for PWD.

2.7 Social support services

According to the WHO (2011), PWD require social support and assistance to equally participate in society with others. Social support enables PWD to feel valued and reduce the burden of care for households living with PWD. This section focuses on the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG.

2.7.1 Non-governmental organizations (NGOs)

According to the WHO (2011), PWD require social support and assistance to equally participate in society with others. Social support enables PWD to feel valued and reduce the burden of care for households living with PWD. First, NGOs are one of the strategies to support PWD. Mostert (2016) argues that NGOs are tasked to perform several activities such as promoting social justice, participation, and equality on behalf of PWD, who are often discriminated, stigmatised and marginalised in mainstream society. Rohwerder (2018) suggests that NGOs should adopt the community-rehabilitation model which utilises community development to equalize opportunities and rehabilitate PWD. The WHO (2011) shows that the multidisciplinary team placed in NGOs, private or public sectors such as social workers, occupational therapists, physiotherapists, doctors, nurses and others should use rehabilitation support to assist PWD to obtain optimal functioning within their environments. The WHO (2011) define rehabilitation as a set of measures used to help

PWD to gain optimal functioning, independently and translate their functioning in the environments that they live in.

For instance, The DSD funds many NGOs in Johannesburg rendering care and support for PWD. Social services range from one-on-one counselling, group counselling, residential care, community interventions, education, employment generation activities, social welfare services, and protective workshops. JOCOD, for example, is one of the NGOs providing support for PWD. There are several NGOs in Soweto, Johannesburg rendering similar but distinctive social services support for PWD. These are Leonard Cheshire Homes, Disabled People of South Africa, Soweto Association for the Disabled, Harvey Cohen Workshop, Modimo O Moholo for the Disabled, and Jerry Hope Protective workshop. The challenges and limitations experienced by NGOs is the lack of funding from government structures, as well as operational and human resources capacity (Dlangamandla, 2011). Social workers are mostly employed in the NGO sector rendering welfare services. JOCOD's social worker assists PWD with the application process and ensuring that they receive their grants. Jelsma et al. (2008) found significant differences between beneficiaries with the DG and those without the DG in the rural provinces of the Western Cape and Eastern Cape. At the 0.05 significant level, participants who did not have access to the DG reported barriers regarding social support given by the community compared to participants with the grant ($p=0.003$). Community support is therefore an essential strategy to assist PWD to participate and access essential social welfare services, equally, with others in mainstream society.

2.7.2 Spiritual support

Garland (2011) found that churches provide socio-emotional support to PWD and their families by meeting their spiritual needs. This author further argues that churches provide limited support to families because they have limited understanding and knowledge of how to deal with them other than through prayer and food parcels. McNair and Sanchez (2008) note that there is a great need for churches to recognize and provide support since PWD are part of the church community. Church support is also essential due to the stigma of being disabled. Evidence shows that disability is a punishment from God or through punishment from ancestral spirits (Mostert, 2016).

2.7.3 Family support

Family support is also essential to support PWD (Garland, 2011). However, this approach has received the least attention in the same research topic while more research has been conducted on family support for children with physical disabilities regarding their parent's coping strategies and access to basic services (Dowling & Dolan, 2001; Tigere & Makhubele, 2019). Disability studies should subsequently consider focusing on similar support services to serve its PWD holistically.

2.8 Conclusion

This chapter focused on the literature review and the theoretical framework beneficial to the understanding of the primary aim of the research study. The challenges and barriers experienced by persons with physical disabilities has been researched and reviewed by many authors. This chapter revealed that challenges and barriers to the DGs access are interlinked. The bio-psycho-social model is concerned with environmental challenges which might be overlooked during the DGs access. It is mandatory for the multidisciplinary team such as social workers, doctors, nurses, occupational therapists, or physiotherapists to work with the SASSA for holistic assessments in the DGs access. Lack of trained practitioners regarding DGs assessment is a major concern, especially in the public healthcare system. Social support services such as NGOs, spiritual and family support were researched as important tools to assist PWD manoeuvre the challenges and barriers regarding access to the DG.While the global estimated ratio is 15% for PWD, the local estimate is 7.5%. Many studies found that disability statistics are old which prevents the sector to provide rigorous recommendations and interventions among groups with physical disabilities, particularly in low-middle income communities. The next chapter will focus on the research methodology used to achieve the primary aim and objectives of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter will focus on the research methodology employed in the study. A brief overview of the research methodology has already been explained in chapter one, and the focus of this chapter is to expand and explain the research methodology in detail. The research employed a qualitative approach to capture thick descriptions from physical disabled participants. A single instrumental case study design was used to understand the main stories shared by the participants sampled at JOCOD. The chapter will, therefore, outline the research question, aim, and objectives. Under the research methodology, population, sample, sampling procedures, research instrument, method of data collection, and method of data analysis will be explained. Issues of trustworthiness such as credibility, transferability, dependability, and confirmability will be discussed and presented. The ethical considerations of ethical approval, voluntary participation, informed consent, confidentiality and privacy, anonymity, as well as the principle of beneficence will conclude this chapter.

3.2 Research Question, Aim and Objectives

This section will focus on the research question, aim and objectives of the study.

3.2.1 Research Question

3.2.1.1 What were the challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg?

3.2.2 Research Aim

The primary aim of the study was to explore the challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

3.2.3 Research Objectives

3.2.3.1 To explore the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

3.2.3.2 To explore the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

3.2.3.3 To probe the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg.

3.2.3.4 To elicit recommendations of how persons with physical disabilities can be assisted regarding their access to the DG.

3.3 Research approach and design

A qualitative research approach was used for this study. Denzin and Lincoln (2018) state that qualitative research approaches serve to explore thick descriptions and explore language meaning in detail from the participants' point of view. According to Padgett (2016), qualitative approaches are characterised by open-ended questions based on the topic that the researcher wants to explore. Creswell (2016) shows that a qualitative approach is mostly used in social sciences to study human behaviour. Some of the characteristics of this approach are that the insights and understandings are drawn from the data collection depart from the participant's emic (insider's) view than the etic (outsider's) view (Denzin & Lincoln, 2018). This approach thus explores rich descriptions or meanings from the participant's perspective.

According to Grbich (2013), a research design is a procedure used to collect, understand, and interpret information during fieldwork. A case study design was therefore used for this study. Harrison, Birks, Franklin, and Mills (2017) state that case studies enable a researcher to explore a particular research topic in-depth regarding a single, group or multiple cases to explore thick descriptions or themes. Creswell (2013, p.74) on the other hand describes a case study design as "the study of an issue explored through one or more cases within a bounded system (i.e., a setting, a context).

The type of case study used was a single instrumental case study design. In a single instrumental case study (Creswell, 2013), the researcher focuses on a particular topic and then selects one bounded case to understand this topic. For this study, JOCOD was used as a single instrumental case of the study. This type of case study also involves dealing with several participants within one bounded system. For example, in the current study, a total number of twelve participants with a physical disability were interviewed. Since case studies allow for thick descriptions, researchers can present in-depth insights into phenomena, which researchers could fail to gain in any other way (Babbie & Mouton, 2001). Some of the disadvantages of qualitative approaches and case

study designs are that they are not possible to replicate findings to other populations with similar challenges (Grbich, 2013).

3.4 Population, Sample and Sampling procedures

This section will focus on the population, sample and sampling procedures used to achieve the primary aim of the study.

3.4.1 Population

A population is defined by Creswell (2013) as the entire bounded system that a researcher aims to explore and generate findings. In this study, the population for persons with physical disabilities was drawn from the JOCOD's database, consisting of 382 participants with different forms of disabilities.

Table 3.1 Geographic information of JOCODs population (N=12)

Geographical distribution	**Number of beneficiaries**
Lenasia South and Thembelihle	172
Diepkloof, Meadowlands, Dube, Mzimhlophe, and Orlando	34
Dobsinville, Roodepoort, Doornkop, Snake Park, Kagiso, Tshepisong, & Braamfisher	23
Protea Glen and Lefereng	28
Ennerdale, Migson manor, Lawley and Poortjie	33
Lehae, Vlakfontein, and Zakaria Park	24
Fine Town, Grasmere, Orange Farm, and Thulamtwana	43
Vereeniging, Eatenside, Lakeside, Everton, and Sebokeng	6
Eldorado Park, Slovo Park, Devland, and Freedom Park	19
Total	382

Table 3.1 summarises the geographical information of the entire population requesting JOCOD's services. JOCOD was an appropriate location to explore challenges and barriers as it provides social welfare services to persons with all types of disabilities (that is, mental, physical, cognitive,

or neurological). An internal social worker works with beneficiaries regarding the DGs application process. The organisation also provides other services summarised in the figure below:

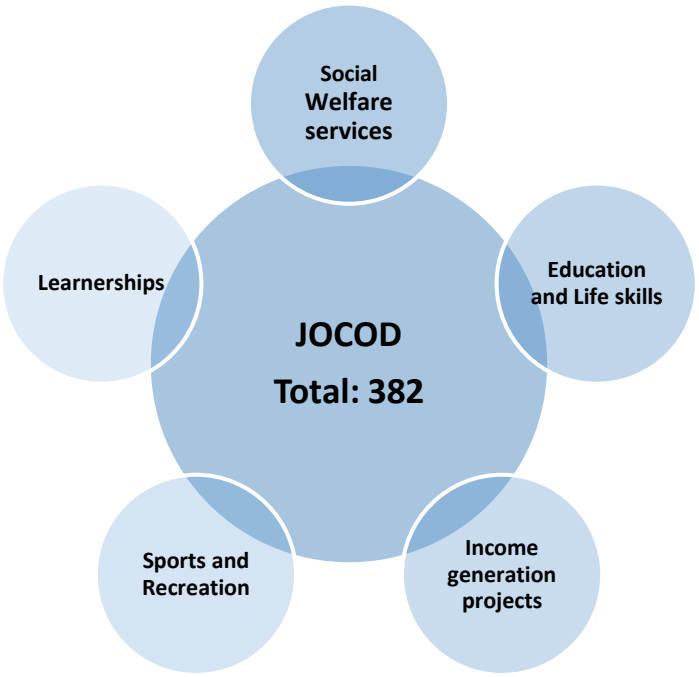


Figure 3.1 JOCODs service provision

Figure 3.1 shows that JOCOD provides other social services such as learnerships, education and life skills, sports and recreation, and income generation projects.

