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Analysis of the disability framework and strategy in South Africa: access to healthcare for persons with disability

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ANALYSIS OF THE FRAMEWORK AND STRATEGY FOR DISABILITY AND REHABILITATION FOR SOUTH AFRICA:
ACCESS TO HEALTH CARE FOR PERSONS WITH DISABILITIES

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A research dissertation submitted to The University of The Witwatersrand, Johannesburg, in fulfilment of the requirements for the degree of Master of Science in Physiotherapy.

Supervisors: Mrs Sonti Pilusa
Dr Khetsiwe Masuku

DECLARATION

I, Naeema Ahmad Ramadan Hussein El Kout, hereby declare that this dissertation is my own work, all the sources which have been used in this dissertation have been referenced appropriately. I declare that this dissertation has not been submitted to another university previously, in order to obtain a degree.



Signed **Date** **04/11/2020**

ABSTRACT

Background: The prevalence of disability is increasing across the globe and disability rights are not upheld. Currently in South Africa, there is no disability policy except for the framework and strategy for disability and rehabilitation which seeks to address inequalities in health care access for people with disabilities and promote rehabilitation across the continuum of health. The framework and strategy for disability and rehabilitation has been developed for 2015-2020 and it aims to improve access to health care. Analysis of policy has been recommended to expose gaps in the processes, and recommendations for future policy. To date the analysis for framework and strategy for disability and rehabilitation has not been conducted.

Aim: To review the framework and strategy for disability and rehabilitation in South Africa, related to access to health care for persons with disabilities.

Method: A qualitative single case study design comprising of a document review and key informant interviews with twelve key informants was employed. A framework approach was used to analyse data obtained from both the document and the key informant interviews. In accordance with the framework approach, inductive and deductive thematic analysis was done, utilising the predetermined dimensions of the Walt and Gilson triangle framework for health policy analysis, and Penchansky and Thomas framework of access to health care.

Results: Findings indicated that, there was a broad range of role players in development of the framework and strategy for disability and rehabilitation, with the exclusion of health economists. The context of the FSDR included global legislation, situational and structural factors. There was a lack of alignment of the content to access to health care, resulting in a minimal distributional impact of the document. Development and implementation followed a top down approach with no formal monitoring and evaluation of the FSDR. Barriers to the processes of the FSDR include a lack of leadership and resources, and poor staff attitudes. Facilitators of the FSDR processes were a broad range of actors, mentorship and a case study.

Recommendations: The development of a comprehensive framework for monitoring and evaluation of disability policy is recommended. These study findings suggest a need for disability training and conscientisation amongst rehabilitation staff and the general public to ensure improved awareness of

disability and rehabilitation. Furthermore, the barriers to the policy processes need to be addressed to ensure adequate policy implementation and monitoring.

Conclusion: The framework and strategy for disability and rehabilitation lacked alignment to access to health care specific to Penchancky and Tomas (1981) theory of access, and despite facilitators to the processes, multiple barriers to the processes resulted in poor outcomes of the FSDR. Further research of the analysis of the FSDR at national level is needed, prior to the formation of a disability policy for SA.

DEDICATION

I dedicate this work to God firstly, to my two mothers (Aysha and Monica), my beloved father, my dear husband, my family and my admirable grandmother.

Your support has been indescribable.

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LIST OF ABBREVIATIONS

BA	- Bachelor of Arts
BSc	- Bachelor of Science
CHBAH	- Chris Hani Baragwanath Academic Hospital
CRPD	- Convention on the Rights of Persons with Disabilities
DIP	- Diploma
DPO	- Disability Persons Organisation
FSDR	- Framework and Strategy for Disability and Rehabilitation
GDOH	- Gauteng Department of Health
HPCSA	- Health Professions Council of South Africa
JHB	- Johannesburg
MandE	- Monitoring and Evaluation
MIC	- Middle income countries
M(Log)	- Masters in Logistics
NDOH	- National Department of Health
NGO	- Non-Government Organisation
PC	- Primary care
PHC	- Primary health care
PhD	- Doctorate
SA	- South Africa
SAHRC	- South African Human Rights Commission
UN	- United Nations
WHO	- World Health Organisation

CHAPTER 1

1. INTRODUCTION

Disability is the term used to encapsulate limitations, impairments and restrictions in participation that persons with disabilities experience in their functional activities and daily life (WHO, 2018). It is a phenomenon, which reflects how persons with disabilities and their bodily features interact with feature within their societies. Globally, 15% of citizens are living with disability where the number of adults range from 110 to 190 million individuals (WHO, 2011). The United Nations Development Program (UNDP) estimates that approximately 80% of persons with disabilities are in developing countries (United Nations, 2019) and this high prevalence has been linked to the vicious cycle of poverty and disability, emergence of new diseases, physical injuries from accidents, chronic conditions and global economic crises (Sherry, 2015; Zakiei et al., 2018; Theis, 2019; Joubert and Bradshaw, 2009). In South Africa (SA), the national prevalence of disability is 7.5% and more than 50% of persons with disabilities are above the age of 85 years (Statistics SA, 2016). The main causes of disability have been attributed to HIV/AIDS, non-communicable diseases, injuries, arthritis and cancer (Maredza and Chola, 2016; Myezwa et al., 2019). Disability poses the risk of persons with disabilities developing secondary health complications (Pilusa, Myezwa and Potterton, 2019). Given the increasing prevalence of disability there is a need to ensure access to needed health care services including rehabilitation across the continuum of care.

The increase in the burden of disability poses a challenge for the health care system in terms of accessing rehabilitation care across the continuum. Persons with disabilities have specific needs and experience associated secondary complications, which can lead to poor health, decreased quality of life and increased rehospitalization (Mitra et al., 2017). There is evidence indicating that PERSONS WITH DISABILITIES seek more health care services but have more unmet health care needs and health promotion and prevention activities seldom target this group (Kuper et al., 2018, Houtrow et al., 2019). Although access to health care is a human right PERSONS WITH DISABILITIES in South Africa are still vulnerable to discrimination and their right to access to health care has been compromised (South African Human Rights Commission, 2019).

Persons with disabilities have the right to basic human rights just as any other individual, particularly the right to access to health care as it is the foundation of all other rights (United

Nations, 2010). Access to health care is defined as the interface between the providers of health care resources and potential users of the service (Haenssgen, 2017; Waters, 2000). There is evidence indicating that persons with disabilities face various barriers when accessing the health care system which impacts negatively on the health outcomes (Dowthit et al., 2015 Richard et al., 2016, Vergunst et al., 2017). The barriers to accessing health care for persons with disabilities include lack of physical access, negative attitude, stigma and unaffordable costs (Vergunst et al., 2017; Ganle et al., 2014). A study conducted by Richard et al., (2016) describes that health care access is a right and not a privilege. Thus, to ensure the rights of access to health care for persons with disabilities are realised, health policy and legislation must be developed and implemented.

Health policy refers to the plans and processes undertaken to achieve a society's goals related to health care (WHO, 2018). It includes assessing existing policies and services, identifying ways to reduce the inequalities identified and plan interventions for improvement for access to health care and inclusion of individuals with disabilities. Standards of care, specific to disability, should be established, with adequate mechanisms to enforce it (Navarro, 2007). The World Health Organisation (WHO) emphasises that disability should be a component in national health policies, through increasing capacity among health service providers and health policy makers (World Health Organisation, 2018). An example is the United Nations Convention on the Rights of Persons with disabilities (CRPD) a human rights treaty and instrument aimed at preserving and maintaining the rights and dignity of persons with disabilities , particularly their right to access to health care (United Nations, 2019). South Africa is a signatory to the CRPD, thus has an obligation to develop a policy to enforce the rights of persons with disabilities (Hussey et al., 2016). To date, South Africa has not established a disability policy. The Strategy and Framework for Disability and Rehabilitation (FSDR) was developed for 2015-2020 to address access to health care for persons with disabilities (Gretschel, Visagie and Inglis, 2017). Global policies which prompted the development of the FSDR include the UNCRPD as well as the 2030 Sustainable Development Goals which seek to promote and ensure the realisation of the right to health care and well-being for all. Prior to the development of these policies, other policies were developed such as the United Nations Rules for the actualisation of opportunities for persons with disabilities; The African Charter on the Human Rights of persons with disabilities; The Constitution of the World Health Organisation (Alma Ata)- Health for all (1948).

The FSDR outlines the disability and rehabilitation services in South Africa to facilitate better access to health care (Gretschel, Visagie and Inglis, 2017). It advocates for community-based rehabilitation (CBR); which is "a strategy within community development for the rehabilitation, equalization of opportunities, poverty reduction and social integration of people with disabilities" (World Health Organization, 2004, p. 2). There is a need to review the policy frameworks such as the FSDR in order to identify gaps in the policy and areas of improvement to implement in future disability policy in South Africa. According to El-Jardali et al., (2014), policy documents must be reviewed on a regular basis to better understand the policy processes and identify areas for improvement of the policy. To "ensure healthy lives and promote well-being for all at all ages" access to rehabilitation has been identified as key to achieving Sustainable Development Goal number three, (Norheim et al., 2015; UNSDG, 2015). To ensure the wellbeing of persons with disabilities is achieved there is a need to understand policy frameworks that are inexistence to support access to health care system. There is a need to review the policy frameworks such as the FSDR in order to identify gaps in the policy and areas of improvement to implement in future disability policy in South Africa.

1.1 PROBLEM STATEMENT

From the researcher's experience, access to rehabilitation for persons with disabilities is a problem in South Africa. A survey conducted in 2018, indicates that between 76 percent and 87 percent of persons with disabilities did not receive the necessary treatment for their health needs (World Health Organisation, 2018). A study conducted by Vergunst., et al (2017) demonstrated that 24.4 percent of persons with disabilities reported not receiving the helath services which they required when accessing health care. The lack of access to rehabilitation services for persons with disabilities has negative implications thereof for the individuals, their families and society in general, particularly to socio-economic development of the country (Sherry, 2015). These negative implications include inadequate health care service provision which hinders progress, and an increased burden on the families of persons with disabilities to due to the lack of independence (Dassah et al., 2018). At times, persons with disabilities are rehabilitated and discharged with no follow up. This leads to increased rehospitalisation and at times untimely deaths. These challenges are occurring despite the FSDR been in existence since 2015 and it expire this year, 2020. To date, there is no evidence on the analysis of the FSDR. There is no study that has explored the experiences of health therapists and programme managers in the processes of the FSDR. There has been some

research done in the Western Cape and Kwa-Zulu Natal provinces on the barriers to the implementation of rehabilitation and health articles of the UNCRPD in South Africa (Hussey, MacLachlan,and Mji, 2017). However, in Gauteng there has been minimal research done regarding the FSDR, even though Gauteng is a very populous area with the majority of the South African population living there and has the second highest prevalence of disability in the country (Statistics SA, 2016, 2011). The review of the FSDR is imperative to enhance access to rehabilitation services for persons with disabilities in south africa.

1.2 AIM OF THE STUDY

To review the South African Framework and Strategy for Disability and Rehabilitation (FSDR).

1.3 RESEARCH QUESTION

What is the status of the South African Framework and Strategy for Disability and Rehabilitation (FSDR), in relation to enhancing access to rehabilitation services for persons with disabilities?

1.4 OBJECTIVES OF THE STUDY

- To identify key-role players in the conceptualisation, development and implementation processes of the framework and strategy for disability and rehabilitation (FSDR) in South Africa (SA)
- To describe the content of the FSDR in SA
- To describe the context of the FSDR in SA
- To determine the processes of the FSDR in SA, related to access to health care for persons with disabilities
- To describe factors affecting the process of implementing the FSDR

1.5 SIGNIFICANCE OF THE STUDY

The analysis of the FSDR will give an in-depth understanding of the processes of the health policy analysis triangle framework, main goals and gaps in the policy's processes, context, content and the processes between the stakeholders. The study may contribute to the improvement of health programmes and services, policies, and legislations that targets persons with disabilities . This study may provide insight on the status of rehabilitation

services for persons with disabilities as well as provide insight into gaps in the current service delivery for persons with disabilities , that need to be strengthened.

1.6 CONCLUSION: INTRODUCTION

This chapter discussed the broad overview of the study, outlined the aim and the objectives of the study. Lastly, the research gap was discussed in the problem statement and the significance of the study was outlined. The next chapter will review literature related to the study topic.

CHAPTER 2

2. LITERATURE REVIEW

2.1 INTRODUCTION

This chapter entails a detailed literature review for this study. An effective literature review forms the foundation of any academic project to ensure the advancement of knowledge exploring current research in the field, identifying gaps in the research through critical evaluation and analytical thinking (Watson, 2010; Winchester and Salji, 2016).

This review entails a detailed search of the literature around disability, health policy, access to health for persons with disability and the disability strategy and framework in South Africa (SA). While it is acknowledged that community-based rehabilitation (CBR) is a foundational philosophy of the FSDR, for the purpose of this study, a detailed review of CBR is not included. This is due to the scope of the aims and objectives of this particular study, which is bound to focusing on reviewing the FSDR in relation to access to health care for persons with disability.

The literature search used for this literature review includes the use of various academic search engines namely, PubMed, Science Direct, Research Gate, Google Scholar and SCOPUS. The databases were accessed through the University of the Witwatersrand library and the following key words were used to obtain the relevant literature: disability, burden of disability, access to health care, health policy, as well as disability strategy and framework for rehabilitation. Most of the articles selected were between 2009 and 2020. In some instances, older articles were used to establish theoretical frameworks and display contextual factors.

2.2 DISABILITY

This section of the literature review looks at disability in the context of South Africa, and the various definitions of disability which have been defined by the evolution of the models of disability. It then covers a broad range of topics related to the objectives of this study. The structure of this review is that it begins with the prevalence of disability, defining disability and the various models of disability. The next section discusses the history of disability in South Africa where it elaborates on the cycle of poverty and disability, as well as the burden of disability globally and in South Africa. Studies have shown that disability impacts

negatively on the quality of life of persons with disabilities , particularly affecting the psychological domain which has other ramifications such as a low self-esteem (Kuvaleka et al., 2015., Weisscher et al., 2007). The quality of life of persons with disabilities is considerable, however the implementation of the biopsychosocial model enables the holistic use of advances in research and assistive technology to optimise function (Bray et al., 2019).

Disability is an interaction between bodily impairment, functional limitations, and restrictions in participation influenced by contextual factors (WHO, 2018; Kazou, 2018). Disability is a loosely used term depending on the model used to view it. There are various models used to define disability depending on the field of study and context, reflecting the differences in the understanding of disability (Krahn, Walker, and Correa-de-araujo, 2015). Over time, there have been various developments in different models of disability. This review describes the four models of disability, namely, medical, social, biopsychosocial and human rights model of disability.

There has been an evolution of the definitions of disability influenced by the various models of disability. Each model of disability is discussed below; along with the various strengths and weaknesses of each model.

2.2.1 **Models of Disability**

2.2.1.1 **The medical model of disability**

The first model of disability to be established was the medical model. This gave rise to the initial definitions of disability. From as far back as the 1960s, attempts have been made to establish a cohesive definition of disability linking to factors such as impairments and illness, however, the validity of these definitions have not always been accepted both by researchers and organisations for persons with disability, hence disability is still a contested subject (Worthington et al., 2005). The medical model of disability was initially developed when the role of medicine and clinical research was established in society globally through their ability to identify and treat illness or impairment(Haegele et al., 2016). This model describes disability in terms of the physical medical deficit within an individual thus causing limited function. It also looks at disability in terms of the biology of the disability being deficient (Romel et al., 2016). As opposed to other models of disability, the medical model identifies the physical impairment of disability as the main limitation leading to decreased functional abilities (Letsosa, 2018).

A major critique of this model is the portrayal of complete reliance on the health care system and staff to treat or medically manage impairments. This is limiting as it does not give the persons with disabilities any sense of independence or ability to actively contribute to their wellbeing (Haegele et al., 2016). This model created stereotypes which persons with disabilities fell into due to categorising persons with disabilities as different to the general population (Creamer, 2009). Thus, due to their specific needs, persons with disabilities are referred to as 'sick' as opposed to having an impairment (Retief and Lotsosa, 2018). This then results in impairments being measured and managed medically without considering the social factors. It further narrows down the complex issue of disability to merely medical prevention and cure (Shakespeare and Davis, 2014). Due to the critiques and limitations identified within the medical model, further research was needed to establish a more comprehensive model. This gave rise to the social model of disability which then contributed to the evolution of the definition of disability from being focused on impairment to the social environment. This model is discussed in the next section.

2.2.1.2 **Social model of disability**

The social model of disability was developed to address the gaps and disadvantages of the medical model of disability (Oliver1996). The social model of disability differentiates between disability and impairment by defining disability as a disadvantage which stems from a lack of adaptation in the social environment for the individual with a disability (Goering, 2015). In some views disability is a complex process which refers to the output resulting from the interaction between an individual and their environment (Madans et al, (2011).

There have been critiques of the social model of disability. A strength of the social model is that it suggests that it is not only the physical impairments which limits the functional abilities and social integration of an individual but rather the societal context that is limiting (Barney, 2012). This model offers an alternative to how disability is viewed and encourages the social inclusion of persons with disabilities in society (Romel, 2016). Another strength of this model is that it allows the persons with disabilities to assert their capabilities in all spheres of life (Mackelprang, 2012). While this model was an improvement of the medical model, it has been criticised for viewing disability as purely a social problem and not considering individual attributes such as impairments, economic, labour, and educational factors (Palmer and Harley, 2012; Shakespeare, 2014).

The social model neglects factors such as impairment which plays a role in disability (Shakespeare, 2014). In addition to this, this model fails to recognise the challenges that persons with disabilities face regarding the lack of realisation of their human rights (Degener, 2017). As a result of these critiques, the biopsychosocial model was developed, which is explained in detail in the section below.

2.2.1.3 **Biopsychosocial model of disability**

To combine the two approaches of both the medical and social model, the biopsychosocial model was established to take a cohesive approach to disability by viewing disability due to physical impairment as well as the role of the social environment on participation (Wade and Halligan, 2017). The World Health Organisation (2011) has acknowledged the importance of a holistic approach to disability which views disability from a biopsychosocial viewpoint by developing the International Classification of Functioning, Disability and Health (ICF) framework (WHO, 2011). The ICF was developed to holistically view disability according to the interaction between the impairment, personal factors and physical activities and the environment (WHO, 2011). One criticism for this model is the exclusion of the influences of human rights and access to health care by excluding the role that health legislation plays (Pilgrim and Pilgrim, 2015). The next section describes the human rights model of disability.

2.2.1.4 **Human rights model of disability**

Some researchers view the social model as being synonymous with the human rights model of disability. However, Degener (2017) clarifies that the human rights model expands on the social constructs of the social model, by providing theoretical frameworks to ensure the human dignity of persons with disabilities . The human rights model of disability states that all individuals including persons with disabilities , have rights which protect them by law (De Bie and Brown, 2017). It aims to address the issue of discrimination of persons with disabilities where their rights such as access to health have not been upheld (Crowther et al, 2016).

One critique for the human rights model is that despite the approach to enforcing the rights of persons with disabilities , this model has the potential for no enforcement as well as poorly defined linkages with other legislative bodies. This is because there is no accountability

attached to certain human rights efforts, hence the implementation of these models tend to be lacking (Jackson, 2018).

The human rights model has had various strengths identified. One of the advantages of this model is that it ensures that the rights of persons with disabilities are actualised and goes beyond discrimination rights by including general human rights as well. Moreover, physical impairments are not disregarded and are recognised and acknowledged as an important factor in the lives of persons with disability (Degener, 2017). Another strength is that the human rights model highlights the importance of identification politics by allowing a space for cultural identification (Degener, 2017; Letsoso, 2018). While the social model identifies why PERSONS WITH DISABILITIES face so many challenges, the human rights model suggests proposals for improving the general quality of life of PERSONS WITH DISABILITIES (Degener, 2017). Degener (2017), states it is an improvement of the social model as it incorporates the importance of the provision of rights for PERSONS WITH DISABILITIES and factors in the impairments and its impact on the lives of PERSONS WITH DISABILITIES . Moreover, the shift from the social model to this human rights model has created a shift in mindset, placing rights of PERSONS WITH DISABILITIES as an important aspect of health policy (Crowther et al, 2016).

It is for these strengths mentioned above, that the human rights model of disability has been selected, in addition to the biopsychosocial model, to guide this study as they are both aligned with the objectives of this particular study. This study aims to review the FSDR, which is aligned with the human rights model as it is a constructive proposal for the improvement of the life situations of persons with disabilities . This is because the human rights model is a tool which guides the United Nations Convention on the rights of persons with disability (UNCRPD) which contributes to the context of the FSDR which will be discussed further below (Degener, 2014). This model resonates with this study as the FSDR seeks to realise the human rights of persons with disabilities .

The above section has described the various models of disability namely medical, social, biopsychosocial and human rights models of disability. Aspects of the biopsychosocial and human rights models have been drawn on for the purpose of this study. The reasons for this selection have been stipulated above. While various models have defined and redefined

disability, the evolution of disability statistics and data has also been evolving. The prevalence of disability both globally and in SA is explained below.

2.2.2 Prevalence of Disability

A global estimate of 15% of citizens are living with a disability where the number of adult's ranges from 110 to 190 million individuals (WHO world report on disability, 2011). Due to the varying definitions of disability, the disability statistics are dependent on the way that disability is defined (Graham et al, 2010). Moreover, it is important to acknowledge that disability statistics are collected for different purposes according to different constructs, which may affect the comparability of the statistics (Madans, Loeb, and Altman, 2011). The United Nations Development Program (UNDP) estimates that approximately 80% of PERSONS WITH DISABILITIES are in developing countries (UN, 2019). This high prevalence in developing countries has been linked to the vicious cycle of poverty and disability (Mitra, Posarac, and Vick, 2013).

Prevalence data on disability in South Africa is scanty. The national prevalence of disability in South Africa was estimated at 7.5% and more than 50% of PERSONS WITH DISABILITIES are above the age of 85 years old (Statistics SA, 2016). A household survey conducted by Statistics South Africa (2017) shows that a larger percentage of women experience disability as opposed to men (Statistics SA, 2017). It has been found that most PERSONS WITH DISABILITIES reside in rural areas with lack of access to basic health care services (Picardo, 2014). Moreover, data displayed by the United Nations (2019) flagship report on disability shows that in South Africa, 28% of PERSONS WITH DISABILITIES do not have access to rehabilitation services which they need (UN, 2011).

It is important to note that statistics on disability is contentious due to the variations in the definitions of disability, the way that data is collected and a lack of understanding of the different types of disability (Schnelder et al, 2009). Despite disability statistics being established by Statistics SA, further research into specific statistics is required to establish the disability prevalence in SA according to the various definitions, due to the influence of the various disability models which have been explained previously (Sherry, 2015).

The above section described the prevalence of disability and has shown the high prevalence of disability in both SA and on a global front. This prevalence is as a result of various

underlying causes linked to the context in which the disability occurs. These causes are discussed further below.

