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EXPLORING THE QUALITY OF LIFE OF DISABILITY GRANT BENEFICIARIES: THE CASE OF MAGALENI AND DEBE-NEK TOWNSHIPS IN RAYMOND MHLABA MUNICIPALITY, EASTERN CAPE PROVINCE

By

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DECLARATION

I, Nondwe Gamnca (Student Number: 201101299), the undersigned, hereby declare that the work contained in this dissertation is my own work, except where due acknowledgement is made with full references in the text. This document has never been submitted to any university or institution of higher learning.

This project is submitted in the fulfillment of the requirements for the degree Master of Social Work at the University of Fort Hare.

Signed ..N. Gamnca.....

Date ..29/08/2017..........

DEDICATION

This work is dedicated to my late grandmother Nonzwakazi Sophlina Gamna. May your soul continue to rest in peace grandmother.

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ABSTRACT

The aim of this study was to explore the quality of life enjoyed by disability grant beneficiaries through a case study conducted in the townships of Debe Nek and Magaleni in the Raymond Mhlaba Municipality in the Eastern Cape, South Africa. The study utilized a qualitative approach through interviews conducted with a sample of 32 participants from the relevant population of beneficiaries of disability grants, family members and social workers. The study used individual interviews as a method of data collection, with different questions presented to disability grant beneficiaries, family members and social workers respectively. The findings of the study indicated that disability grants have a significant influence on poverty alleviation in terms of enabling recipients to afford basic needs. The study also showed that the grants enabled entire households to pay for basic items such as water and electricity. Furthermore, grant money was used to pay for items that were non-essential to the actual beneficiaries, but which contributed to improving the lives of the family as a whole, such as school fees of children living with grant beneficiaries. It is recommended that the government should offer more health care facilities to disabled people, based on the finding that health is a significant barrier to their ability to function independently in society. Secondly, government should provide adequate housing to disabled people so that it is not necessary for them to utilize grant money for the purpose of securing housing with the appropriate facilities for disabled people. Finally, suggestions for further studies are also presented.

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
CDG	Care Dependency Grant
CSG	Child Support Grant
CSS	Central Statistical Service
CPR	Cardiopulmonary Resuscitation
CWP	Community Work Projects
DG	Disability Grant
DSD	Department of Social Development
EC	Eastern Cape
EPWP	Expanded Public Works Program
FS	Free State
GEAR	Growth Employment and Redistribution
GP	Gauteng Province
GIA	Grant in Aid
HIV	Human Immune Deficiency Virus
ILO	International Labour Organization
KZN	Kwazulu Natal
MP	Mpumalanga Province
NW	North West

NC	Northern Cape
OAG	Old Age Grant
RDP	Reconstruction and Development Programme
SASSA	South African Social Security Agency
SMG	State Maintenance Grant
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
WVG	War Veteran Grant

CHAPTER ONE

GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

This chapter seeks to give general direction to and a summary of the whole study. It is the general introduction to the study, whose focus it was to explore the quality of life of disability grant beneficiaries. The chapter provides the background of the study and the motivation for conducting the study. The problem statement, research questions, aims and objectives, justification of the study, significance of the study, delimitation and scope of the study are also included in the current chapter. Finally, the chapter outline for the entire study is provided as an overview of and a guide to the contents.

1.2 Background of the study

Varney (2013:129) defines disability as a physical or mental impairment, which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities. People with disabilities tend to be disempowered and deprived of economic and social opportunities and security because of social and physical barriers in society. Furthermore, they are also underserved by most public and private institutions and services. As a result, people with disabilities tend to be the poorest of the poor (Shrestha & Deepak, 2009). Women with disabilities in particular are often vulnerable to poverty because they have fewer economic means compared to both their disabled male counterparts and the non-disabled and may resort to begging for survival (Elwan, 2000: 56).

According to Chalklen (2003:14), under apartheid South Africa, the experiences of disabled people were also the experiences of people living in a deeply divided and unequal society. Both black and white disabled people were discriminated against and marginalized because of their disabilities. They had limited access to fundamental socio-economic rights such as employment, education and appropriate health and welfare services. This kind of discrimination and marginalization occurred because disabled people in general were seen as people who were sick or in need of care, rather than as equal citizens with equal rights and responsibilities (Chalklen, 2003:35).

Presently there is no legislation dealing with disabilities and to address the situation of, and protect the rights of people with disabilities in South Africa. The South African government is developing a national disability policy that will culminate in a Disability Act, but the actual implementation of the Act and the practicalities involved are still being conceptualized. However, notwithstanding this lacuna in the legislation, the South African Constitution of 1996 protects the rights of disabled people. In addition to the protection of disabled people's right against discrimination by the Bill of Rights, the Constitution also provides provisions for the rights of disabled people in terms of Social Security. Section 27 (1) of the Bill of Rights (Chapter 2) states: "Everyone has the right to have access to social security, including, if they are unable to support themselves and their dependants, appropriate social assistance" (Child Health Policy Institute & South African Federal Council on Disability, 2001:12).

One of the ways the government meets this responsibility is through the provision of a disability grant. The disability grant offers monthly income support of R1500.00 for people of all ages who have a disability that prevents them from being able to support themselves. The amount changes every year (South African Social Security Agency, 2016). To be eligible for a disability grant, the applicant must have a medical assessment that is no less than three months old and which confirms that they have a disability in terms of the Social Assistance Act; be between 18 and 59 years old; be a South African citizen, a permanent resident or a refugee living in South Africa; and have assets and income that qualify them as being in need. They will not qualify if they refuse to undergo medical treatment or to do any work that they could do, or are cared for by an institution wholly funded by the state (Department of Social Development, 2016).

While the purpose of the disability grant is to ensure that the needs of the disabled are provided for, it is uncertain whether the disability grant offers anything over and above covering the basic needs. In other words, its purpose is not linked to quality of life. It was the goal of this study, therefore, to establish whether or not the quality of life of the beneficiaries of the monthly disbursement was affected in a significant way by the grants.

Quality of life means a life that allows a human being to experience pleasure from being alive, over and above basic survival. A good life can be equated with living a life of high quality. Quality of life can thus be considered as a concept that identifies what is important, necessary and satisfying in human existence. The concept dates back many hundreds of years. The earliest known reference to quality of life is made by Aristotle, who used the term “eudemonia”, or a “good life” in the sense of human well-being and a state of existence in which a human being flourishes. However, this idea did not enter into the Social Sciences, particularly the disciplines of Sociology and Psychology, as a defining concept until the beginning of the 20th century, and it only began being researched on in the field of disability in the 1980’s and 1990’s. Since then, there has been a significant growth in the use of the concept and its application within the field of both intellectual and related disabilities. Quality of life comprises a number of objective factors such as state of health, level of education, income, property, relationships with others and the economic situation of the country. In the field of intellectual and developmental disabilities there has been an attempt to define and consolidate ideas about quality of life. Quality of life is therefore essentially an integrating concept, which takes into account a number of previous approaches and concepts such as normalization, inclusion and empowerment, though the development of quality of life has resulted in some modification to those practices (Ventegodt et al, 2003:1031).

1.3 Research problem

This study was prompted by the need to establish if the grant amount that is allocated to disabled people met, the fundamental needs of the beneficiaries for them have quality life. Although the South African government has committed itself to championing equality within society, the depth and scope of the issue of disability was underestimated, as the disabled are often marginalized in the workplace and other communal developments and obtaining the requisite information has proved a greater task than anticipated (Chalklen, 2003). Nonetheless, to address the immediate needs of the disabled, the government has come up with some measures and strategies to accommodate and lessen the burden experienced by disabled people in South Africa. These measures and strategies include, among others, the issuing of the disability grant to all registered disabled people to sustain their well-being. However, the effectiveness of the disability grants in countering poverty and marginalization has not yet been effectively established. It is against this backdrop that the study sought to explore the ability of the disability grant to sustain quality of life of the disabled in South Africa; to establish whether the grant is able to ensure the well-being of beneficiaries of the disability grant. This was important in order to establish whether grant beneficiaries enjoy quality of life.

1.4 Research aim and objectives

The aim of this study was to explore the quality of life of disability grant beneficiaries and this was guided by the following objectives:

- To investigate whether disability grant beneficiaries are financially satisfied with the money they receive from the government.
- To explore the impact of the disability grant on the physical health of beneficiaries.
- To find out whether the disability grant helps in social relations and enhances support to beneficiaries.
- To explore the general life satisfaction and wellbeing of disability grant beneficiaries

1.5 Research questions

The study sought to answer the following research questions:

- How effective is the disability grant in providing financial satisfaction to disability grant beneficiaries?
- What is the impact of the disability grant on the physical health of beneficiaries?

- To what extent does the disability grant enhance social relations and support to beneficiaries?
- What is the extent of general life satisfaction of disability grant beneficiaries?

1.6 Significance of the study

This study's investigation of the circumstances of beneficiaries of the disability grant informs the government and stakeholders on whether there is need for more funding and more socially channeled involvement by government in order to meet the needs of people with disabilities in South Africa. The study's findings contribute to the existing body of knowledge and research concerning the quality of life of disability grant beneficiaries. It was hoped that this study would stimulate and provide objective and new academic research for further investigation and policy planning. Professionals, policy planners and students are likely to benefit directly from the findings of this research.

1.7 Delimitation and scope of the study

The research explored the quality of life of disability grant beneficiaries by means of a case study that encompassed two villages, namely, Magaleni in Fort Beaufort and Debe Nek in Middledrift. Both villages are in the Raymond Mhlaba Municipality in the Eastern Cape province of South Africa. The research was conducted between September and October 2016.

1.8 Limitations of the study

There were no limitations encountered, either during or subsequent to the research being conducted. Since the study was exploratory in nature, it intended to offer an in-depth understanding. Due to the qualitative nature of the study and the methodology utilized, which produced information that is specific to the context of the research, the findings are not transferable and cannot be generalized to other contexts. The findings of the study can be considered valid in the specific context in which the research was conducted and within the context delimited by the constraints of space and time within which the research was conducted.

1.9 Definition of terms

Key terms of the study are defined below. The key terms include such terms as disability, quality of life, social grant beneficiary and caregiver.

1.9.1 Disability

The Convention on the Rights of People with Disabilities identifies persons with disabilities as those "who have a long-term physical, mental, intellectual or sensory impairment which in interaction with various barriers may hinder their full and effective participation in society on equal basis with others" (Iriarte et al, 2015:5). This is adopted as the working definition of "disability" in this study.

1.9.2 Quality of life

"Quality of life" means different things to different people and takes on different meanings according to the area of application. It is agreed that although the relevant aspects may vary from study to study, they usually include three broad areas covering physical, social, intellectual, and emotional aspects. These encompass general health, physical functioning, physical symptoms and toxicity, emotional functioning, cognitive functioning, role functioning, social well-being, sexual functioning and various existential issues (Fayers & Machin, 2015:5). The aspects stipulated by these authors guide the meaning of "quality of life" as used in this study.

1.9.3 Social grant beneficiary

A "beneficiary" is generally understood as a person who derives advantage from something, especially a trust, will, grant or life insurance policy. As such, a social grant beneficiary, according to this definition, is intended to derive benefit from the disability grant (Plessis & Reenen, 2011: 183).

1.9.4 Caregiver

A "caregiver" is defined as an individual who assists ill person(s), often helps with a patient's physical care, typically lives with the patient and does not receive monetary compensation for the help (Fitzpatrick & Kazer, 2011:34). For purpose of this study, in which caregivers live with social grant beneficiaries, this definition is adopted.

1.9.5 Disabled Person

According to Article 1 (1) of Convention No. 159, "the term disabled person means an individual whose prospects of securing, retaining and advancing in suitable employment are substantially reduced as a result of a duly recognized physical or mental impairment" (International Labour Conference, 1998: 17).

1.9.6 Disability Grant Beneficiary

The term refers to a person who, due to their physical or mental impairments, is assisted by the government or any other agency in terms of grants and financial aid (Plessis & Reenen, 2011:185).

1.10 Chapter outline

The study is divided into a total of five chapters. The chapter outline and focus of each chapter are presented below:

Chapter 1: Overview of the Study

In this chapter, the research topic, which explores the quality of life of disability grant beneficiaries, is explained in the background of the study. This chapter also presents the research problem surrounding disability grant beneficiaries, as well as the aims and objectives of the study. The research questions that the study sought to answer, as well as the significance of the same study, are also outlined in this introductory chapter.