3.4.2 Sample

While a population represents the entire bounded system, a sample represents a sub-category of a population selected to participate in a study (Creswell, 2013). Purposive sampling as a type of a non-probability sampling technique was adopted. Purposive sampling refers to the selection of participants based on their ability to provide the necessary information (Padgett, 2016). A total of 12 participants were purposefully selected from the entire population. The eligibility criteria in this study were that the participants had to:

i. Reside in Soweto
ii. Receive services at JOCOD

iii. Men and women, 21-44 years from all racial groups (This age group was identified through the JOCOD's database as most of the beneficiaries in the organisation ranged between this age range).
iv. Diagnosed with a physical disability
v. Beneficiaries, with and without the DG

The exclusion criteria were participants residing outside of Soweto and persons with visual or hearing disabilities.

3.4.3 Sampling procedures

A sampling procedure entails the process followed in selecting the sample to participate in a study (Denzin & Lincoln, 2018). Prior to the data collection, the researcher obtained permission from the General Manager of JOCOD. The researcher was first introduced to the potential participants by the General Manager during support groups at the organisation. The General Manager then referred me to the social worker to assist with sampling the required participants. A list of potential participants was provided where I chose thirteen participants. One participant was meant for pre-testing while the remaining twelve participants formed part of the target sample. I then met with the participants through an arranged meeting by the social worker. The consent for participation (Appendix C) was obtained from the participants themselves before the data collection during our meeting. The participants were not forced into participation in the study and participation was voluntary. The social worker was in the right position to assist with sampling since she works with the participants in the organisation. Since I am not trained to work with persons with physical disabilities, the inclusion of the social worker to assist with sampling potential participants compromised the ethical principle of anonymity. To achieve this limitation, the interviews were transcribed by assigning pseudonyms of the participants.

3.5 Research Instrument and Pre-testing

The research instrument was a semi-structured interview guide with twelve participants from JOCOD. Rubin and Bubbie (2010) stated that a semi-structured interview guide attempts to ensure that all participants are asked the same questions in the same pattern to increase the comparability of the responses. The researcher pre-tested the interview guide with one participant, who did not form part of the final data collection process for the study. The purpose of pre-testing with this participant was that he had similar characteristics to the target study sample and the responses

explored were evaluated to rightly fit the target sample. A demographic questionnaire (Appendix E) was also used to gather the demographic information of the participants which ranged from a pseudonym, gender, age, race, and township located in Soweto.

3.6 Method of data collection

The method of data collection was in-depth, one-on-one interviews. This method was suitable as it gave the researcher much adjustability by making follow-ups on interesting responses that came about in the interview (Rubbin & Bubbie, 2010). Each participant was assigned a code that was written in all interview forms, research notes, and transcripts for the purpose of anonymity and confidentiality. The participant interviews lasted for no longer than 90 minutes and were recorded with the participants' consent. The researcher also had handwritten notes, which were taken during the interviews. These interviews were conducted in a private room at JOCOD for a maximum of one hour. Privacy and confidentiality were adhered to in this regard. Some of the interviews were collected in Zulu, Tswana, and Tsonga. The researcher is multilingual, and the interchange of languages did not affect the interview transcription and data analysis. With permission from the participants, an audio-tape recorder (Appendix D) was also used to record the interviews to assist in transcribing the verbatim interviews chronologically and limit research biases from the raw data explored.

3.7 Method of data analysis

Braun and Clarke's (2012) six steps of thematic analysis method was used in the study. The primary aim of thematic analysis is to explore and capture 'themes' that are deeply embedded in the stories that participants tell (De Vos, Strydom, Fouche, & Delport, 2011). Mogashoa (2014) states that a 'theme' is a cluster of inter-related groups focusing on similar or different meanings conducted from interviews. The proposed six steps of thematic analysis are described below:

3.7.1 Familiarisation with the data

The first step is to get to know the data collected before analysing the themes. The familiarisation with the data included transcribing the interviews word for word from the audio-tape recorder. During this step, Braun and Clarke (2012) state that researchers should start by re-reading the data repeatedly to ensure that any theme that appears to be of relevance or interest is noted down. Two approaches were used to achieve this step: moving from semantic to latent theme approaches (Braun & Clarke, 2012). The sematic approach means that the researcher identifies themes that are

at the surface without attaching deep meanings to them. The latent approach on the other hand means that the researcher identifies themes while attaching deep meanings, ideas, and understandings of these themes using literature and theory.

3.7.2 Identifying themes

The themes were identified according to two approaches: inductive and deductive approaches. According to Boyatzis (1999), in an inductive approach, the themes identified are deeply linked to the data because assumptions are data-driven. This means that the process of coding occurs without trying to fit the data into a pre-existing model or frame (Braun & Clarke, 2006). The deductive approach, on the other hand, is theory-driven. For instance, the themes were identified using the bio-psycho-social model and relating the themes to existing literature in the Disability sector.

3.7.3 Searching for themes

During this step, it was important for the researcher to conceptualise the themes identified. In doing so, the researcher refocused the analysis towards a broader level of themes instead of codes. The use of visual representations such as a thematic map, was advantageous to help visualise the corresponding of themes in a coherent way.

3.7.4 Reviewing the themes

This step involved the iterative process of relating the themes to the overall data. It entailed verifying and re-verifying the extracted themes so that they can undergo a process of refinement. In doing so, some of the themes were added and removed due to similarities gained from earlier themes.

3.7.5 Defining and naming themes

The first-order-themes emanating from ‘searching the themes’ step were categorised according to "higher-order themes" which are distinctively defined. Furthermore, it was important to define specifics within the themes by using quotes from the raw data.

3.7.6 Producing the report

In the final step of the analysis, the researcher presents the data. Javadi and Zarea (2016) state that researchers should ensure that they refrain as much as possible from reporting the data in a manner that fits into their pre-existing theories or beliefs. thematic analysis is criticised for being too flexible, descriptive, and subjective to researcher bias (De Vos, Strydom, Fouché, & Delport

2011). This limitation means that the researcher can analyse the raw data according to his or her own preference of writing.

3.8 Trustworthiness

Shenton (2004) states that trustworthiness in qualitative research seeks to ensure that the study's objectives conclude what is intended to measure. Trustworthiness is thus divided into four sections: credibility, transferability, dependability, and confirmability.

3.8.1 Credibility

Credibility is similarly defined as the primary goal of trustworthiness by ensuring that the study measures what it is intended to measure (Shenton, 2004). This component was achieved using open-ended questioning and summarisation of the interviews with participants during data collection. These set of skills assisted in obtaining rich descriptions and ensuring that the data collected reflects the true meaning of what was said.

3.8.2 Transferability

Shenton (2004, p.69) indicates that transferability "is concerned with the extent to which the findings of one study can be applied to other situations". Since qualitative research studies consist of smaller samples, it is not always possible to replicate or transfer the results to other populations. However, the findings of this study are presented with more detail to allow other researchers to transfer them to their populations with similar contexts. The research topic was also informed by other previous research studies in the Disability sector-in doing so, the results have an equal chance of being transferred to other populations.

3.8.3 Dependability

Dependability shows that, if the results were to be conducted once more, in a similar population, with similar research methodologies, similar results would be obtained. The research process and the documents such as interview transcripts, demographic questionnaires, and consent forms were made available for the research supervisor, and in the process, the research supervisor assisted the researcher throughout the process of the study. Another way to ensure dependability is that the report was presented and organised in a manner that will allow replication.

3.8.4 Confirmability

Confirmability means that research findings can be confirmed by another researcher so that research bias can be reduced (De Vos et al., 2011). To ensure confirmability, the researcher stored the audio recordings on a password-protected computer, and the interview transcripts were transcribed after data collection. Another method used, was an audit-trail to keep track of the dates of interviews conducted (Appendix H).

3. 9 Ethical considerations

"Ethics are set of moral principles of conduct used to govern the decision making behaviour of an individual or a group of individuals" (Agwor & Adesina, 2017, p. 185). These principles guide researchers to decide whether a particular behaviour during data collection is right or wrong (Creswell, 2014). Researchers are safeguarded by ethical principles to protect participants from inflicting harm on themselves and on others. The following section focuses on some of the ethical principles that were considered in the study: ethical approval, voluntary participation, informed consent, confidentiality, anonymity, and principle of beneficence.

3.9.1 Ethical approval

The ethical approval was obtained from the Departmental Human Research Ethics Committee (SOCIAL WORK)) at the University of the Witwatersrand (Appendix A).

3.9.2 Voluntary participation

De Vos et al. (2011) provides that voluntary participation ensures that participants are given the right to volunteer to participate and the right to discontinue the interviews if they feel uncomfortable. After participants received the Participant Information Sheet (Appendix B) containing the aims of the study, a consent form was administered and signed. Before continuing with data collection, a consent form to ask for their participation in the study was granted. During the interviews, some of the participants were sobbing since the topic was sensitive to them, the researcher then asked if they would like to continue, discontinue, or be referred to the social worker. That way, voluntary participation was adhered to, to protect participants from self-harm.

3.9.3 Informed consent

Creswell (2014) states that informed consent is all about informing participants on the study aims, methods, potential risks, anticipated benefits and right to withdraw from the study at any time. The following three steps to informed consent were followed in the study: (a) provided information

about the study, (b) confirmed that the information has been understood, and (c) decision of the individual regarding participation. The last step was accompanied by two consent forms, such as the consent form to participate in the study (Appendix C) and a consent form to audio record the interview (Appendix D).

3.9.4 Confidentiality and privacy

Confidentiality is an extension of privacy (Dhai, 2019). Denzin and Lincoln (2018) defines confidentiality by stating that the data collected between the researcher and the participant will stay between them, and the information will only be shared with other key personnel only if participants threaten to harm themselves. This ethical principle was ensured by conducting the interviews in a private room at JOCOD. Another way to ensuring confidentiality and privacy was to store the interviews recorded with an audio recorder in a password protected computer, of which only the researcher and the supervisor had access to this data.