2.2.3 Causes of Disability and burden of disease

Disability is caused by numerous factors ranging from chronic lifestyle disease such as diabetes and hypertension which may result in secondary complications and long-term disability. Additional causes include physical trauma, birth defects, complications during pregnancy and at birth (World Health Organisation). In South Africa, the main causes of disability have been attributed to HIV/AIDS, non-communicable diseases, injuries, arthritis and cancer (Maredza and Chola, 2016; Myezwa et al., 2019).

Studies related to the burden of disease, display the trends in population health which may contribute to the prevalence of disability in a country. Globally, between the period of 1990 and 2017, the total burden of disability increased by 52 %, with non-communicable disease accounting for 80% of disability (Global Burden of Disease, 2017). Moreover, the burden of disability is increasing globally due to the increasing aged population (World Health Organisation, 2011). The current increase in disability poses a challenge for the health system as it places an increased associated load as more secondary complications need to be treated due to the disability. The social determinants of health refer to the socio-economic conditions as well as factors such as employment, education inequalities which result in a wide range of health outcomes. The impact of the social determinants of health on access to health care is considerable. Individuals in disadvantaged social environments face greater challenges to accessing health care (Braveman & Gottlieb, 2014). A study conducted in South Africa by Omotoso and Koch (2018) expose the close relationship between health inequalities and the social determinants of health.

The Global Burden of Disease Study (2017), conducted by The Institute for Health Metrics and Evaluation in association with The World Health Organisation showed the impact of socio-economic factors on the higher prevalence of disability in middle to low socio-economic index, such as South Africa (GBD, 2019). In SA, the quadruple burden of diseases such as chronic diseases like HIV/AIDS, TB, cancer, non-communicable diseases and injuries have been associated with disability and have major implications (Roser and Ritchie, 2018; Sherry, 2015). Disability results is an increased burden on the health care system due to the increased

demand for medical care, decreased employment rates and an increased load on social disability grants (Roser & Ritchie, 2016).

2.2.4 Factors affecting persons with disabilities in South Africa

PERSONS WITH DISABILITIES experience various factors which affect their quality of life, and activities of daily living. These factors include socio-economic conditions, violence, gender, human rights, social stigma and cultural factors. These factors are discussed further below.

2.2.4.1 Socio-economic conditions affecting disability

There is evidence correlating poverty and the high prevalence of disability (Hanass-Hancock &McKenzie, 2017; Sherry, 2015). People with disability (PERSONS WITH DISABILITIES) have a higher likelihood of experiencing adverse economic outcomes than people who do not have a disability (World Bank Group, 2019). Poor people are at risk of being disabled and PERSONS WITH DISABILITIES at risk of being poor due to the extra costs associated with living with a disability (Sherry, 2015). These costs include increased equipment costs for assistive devices, transport costs for wheelchairs, caregiver costs and general medical costs (Mitra et al., 2017). In addition, disability is associated with lower levels of education which exacerbates the cycle of poverty and disability (Moodley& Graham, 2015). Due to the high correlation between poverty and unemployment related to disability, disability social grants have been issued in an attempt to decrease the economic vulnerability of PERSONS WITH DISABILITIES (South African Health Review, 2015). Despite the grants being beneficial in assisting with basic costs, it still affected the perception on disability that PERSONS WITH DISABILITIES needed to be taken care of as opposed to facilitating support structures to enable them to be active contributing members of the South African society (South African Health Review, 2015).

The cycle of poverty and disability affects access to health care in various ways. One of these ways is that low income and poverty is associated with a lack of education, which results in a lack of understanding disability and how to access health care services (Porterfield &McBride, 2011). Moreover, PERSONS WITH DISABILITIES experience poverty and as a result live in more rural areas, where there is poor access to healthcare. This is due to poor financial and geographical accessibility (Graham et al., 2010). The influence of poverty on PERSONS WITH DISABILITIES can be seen with access to health care still being a major challenge

due to barriers which are a result of the poor socio-economic conditions. persons with disabilities experience barriers to access such as increased distance to health care institutions, lack of transport and exclusion from mainstream social and economic activities (Department of Social Development, SA, 2009). Access to health care is still a challenge due to the vicious cycle of poverty and disability in South Africa (Graham et al., 2010).

2.2.4.2 **Gender, violence and disability**

Gender plays a role in the relationship between poverty and disability (Palmer, 2011). In SA, there is a higher rate of violence against women with disabilities. Women with disabilities are recognised to be more disadvantaged than men due to disability and gender both playing a role (Parnes et al., 2009). The prevalence of disability in SA is higher in females than in males (Statistics SA, 2017). This difference in prevalence is a result of increased domestic violence and violence against women in SA. The result of disability in women then triggers the cycle of poverty and disability which has been discussed above. Despite this discrepancy in prevalence, insufficient attention is given to this issue in disability research in South Africa (Heijden et al., 2019). Gender and disability have been overlooked, yet globally, research has highlighted the gaps in the outcomes of disability where there are variations in the prevalence of men and women (Moodley & Graham, 2015). It is therefore important, in the case of this study, to understand the contextual factors such as poverty and disability, violence, culture and stigma, in order to understand the relationship between poverty and disability (Neille & Penn, 2017).

2.2.4.3 **Cultural, religious factors and disability**

Culture also has a role to play in labelling people as having a disability based on cultural or religious predispositions in a society. Valencia (2010) explains that the impact of globalization being informed by culture has led to persons with disabilities being referred to as different from the general population hence varying in their levels of ability. This cultural perception, in turn, causes a difference amongst the population by isolating persons with disabilities as a minority and as a result, increases their vulnerability to injustices (Artiles, 2014).

The cultural perceptions of disability within a society, affect the way policies are developed. Furthermore, it contributes to inequities and injustices that persons with disabilities experience and have experienced as a result of poorly executed policies which have been influenced by culture (Artiles,2011). Culture spans across various policy processes in

problematic ways such as misinterpretation of the needs of persons with disabilities , hence public policy does not always meet the needs of persons with disabilities (Lee, 2009). In addition to this, cultural perceptions of race influence how the prevalence of disability is documented (Artiles et al., 2011). Moreover, societal and cultural perspectives do not always recognize diversity within the population of persons with disabilities and functional ability levels are not specified hence specific needs are not met (Artiles et al., 2010). As a result of cultural perceptions, social stigma arises affecting how disability is viewed and how disability data is collected and documented. This is discussed further below.

2.2.4.4 **Social stigma and disability**

Apart from the distress and loss of function associated with disability and disease, persons with disabilities face prejudice and discrimination (Corrigon, 2014). In addition to this, models of disability affect the way society perceives disability and results in stigma and negative attitudes towards persons with disabilities (Livneh et al., 2014). Culture can also influence the severity of stigmas around disability (Rao and Valencia-Garcia, 2014). The experiences of persons with disabilities can be worsened by stigma, (Corrigan, 2014). Stigma around disability is a major barrier to the recovery process, access to health care and social integration of persons with disabilities into their communities. This hinders access to health care as it limits community integration of persons with disabilities which is one of the aims of community-based rehabilitation. (Roe at al., 2014).

2.2.5 **Human Rights and Disability**

Despite the South African constitution and the UNCRPD aiming to promote the rights of persons with disabilities , the right to access health care for persons with disabilities have not been upheld. The different challenges within the South African health system and the structural conditions around poverty and disability have had major implications on access to health care for persons with disabilities (Sherry, 2016). The above section has discussed the various factors which affect persons with disabilities . As a result of these factors, access to health care becomes affected as well. Access to health care plays an important role in the management and rehabilitation of persons with disabilities . The topic of access is defined and discussed further below.

2.3 ACCESS TO HEALTH CARE AND REHABILITATION FOR PERSONS WITH DISABILITIES

This section of the literature review focuses on access to health care and rehabilitation. It begins by defining access to health care, discusses various theories on access, and then it highlights the numerous factors which affect access to health care, particularly in the South African context of this study.

2.3.1 Defining access to health care

Access is acknowledged by researchers to be the physical entry into or utilisation of a health care system, while other authors preferred to look at access from the perspective of the factors which characterise access (Levesque, Harris, & Russell, 2013; Meade, Mahmoudi, & Lee, 2014). Another framework on access developed in South Africa by McIntyre, Thiede & Birch (2009), looked at the interaction between the users and providers of health care and access to health care as the empowerment of individuals to use the health care services which are provided. Alternately, access to health is then viewed as the opportunity for the users of the health care system, to obtain and achieve specific outcomes. This includes the chance to identify, seek and fulfil medical needs within a health care system (Levesque et al., 2013). More recently, access has been defined as the interface between the providers of health care resources and potential users of the service and an important aspect of the rehabilitation care for persons with disabilities (Bhatt & Bathija, 2018). Due to access to health care being a topical issue, there has been the development of multiple frameworks on access over time.

According to Penchansky and Thomas (1981), access to health care encompasses specific influential dimensions which express the relationship between the providers of health services and the patients or potential users who utilise the health care system. This theory looks at different dimensions of access and describes the relationship between patients and health service namely: availability, accessibility, accommodation, affordability, and acceptability. In this theory, availability of health care refers to the volume and adequacy of health services in relation to the needs of the users to ensure the needs of persons with disabilities are fulfilled appropriately. Accessibility is defined as the relationship between where services occur and the location of the users of the service, while factoring in architectural, attitudinal and transportation factors which facilitate accessibility (Penchansky and Thomas, 1981). Affordability is defined as the relationship between the cost of the health service and the financial ability or income of the user of the service (Penchansky and Thomas, 1981). For

health care to be accessible, it must be acceptable. Acceptability is defined as the relationship between the perceptions of the health services by the users of the service, and the attitudes of health care service providers (Saurman, 2016). Accommodation refers to the level of convenience for persons with disabilities to access health services and ensure patient satisfaction (Saurman, 2016). The dimensions of access give a holistic view of accessibility and thus can be applied through different contexts and relevance through varying periods (Moore and Evans, 2017).

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While the theory of access cemented the foundation of many other studies on access to health care, modification and improvement of this theory was explored by Saurman, (2015), who acknowledged that even though these dimensions are interconnected, one dimension is missing. It was proposed that the missing dimension is awareness, arguing that it is an integral component of access and that it should form a permanent dimension as part of the theory, particularly when being utilised in research regarding health policy(Saurman, 2015). Saurman (2015) explains that awareness refers to the effective communication with and dissemination of information to the users of the service. Similarly, Levesque et al, (2013) expanded on the theory of access by adding the capabilities of the population who interact with these dimensions. The added concepts were: approachability which refers to looking at the individual's ability to perceive the health care service and acceptability corresponding to the ability of the individual to seek medical care. the availability and the ability to reach the health service and affordability the ability to pay. The last dimension of appropriateness corresponds to the ability of the population to engage with the providers of the health services. From the above-mentioned theories of access. access to health care is exceedingly dynamic and comprehensive and must be conceptualised specifically to the context in which it is being applied (Levesque et al., 2013).

McIntyre, Thiede and Birch (2009), applied the theory of access developed by Penchansky and Thomas (1981), to the South African context for a general population accessing health services. They identify three of the five dimensions of the theory, namely, availability, affordability and accessibility, as a means of evaluating access in the health care system. Access to health care in the context of middle-income countries (MIC) such as South Africa cannot only be viewed from the perspective of researchers in public health but in health economics as well. This is because intersectoral collaboration is essential in achieving optimal access to health care for persons with disabilities and the general population (Mcintyre and

Ataguba, 2009). In addition to intersectoral collaboration, the diversity of disability-specific needs and care need to be considered, in order to improve access to health care (Hanass-Hancock, Nene, Deghaye, and Pillay, 2017). The impact of health economics on the implementation of policy is that the greater the investment from health economists, the better the implementation of public health policy due to increased resource allocation (Roberts, Healy & Sevdalis, 2019).

2.3.2 **Challenges to accessing health care and rehabilitation in South Africa**

Access to health care and rehabilitation for persons with disability is a challenge globally, and in South Africa (Vergunst et al., 2017). This is due to personal, economic and social barriers to access (Robert, Malle, and Marchal, 2017). Persons with disabilities face various barriers such as the lack of physical access and unaffordable costs of the health services (Eide et al., 2015). This results in a decrease in health care use patterns (Cheung et al., 2012). There are numerous studies such as Carol (2012), O'Toole et al., (2009) and Jacobs et al., (2012), which have highlighted barriers to access to health care for persons with disabilities . It is acknowledged that identifying barriers to access for persons with disabilities must be from the perspective of persons with disabilities , who are the utilisers of the health care services, as opposed to the perception of the providers of the health services as this may skew the data (Eide et al., 2015).

Studies in middle-income African countries found four major barriers to access to health for persons with disabilities . These include the lack of geographical access, a lack of transport, a lack of resources such as equipment and medication, as well as high costs of health care (Huot et al., 2019). Another study in Ghana, identified barriers to access for persons with disabilities through focus group discussions with persons with disabilities , and found that health systems in low-income settings face barriers such as the lack of resources, which result in sub minimal quality of care (Ganle, Parker, Fitzpatrick, and Otupiri, 2014) . Furthermore, this study revealed that persons with disabilities experienced more problems with accessing health care. A study conducted by Varela et al., (2019) reviewed access to health care in Malawi, and found that the lack of finances, transport and poor geographic accessibility were barriers to accessing health care.

While these studies provide insight into middle income African countries, it must be noted that there are substantial socio-economic differences between countries leading to variation in perceived barriers from the perspective of persons with disabilities (Harris et al., 2011). Despite disability research in South Africa, most research covers the Western and Eastern Cape provinces, while there are studies yet to be done in Gauteng on this topic as each province has varying contexts (Vergunst, 2016). The study by Vergunst (2016) in a rural area in SA, suggest that persons with disabilities experience more attitudinal, physical and communication barriers when accessing health care. In the South African context, extrinsic socio economic factors play a major role and this is a gap in the research which needs to be further explored (Graham et al., 2010; Mitra et al., 2017). These studies demonstrate how the barriers overlap such as transportation and high costs of health services. As a result of barriers to access to health care for persons with disabilities , non-medical consequences arise. The population of persons with disabilities experience frustration and anger due to multiple barriers to accessing health care. While efforts are being made to reduce the barriers to access, it is important for persons with disabilities who utilise the health services, to be empowered to advocate for themselves in addition to other efforts being made. Moreover, improving access to health care for persons with disabilities , will result in improvements in the quality of general health care systems.

In summary, access to health care comprises of multiple definitions, frameworks and influential factors. It is important to acknowledge that access to health care is a right and not a privilege. The importance of it is seen in the development of the UNCRPD to ensure the rights of persons with disabilities are achieved, as persons with disabilities have been subjected to unfair discrimination and a lack of enforcement of their rights (SAHRC, 2019). This human rights treaty highlights the important role that disability policy and legislation reforms play in ensuring the right to access to health care. These policy reforms are discussed further below.

2.4 HEALTH POLICY AND LEGISLATIVE FRAMEWORKS

In this section of the literature review, health policy is discussed as a tool for advocacy to realise the right of access to health care for persons with disabilities . Health policy reforms will be discussed focusing on the global legislature as well as legislation around disability in South Africa. The literature review section then discusses the policies and documents leading

up to the framework and strategy for disability and rehabilitation (FSDR). This discussion is followed by a description of the links between the FSDR and the concept of access to health care for persons with disabilities . Over time, various policy reforms around disability legislature has occurred such as the United Nations convention on the rights of persons with disability (UNCRPD) and the national rehabilitation policy (2002) in SA (Böheim and Leoni, 2017). These have been to ensure that the rights of persons with disabilities are enforced and fully realised.

2.4.1 **Defining Health Policy**

Health policy refers to the plans and processes undertaken to achieve a society's goals related to health care (WHO, 2018). It includes assessing existing policies and services, identifying ways to reduce the inequalities identified and plan interventions for improvement for access to health care and inclusion of individuals with disabilities. Standards of care, specific to disability, should be established, with adequate mechanisms to enforce it (Navarro,2007). Public health policies work in conjunction with social policies to improve health care systems for general populations. This is bidirectional where the first impact is the reduction of the risk of illness by addressing the social determinants of health. The second way it assists in the improvement of health care, is facilitating the financial access to health care, particularly, for vulnerable populations such as persons with disabilities . In addition to health policies, social protection policies aid in ensuring the financial availability of health (Israel, 2016).

Health policy is multifactorial and influenced by the socio-economic, political and historical background to the contexts it is developed in and applied to. In South Africa, the health care system and health infrastructure have been influenced by previous government systems which dictated the way the health system has evolved. South Africa's history has been affected by racial and gender discrimination based on the effects of previous colonialism, followed by Apartheid. SA faced major challenges in the health care systems post-apartheid and continues to face various issues (Delobelle, 2016). Policies have been developed as a tool to overcome these challenges, however, insufficient focus has been placed on the development of disability policy in the South African legislature to ensure that the rights of persons with disabilities are achieved (Coovadia et al., 2009).

Further factors affect the equity and quality of health systems. A study by Ataguba et al., (2011) reviewed socio-economic related health inequities in SA and this study suggests that

for SA to establish a strong health care system which promotes health equity, it is vital to have sustainable and strategic leadership to guide the processes of policy (Ataguba, Akazili, and Mcintyre, 2011). As part of the process of improving health care systems, health policies are an important tool to ensure the goals of a strong and equitable health system(Skempes, Stucki, and Bickenbach, 2015). However, there are various challenges to policy implementation across different sectors and this has been recognised as a weakness within the health system of SA (Hussey, MacLachlan, and Mji, 2017).

Challenges include resistance to promoting health equity, lack of addressing and removing barriers to access and undermining the quality of care as opposed to improving it (Sanneving et al., 2013). It is important to note that as new policies are developed, they must interact with previous policies under strong leadership. Local leaders are influential in policy development and implementation; hence it is imperative to engage these leaders in research. A gap in the research is identified where there is lack of engagement with policymakers and implementors regarding ensuring access to health care for persons with disabilities specifically (Sanneving et al., 2013; Gilson and Daire, 2014).

2.4.2 Disability Health Legislation

2.4.2.1 International legislature: The provision for disability rights globally

The World Health Organisation emphasizes that disability should be a component in national health policies, through increasing capacity among health service providers and health policymakers (WHO, 2018). The UNCRPD has brought disability rights to a platform where it has been internationally recognised as an enforceable human rights issue (Hussey et al., 2017). It is founded on the principles of the human rights and social model of disability, and focuses on the importance of legislation, and the social environment in enforcing the rights of persons with disabilities (Celik, 2017).

The CRPD encompasses many human rights of persons with disabilities , which includes and focuses on access to health care. Access to health care is amongst the human rights of persons with disabilities which are yet to be enforced in South Africa (Sherry, 2015). As a result of multiple barriers to implementation of the UNCRPD, there has been a lack of compliance hence a lack of reformation of policy to ensure the rights of persons with disabilities are achieved, which falls under an adequate standard of living. In support of this approach, many African countries such as Malawi, Zambia, Ghana and South Africa became signatories to the

UNCRPD. SA is a signatory to the CRPD since 2007, thus has an obligation to develop a policy to enforce the rights of persons with disabilities (Hussey et al, 2016).

Despite being a signatory to the CRPD, the implementation of the rehabilitation and health articles 25 and 26, in SA has not been optimal due to various implementation barriers as shown by Hussey et al., (2017). These barriers include the centrality of attitudinal barriers which then subsequently cause financial, economic, political, physical and health systems barriers. They show that these gaps are a result of poor resource and budget allocation to ensure the implementation is achieved (Hussey, Machlalan and Mji., 2017). In addition, SA has inadequately incorporated the articles of CRPD into its legal framework which reduced the effect that the CRPD was meant to have on disability and rehabilitation in South Africa (Parliamentary Monitoring Group, 2011). As a means of operationalising the CRPD, South Africa developed the FSDR, which is a framework and strategy for disability and rehabilitation services. SA still has a long way to go to achieve compliance through disability policy reform because of barriers which were identified including attitudinal, political and health systems barriers to implementation (Hussey, Machlalan and Mji., 2017).

2.4.2.2 **South African legislature: The provision for disability rights nationally**

In South Africa, public health policy is founded upon the assumption that historical, political and economic factors have resulted in the high prevalence of poverty, especially amongst persons with disabilities (Graham et al., 2010). Following on this point, health legislation in SA has undergone many changes since 1994 to date. When discussing health policy in SA, it is important to note the link between poverty, and how it affects health policy reform for persons with disabilities (Mcintyre and Ataguba, 2009).

The understanding of disability has also evolved. Van De Byl (2014), reviewed disability health policy in SA over a 20-year period between 1994 until 2014. She discusses the culmination of inclusion of persons with disabilities into society and their rights into the constitution in 1996. She then describes The National Disability Strategy (NDS) which was developed in 1997.The NDS was a White Paper which sought to view an all-inclusive society in SA, where the rights of persons with disabilities were enforced and accessibility to rights was at the forefront of the goals (Office on the Status of Disabled Persons, 1997). Van De Byl (2014) then describes the attempts to revise and improve disability legislature between 2001 and 2013. In 2007, SA ratified the UNCRPD and its optional protocol. As an attempt to follow

the mandate of the UNCRPD, as well as work towards the fulfilment of the 2030 vision of South Africa, The Framework and Strategy for Disability and Rehabilitation (FSDR) was developed for 2015 until 2020. The table below gives an overview of the build-up of the South African legislation which lead to the eventual formulation of the FSDR.

Table 2.1: Table Showing the Overview of Legislation Leading up to the FSDR

Title of Legislation	Regulatory Body	Date Published	Description
Universal declaration of Human Rights	United Nations	1948	Articulated all the rights which every human being is equally entitled to.
Integrated National Disability Strategy White Paper	Office of the Deputy President, South Africa	1997	Vision of inclusive society for all with disability issues integrated into all government strategies and efforts.
National Rehabilitation Policy	Ministry of Health, South Africa	2000	Aims to ensure the right to access to health care through improving access to rehabilitation services.
United Nations Convention on The Rights of Persons with disabilities (UNCRPD)	United Nations	2006	International human rights treaty aimed at protecting and promoting the rights of PERSONS WITH DISABILITIES .
Disability Framework for local government	Department of provincial and local government, South Africa	2009	Aimed to support local government departments with the implementation of The Integrated National Disability Strategy (INDS)
Disability and the ICT strategy	Department of Communications, South Africa	2013	Outlined a systematic approach to mainstream disability in the field of information and communication technologies (ICT).
Framework and Strategy for Disability and Rehabilitation (FSDR)	Ministry of Health, South Africa	2015-2020	Aimed at ensuring service provision of disability and rehabilitation services at all levels

2.4.2.3 **The framework and strategy for disability and rehabilitation (FSDR)**

The FSDR outlines the disability and rehabilitation services in South Africa to facilitate better access to health care. It advocates for community-based rehabilitation (CBR); which is “a strategy within community development for the rehabilitation, equalization of opportunities, poverty reduction and social integration of people with disabilities” (World Health Organization, 2004, p. 2). Access to health forms a main component of the CBR matrix, with five subdivisions namely, health promotion, prevention, medical care, rehabilitation services and assistive devices (United Nations, 2010).

To better understand disability health policy and its implications, the process of health policy analysis has been developed and established to critically analyse these documents. This is discussed further in the section below.