Chapter 2: Literature Review

This chapter presents an overview and discussion of the relevant literature on the impact of disability grants on the quality of life of beneficiaries. The history of social security and the developments that have taken place in providing for the disabled is also discussed, along with a discussion of the different types of the social security systems.

Chapter 3: Research Methodology

This chapter elaborates in detail the research design and methodology that were conceptualized, developed, adopted and implemented in collecting data.

Chapter 4: Data Analysis, Presentation and Interpretation of Findings

Chapter 4 presents analyses and interprets the data that was collected. It also offers an overview of the findings relating to the quality of life of disability grant beneficiaries in the area under investigation.

Chapter 5: Summary of the findings, Conclusions and Recommendations

This chapter presents a summary of the findings and conclusions, whilst also making recommendations relating to the topic insofar as changes to existing provision and practices are concerned. It also offers suggestions relating to further research that could be undertaken in this field to expand the existing body of knowledge.

1.11. Conclusion

This chapter introduced the study, provided the background of the study, the problem statement, study purpose, research objectives, research approaches and significance of the study, as well as indicating the organization of the research into chapters. The next chapter offers a critical discussion of the literature relating to the topic of the study, as well as providing the theoretical framework used in the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Introduction

The previous chapter (Chapter 1) provided the background of the study, the problem statement, study purpose, research objectives, research approaches and significance of the study. This chapter discusses the literature review on the topic, which explores the quality of life of disability grant beneficiaries. The discussion in this section deals with the theoretical framework utilized in the study, followed by an overview of various aspects relating to the topic under research. These aspects include the history of social security (from welfare to social development), disability in relation to quality of life, social assistance and different types of social grants, the implementation of the disability grant and challenges faced by people with disabilities, as well as existing policies protecting people with disabilities. The chapter also provides tables offering statistical summaries of disability grant beneficiaries in different provinces of South Africa

2.2 Theoretical framework

The theoretical framework constitutes concepts and ideas that help to integrate the concepts of the study into a wider body of widely accepted theories relating to the research area (De Vos, 2005). A thoughtfully developed conceptual framework gives a convincing platform that shows how the researcher's investigation is linked to or forms part of a wider theoretical dispensation. The theory used in this study is Maslow's hierarchy of needs (1970), an approach that offers an appropriate lens for the research, as it deals with the nature of human needs and their prioritisation in order to achieve human satisfaction, or quality of life. At the same time, Maslow's hierarchy of needs provides a framework for explaining the objectives and intentions of social grants in relation to their contribution to the implementation of policy that is aimed specifically at improving the quality of life.

2.2.1. Maslow's hierarchy of needs

Born in 1908, Abraham Maslow is one of the founding fathers of humanistic psychology, an approach to understanding behaviour that developed in the middle of the 20th century. Maslow first proposed his "hierarchy of needs" in his 1943 paper (A Theory of Human Motivation). It was fully expressed in his 1954 book "Motivation and Personality". As an academic, he spent most of his professional career teaching, conducting research and developing his theories of behaviour. One of the key elements of Maslow's theory is that of the human hierarchy of needs. Maslow recognized that there were a number of different motivating forces, or needs, that influenced human behavior, and he created the "hierarchy of needs" to explain and to help understand how these different forces worked in relation to one another (Maslow: 1970:35)

2.2.2 The Hierarchy of needs model

Maslow's hierarchy of needs model describes human motivation. In this model, he separated people's needs into a hierarchy of five needs. The arrangement of the pyramid starts from the bottom and continues upwards, presenting the importance of the human needs which regulate human behaviour as illustrated in figure 1 below. Physical needs signify the lower-order needs, whereas socio-psychological needs characterize the higher-order needs. As soon as an individual fulfils the needs of each level, his or her behaviour is directed towards satisfying and reaching higher level needs. Once the fundamental physiological, safety and social needs have been fulfilled, the higher order needs become sought after and influence motivation and behaviour appropriately (Kuar, 2013:1061).

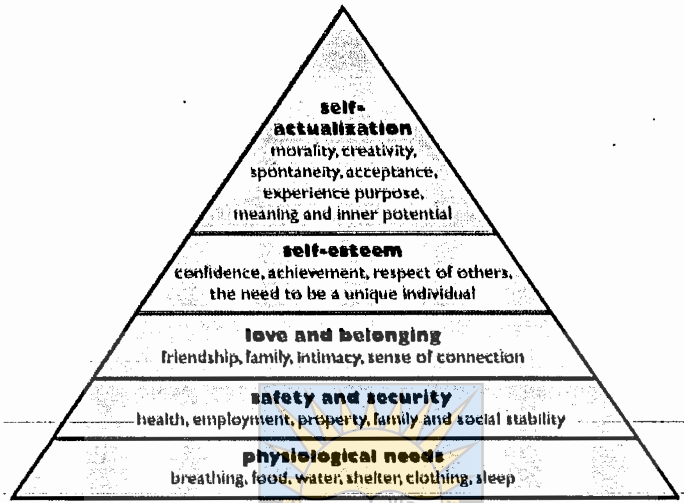

Figure 1: Maslow's hierarchy of needs pyramid

The pyramid above provides a visual description of the different levels of human needs as follows:

- **Physiological Needs** –The motivation to acquire food, water, and shelter is high and behaviours that secure these needs are strongly reinforced. Most people do not require assistance in this process, but some, especially those with some cognitive impairment may not be able to meet their physical needs consistently. This level includes the most basic needs that are vital to survival, such as the need for water, air, food, and sleep. Maslow believed that these needs are the most basic and instinctive needs in the hierarchy, because all needs become secondary until these physiological needs are met.

- **Security Needs** - When physical needs are met, people seek protection from physical and emotional harm. This level of need has both short-term consequences, like staying away from dangerous environments, and long-term consequences, like trying to build a safer world. This level includes needs for safety and security. Security needs are important for survival, but they are not as demanding as the physiological needs. Examples of security needs include a desire for steady employment, health insurance, safe neighbourhoods, and shelter from the environment.

- **Social Needs** - The next level of needs is to feel loved and accepted by others. People desire communication and attachment and seek out opportunities to relate meaningfully with others, especially family. These include needs for belonging, love, and affection. Maslow considered these needs to be less basic than physiological and security needs. Relationships such as friendships, romantic attachments, and families help fulfil this need for companionship and acceptance, as does involvement in social, community, or religious groups.

- **Esteem Needs** - People seek to have confidence and to be respected. After the first three needs have been satisfied, esteem needs become increasingly important. These include the need for things that reflect self-esteem, personal worth, social recognition and accomplishment.

- **Self-actualizing Needs** - The highest level of human needs involves being true to one's own nature and seeking self-fulfillment through creativity. Self-actualization can be achieved when all the other levels of need have been satisfied, by engaging in activities which give a sense of being truly alive or participating in something with broader meaning. Self-actualizing people are self-aware, concerned with personal growth, less concerned with the opinions of others, and interested fulfilling their potential (Thielke et al, 2012:475)

The needs have also been discussed by Yawson, Armar & Pappoe (2009) who have applied it to sustainable development, a subject not far off the current study. In general terms, this theory is appropriate for the study of the needs of disabled individuals, as people with disabilities experience different categories of needs as pointed out by Maslow (1970). People with disabilities have basic needs such as those for food, water and shelter for survival (UNHCR, 2011). It is the argument of this study that beyond these basic needs, they need to be protected from discrimination, whilst they also have a right to live freely and not in fear which, according to Maslow (1970), is a security need. According to Baladerian, Coleman & Stream (2013), discrimination of the disabled is tantamount to abuse of persons with disability. People with disabilities need to be self-confident, be in control and not to be judged because of their disability. They need to be able to interact with and enjoy relationships with other people, to socialize and to feel welcome as members of society at all times. Lastly, self-actualization applies as much to people with disabilities as it does to every human being, as people with disabilities need to be given a chance to make the choices and to participate in those activities that make them feel truly fulfilled in the sense of realising their potential, or becoming and being what they are capable of.

Precisely, the theory has the following functions: motivates, energizes and sustains behaviour hence the theory energizes the behaviour of the organisms and stimulates it for action. It also sustains behaviour for longer periods in the activity (Maslow as cited in Hoffman, 1988: 191). In Maslow hierarchy of needs, it is of highly importance that physiological needs are met. In this regard, the theory helps to understand how the disability grant sustains the life of the disabilities in the form of improving the quality of their lives.

Further, important to this theory is that Maslow felt that unfulfilled needs lower on the ladder would restrain the person from climbing to the next step. Thus, the disabled cannot achieve their life prospects if their quality of life is deprived. According to Maslow's theory of motivation, positive theories of human behaviour and motivation were pragmatic as well as hopeful, realistic and optimism about human beings' capacity to develop, address social problems and improve the human condition. Therefore, Maslow's theory of motivation embraces all the aspects of enthusiasm brought by the disability grant in order to keep the disabled people in a healthy and less deprived manner.

Further, the theory advances that physiological needs are the physical necessities for human survival. Failure to meet these necessities, human body cannot function properly and will eventually fail (Vanderbuilt University, 2009). Therefore the theory guides the study by exploring the positive effects of disability grant, hence in this case, the disability grant act as a motivation factor among the disabled in that they can meet at least meet me agree standards of living.

The theory has been used in other studies such as the implementation of school feeding programs and employee motivation in various organizations. In school feeding programs, the theory is used to embrace all the aspects of enthusiasm brought by the School Feeding Program by exploring the positive effects of motivation to the learners. The school feeding program act as a motivation factor for learners to have passion for school.

Therefore, the theory embraces that learners are motivated as well as energized to have the zeal of going to school with healthy bodies.

In employee motivation, the theory advances that workers need be motivated at work so that they can work productively. The employees perform well if their needs both at home and work are met. Failure to meet these needs, there will be no improvement in the service delivery because employees are not motivated and think that the rewards that are given to them are their benefits. During the interviews with the employees of the Department of Social Development has indicated that they believe that their needs are their rights and that they do not need to work and achieve more than what they are required to do. Therefore, the hierarchy of needs as a way of motivation are of paramount importance in all areas human life i.e. home, work and at school.

2.3 EMPIRICAL LITERATURE REVIEW

This part of empirical literature review deals with the history of social security, from welfare to social development, through social assistance to policies for people with disabilities. Further, it deals with literature on different types of social grants and the implementation of the disability grant.

2.3.1 History of Social Security

Prior to 1994, the approach to social security in South Africa was one of meeting the needs of the white minority. Social security for the elderly began with the Old Age Pensions Act of 1928 but under this one most black South Africans were not included (Sekhampu and Grobler, 2011). They add that in 1937 a disability grant was extended on the same racial basis and in the late 1930s and 1940s, the social security system was extended more widely, but with racially differentiated benefit levels. By 1987, child support grants to black majority remained a small fraction of the size of grants given to whites (Samson et al., 2005). In 1994, the first democratically elected government in South Africa inherited a fragmented social security system rooted in a concern for the interests of the apartheid constituency. The challenge faced by the government was to give meaning to the mandate in the new Constitution, that “everyone has the right to have access to social security, including if they are unable to support themselves and their dependents, appropriate social assistance" (1996 Constitution of the Republic of South Africa, Section 27, 1c). At the same time, however, the levels of benefits previously provided to the white minority were such that they could not be universalized in a fiscally sustainable manner (Samson et al, 2006:1).

The democratic South Africa of 1994 thus inherited a fragmented social security system which was not based on comprehensive coverage for the population as a whole, but which had started as a social security net for mainly 'whites'. Although it had been extended to other groups over time, the coverage remained inadequate. The White Paper on Social Welfare of 1997 adopted by the new government committed itself to an integrated and national comprehensive social security system (White Paper, 1997:51) and states that every South African should have a minimum income, sufficient to meet basic subsistence needs, and should not live below minimum acceptable standards (White Paper, 1997:49). The South African constitution supports this goal by entrenching the rights to social security and appropriate social assistance.