3.9.4 Anonymity

Anonymity means that participants identifying information should be kept private or anonymous (Agwor & Adesina, 2017). Anonymity was ensured by assigning the participants pseudonyms in the transcribed interviews.

3.9.5 The principle of beneficence

The principle of beneficence means that no harm will be inflicted during data collection (De Vos et al., 2011). When participants faced psychological discomfort, an opportunity was provided for them to be referred to the social worker or discontinue the interview.

3.10 Conclusion

This chapter focused on the research methodology used in the study. The chapter informed the way in which the primary aim and objectives of the study was achieved through the design, approach, sampling procedures, instrument, methods of data collection, analysis, issues of trustworthiness and ethical considerations. The next chapter will focus on the findings obtained from the study.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter will present the findings from the fieldwork that explored the challenges and barriers experienced by persons with physical disabilities regarding access to the Disability Grant (DG) in Soweto, Johannesburg. The participants demographic information of age, gender, race, and location are presented in a table form. The themes that emerged from the study are presented using Braun and Clarke's (2012) thematic analysis process. The bio-psycho-social model of disability was used to conceptualise the findings from the study. The empirical evidence will also be outlined to support the themes and sub-themes explored in the study. The strengths and limitations found in the study will also be outlined to provide recommendations for practice, future research, and knowledge.

4.2 Demographic information

Table 4.1 Demographic profile of participants (N=12)

Age	**Number of participants**
20-29	6
30-39	5
40-49	1
Gender	
Female	4
Male	8
Race	
Black	11
Coloured	1
Location	
Lenasia South	5
Orange Farm	2
Eldorado Park	2
Protea Glen	1
Zola	1
Dobsonville	1

4.2.1 Age

Six participants ranged between the ages of 20-29 years, followed by five participants ranging between the ages of 30-39 years and the least with one participant ranging between the ages of 40-49 years. The participant's age distribution was sampled from JOCOD's database. Many of these participants are young adults with or in the process of obtaining the DG. Mitra (2010) shows that DG sub-programme is the only social grant programme for the working-age population. Similarly, to the eligibility criteria for the DG, applicants should be between the ages of 18 and 59 years old The age distribution in the current study, therefore, reflects the age profile of disability beneficiaries in South Africa who are the majority in South Africa (Handcock & McKenzie, 2017).

4.2.2 Gender

Males were eight out of four females. The researcher observed that the majority of JOCOD's beneficiaries are males. However, according to Statistics South Africa (2017) using the General Household Survey (2016), females (50.5%) were more disabled as compared to males (4.7%). It is noted the results of the current study are not representative of the entire South African population for persons with physical disabilities accessing the DG. Consequently, the results represent a small proportion of persons with physical disabilities accessing the DG in Soweto, Johannesburg.

4.2.3 Race

Of the participants eleven were black and one Coloured. According to the General Household Survey (2016), Blacks have the highest proportion of disability (7.8%), followed by Whites (6.5%), Indians or Coloureds (6.2%), and other (5.2%) respectively.

4.2.4 Location

The research was conducted at an organisation in Soweto, Johannesburg located at Lenasia South, 292 Peshwar Street, Extension 11b. The inclusion criterion was that the participants should be from Soweto. Soweto is broad and JOCOD assists persons with all forms of disabilities from the Soweto townships and its surrounding areas. Table 4.1 shows that five participants were from Lenasia South, followed by two participants from Orange Farm, two participants from Eldorado Park, and one participant from the following areas: Protea Glen, Zola, and Dobsonville.

4.3. Themes that emerged from the study

The findings are presented according to the four objectives of the study.

4.3.1 Objective one: To explore the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg

The first objective explored the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. These are the sub-themes that emerged from this objective: Denial or self-denial, unstable family financial realities or conditions, limited access to medical assessment, shortages of finances, as well as stigma and discrimination.

Table 4.2 Challenges (N=12)

Theme	Sub-themes	Number of participants who mentioned the sub-theme
Challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg	Denial or Self-denial	4
	Unstable family financial realities or conditions	1
	Limited access to medical assessment	7
	Shortages of finances	9
	Stigma and discrimination	5

4.3.1.1 Denial or Self-denial

Challenges in relation to denial or self-denial emerged as a sub-theme from the study, with four participants reporting it. Participants indicated that they struggled to accept that they were physically disabled, low self-esteem (such as, always viewing the self as a victim). These challenges have consequently resulted in them not being able to apply for the DG. The current

findings were evidence to show that persons with physical disabilities experienced challenges regarding access to the DG, even before they consulted with the SASSA offices. To support this sub-theme, below are the quotations from participants:

Participant eleven shared the following regarding denial or self-denial:

> *"At first, I did not understand why I needed to apply for the grant because there was nothing wrong with me. I could read and write just like everybody else. It was only when I started going to special needs schools where I realized that I had a disability because I was different from everybody else. I was insecure for many years…"*

Participant three shared similar experiences regarding denial:

> *"I didn't know that I had a disability until my grandmother told me that I can't wash dishes because they fell whenever I washed them…. I couldn't understand until she took me to a disabled school where I started applying for the grant."*

Participant six shared the following challenges in relation to accepting their disabilities:

> *"The doctors said that I sustained a brain tumour in 2017. I had an operation as I can't walk properly, and my thinking is slow. My parents (pauses)... my parents, went to SASSA to apply for the grant on my behalf, but SASSA wanted to see me before getting the grant. I did not want the grant because I knew I would heal (participant faced down for a bit) … I will heal."*

And Participant two shared the following regarding low self-esteem (always viewing the self as a victim):

> *"I was scared to apply for the grant because I felt like everyone around me was gossiping about me (pauses)…. they strangely looked at me (looks sideways). I was always alone. Sometimes I felt like my own family, friends, and the people at the hospital where I applied for a doctor's letter were gossiping about me."*

The above responses are indicative of the fact that participants have faced challenges in accepting their physical disability or coming to terms with their diagnosis. For instance, Participant eleven was born with a physical disability but struggled to understand why she had to apply for the DG since she perceived herself as a person without a physical disability. She was also insecure for

many years and only realized that she had a physical disability when she attended special needs schools. Participant three, on the other hand, shared that her grandmother made her aware that she was disabled since she faced difficulties with washing dishes. Similarly, with Participant eleven, participant three also applied for the grant when she attended a special needs school. Participant six has sustained a brain tumour, which led to the inability to walk and slurred speech. This participant further stated that his parents applied for the grant on his behalf because he believed that he would heal from the tumour. Participant two expressed that family, friends, and the people around her were gossiping about her or gave her strange looks. Stigma and discrimination manifested in ways of gossiping and strange looks-making persons with physical disabilities uncertain of themselves in general.

The verbatim responses from the participants resulted in them not being able to apply for the grant because they faced challenges in accepting themselves as physically disabled persons. Such experiences have further sustained a feeling of vulnerability and isolation in their lives, as well as making independent life choices such as accessing the DG. Regarding the bio-psycho-social model guiding this study, challenges to access basic services should not only be considered as emanating from the individual but rather, challenges should also consider how other negative societal challenges such as gossiping or strange looks could impact on their participation in the society at large.

By noting the psychological challenges of acceptance and denial regarding access to the DG for the participants in the study, Penn and Penn (2015) found similar results with thirty participants with a variety of disabilities in the rural communities of the Mpumalanga Province. The results from this study regarding service provision experienced by persons with disabilities were that psychological challenges limited them from accessing the DG. To support this view, Participant nineteen from Penn and Penn (2015)'s study expressed the following:

> *"When I am home alone, I need to move on the floor like a snake to get to the toilet and they (neighbours) are laughing and pointing at me." (Penn & Penn, 2015, p.9).*

With that said, the findings from the current study are further in contrast with previous studies focusing on the same research topic in the South African context. Many of these studies have however focused on different research areas such as the socio-economic effects of the DG and

their household. For example, Johannsmeier (2007) focused on how poverty affects the sustainability of the DG in low-income communities for persons with disabilities, Hancock and McKenzie (2017) focused on the demographics of who gets the DG in South Africa, Jelsma et al. (2008) focused on the implications of policy and service delivery experienced by persons with disabilities in rural communities, Sekele (2017) focused on how the DG is administered and managed for persons with physical disabilities in Limpopo. The limitations emanating from the current study were the voices of how participants survived without the grant before the DG's application. The results are consistent with the bio-psycho-social model which recognized the importance of psychological factors such as motivation or self-esteem to understand disability-related matters (Thomas & Woods, 2003). These factors have hindered persons with physical disabilities to access the DG and thereby limited their participation in society.

4.3.1.2 Unstable family realities or conditions

Unstable family financial realities or conditions also emerged to further understand the implications of denial or self-denial. While Participant eleven faced challenges with denial and acceptance of her disability, she further expressed that she had to accept the situation and apply for the grant to sustain the household financially.

Participant eleven expressed the following:

> *"My mother lost her job before I applied for the grant. I had to accept the situation and apply for it because we were primarily dependent on my mother's income. My mom was a domestic worker, and she lost her job. We used the grant money for transport, food, clothes, water, school fees, and other things."*

Hancock and McKenzie (2017) confirmed that the DG is an alternative source of income for individuals residing in low-middle income communities. Using the GHS (2011), these authors conducted a quantitative study for PWD and their households to investigate the factors leading to income loss in KZN. The sample consisted of PWD from the ages of 15-59 years. The results concluded that households caring for persons with severe walking, hearing, and self-care earned less income and were considerably unemployed compared to a household with persons without disabilities. Even when the family members are employed, they were found to be earning less and fell far behind the national minimum wage. This means that individuals with severe physical

disabilities require more care from their family members, which further reduces the family's ability to look for a job. Johannsmeier (2007) further confirmed that even when the grant is received, PWD and their households use the money for essential household expenditures such as funeral covers, food, clothes, school fees, water, or electricity. Overall, literature has limitedly highlighted this sub-theme in the South African context and as a recommendation, disability studies should consider focusing on similar challenges to be understood holistically.