2.5 HEALTH POLICY ANALYSIS

The above section has described, in detail, the health policy reforms by defining it and giving a timeline of the various global and national policy reforms which have occurred. The next section focuses on methods of analysing these policy and legislative documents through methods such as a document review. These form part of the methodological considerations of this study, which is discussed further below.

2.5.1 Methodological Considerations

This literature review also discusses the support of the methodologies used in this study, namely a document review as well as Key informant interviews. This study used document review as part of the policy analysis to review the disability framework and strategy in South Africa related to access to health care for persons with disabilities .

Health policy analysis refers to the holistic approach used in evaluating and assessing public policy documents, which explains the interactions between the policy processes and other contributing factors such as institutions and stakeholders (Walt at al., 2008). It is a systematic way to study how factors such as actors, impact on the way public policy is developed, implemented and evaluated (Lehmann, 2016). The value of doing a health policy analysis is that it provides a conclusive framework for facilitating health reform as opposed to approaches which focus only on the technicality of content reform in the policy (Walt and Gilson, 1994). Health policy analysis is central to health systems research and is a technical tool which underpins the development of new and improved policies (Gilson, 2012).

2.5.2 Health Policy Analysis Frameworks

Health policy analysis is done using established conceptual frameworks which analyse public policy by focusing on various factors and their interactions. An overview of the steps taken to conduct policy analysis includes defining the problem initially, establishing evaluation criteria

through a framework, critically analyse the policy through the dimensions of the framework, and then monitoring the outcomes of the policy (Patton et al., 2012).

There are multiple policy analysis frameworks and tools which are utilised in the process of policy analysis. An example of such a framework is the Institutional Analysis and Development (IAD) Framework developed by Aligica (2006). It looks at the social action arena as the main focus of public policy and research. The focus of examining and mapping the action arena, is to analyse the interactions between the actors and the action situation component, with the final analysis being on the outcomes of the public policy as a result of these interactions(Aligica, 2014). While it is important to analyse the interactions between the actors and the actions of a policy, we did not include this framework in this study as it does not focus on other contributing factors such as context.

Another example of a framework for policy analysis is the contemporary model developed specifically for disability policy analysis by Wilson and Depoy (2018). It is a conceptual framework which is expansive, with the focus being on explanatory legitimacy to analyse policy on disability, by viewing the process as being pivoted around an axis (Wilson and Depoy, 2018). While the focus of this model is on the end-users of disability policy such as persons with disabilities , it does not fully encompass the analysis of the other factors which impact on health policy such as the stakeholders in the processes of the policy as well as the context of the policy, hence this model has not been used in this study.

Before the development of this conceptual framework, Wilson (2014) developed the Disability and Inclusion Based Policy Analysis (DIBPA) model. This refers to a policy process that was designed to assist policy analysts to conclusively evaluate policy centred around disability. It identifies the main factors which have major policy implications such as socio-economic factors, as well as the processes of policy development and implementation. While this is an inclusive model, it does not focus on the role of the actors in the policy and the interactions between the policy factors.

2.5.2.1 **The Walt and Gilson (1994) health policy analysis triangle framework**

Another extensive and established framework for policy analysis is the Triangle Framework for health policy analysis developed by Walt and Gilson (1994). It is closer to political approaches but it also includes other disciplines (Walt and Gilson, 1994). This framework

was developed in an attempt to improve the then-current frameworks which excluded the factors which extend beyond the policy content. It is a simplified way of analysing and understanding complex components and relationships in the process of policy analysis (Buse et al., 2005).

For this study, the Walt and Gilson (1994) Health Policy Analysis Triangle Framework has been selected for the review of the FSDR. This is because it emphasizes the importance of going beyond the content of the policy, to include the context, actors and policy processes and how they interact to influence policy (Sanneving et al., 2013). It then triangulates the components to help the policy analyst in understanding how these interactions impact health policy (Walt and Gilson, 1994). This framework has influenced an array of public health issues ranging from mental health to reproductive health and has been utilised effectively in many African countries including South Africa (Ditlopo, 2018; Mukanu et al., 2017; Faraji et al.,2015, Osore, 2015; Mannan at el., 2012; Gilson and Raphaely, 2007).

The next section explains the Walt and Gilson (1994) Health Policy Analysis Triangle Framework components of the triangle framework as well as the factors influencing these components namely: actors, content, context and processes of the policy and the interactions between these components.

2.5.2.1.1 Actors

Actors refer to the key stakeholders involved in the processes of the policy from development, implementation and monitoring and evaluation. This includes the state, the public and individuals that impact on policy (Buse et al., 2005). Not only does it focus on the actors but factors which affect the actors such as the position of power, value systems, personal and public interests, as well as their roles and responsibilities (Ditlopo, 2016). The resulting public policies are dependent on the power dynamics of and between the various actors involved in the processes of a policy (Buse et al., 2005). Other factors influencing the actors in public policy include the influence of the political context on the actors Dayal (2010) and the level of understanding of policy by the actors (Lorenzo, 2010).

When analysing actors, it is important to understand the dynamics of the actors and their level of importance of influence in impacting the policy. This is referred to as stakeholder analysis, where identifying the role of the stakeholder is important. This includes analysing if the actor

is low or high-priority, and whether they are advocate stakeholders or antagonistic stakeholders. While it is important to understand the impact of the actors in health policy, it is equally important to analyse the contextual factors which have public health policy implications.

2.5.2.1.2 Context

The role of contextual factors in public policy is not to be understated. The context is made up of subcomponents namely structural, situational, cultural and exogenous factors which pervade public policy (Walt and Gilson, 1994). Ditlopo (2016), explains each of the subcomponents as seen below. Situational context refers to the conditions in the context both past and present which impact public policy reforms. Structural context refers to the state and circumstances in society that are characterised by politics and economics. Cultural context includes the value system and commitments of a society in which the policy processes occur.

2.5.2.1.3 Content

Content speaks to the policy goals, the actual design of the policy and the nature of the policy reform. It also includes the interactions between the health policy and policies from other relevant disciplines as well as guidelines for the process of policy implementation (Ditlopo, 2016). The concepts developed in the content of a policy stem from political, economic and social science influences (Walt and Gilson, 1994). The content of disability health policy is also affected by the understanding of the health issues addressed. Lorenzo (2010), describes how the evolution in understanding rehabilitation as a circular process as opposed to a vertical process, has helped to shape the content of disability-related health policy.

2.6.1.3.4 Processes

Policy processes refer to the various steps taken to develop, implement and monitor public health disability policy. The first part of the policy process is to understand how the health or disability issues reach the agenda for policy reforms and once they reach there, how they are dealt with and reflected in health and disability policy (Buse et al., 2005). From 1991, Grindle and Thomas showed the value of including policy processes in policy analysis, in order to understand how policies are developed and influenced. Based on this, Walt and Gilson (1994) included processes in the triangle framework looking at the range of processes from development, to implementation to monitoring and evaluation. The processes include the timing of the policy, the strategies used to fulfil the processes, as well as the mechanisms

utilised to move forward in achieving the policy goals (Ditlopo, 2018). Furthermore, the analysis of the policy processes can be utilised to support policy change (Walt, Shiffman, Schneider, Murray, and Brugha, 2008).

The initial process of policy is the information for policy. This refers to the data collection and analysis to assist with decisions in the policy. Part of this step is policy advocacy which is to use the data analysis and information collected to argue the importance for a health or disability policy to be developed and followed through upon (De Coning, 1995). De Coning (1995) continues to explain that after policy initiation, the policy design process takes place where there is an agreement on the process and agenda-setting. The next step is policy formulation where the format is reported and confirmed on through consensus of stakeholders. Following this, he describes policy implementation as the strategy to achieve the goals of the policy. Dye (2013), describes the implementation of policy as the process of assigning new responsibilities to existing organisations and carrying out activities to enact the policy from the legislative branch. The last step of policy analysis is the monitoring and evaluation of the policy through the use of the objectives and indicators. The whole process of policies can either be a top-down or bottom-up approach. The whole process of policies can either be a top-down or bottom-up approach based on different community development paradigms and power dynamics.

Top-Down versus Bottom-Up Approach

The top-down approach refers to a structured system of power and control, followed by commands from stakeholders in positions of power. It as the authoritative decision where the central actors are recognised as the most relevant to the policy (Matland, 1995). It excludes the process of consultation before decision making and focuses on certain actors in particular (Liedl, 2011). Because this approach doesn't involve stakeholder participation and is less empowering it not a preferred approach to the public policy process compared to the bottom-up approach. The bottom-up approach is the process where end-users of the policy are acknowledged to play a major role in the implementation of the policy, hence, service deliverers are the stakeholders that initiate and guide the policy (Political Pipeline, 2013). This is where local organisations on the ground identify problems and develop guidelines which they implement. This approach allows the implementers to form and impose their opinions on policy (Liedl, 2011).

The processes of public policy are affected by various contextual factors. An influential factor in policy processes is legislation and treaties. This includes other global and national policies and treaties which mandate the development and implementation of certain policies. An example of this is shown by Lorenzo (2010), where globally, The United Nations Convention of the rights of persons with disabilities (UNCRPD) informs the processes within public health and disability policy in South Africa and mandates its signatories such as South Africa to have disability legislation in place to uphold the rights of persons with disabilities . Secondly, the level of awareness amongst the actors regarding disability policy affect the development and implementation processes (Dayal, 2010, Lorenzo,2010).

Barriers to implementation include attitude barriers as a central factor to the other barriers such as political and financial barriers, physical and communication barriers as well as health system barriers (Hussey et al 2017). Other factors that can hinder the implementation process of a policy include political influences from external bodies such as disability rights activist groups; lack of intersectoral collaboration and coordination (Hogwood and Gunn, 1984. Lastly, monitoring and evaluation is also affected by various factors such as poor budget allocation, limited resources and weak institutional capacity (Callistus and Clinton 2016). The above section has discussed health policy analysis by highlighting the methodologies used to achieve it, as well as various frameworks which have been developed for it. It has been shown that the Walt and Gilson (1994) Health Policy Analysis Triangle Framework has been selected, and the various components have been discussed in-depth, as well as the factors which affect the components.

2.6 CONCLUSION: CHAPTER 2

This review comprised of a detailed search of the literature around disability, models of disability and factors affecting disability; health policy reforms as well as its analysis; access to health for persons with disabilities and its factors; and the disability strategy and framework in South Africa (SA).The multidimensional relationship between access to health care and disability; provision for the right to access health care; health policy as a tool to ensure the realisation of the right to access to health care; and the FSDR in SA which is reviewed. This chapter has shown that access to health care is a right and is yet to be fully achieved for persons with disabilities . However, health policy is a means of ensuring the rights of persons with disabilities are upheld and an example of such documentation is the FSDR, which this study

seeks to analyse. Chapter three will outline the methodology used to address the aim of the study.

CHAPTER 3

3. METHODOLOGY

3.1 INTRODUCTION

This chapter entails the details of the methodology for this study. An outline of this chapter includes the study objectives, study design, study setting, study population and sampling, data collection, data analysis, strategies to ensure trustworthiness and ethical considerations.

3.2 AIM OF THE STUDY

To review the framework and strategy for disability and rehabilitation in South Africa

3.3 RESEARCH QUESTION

What is the status of the South African Framework and Strategy for Disability and Rehabilitation (FSDR), in relation to enhancing access to rehabilitation services for persons with disabilities (PERSONS WITH DISABILITIES s)?

3.4 OBJECTIVES OF THE STUDY

- To identify key-role players in the conceptualisation, development and implementation processes of the framework and strategy for disability and rehabilitation (FSDR) in South Africa (SA), related to access to health care for persons with disability (PERSONS WITH DISABILITIES)
- To describe the content of the FSDR in SA
- To describe the context of the FSDR in SA
- To determine the processes of the FSDR in SA, related to access to health care for persons with disability
- To describe factors affecting the processes of the disability framework and strategy in South Africa, related to access to health care for persons with disability

3.5 STUDY DESIGN

This study undertook a qualitative case study design as this design is a valuable tool to explore complex issues (Tetnowski, 2015). A qualitative descriptive case study design seeks to describe a phenomenon and the realistic context in which it occurred (Baxter & Jack, 2010).

This descriptive case study included an exploratory design because the researcher wanted to explore the issue around access to disability and rehabilitation services (Kaur, Singh & Sharma, 2020).

A case study is defined as an intensive systematic study, which investigates a single unit, where the researcher does an in-depth analysis of data related to the unit (Heale and Twycross, 2018). This is an appropriate study design as this study explored access to health care for persons with disabilities through a document review of the Framework and Strategy for Disability and Rehabilitation (FSDR) and the Key informant interviews with key role-players. The overview of this study for each objective, study design, data collection and analysis are outlined in table 3.1 below:

Table 3.1: Table Showing the Outline of the Study

Objectives	Key-Role Players	Content	Context	Processes	Factors
Data Needed	Roles and responsibilities of key stakeholders	Components of the FSDR	Why it came about, SA context of disability	Experiences of key stakeholders in the processes (development, implementation and monitoring and evaluation)	Barriers and facilitators affecting the processes (development and monitoring and evaluation)
Study Design - Descriptive and exploratory	Key informant Interviews Document review	Document review	Document review Key informant interviews	Document review Key informant interviews	Key informant interviews
Data Source	Key Stakeholders Health professionals working with PERSONS WITH DISABILITIES	FSDR document	Key stakeholders in the processed of the FSDR Health	FSDR document Key stakeholders Health professionals working with PERSONS WITH DISABILITIES	Stakeholders from Gauteng Department of health and Johannesburg Metropolitan district, professional organisation

3.6 STUDY CONCEPTUAL FRAMEWORK

This study used two conceptual frameworks namely the Walt and Gilson (1994) policy analysis framework (Figure 3.1) and the Penchansky and Thomas (1981) theory of access.

3.6.1 The Walt and Gilson (1994) Health Policy Analysis Triangle Framework

The Walt and Gilson Health Policy Analysis Triangle Framework is a triangular descriptive tool for the policy analysis methodology that places emphasis on a holistic approach to policy analysis. This extends beyond content analysis, by including the interactions between the

different aspects of policy, and how these interactions affect the shape of the policy and its processes (Sanneving et al., 2013; Walt and Gilson, 1994).The advantage of utilising this framework is that it was developed with the understanding that there was a lack of frameworks to analyse public policy in developing countries (Walt et al., 2008). Therefore this framework will be an appropriate tool to be used in the South African context (Walt et al., 2008). In this study, the Walt and Gilson policy analysis framework was used as a conceptual framework to identify the actors, context, content, processes and explore factors that influence FSDR policy making.

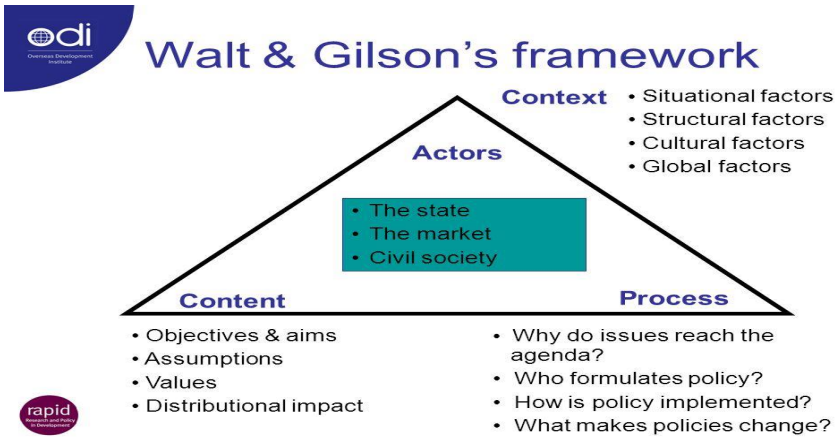


Figure 3.1: The Walt and Gilson (1994) Health Policy Analysis Triangle Framework

Table 3.2: Operational Definitions for the Components of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework

THEME	OPERATIONAL DEFINITION
Actors	Individuals involved in the processes of the FSDR (development, implementation, MandE, and the end users)
Development	Individuals involved in the conceptualization, development and drafting of FSDR
Implementation	Individuals involved in the implementation of the FSDR at departmental and clinical levels
End Users	Individuals utilizing the FSDR post implementation
Context	The reasons why the FSDR was developed and preluding factors which lead to the development of the FSDR **Structural Context** Structure of the health care system in South Africa, ranging from primary health care to super specialised hospitals, including referral pathways **Situational Context** Socio-economic status of South Africa, the health system and the patient, including the cycle of poverty and disability. **Cultural Context** Cultural and religious beliefs of the patient and surrounding community and alternate therapies including traditional healers

Content	What makes up the FSDR and how it relates to access to health care for PERSONS WITH DISABILITIES
Processes	Subdivisions of access to healthcare: accessibility, affordability, acceptability, accommodation and availability The steps taken to develop, implement and monitor and evaluate the FSDR

3.6.2 Penchansky and Thomas (1981) Theory of Access

Theory of access describes access to health care as multifactorial and is viewed as the fit between the patient and the system of health care in relation to accessibility, acceptability, affordability, accommodation and availability (Penchansky and Thomas, 1981).



Figure 3.2: Figure Showing the Five Components of Access to Health Care Developed by Penchansky and Thomas (1981)

Image credit: UKIT (2020)

3.7 STUDY SETTING

The study was based in the Johannesburg Metropolitan District, Gauteng province South Africa. Gauteng is one of the most populated provinces in South Africa, with the prevalence of disability estimated to be 3.5 % of the general population and 21% of the total number of persons with disability in SA (Statistics SA, 2017). The study setting included the National Department of Health, Gauteng Provincial Department of Health, Johannesburg Metropolitan District, as well as a major hospital and primary health care facility in the district.

3.8 DATA SOURCES

The study utilised two data sources namely, the FSDR document (Appendix 10) and the key actors. The FSDR is a framework and strategy developed to address access to health care for persons with disabilities . It aims to improve rehabilitation service provision for persons with disabilities at all levels of care. This document was chosen as it is the most recently developed disability framework and strategy in SA, and it expires in 2020, where no analysis of the document has been done yet.

3.9 STUDY PARTICIPANTS (Key Role Players)

The population of a study refers to the set of participants who have the similar characteristics which enable them to be included in the study according to the selection criteria. For qualitative research, these participants provide their experience and insight into the research question (Majid, 2018). Study participants were individuals from the Gauteng Department of Health, presidents and members of professional associations and non-profit organisations for disability and rehabilitation as well as disability persons organisations (DPOs).

Sampling approach: This study utilised a purposive and snowball sampling approach. The purposive sampling technique is a tool used to deliberately select informants due to the knowledge and experience of the informant that will enable them to answer the research question of the study (Dolores & Tongco, 2007). The study participants were defined as members in the field of interest who are knowledgeable on the unit being studied and are identified as key informants (Bernard, 2002). A purposive sampling approach is effective and reliable for studies associated with policies and frameworks and is demonstrated below in figure 1 (Dolores and Tongco, 2007).

Snowball sampling refers to the researcher being referred to another interview participant from a purposively sampled participant, often identified as an index participant (Biernacki and Waldorf, 1981). From the key informants identified through purposive sampling, other participants, referred to as index participants, were identified through snowball sampling. Snowball sampling is the process of selection through the utilisation of networks. Key informants identified through purposive sampling directed the researcher to other individuals who were actors in the FSDR (Etikan & Bala, 2017).

3.10 INCLUSION CRITERIA

The following study participants were identified as key informants through purposive sampling, and were approached for participation in this study:

- The rehabilitation services manager for Gauteng and cluster managers
- The Johannesburg Metropolitan District rehabilitation managers and chief therapists
- Presidents of the professional bodies in the various allied disciplines

The purposively sampled key informants above referred the principle investigator to other relevant individuals who were able to contribute to the study. These index participants identified through snowball sampling is seen below:

- Professional liaison for professional body one (SASP)
- Presidents of the 2 non-governmental organisations (DART and Rure SA)
- Clinical head of department at a Gauteng health facility

Participant exclusion criteria: Any participants who were identified and approached through purposive and snowball sampling and did not give consent to the interview.

3.11 DATA COLLECTION PROCEDURES

The document review and key informant interviews were conducted. These two sources brought a diverse range of information around the topic of this study. The document review provided in depth information into the FSDR content, whereas the Key informant interviews provided more in-depth information on the FSDR and filled gaps, which occurred from the document review.

This study used two methods of data collection namely, a document review and Key informant interviews to address the above stated objectives.

3.11.1 Document Review

A document review of the FSDR was conducted to identify the key role players, content, processes and the context. A document review is a systematic method for the review and evaluation of public and private documents (Rapley, 2007). . In general, it is important that the data in the review must be examined and interpreted to give meaning to the findings. The analytic procedure of a document review of the FSDR includes appraising and synthesizing the data collected from the document (Bowen and Glenn, 2009). It is an appropriate data

collection method to extract and interpret valuable data from the policy document in order to draw meaningful information related to the research problem (Merriam, 1988). The analytic procedure a document review includes appraising and synthesizing the data collected from the document (Bowen and Glenn, 2009).

A document review guide was developed using the concepts of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework, which served as themes for reviewing and analysing the FSDR (Appendix 1). To ensure rigor, as seen by Saldhana (2009), the framework components were operationally defined specifically for the study and this was utilised in the coding manual developed by the researcher and two supervisors, as part of collaborative coding. The document review guide was piloted on the FSDR by the principal researcher and the supervisors separately to identify the FSDR processes as per the outlined objectives. The recommendations post pilot phase was discussed and incorporated in the actual document review guide. This is seen in the figure below.

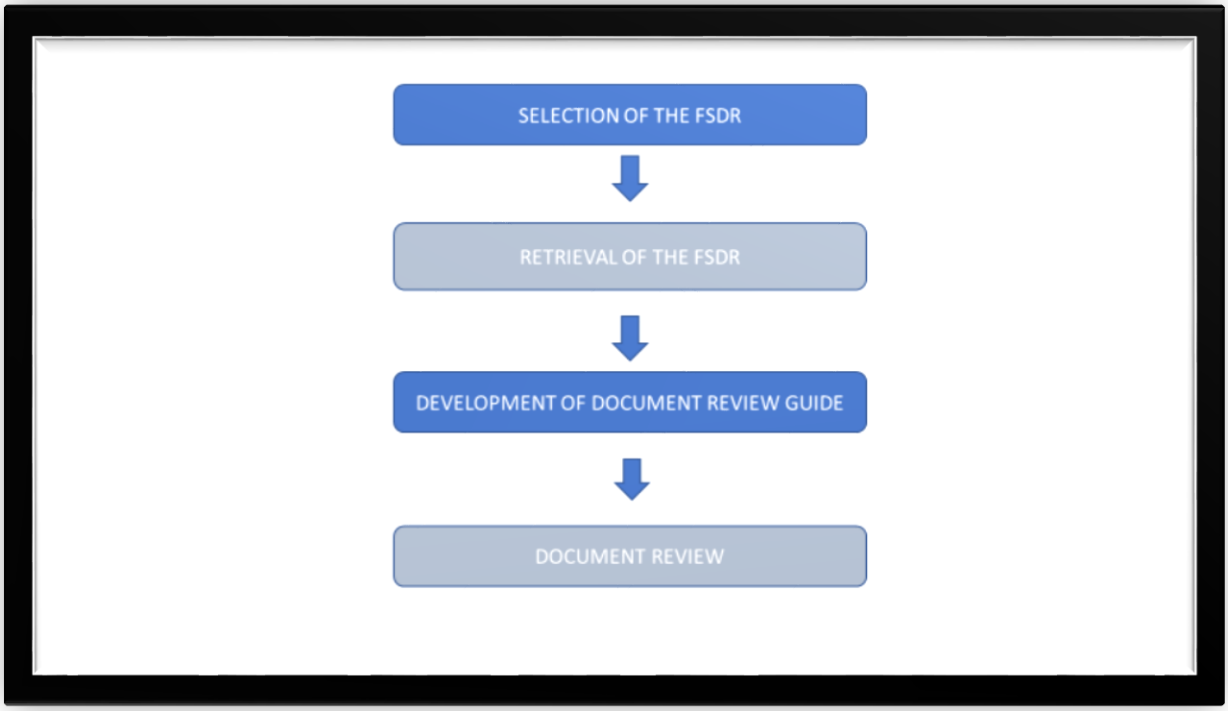


Figure 3.3: Figure Showing an Overview of the Document Review Procedure

The following steps were carried out during the document review:

- The FSDR was read line by line by the principal researcher to identify the processes of the FSDR. Thematic analysis was used to categorize the different processes according to the markers of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework.