South Africa's current social security system constitutes the government's chief initiative in tackling these problems. According to Tanga and Gutura (2013; 128), the social security system has two main objectives: the first is to immediately reduce poverty among groups who are not expected to participate fully in the labour market and who are therefore vulnerable to the poverty experienced by people with low or no incomes, such as the elderly, those with disabilities and children. The second objective is to increase investment in health, education and nutrition, so as to increase economic growth and development. These objectives are reflected in the Government's White Paper on Social Development (1997:47), which states that "a social security system is essential for healthy economic development, particularly in a rapidly changing economy, and will contribute actively to the development process. It is important for immediate alleviation of poverty and is a mechanism for active redistribution".

2.3.2 From Welfare to Social Development

The transition to a multi-racial democracy provided the motivation for initiatives to address the poverty that existed on a wide scale in South Africa. The flagship policy of the new government in South Africa was the Reconstruction and Development Programme (RDP), introduced in 1994 after the first democratically elected government came to power. This policy framework provided an integrated, coherent, socio-economic program for addressing the ills of apartheid, including the alleviation of poverty arising from long-term discriminatory policies and practices (African National Congress, 1994). The RDP provided a framework for social development that would lead to a transformation of welfare policy in South Africa in pursuit of the values of social justice, democracy, equity and people centred development. Besides emphasizing fiscal discipline, increased social spending was required to address poverty alleviation by focusing on the marginalized sectors of the population and the welfare of impoverished women and children, in particular. This RDP framework informed subsequent government policies and programs relating to welfare provision and poverty alleviation.

In conjunction with the RDP framework, welfare policy was debated and reviewed, and the White Paper for Social Welfare (1997) was formulated within a social development paradigm. The main concern was to address poverty, which was widespread throughout South Africa, particularly in the rural areas. The transformation of welfare policy towards a social development paradigm, with its concomitant vision of inclusivity, would attempt to reach many more people who were in abject poverty. This shift in welfare policy and vision was in direct contrast to the previous welfare policy of the Nationalist-led government of the pre-1994 apartheid era in South Africa. Later, in 2000 the Department of Welfare changed its name to the Department of Social Development, which symbolized the shift in welfare policy and practice in South Africa. However, the RDP had soon after its introduction given way to a more conventional economic policy known as Growth, Employment and Redistribution (GEAR) of 1996. GEAR was launched as a structural adjustment program with the purpose of containing government spending and targeting specific areas that would improve economic growth by increasing industrial growth, trade and industry across national boundaries, thereby concomitantly promoting employment.

Job creation has proved increasingly difficult because of labour market conditions, including retrenchments and the shedding of jobs as a result of economic restructuring. It reflected the influence of the business sector and international socio-economic policies promulgated by the ANC-led government and its move to liberal economic policies aimed at increasing economic growth and international trade. As part of the global economy, South Africa is influenced by international capitalism, and as a result, by the World Bank and International Monetary Fund requirements. Thus, poverty alleviation became a secondary consideration, which had direct consequences for welfare policy. Midgely (2014) notes the valid criticism that the ANC government has placed a higher priority on attracting international investments and attaining economic growth than on alleviating poverty and meeting basic social needs. The South African Constitution (Republic of South Africa, 1996) made provision for welfare to be a concurrent responsibility of both the national and provincial governments. The national government is responsible for the development of policies, norms and standards, while the provincial government has administrative responsibilities relating to the delivery of welfare services, including pensions and grants. The formulation of the South African Constitution was a historic milestone in protecting the human rights of people who had previously been disenfranchised and provided the mechanism for poverty alleviation. Despite this, 45 per cent of the population is poor (Midgely, 2014:35).

2.4 Social Assistance

South Africa's social assistance system originated as a result of the state's response to poverty among white citizens in the 1920s and 1930s. The system first launched non-contributory old-age pensions, followed by programs for disabled and poor parents, followed by the introduction of a limited system of contributory unemployment insurance. In part, this system was de-racialized in the 1940s, but it was not until the end of apartheid that the racialization of social assistance was completely abolished with respect to old-age pensions, and access to social assistance as a whole was de-racialized (Seekings, 2008).

Today, South Africa's social assistance system is accessible to more beneficiaries than ever. The government has significantly increased its spending on social grants from an estimated 4-million in 1994 to 16.9 million in 2015 (Treasury, 2016). Prior to the late 1990s, the government offered social grants only to children (individuals under 14) and seniors (65 and over) which left an enormous gap in which the majority of the population did not have access to government assistance. This assistance gap closed in the 1990s as a result of a shift in the direction of the ANC social policy, in which an emphasis on reconstruction and redistribution was replaced by a vision of social policy that is responsive to both the constraints of limited resources and the need to achieve higher rates of economic development (Van Der Berg & Siebrits, 2010). This indicated a major ideological shift in the objective of social welfare in South Africa and opened the system to a large demographic that previously lacked access.

Today, more South African citizens than ever are recipients of social assistance as the coverage of social grants increased gradually over the years (Van Der Berg and Siebrits, 2012). The number of grants available and the scope of assistance offered to South Africans have expanded from offering grants to just children and seniors, to introduction of three coverage areas: childhood, working age, and old age. The assistance system is currently comprised of the following grants: Child Support Grant, Care Dependency Grants, Foster Care Grants, War Veteran, Disability Grant, and the Old Age Pension Grant. The Old Age Pension, the Child Support Grant, and DG are the largest programs in the share of social expenditures, it accounts for (37%, 31%, and 25%, respectively) and in the number of beneficiaries (2.2 million, 7.9 million, and 1.4 million beneficiaries respectively) (Brockerhoff, 2013:20).

2.5 Categories of social grants

In South Africa, social grants or cash transfers target particularly vulnerable parts of the population, such as the disabled, children, foster children, people who need care and the elderly (Department of Social Development, 2006; Dinbabo, 2011). Grants are awarded subject to a means test and provide an important source of income to households that would otherwise face devastation. However, income through social grants merely provides a basic relief against hardship important as it may be and can thus never fully compensate for the lack of employment and a decent income through wages (Brockerhoff, 2013:10). He further states that a mechanism that eases the hardship of poverty, but fails to tackle its root causes unemployment and marginalization.

2.5.1 Social Grants for Children

Throughout the world, particularly in developed countries, nation states provide support to children, highly emphasizing their vulnerability (UNICEF, 2009; September 2006; WHO, 2003). The needs of children have begun to take a centre stage in the whole issue of child rights (European Commission, 2005). However, in America the government is not strictly involved in social welfare issues, leaving most of the burden to the private sector (Karger and Stoesz, 2005). In most parts of the world, poverty and social exclusion still affect children (Noble et al., 2007).

Globally, the impact of social welfare policies on child poverty, inequity and social transformation has also in recent years become a higher priority on the policy agenda since the declaration of the United Nations Convention on the Rights of the Child. This is because children are regarded as the most vulnerable in society (September, 2006; UNICEF; 1998 UNICEF, 2009; WHO, 2003). In this regard, Ray (1998) argued that child welfare in a society is an index of the social and economic development of that society. According to Ray, the more important reason why child welfare has to be monitored is because children's contribution to the society in adulthood is determined to a large extent by their treatment during their childhood.

Dixon (1987) and Osei-Hwedie and Bar-on (1999) argue that in most sub-Saharan African countries, successive governments have, under diverse political-economic frameworks, set their social policy development objectives based on ideological definitions of their national problems. Hence, the process of change of social policy in Africa has been dominated, led and at times held to ransom by ideology. In general, for the analysis of social policies in Africa, Osei-Hwedie and Bar-on (1999) identified three distinctive periods, namely, the colonial period, the first decades of independence, and the more recent era of structural adjustment.

According to Osei-Hwedie and Bar-on (1999), the three distinctive historical-ideological periods are each associated with particular social policy welfare orientations. For example, in the colonial period, the European powers managed economic, social and political activities to the benefit of their interests, whereas, independence was a period of rising expectations and African socialism became a vehicle to completely eradicate the colonial social policy and its related structures by most sub-Saharan African countries. Osei-Hwedie and Bar-on further noted that, recently, the International Monetary Fund (IMF) intervened, introducing a new period in the history of African social policy: the era of structural adjustment. According to them, the essence of the IMF's approach to structural adjustment is the neoliberal notion that the state must divest itself of direct participation in the economy and the provision of social services to make way for free-market exchange.

Dixon (1987) observed that in the context of sub-Saharan Africa, social welfare programmes are mostly based on employers' contributions for pensions. Palacios and Sluchynsky (2006) also noted that in most sub-Saharan African countries, social welfare programmes, especially pension schemes, largely serve the wealthiest people, who reside in towns and have protected professions in the public sector.

However, Thulo (2006) shows that on the African continent, numerous initiatives have been made by the African Union and regional organisations in supporting efforts to promote the development and implementation of social welfare programmes, encouraging the social protection systems, mainly to protect children, women and elderly people. Thulo (2006) further noted that over the last decade, a growing number of countries have expanded or developed new programmes in an effort to reduce poverty and invest in social and economic development. For example, South Africa, Namibia, Ghana, Mali and Senegal have mainstreamed social protection into their Poverty Reduction Strategy papers and some have developed specific national social protection plans.

In South Africa, just as elsewhere in the world, children are considered as one of the most vulnerable groups in society, and the South African government has broadened social assistance grants for them. Three social grants are currently directed at children in South

Africa: the child support grant, foster care grant and care dependency grant. The South African situation on child support grants is discussed below.

2.5.1.1 Child Support Grant in South Africa

The Child Support Grant (CSG) was introduced in 1998, replacing the State Maintenance Grant, which was a state support program for single parents created by the apartheid regime. In its latter years, the SMG (R430 per month for the parent and R135 for the child in 2006) went mainly to the coloured group (Berg et al., 2011). With the introduction of the CSG in 1998 the pot of resources available after the phasing-in period had to be shared more widely, with the result that its value was driven down to R100 per month for each eligible child. Apart from its racially exclusive nature, the SMG had also been criticized a year earlier by the Lund Committee (1996) for its discrimination against children not living in nuclear families and those living with single mothers. The CSG was designed to follow the child and be paid to the primary caregiver, irrespective of the nature of the family in which the child was living. Because of the anticipated increase in the number of beneficiaries, the value of the CSG was fixed at a much lower level than that of the SMG. The CSG came into effect on the 1st of April 1998 and was provided at R100 per child for children under the age of 7. According to SASSA (2016), child support grant recipients are 11.9 million and are receiving R350 per month.

2.5.1.2 Foster Grant

The Constitution of the Republic of South Africa sets out minimum standards pertaining to socio-economic rights, including social security, social assistance and social services. Section 28(1) of the Constitution states that "every child has the right to family care or parental care or to appropriate alternative care when removed from the family environment", while Section 28(2) of the Constitution further states that "the best interests of the child are of paramount importance in every matter concerning the child". The provision of social assistance grants for children is executed not only through the CSG but also through the FCG. The Foster Child Grant (FCG) is paid to those who have gone through a court process to become registered as the foster parents of the child. The Grant is intended for children up to the age of 18 who are "in need of care" and who are not receiving such care from their biological parents (SASSA, 2016). This includes children who are abused, as well as children in trouble with the law. It has also been used to provide support for children orphaned by HIV and AIDS. It is orphans who have lost both parents who are most likely to be receiving the grant, provided that these children remain in the care of foster parents (Leibbrandt et al, 2011:57). According to SASSA (2016), there are over 533,000 foster grant recipients and they are receiving R890 per month.

2.5.1.3 Care Dependency Grant

The Care Dependency Grant (CDG) supports carers of disabled children up to the age of 18 by replacing lost earnings. Paid to a parent, primary caregiver or foster parent, it helps carers to take care of any child with a severe disability who requires full time or specialist care. The CDG is allocated to the caregivers of children suffering from severe mental or physical disability and in the permanent home care. The grant is valued at R1500 a month. To date, 129,000 children receive the care dependency grant (SASSA, 2016).

2.6 Social Grants for the Elderly

The elderly in South Africa are eligible to receive two grants, namely the Old Age Grant (OAG) and the War Veteran's Grant (WVG). These are discussed below.

2.6 .1 Old Age Grant

The Old Age Grant was introduced in 1928, initially to address poverty among elderly white people (Sagner, 2000; Triegaardt, 2006). Pension coverage was extended to the coloured and black population during the late 1930s and early 1940s (Aliber, 2001). The value of the grant was originally differentiated on the basis of race: in 1970, the pension for a white person was over seven times the value of the pensions for an African. In 1987, the National Party government (the 'Apartheid' regime) commenced the process of de-racialising pensions and this was complete by 1993 (Zanker & Morgan, 2011:6).