4.3.1.3 Limited access to medical assessment

Limited access to medical assessment for the purpose of confirming the degree or severity of disability emerged as a sub-theme from the study, with seven participants reporting these challenges. The main findings from these challenges were inadequate outcomes of the medical assessments, the long process in obtaining a doctor's letter, and a lack of privacy during the assessments. The importance of this theme is that it is consistent with one of the SASSA's eligibility criteria to qualify for the DG. This means that beneficiaries must provide a medical assessment letter confirming their degree of disability by a recognized medical practitioner, and that is no longer than three months to qualify for the grant (SASSA, 2017/2018). Participants have thus expressed their views and the quotations below will support this theme:

Participant seven stated that:

> *"I didn't get a doctor's letter in the beginning because they didn't see my disability. I had a problem with walking. The doctor said that I was able to get a job: hence I didn't qualify for the doctor's letter."*

Participant eleven stated that:

> *"I went to the physio before the doctor's approved my disability but the physiotherapist said that I could walk, write and do any other things that non-disabled people cannot do……(sobbing) I couldn't get the letter. I then went to a different physio once a month at the nearest clinic. Until they saw that I was struggling to walk, the physio then wrote a letter to the doctor at Bara that I should get a letter. It was a long process."*

Similarly, Participant eight shared the following:

"The doctor examined me to check whether I take medication or not. I tell you…. I then told the doctor that noooo! I do not take medication, because I had a disability not sick. I do not remember… but it took like seven months for my letter to be approved.

Participant ten had this to say:

> *"…my disability was checked in a small room… I could see everyone outside, and the door was not closed"*

And, Participant one had a different view and shared the following:

> *"I didn't encounter any problems as my parents had a medical aid and I couldn't walk on my own……my disability was approved on the same day."*

The responses shown above are indicative of the fact that challenges in obtaining a medical assessment letter were a concern that led to challenges in accessing the grant. For instance, participant seven stated that his disability was not seen as a disability enough. This experience was because he was able to read and write; meaning that he was capable enough to look for a job. Similarly, participant eleven first consulted with a physiotherapist but was unfortunately told that she could look for a job and perform other duties that persons without physical disabilities can do. Furthermore, this participant then consulted with a different physiotherapist, who examined that, indeed, she had walking limitations. The physiotherapist, therefore, advocated for her to obtain an approved medical letter from a doctor at the Chris Hani Baragwaneth Hospital. As part of the medical assessment, participants eight was asked by a doctor whether she takes medication or not. This question is consistent with the traditional or medical model of disability that defines disability as an illness that originates from the individual. The aim of this model is focused on treatment and rehabilitation (Seligman & Darling, 2007). The model states that treatment should be solved, and often fails to consider the various factors leading to disability, such as environmental factors (WHO, 2011). The limitation of this model is that it blames the victim for their disability, without assessing the person's life.

Participant ten, on the other hand, shared a lack of privacy during medical assessments. This participant voiced that he could see everyone outside during the consultation as the door was not closed. Participant four had a different view from the previous findings and stated that his parents

had a medical aid, which aided to the delimitations of obtaining the letter. The experiences from the participants revealed challenges that individuals encounter in public hospitals. Kubheka (2018) reported at City Press that public hospitals in the Gauteng Province are often overcrowded with limited consultation rooms, doctors, limited time spent per consultants, leading to long-delayed medical attention.

Drawing from the City Press findings, this sub-theme is closely related to the challenges of health-care access for PWD the country. It is therefore essential to explore what these challenges are to offer reasonable recommendations for social security programmes. While previous research studies have explored challenges to accessing health for persons with all forms of disabilities (Penn & Penn, 2015; Vergunst et al., 2017), limited research studies focusing on how these challenges impact on beneficiaries not being able to access the grant is limited. In compliance with the SASSA's eligibility criteria for a medical letter confirming a disability, such challenges need to be explored in the country.

Penn and Penn (2015) found similar results in a study conducted in the rural areas of the Mpumalanga province with PWD. In a sample of thirty participants, the results have revealed that challenges in health care were a concern for PWD. Similar results were found in a cross-sectional study conducted by Vergunst et al. (2017) in the Eastern Cape Province. The results concluded that persons with physical disabilities faced challenges with hospital consultations such as joining long queues and not accessing the healthcare that they require at a specific time.

Vergunst et al. (2015) also confirm that they found similar results that participants were perceived as "not sick enough" to access health-care related services. While the medical model of disability focuses on the degree of how disabled a person is, the bio-psycho-social model stresses that environmental factors leading to a disability should also be considered in medical assessments (Wade & Halligan, 2017). Environmental factors relate to how a person with physical disability functions in society and how that impacts on their daily activities. Simply focusing on medical factors is not enough. The researcher concludes that persons with physical disabilities have a right to adequate medical assessments, physical assess to the hospitals, and privacy during medical assessments. Without a medical assessment letter from a qualified doctor, participants with a physical disability are less likely to be granted the DG-which is a major challenge experienced by the participants in the study.

4.3.1.4 Shortages of finances

Shortages of finances emerged as a sub-theme emerged from the study with nine participants reporting it. The cost of services and care is huge due to the special needs of persons with physical disabilities. These challenges are linked to extra medical costs and transportation during hospital consultations, home affairs, and the SASSA offices. Most participants have revealed how extra medical costs were inextricably linked to the process of obtaining a medical assessment letter confirming their disability. Below are some of the quotations supporting this theme:

Participant four shared the following:

> *"I don't have a job, I had to borrow money from my friend to go to the hospital…My money was not enough… we had to buy food in the house. I couldn't return the money as soon as possible because I was broke."*

Participant twelve expressed his view on hired private transport:

> *"You see, I paid a private doctor more than R500 to get my letter. I applied for years and I could not get it because I did not have a doctor's letter."*

Participant eight said that:

> *"Imagine, my mother was not working. We couldn't afford a private car. Most of the time I used the Rea Vaya bus…" (Participant eight).*

Participant five stated that:

> *"I used a private car at first… it was expensive because I had to run around looking for a medical letter…moving around in Joburg is not cheap. Taxis are cheaper and move faster."*

And, Participant one had a different view by saying that:

> *"I used a private car because they are easy, and I travelled at my own time. Taxis are always in a rush.*"

The above quotations provide evidence that financial challenges have led to extra medical costs and in return, led to delayed hospital consultations. Subsequently, participants delayed in starting

the DG's application process. For example, participant four voiced that she had to borrow money from a friend and could not return the money at a required time because she did not have enough money. Participant twelve indicated that he was rejected in the DG's access because he did not have a doctor's letter. He then paid a private doctor more than R500 to obtain this letter. Participant five initially used a private car but it was expensive and changed to cheaper taxis. Participant one had a different view and said that private cars are convenient as they travelled according to own time.

The findings are suggestive of that extra medical costs and the mode of transportation used to revolve around paying private medical doctors to obtain that medical letter confirming their disability. Comparable findings from the study are supported by (Hanas-Hancock., 2017; Johannesmeier, 2007). For instance, Hancock et al. (2017) conducted a qualitative study with seventy-three participants with all forms of disabilities in the Western Cape, KZN and Gauteng provinces. They administered a focus group discussion in the respective provinces to explore disability-related costs such as health care, transport, and other essential services. The results of the study revealed that disability-related costs were more prominent in medical consultations, especially for persons with physical disabilities. Moreover, the need of specialized health care travels, and long queues have increased unnecessary repeated health care visits. Since comparable findings have been found, it is recommended that the disability sector should consider an education and awareness or approaches to reduce the extra-cost in accessing the DG.

Participants also show how expensive private transport system was, regardless of them being convenient, especially for persons with disabilities. Participant five had a different view and stated that taxis are cheaper and move faster. These findings are like the findings by Johannesmeier (2007) found in terms of transport-related costs with a physical disability. The results indicated that sometimes it was not only the financial challenges of affording the mode of transportation used, but the attitudinal challenges (For example, taxi drivers that were not willing to transport a wheelchair, or charged the person double the fare because of a wheelchair) and physical inaccessibility (For example, the step of a bus or taxi too high).

4.3.1.5 Stigma and discrimination

Stigma and discrimination emanated from the study with five participants reporting the sub-theme. Stigma and discrimination are an example of attitudinal barriers. This sub-theme emerged for the second time. The quotations below will support it:

Participant eleven said that:

> *"People always talk and look at me in a certain way. They will ask what happened to me. I cannot explain because they can see."*

Participant one stated the following:

> *"I was alone. People strangely looked at me when my mother carried me. My mother used to carry me when I was young. I couldn't walk around, and people would ask why."*

Participant five shared that:

> *"This one time, I took a taxi to home affairs, people were staring" what should I do? People were not patient; I could not even ask where I can get the office. I had to find home affairs by myself."*

Participant eight also shared the following:

> *"…people are impatient and say that we are making them late."*

The responses show the negative attitudes toward persons with physical disabilities. Most participants reported that they were stigmatized when using public transport and that the people in communities would look at them in a certain way. Participant eight specifically shows that taxis are not for persons with physical disabilities as taxi commuters are not patient. Negative attitudes also worsened when participants asked about essential services such as a location directly to the home affairs. Research shows that persons with disabilities are prone to stigma and discrimination, all which limits participation in the community at large (Parodi & Sciulli, 2019; Penn & Penn, 2015; Rohwerder, 2018).

Alternatively, Rohwerder (2018) reported the impact of stigma and discrimination for persons with disabilities in developing countries accessing different service Provisions-South Africa is one of

the developing countries. About persons with physical disabilities, this author argues that persons with sensory disabilities, severe mental conditions, albinism, and intellectual disabilities are more prone to stigma and discrimination than persons with physical disabilities. The researcher in the current study argues that such conclusions should not be universal as participants in the current have expressed their concerns around how they are looked at and being asked questions about their disability during their access to the DG. The South African Human Rights Commission (2017) indicates how urgent consideration should be paid to enhancing inclusion and equality for persons with disabilities in the country. Within the bio-psycho-social model, the "social model does not view disability as an individual problem to be cured, but rather sees the problem as lying in society" (Johannesmeier, 2007, p.4). This view of the model shows how societal negative attitudes such as shame and strange looks could lead to the social exclusion for persons with disabilities. Bringing awareness of such challenges could bring changes at a societal level, rather than on the individual level of disability. Additionally, such challenges have implications to access to the DG, as stigma and discrimination are socially constructed. While polices to remove stigma and discrimination are written in paper, stigma and discrimination remain a challenge experienced by persons with physical disabilities.