- An external coder conducted the coding of the FSDR document and responses were compared.
- MAXQDA version 2018.02, a qualitative data management software was used to code the FSDR document. The content component zoomed into access to health care, informed by the theory of access, as this is the focus of this study (Saurman, 2015).
- A pilot document review was done by the researcher and two supervisors, following this, findings and changes were considered during the main study.

3.11.2 **Interviews with Role Players**

This study conducted qualitative semi-structured interviews. This type of qualitative interview enabled the researcher to obtain the experiences, feelings, and opinions of the study participants (Kaae et al., 2016). Prior to conducting the Key informant interviews, the researcher developed an interview guide (Appendix 5) to ensure that the process of the Key informant interviews was concise, systematic and in line with the study objectives (see Appendix 5). The interview guide was developed by the researcher, discussed with two additional researchers, and where discrepancies arose, consensus was reached between the three researchers and the interview guide was revised and finalised. In addition, the interview guide was informed by the Walt and Gilson (1994) Health Policy Analysis Triangle Framework subdivisions namely the actors of the policy, content, context and processes.

Data collection commenced as soon after ethical clearance was received from the Medical Human Research Ethics committee at the University of the Witwatersrand and permission from the Gauteng department of health was granted. The Key informant interviews were conducted because this enabled the researcher to explore the experiences, feelings, and opinions of the study participants on the study phenomenon (Kaae et al., 2016).

3.11.2.1 **Pilot study for the interviews**

A pilot study with one of the interview participants was conducted to familiarise the researcher with the process of the Key informant interviews, the audio recordings, transcription as well as the process of data collection and analysis (Van Teijlngen & Hundley, 2002).

The participant was given information on the study and informed consent was sought. The interview was conducted, and audio recorded using a mobile audio recorder. Upon completion of the pilot study, the researcher transcribed the interview and discussed the experience with

the two other researchers involved in this study. There were only slight recommendations and adjustments hence the data collected from the pilot study has been included in the final data set of this study.

Upon completion of the pilot study, the rest of the participants were contacted via email and telephonic communication. Participants who consented were included in the study. the researcher familiarised the participant with an overview of the interview questions and completed demographic information survey.

Most of the Key informant interviews were conducted in person, face to face. In three cases, participants were unavailable for a face to face interview, hence Skype video call interviews were conducted in the same manner as the face to face interviews. The Key informant interviews were conducted until data saturation was reached. Data saturation is described as the point where repetition occurs in the interviews, hence no new themes or points of interest arise in the interviews and where interviewees express similar experiences (Guest, et al., 2006).

3.12 DATA ANALYSIS

Due to the study design used in this study, qualitative case study analysis of the data is an important process to ensuring accurate and reliable results, as in-depth descriptions of how the data was analysed ensures rigour in reporting the qualitative research (Houhgton et al., 2014). All the Key informant interviews were transcribed verbatim and rechecked against the original recordings. All the transcripts were read and cleaned for errors in grammar or miswording. Memos were added to the transcripts as the transcripts were read. The transcripts were uploaded on, MAXQDA version 2018.2 which is a software for data management and coding.

This study utilised thematic analysis to analyse the data from the Key informant interviews. Thematic analysis is deemed accessible and flexible in the approach to the analysis of qualitative data (Braun and Clarke 2006). It is effective in reflecting the reality and unravelling what is beneath the surface. Thematic analysis is not bound to any standardized framework which allows for flexibility in applying to this study. To provide a rich thematic description of the data set, the researcher identified various themes and coded it accordingly. Braun and Clarke (2006), suggest that this is a useful method in studies where the perspective of the

interviewee is unknown. In the case of this study it is appropriate because the FSDR has not been evaluated nor have key role-players been interviewed regarding the FSDR.

The following steps were followed during thematic analysis:
The researcher searched for broader memos in the transcripts. From the broad memos, the researcher then sorted the memos into different codes. The codes were then categorised into categories and finally, the categories were put into themes (Hsieh et al., 2005). The next phase was to review the themes and identify overlapping themes which was then collated into more specific themes (Erlingsson and Brysiewicz, 2017). The above process of coding and identifying themes was done, reviewed, and redone to ensure no information was missed during the data analysis process.

3.13 TRUSTWORTHINESS STRATEGIES

The trustworthiness regarding qualitative research is implemented four different strategies (Guba and Lincoln, 1994). These strategies are seen in the table below. Additional to these strategies, is reflexivity which was a result of the researcher being a physiotherapist with experience in working with persons with disabilities . Reflexivity refers to the role of the researchers experience in conducting qualitative research where the researcher relates to the interview participants. A benefit of this strategy is that participants are more likely to fully express themselves due to the shared understanding and experience between the researcher and participant (Berger, 2015). Subjectivity may have also played a role in the interpretation of the findings based on the researcher's experience (Palaganas et al., 2017).

Credibility	:	Credibility is considered the most important criterion because it requires the researcher to make a clear link between the study findings and the reality to demonstrate the truth of the findings (Marshal and Rossman, 1995). Two techniques were utilized to achieve credibility namely, triangulation and member checking. Triangulation refers to the use of two or more data collection methods, as discussed below.

Triangulation of Results : Triangulation refers to the use of two or more data collection methods, as discussed above. Due to the utilisation of two data collection methods, this study triangulated the data from the results of both methods. This was to allow the researcher to tie the loose ends on the data and draw conclusions from the results of the interactions of the two data collection methods (Flick, Hirseland and Hans, 2019). Upon completion of both the document review and the Key informant interviews, the researcher triangulated the data from the results of both data collection methods. The triangulation of data enabled the researcher to view the results and analyse the data from a birds-eye view to ensure the holistic approach to the data analysis. This was also done to ensure the trustworthiness of the study.

Transferability : This refers to the ability of the findings of a study, to be applied to different contexts and situations (Anney, 2014). In this study, the researcher described in detail the study boundaries by stipulating the individuals who were included in the Key informant interviews, the data collection methods as well as the period of data collection (Cole and Gardner, 1979).

Dependability : The dependability of this study refers to the ability of the results to be repeated if the same study design and participants were used. In this study, in depth descriptions of the data collection methods were documented, ensuring no steps were missed out.

Confirmability : This refers to steps taken to ensure that the study findings correspond with the interview participant's experiences, as well as where another study can confirm the findings, if it were to be repeated with the participants (Leonard, 2005). It is also imperative that the researcher admits their own predispositions. This study utilized the reflective commentary from the reflective journal, in-depth descriptions of the methodologies used and the use of co-coders who were the two supervisors. During the process of the Key informant interviews, the researcher documented their experiences in a reflective journal. The reflective journal was started from the pilot study, to include the experiences of the pilot study and recommendations for the remaining interviews. Items included in the reflective journal were the environment the interview was conducted in, notes on the body language and pauses of the interview participants. This also contributes to the trustworthiness of the study and allows the researcher to reflect on their data collection methods and look for ways to improve the next process.

3.12 ETHICAL CONSIDERATIONS

The ethical considerations of research in health care are imperative to ensure best practice principles are implemented and that the rights of participants are upheld (Parker and Bull, 2011). Pratt et al., (2017), discuss the importance of ethics in public policy research where the emphasis of the research should be to aim to reduce health desparities while protecting the rights of participants. Ethical clearance was granted by the Medical Human Ethics Research Committee of the University of the Witwatersrand (M190438) (Appendix 1). The research protocol was registered on the National Health Research Database. A permission letter (Appendix 10) to conduct research in the Gauteng Department of Health was submitted and permission was then granted (Appendix 2) (GP_201905_45). Study participants were approached for participation, the study was explained to the participants in an information sheet and written informed consent was obtained (Appendix 8). Separate written informed consent for the audio recordings was obtained (Appendix 9) (Al-Yateem, 2012).

Confidentiality was maintained by allocating a number to each interview participant to ensure that no reference is made to their name from the transcription and the write-up. All the interviews audio recordings were stored in a secured folder and saved according to identifier codes. Transcripts were saved according to the participant number in a private folder, which the researcher had exclusive access to. This was all done to ensure the confidentiality of this study.

3.13 CONCLUSION: CHAPTER 3

This chapter outlined the methodology the study followed to address the study objectives. The next chapter will present the results of the study.

CHAPTER 4

4. FINDINGS

4.1 INTRODUCTION

This chapter presents the findings from the two distinct related data sources utilised in the study, namely the document review and the Key informant interviews. The findings are presented according to the objectives of the study, which are listed below:

- To identify key-role players in the conceptualisation, development and implementation processes of the framework and strategy for disability and rehabilitation (FSDR) in South Africa (SA), related to access to health care for persons with disability (PERSONS WITH DISABILITIES)
- To describe the content of the FSDR in SA, related to access to health care for PERSONS WITH DISABILITIES
- To describe the context of the FSDR in SA, related to access to health care for persons with disability
- To determine the processes of the FSDR in SA, related to access to health care for persons with disability
- To describe factors influencing the processes of the disability framework and strategy in South Africa, related to access to health care for persons with disability

4.2 OVERVIEW OF FINDINGS

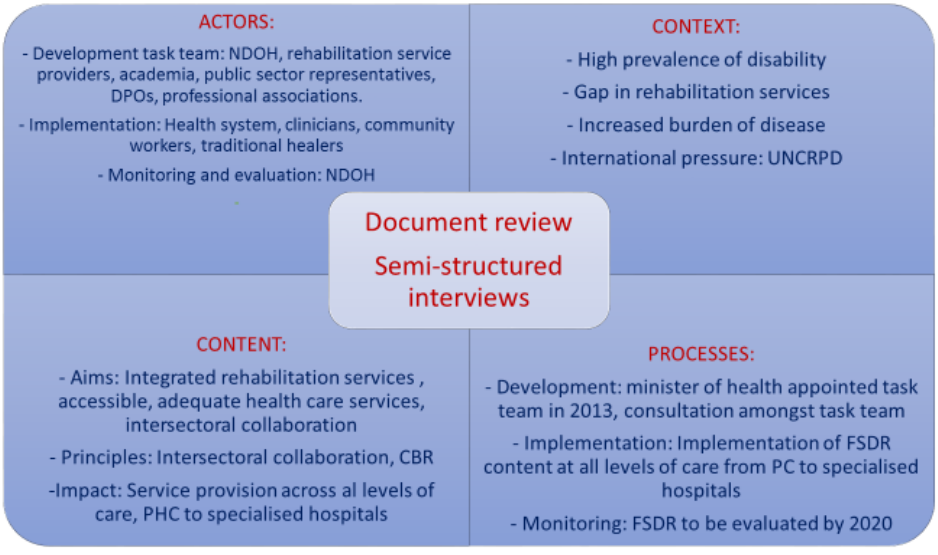


Figure 4.1: Overview of Findings

Table 4.1: Demographic Information of Key Informants

Participant Number	1	2	3	4	5	6	7	8	9	10	11	12
Gender	F	F	F	F	F	M	F	F	M	F	F	F
Level of Education	BA, M(log)	PhD	BA	BSc (PT)	BSc	PhD	Dip (PT)	BSc	BSc	BSc	BSc, Dip	PhD
Sector	Professional association and private sector	Academia	Central Hospital	Central Hospital	NGO	Professional association and academia	Professional association	GDOH	NDOH	GDOH-JHB Metro district	GDOH-JHB Metro district	GDOH-CHBAH

Descriptor for the above demographic profile

The key informants were professionals registered with the Health Professionals Council of SA (HPCSA) who work in both the public (8 participants) and private sectors (4 participants). The above table shows the sector in which they are employed since the inception of the FSDR. Participants were primarily female, and the level of education ranged from undergraduate (8 participants) to post graduate (4 participants). Most of the participants (9 participants) are in influential positions in their departments and associations and most of them were in these positions at the time of the development of the FSDR.

The findings of the actors and their roles; content, context, processes and factors influencing the FSDR, is presented below.

4.2.1 Actors of the FSDR

There was a range of actors who were involved in the conceptualisation, development, implementation and monitoring of the FSDR framework. The study findings reveal that each role player was assigned specific roles during the processes of the FSDR. Some role players were involved across all processes, and in other cases, certain role players were involved in only one or two processes. The table (4.2) below shows the actors and their roles and responsibilities during the development, implementation and monitoring and evaluation of the FSDR.

Table 4.2: Actors from the Public Health Sector and Private Health Sector and Their Roles

ACTORS	FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM THE KEY INFORMANT INTERVIEWS		
	Roles			Quotes		
	Development	Implementation	Mand E	Development	Implementation	Monitoring and Evaluation
NDOH Rehabilitation Manager	Development of the conceptual framework of the FSDR Drafting of the document, get input from stakeholders and finalise the document. Final editorial drafts and publishing of the FSDR.	Implementation of FSDR in all provinces, by provincial managers under National Health Department o	**X**	*"I became the secretariat for the Task Team. was responsible for organising meetings and recording meetings half the meetings I also facilitate. So, I would play you know both roles of facilitating and secretariat." (Participant#9)*	*"I had the responsibility to facilitate implementation." (Participant#9)* *"I have personally gone to Limpopo North West to do training and North West wanted to have another follow-up training with the senior managers." (Participant#9)*	*"I'm essentially the only one involved in MandE. "(Participant#9*)
NDOH Consultant	Development of the conceptual framework of the FSDR	**X**	**X**	**X**	**X**	*"…when there was an opportunity to have somebody (NDOH consultant) on contract, that person was then given the role of doing MandE (monitoring and evaluation) for FSDR implementation." (Participant#9)*
Private Hospital Groups	**X**	**X**	**X**	*"we also had representation from the private hospital groups. Was part of the task team." (Participant#9)*	**X**	**X**
Traditional Healers	**X**	Community workers and traditional healers to implement FSDR in communities to create awareness	**X**	**X**	**X**	**X**

Table 4.3: Actors from the Health Care System and their Roles

ACTORS	FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM THE KEY INFORMANT INTERVIEWS		
	Roles			Quotes		
	Development	**Implementation**	**Monitoring**	**Development**	**Implementation**	**Monitoring and Evaluation**
Provincial Rehabilitation Coordinators	Provision of inputs	Health care providers to implement the FSDR at all levels of care (primary health care to specialised health care)	Monitor and evaluate rehabilitation services at clinical and community levels	*"…look there is Rehab Coordinators in each Province. We were all invited to a meeting at National (to give inputs)." (Participant#8)*	*"…primarily Provincial coordinators were tasked with the implementation." (Participant#9)*	*"Provinces you know the Provincial Offices are also expected to do MandE."(Participant#9)*
Clinicians	**X**	Health care providers to implement the FSDR at all levels of care Clinicians to utilise the FSDR in daily care of PERSONS WITH DISABILITIES	Monitor and evaluate rehabilitation services at clinical and community levels	**X**	*"we looked at how we could use that (FSDR) in our context, and implement what was recommended in our context… "(Participant#10)*	**X**
Community Health Workers	**X**	Community workers and traditional healers to implement FSDR in communities to create awareness	**X**	**X**	**X**	**X**

Table 4.4: Actors from the Associations, Community Organizations, and their Roles

ACTORS	FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM THE KEY INFORMANT INTERVIEWS		
	Roles			Quotes		
	Development	Implementation	Monitoring	Development	Implementation	Monitoring and Evaluation
DPOs	Provision of inputs	PERSONS WITH DISABILITIES , vulnerable groups, their families and disability activist groups to utilise the FSDR for advocacy	**X**	*"DPOs were the ones that made that specific approach [for the FSDR]" (Participant#9)*	**X**	**X**
NGOs	Provision of inputs	**X**	**X**	*"My role was simply to make sure that the rural anomalies and needs and primary health care needs and strategies were firmly articulated within the FSDR…" (Participant#4)*	**X**	**X**
Public Sector Representatives	Provision of inputs	**X**	**X**	"*we had selected key National Departments, Education, Social Development, Higher Education and Training [to provide input])" (Participant#9)*	**X**	**X**
Professional Associations	Provision of inputs	Utilisation of FSDR in strategic plans	**X**	*"…as part of the task team sort of we had to look at what's involved in the discussions around developing the document…providing information to the associations after a meeting, get the feedback of what was required and the task that we had to do. "(Participant#7)*	*"we have also used this document [FSDR] in our strategic planning" (Participant#2)*	**X**
Academia	Provision of inputs	**X**	**X**	"*There was also the public sector forums and academia [to give input]" (Participant#7)*	**X**	**X**

Note: The X icon indicates the lack of involvement of an actor in a process - X

4.2.2 Content

Since the analysis was focused on the intended provisions of the FSDR for access to health care. Access to health care framework was therefore used to further analyse the content of the FSDR, as proposed by Masuku (2020). The five subdivisions of access to health care by Penchanksy and Thomas (1981) are used as themes. These dimensions under the content are availability, acceptability, accessibility, affordability and accommodation. This is seen in table 4.5 below.

Table 4.5: The Content of the FSDR as per the Five Dimensions of Access by Penchanksy and Thomas (1981)

FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM KEY INFORMANT INTERVIEWS
Theme	**Subtheme**	**Document Quote**	**Quote**
ACCESSIBILITY	Distributional Impact	*"This Framework and Strategy on Disability and Rehabilitation proposes disability and rehabilitation services at all levels of care, from home to tertiary services…" (FSDR document, page#6)*	*"People are using the FSDR for the strategic plans and they're using …in their operational plans" (Participant#11)* *"I think people have been able to use the document [FSDR] when they haven't been able to access services…" (Participant#2)*
AFFORDABILITY	Affordable Services	*"4.1. Vision: Accessible, affordable, appropriate and quality disability and rehabilitation services throughout the life course..." (FSDR document, page#13)*	*"It (FSDR] has influence, but we have also accepted certain realities that we are not where we thought we would be, primarily because expanding rehabilitation, expanding the access goes hand in hand with resources, financial resources and not just rehab but the whole Health system has not grown in the last ten years, the budget has not grown. If anything in the last three to five years, the budget has struck. So that impacts directly on the service offering" (Participant#9)*
ACCEPTABILITY	Underlying CBR Philosophy	*"Values: 1.1.1. Ensuring appropriate disability and rehabilitation services through the participation and inclusion of persons with disability, based on the principles of community-based rehabilitation and using a disability-inclusive developmental approach and evidence-based practice." (FSDR document, page#13)*	*"The FSDR says a rehabilitation does not occur in a facility. We must take it to the people…… s rehabilitation is not the exclusive domain of professionals and there must be you know collaboration with non-professional groups, your community health workers, your mid-level workers in rehabilitation that links directly to access." (Participant#9)*
ACCOMMODATION	Appropriateness	*"Goals: 4.4.4. Implement accessibility standards for infra-structure, communication, signage and information. "(FSDR document, page#13)*	*"…the FSDR is quite big on access and, also makes a point that this access should also be tied to the Government responsibility to provide the service. You see that's why you know the orientation and mobility services that NGO's providing should also come into the Government volt you know because it's Government's job to provide that service." (Participant#9)*
AVAILABILITY	Adequate Service Provision	4.2. Mission: The provision of integrated, comprehensive, appropriate disability and rehabilitation services through effective and equitable resource allocation and inter-sectoral collaboration." (FSDR document, page#13)	*"…it [FSDR] says it goes further to say in all the levels you know from PHC to tertiary, rehabilitation should be available and accessible." (Participant#9)*

Additional to this, the content was analysed under four themes from Walt and Gilson (1994) content component, where the subdivisions of content are the aims, distributional impact and the underlying principles of the FSDR, this is seen in table 4.6. The findings of the document analysis on the content of the FSDR were substantiated by findings from key informants. The table below provides an overview of the themes, sub themes and quotes from participants on the themes, which emerged through inductive analysis and correlates with the content component of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework. This is seen in table 4.6 below.

Table 4.6: Table Showing the Content of the FSDR as per Walt and Gilson (1994) Content Component

FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM THE KEY INFORMANT INTERVIEWS		
THEME	**SUBTHEME**	**QUOTE**	**THEME**	**SUBTHEME**	**QUOTE**
AIMS	Define and Guide Rehabilitation Service Provision	*"…to achieve equal access to health care services as well as to provide specified rehabilitation services where and when required." (FSDR document, page#7)*	**AIMS**	Define and Guide Rehabilitation Service Provision	*"…So FSDR also seeks to say how can we structured the human resource aspect. "(Participant #12)*
				Implementation of CBR in PHC	*"I feel the FSDR does pull that back together and say firmly we are looking at CBR approach, we are looking at a multidisciplinary rehab team…" (Participant#4)*
				Lack of Intersectoral Collaboration	*"I think what it does is that it talks to interprofessional and intersectoral collaboration." (Participant#2)*
DISTRIBUTIONAL IMPACT	All Levels of Healthcare	*This Policy Framework and Strategy for Disability and Rehabilitation services in South Africa outlines comprehensive and integrated disability and rehabilitation services within the broader health and developmental context to facilitate improved access at all levels of health care. "(FSDR document, page#8)*	**DISTRIBUTIONAL IMPACT- PERCIEVED EFFECTIVENESS**	Improved Organisation of Rehabilitation Systems	*"I think in some ways it did help us to actually organise our thoughts and give us some … some motivation or drive to start doing strategic planning you know more formalised and less haphazardly." (Participant#8)*
				Increased Awareness of Rehabilitation	*"I think that's guided us quite a bit as well in terms of understanding what the different levels of care provide for the patients and being enable then to direct them appropriately and then also looking at the referral system between all levels of care and the referrals to the rehab units. "(Participant #10)*
			LACK OF DISTRIBUTIONAL IMPACT	Lack of Substance	*"…It's a very scant document. There's not enough to develop an action plan." (Participant#12)*
				FSDR Carries no Weight	*"…it (FSDR) is only also a framework and so on, it's not a full policy that has been accepted and so on. So, in that sense it has less of a value than what a full policy, implemented policy document would be. "(Participant#7)*
				Lack of Paradigm Shift	*"…there hasn't been any major shift or paradigm shift in people's thought processes which is what I would have expected a document like this to bring about." (Participant#12)*
				Contradictions in the FSDR	*"…there are contradictory things for me in the FSDR, which are contradictory to how people could practice…" (Participant#2)*
PRINCIPLES	Community Based Rehabilitation (CBR)	*"This strategy focuses on the mandate of the health sector but fully subscribes to the CBR philosophy." (FSDR, page#13)*	**PRINCIPLES**	Community Development	*"… it relates to how rehab should be rolled out to the community." (Participant#11)*

4.2.3 The Context of the FSDR

Different factors influenced the development of the FSDR. Specific themes depicting these factors are presented in table 4.7 and they are substantiated with quotes from the FSDR document and Key informant interviews. The themes were categorised according to structural, cultural, situational and global factors, based on the context component of the Walt and Gilson (1994) triangle framework for policy analysis.