The OAG is a non-contributory scheme financed from the national budget and general taxes and is made available for the elderly. According to SASSA (2016), the age of eligibility for the grant for older persons is 60, provided they meet the criteria. Previously men aged 65 or older and women aged 60 and older qualified for the grant. Now both men and women aged 60 and older qualify. Currently over 3, 1 million people are benefiting from the Old Age Grant, receiving R1500 per month for people over 60, and R1520 for beneficiaries older than 75 years (SASSA, 2016).

2.6.2 War Veterans Grant

The War Veterans Grant is money that the Government gives to war veterans who took part in World War I, World War II or the Korean War. People involved in any other conflict are not eligible for this grant, although those who were active in the recent struggle for democracy in the country may access financial support from the Special Pension. The current amount of the War Veterans Grant is R1 500 (SASSA, 2016). Furthermore, the recipient of the War Veterans Grant must not be in receipt of another social grant for himself/herself.

2.7 Social Grant for the Disabled

South Africa uses the definition of disability adapted from the Convention on the Rights for People with Disabilities, which states that disability is 'the loss or elimination of opportunities to take part in the life of the community, equitably with others that is encountered by persons having physical, sensory, psychological, developmental, learning, neurological or other impairments, which may be permanent, temporary or episodic i nature, thereby causing activity limitations and participation restriction with the mainstream society' (Statistics of South Africa, 2011). According to the documented history of grant provision in South Africa in the form of social assistance for the elderly, disabled and children, financed by the state, the Social Grant for the Disabled started as early as 1910. In 1944 and 1947 old age pensions and disability grants were extended to Indians and Africans respectively (Sibanda, 2012). Nevertheless, inequality on the basis of race remained due to the level of the grants (Haarmann, 2000:12).

The disability grant is for adults who are severely incapacitated by mental or physical disability and therefore unable to work. Adults from the age of 18 who are unable to work because of a mental or physical disability are eligible for a means-tested disability grant, consisting of a monthly payment from the state to be used to cover basic living expenses. The disability section of the Social Assistance Amendment Act, 2010 states that a person is eligible for a disability grant, if he or she has attained the prescribed age and is, owing to a physical or mental disability, unfit to obtain by virtue of any service, employment or profession the means needed to enable him or her to provide for his or her maintenance (South African Government, 2016).

According to der Berg and Siebrits (2010), payment of the Disability Grant is determined based on a number of factors: applicants must meet age eligibility strategies (18-59 for females, 18-64 for males); they must be within the threshold of the means income and asset tests; and they must provide proof of assets, financial statements, proof of marriage, and proof of unemployment. Eligibility is determined by medical criteria, working age (between 18 years and retirement age), and is subject to a means test. Grants are either temporary (six months) or permanent (subject to periodic review), and the grant of R1500 in 2016 is received by approximately 1.3 million people of the South African population.

In order to qualify, one must be a citizen or permanent resident of South Africa and living in South Africa at the time of applying for the grant and must be unable to work. If the individual is under 18 years of age, the parents or guardian must apply for the care dependency grant instead. Should the disability be as a result of an accident at work or a motor vehicle accident, one is also eligible to have a compensation claim. The grant is not available to people in prison, living in a state institution (such as an old age home), living in a psychiatric hospital, getting care from a state treatment centre, or if one is getting state care from a state treatment centre, or if one is getting state care for a drug habit. It is also not accessible to individuals who refuse to undergo medical treatment (SASSA, 2016).

The number of people receiving disability grant has grown substantially in recent years, increasing from 646, 387 in 2010 to 817,045 in 2016. According to Paoli et al (2012), the disability grant plays an important role in reducing poverty and relieving the conditions of people with disabilities and health constraints. He argues further that the recipients generally belong to the black African population who also tend to have lower levels of formal education. The disability programme absorbs those who are already excluded from the labour force.

2.8 Medical assessment (for disability grant applicants)

The provisions of the Social Assistance Act of 1992 require that a person seeking benefits under the disability grant program should apply for them at an office of the South African Social Security Agency (SASSA). After the Agency officials and the applicant have gathered sufficient information to complete the application, it is forwarded to a state-appointed medical doctor for disability determination. The applicant is also referred to a state-appointed medical doctor for the same. At this stage, the disability examiners, with the aid of vocational and medical consultants, then determine whether a person is disabled basing on whether they satisfy eligibility rules and meet the criteria laid out in the act. The Act requires that each applicant goes through a progressive disability determination process where medical factors as well as vocational factors (such as age, marital status, value of assets owned) are used to determine an applicant's ability to work (SASSA, 2016).

Historically, the medical assessment of disability grants (DG) applicants has been conducted by medical practitioners appointed by the state. The practitioner, on completion of the examination process, compiles an assessment report upon which, the Department of Social Development will base their final decision. The report is valid for thirty days and if the application is approved, payment will be effected after three months. If the application is rejected, an individual is allowed to lodge an appeal within thirty days of receipt of the rejection advice (SASSA, 2011). Medical practitioners receive little or no training in the process of making assessments for disability and care-dependency grants. With shortages in such practitioners, in rural areas in particular and in the context of an enormous and rising healthcare burden in South Africa, it has become an increasing challenge to the health system to provide assessments. Where health resources are few, medical practitioners may resent the additional burden and try to avoid work that they see as administrative, such as assessments for grants, rather than the clinical work for which they were trained (Swartz and Schneider, 2006).

Partly because of the above issues, and mindful of the challenges in releasing equitable and efficient access to disability and care-dependency grants, the Department of Social Development circulated regulations in 2001, enabling assessment panels to make the assessments for grants. The panel may, but is not required to, have medical practitioners as part of its composition. The panelists are required to evaluate the information and determine disability for both disability and care-dependency grants. The panels themselves may have flexible membership, but should have representation from; a senior social security official; a rehabilitation therapist (nurse, social worker, occupational); or a reputable member of the community, namely a priest, the chief, or a person who is familiar with the community and its circumstances; and a member of the medical fraternity such as a doctor or specialist doctor if necessary (Mutasa, 2010:10).

2.9 Calculation of Benefits

Only those people whose financial situation is below a certain level are eligible to receive the disability grant. The test depends on the applicant's level of income (if one is not married), or on the income of both the applicant and spouse (if married). As of February 2009, a single applicant's income was supposed to be less than R23 500 per year and the value of their assets less than R451 200 in order to be eligible. In this case, assets are any items of value that one owns, such as a car, a television and an oven. If the applicant owns and occupies a house and does not lease it out, then this house does not contribute towards the asset value threshold. For married individuals, joint income must not be more than R43, 700 and the value of their joint assets must amount to less than R902, 400 and the house is applicable in the same way it applies under single individuals (Mutasa, 2010:11). The table below shows the monthly social grant values between the 2012/13 and the 2015/2016 period.

Table 2: Monthly social grant values 2012/13 to 2015/16

Type	2012	2013	2014	2015	2016
Old age grant	1220	1260	1370	1410	1500
Old age over 75's	1260	1280	1370	1430	1500
War veterans	1220	1260	1350	1410	1500
Disability grant	1200	1260	1350	1410	1500
Child support grant	280	290	310	330	350
Foster care grant	770	800	810	860	890
Care dependency grant	1200	1260	1350	1380	1500

SOURCE: SASSA

2.10 A statistical summary of social grants in South Africa

In revealing the current status quo of all the social grants in South Africa, SASSA (2016) makes use of a statistical fact sheet, which provides a summary of all social grants in the nine provincial regions of the nation, including the Eastern Cape (EC) that this study focuses on. The eight other provinces included in the fact sheet are the Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), North West (NW), Northern Cape (NC) and Western Cape (WC). The fact sheet presents the state of social grants in the country, including the disability grant, as at 31st March 2016. Social grants in this instance refer to the Old Age grant (OAG), War Veteran's grant (WVG), Disability grant (DG), Grant in Aid (GIA), Care Dependency grant (CDG), Foster Child grant (FCG), and the Child Support grant (CSG).

Table 3: Total number of social grants by type and region as at 31 March 2016

	GRANT TYPE							
Region	OAG	WVG	DG	GIA	CDG	FCG	CSG	TOTAL
EC	537,250	40	181,263	18,671	19,671	110,007	1, 875,603	2, 742,505
FS	187,887	2	73,915	2,777	6, 759	35,426	696,854	976,620
GP	514,733	66	111,438	4,358	16, 916	51,568	1, 727,620	2, 426,699
KZN	649,094	30	262,512	47,109	37, 148	106,755	2, 815,815	3, 918,463
LP	441,175	14	95,658	28,349	13,850	52,272	1,749,230	2,380,548
MP	234,576	13	77,577	7121	9, 928	33,735	1,053,716	1,416,666
NC	81,241	8	49,580	7,311	5,020	14,075	297,280	454,515
NW	240,084	6	82,305	8,134	9,122	36,001	817,437	1,193,089
WC	308,047	66	151, 293	13,976	12,626	30,176	966,345	1, 482,529
TOTAL	3,194,087	245	1,085,541	113,087	131,040	470,015	11, 972,900	16, 991,634

SOURCE: SASSA (2016)

Table 2 shows the status quo of social grants in South Africa per province as at 31st March 2016. It can be noted that as at 31st March 2016, the Eastern Cape had a total number of 181, 263 of disability grants that were distributed.

2.11 Quality of life and disability

Defining quality of life has never been easy. There is a strong subjective component in defining quality of life. Each individual's unique situation and experiences of the individual shape quality of life. However, Higgs (2011:33) defines quality of life as "a function of the resources and external factors that affect how that person is able to live, the internal choices that a person makes and their effects on that person, how that person perceives her or his individual needs are being satisfied, and his or her perceived level of subjective well-being or happiness". Quality of life is also often theorized as subjective well-being, a term that is often used interchangeably with 'quality of life' and is also imagined as comprising of life satisfaction, happiness and optimism" (Moller, 2004:45).

People with disabilities are entitled to a good quality of life. In order for an individual to have a good quality of life, certain needs must be considered. These most important areas include physical health, emotional well-being, family and social support, physical environment and care environment (Tiraphant, Peltzer, Thamma-Aphiphol and Suthisikon, 2017). Physical health is important to the quality of life of a person with a disability, regardless of his or her condition. Psychological well-being plays an important role as it impacts on how people deal with fact of disability (Blanchflower and Oswald, 2002). Families provide not only practical support, but emotional support also, which may be essential in helping the individual cope with their disability. Opportunities to connect socially with families and friends remain central to the lives of people with disability. The physical environment is also important for quality of life for people with a disability. The care environment also matters as people with disabilities must be empowered, provided with a choice, and given independence over their lives in both community and residential care settings (Murphy et al, 2007: 26).

2.12. Poverty and disability

South Africa has no official definition of poverty, nor any official measurements of poverty. Gumede (2012:12) highlights that even though poverty appears to have declined in the recent past, it still remains high. Gumede adds that poverty is apparent to the human eye and is profiled by shacks, homelessness, unemployment, casualized labour, poor infrastructure and lack of access to basic services. People with disabilities are excluded from the mainstream of society and experience difficulty in accessing fundamental rights (CHPI and SAFCD, 2001). Furthermore, there is a strong relationship between disability and poverty. Poverty makes people more vulnerable to disability and disability strengthens and deepens poverty. Particularly vulnerable are the usually disadvantaged groups in South Africa, including additionally, people with severe mental disabilities, people disabled by violence and war and people with AIDS (Gumede, 2012: 12).