4.3.2 Objective two: To explore the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

The second objective explored the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. These are the sub-themes that emerged from the study: Physical barriers, organisational barriers related to the application process and approval, and organisational barriers related to the pay-points.

Table 4.3 Barriers (N=12)

Theme	Sub-themes	Number of participants who mentioned the sub-theme
Barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.	Physical barriers	6
	Organisational barriers related to the application process and approval	8
	Organisational and attitudinal barriers related to the pay-points	3

4.3.2.1 Physical barriers

Physical barriers have emerged as a sub-theme from the study with six participants reporting the theme. These barriers consisted of the mode of transportation used to the SASSA offices, as well as the office set-up at the offices. To support this theme, below are the quotations from participants:

> *"I have problems with walking, and it takes time for me to reach where I'm going. When I remember, I took two taxis to the office 2 hours earlier before they opened. There is no one to push us or take us out of the taxis because there is no space in between the seats to do so."* (Participant six).

And,

> *"My mom hired a private car because I was using a wheelchair when I was younger…like I said, my mom, carried me as I couldn't walk. So, imagine what would have happened to me had I used public transport."* (Participant one).

Similarly, another participant said:

> *"I was fortunate enough that Metro buses come to my area. But the steps were too high and that took time for me to get to the bus… you know, I got a bus but it did not drop me off at the SASSA office, I had to walk a bit to get there."* (Participant ten).

Also, participant two elaborated and said the following:

> *"SASSA offices had a ramp for me to walk in since I can't walk properly"* (Participant two).

In support of the above, participant three also said:

> *"The lift was better for me because I didn't have to take the stairs"* (Participant three).

In a similar vein, participant eleven said:

> *"The seats in the admin office are always full and they are not enough… I got tired of waiting and waiting (shakes head sideways) … I sat down… since the queue kept on moving, I was exhausted from moving and moving… until I reached a point of seating in the chairs."* (Participant eleven).

The above responses are evidence to show that physical barriers can hinder persons with physical disabilities to reach the SASSA offices, where DG applications are made. Transportation barriers are yet reported for the second time in these findings. Participant six, for instance, stated that he had to take a taxi two hours earlier because there is no personnel available to assist persons with physical disabilities at the taxi rant. Other barriers relate to the set-up of taxis and buses, such as lack of space between seats, steps into bus being too high, using more than one taxi to reach the offices, and a walking distance to the office from the bus stop. These barriers are experienced differently by participants who had access to private cars. While the participants in the study have reported the accessibility of public transport to the SASSA offices, the main barrier is the time it takes to get there, queue and begin the application process at the offices. A qualitative study conducted by Sekele (2017) found similar results for persons with physical disabilities accessing the DG in the Limpopo province, Sekhukhune district. Twenty participants in Sekele's study reported that public transport is not designed for disabled persons-such that public transport such

as minibuses does not have specialized seats and participants lived far away from the offices. The bio-psycho-social model states that physical barriers to accessing essential services should be removed as they create inequalities in service provisions. Jansuwan, Christensen, and Chen (2013) provides that transportation is a necessity for full participation for persons with disabilities in society at large.

Physical barriers also manifested in the office set-up at the SASSA offices. While participants have reported positive characteristics of the office set-up such as the accessibility to a ramp and lifts, others reported that chairs at the offices were fewer with long queues. The consequences were that participants were often tired and eventually sat on the floor at the administration block. Office set-up in Sekele's (2017) study was also a theme that emerged for sixteen participants who were physically disabled in the Limpopo province. The results have concluded that entry into the offices had ramps that were user friendly for participants. However, four of the sixteen participants found the administration block being too small to accommodate all beneficiaries of the DG. Participants also indicated that during cold and raining weather, they had to wait in the office corridors. I could hear the participants frustrations regarding physical barriers and that these barriers may suggest additional investment in infrastructure at certain SASSA offices.

4.3.2.2 Organisational barriers related to the application process and approval

Eight of the twelve participants reported barriers to the application process. These barriers are organisational as they refer to the SASSA administration of the grant. Participants identified several barriers under this sub-theme; the application process was too long, application requirements, misinformation, limited access to medical assessment, and the DG's approval or outcome. The following quotations are evidence supporting the sub-theme.

Participant twelve stated the following regarding the application process being too long:

> *"Eish! My goodness, the application took too long. The things they wanted were too many. That time is not even simple to get the grant… you get rejected, and they say we must re-submit the application."*

Participant nine and five stated the following about the application requirements:

"Yaaah! They say we must bring certified copies of parent's income. I did not have those copies since my mother was not staying with me. I was not sure whether I had to bring my uncle's certified copy or not. Yhii! I struggled to find my mother and convinced her to give me her ID. When I finally got hold of her, we both went to the police station to get an affidavit that she is unemployed, then we went back to SASSA with my mom. This run around has cost us more and more. I didn't have enough money."

"They also wanted proof of my disability. They said that I should go back to the disabled schools and get the letters that show how disabled I am." (Participant two).

With regards to the outcome of the applications, Participant twelve shared the following:

"It also took so long for my grant to be approved…. (thinking out loud) … when I remember, it took a year and a few months for my grant to be approved."

Participant one shared the following in terms of misinformation:

"My parents took me to apply when I was 12 years old, but I didn't get it because I needed to be 18 years old before applying. I did apply when I turned 18 years old…. but, I only got it when I was 21 years old."

Participant eleven showed her concerns regarding the medical assessment conducted by the SASSA:

"You know! This was so strange because I went through the same process that I came across before going to SASSA. Another doctor at SASSA checked my disability. He asked me to write my full names and I wrote them… he then said that I could look for a job… you know... I did say, I attended physio because I had a problem with walking not writing. I was also asked for proof of my physio consultations. I did not know that I had to go with it. I went back to the hospital to get this proof… I think it's because I didn't know that I had to be checked again by another doctor at SASSA."

The responses above show evidence that barriers to the DG's application process take on different factors and that the experiences differ from one participant to another. For instance, participant twelve frustrations on how long the application process takes and the fact that it is accompanied

by numerous requirements. This participant further voiced that getting the grant is not simple as participants get rejected or asked to re-submit their applications. From this experience, participant twelve showed that it took a year and a few months for his grant to be approved. On the same light, participants nine and five have indicated some examples of how long the application process took. Participant nine did not bring the proof of parent's income or proof to show that her parents were unemployed. During the time of the DG's application, this participant was not staying with her biological mother but stayed with her uncle. She then struggled to get hold of her mother and was eventually successful. They both went to the police station to obtain a signed affidavit proving that the mother was unemployed. She further stated that the barriers to the application process were not about getting the right documentation, but the extra costs related to obtaining the right documentation. Participant five had to provide proof confirming her disability and she then had to go back to the schools of the disabled attended to obtain this proof.

Joseph (2012) has noted that the grant administration process takes on various steps before issuing an approval or rejection decision. This author conducted interviews with data-captures at four districts based SASSA offices in the Northern Cape. Data-captures have indicated that they receive up to thirty applications per day and spend more than an hour capturing one application. Even though the application process takes on different steps, data-captures were also found to misplace documents and record applications incorrectly. Such barriers to the DG's application have implications for beneficiaries to start the process all over again and struggle with transportation costs. Sekele's (2012) study in the rural provinces of the Limpopo province found similar results whereby twenty participants complained that the application process was inevitably long and advised that it should be shortened. They expressed how much time it took to be booked to start the application process, be accessed, and wait for the outcome. Overall, the required steps for the application administration consequently explain how long the application process takes and the fact that a required process should be followed to ensure efficiency.

In connection with misinformation regarding the application process, participant one explained that his mother first applied for the grant when he was twelve years old and the grant was not awarded because he needed to be eighteen years old to quality. From previous engagements of the interview conducted with this participant, he expressed that his mother used to carry him and used a wheelchair when he was younger. The barrier that this participant encountered was that his

application was rejected, even when he had a physical disability. The possibility of being rejected was that the parent was hoping for the care dependency grant instead of the DG. As previously indicated, the CDG is awarded to parents or caregivers looking after a disabled child, who is under the age of 18 years. Once the grant is awarded and the child reaches the age of 18 years, the parent or caregiver is eligible to renew this grant to the DG, which is awarded to the working-age adults from the age of 18-59 years old (Joseph, 2012). Given this view, it is unclear how participant one was rejected when he was twelve years old and was only awarded when he reached eighteen years old, which extends that future research should focus on the views of parents or caregivers regarding access to the care dependency grant. Those views will determine the barriers to the administration of the care dependency grant so that sufficient views of the DG can be understood holistically in the Disability sector.

A medical assessment has again emerged as a barrier in the DG's application process. Participant eleven voiced her experiences regarding this barrier. Before she went to the SASSA's offices, she had a medical letter confirming her disability but was again assessed by another doctor at SASSA. SASSA (2017/2018) annual report shows that beneficiaries should be an assessment by a medical doctor contracted by SASSA because previously, SASSA found that applicants bring false medical letters granted by doctors who take bribes to falsely confirm that an applicant has a disability to get the grant. Participant eleven continued to state that she needed to bring a proof disability showing that she had difficulties walking. It also appears that this participant was uncertain that she needed to bring this proof to the SASSA offices.

To account for the barriers experienced by participants in the study regarding access to the DG such as the application requirements (that is, parent’s income) and medical assessment by a contracted medical doctor from SASSA, Mitra (2010) shows literature and evidence from South Africa regarding the DG’s application process and its assessment procedures. Using disability-related self-reports from Gauteng and Northern Cape provinces, this author found that exclusionary factors to the DG are alarming and many because the DG programme uses two systems of assessment: a work disability test and a means test. Work disability is administered in two ways. First, beneficiaries are asked if they have worked in the past seven days. If they did not work, twelve questions are asked in terms of the state of "illness, invalid, disabled, or unable to work" (Mitra, 2010, p. 1694). Secondly, activity limitation questions from the past three days are

also asked as follows; "*Is the person limited in his/her daily activities, at home, at work, or at school, because of long-term physical, sensory, hearing, intellectual, or psychological condition, lasting six months or more?*" (Mitra, 2010, p. 1694).