Under these main themes, subthemes emerged such as the need for a new policy, gap in rehabilitation services and international pressure.

Table 4.7: Table Showing the Context of the FSDR as per the Walt and Gilson (1994) Context Component

FINDINGS FROM THE DOCUMENT REVIEW			FINDINGS FROM THE KEY INFORMANT INTERVIEWS		
Theme	**Subtheme**	**Quote**	**Theme**	**Subtheme**	**Quote**
STRUCTURAL	**Poor Medical Model**	*"A medical model resulting in poor access to a comprehensive disability and rehabilitation service especially to persons in rural and disadvantaged areas."(FSDR document, page#10)*	**STRUCTURAL Need for New Policy**	Outdated National Rehabilitation Policy (2002)	*`"The gap in that there is nothing in terms of, let's say, a rehab policy in South Africa" (Participant#12)*
	Non-Integrated Services	*"The implementation of disability and rehabilitation services as a vertical programme with little or no scope for integration with priority health programmes, such as Non-Communicable Diseases, Maternal Child and Women's Health (MCWH), HIV and AIDS." (FSDR document, page#10)*	**Gap in Rehabilitation Services**	Plea for inclusive rehabilitation care from DPOs	*"There have been approaches you know to the executive management by Disabled People's Organisation's to say "we appreciate what you're doing, we appreciate that you know you have a rehabilitation policy. We appreciate that you have guidelines for assistive devices, but we think you are still falling short especially on services that were either to not part of the package that we are providing" (Participant#9)*
	Inadequate Follow Up	*"Inadequate follow-up due to a lack of clarity on referral pathways as well as poor availability of services." (FSDR document, page#10*		Unmet needs of PERSONS WITH DISABILITIES	*"…it was the concern regarding our associations and rural health for the persistent lack of recognition of the needs of people with disabilities (PERSONS WITH DISABILITIES)." (Participant#1)*
	High Vacancy Rates	**"***There is an inequitable distribution and high vacancy rate of service providers at the different levels of care especially rehabilitation staff at primary level. "(FSDR document, page#10)*		Exclusion of rehabilitation services for the blind	*"…some of the DPO's that raised concern, were especially from the Blindness Sector you know because they were right in that you know what we were providing as a package excluded a lot of what they would want to access you know as a Government service." (Participant#9)*

	Lack of Rehabilitation Indicators	*"The paucity of appropriate rehabilitation indicators in the national and provincial data sets impairs the quality and type of service, as there is no proof of effective service delivery which could be used to motivate for resources. "(FSDR document, page#10)*		Lack of disability data	*"…it's a given, that the data, especially in our profession, uhm that is currently available doesn't really mean anything. We haven't got proper statistics." (Participant#1)*
SITUATIONAL	**Lack of Access to Health care**	*"Inaccessibility of health services with regard to facility infra-structure, signage and information in an appropriate medium including sign language and Braille." (FSDR document, page#10*	**SITUATIONAL** **Challenges to Health care Access**	Resolve for guidance on rehabilitation	*"So, a process was set in motion then you know to look at that and then to try as much as possible to have then an inclusive approach to disability and rehab services. "(Participant#9)*
	Inaccessible and Unaffordable Transportation	*"Families of people with disabilities incur significant costs for public transport and car hire in order to access health care." (FSDR document, page#10)*		Rehabilitation side-lined	*"what is very clear is that rehab is an afterthought. It's not an integral part of the health system." (12)*
	Lack of Awareness of Health care Workers	*"The lack of awareness, knowledge and training among healthcare providers…Rehabilitation professionals are often not "culture-sensitive" and do not respect the value systems and beliefs of their clients, which may delay early identification and intervention." (FSDR document, page#10)*		Misconceptions of rehabilitation	*It's like we are uhm these step-sister people which you call on when you don't know what to do with anybody." (Participant#2)*
	Inadequate Resource Provision	*"Inadequate provision of appropriate assistive devices/technology and accessories" (FSDR document, page#10)*		Challenges in accessing rehabilitation	*"I think that when people get discharged from hospital, there isn't good sense of how people, that those services get handed down." (Participant#2)*
CULTURAL	**Lack of Culture Sensitivity in Rehabilitation**	*"Rehabilitation professionals are often not "culture-sensitive" and do not respect the value systems and beliefs of their clients, which may delay early identification and intervention." (FSDR document, page#10)*	**CULTURAL**	Culture of community service	*"Sometimes we come across volunteers in the community as well who give up their time…"(Participant#10)*
GLOBAL FACTORS	**UNCRPD**	*"The UN Convention on the Rights of Persons with disability (CRPD) was signed and ratified by the South African government in 2007 and its provisions reflect the obligations of the State." (FSDR document, page#10)*	**GLOBAL FACTORS**	UNCRPD	*"I think it had to do with the fact that our government has signed a number of agreements. And rehab internationally is something that is on the agenda, that it has to be looked at." (Participant#12)*

4.2.4 **Processes of the FSDR**

The processes of the FSDR were subdivided into three main categories namely, development, implementation and monitoring and evaluation. According to the policy document, the following steps were followed during the processes of the FSDR, namely development, implementation and monitoring and evaluation.

4.2.4.1 **Development**

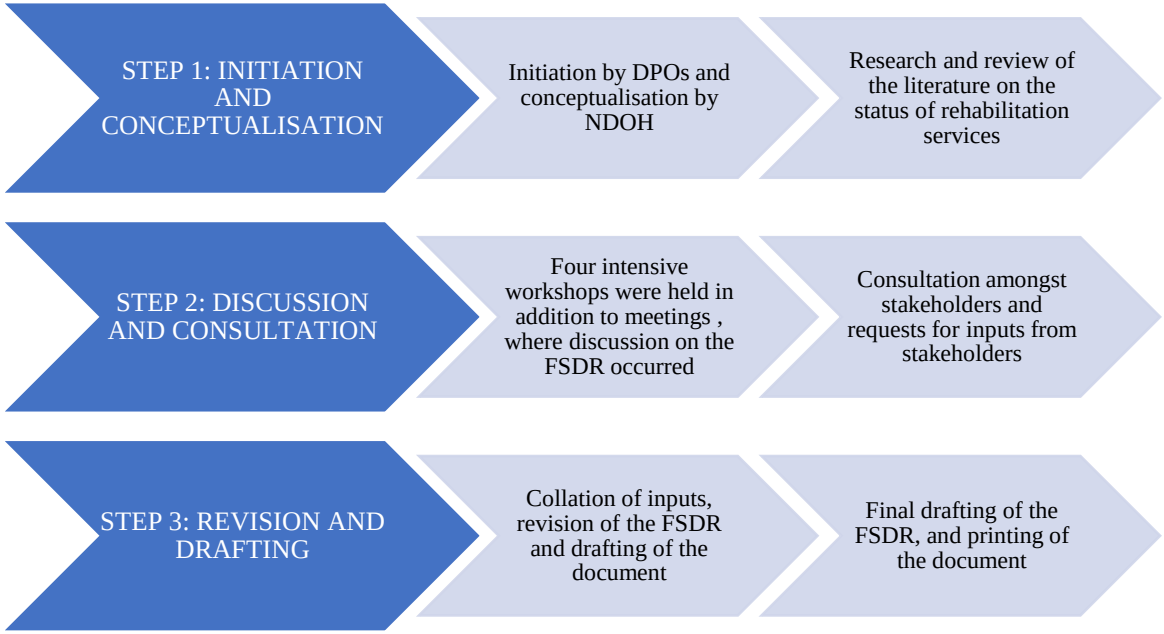


Figure 4.2: Steps in the Process of Development of the FSDR

According the document review of the FSDR, in 2013, The Minister of Health appointed a task team to develop a framework and strategy for disability and rehabilitation services. Consultation with various stakeholders, as previously mentioned under actors, then occurred. The final inputs of the FSDR were then managed by the head of a disability non-government institution.

4.2.4.2 **Implementation**

The process of implementation of the FSDR began at the National department of health and was planned to filter down to end users through the nine-provincial rehabilitation co coordinators. The process is seen further below in the visual.

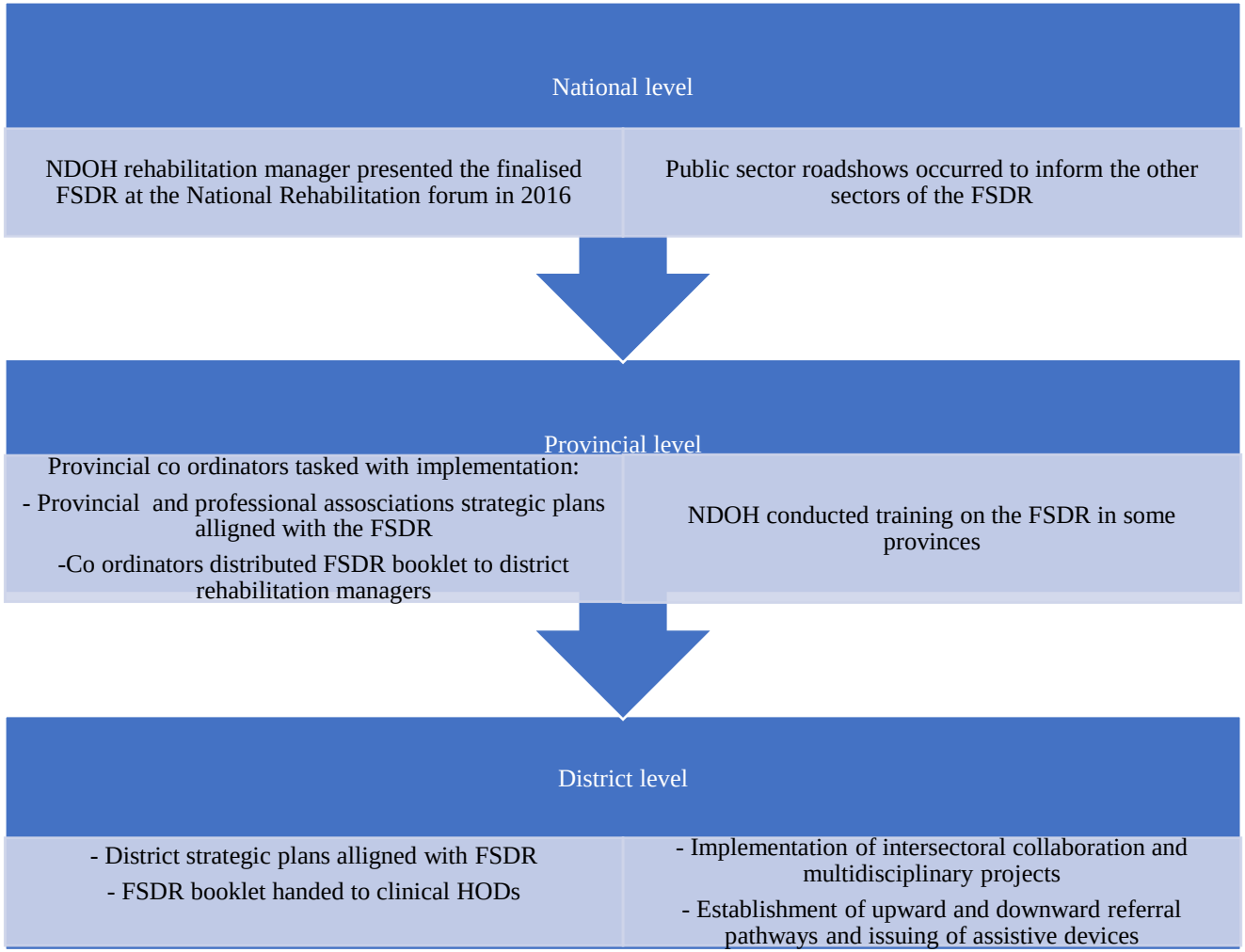


Figure 4.3: The Implementation of the FSDR at District, Provincial and National Level

Implementation refers to the process of ensuring that the goals of a policy are reflected, following a step by step process to ensure this. In the document, the National Department of health commits to the implementation process of the FSDR. This is seen in the quote below:
*"We will endeavor to implement this framework and strategy to ensure that services for persons with disabilities are available at all the levels of health care. "(*FSDR document, page#7).

The initial point of implementation is seen in the goal below which seeks a committee to guide the process of implementation by 2015.
*"Establish an Inter-sectoral Disability and Rehabilitation for Health Steering Committee to be housed within the National Health Commission," (*FSDR document, page#18*).*

An important step in implementation is highlighted in the goal of the FSDR, which aims to integrate rehabilitation services into the mainstream priority health programs such as maternal health. The process of implementing the document is seen in the goals of the FSDR where the goal in 2016, was to develop a human resource plan to ensure the other goals are implemented. The next step in achieving the vision of the FSDR, was to educate the health care providers on disability management by 2017. The document also focuses on reviewing and implementing standards for accessibility related to infrastructure and communication. It then describes the need for intersectoral collaboration to review social determinants. Another goal is to develop an effective referral pathway across all levels of care to ensure adequate service provision, which the document aims to achieve.

4.2.4.3 **Monitoring and evaluation**

This refers to the process of reviewing the document and assessing if the goals have been achieved effectively. Minimal information is given in the FSDR regarding monitoring and evaluation processes except for goal six, which seeks to develop and implement a monitoring and evaluation framework to monitor rehabilitation service provision for disability.

The monitoring and evaluation process of the FSDR is currently underway as the FSDR expires in 2020. Various processes are being developed and implemented to monitor the FSDR document. Monitoring and evaluation refer to the assessment of the implementation of the FSDR in order to ascertain the effectiveness of the document.

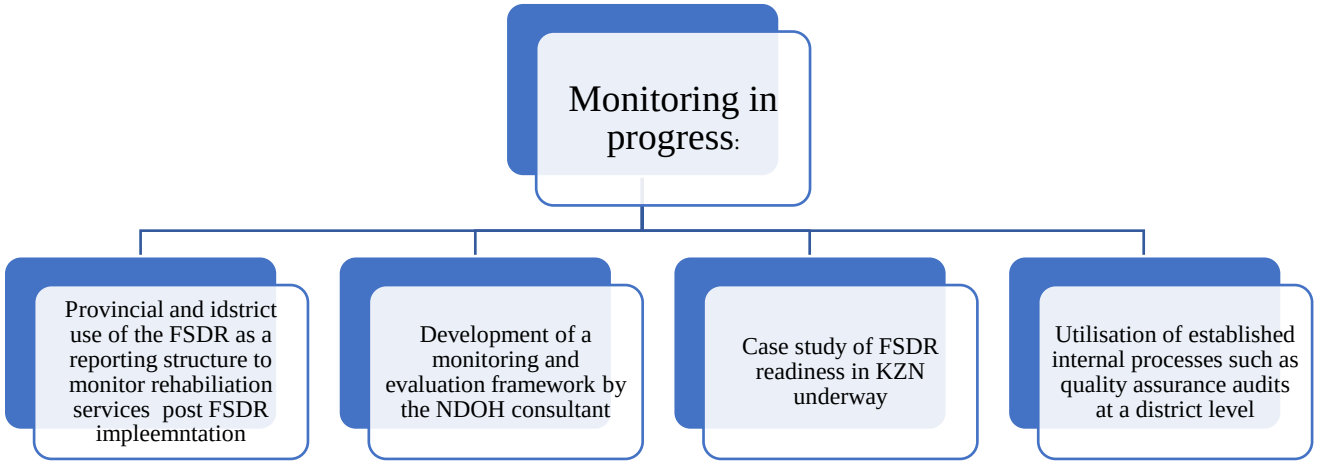


Figure 4.4: The Monitoring and Evaluation of the FSDR which is Currently Underway

4.2.5 Factors Influencing the Processes of the FSDR

The study identified numerous factors influencing the processes of the FSDR. The factors are according to each process of development, implementation and monitoring and evaluation. Under each process, key themes and subthemes emerged under barriers and facilitators. This is seen in the tables below.

Table 4.8: Factors Influencing the Development Process of the FSDR

BARRIERS			FACILITATORS		
THEME	**SUBTHEME**	**QUOTE**	**THEME**	**SUBTHEME**	**QUOTE**
ACTOR DYNAMICS	Actor conflict	"it's quite a difficult process coming up with the document because there were many role players with very different agendas in the same room." (Participant#12)	**BROAD SPECTRUM TASK TEAM**	Intersectoral involvement	*"So, we had a broad range of representation." (Participant#12)*
	Lack of leadership	*I also felt that the whole process lacked leadership and direction. So, from the start, there wasn't a very clear vision as to what we were trying to achieve." (Participant#12)*	**EXPERIENCED TASK TEAM**	Policy consultancy guidance	*"…some people had more idea, like had been involved at policy level before…had like policy training. "(Participant#4)*
LACK OF RESOURCES	Poor remuneration of task team	*"I basically had to work for free for those 3 months – they paid me in the end for I think 23 days – but it took me 3 full months day and night." (Participant#5)*	**POSITIVE ATTITUDES OF TASK TEAM**	Anticipation of positive outcomes	*"I think we had you know general acceptance of the framework. I haven't come across a stakeholder that is you know negatively disposed to the framework." (Participant#9)*
RUSHED PROCESS	Limited time frame	*"They [NDOH] said it had to be done in maximum – I think it was 15 days." (Participant#5)*	**CONSULTATIVE**	Inclusive approach	*"…we wanted to be, you know consultative and inclusive." (Participant#9)*
POOR RECORD KEEPING	Lack of documentation of process	*"There were no minutes taken... Nothing was verbally, was audio recorded. "(Participant#4)*	**OPEN INVITATION TO PARTICIPATION**	Open invitation to inputs	*"The Department of Health then opened it up to all the other organisations which was then involved in development." (Partcipant#9)*

Table 4.9: Factors Affecting the Implementation Process of the FSDR

BARRIERS			FACILITATORS		
THEME	**SUBTHEME**	**QUOTE**	**THEME**	**SUBTHEME**	**QUOTE**
LACK OF RESOURCES	Lack of human resources	*"…the services provided at the hospitals are so constrained and people are demotivated. They just don't want to carry on. I mean I've heard some really scary stories about demotivation of therapists. And I mean you know, what's the point of training people if they are going to be demotivated, become depressed and not continue with their profession" (Participant#5)* *"I mean it (FSDR) doesn't operationalise anything either because there aren't resources." (Participant#2)*	**MENTORSHIP AND SUPPORT**	NDOH Offered Supportive Training	"*National made itself available to take Provincial actors through you know some training which some Provinces took up and others felt they are you know okay*." (*Participant#9*)
	Poor socioeconomic conditions of patients	*"I'm talking now your lower socioeconomic class because that's what we deal with in government mostly." (Participant#11)*			
	High staff turnover	*"Most of our staff are community service staff, we roll over and change every year. Patients then… they get nervous when they get used to a specific therapist and the next year there's a new therapist. The other issue with that also is that a new therapist comes in with new ideas, sometimes, you know, things get then brushed off because, oh, you know what, I prefer doing these groups or I prefer doing like this. And patients are not very flexible in how they look at their therapy. When they want something, they want it to be a specific way. So, change of staff and turnover of staff has been a big problem." (Participant#11)* *"you see rotating people, so there is no carry over from one to the other, so the ability to actually progress with treatment is very difficult." (Participant#2)*			
	Lack of resource allocation	*"what was also lacking is there wasn't an alignment to budgeting processes also. So, no commitment that, if let's say, early intervention is a priority, what does that actually mean in terms of implementation and what does that mean in terms of provinces dedicating a budget to making it happen." (Participant#12)*			
	Inaccessible and unaffordable transport	*"there's a lot of issues with transport, especially for patients with disabilities that have an assistive device that they've got to… I'm talking now your lower socioeconomic class because that's what we deal with in government mostly. So, we're not dealing with patients that have access to private vehicles, they've got to take public transport, or they've got to hire a private vehicle to take them to and from the clinic. And sometimes it costs in excess of R150 for a car." (Participant#12)*			

LACK OF LEADERSHIP	Lack of Political Commitment	*"I think the lack of urgency, perhaps, you know, or leadership, governance, you know, of, you know, how serious do you really take the document. The fact that some of the deadlines have passed already and there was not an update or anything like that." (Participant#7)*		External Professional Support	*"…at that stage, we were very lucky to have a company and I can't remember their name that was doing work for Gauteng Health in terms of strategic planning and they took that document and with senior representatives from Gauteng Health, we actually then developed a strategic plan, emanating from that." (Participant#8)* *"But that really helped because they were a company working in terms of eliciting strategic planning etcetera and they did most of the reports etcetera." (Participant#8)*
	Lack of Training and open interpretation	*"We didn't have any training specifically on the policy except the booklet to refer back to." (Participant#11)* *"…everybody interprets that content in the way that they think it should and so there is not necessarily a collective vision about that, nor does it necessarily reflect the needs of the people" (Participant#2)*			
	Lack of Accountability	*"You know the Provinces can basically do as they want." (Participant#8)*			
	Inefficient Procurement Systems	*"…basic problems like just getting procurement on a systematic… in a systematic way." (Participant#11)* *"your systems are not working properly. Basic ordering systems, basic, you know…" (Participant#11)*			
	Inconsistent Provinces	*"The implementation varied from Province to Province." (8)* *"I think that the leadership, context of provinces, how they are organised provincially, makes a very big difference to the way its implemented. "(Participant#2)*			
	Top-down approach				
POOR AWARENESS	Lack of Intersectoral Collaboration	*"… there's a lot of things about you should plan with the TB sub-directed or with the HIV or with the that and that does not necessarily happen because they don't necessarily invite us." (Participant#8)*		Provincial and District Mentorship	*"a facilitator to help with implementation was that I think mentorship from occupational therapists in higher management posts. For me, I think that's helped. And people who had a broader view of the workings and the understandings of that, you know, the FSDR too hard in the context that they are in so I am inside talking about managers above my level, maybe like the assistant directors and I think being able to speak to, to different people with different views and understandings of it and how to be implemented that helped me. "(Participant#10)*
	Staff Attitudinal Barriers	*"sometimes we encounter staff who may have attitudinal barriers." (Participant#10)*			

Table 4.10: Factors Affecting the Monitoring Process of the FSDR

THEME	BARRIERS		FACILITATORS		
	SUBTHEME	**QUOTE**	**THEME**	**SUBTHEME**	**QUOTE**
LACK OF FRAMEWORK FOR MONITORING	Lack of Indicators	*"I think because there's no clear reporting structures, so we had no baseline as to what existed before the framework, there's nothing to compare if this framework actually made any difference in terms of implementation. Indicators were not developed." (Participant#12)*	**CASE STUDIES**	Pilot Study Underway	*"…I only know that the [Non-Government Organisation] was then commissioned and it probably was at the beginning of 2017 to do a research on readiness for rehab, to look at, I believe [they] wanted to know how ready is South Africa to implement this frame work and strategy. And so, they took it on, and out of the nine provinces, they chose Kwa-Zulu Natal as the province to work in." (Participant#5)*
NEGATIVE STAFF ATTITUDES	Top-Down Approach	*"I was monitoring what was happening. Um but it was … a lot of it was high level." (Participant#8)*			
	Poor Task Allocation	*"I'm not familiar with a specific strategy that was followed and so on to say, you know, you have to do it, you don't have to do it, and by when, and so on." (Participant#7)*			
LACK OF DATA COLLECTION	Poor Data Collection Systems	*"…if you don't know what is happening in the area, what is the burden of disease, then how can you plan any service really. So, the monitoring and the evaluation definitely needs to be addressed and so on, so that one can plan, you know, base your planning on proper evaluation and monitoring." (Participant#7)*			
LACK OF CAPACITY	Lack of HR	*"I'm essentially the only one, the other person is admin." (Participant#9)*			

4.3 CONCLUSION: CHAPTER 4

The above chapter has shown the findings of both the document review and Key informant interviews. Various themes, as well as subthemes and categories emerged through the two data collection methods under the main components of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework namely, actors, content, context and processes. These components were analysed using pre- determined themes from the Walt and Gilson (1994) triangle framework. In addition, the content component was analysed using the Penchansky and Thomas (1981) theory of access, with the five dimensions. Additional to this, were the factors, which have influenced the processes. These barriers and facilitators played a role in the outcomes of the FSDR. The above findings are discussed further in chapter 5 below.