Definitions of poverty are controversial. However, there is common agreement about the degrees of poverty. These are absolute poverty; moderate poverty, and relative poverty (Ravallion and Chen, 2009). Absolute poverty implies that households are unable to meet the basic needs for survival. They are chronically hungry, unable to access health care, lack the facilities of safe drinking water and sanitation, cannot afford education for some or all children, and perhaps lack fundamental shelter, and basic article of clothing like shoes (Sachs, 2005:20). Moderate poverty refers to conditions of life in which basic needs are met, but just barely, whereas relative poverty is generally perceived to be a household income level below a given proportion of average national income. While calls have been made to look at poverty in non-economic terms (Sigalla, 2005), almost half of the population continues to live under the poverty datum line. There are estimates that just over twenty-two million people in South Africa live in poverty (Aldezadeh, 2011:23; cited in Mashamaite, 2016)

Poverty and disability are closely linked (MRC South Africa Technical Report, 2001). Disabled people across the world are highly represented among the poor. It is estimated that about 80% of disabled people in South Africa live in poverty (South African Government, 2015). Disabled children and children in general are highly represented among the poor and they are often subjected to social, cultural and economic disadvantages that limit their access to health care, education, vocational training and employment. It is argued that disabled people are likely to experience higher levels of financial difficulties (African Child Policy Forum, 2011). Although disabled people need higher income to maintain the same standard of living as non-disabled members they usually receive less, which makes in more difficult to meet their basic needs for survival (Groce et al, 2011).

2.12.1 Poverty in South Africa in general

Statistics South Africa (2007), as cited by Moyana (2008), reveals that in South Africa there is no universal or standardized way of measuring poverty. However, this brief review of literature on the nature of poverty in South Africa reveals that poverty is often understood in quantitative terms. In South Africa, the poor seem to be often been defined in terms of their income, specifically by how much they earn per month or per day.

2.12.2 Poverty in South Africa per region

Statistics South Africa (2012), discusses poverty in South Africa per region by making use of three distinct poverty lines, namely the food poverty line, the lower-bound poverty line and the upper-bound poverty line. Any person who lives below the minimum income stipulated by these three poverty lines is regarded as poor. The food poverty line is pegged at R305, the lower-bound poverty line at R416 and the upper-bound poverty line at R577.

According to Statistics South Africa (2012), between 2008 and 2009 when the food poverty line was used, Limpopo was the poorest province with 48.5% of the total share of its population living below the food poverty line, followed by the Eastern Cape with 35.7% and then KwaZulu-Natal with 33%. When using the lower-bound poverty line of R416 during the same period, Limpopo ranked the poorest, with 62.1% of the total share of its population living below the lower-bound poverty line, followed by the Eastern Cape with 51% and then Mpumalanga with 47.6%. Between 2008 and 2009, if the upper-bound poverty line of R577 is used, it can be noted that Limpopo was the poorest, with 74.3% of the total share of its population living below the upper-bound poverty level, followed by the Eastern Cape with 66.1% and then Mpumalanga with 62.5%. One can note that the Eastern Cape has constantly remained amongst the two poorest provinces in South Africa between 2008 and 2009.

Furthermore, Statistics South Africa (2012) presents data indicating that in 2008 and 2009, of the total population of people living below the upper-bound poverty line of R577 in South Africa, 23.8% were in KwaZulu-Natal, 17% in the Eastern Cape, 15.4% in Limpopo and 11.9% in Gauteng. It can be noted from the above data that the Eastern Cape has remained amongst the poorest provinces in South Africa ranking second of the poorest provinces after KwaZulu-Natal.

2.12.3 Poverty in South Africa per population group

According to Statistics South Africa (2012), between the period of September 2008 and August 2009, black Africans were the population group most affected by poverty in South

Africa, with 61,9% of a share of the population earning below R577. The figure of R577 is considered as the upper-bound poverty line and is used as a measure for indicating poverty in South Africa as noted by Statistics South Africa (2012). Coloured people had the second highest proportion of people living below the upper-bound poverty line, with figures standing at 32.9%, followed by Indians with 7.3 % and whites with 1.2%. Whites were the population group least affected by poverty.

Again with reference to data presented by Statistics South Africa (2012), of the total population of people who were living below the upper-bound poverty line of R577 between September 2008 and August 2009, blacks contributed the highest figure. According to Statistics South Africa (2012), 93% of the total population of people living below the upper-bound poverty line were black Africans, whilst coloureds, Indians/Asians and whites shared the remaining 6.2%. Coloureds contributed the largest percentage to that population with a figure of 5.7%.

Furthermore, Statistics South Africa (2012) revealed that most of the population of poor people (that is 47.5%) who participated in the 2008-2009 living conditions survey reported that social grants and social security constituted their main source of income. This alone reveals that social grants are a major source of income for poor households in South Africa. On average, according to Statistics South Africa (2012), the annual household income from social grants and social security for poor households was at R9 159 during the period between September 2008 and August 2009. This translates into a figure of about R760 per month.

2.13 Disability and Exclusion

In many respects, the exclusion and discrimination faced by disabled people bears many similarities to other forms of oppression (Russell & Malhotra, 2012:54), for example, racism and sexism. There is, however, one fundamental difference: people with some forms of impairment may experience reduced capabilities. This is often used as a justification for exclusion. Unless additional practical needs are met, it is indeed more difficult for some disabled people to organize, campaign and to work to reduce their own poverty. Yet many disabled people, even those with only mild and moderate forms of impairment continue to be excluded from poverty reduction work. The majority of people with disabilities in South Africa has been excluded from the mainstream of society and have thus been prevented from accessing fundamental social, political and economic rights. The exclusion experienced by people with disabilities and their families is the result of a range of factors

- The political and economic inequalities of the apartheid system
- Social attitudes which have perpetuated stereotypes of disabled people as dependent and in need of care; and
- A discriminatory and weak legislative framework which has endorsed and protected exclusionary barriers (South Africa Integrated National Disability Strategy, 1997)

2.14 Poverty and Exclusion

Poor people face a greater risk of impairment or disability (Quintana and Malo, 2012). In addition, the birth of a disabled child, or the occurrence of disability in a family, often places heavy demands on family morale, thrusting it deeper into poverty. This means not only that there is a higher proportion of disabled people amongst the very poor, but also that there is an increase in families living at the poverty level as a result of disability. This phenomenon seriously hinders the development process.

The International Labour Organisation (ILO) (2001) and the UN Development Programme (UNDP) (2001) state that a key pointer of poverty is the step to which people are left out from accessing basic goods and services. Poor people do not have enough income to obtaining goods (CHPI and SAFCD, 2001). CHPI and SAFCD (2001) add that poor people also live in small areas where there is a lack of sanitation, water, electricity, health services, job opportunities and educational and recreational facilities.

The Central Statistical Service (CSS) 1995 October Household Survey confirms the above and point out that large numbers of people with disabilities live in areas where the infrastructure for the provision of basic services is at its weakest. Hence, a relatively low percentage of disabled people have access to piped water, electricity and inside toilet facilities as contained in the Integrated National Disability Strategy of 1997 (Republic of South Africa, 1997:11).

2.15 Unemployment and Exclusion

People who receive social security benefits in South Africa tend to be totally dependent on them for their survival (White Paper, 1997). Most of the people with physical disabilities, however, receive no grant at all. On the other hand, it is projected that 99% of disabled people are excluded from employment on the open labour market (Kaserera, 2012). The extremely high levels of unemployment amongst people with disabilities can be attributed to a number of factors, low skill levels due to inadequate education, discriminatory attitudes and practices by employers, lack of enabling mechanisms to promote employment opportunities, inaccessible public transport, inaccessible and unsupportive work environments, generally high levels of unemployment, inadequate access to information, and ignorance in society (Kaserera, 2012).

The high level of functional illiteracy amongst disabled adults is a direct result of the lack of educational opportunities for children with disabilities, especially in rural areas. The result is low skill levels and a correspondingly limited access to employment (Kiani, 2009). As a result, those people with disabilities and do have jobs often find themselves working in sheltered/protective workshops run either by the Departments of Welfare and Labour, by private welfare organizations or by disabled people themselves. Although the nature and scope of these workshops and self-help projects vary considerably, they do not provide people with disabilities and their families with sustainable incomes or opportunities for competitive economic activity (National Disability Strategy, 2010-2020:42).

2.16 Policy mandates

South Africa has adopted a number of policies to guide the successful inclusion of persons with disabilities in mainstream society. A number of national policies have thus been re-aligned to redress inequalities and empower persons with disabilities. The adopted legislative framework and guidelines include:

- White Paper on the Transformation of the Public Service, 1995
- White Paper on Affirmative Action in the Public Service, 1997
- White Paper on Integrated National Disability Strategy, 1997
- White Paper 6 on Special Needs Education, 2001
- South African International Relations and Cooperation Framework
- White Paper on Special Needs Education
- Employment Equity Act (Act 55 of 1996)
- Promotion of Equality and Prevention of Unfair Discrimination Act (Act 39 of 1996)
- Basic Conditions of Employment Act (Act 75 of 1997)
- Skills Development Act (Act 97 of 1998)
- Broad Based Black Economic Empowerment Act (Act 53 of 2003)
- UN Convention on the Rights of Person with Disabilities and
- The Constitution of South Africa (Act 106 of 1996).

The Constitution of South Africa spells out the principles of non-discrimination based on disability, gender or age, equality between men and women, equality of opportunity, accessibility, respect for diversity and full inclusion in society. The National Development Plan, which outlines South Africa's development agenda for the period 2010-2030 stipulates the need to create an inclusive social protection system that addresses the vulnerability and responds to the needs of those at risk, person with disabilities, the elderly, orphans and children (National Integrated Disability, 2010-2020:48).

2.17 Challenges faced by people with disabilities

People suffering from disabilities face many significant challenges every day (Ndlovu, 2016). Simple tasks that ordinary people perform on a daily basis as routine are extremely delicate and difficult to those suffering from disabilities. Thus accomplishing simple tasks such as taking a shower, dressing up, brushing teeth or even having a meal are tasks that may take much longer than normal and in many cases, may require the assistance of others. Individuals with disabilities are faced with stigma and discrimination from the society where they live (Burns, Watson and Paterson, 2013; Shulman et al., 2008). Most people look down on them and treat them as special (Eisland, 2002). Disabled people may find it hard to socialize with members of the society. This can lead to depression as well as self-pity if not checked (American Association of People with Disabilities, 2009).

People with disabilities are still a marginalized group that has limited or no access to medical and rehabilitation services, education and employment (White Paper on the Rights of Persons with Disabilities, 2015). Disabled individuals in rural areas face far more challenges than a disabled person an urban setting, which makes obtaining a better quality of life a more difficult process. One challenge that affects all individuals with disabilities, but more so in rural areas, is the lack of health services. Lack of educational opportunities is also a hardship that people with disabilities in a rural environment experience. Many children in rural areas often do not even attend school because families cannot afford school fees, because they have to use the grant money to pay as an entrance fee for a child in those schools catered for them (James, 2011:14)

Discrimination is another issue that affect people with disabilities, as there are common misconceptions that a person with a disability is cursed and is a disgrace to his or her family. In fact, they are often seen as a burden for their family. As a result, many are neglected, mistreated and isolated. The social and cultural stigma associated with disabilities also creates economic barriers for individuals with disabilities. It is very hard for a person with disabilities to work in rural environments because most of the work done is agriculture based, which requires abled bodied people (James, 2011:15).

2.18 Family caregiver support

A caregiver is someone who watches, guards, supervises or oversees and delivers or provides a service and Emblem Health (2010) describes a caregiver as someone who is responsible for attending to the daily needs of another person. Family caregivers take on many different roles and tasks. A caregiver may be a child who takes care of an older parent, a parent caring for an adult child with a disability, or a spouse who provides for the daily needs of a husband or wife with a disability or chronic health condition. Adding to taking care of the basic emotional and physical needs of a loved one, family caregivers transport loved ones to medical appointments provide daily personal care including bathing, dressing and meals preparation, manage finances and medications and act as an overall healthcare coordinator (Carnie et al ,2011:19).

Family caregiving is considered as one of the most precious and fulfilling gifts of love that can be given to another person and one of the most difficult things to undertake. Most family caregivers have no formal medical training other than basic first aid and Cardiopulmonary Resuscitation (CPR) training (Lewis, 2012). She further say family caregivers need to have a thorough understanding of the patient personal and family medical history, current symptoms and medical conditions. Meanwhile family caregiving is a job, which demands love and deep attachment to the family member or friend to be cared for. The family caregiver must balance love and pampering against the responsibility to objectively exercise appropriate medical process and protocol as required by the patient's treatment or rehabilitation plan (Lewis, 2012).