The main conclusion from Mitra's (2010) study indicates that the DG is the most difficult programme to administer and manage due to the work disability test which relies on how a person perceives himself than how his disability impacts the inability to work. Mitra further state that the DG's assessments deviate from helping individuals who cannot work due to a disability and means that are beyond that individual's capability. The bio-psycho-social model of disability indicates that medical practitioners should not only focus on biological factors (For example illness or disability leading to the inability to work) but extend assessments to the wider interactive social systems. Additionally, some of the reasons why persons with physical disabilities are removed from the DG's outcome is because the GHS is conducted by Stats SA instead of the SASSA itself (Mitra, 2010). It is worth noting that interviews with SASSA officers should also be conducted to hear their views on the administration, process, and outcome of the DG for persons with physical disabilities.

4.3.2.3 Organisational and attitudinal barriers related to the pay-points

Three of the twelve participants have reported organisational and attitudinal barriers to the pay-points. Pay-points are the locations where beneficiaries receive their grants (Joseph, 2012). These barriers are also organisational as they refer to the SASSA administration of the grant. Even though the DG's outcome was approved, participants still voiced that accessing that money was a major concern. Given this view, the barriers of grant payments have been reported in two ways; at community pay-points and banking institutions. To explore the experiences of the participants, the following quotations are outlined below:

Participant one shared this:

> *"My mother used to go to the community pay points on my behalf. There were always long queues. People who are not disabled did not care much about our disability. The securities were sometimes helpful by making the right of way for disabled people. But now, I take my money at the bank so that I do not have to stand in long queues. The problem is that even when we go to the banks, people still strangely look at us."*

Participant twelve stated that:

> *"I don't get all the money. The machines are also not enough, with people looking at us like we are not humans. The officers have no patience. Unless if someone has a wheelchair, then they shift and help quicker. They check how disabled someone is in and help."*

Participant six expressed that:

> *"I made my money to be deposited at Capitec because of long queues at the community hall. But, even if I have a disability, I still join the queue with other people."*

The above responses showed that community pay-points consisted of long queues, not receiving all the payment and limited machines for payments. Participants were also experienced attitudinal barriers such as being stigmatised and looked at strangely by persons without disabilities. For banking institutions, participant one shared that they are convenient because of shortened queues. Also, participant six stated that his payment is deposited at Capitec bank, but still joins the queue irrespective of having a physical disability. Joseph (2012) found similar results in terms of beneficiaries experiencing barriers at the pay-points. Only one out of the twenty-six participants in three districts of the Northern Cape reported experiencing barriers to grant payment at pay-points. The study did not show how this participant faced such barriers because the study employed a quantitative approach focusing on numbers instead of stories.

The findings from the current study are also indicative of the fact that attitudinal barriers of stigma and discrimination to accessing the payment manifested in different ways at pay-points. The bio-psycho-social model recognizes that attitudinal barriers are societal problems for persons with disabilities (McNair & Sanchez, 2008). The model further states that persons with disabilities may be socially excluded due to attitudinal barriers. Overall, in comparison with Joseph's study and the current study, most participants have reported that they never experienced barriers at the pay-points. The researcher concludes that the services rendered for payments improved and addressed the needs of beneficiaries.

4.3.3 Objective three: To probe the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg.

The third objective focused on the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg. These are the sub-themes that emerged from the study: family support, spiritual support, and NGO support.

Table 4.4 Social support services (N=12)

Theme	Sub-themes	Number of participants who mentioned the sub-theme
Social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg.	Family support	4
	Spiritual support	2
	NGO support	3

4.3.3.1 Family support

Family support emerged as a form of social support available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG. Four participants have highlighted that family support manifested in different ways, such as financial support and emotional support. The following quotations from participants are expressed to support this theme.

The participants below recognized the importance of emotional support:

> *"The support that my grandmother gave me… (Looks down) … she first took me to SASSA at Dobsonville and then to Lenasia. I have the grant now and we use that money for things that we need at home."* (Participant three).

"My dad took me to SASSA and was there forever since I had a brain tumour (sobbing)… my dad tells me that I will be fine." (Participant six).

"I think… like I said before when I was younger, my mother used to carry me because I couldn't walk. I used a wheelchair. My sister was also there when I applied for the grant. The support that my mother shows me every day… I love it so much as she doesn't disown me, she motivates me that in whatever I do, she will be there all the way… and that I should tell her everything that I want in life." (Participant one).

Participant eleven showed that importance of financial support:

"My mother was supportive from the beginning. We went to the hospital to get a doctor's letter, and to SASSA. My mother paid for everything... physio consultations, money for transport, food along the way."

The above responses highlighted the importance of emotional and financial support given participants and how that has greatly influenced their way of minimizing stress during the DG's application. Participant three indicated that her grandmother was present when she moved from one SASSA office to another. Participant six explained that ever since he had a brain tumour, his dad was there for him. The researcher had to pause and ask if he would like to be referred to the social worker at the organisation since he was sobbing during the interview. The participant then consented to continue with the interview. Participant one showed how his mother and sister were emotionally supported by being present by offering motivation. Through financial support, participant eleven indicated that her mother assisted with paying for costs such as physiotherapy, transport, and food along the way.

4.3.3.2 Spiritual support

Two of the twelve participants noted that spiritual support such as the church assisted them in maneuverer the challenges and barriers experienced regarding the DG's access. To support this sub-theme, Participant seven and nine shared the following:

"I go to church twice a week. This one time, I told my pastor that I need a grant. He prayed for me. My pastor told me that I should always motivate myself and have faith that the grant is mine." (Participant seven).

"I used to pray, pray that my grant should be approved. I applied for years with no luck. I was happy when I started receiving my money." (Participant nine).

The participants have a belief that prayer and motivation from church members assisted them with the grant access. For example, participant seven stated that his pastor told him to motivate himself and that he will get the grant and participant nine stated that praying about the grant has resulted in being awarded the grant. Garland (2011) illustrate that social support from the church is strongly associated with minimising stress. That is, the positive feeling of being supported by other church members is significantly associated with happiness and a decreased state of stress. Higashida (2019) also indicates that the religious model of disability emanates from negative societal stereotypes of living with a disability. This author shows that 'karma' is the result of how persons without disabilities in society perceive persons with disabilities by saying that 'what goes around comes around. Higashida concluded that religion is a coping strategy that fosters participation in society for persons with disabilities. Hodge and Reynolds (2018) documented the importance of spirituality among persons with four different types of disabilities (For example, hearing, vision, physical and emotional disabilities). The prominent findings from this study are that persons with disabilities are more likely to engage in prayer several times a day than persons without disabilities. Prayer therefore helped PWDs to cope with challenges and participation in society.

4.3.3.3 NGO support

NGO support emerged as a sub-theme with three of twelve participants reporting it. This involved the assistance of social workers. Participants have expressed how the social worker employed at JOCOD has assisted them in obtaining the grant. Social workers at the organisation assist beneficiaries with welfare and related services. DG's application and administration are one of the social work interventions offered to beneficiaries. To support this theme, participants stated the following:

Participant three shared that:

"My grant was not permanent at first. The social worker here at the organisation then did the application on my behalf after it ended… later, my grant was permanent." (Participant three).

Participant eight expressed his views on grant approval:

> *"The social worker applied the grant for me. I am not sure how long it took for the grant to be approved. I just heard from the social worker that I got the grant."* (Participant eight).

And Participant five shared what social workers do at JOCOD:

> *"The social worker here works with disabled persons. She applies and takes us to the nearest SASSA offices for us to get the grant."* (Participant five).

The above responses show that social workers play an important role in the process of the grant application to approval. For instance, participant three showed that her grant was temporary at first and was later approved as permanent due to the social worker's assistance. Participant eight and five indicated that the social worker works with persons with disabilities helps with the application process and alerts them regarding the grant's outcome. The researcher imagines what happens to persons with physical disabilities who do not have the grant and live in remote areas without access to schools of the disabled and social workers working with disability-related matters. Concerning social grants in South Africa, social workers are the primary practitioners who work with applicants to start and finish the application process, as well as conducting home-visits, and file evidence for beneficiaries who quality for the grants. The DSD is the core department for the employment of social workers in South Africa and in turn, the DSD monitors the administration, management, and payment of social grants in the country. This department should account for the minimisation of barriers that hinder PWD from accessing the DG. Social workers should be activists and advocates on behalf of PWD. PWD should not go through all these barriers to accessing the DG. Where are the ethical principles such as integrity to the social work profession in protecting the disabled?

In a research study conducted by Dlangamandla (2010), which explored "*the experiences of social workers regarding the implementation of a developmental social welfare approach within the department of social development Gauteng province*," it was revealed that human resources emerged as a challenge to delivering social services such as social grants. Participants highlighted the limitations of resources that hinder the delivery of social security programmes. Findings showed that social grants create a dependency syndrome for many communities. They also highlighted the lack of guidelines needed for social workers to assist with the grant. Home-visits

was the only strategy. Limited research was given on the interventions by social workers on grant access and future research should consider this limitation.

4.3.4 Objective four: To elicit recommendations of how persons with physical disabilities can be assisted regarding their access to the DG.

The fourth objective explored the recommendations of how persons with physical disabilities can be assisted regarding their access to the DG. Three sub-themes emerged, community education and awareness, intervention from the DSD, and multidisciplinary team intervention.

Table 4.5 Recommendations (N=12)

Theme	Sub-themes	Number of participants who mentioned the sub-theme
Recommendations of how persons with physical disabilities can be assisted regarding their access to the DG	Community education and awareness	3
	Intervention from the SASSA	2
	Multidisciplinary team intervention	1

4.3.4.1 Community education and awareness

Community education and awareness emerged as a recommendation, with three participants mentioning it. This recommendation was mentioned in different ways, involving social workers, and families. The quotations from participants are shown below:

For instance, participant eleven had about social workers working in communities:

> *"Social workers should reach out to communities… through community education so that society can be aware of the challenges that persons with disabilities are facing daily. They should not be excluded because of their disability. They must also encourage them to go to the SASSA offices and apply. Tell me what they need to bring to SASSA because applying*

for the grant is a step by step process. Motivate them not never give up in applying for the grant." (Participant eleven).