CHAPTER 5

5. DISCUSSION OF FINDINGS

5.1 INTRODUCTION

This study explored the actors, content, context, processes and factors influencing the processes of the Framework and Strategy for Disability and Rehabilitation (FSDR), with specific reference to access to health care for PERSONS WITH DISABILITIES . To achieve this, two data sources namely, a document review of the FSDR and Key informant interviews were utilised. The findings of the document review and the Key informant interviews will be contrasted in this chapter.

In line with the available literature, dimensions from the Walt and Gilson (1994) Health Policy Analysis Triangle Framework and dimensions from the theoretical framework by Penchasky and Thomas (1981) the discussion is presented according to the objectives of the study. The objectives are to identify actors involved in the FSDR processes, to describe the content and context of the FSDR, to determine the processes that were involved as well as to identify factors which have influenced the FSDR.

5.2 ACTORS INVOLVED IN THE PROCESSES OF THE FSDR

5.2.1 Actors

The findings from the current study indicate that there was a broad range of role players appointed by the Deputy Minister of Health, in the conceptualisation and development process of the FSDR. Actors included disability persons organisations (DPOs), national and provincial rehabilitation managers, academia, professional associations, public sector departments of social work and education, private hospital groups, rural representative's department of education and non-governmental organisations (NGOs). These role players played an advisory role to ensure that appropriate content is included in the FSDR.

The involvement of various actors in policy development is supported by Lemke and Harris-Wai, (2015) and Thizy et al., (2019) who posit that the engagement of various role players is an essential element in policy development as it ensures that adequate public health policy decision making happens therefore improving the trustworthiness and credibility of the content of the policy. Various stakeholder engagement also ensures that agreements and disagreements are identified and resolved (Boaz et al., 2018).

While there was a broad range of actors in the conceptualisation and development stages of the FSDR, there was however a reduced range of actors in the implementation stage and an even lesser range of actors during the monitoring and evaluation stages. Actors involved in the implementation stage were the national and provincial rehabilitation managers and the clinical health care professional at ground level while those involved in monitoring and evaluation were only representatives of the national and provincial rehabilitation managers and the NDOH consultant. In agreement with findings from the current study, Flanagan et al., (2011) acknowledges that during policy processes, actors play different roles at different times, indicating that they may not all be involved across the full spectrum of processes from development to monitoring and evaluation. Flanagan and Uyarra, (2016) further agrees with the findings, by stating that the active roles of actors within a policy differs at each stage and may not necessarily include the same actor at every stage.

Despite the inclusion of multiple actors, which was commendable of this policy document, it was however noticeable that, there was a lack of inclusion of health economists, which proved to be problematic and was reflected in the poor budget allocation to the FSDR, which consequently impacted on the success of the document. The value of having health economists involved in public health policy should not go unnoticed. Vieira (2016) agrees, that health economists play a valuable role in policy development. The value of including health economists as actors in policy documents is also acknowledged by Terktratok et al. (2017) who explains that health economists bring adequate and realistic budgeting to health policy, which in turn, is a tool to assist the policy to achieve its goals.

5.2.2 **Responsibilities of the Actors**

The findings of this study indicate that during the development phase of the FSDR, each actor was allocated a specific role by the National Department of Health. For example, the DPOs were tasked with, bringing the issues of PERSONS WITH DISABILITIES to the attention of the task team. The representatives of academia and professional organisations were tasked with engaging other actors in their respective field on disability and rehabilitation service delivery, and to provide inputs from their relevant fields of expertise on the content of the FSDR as well as discussion and consultation; the representatives from rural based Non-Government Organisations (NGOs) were tasked with ensuring that issues at ground level in rural areas are included in the content of the FSDR under primary health care service

provision; the NDOH were tasked with collating information and sending out drafts which were edited by professionals; and the provincial rehabilitation managers were tasked with implementing the FSDR at all levels of care and within their contexts.

Lemke and Harris-Wai, (2015) agree that clearly defined roles are necessary and key to ensuring the success of policy processes, and subsequently the lack of this hinders policy outcomes. Mbachu et al., (2016) in a retrospective study where they analysed key influences over actors in the processes of a national health public policy in Nigeria further agreed with the findings of the study at hand, by revealing that actor's preferences regarding the policy content, are influenced by their specific roles and the level of influential power which they gain through these specified roles.

Mbachu et al., (2016) particularly states in relation to DPOs that they are unofficial policy makers who influence official policy makers, such as government, to factor the interests of persons with disabilities into the content of the policy documents during the policy development process.

Therefore, involving the DPOs added value to the FSDR as DPOs understand better the challenges of PERSONS WITH DISABILITIES than other individuals or groups (Liedll 2011). Strasser, Kam and Regalado (2016), in their study which reviewed literature on access to health care in rural areas as well as policy development in sub-Saharan African countries supports the roles stipulated for rural representatives. Norris et al., (2014) agrees that policies are generally developed at a national level and then implementation occurs at a subnational level thus supporting the role of provincial rehabilitation managers in the FSDR implementation. Despite this, Hudson, Hunter and Peckham (2019) explain that this method of implementation poses its challenges as each province has some separate level of political authority. A study by Sausman et al., (2016), describes this as 'local universality' where the implementation is shaped by local contexts within each setting, as in the case of the provinces. Despite the acceptance of the plea of inclusion of rehabilitation from DPO's, the study findings from the Key informant interviews revealed that there was a lack of commitment from the government. A study by Osore (2015) discusses how the commitment of the government of Botswana to a public health policy, resulted in its successful implementation, thus the lack of commitment hinders its implementation. Avert (2012) also showed that a high

level of government commitment to a public health policy in Malawi, ensured the success of it and subsequently proved that the lack of this, affects the success of any policy.

A consultant was allocated the role of monitoring and evaluation (MandE) as well as all provincial rehabilitation managers who were also tasked with this role in their contexts. Majola (2014), agrees that the primary role of MandE is that of the government, as the SA government aims for a greater developmental impact which can be achieved through adequate MandE.

5.3 CONTENT OF THE FSDR

The content of the FSDR will be discussed according to the content components of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework namely, the aims of the FSDR, the distributional impact and the values of the document. Additional to this, the five pre-determined themes of access to health care as proposed by Penchasky and Thomas (1981)'s theory of access which are accessibility, acceptability, adaptability, adequacy and availability will be utilised.

5.3.1.1 Aims of the FSDR

The study findings revealed that the aim of the FSDR was to define and guide rehabilitation services for PERSONS WITH DISABILITIES , and in so doing, ensuring rehabilitation service provision at all levels of care from primary health care to specialised hospitals.

The aims of the FSDR however lacked specific guidelines for the process of implementation. Campos and Reich (2019) recommends that a public health policy which aims to improve the health service provision in system, should include and consider the challenges to implementation, as part of its aims in the content. Ditlopo (2016) agrees that the design and process of implementation of policies in South Africa should stipulate the implementation process of policy documents. Similarly, these issues of lack of policy implementation guidelines have been highlighted by Osore (2015), in a study that was conducted in Botswana where they analysed the Safe Motherhood Initiative policy for using the Walt and Gilson Health Policy Analysis Framework indicated that, the lack of including pre-planned guidelines for implementation, in the content of the policy, may result in hindered outcomes during the implementation process of the policy.

5.3.1.2 **Distributional impact**

The distributional impact of the FSDR refers to the effect that the implementation of the document has on its intended outcomes such as rehabilitation services for PERSONS WITH DISABILITIES (Buse and Harmer, 2004; Callan et al., 2014). It is often perceived by people on the ground roots for which policy documents are meant to benefit. Distributional impact of health policy shapes the service which it aims to provide thus the lack of impact may result in health inequalities amongst the marginalised and disadvantaged groups such as PERSONS WITH DISABILITIES (Callan et al., 2014).

The intended impact of the FSDR was to be seen from primary and home-based level of care all the way through to centralised and specialised hospitals. The majority of key informants perceived minimal to no impact of the FSDR in the field of rehabilitation, which was attributed to what they perceived as an incomplete implementation of the FSDR. Oliver at el., (2019) agrees with the findings that the impact of policies may not be experienced by the individuals whom the policies are intended for such as PERSONS WITH DISABILITIES because of poor design of public health policies, poor articulation of the goals of a policy, and the need for inclusion of all stakeholders in the policy design process.

5.3.1.3 **Values**

The underlying values and principles of the FSDR refer to the underlying philosophy which underpins the content of the document (Walt and Gilson, 1994). In the case of the FSDR, the underlying philosophy of the FSDR is the Community Based Rehabilitation (CBR), a strategy within community development meant to ensure the integration of PERSONS WITH DISABILITIES into their communities through rehabilitation as a means of facilitating this process (De Mauro, Greco and Grimaldi, 2015). A study by Luruli et al., (2016) confirms that the CBR forms the foundation of many rehabilitation-based interventions and strategies in Africa. CBR plays an important role in applying rehabilitation policy documents and thus serves as a tool to overcome rehabilitation challenges experienced by PERSONS WITH DISABILITIES (Luruli et al., 2016).

5.3.2 **Access to Health Care**

Access to health care is the interface between the service providers of health care and the potential users of health care services (Bhatt and Bhatiija, 2018). In this study, access to health care was explained according to the five dimensions in the theory of access as proposed by

Penchansky and Thomas (1981) namely; accessibility, acceptability, affordability, availability and accommodation.

5.3.2.1 **Components of access to health care**

The Penchansky and Thomas (1981) theory of access provides clearly defined subcomponents of access to health care. Thus, these dimensions were utilised as pre-determined themes to further analyse the content of the FSDR. This allowed the researcher to ensure that access to health care was viewed in a holistic way.

5.3.2.1.1 Accessibility

Policies need to be explicit on accessibility to health care for PERSONS WITH DISABILITIES , as each PERSONS WITH DISABILITIES may have specific needs Peacock and Vecchione (2020). From the findings of the document review, the FSDR committed to ensuring accessibility of services to all people of South Africa. However, there was a lack of detail on how the FSDR intended to ensure that these services are accessible. Christian (2014) and Louw et al., (2018) agree with the findings that a focus on accessibility to healthcare for persons with disabilities is important because given the context of SA, there are many PERSONS WITH DISABILITIES who cannot access adequate healthcare and rehabilitation. A study by Shah et al., (2017) further lamented how the lack of provisions for accessibility to healthcare in policies results in a reduced distributional impact of the policy. This in turn results in reduced health resources and lower quality of healthcare systems in underprivileged communities which perpetuates the continued social exclusion of vulnerable groups from the basic human right of healthcare (Christian, 2014). Findings also revealed that accessibility was further compounded by the complex structure of referral pathways in the South African health system, a finding that was supported by Mojaki et al., (2011). Vergunst et al., (2019) further explains that poor health planning affects PERSONS WITH DISABILITIES as they have specific needs relative to the general population and have a greater need for health services thus the lack of it results in additional challenges.

5.3.2.1.2 Affordability

PERSONS WITH DISABILITIES have a higher likelihood of experiencing adverse socioeconomic outcomes in comparison to individuals without a disability (Moodley and Graham, 2015; Sherry, 2015; World Bank Group, 2019). It is therefore imperative that policy documents pertaining to disability, access to health care and rehabilitation consider

affordability of health care in their content. Findings from this study revealed that affordability was not sufficiently provided for in the FSDR document nor was there any budget allocation to ensure access to health care, regardless of the FSDR having made mention of the cycle of poverty and disability. Masuku (2020) in a study that analysed the national disability policy reform documents of Eswatini also identified gaps in policy provisions for financial accessibility thus supporting the findings of this study. The lack of financial planning in the context of access to health care and inclusion of it in a policy process therefore negatively affected the outcomes of the policy a finding consistent with Yang et al., (2016).

5.3.2.1.3 Availability

The findings of the study indicated that, the specifications of the availability of the services were not made in the document. The FSDR document states that the availability of health resources for PERSONS WITH DISABILITIES should be at all levels from primary health care to central and specialised hospitals. On the contrary, the Key informant interviews reported a lack of availability of health services and resources especially in rural areas. Agyemang-Duah et al., (2019), supports the findings, in a study that identified barriers to health care utilisation in Ghana and reveals that policy documents often do not provide for access to health care. The study further posits that, the lack of planning for availability resulting in gaps in the outcomes of a policy document. Anderson et al. (2011) further agrees that disability policy processes must endeavour to align the content of the policy to the availability of health services. A study in SA, by Maphumulo and Bengu (2019) describes discrepancy between policy promises and the lack of delivery of these promises at a grassroots level, can impact on the overall service delivery of availability of health care.

5.3.2.1.4 Acceptability

For health care to be accessible, it must be acceptable (Penchansky and Thomas, 1981). While the FSDR document suggests appropriate rehabilitation interventions and ensures the inclusion of assistive devices, further clarification is required about additional specialised equipment which is required to ensure the service is acceptable for PERSONS WITH DISABILITIES and appropriately provided (Williams, Maseko and Buchanan, 2017). The study findings reveal that acceptability was not clearly defined which impacted on the effectiveness of the document. A study by Sekhon, Cartwright and Francis (2017), support these findings that poorly defined accessibility in health care interventions impacts on the

service delivery of the health care service. Another study in Tanzania by Dillip et al., (2012), further support these findings that acceptability is a neglected dimension of access to health care. Studies on policy research agree that poor health planning in health policy results in limitations to the policy outcome and poor acceptability in the provision of health services (Bogren et al., 2019; Hassah et al., 2018). Key informants of the study, particularly government representatives perceived the FSDR to be aligned to acceptability as it provides for community development and the attitude of service provision to where the patient requires the need. A study in South Africa, by Masuku (2020), supports these findings by explaining that government representatives perceived policies to be aligned to acceptability.

5.3.2.1.5 Accommodation

Information on the specific needs of PERSONS WITH DISABILITIES being accommodated is scanty in the FSDR. The document review provided for accommodation of persons with disabilities through providing signage and adequate communication pathways while Key informant interviews, perceived the FSDR as having no alignment to accommodation .The UN, (2016) in a report on the toolkit for disability in Africa confirmed these findings by reporting that despite being well-intended, policies often neglect provisions for the accommodation of persons with disabilities in health care. This finding was further corroborated by the South African Department of Public Service (2014) and Hannas-Hancock (2017) who stipulated that it was imperative that public policies address the accommodation of the needs of persons with disabilities if public policy is to ensure favourable outcomes in their goals to ensure that the rights of persons with disabilities are fulfilled. Pharr (2014) describes the lack of accommodation for the needs of PERSONS WITH DISABILITIES as a barrier to access.

5.4 CONTEXT OF THE FSDR

The context component of the FSDR was analysed according to the context component of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework. These themes are global, cultural, structural and situational contextual factors. Global factors refer to the contextual factors which stem from international sources and place pressure globally on all states. Cultural factors then refer to the context in which a policy occurs and how cultural and religious beliefs of a community affect the policy. Situational then refers to the socio-economic factors as well as prevalence of disease which influence policy. Lastly, structural

contextual factors refer to the political and health care system structures in a specific context, which also impacts on why and how policies are developed (Osore, 2015).

5.4.1 Global Factors

Need for New Policy

Findings from the Key informant interviews revealed that prior to the development of the FSDR, South Africa had an outdated National Rehabilitation Policy in 2002 which required revision with the current context of the South African health care system (Ned, Cloete and Mji, 2017). A study by Leshota (2013), supports these findings that disability interventions and strategies evolve as the understanding of disability and rehabilitation evolves. Thus, an outdated policy necessitated the development of a new one to enable reconceptualization in the current context. Another study by Du Plessis (2013) describes that the SA society underwent rapid change, thus as change occurred, outdated policies needed to be renewed to address the new challenges. A study by Van De Byl (2014) reviewed public health policy in SA over a 20-year period and found that the expiration of one policy leads to the development of a new policy with attempts to improve the previous policy.

International Pressure

Findings from both the document review and the Key informant interviews revealed that international pressure from legislative bodies played a role in the initiation of the FSDR and further guided the processes. International pressure from SA being a signatory of the CRPD and WHO protocols. The document review showed that South Africa became a signatory to the UNCRPD in 2007. The CRPD mandates for its signatories to have disability policies in place in their respective countries (United Nations, 2019). A study by Shumba and Moodley (2018) supports these findings and discusses that global legislature places international pressure, thus forming part of the contextual factors which prompt the development of policies and documents such as the FSDR. Furthermore, Shumba and Moodley (2018), state that the policy documents emerged as a result of the SA states mandate to the CRPD.

The findings further show that it was not international pressure alone, but also key national instruments which also played a role such as The Constitution of South Africa Act (108 of 1996) and the National Development Plan, which promote the realisation of the right to access to health care for all individuals. A study by Chichaya, Joubert and Mccoll (2018) analysed

the disability policy in Namibia, and found that the legislation in a country forms a part of the contextual factors which lead up to its development.

5.4.2 Situational Factors

High Disability Prevalence

The findings of the study show that the prevalence of disability and high burden of disease in SA contributed to the reason for development of the FSDR. According to the United Nations (2019), the UN Development programme states that 80% of PERSONS WITH DISABILITIES are living in developing countries. In SA the prevalence was estimated to be 7.5% of the population (Statistics SA, 2016). The increase in the prevalence has been linked to poverty, non-communicable diseases (Sherry, 2015), HIV (Myezwa et al., 2019), and an increase in the elderly population (Statistics SA,2016). The increase in the prevalence of disability means that the health care system needs to find ways to address their pertinent needs. A study conducted in South Africa by Maart et al., (2019) on the context of disability prevalence, corroborates the findings by stressing that the high prevalence of disability creates an urgent need for attention amongst policy makers to focus on disability policy. Willemsen (2018) further advocates for the need for the urgent identification of disability as a significant problem so that it is urgently included as part of the policy agenda.

Gap in Rehabilitation Services

Findings from the Key informant interviews revealed that key informants perceived the FSDR as coming into being to address the South African health care system which is under a lot of strain with a high patient load and subminimal resources. A study by Coovadia et al., (2009) agrees with these findings that the SA health system has insufficient human and financial resources to cope with the demands on the system. Findings also showed that the FSDR was developed because health care system in South Africa prioritised resource allocation to other health care departments while neglecting and side-lining, rehabilitation services. Key informants also expressed that despite rehabilitation being side-lined, awareness of the effectiveness of rehabilitation in reducing the long burden on the health care system by adequate patient maintenance and prevention of secondary complications, is increasing. A study by Mabunda (2018) where one of their objectives were to determine what factors lead to poor care of patients with mental health issues in Limpopo, SA, agrees with these findings by emphasising that despite rehabilitation being a vital service in health care, it is often side-

lined in health care provision and prioritisation. The study findings reveal that the gap in rehabilitation services resulted in a plea for inclusive care which arose from disability persons organisations (DPO's). The study findings show that the initial reason for conception of the FSDR was an approach from DPO's themselves, particularly associations for individuals with visual impairments, who felt that there were major gaps in the rehabilitation services which did not speak to their specific needs. As a result of their advocacy, the National Department of Health began the process of conceptualising the FSDR with the elected task team by the deputy minister of health.

5.4.3 **Structural Factors**

Structural factors refer to the way in which the political system and structure of the health care system has defined health care service provision (Osore, 2015; Walt and Gilson, 1994). The findings from Key informant interviews revealed that the gaps in the structure of the health care system has impacted on resource provision. Coovadia et al., (2009) agrees with findings from the study by stating that policies have come into existence because the structure of the SA health care system is resource deprived and how this resulted in a health care system under very high demands and insufficient resources to meet these demands, particularly for PERSONS WITH DISABILITIES . Delobelle (2016) agrees with the findings by providing an explanation of how the apartheid era posed many challenges to post-apartheid SA, as the bulk of the population were provided with subminimal health care, and minimal or inadequate data collection and health information systems, thus in the case of the FSDR being developed in this era. Additional to this strained system, is the high vacancy rates in government health care institutions where the document review showed the high demands on rehabilitation services (Sherry, 2015).

5.5 **PROCESSES OF THE FSDR**

The study findings show that the processes of the FSDR included the development, implementation and monitoring and evaluation. These processes are discussed further below.

The development process of the FSDR used both bottom up and top down approaches. A top down approach refers to decision making during policy development, by either the state, or executive role players, whereas a bottom up approach is the process of initiation and development of public policy by end users and individuals at grassroots level (Liedl, 2011). The DPOs were involved in the development process by informing the policy content of the

FSDR. The initiation of the development of the FSDR was a bottom up approach where the request came from DPOs who were advocating for the realisation of their rights to affordable, appropriate and accessible health care in South Africa. Thereafter the National Department of Health (NDOH) began developing the actual FSDR. Ossenbrink et al., (2019) supports the idea of using a bottom up approach to policy development and has further recommended it as the best approach to ensure that inputs from end users are included as it ensures the goals of the policy are aligned with the issues on the ground .