2.19 Conclusion

The chapter reviewed literature related to the current study, putting the study into the context of existing and ongoing research in the field of social work. Several sub-themes were explored in reviewing the study. The chapter discussed the trends in welfare and social development in terms of changes to government policy on disability. The categories of social grant and processes that one currently needs to follow from the application in the grant were explained. In addition, policies which protect people with disabilities were also reviewed. The following chapter discusses the methodology of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter dealt with the literature and underpinnings associated with exploring the quality of life of disability grant beneficiaries. It looked at the history of social security in South Africa, from welfare to social development, and outlined different types of social grants and their implementation. This chapter discusses the manner in which research was conducted and processes involved in data collection. It presents the research design, methods of data collection and research instruments, the population under study, sampling and sampling procedure, as well as ethical issues that were adopted and applied in this study to avoid ethical lapses.

3.2 Research Design and Methodology

According to Leedy and Ormrod (2001), research design is the technique for attack on the focal research problem. A research design provides the general structure of the procedures taken by the researcher. In simple terms, a research design is the overall plan of how the data is collected, coded and analyzed (Welman, Kruger & Mitchell, 2006). In this study, the researcher adopted a qualitative research design. According to Denzin and Lincoln (2005), “A qualitative research design is based on a situated activity which studies things in their natural setting in an attempt to make sense of, or interpret, phenomena in terms of the meanings people bring to them”. As the strategy adopted for this study, the researcher had drafted suitable research questions, solicited data required to answer the research problem, decided the participants from whom the data should be obtained, and what exactly the best criterion to gather detailed data. For the case of this study, the researcher employed the exploratory, descriptive and contextual design, because of the interest in the experiences of the disability grant beneficiaries in Raymond Mhlaba Municipality.

Babbie and Mouton (2006:232) referred exploratory studies as, "… a mode of inquiry used to explore new topics or to learn more about issues where little is known". Exploratory studies are conducted to gain rich information about a certain phenomenon, community, situation or an individual. Descriptive design will be applied in the analysis section to vividly explain problems, situations, living conditions and participants' attitudes towards certain issues (Babbie and Mouton 2006). In addition, the descriptive design is important in presenting different social settings, relationships and situations. It focuses on why and how questions (Babbie and Mouton 2006). Descriptive data produces participants' information in form of spoken or written words. It thus identifies the participant's values and beliefs that underlie a phenomenon. In this study, a descriptive design was employed as the researcher interviewed thirty (32) participants covering the sample in order to accurately describe their experiences with regard to the quality of life of disability grant beneficiaries in Raymond Mhlaba municipality.

The term methodology generally refers to the methods that the researchers utilize in carrying out research and these methods can either be qualitative or quantitative (Durrheim, 2006). An eminent qualitative researcher, Babbie (2010) subscribes to this definition of qualitative methodology by arguing that qualitative research tends to be associated with the idea that social life is the product of social interaction, relationships and actions that characterize the social world. This means that qualitative researchers study objects in their natural settings and attempt to make sense of or interpret phenomena in terms of the meaning people bring to them.

Therefore, a qualitative research method was found to be the most appropriate and useful for this study, because it emphasizes the importance of the social context for understanding the social world. The qualitative approach enabled the researcher to explore the quality of life of disability grant beneficiaries by engaging with their responses and the significance attributed to various facets of disability and aspects of ordinary life in the context in which they appeared.

Martinez et al. (2014:3) observe that the methods associated with qualitative research, such as participant observation or case studies, result in narrative and descriptive accounts of a setting or practice. Using these methods, sociologists typically reject positivism and adopt a form of interpretive sociology (Martinez et al, 2014:3). Other definitions focus on the process and context of data collection. Qualitative research is an activity that locates the observer in the world (Denzin and Lincoln, 2002). It consists of a set of interpretive material practices that make the world visible. These practices transform the world and turn it into a series of representations, including field notes, interviews, conversations, photographs, recordings and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world (Merriam, 2009:13). Because qualitative researchers study aspects in their natural settings, factual descriptions based on face-to-face knowledge of individuals and social groups in their own environments are produced, instead of generating numerical data that supports or refutes clear-cut hypotheses, as is the case with a positivist approach.

Qualitative research is inductive in nature, meaning the initial step is observation and theories are formulated towards the end of the research and are a result of observations (Goddard and Melville, 2004). It thus involves the search for patterns from observation and the development of explanations or theories for those patterns through a series of hypotheses (Bernard, 2011: 7). Theories are inapplicable at the beginning of the research and the researcher is free in terms of altering the direction for the study after the research process had commenced. Neuman (2003:51) affirms that inductive research begins with detailed observations of the world, which move towards abstract generalizations and ideas. In others words, when following an inductive approach, beginning with a topic, a researcher tends to develop empirical generalizations and identify preliminary relationships as he or she progresses through the research.

3.3 Research Paradigm

Parahoo (2006) defined a research paradigm as a world view that exists from a general point, or a way of breaking down the complexities of the real world to make concepts simpler. In this way, a research paradigm entails the set of beliefs that normally guides action, particularly in terms of disciplined inquiry in a wider sense, developing concepts that permit the study and understanding of a particular phenomenon (Wellington, 2008).

The paradigms mainly used in research in the social sciences are the interpretive, the critical and the positivist paradigms.

The interpretive research paradigm seeks primarily for understanding, rather than explanation. It places emphasis on the human capacity as it seeks to understand others through sympathetic introspection and reflection based on detailed narrative gathered through direct observation, in-depth, open-ended interviewing, and case studies (Cooper & Schindler, 2003). The critical paradigm focuses on relationships of power and oppression, and aims to promote democracy by making changes in different social, political, cultural, economic, ethical as well as other society-oriented beliefs and systems. The positivist paradigm applies distinct concepts to produce constructive results, that is, it involves experiments and testing in order to gather data (Wellington, 2008).

In addition, other researchers employ, the social constructivism as a paradigm to which human development is socially situated and knowledge is constructed through interaction with others. The main purpose of a paradigm is that it defines how the knowledge is extracted, how one thinks, talk, write and talk about this knowledge (Neuman, 2006). In this respect, the study was based upon the social constructivism paradigm because the researcher had to interact with the participants so as to understand the phenomenon under investigation based on open-ended interviewing, direct observation and focus group discussions (FGD).

Precisely, the main functions of a paradigm are that it defines how the world works, how knowledge is extracted from this world, and how one is to think, write, and talk about this knowledge (Neuman, 2006). In that respect, the study was based on the interpretive research paradigm in the form of qualitative research that would lead to understanding the representation of quality of life by disability grant beneficiaries and their caregivers.

3.4 Research Site

For the research site and location, the researcher selected the Raymond Mhlaba Local Municipality in the Eastern Cape, South Africa. More specifically, in the Raymond Mhlaba Municipality itself, Magaleni in Fort Beaufort and Debe Nek were selected as the focal points. The Raymond Mhlaba Municipality is situated along the southern slopes of the

Winterberg Mountain range and the escarpment, and is within the greater Amathole District Municipality in the Province of the Eastern Cape. The municipal area covers approximately 3 725 km2, with major towns being Alice, Fort Beaufort and Middledrift. Smaller settlements include Hogsback, Seymour, Balfour, Blinkwater and Debenek. Main access is provided by the R63 road from King Williams Town through Alice and Fort Beaufort towards Adelaide and the R67 from Grahamstown through Fort Beaufort towards Queenstown. Raymond Mhlaba is comprised of 21 wards with a population of approximately 127 115, of which the majority (72%) reside in rural villages and farms (Raymond Mhlaba Municipality IDP, 2015/16). Urbanization is concentrated in the small towns of Alice and Fort Beaufort. The municipal area includes parts of the former Ciskei homeland and Cape Provincial Administration areas, which means that it has a history of land expropriation and disposition in many parts, due to the consolidation of land to create Ciskei in the 1960s. A distinct land tenure and land use system prevails, with two different systems in the former Ciskei homeland and Cape Province areas (Raymond Mhlaba Municipality IDP, 2015/2016).

Raymond Mhlaba is a predominantly rural municipality and the economy is largely driven by the agricultural sector, which includes citrus, forestry and crop production. The citrus industry is one of the municipality's largest employers. Forest plantations and timber processing are also undertaken in the area. Raymond Mhlaba Local Municipality is well-known for its rich heritage and culture. The historic educational institutions of Healdtown, Lovedale College and the University of Fort Hare are important heritage sites in Raymond Mhlaba, but are as yet underutilized as tourism or cultural sites. The tourism sector remains largely unsupported and underexploited in a municipality with iconic natural resources in the form of the Amathole Mountains and national significant heritage sites. Some of the major challenges facing Raymond Mhlaba Local Municipality include infrastructure challenges and high levels of unemployment and poverty (Raymond Mhlaba Municipality IDP, 2015/2016).

3.4.1 Community profile of Magaleni

Magaleni (also known as Hillside) is one of the “locations”, or black townships, under the administration of Raymond Mhlaba Municipality and it is about 6 kilometres from the town of Fort Beaufort. The location does not display much racial diversity as 99.9 % of the residents are black Africans (Statistics South Africa, 2011).

The approximate total population for Magaleni is 1 568, but was projected to reach approximately 4 500 in 2016 (Statistics South Africa, 2011). In 2011, only 15% of females and 21% of males were employed and the total working population was approximately 36%, with 64% unemployed (Statistics South Africa, 2011).

One can say that the populace of Magaleni is living in poverty due to high rate of unemployment. Hillside location has more than 20 shops, of which most of them are owned by people from outside the country. In terms of education, the locations have three pre-schools, one primary school and no high school. The community has one clinic that serves the whole community and others nearby. There is also a disability centre taking care of vulnerable children and adults.

3.4.2 Community profile of Trust 2 in Debe Nek

Debe Nek Trust 2 is a location under Raymond Mhlaba Local Municipality in the Eastern Cape province of South Africa. It is a settlement 19 kilometres west-north-west of King William's Town and 38 kilometres east of Alice. It takes its name from the Debe (Khoekhoen for 'brackish') River, from the gorge ('nek') through which the Debe River flows. This was the site of the Battle of Amalinda between Ndlambe and Gaika in 1818. It is estimated to be the same size as Magaleni and hence the population of Debe Nek can be estimated to have the same population size, that is, 4500. The location is subject to the same economic conditions of poverty, and unemployment is high. Most of the available jobs are temporary and the absence of permanent posts poses a threat to job security (Raymond Mhlaba Municipality IDP, 2015/16).

3.5 Population

The population can be defined as any set of people from which the sample is selected and which gives rise to the research results and findings. According to Kalat (2012), a population is the group of people to whom we want the results of the research to apply, while Bless & Higson Smith (2000) cited in De Vos (2012), define a population – sometimes referred to as a target population – as the set of elements that the research focuses upon and to which the results obtained are relevant.

The population of the study was made up of all grant beneficiaries, senior members within the families of beneficiaries, and social workers from the Department of Social Development, and was located in Fort Beaufort in the Magaleni location and in Debe Nek Trust 2 Location, both in the Raymond Mhlaba Municipality.

3.6 Sampling and Sampling Procedure

A sample is a group of people or events drawn from a population (De Vos, 2011) and a research study is carried out on a sample from the population. As such, this study adopted non-probability sampling through purposive sampling and the total sample of the study was 32. The sample comprised of fifteen grant beneficiaries, of which ten were female and five were male; fifteen senior family members who were also care-givers; and two social workers. All participants were interviewed using in-depth interviews, and, in the case of family members, a focus group discussion was conducted.

Houser (2011:159) refers to a sampling strategy as designed to choose the actual subjects from the sampling frame. In order to draw a qualitative sample, the study used non-probability sampling. The study made use of non-probabilistic sampling through a purposive sampling technique to come up with the qualitative sample. As maintained by Barbie (2016:195), non-probability sampling is adopted in circumstances when it is not feasible to utilise a random sampling technique due to time and cost, or, most significantly, when the research objectives do not permit the use of a random process. The researcher used purposive sampling because it increases the likelihood of variability common in any social phenomena to be presented in the data (Babbie and Mouton, 2010:106). In addition, the sampling technique was used to select participants in order to obtain the most relevant information on the quality of life of disability grant beneficiaries in Raymond Mhlaba municipality. A non-probability technique according to Sarantakos (2005) is when chances of selecting any case are not known because cases are non-randomly selected. For the purpose of this study, the researcher utilized purposive sampling to carry out in-depth interviews with the targeted participants. Last but not least, was employed since it explains the selection of a sample based on the researcher's judgement about which units are most representative or purposeful (Rubin and Babbie, 2009: 151).