Participant five shared her views on the elimination of stigma and discrimination:

> *"Educate communities not to discriminate persons with disabilities. However, this is not easy. I managed to accept my situation because of the people I lived with at home, church, and community. The people got used to being with me. Other than that, others who are not familiar with me still look at me in a certain manner.* (Participant five).

And Participant one acknowledged that social workers should work with families:

> *"Social workers should invite families so that they can give people with disabilities support. Other parents cannot even accept that their child is disabled. Family support can be addressed so that families can accept us... without families, people can go to community centres to help with the grant."*

The above responses are evidence to show that education and awareness are important in how persons with physical disabilities can be assisted regarding their access to the DG. Participant eleven shared extensively on how education and awareness can be achieved. She said that social workers should reach out to communities by raising awareness and educating community members about the challenges encountered by persons with physical disabilities. Social workers should provide guidelines on the application and the required documentation for the grant's application. Persons with disabilities should be empowered by instilling motivational talks to accepting their disability.

Participant five similarly shared the same recommendations by alluding that awareness and education should address communities do not discriminate against persons with physical disabilities. Stigma and discrimination have been occurring theme throughout the objectives of this study and participants still view it as an important step in community education and awareness. Participant one adds to what participant eleven has expressed by saying that social workers should invite families for them to become aware of the challenges that persons with disabilities are facing and accept them for who they are. For those without families, participant one concluded that persons with physical disabilities can visit local community centres whereby they can assist them to apply for the grant. The recommendations mentioned by participants are consistent with the bio-

psycho-social model of disability, especially the social model. The social model argues that the social world comprises of the society, community, and family and as individuals interact with each other, change in behaviour is a two-way process. Rohwerder (2018) suggests that NGOs should adopt the community-rehabilitation model which utilizes community development to equalise opportunities and rehabilitate PWD.

4.3.4.2 Intervention from the SASSA

Intervention by the SASSA has emerged as a recommendation mentioned by two of the twelve participants. A home visit is a strategy that was mentioned by participant six and the following supports this view:

> *"SASSA should do home visits. Help people who can't walk by applying for the grant on their behalf because other people have problems with transport to SASSA"* (Participant six).

And Participant eleven said that SASSA should offer training of external medical doctors on the DG's medical assessment:

> *"SASSA should train doctors in public hospitals so that we don't go around doing the same consultations."*

Participant six voiced that SASSA must conduct home-visits for persons who have difficulties walking because transportation barriers are a major concern. Persons using wheelchairs face the most transportation challenges to navigate their way to the SASSA offices (Johannesmeier, 2007; Sekele, 2012). On the same light, participant eleven said that SASSA should offer training to external medical doctors in public hospitals regarding DGs medical assessments. The current study has also shown the challenges and barriers faced by participants regarding access to the DG due to extra transportation costs and how unfriendly public transport is to them. The researcher in the current study argues that home-visits should not only focus on assessing the household circumstances of an individual to qualify for the DG but should also be a mechanism to assist those who cannot afford transportation for the application process.

4.3.4.3 Multidisciplinary team intervention

Professional intervention such as teacher's intervention has emerged as a recommendation with one participant mentioning the theme. The participant stated that teachers working with persons with disabilities at the schools of the disabled should also contribute to offering motivation for persons with physical disabilities to access the grant. Teachers at JOCOD, for example, assist participants with education and life skills training programmes and they can make recommendations of where or how an individual struggle with their locomotion skills.

Participant ten said the following:

> *"Teachers in disabled schools should also contribute to motivating for persons with disabilities to access the grant… we work with them a lot and they can motivate us." (*Participant ten).

The above response shows that teachers' intervention could bring change in the DGs accessibility. Teachers at special needs schools of the disabled closely work with applicants and they are most aware of the challenges and milestones they face. This recommendation points to the intervention of the multidisciplinary team to assist persons with physical disabilities n accessing the grant.

4.5 Conclusion

This chapter presented and discussed the findings conducted qualitatively with persons with physical disabilities regarding access to the DG. The demographic information of age, gender, race, and location were presented. The types of physical disabilities should have also been considered as a demographic. This demographic stands as a limitation in the study. The first objective was to explore the challenges experienced regarding access to the DG. Denial, unstable family realities, limited access to medical assessment, shortages of finances, as well as stigma and discrimination were the challenges found in the study. Participants voiced that even before applying for the grant, they faced psychological challenges for coming into terms with their physical disability. The second objective was to explore the barriers experienced by persons with physical disabilities regarding access to the grant. Physical barriers such as limited access to disability friendly transportation was found. Organisational barriers were the main findings in the study. These barriers were related to the application process and pay-points. Attitudinal barriers were cross-cutting between the physical and organisational barriers. The social support services

revolved around family, spiritual and NGO support. The participants recommended that education and awareness, SASSA's intervention to work with the multidisciplinary team is important to assist them to manoeuvre the challenges and barriers regarding access to the DG. The next chapter will focus on the main findings, conclusions and recommendations emanating from the study.

CHAPTER FIVE

MAIN FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter focuses on the main findings, conclusions and recommendations emanating from the study conducted with persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. The research aim and objectives are outlined to inform the main findings and conclusions of the study. The recommendations are presented according to how persons with physical disabilities can be assisted regarding access to the DG, recommendations for social work knowledge and recommendations for future research.

5.2 Research Aim

The primary aim of the study was to explore the challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg. The aim was achieved through the following objectives:

5.3 Research Objectives

5.3.1 Objective one: To explore the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

This objective was achieved through the following sub-themes: denial or self-denial, unstable family realities or conditions, limited access to medical assessment, shortages of finances, as well as stigma and discrimination.

5.3.2 Objective two: To explore the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

This objective was achieved through the following sub-themes: physical barriers, organisational barriers related to the application process and approval, as well as the organisational and attitudinal barriers related to the pay-points.

5.3.3 Objective three: To probe the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg.

This objective was achieved through the following sub-themes: family support, spiritual support, and NGO support.

5.3.4 Objective four: To elicit recommendations of how persons with physical disabilities can be assisted regarding their access to the DG.

This objective was achieved through the following sub-themes: community education and awareness, intervention from the SASSA, as well as the multidisciplinary team intervention.

5.4 Main findings and conclusions

Objective one: To explore the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

Denial, unstable family realities, limited access to medical assessment, shortages of finances, as well as stigma and discrimination were the challenges found in the study. Participants voiced that even before applying for the grant, they faced psychological challenges such as denial or self-denial for coming into terms with their physical disability. Unstable family realities included shortages of finances to navigate the costs of applying for the grant. Medical reports are mandatory to the application of the grant and participants experienced challenges accessing these reports. The challenges to access medical reports were disabled friendly transportation such as taxis, long queues at the public hospitals and lack of privacy during these assessments. The stigma and discrimination experienced in communities also prevented them from visiting the SASSA offices to access the DG. The limitation from previous studies is that they did not focus on the environmental factors such as unstable family realities that might hinder persons with physical disabilities from accessing the grant. The conclusion is that future studies need to consider psychological challenges and environmental factors that might hinder persons with physical disabilities from accessing the grant.

Objective two: To explore the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

Physical barriers, organisational barriers related to the application process and approval, as well as organisational and attitudinal barriers related to the pay-points were the main barriers found in the study. Regarding physical barriers, participants expressed that the mode of transportation used and office set-up at the SASSA prevented them from accessing the grant. The main issues raised for the mode of transportation used were that taxis and buses lacked spaces between seats, steps being too high and lack of personnel to assist participants to get to a taxi at the taxi rank. The office set-up at the SASSA were that chairs at the administration block were fewer and accompanied

with long queues. The main conclusion from the bio-psycho-social model is that physical barriers should be removed for PWD to fully access social services. The researcher concludes that there should be additional workers at the taxi ranks to assist PWD from accessing taxis. Additional investment in infrastructure at taxi ranks and SASSA offices should also be considered by the government.

Organisational barriers related to the application process and approval emerged as a prominent sub-theme. The main findings were that the application process was too long, misinformation, and limited access to medical assessment. Under misinformation, one participant expressed that he applied for the Care Dependency Grant (CDG) when he was twelve years old and was rejected, even though medical reports and caregiver's income were produced. This participant applied for the DG when he reached eighteen years old and the DG was approved. It is unclear why the CDG was rejected and the DG was approved. This view concludes that future research should focus on the views of parents or caregivers regarding access to the CDG. Those views might determine the barriers of the CDG so that sufficient views of the DG can be understood holistically in the Disability sector.

Limited access to medical assessment emerged again as a prominent sub-theme. Participants expressed that they should bring medical reports from a professional doctor prior to the application process at the SASSA. However, when they arrive at the SASSA offices, participants are required to go through the same medical assessment process with another medical doctor employed by the SASSA. This requirement raised more barriers as some of the participants were rejected, more transportation costs, and a vicious cycle of the application process. The main conclusion is that the SASSA should work together with other multidisciplinary teams in public hospitals to assist with the assessments so that PWD should not do the assessments twice.

Organisational and attitudinal barriers to the pay-points also emerged as a prominent sub-theme. Participants expressed that they face stigma and discrimination at the community and banking institutions pay-points. People tend to look at them strangely and they must join the queues like everybody else. The conclusion is that community awareness and education are imperative to reduce attitudinal barriers and allow persons with disabilities to enjoy the government's social provisions.

Objective three: To probe the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg.

Family support, spiritual support, and NGO support were the main social support services voiced by the participants. Under family support, participants expressed that their families assisted them with finances to pay for medical costs and transportation. Previous research studies in the same topic have not highlighted this theme in the South African context, while more research has been conducted on family support for children with physical disabilities regarding their parents coping strategies and access to basic services (Dowling & Dolan, 2001; Tigere & Makhubele, 2019). Disability studies should subsequently consider expanding on this theme with similar research topics to give robustness in the Disability sector. Spiritual support relates to receiving support from the church. This is a coping mechanism by reducing stress and gaining motivation to continue with the application process of the DG.