Implementation of policy forms an integral part of the policy processes and is sometimes more important than the formulation (Jooste and Fourie, 2009). During the implementation process of the FSDR, representatives of government were mostly the driving forces behind the policy processes indicating a development, reflecting a top down approach. This approach allows the government to be an actor with central control creating a system where the government is at the front line of implementation and have the greater influence over the strategies used to achieve the policy goals (O'Brien and Li, 2017; Green et al., 2014.). Liu and Ravenscroft, (2017) agrees with the finding that policy implementation and evaluation are usually seen as the responsibility of government. While this role of government is the general approach taken to policy implementation it does have its advantages and disadvantages (Cerna, 2013). The disadvantages of the top down approach are that it gives central control to authoritative powers who then influence the policy based on government interest and not necessarily, the interests of the PERSONS WITH DISABILITIES at ground level (Coburn, 2016). Additional to this, the implementation of policy by government officials, often allows lee way for adjustments to the policies, resulting in unmet goals which were initially developed in the policy (O'brien and Li,2017).

The implementation of the FSDR was a linear process beginning at national level of DOH, followed by the provincial and district DOHs. This method of filtering down the information and communication about implementation has its consequences as often information is lost in translation and there is a lack of follow through at the various stages. This is seen in the study by Matland (1995), where the authoritative power has the control and influence over the content of the policy and the implementation processes to be followed. While this method allows for a structured system of implementation, it risks the loss of buy in from end users and follow through in processes from actors on the ground who are expected to implement it. In a study by Osore (2015), the top down approach to implementation of a health policy was

also seen and portrayed as lacking consultation with actors identified as implementors. The top down approach has also been criticised by Ditlopo et al., (2013) as it results in minimal consideration of implementing actors who have the potential to resist implementation. These findings are supported by Richards and Sang (2019), who show how the poor implementation of a public health policy may result in poor lived experiences of the policy content such as availability amongst PERSONS WITH DISABILITIES .

While it was beneficial to have the end users such as DPOs involved during initiation, conceptualisation and development of the FSDR, the exclusion of these groups from the actual implementation of the FSDR resulted in the absence of what Berman (1978) described as 'micro-implementation' where end users not only identify issues on the ground, but also develop and implement guidelines to resolve these issues. In the case of the FSDR, the end user involvement stopped at the point of development. Very often, the policy then does not speak to the issues at ground level due to not enough input from end users during the development and implementation processes. Albeit, the only advantage of the involvement of government through a top down approach is that the government is an authoritative power that can legislate documents and hold individuals accountable for the implementation of interventions (Winter, 2012; Grindle, 2017).

The monitoring and evaluation of the FSDR was mainly driven by government. Lamhauge et al. (2012) describe the process of monitoring and evaluation as an essential part of any intervention such as a policy like the FSDR as it ensures the realisation of possible benefits of the document as well as areas for future improvement to ensure the effectiveness of interventions such as the FSDR. In addition to providing objective evaluations, MandE allows for systematic accountability to ensure all relevant individuals fulfil their roles and responsibilities as allocated (WHO, 2015). Key informants have monitored the rehabilitation services since the implementation of the FSDR through their strategic plans and internal quality assurance audits. Despite this norm, the National Department of Health, has stipulated that a monitoring and evaluation framework is being developed in order to conduct monitoring and evaluation of the FSDR by its expiry date in 2020. To date there is no evidence of monitoring and evaluation of the FSDR.

5.6 FACTORS INFLUENCING THE PROCESSES OF THE FSDR

The factors influencing the processes of the FSDR as reported by the Key informant interviews have been categorised as barriers or facilitators in the different phases of the policy process.

5.6.1 FSDR Development Phase

5.6.1.1 Barriers influencing the development of the FSDR

a) Poor strategic management

The key informants reported that there was a lack of clear leadership; poor planning ("rushed process"), poor information management ("poor record keeping") and poor allocation of resources in the development of the FSDR. Adequate leadership and strategic management form the foundation for the success of any organization (Papulova and Gazova, 2016). Without clear objectives, plans, actions, organization, budget allocation and information get lost in translation and plans do not get carried out into action resulting in poor outcomes (Pearce and Robinson, 2007). The lack of leadership from the authoritative powers in guiding the FSDR implementation, as seen by the perspectives of key informants, proved to be a barrier which resulted in open interpretation to the implementation strategies of the policy, as well as underlying causes such as poor political commitment. Olufemi (2016) and Osore (2015), agrees with these findings and further describes this lack of leadership and co-ordination to be a result of the lack of skills and professionalism to guide the process of implementation.

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5.6.1.2 Facilitators to development

a) Intersectoral collaboration and engagement

The intersectoral involvement of actors from different fields facilitated the process of development of the FSDR by allowing inputs from actors in their respective fields of interest. This broad range includes public and private sector as well disability persons organisations (DPOs). Promotion of inclusive participation and intersectoral collaboration of all the stakeholders is considered key principles in community development and community-based rehabilitation (De Mauro, Greco and Grimaldi, 2015; Nguyen and Nguyen,2018). These studies support the study findings by agreeing that the inclusion of a multidisciplinary approach is integral to achieve the outcomes of the FSDR.

b) Task team experience and positive attitudes

The study findings reveal that the experience of the task team in disability and rehabilitation service provision and policy, facilitated the process of development. Certain members of the task team had previous experience in policy which facilitated the guidance of the consultation process during the development phase. A study by Owens (2008) states that the experience of actors can facilitate a holistic approach in the policy processes. The study findings also show that the positive attitudes of task team members were also a facilitator as these individuals were hopeful and anticipated positive outcomes of the FSDR. A study by Skog (2018) supports this study findings by stating that the attitudes of actors in policy can facilitate the development process. When actors have positive attitudes, they play more of an active role which is also a facilitator (Knoepfel et al., 2011).

5.6.2 Implementation Phase of the FSDR

Barriers to implementation

a) Poor awareness the FSDR

The study findings reveal that there was poor communication and lack of awareness around the FSDR content and strategies for implementation, particularly amongst end users such as district level practitioners and community health workers. There is evidence indicating that lack of awareness of public health policy by actors can hinder the implementation processes of the policy (Lorenzo, 2010, Dayal 2010). The study findings also show that there was a lack of intersectoral collaboration during the implementation process. An example of this is where a key informant explained the lack of awareness of the FSDR amongst hospital management, and the allied health care practitioners were trying to implement the FSDR, yet the process was hindered due to management protocols. A study by Kalaba (2016) agrees with this as it shows that this type of lack of intersectoral collaboration can hinder the implementation of policy. Another study by Osore (2015) showed the lack of awareness amongst actors lead to poor implementation of a health policy.

b) Poor staff attitude towards the FSDR

The study findings show that the younger and ground level staff were reported to have negative attitudes towards the implementation of the FSDR because of the lack of awareness of the FSDR and the lack of understanding of the FSDR content and its greater role in contributing to rehabilitation services for PERSONS WITH DISABILITIES . The negative attitude could be due to not being consulted throughout the process of the FSDR

and the lack of awareness on the framework. This should serve as a lesson for future policy development, that stakeholders want to be engaged throughout the policy process to ensure buy in and success during the implementation phase. Studies by Hussey et al., (2017), Kielstra (2010) and Spratt (2009) support these findings by describing that poor attitude towards a policy can affect the buy-in of the implementers of the policy and eventually the outcomes thereof.

c) Lack of resources

Without human and financial resources any project will fail. The majority of the key informants agreed that the lack of resources proved to be a major barrier to the implementation of the FSDR. Resources that were highlighted were human and financial resources. The FSDR document had minimal information on the resource and budget allocation for the implementation of the FSDR. This is necessary as numerous resources are required to ensure effective implementation of the FSDR. Grindle (2017) looked at politics and policy implementation in third world countries and argues that the lack of available resources contributes greatly to the variable and inconsistent nature of the policy implementation process. This proved to be a barrier, and this has been shown by Hussey et al (2017) where the authors investigated the barriers to the implementation process of an international policy namely, the UNCRPD. A barrier identified here was financial barriers as the lack of resources, which hinders the process of implementation as is the case with the FSDR. The lack of resources reflects poor strategic management during the development phase of the FSDR. A study by Ndalamaba (2019) describes how poor strategic management results in the lack of trust in leadership which in turn contributes to the poor implementation of public policies in Africa.

5.6.2.1 **Facilitators to implementation**

a) Mentorship and support

While the general perspective was that the process from development to implementation to MandE lacked leadership, certain key informants at the district level perceived there to be pocket of excellence in terms of mentorship and support from their respective provincial superiors. According to the document review results, no system of mentorship and support was planned under implementation processes, however, this positive outcome proved to be a facilitator as there was guidance and support in terms of implementing the FSDR. A study done in South Africa by Jooste and Fourie (2009) state that part of effective leadership in the implementation of interventions, is strategic direction being

provided to the relevant individuals and this was carried out within the Gauteng province. Here, strategic direction refers to adequate and appropriate mentorship of implementors to ensure that the process is conducted effectively.

5.6.3.1. **Barriers to monitoring and evaluation**

The perceived barriers to monitoring and evaluation include the lack of a framework for monitoring and evaluating the FSDR as well as the lack of data collection and capacity.

a) Lack of framework for monitoring and evaluation

MandE framework allows for the intervention to be adequately evaluated in the specific context of the intervention. The original FSDR document does not have a framework for MandE. Therefore, to assess progress made the provincial and district DOH staff utilised their internal MandE tools to monitor the rehabilitation services since the implementation of the FSDR. Hence there was no uniform MandE protocol followed across provinces and districts due to the utilisation of their internal protocols. Lamhauge et al., (2012) corroborates these findings and further states that the lack of MandE framework hinders the ability of the policy actors to assess the effectiveness of the FSDR as well as possible future improvement (Lamhauge et al., 2012). Despite this being mentioned, the study findings reveal that the National Department of Health has stated that a MandE framework is currently being developed to be used once the FSDR expires in 2020.

b) Negative staff attitudes

The top-down approach and poor task allocation of monitoring and evaluation was a result of negative staff attitudes towards monitoring and evaluation. A study conducted in Uganda, by Kananura et al., (2017) reviewed the MandE approaches and how this influences actor's decision making. This study supports these findings that negative attitudes towards MandE is a barrier. Another study conducted by Muindi (2018) in Kenya, further supports the findings by discussing how negative attitudes of staff can limit the MandE process.

c) Lack of data collection

Information of the health system through collection of relevant data, is one of the pillars of a health care system. Poor information system or lack of adequate data collection services will hinder progress assessment. Lack of indicators for rehabilitation in South

Africa is a barrier to MandE particularly in the case of the FSDR. The United Nations Development Group (2005), explains the importance of having clear indicators for monitoring human rights policy, and thus the absence of this hinders this process. The lack of data collection and MandE results in a lack of accountability in task allocation thus hindering the progression of the FSDR (Peersman, 2014).

d) Lack of capacity

Lamhauge et al. (2012) describes the process of monitoring and evaluation as having pre-determined objectives, budget and resource allocation as well as specified time frames. In the case of the FSDR, no clear budget allocation or human resource allocation was made to ensure efficient monitoring and evaluation of the FSDR. Hence, the provincial and district rehabilitation managers resorted to utilising their established internal audits and monitoring tools to evaluate the services and not the FSDR itself as no framework for MandE accompanied the FSDR when it was distributed. Callistus and Clinton (2016), conducted research in Ghana evaluating the barriers to MandE and they also confirmed that poor budget allocation was a barrier to policy monitoring and evaluation. Furthermore, the lack of capacity amongst staff resulted in certain staff members being overwhelmed with multiple duties in which their capacity was compromised due to time constraints hence MandE was not fully carried out, a finding that was confirmed by Mthethwa and Jili (2016).

5.6.3.2 **Facilitators to monitoring and evaluation**

Case studies

Despite no framework being developed for MandE of the FSDR, an attempt to monitor and evaluate the FSDR was conducted in at least one province, KwaZulu Natal using a case study, with the outcome of this evaluating still pending. Case studies have been shown to be an effective way of facilitating the process of M and E by assessing the effectiveness of an intervention or policy in an isolated case study (Warwick Institute for Employment Research, 2013). This allows for detailed evaluation and analysis of the positive effects of the policy as well as potential for improving the policy in future (United Nations Development Group, 2005).

5.7 **CONCLUSION: CHAPTER 5**

This chapter presented the discussion of findings of the study. The discussion was done under each sub aim of the study. In conclusion, it can be noted that various key themes as well as sub themes emerged in the results, which have been discussed in relation to the current relevant literature through data triangulation of the two data collection methods namely, the document review and Key informant interviews. In conclusion, the results have agreed with various literature in certain instances, and in other cases, the results have suggested otherwise. It has been seen that there is major discussion around the factors which influence public health policy such as the FSDR. Further research in this field is suggested to further comprehend the issues which have arose. Limitations and strengths of this study, as well as a final conclusion of the entire study is seen in the next section of this dissertation.

CHAPTER 6

6. CONCLUSION

This chapter discusses the concluding remarks of the study. It also gives an evaluation of the study by first summarising the findings and discussing strengths, weaknesses and implications of the study. Recommendations for disability policy improvement and for future studies are also suggested. This study analysed the FSDR utilising two data sources namely a document review and Key informant interviews. The Walt and Gilson (1994) Health Policy Analysis Triangle Framework and the dimensions of access as proposed by Penchansky and Thomas (1981) were used as a basis for conducting the policy review and these were most appropriate for this study. This is because these frameworks have been effectively utilised in similar studies such as Masuku(2020) due to its flexibility and comprehensiveness Data obtained from the two data sources were analysed using a computer software programme namely, MAXQDA and mapped against the pre-determined themes of the Walt and Gilson (1994) Health Policy Analysis Triangle Framework. The content component of the framework was further analysed for access to health care using the dimensions of access proposed by Penchansky and Thomas (1981) as proposed by Masuku (2020).

Summary of Findings

The findings of the study revealed that during the development of the FSDR, a collaborative approach involving numerous actors representing different sectors of the country such as academia, DPOs, clinicians, provincial, district and national rehabilitation managers. This approach mirrored the bottom up approach to policy development, which is usually favoured by authors in policy analysis studies as it ensures that issues at ground level are addressed in the policy document. It was however noted, that during the FSDR's implementation, monitoring and evaluation, the approach reflected a top down approach and the representation of different sectors declined, with these processes (implementation, monitoring and evaluation) left predominantly in the hands of the government. The repercussions of this decision were evident in the obvious disjoint between the processes of development and implementation and ultimately negatively influenced the outcomes of the FSDR. The negative outcomes of the FSDR were evident in the minimal distribution impact of the FSDR.

The FSDR, came into being as a result of the DPO's pressure for the state to address the human rights of persons with disabilities, including the right to health care. South Africa

having ratified the CRPD in the 2007 was experiencing pressure from international legislature bodies such as the WHO and UN to operationalise the CRPD, by putting in place disability policies and frameworks and also updating existing policies. The FSDR was therefore one of the frameworks that emanated as a result of these pressures. Prior to the FSDR, rehabilitation was not given the same status as other programs in the South African health system and as a result, rehabilitation was not prioritised in terms of budgeting, which unfortunately had negative repercussions for assistive devices and overall rehabilitation services to persons with disabilities. The FSDR was therefore developed to mitigate these challenges.

Despite its original intentions to improve rehabilitation at all levels of care, the content of the FSDR unfortunately lacked full alignment to access to health care and thus, the distributional impact of the FSDR was minimal. In particular, the FSDR did not give due regard to availability of services, acceptability of services, the accommodation of persons with disabilities in health care facilities, the accessibility of services and the affordability of services. The FSDR committed to ensuring accessibility of services to all people of South Africa. However, there was a lack of detail on how the FSDR intended to ensure that these services are accessible. The poor definition of and inclusion of acceptability proved to show this was a neglected dimension of access. The study further posits, that the lack of planning for availability results in gaps in the outcomes of a policy document. Findings from this study revealed that affordability was not sufficiently provided for in the FSDR document nor was there any budget allocation to ensure access to health care.

A bottom up approach to policy development was employed where a consultation with numerous actors representing different spheres was done. The implementation, monitoring and evaluation on the other hand portrayed a top down approach. Factors such as mentorships and support and inter sectoral collaboration and engagement facilitated the process of the FSDR, while poor strategic planning, negative attitudes of staff towards the FSDR, lack of human and financial resources, lack of a framework for monitoring and evaluation and lack of reporting structures are all factors that negatively influenced the processes of the FSDR .

Study implications

In conclusion, the study findings suggest the need for alignment of the policy content to access to health care. This study identified the gaps in policy implementation of the FSDR and the lack of awareness at a grassroots level. It also revealed poor uptake of the FSDR at a grassroots

level which then impacts on access to health care and results in poor service delivery due to poor implementation. This study identifies the need for training for those who are implementing the FSDR and future disability policies. There is an urgent need for an effective monitoring and evaluation system. Additional to this, the gaps between development and implementation of the FSDR was a result of multiple barriers. These barriers should be considered in the content of the FSDR to improve it and ensure that the challenges are overcome to achieve the goal of inclusive rehabilitation service delivery.

Furthermore, this study has clinical implications as clinicians can use these findings to advocate for rehabilitation resources such as equipment and patient transport, when rendering services for people with disabilities and as a resource for future development of the disability policy. Additional to this, this study may be utilised by DPOs as a tool for advocacy to demand a comprehensive disability policy which should be a law to ensure that the rights of PERSONS WITH DISABILITIES are upheld and that access to health care for PERSONS WITH DISABILITIES is fully recognised in SA.

Strengths of the study

This study utilised an integrated framework approach using two frameworks namely; the Walt and Gilson (1994) health policy analysis triangle framework and the Penchansky and Thomas (1981) theory of access to health care. This brought rigour into this study to ensure that no information was missed. Policy studies generally use only the one framework for policy analysis, but this study further added an additional framework in order to be thorough and logical in reporting of findings, especially in the quest to establish how the FSDR was aligned to access to health care. This approach has been used before in a PhD study that looked at access to health care. Furthermore, the collaborative approach to data analysis and reporting that was applied in this study through the involvement of three coders in both the document analysis and the Key informant interviews ensured the trustworthiness of the study. Additional to this, this study utilised two sources of data and applied the same principles across both data sources to analyse the data using the two frameworks in an integrated approach. Moreover, the value of corroborating findings from the key informant interviews and the data from the document review was valuable. The rigour of this qualitative study was ensured through trustworthiness strategies. The thematic analysis was done using software as well as manual analysis.

Study limitations

The combination of the actors was skewed in favour of just twelve participants in the Johannesburg Metropolitan District. There was a lack of end user engagement with PERSONS WITH DISABILITIES . There was a lack of representation of therapists who are first in line to address the needs of the persons with disabilities and interact with them on a day to day basis. The results of this study are the perceptions of policy makers and not necessarily the lived experience of persons with disabilities for whom the framework is meant to benefit. The key informants were also all based in Gauteng which means that they could only give information on the processes of the policy as they pertaining to Gauteng regardless of the FSDR being a national framework which is meant to be implemented in all the provinces of SA. The interpretation of key informant responses could be subjective and influenced by the researcher's bias.

Recommendations

The development of a comprehensive framework for monitoring and evaluation of disability policy is recommended. This study findings suggest a need for disability training and conscientisation amongst rehabilitation staff and the general public to ensure improved awareness of disability and rehabilitation. An analysis of the FSDR should be conducted nationally, with focus on actors in all provinces of SA to identify successes and areas for improvement, as well as to compare similarities and differences between provinces. The framework is based on CBR, thus there needs to be an evaluation into this to establish if the framework meets the recommendations of the CBR. Further research into disability rights and policy is recommended for policy makers prior to the development of a new disability policy for SA. The FSDR could be utilised as a springboard to develop a formal disability policy for SA. This policy should ensure the alignment of the content to all the dimensions of access to health care namely, accessibility, affordability, acceptability, availability and accommodation.

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APPENDIX 1

- **ETHICAL CLEARANCE CERTIFICATE**

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Naeema Ahmad Ramadan Hussein El Kout

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190438

NAME: (Principal Investigator)	Miss Naeema Ahmad Ramadan Hussein El Kout
DEPARTMENT:	School of Therapeutic Sciences Gauteng Department of Health
PROJECT TITLE:	Analysis of the disability framework and strategy in South Africa: Access to healthcare for persons with disability
DATE CONSIDERED:	26/04/2019
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Sonti Pilusa and Khetsiwe Masuku
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	25/09/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

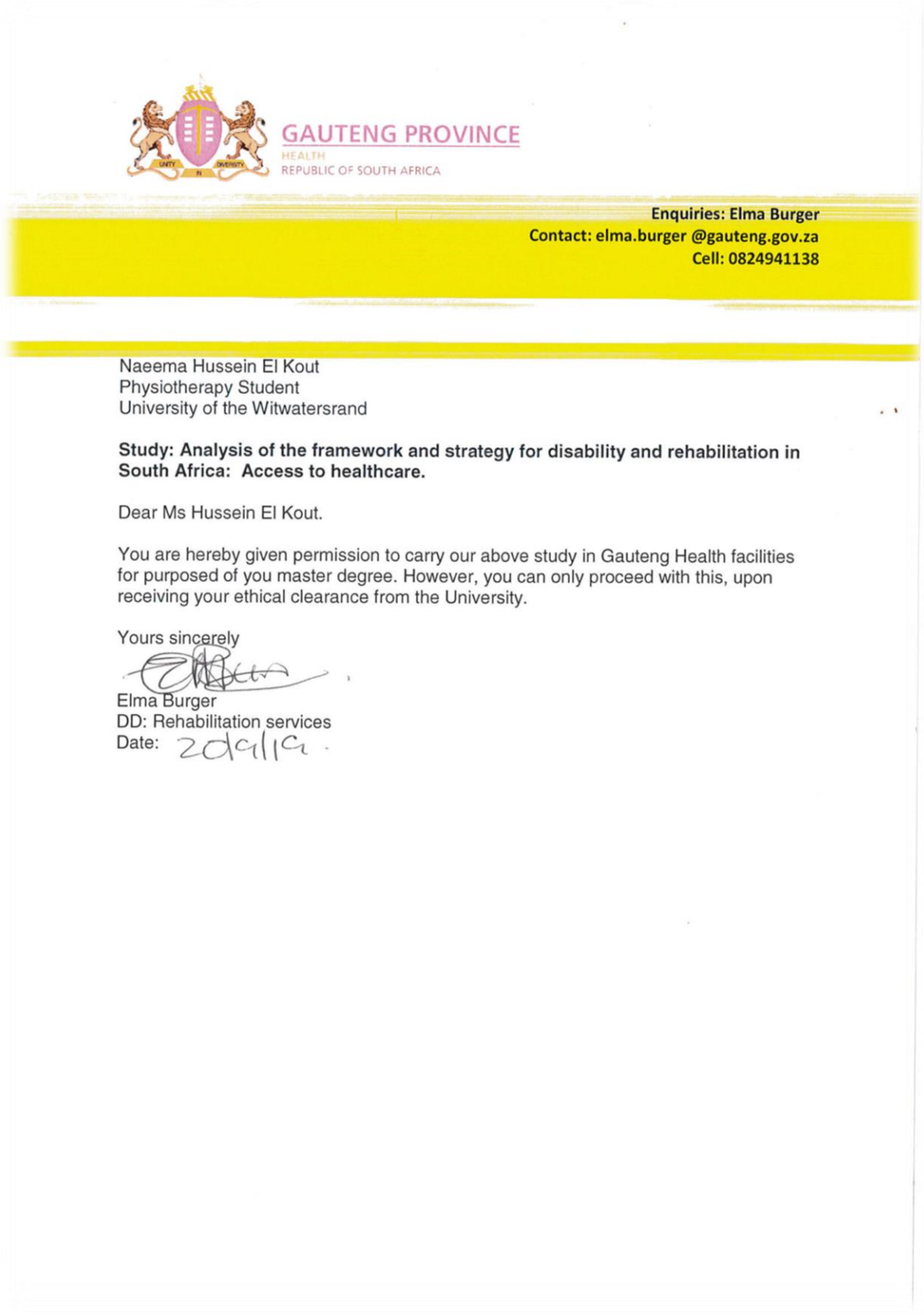
To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **April** and will therefore be due in the month of **April** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX 2

- **PERMISSION FROM GAUTENG DEPARTMENT OF HEALTH**



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enquiries: Elma Burger
Contact: elma.burger @gauteng.gov.za
Cell: 0824941138

Naeema Hussein El Kout
Physiotherapy Student
University of the Witwatersrand

Study: Analysis of the framework and strategy for disability and rehabilitation in South Africa: Access to healthcare.