3.7 Methods of data collection/Instruments

This section of the study explains the procedures and or processes that were adopted in collecting data. The following research methods were utilized in this study.

3.7.1 In-depth interviews/guide

An in-depth interview is a one-to-one method of detailed data collection that involves an interviewer and an interviewee discussing specific topics in depth (Hennink, Hutter and Bailey, 2011). In depth interviews were adopted to collect in-depth data on views, perceptions and thinking of grant beneficiaries through the guidance of an interview guide with a set of questions based on the research topic. The study utilized in-depth interviews of individual participants and these are particularly useful to this study because they encouraged the participant to respond freely and the researcher to probe for more data capturing. The process of collecting information using this method involved presenting the participant with a warm and welcome environment that was comfortable. Although the order of questions was respected, the researcher was flexible so that the participant could be free to answer any question in the order they viewed appropriate and comfortable. Appropriate attention was given by the researcher to the participants so as to avoid boredom, repetition and to keep the interview focused.

3.7.2 Focus group discussions

A focus group is defined as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment (De Vos et al, 2012: 361). A focus group is a type of in-depth interview accomplished in a group that presents those characteristics defined with respect to the proposal, size, composition and interview procedures. The focus or object of analysis in using this method was the interaction inside the group. The participants influenced each other through their answers to the ideas and contributions during the discussion. The moderator, the researcher in this case, stimulated the discussion with comments. The fundamental data produced by this technique are the transcripts of the group discussions and the researcher's reflections and annotations. In this study, focus group discussions were conducted with the participants. The main reason for using this technique was that the researcher wanted to understand the phenomenon under study from a group perspective rather than from individuals only. More so, focus group discussions enabled the researcher to weed out false or extreme views thus providing in-depth information on the phenomenon under investigation. Various techniques were used to obtain clarity and these are inclusive of probing and repeating same questions to different participants so as to ensure the same understanding.

3.8 Trustworthiness

Babbie and Mouton (2005:277) posited that the key criterion or principle of good research is found in the notion of trustworthiness and neutrality of its findings or decisions. Flick (2007) argues that qualitative researchers need to be as vigilant as positivist researchers about ensuring trustworthiness, even if they use other terms such as credibility and authenticity to describe the qualities that establish the trustworthiness of their studies. Trustworthiness has four criteria, namely, credibility, transferability, dependability and conformability. The first, credibility, refers to the relationship between findings and collected data, while transferability signifies whether the findings can be transferred justifiably to other contexts. Dependability is the assurance given to people about the reliability of the findings from the raw social context, and lastly, conformability assures the public of the unbiased nature of the findings (Lee and Lings, 2008). Therefore, to determine the trustworthiness of this research, the study should yield reliable results characterized by production of similar results when carried out on similar groups of respondents in similar contexts that are nonetheless not on the same site or carried out on the same subjects.

In order to ensure trustworthiness in the study, the research tools developed for this purpose was shared with the peers though the researcher tested by himself in the field during the pilot study. The tools were developed to ensure that the researcher could generate the information required to explore the quality of life of disability grant beneficiaries in Raymond Mhlaba municipality. The researcher tested the tools for suitability of use. The field testing was done to check the validity of the instrument that is; to determine whether the tool exactly addresses the main aims of the study under investigation.

The research tool used in this study was the interview guide. This was to find out whether the instrument indeed measured what it was supposed to measure, given the context within which it is to be applied. The process of sharing the tool with the respondents was done to ensure content validity which is normally used in the development of interview guides.

In order to ensure trustworthiness, the researcher also employed documentary research to supplement the information that was collected from the interviews. In addition, whilst conducting the interviews and the focus group discussions, observations were conducted and they gave an impression of how the people were reflecting on the the quality of life of disability grant beneficiaries at the time of the research. In social science research, the use of different research methods to study the same phenomenon is known as triangulation (Denzin, 1978). It has been noted that triangulation enables the research to construct a comprehensive understanding of phenomena under investigation.

The correctness, validity and reliability of the information are crucial to the study as there are recommendations to be developed at the end of the study which could be used as a solution to the challenges identified. Since this study aimed to dig deep into people's perceptions and attitudes the researcher also conducted focus group discussions. The reason for focusing on a small area was to get a deeper view and understanding of people's experiences and viewpoints as well as to explore the associated feelings and to observe the non-verbal expressions.

3.9 Data analysis

According to Mouton (2001:108-109), "data analysis involves breaking up the data into manageable themes, patterns, trends and relationships". The aim of analysis is to understand the various constitutive elements of one's data and to see whether there are patterns or trends that can be identified or isolated, or to establish themes for purposes of interpretation. In this way, the researcher had to categorize, order, manipulate and summarize the data in order to obtain answers to research questions.

For the purpose of this study I used thematic analysis in order to scrutinize the data. The kind of thematic analysis adopted in this study was based on the tradition of Grounded Theory as articulated by Glaser and Straus (1967:2). This means that data that is rich in detail is collected from the interviewees themselves. Following Glaser and Strauss (1967); Glaser (1978) and Strauss (1987); the descriptive data was used to identify themes emerging from interviewees responses. This therefore means that the researcher employed an inductive approach in the analysis of data. An inductive approach means the themes identified are strongly linked to the data themselves (Patton 1990; cited in Braun and Clarke 2006:83). In other words, a bottom-up approach was adopted so that the data collected from the field could be used to generate the themes and critically engage with existing theoretical presuppositions. One advantage associated with inductive approach to data analysis is that it tends to provide for rich description of data which in turn allows the researcher to generate theory from below (Braun, 2006). The following procedure was used when analyzing the data:

Interviews were conducted during which they were captured on recorder. After the interview, the researcher listened to the recordings to gain familiarity with the data. After listening at least twice to each recording transcriptions were conducted. The data were translated verbatim. From listening and transcribing the data, themes began to emerge. On the basis of themes the categories were developed from the data. Relationships between the various themes were explored, and based on a further refinement of the themes; these were appropriately broken down into sub-themes. This procedure was followed in order to remain true to the tradition of grounded theory in terms of which the data is used to generate new knowledge or to evaluate the validity of existing theory in specific social research contexts.

3.10 Ethical Considerations

Ethical issues are widely regarded principles that demarcate the most appropriate professional conduct in carrying out research safely, fairly and with integrity, whether in data collection or in data analysis, and which prevents ethical lapses (Thomas & Hodges, 2010). These ethical lapses range from emotional or physical harm, and even the application of coercion in order to obtain data. This study took cognisance of ethical considerations so as to avoid ethical lapses, as outlined in the following section.

3.10.1 Informed consent

None of the participants in this study were forced to undergo the process of interviewing and proper informed consent was sought from the study participants prior to the launch of the study. An 'informed consent' paper was given to participants to read so that they were able to understand the significance and aims of the research, and reasons for requesting their participation were explained. The study participants were then requested to sign the consent forms in agreement that they were participating freely and willingly and that they were aware that the interviews were being recorded by the researcher. It was also explained to participants that they were under no obligation to answer questions they were not comfortable with and also that they were able to withdraw at any time, although none of them chose to do so.

3.10.2 University Permission

Formal authority to embark on the research and permission to collect the data was requested from disability centres in the community of Magaleni and Debe Nek and ethical clearance was obtained from the Govan Mbeki Research Development Centre at the University of Fort Hare.

3.10.3 Human Dignity and Human Rights

Participants were treated with dignity and their right to withdraw from the proceedings at any time was clearly indicated, accompanied by the explanation that this was to protect them from coercion, which would yield invalid results as well as intrude on their dignity and on their human rights. There was no form of behaviour towards participants that could be deemed to deprive them of their dignity or reduce their dignity.

3.10.4 Privacy and Confidentiality

One of the most important elements of primary research involving human beings is that of confidentiality. According to Thomas and Hodges (2010), whatever information is collected from the participants, whether sketches or notes of what they said should not reveal any personal identification of the participants. Participants were assured that their personal details would not be disclosed to any third party and that their anonymity was therefore guaranteed. They were informed that the data obtained from them would not disclose anything they would perhaps be uncomfortable with, and that every aspect of data collection was treated with confidentiality and anonymity.

3.10.5 Transparency

Finally, part of the moral fabric of research entails conducting research "truthfully" and researchers are expected not to intentionally or "knowingly" falsify information (Gomm, 2008). All participants of the study were informed of the research objectives and purpose so that they were aware of what the study was about and any questions they had were clarified.

3.10.6 Voluntary participation

Voluntary participation seems to be a necessary condition for non-coercion and it should be maintained at all times (Winer & Vazquez, 2014). The researcher requested the permission from participants(grant beneficiaries, family members and social workers) to participate in the study. Participation was voluntary, participants were not forced.

3.11 Conclusion

This research methodology chapter offered a complete explanation of the research design and the research approach, including data collection, measuring methods, sampling, ethical considerations made and how the data was analysed in this study. The next chapter presents and analyses the data collected, with a view to revealing the findings of the study, which will cast more light on the issue of quality of life among the disabled.

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

The primary purpose of this chapter is to discuss the major findings, interpretations and implications of the study. Furthermore, the chapter reviews and engages with major themes of the study, and relates them to the relevant theory and literature. The data from the interviews held with participants as well as observations is analyzed according to the specific objectives of the study. Therefore, the data is presented and analyzed in the sequence of the objectives. The data is analyzed by firstly presenting the research process, namely, reporting the findings that emerged from the process of data analysis, and secondly, by verifying the findings by means of literature control. Creswell (2004:20) postulates that, "…in a qualitative study, literature should be used inductively". In other words, the research findings must be compared and contrasted with the already existing literature in order to establish a relationship between the general and specific.

In the following section of the dissertation, the narratives of the participants are presented alongside identified themes and sub-themes. The aim of the study was to explore the quality of life of disability grant beneficiaries. Thus, the key issues investigated were whether grant beneficiaries were financially satisfied with the money they received from the government, and the effects of disability grants on the physical health of beneficiaries. Further, the possible contribution of disability grants to improved social relations and enhanced support to beneficiaries was examined, along with the general life satisfaction and physical wellbeing of disability grant beneficiaries.

4.2 Biographical information of study participants

Table 4.1 below provides the age, gender, education, marital status, and employment status analysis of the family members participants.

4.2.1 Biographical information of family member participants

Table 4.1 shows biographical information of family members participants.

Participant	**Age**	**Gender**	**Education**	**Marital status**	**Employment status**
Participant 1	35	Female	Grade 6	Married	Unemployed
Participant 2	38	Male	Grade 8	Married	Unemployed
Participant 3	27	Female	Grade 8	Single	Unemployed
Participant 4	34	Female	Grade 6	Single	Unemployed
Participant 5	35	Female	Grade 12	Married	Employed
Participant 6	38	Male	Grade 10	Married	Unemployed
Participant 7	30	Female	Grade 10	Single	Unemployed
Participant 8	37	Female	Grade 8	Single	Unemployed
Participant 9	70	Female	Grade 6	Single	Unemployed
Participant 10	76	Male	Grade 6	Single	Employed
Participant 11	61	Female	Grade 3	Single	Unemployed
Participant 12	35	Female	Grade 4	Single	Unemployed
Participant 13	38	Male	Grade 5	Single	Unemployed
Participant 14	27	Male	Grade 2	Single	Unemployed
Participant 15	34	Female	Grade 8	Married	Unemployed

The researcher also interviewed fifteen family members of the disability grant beneficiaries. Most were females, and the vast majority, were under the age of 40. Similar to the case of the disability grant beneficiaries above, a few family members had progressed beyond Grade 8 and almost all were unemployed. In terms of marital status, most were single. Of great relevance to the study and to the study objectives is the fact that the overwhelming majority of them were unemployed and not earning an income.