NGO support included the intervention of social workers to assist persons with physical disabilities regarding access to the DG. Home-visits were most reported. Social workers are the primary practitioners working with the application process of social grants in South Africa. The DSD monitors the SASSA to administer social grants in South Africa. This department employs social workers to work with social grants. However, the limitation is that there is limited training for social workers to work with medical assessments for the DG's access. The conclusion is that social workers should be trained to work with medical assessments to limit the accessibility barriers to the DG.

Objective four: To elicit recommendations of how persons with physical disabilities can be assisted regarding their access to the DG.

Community education and awareness, intervention from the SASSA, as well as the multidisciplinary team intervention were the main findings reported in the study. Under community education and awareness, participants reported that social workers should educate communities and families about the attitudinal barriers of stigma and discrimination. Communities should be concientised about the implications of having a disability and teach communities not to stigamitise and discriminate against PWD. Such an awareness might motivate PWD to equally

participate with others in accessing essential services such as social grants. The SASSA intervention was all about training external medical doctors in public hospitals to work with medical assessments. The multidisciplinary team should not work in silos to minimise the barriers to accessing the DG.

5.5 Recommendations

5.5.1 Recommendations regarding how persons with physical disabilities can be assisted regarding access to the DG

The following section will focus on community education and awareness, as well as the intervention from the DSD.

5.5.1.1 Community education and awareness

Community education and awareness should focus on the involvement of the multidisciplinary team such as social workers, medical doctors, nurses, physiotherapists, and occupational therapists to the understanding of living with a physical disability. Communities should be educated of what physical disability means, and the implications it has on the individual and family. When communities are concientised about the implications of having a physical disability, the attitudinal barriers of stigma and discrimination will subsequently be minimised. The DSD should educate communities about the DG's application process and the requirements for the applications. The organisational barriers of misinformation regarding the application process, limited access to medical assessment or shortages of finances to obtain medical reports might be minimised through community education and awareness. Some of these barriers exist because applicants are not aware of the DG's application requirements. Social workers can focus on preventative, responsive and promotive services, provided at macro, mezzo, and micro levels (United Nations Children's Fund, 2020). For promotive services, social workers should raise awareness of physical disability and the implications of it. For preventative services, social workers should organize community groups to protect PWD and support community programmes safeguarding the needs of PWD. For responsive services, social workers can promote PWD's participation in society such as establish strengths-based, culturally appropriate collaboration with families and communities.

5.5.1.2 Intervention from the DSD

The DSD should not work in isolation with the SASSA. The training of data captures is also an important strategy for the DSD to embark on, so that organisational barriers such as the incorrect capturing of information during the application process can be minimised. The DSD should introduce an on-going professional training for all the SASSA workers working with social grants applications to minimise errors and rejections of applications. The SASSA should entirely perform their own medical assessments instead of requiring applicants to bring a medical report from an external medical doctor. This recommendation can subsequently reduce transportation costs for those who cannot afford.

5.5.2 Recommendation for social work knowledge

(i) Social workers working in multidisciplinary team settings should collaborate with other practitioners in conducting medical assessments. This recommendation will prevent potential rejections by the SASSA since medical reports will reflect robust information from different practitioners such as doctors, nurses or physiotherapists.

(ii) Social workers working in the NGO sector should conduct home-visits that will consider the environmental factors that PWD are faced with during the DG's application process. Such information will assist social workers to motivate for the grant for those who cannot afford due to lack of access to basic services.

5.5.3 Recommendations for future research

(i) Previous research studies in South Africa have not highlighted family support as a theme to assist persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG. Disability studies should subsequently consider expanding on this theme with similar research topics to give robustness in the sector.

(iii) The DG is cross-cutting amongst all the social grants. Participants raised confusion between the application requirements of the CDG and the DG. Future research should focus on the views of parents or caregivers regarding access to the CDG. Those views might determine the barriers of the CDG so that sufficient views of the DG can be understood holistically in the Disability sector.

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Appendix A: Ethical Approval

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

DEPARTMENTAL HUMAN RESEARCH ETHICS COMMITTEE (SOCIAL WORK) CLEARANCE CERTIFICATE

PROTOCOL NUMBER: SW/19/08/05

PROJECT TITLE: Barriers to the universal access to the Disability Grant: Experiences of people with physical disabilities residing in low income communities in Soweto, Johannesburg

RESEARCHER/S: N. Baloyi

STUDENT NUMBER: 848569

SCHOOL/DEPARTMENT: Social Work

DATE CONSIDERED: 8 August 2019

DECISION OF THE DEPARTMENTAL COMMITTEE: Approved

RATIFIED BY THE WITS HREC (NON-MEDICAL): 13 September 2019

EXPIRY DATE: 13 September 2021

DATE: 17 September 2019

CHAIRPERSON: Dr F. Masson

Cc: Supervisor: Dr Nkosiyazi Dube

DECLARATION OF RESEARCHER(S)

To be completed in **DUPLICATE** and **ONE COPY** returned to the Administrative Assistant, Room 8, Department of Social Work, Umthombo Building Basement.

I/We fully understand the conditions under which I am/we are authorised to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the committee. **For Masters and PhD an annual progress report is required.**

---------- --------/--------/----------

SIGNATURE DATE

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Appendix B: Participant Information Sheet

Good day

This is Nkhensani Baloyi, a Social Worker and a master's student in the field of Social Development at the University of the Witwatersrand. As part of this degree, I am required to complete a research report in any topic of my interest. I am interested in the challenges and barriers experienced by persons with physical disabilities regarding access to the Disability Grant in Soweto, Johannesburg.

In other words, I am interested in finding out the experiences that persons with physical disabilities faced during the application process. I am hoping to contribute to programmatic interventions done by both the public and the private sectors in a bid to improve access to the DG for persons with physical disabilities. Participation in this study is completely voluntary. You may withdraw at any time and there will no negative consequence. Your participation would consist of a one-on-one interview (1 hour long) with me where you be asked several questions based on the topic mentioned above. No identifiable information such as your name will be used. You will be referred to using a pseudonym such as participant 1, participant 2, etc. There will be an audiotape recording during the interview and these will be kept safely and upon completion of the research through a password protected computer. There are no risks and benefits within the study. The findings of the study will be made available to the participants once available on request.

Should you feel you would like to talk to someone after the interview may you kindly speak to the social worker working at the organization?

If you would like to inquire more about the study, you are welcome to contact my supervisor or l. Our details are provided below:

Dr. Nkosiyazi Dube

0117178686

Nkosiyazi.Dube@wits.ac.za

Nkhensani Baloyi

081 704 87722

848568@students.wits.ac.za

Your participation in this Study will be highly appreciated.

Kind regards

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Appendix C: Consent Form to participate in the study

Title of the study: Challenges andbarriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg

I hereby consent to participate in the research study. The purpose and procedures of the study have been explained to me.

I understand that:

- My participation in this study is voluntary and I may withdraw from the study at any time, without being disadvantaged in any way.
- I may choose not to answer any specific questions asked if I do not wish to do so.
- There are no foreseeable benefits or particular risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me will be removed from the interview transcript.
- A copy of my interview transcript without any identifying information will be sorted permanently in a locked cupboard and may be used for future research.
- I understand that my responses will be used in the write up for a Masters research report and may also be presented at conferences, in a book chapter or journal articles.

Name of participant: _____

Date: _____

Signature: _____

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THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

Appendix D: Consent Form for audio-tape recorder

Title of the study: Challenges and barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg.

I hereby consent to tape-recording of the interview.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password-protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed and any information that could identify me will be removed.
- When the data analysis and write-up of the research study are complete, the audio-recording of the interview will be kept for two years following any publications or for six years if no publications emanate from the study.
- The transcript will all the identifying information directly linked to me, will be stored permanently and may be used for future research.
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of the research.

Name of the participant: _____

Date: _____

Signature: _____

Appendix E: Demographic questionnaire

Pseudonym	
Age	
Gender as observed • Female • Male	
Race	
Township located in Soweto	

Appendix F: Semi-structured interview guide

The schedule comprised of the following questions:

Objective one: What are the challenges experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg?

- Please tell me what happened when you were applying for the grant?
- What do you think were the challenges or problems that you faced when applying for this grant?
- What steps did you follow when applying for the grant? Were these steps helpful to assist you in getting the grant?
- Please share with me the kind of papers you took for the grant application and where did you get these papers?
- What do you think were the problems that you faced when going to apply for the grant at the SASSA?
- Please share with me the kind of transport you used when applying for the grant. Was this transport helpful and how so?

Objective two: What are the barriers experienced by persons with physical disabilities regarding access to the DG in Soweto, Johannesburg?

- From the answers you gave me, what do you think were the main issues or problems that might have prevented you from getting the grant?
- What examples can you give me of how these issues or problems prevented you from getting the grant?

Objective three: What are the social support services available to persons with physical disabilities to manoeuvre the challenges and barriers regarding access to the DG in Soweto, Johannesburg?

- Please share with me, who helped you or the kind of support you received when applying for the grant.
- Was this support enough to help you get the grant? And if so, in what way did that help you?

Objective four: What are the recommendations of how persons with disabilities can be assisted regarding their access to the DG?

- What do you think we can do to help others that do not have the grant? And how can we do this?
- How can we help others who are currently applying for the grant so that they do not go through the problems or issues that you have faced?

Appendix G: Permission Letter from JOCOD



292 Peelhouse Street, Ext. 11a, Lenasia, Johannesburg, South Africa P.O Box 1511 Lenasia 1820
Telephone: +27 11 852 2144/7 Facsimile: +27 11 852 3469 E-mail: info@jocod.org.za Website: www.jocod.org.za

24 July 2019

To whom it my concern

This is to confirm that Nkhensani Baloyi is accepted at Johannesburg Council for the Disabled (JOCOD) to do her research report as a student social worker.

Should you require more information please contact us at the above number.

Yours Sincerely

Mrs Linda Pounasamy

Director.

Appendix H: Audit Trail

Number of interviews conducted	**Date of interviews**	**Date transcribed**
2	07 October 2019	07 October 2019
3	08 October 2019	24 October 2019
3	21 October 2019	25 October 2019
1	22 October 2019	06 November 2019
3	23 October 2019	07-09 November 2019
Total: 12		