Dear Ms Hussein El Kout.

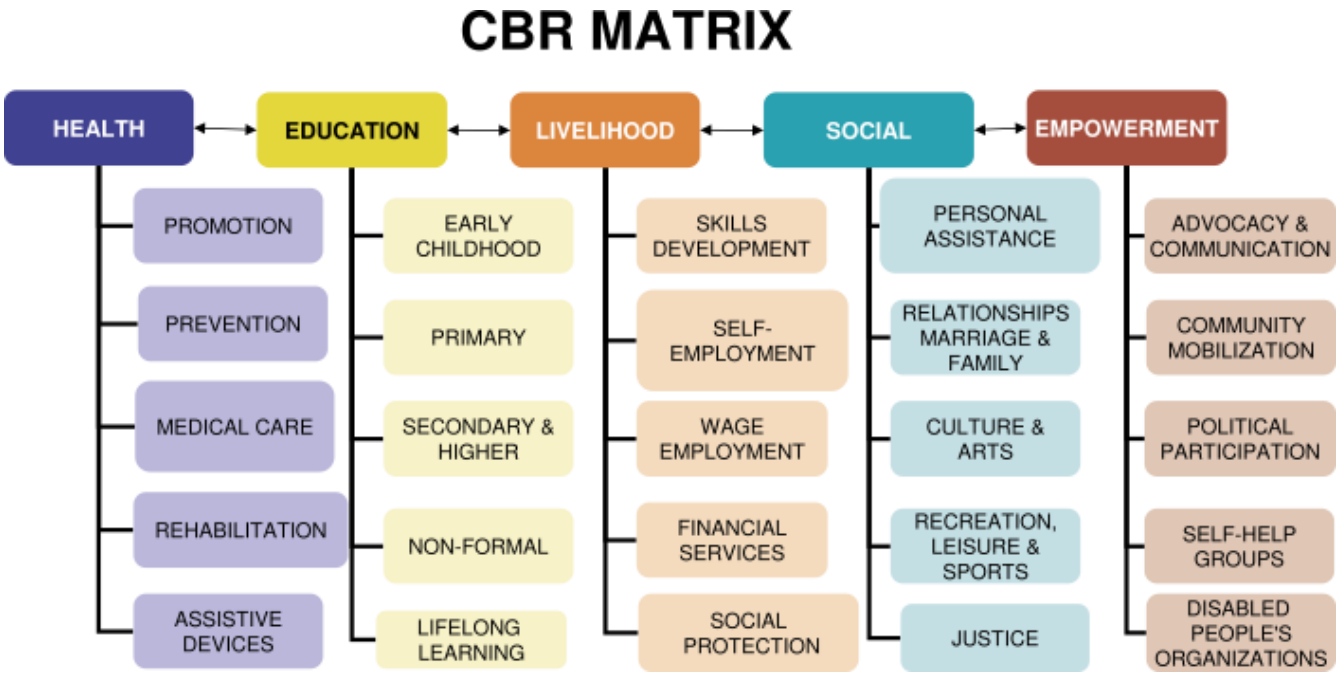
You are hereby given permission to carry our above study in Gauteng Health facilities for purposed of you master degree. However, you can only proceed with this, upon receiving your ethical clearance from the University.

Yours sincerely

Elma Burger
DD: Rehabilitation services
Date: 20/9/16

APPENDIX 3

- **CBR MATRIX**



World Health Organisation, 2010

APPENDIX 4

- **HEALTH POLICY TRIANGLE** (Walt and Gilson, 1994)

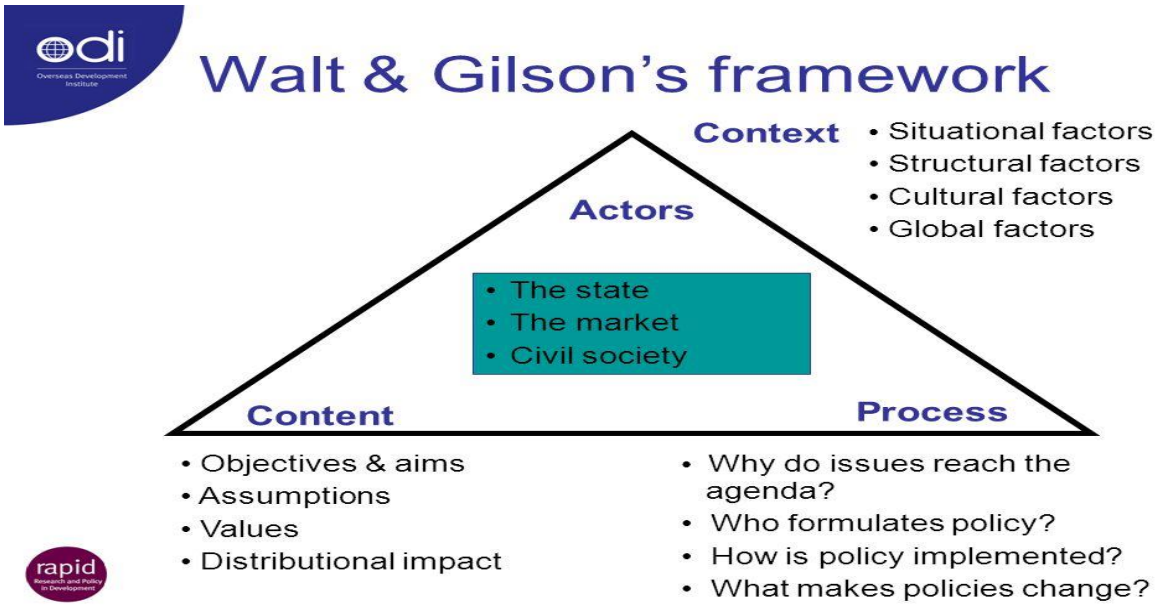


Image credit: (Buse and Young, 2006).

APPENDIX 5

SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE GUIDE

INTERVIEW GUIDE

Good morning/afternoon. Thank you for giving your time to interview you. My name is Naeema AR Hussein El Kout and I am a Masters student at the University of the Witwatersrand. Today I would like to learn from you about the Framework and Strategy for Disability and Rehabilitation (FSDR) related to access to health care for persons with disability. Lastly, would like to ask you about any factors influencing the FSDR related to access to health care for persons with disability.

This interview should last 30 minutes to an hour approximately and will be audio recorded. I have specific questions I would like to ask, but feel free to provide additional information. Please ensure throughout the interview you remain anonymous by avoiding the use of your own name. Please try to speak loudly, clearly, slowly so that your comments can all be audio recorded.

Do you have any questions?

Section 1: Identification Information

1.1 Participant identifier(number):	**1.3 Name of Interviewer:**
1.2 Date of interview	**1.4 Interview venue**

Section 2: Demographic Data Sheet for Key Informants

1.8 Identifier code:	
1.2 Gender	
1.3 Age	
1.4 Level of education	
1.5 Occupation	
1.6 Position in the department	

Interview Guide

Theme 1: **key Informant Role**	Can you tell me a little bit about your role in this department? Can you tell me a little bit about your role in disability management and what your thoughts are on the FSDR? Probe: How do you feel about policy related to access to health for persons with disability?
Theme 2: **The Context of the FSDR**	How did the FSDR come about? Probe: What was the reason for the development of the FSDR? Probe: How was the FSDR developed?
Theme 3: **The Content of the FSDR**	How does the content of the FSDR relate to access to health for persons with disability? Probe: in your experience, what are factors affecting access to health for persons with disability?
Theme 4: **The Processes of the FSDR and Factors Influencing the Processes of the FSDR**	In your experience, what factors affect the processes (initiation, development and implementation) of the FSDR? Probe: did you play a role in the processes of the FSDR?
Suggestions	What are some suggestions for the processes and factors affecting the processes of the FSDR and future disability policy in South Africa? Probe: What are some suggestions to improve access to health for persons with disability

This concludes the interview.

Thank you for your time and input

Interview Guide Checklist

Checklist	**Tick**
▪ Consent for interview and recordings	
▪ Audio recorder and extra batteries	
▪ Demographic information of the participant	
▪ All questions addressed	
▪ All responses rechecked with participant	

APPENDIX 6A

- **DOCUMENT REVIEW GUIDE**

DOCUMENT REVIEW GUIDE

This is a document developed by the researcher and the supervisors to be used as a tool to guide the process of the document review. It ensures that all aspects of the Walt and Gilson (1994) triangle framework have been analyzed and that all individuals are following the same system. This ensures that valuable information is realized, analyzed, coded and finally document (Witkin et al., 1995). The guide is in the form of a checklist and as each reviewer covers a section of the triangle framework, the checklist must be completed. The checklist covers the four aspects of the triangle framework namely, actors, content, context, and processes, as well as the respective descriptions.

The process of the document review: The markers will first be operationally defined specifically for the study. Following the final agreement of the coding manual by the student and the two supervisors, collaborative coding of the FSDR will commence. Saldhana, (2009) postulates that collaborative coding useful as a means of ensuring rigor. The FSDR will be read line by line by the student researcher and the two supervisors. Text segments from the policy will be classified as either pertaining to actors, context, content, and processes. Responses of the three coders will be compared and in cases where disagreements arise, the coders will engage in a discussion and reach a consensus.

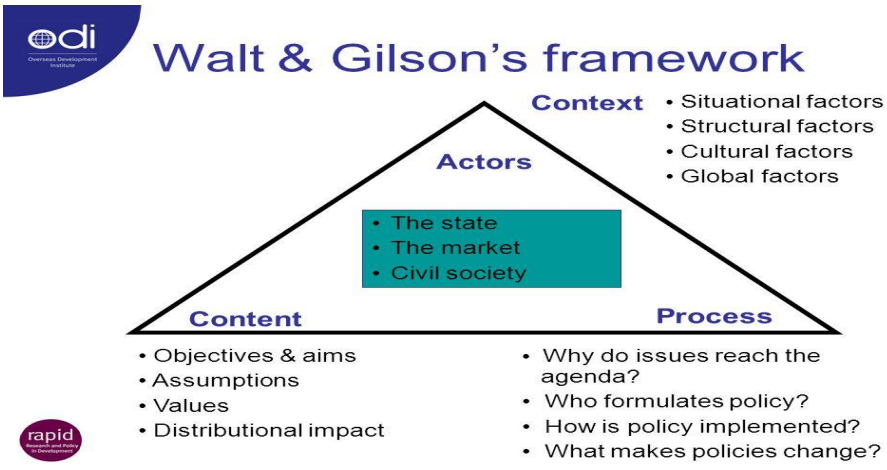


Image credit: (Buse and Young, 2006). Framework developed by (Walt and Gilson , 1994)

APPENDIX 6B

- **DOCUMENT REVIEW GUIDE**

Theme 1: **Actors in the FSDR**	- Identify actors in the FSDR - Identify the specific roles and responsibilities of the actors
Theme 2: **The context of the FSDR**	- Reasons for development of the FSDR - Situational factors - Structural factors - Cultural factors - Global factors and specific to SA
Theme 3: **The content of the FSDR**	- Aims and objectives of the FSDR - Assumptions - Values - Distributional impact - Access to health for persons with disability - CBR Matrix health component: promotion, prevention, medical care, rehabilitation, assistive devices
Theme 4: **The processes of the FSDR**	- Conceptualisation of the FSDR - Development of the FSDR - Implementation of the FSDR - Evaluation of the FSDR
Interactions between the 4 components of the policy triangle framework	- Actors at the center of the interaction - Content, context and processes interact with each other and around the actors

APPENDIX 7

- **PARTICIPANT INFORMATION SHEET**

STUDY INFORMATION SHEET

Study title: Analysis of the disability framework and strategy in South Africa: Access to Health care for Persons with Disability

Introduction

My name is Naeema AR Hussein EL Kout. I am currently doing my Masters degree by dissertation at The University of The Witwatersrand. My research is focused on the disability framework and strategy in South Africa related to access to Health care for Persons with Disability at Wits University. Research is a process used in seeking new knowledge. In this study, we aim to review the disability framework and strategy in South Africa related to access to health care for persons with disabilities. This study is involving research by document review and interviews and not routine care. This study is being done to identify the status, goals, and gaps in the strategy and framework for disability and rehabilitation in South Africa (FSDR). It may be used to inform future disability policy in South Africa. This study has been given ethical approval by the Human Research Ethics Committee, Faculty of Health Science, the University of the Witwatersrand (*Reference number to be added once obtained*).

Invitation to Participate

We are inviting you to take part in a research study which involves an analysis of the Framework and Strategy for Disability and Rehabilitation document.

The information below describes what the study will entail

1. Study design: A single case study which will use two data collection methods namely, a document review of the FSDR and semi-structured interviews.
2. We would like to request your voluntary participation in the semi-structured interviews in this study.
3. If you wish to participate in this study after reading this information form, you can sign the attached consent form for the interview, and one form for the audio recording. Once permission from you has been obtained, we will arrange for a time and place that is convenient for you to meet where we will conduct the interview. I (Naeema Hussein El Kout) will conduct the interviews myself.

4. The interviews will be approximately 30 minutes to an hour maximum. The interviews will be recorded on an audio recorder and will then be transcribed after the interview.
5. The questions to be asked will be very broad and open-ended about the FSDR, disability, and access to health care for persons living with a disability.
6. You will be given a copy of this information page and the consent forms, to keep for your personal records.
7. Feedback and any other pertinent information on this study during and after the completion of the study, will be available to you, should you request this information.

Risks of being involved in the study

There are no risks associated with participating in the interviews. The interviews will be done out of your stipulated working time so as not to affect your work and permission will be obtained from the Gauteng Department of Health prior to the interviews.

Benefits of being in the study

There are no direct benefits from being in the study.

Participation is voluntary

Your participation in this study is voluntary and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. Moreover, there is no requirement to provide a reason for withdrawing and any data collected on you will in default be destroyed if you withdraw unless you specifically consent to its retention.

Confidentiality

All the information obtained during this research will remain strictly confidential. This includes the audio recordings as well as the transcripts. A number will be allocated to you in the findings and you will be identified as a key informant. The information in the interview will be for the purpose of this study only. This research may be referenced in other studies; however, no reference will be made to your name hence you will not be identified personally. Any information obtained will not be disclosed to a third party, without your permission.

Results of this study may be published, which may, exceptionally, lead to cohort, or more rarely, individual identification. All data collected in the course of the study will be securely retained for two

(2) years, if a scientific publication arises from the study and six (6) years if there is no publication. Thereafter it will be destroyed accordingly.

Outputs

The study may be used as a tool to assist in the evaluation of the FSDR as well as inform future disability policy of South Africa. If you wish, we can share the outcomes of the study once it is completed.

Contact details of researcher/s

Should you wish to clarify anything, or find out more information on this study, please contact me on 0712745405 or email me on 726945@students.wits.ac.za. I will be supervised by two lecturers at Wits University. Their contact details are seen below:

1. Sonti Pilusa (Wits Physiotherapy department) – sonti.pilusa@wits.ac.za
2. Khetsiwe Masuku (Wits Speech Pathology and Audiology department) – khetsiwe.masuku@wits.ac.za

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand. A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.
If you have any concern over the way the study is being conducted, please contact the Chairperson of this Committee who is Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on Clement.Penny@wits.ac.za. The telephone numbers for the Committee secretariat are 011 717 2700/1234 and the e-mail addresses are Zanele.Ndlovu@wits.ac.za and Rhulani.Mukansi@wits.ac.za

Thank you for reading this Study Information Sheet.
Date: Month and Year only (*To be confirmed)*
Principle investigator: Naeema AR Hussein El Kout
Contact number: 0712745405
Email address: 726945@students.wits.ac.za

APPENDIX 8

- **INFORMED CONSENT FORM**

PARTICIPANT INFORMED CONSENT SHEET

STUDY TITLE: "Analysis of the disability framework and strategy in South Africa: Access to Health care for Persons with Disability"

SPONSOR: to be confirmed

Principal Investigators: Naeema AR Hussein El Kout

Institution: UNIVERSITY OF THE WITWATERSRAND

DAYTIME AND AFTER-HOURS TELEPHONE NUMBER(S):

Daytime numbers: 011 717 3715/ 082 0536190/0712745405

Afterhours: 082053 6190

DATE AND TIME OF FIRST INFORMED CONSENT DISCUSSION: dd/mm/yr/time

You are invited to volunteer for a research study. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You should not agree to take part unless you are completely happy about all the procedures involved. If you agree to be a part of this study, we require written informed consent below.

1. I have been given a Participant Information Sheet which explains the nature and processes involved in this study, which is attached hereto;
2. I was given time to read it, or had it read to me, in the language I best understand;
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate benefit to me, should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time;
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained

7. I have been given a range of contact details, listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

Contact details:

Naeema AR Hussein El Kout, Principal Investigator, telephone no. 0712745405 726945@students.wits.ac.za

Sonti Pilusa, Supervisor, on telephone no. 011 717 3715 , sonti.pilusa@wits.ac.za

Khetsiwe Masuku, Co-supervisor, on telephone no. 011 7174584 khetsiwe.masuku@wits.ac.za

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at Clement.Penny@wits.ac.za.

Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: Zanele.Ndlovu@wits.ac.za or Rhulani.Mkansi@wits.ac.za

Name of Participant : _____

Date : _____

Place : _____

Signature or Mark : _____

Name of Researcher : _____

Signature or Mark : _____

Witnessed by

Name of Witness : _____

Signature : _____

Date : _____

APPENDIX 9

- **AUDIO RECORDING CONSENT FORM**

CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION

Project Title: Analysis of the disability framework and strategy in South Africa: Access to Health care for Persons with Disability

I hereby consent for Naeema AR Hussein El Kout to do an audio 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, the research supervisors and the individual doing the transcription.
- The recording will be transcribed and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings, or (b) six (6) years if no publications arise from this research
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

Name of Participant : _____

Date : _____

Place : _____

Signature or Mark : _____

Name of Researcher : _____

Signature or Mark : _____

Witnessed by

Name of Witness : _____

Signature : _____

Date : _____

APPENDIX 10

- **PERMISSION LETTER TO THE GAUTENG DEPARTMENT OF HEALTH**

Request for permission to conduct research at The Gauteng Department of Health

My name is Naeema AR Hussein El Kout. I am a master's student at the University of the Witwatersrand. The title of my research is the following: Analysis of the disability framework and strategy in South Africa: Access to Health care for Persons with Disability. In this study, we want to learn about the content, context, key role players and the processes and associated factors of the disability strategy and framework of South Africa. The prevalence of disability in South Africa is 7.5% (Stats SA, 2016). There are various underlying causes and factors affecting disability in South Africa. Persons with disability (PERSONS WITH DISABILITIES) have the right to access health care and to ensure this, health policy should be implemented. An effort to ensure these rights include the Strategy and Framework for Disability and Rehabilitation, however, it has not been analyzed, which is what this study aims to do.

Research objectives

i. To identify key-role players in the conceptualization, development and implementation processes of the disability framework and strategy in South Africa, related to access to health care for persons with disability
ii. To describe the content of the disability framework and strategy in South Africa, related to access to health care for persons with disability
iii. To describe the context of the disability framework and strategy in South Africa, related to access to health care for persons with disability
iv. To determine the processes of the disability framework and strategy in South Africa, related to access to health care for persons with disability
v. To describe factors influencing the processes of the disability framework and strategy in South Africa, related to access to health care for persons with disability

I would like to request permission to conduct the study by inviting employees of The Gauteng Department of Health to be interviewed as part of the study. This includes the rehabilitation services manager, the cluster managers and the Johannesburg Metro District manager, as well as the chief allied therapists. The interviews require 30 minutes to an hour of the employee's time. This will be done out of their stipulated working time in order not to interfere with their work duties. Ethical clearance will be obtained from the Human Ethics Research Committee of the University of the

Witwatersrand. The data collected from the study will be forwarded to the interview participants, should they request it. This information may be useful in informing future disability policy and to assist in the evaluation of the disability strategy and rehabilitation. Participation is completely voluntary, and the participants can withdraw anytime. The information will be treated with the strictest confidence.

Should you require any further clarity or information regarding the study, you are welcome to contact me on the details provided below.

Kind regards

Naeema AR Hussein El Kout
0712745405,
726945@students.wits.ac.za
MSc Physiotherapy – Student
University of the Witwatersrand

Research supervisors

Sonti Pilusa: 0117173715, sonti.pilusa@wits.ac.za
Khetsiwe Masuku: 011717 4584, khetsiwe.masuku@wits.ac.za

APPENDIX 11

- **TURN-IT-IN REPORT**

FINAL DISSERTATION 7 APRIL

ORIGINALITY REPORT

18%	11%	4%	15%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to University of Witwatersrand Student Paper	3%
2	Submitted to University of KwaZulu-Natal Student Paper	1%
3	www.dgmc.co.za Internet Source	1%
4	www.health.gov.za Internet Source	1%
5	repository.up.ac.za Internet Source	1%
6	Submitted to AUT University Student Paper	<1%
7	hdl.handle.net Internet Source	<1%
8	Submitted to Trinity College Dublin Student Paper	<1%
9	Submitted to University of Cape Town Student Paper	<1%

10	Submitted to London School of Hygiene and Tropical Medicine Student Paper	<1%
11	Submitted to University of Southampton Student Paper	<1%
12	"The United Nations Convention on the Rights of Persons with Disabilities", Springer Science and Business Media LLC, 2017 Publication	<1%
13	digital.library.adelaide.edu.au Internet Source	<1%
14	scholar.sun.ac.za Internet Source	<1%
15	Submitted to University of Sheffield Student Paper	<1%
16	Submitted to 76830 Student Paper	<1%
17	Submitted to University College London Student Paper	<1%
18	pdfs.semanticscholar.org Internet Source	<1%
19	www.spinedragon.com Internet Source	<1%
20	Submitted to University of Leeds Student Paper	

		<1%
21	Submitted to University of the Western Cape Student Paper	<1%
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