4.2.2 Biographical information of grant beneficiary participants

Table 4.2 shows biographical information of grant beneficiaries participants

Participant	Age	Gender	Education	Marital status	Employment status
Participant 1	71	Female	Grade 6	Married	Unemployed
Participant 2	50	Male	Grade 8	Married	Unemployed
Participant 3	80	Female	Grade 8	Married	Unemployed
Participant 4	45	Female	Grade 6	Single	Unemployed
Participant 5	33	Male	Grade 12	Single	Unemployed
Participant 6	35	Female	Grade 10	Single	Unemployed
Participant 7	30	Female	Grade 10	Single	Employed
Participant 8	57	Male	Grade 8	Single	Unemployed
Participant 9	30	Female	0	Single	Unemployed
Participant 10	18	Female	0	Single	Unemployed
Participant 11	42	Female	Grade 4	Single	Unemployed
Participant 12	54	Male	Grade 2	Married	Unemployed
Participant 13	70	Male	Grade 3	Married	Unemployed
Participant 14	76	Female	Grade 1	Widowed	Unemployed
Participant 15	81	Male	Grade 2	Married	Unemployed

The table above shows the age, gender, level of study, marital status and employment status of the beneficiaries of social grant that were interviewed in this study. The majority were females and most of those under the age of 35 were also females. Nearly all the males were over the age of 50. It was noted with concern, in relation to education, that very few beneficiaries of the social grant had proceeded beyond Grade 10, whilst more than half had not progressed beyond primary school and there were even beneficiaries with no education at all. In terms of marital status, slightly less than half were married, and others were single. Finally, and again as a matter of great concern, it was established that all the disability grant beneficiaries were unemployed.

4.2.3 Biographical information of social worker participants

Only two social workers participated in the study, one male and one female. While the female had a Bachelor of Social Work undergraduate degree, the male had a Master of Social Work. Both of them were employed by the Department of Social Development and were working with beneficiaries of the disability grants at the time the interviews were conducted.

4.3 Objective 1: To investigate whether disability grant beneficiaries are financially satisfied with the money they receive from the government

The table below displays the main themes, subthemes and issues raised from the data concerning financial satisfaction of disability grant beneficiaries with the money they received from the government.

Table 4.3: Main themes, sub-themes and issues raised

Theme	Sub-themes	Issues raised
Financial satisfaction issues	Disability grant and poverty alleviation	Interviews indicated that the disability grants make a meaningful contribution to poverty alleviation amongst the grant beneficiaries.
	Inadequacy of disability grant to cover basic needs	The grant money was not adequate especially in the families without any other income besides the grant. Basic needs from the participants' point of view included health, education, food and clothing, electricity and water bills, as well as funeral cover, among other items. Discussions with the social workers and the disabled indicated that the disability grant was not enough to cover all basic needs.
	Disability beneficiaries as sole providers	Basics bought using the grant, such as food, are not sufficient to last the whole month, especially in cases where the grant beneficiary is the sole bread winner.

4.3.1 Main theme 1: Data concerning financial satisfaction issues

This is the data that emerged from the interviews with disability grant beneficiaries under the major theme on financial satisfaction issues. Data is presented and analysed in following subthemes.

4.3.1.1. Subtheme 1: Disability grant and poverty alleviation

The data that emerged from the interviews with participants has shown that the disability grants make a meaningful contribution to poverty alleviation amongst the grant beneficiaries. However, basics such as food are not sufficient to last for the whole month, especially in cases where the grant beneficiary is the sole breadwinner and especially in families without any other income besides the grant.

Social grants are playing a fundamental role in alleviating poverty in South Africa. The majority of the participants (27) in this study acknowledged that the disability grant was helpful in terms of alleviating poverty. Some of them had the following excerpts to explain their stance:

My daughter and his son are the ones benefiting from the grant money. My daughter is unemployed and she is looking after me. And her son is doing high school in Fort Beaufort so I pay for his transport and other school things (Participant 1, October 2016).

My family and children depends on the grant, it helps to buy groceries for the whole family and pay school feeds for my children (Participant 4, October 2016)

What makes my quality of life better is to know that I have the grant every month, what does not make it better is the fact that it is not enough to cover everything. (Participant 7, October 2016).

All the participants indicated that they have been able to survive owing to the disability grants. This is in line with the government's anti-poverty strategy, which incorporates social grants alongside other public works programmes such as Expanded Public Works

Programme (EPWP) and Community Work Projects (CWP). The role being played by grants in poverty alleviation is therefore pivotal (Van der Berg & Siebrits, 2010).

4.3.1.2 Subtheme 2: Adequacy of grant to cover basic household needs

Participants commented that the disability grants help the intended beneficiaries as well as their family or household, and it is therefore seen as a collective grant for household needs. While some showed satisfaction with the amount, many thought it was not enough to cover their needs as well as those of the household. This must be understood by looking at the household composition and how this affected the use of the money. The type of household that put the most pressure on the disability money is a large household, in which the grant was the only source of income. This may interact with a context of high unemployment, where other adult members also rely on the grant. This was the case with a few beneficiaries with up to 11 members, who mentioned only using the grant to buy food and clothing, which are the most popular expenditure items from the disability grant, as indicated by the following responses:

We normally use the money to buy groceries, toiletries and clothes. I do some part-time jobs to supplement this disability grant since we cannot all of us as a family rely on it (Family member 5, October 2016).

I buy groceries for my kids and family, buy electricity, buy clothes, and pay for school fees (Participant 14 October 2016).

We utilize the cash to purchase basics such as food, clothing garments, and toiletries and so on. We are eight in our family my family is so poor and I have to carry all the burdens of this family using the grant (Participant 1, October 2016).

Even where another member of the household was working, this was generally in a low-paid position where they earned less than the disability grant amount (between R250-R600 per month). In one household where the parents had passed away, the disability grant plus an income of R250 supported a household of five siblings. Similarly, even in a household with other income from grants, this must often be divided among the members of a large household.

Financial satisfaction entails the adequacy of the disability grant to cover all basic expenses for the beneficiaries so as to cope up with basic needs. Basic expenses include health, education, food and clothing, electricity and water bills, as well as funeral cover, among other items. Discussions with the social workers indicated that the disability grant was not enough to cover all the medical needs experienced. One participant said;

No, the money is not enough to cover all basics. However, it must be taken to consideration that SA is a third world country and might not afford more (Social worker No. 1. October 2016).

The grant helps; at least it can cover basic costs such as funeral policies, food, and electricity. It is, however, not adequate to cover all costs, especially expensive medical treatment" (Social worker No. 2. October 2016).

When it comes to defining basic needs, Burkey (2006:3) views them as those things an individual must have in order to live as a human being. However, if one would undertake a critical analysis of what basic needs entail, the results would be varied and involve contestation around what these consist of. This is highlighted by Segal and Brzuzy (1998:8), who polemically ask what basic needs depend upon, who defines them and the nature of the group for whom the resources are intended. One can generate a list of needs, but ranking these needs in terms of their importance is difficult, as it becomes a subjective exercise, because people have different preferences.

This is in agreement with Maslow's hierarchy of needs, where physiological needs entail the motivation to acquire food, water, and shelter is high and behaviours that secure them are strongly reinforced. Most people do not require assistance in this process, but those with some cognitive impairment may not be able to meet physical needs consistently. This level includes the most basic needs that are vital to survival, such as the need for water, air, food and sleep. Maslow believed that these needs are the most basic and instinctive needs in the hierarchy, because all other needs become secondary until these physiological needs are met (Thielke et al., 2012). The following subsections look at different sub-themes, one by one, that follow under the theme of financial satisfaction.

4.3.1.3 Subtheme 3: Beneficiaries of disability grant as sole providers of basic needs

In terms of providing basic needs and necessities, the majority of the disability grant beneficiaries are seen to be sole providers. Thus, their responses show that the money is not enough for their needs. In some cases, food was said to be bought on credit to be paid at the end of the month. Several participants, specifically in families where the grant beneficiary was the only source of income for the household, stated that the food purchased was not sufficient to last for the whole month. One of the social workers explained:

The grant money has to be used to bail the entire family out of poverty, yet it is meant to help the beneficiary. However, the money is used to address all the problems of the household and this reduces its impact on the intended beneficiary. Hence deciding on the use of the grant money becomes a source of potential intractable challenges (Social worker No.2.October 2016).

The disability grant was never considered for personal use only, but was considered as an income for the household and spent as such. It did not come as complementary to the family's earnings but the sole source of income.

The total dependence on the disability grant discussed above was described by some of the beneficiaries as follows:

I buy food, clothes for the child and I help the other children here at home with their education. We use the grant but it is not enough for the whole month, you find that the money is finished in the middle of the month and we just have to wait for the end of the month. I just sit and accept because I do not have parents and my brother is sick, he has TB [tuberculosis] and also has to go for treatment' (Participant 7, October 2016).

With the money, I buy groceries and then I am left with nothing. I can't even buy things for myself, it is too little. The reason being that I am the only person to look after the family using this grant money (Participant 8, October 2016)

The sentiments of the participants above show that the disability grant beneficiaries are the sole source of the basic needs in the households. Without any other income to complement the grant, the beneficiaries remain in poverty and cannot meet monthly obligations.

All participants bought clothes for their family as well as themselves. It was never possible to buy all that was required for the month since the money was not enough. An example of this is illustrated by a 41-year-old female disability grant beneficiary staying in a household of ten people who depend solely on grants. This study, in greater detail, relates to the findings by Schneider & Swartz (1998) that the disability grants often supported others beyond the disability grant beneficiary. It shows various examples of income dilution due to large household sizes, even when the disability grant is pooled with other grant or salary income. It verifies discoveries in other societies that a bigger family unit will probably stay poor in spite of the disability grant (Woolard & Klasen, 2005:19).

4.4 To explore the impact of the disability grant on the physical health of beneficiaries

The use of disability money varied from one beneficiary to another. Some beneficiaries used the money for all fundamentals such as food, clothing, health care and rent among others. In this regard, the money may not be enough for some beneficiaries. However, this section is solely based on the information about amount of grant money used for health purposes and the adequacy of the money to meet all the medical expenses.

Table 4.4: Main theme, sub-themes and issues raised

Theme	Sub-themes	Issues raised
Health expenses	Adequacy of grant money for medical needs	The money received plays a significant role in helping the disabled to cope with their own health. However, in some instances the money might not be enough to meet all the medical needs of the beneficiaries.
	Specialised medication	The data obtained from the participants also shows that specialised medication is not available in local clinics, thus they have to go to larger urban centres. Participants said they only received tablets in local clinics and these tablets were sometimes not available.
Health facilities	Access to medical care	Participants reported that they walk long distances to the hospitals where they access medication. Others complained that they have to also wait in long queues in the hospitals.
	Provision of health facilities	The participants said that some of the health facilities needed by the disabled, like automated wheel chairs, were not available. The wheel chairs that they used were very old, moved slowly and some of their parts were broken.

4.4.1 Main theme 1: Health expenses

Some beneficiaries of disability grants needed serious medical attention and as a result, more money was required. On the other hand, some beneficiaries required less. Below are the sub-themes that explains the data from the interviews on the issues concerning the health needs of the beneficiaries.

4.4.1.1 Subtheme 1: Adequacy of grant money for medical facilities

Results regarding the disability grant are discussed in relation to the adequacy of grant money on medical facilities and the nature of treatment that the beneficiaries received. Results are presented in terms of access to medical care, provision of health facilities and the access to the government to subsidise health for the disabled. In this regard, the researcher was interested in knowing if the grant money was enough to cover all their health problems. Below are some of the responses given by the participants;

> *I am in terrible situation because the money is not sufficient, like now I am alone and I am supposed to buy medicine for R300 and other expensive drugs because I am diabetic. Medical practitioners complain that I do not eat the right food. (Participant 5, October 2016).*

The views above indicate that the disability grant is not enough to cater for the participants' health needs. Most of them said that they spent approximately R300, which was not even enough for medical consultation, especially in private health care. In support of the above, the literature states that people with disabilities are excluded from the mainstream society and experience difficulty in accessing fundamental health rights. Particularly vulnerable are the historically disadvantaged groups in South Africa, including, in addition, people with severe mental disabilities, people disabled by violence and people with HIV (Gumede, 2012: 12). However, the inadequacy of the disability grant is supplemented by the government through the National Health Act, which aims at protecting, respecting, promoting and fulfilling the rights of vulnerable groups such as women, children, older people and people with disabilities. The Patients' Rights Charter, in addition, says there must be provision for the special needs of vulnerable groups, such as infants, children, pregnant women, the aged, people with disabilities and people living with HIV (SASSA, 2010).

4.4.1.2 Subtheme 2: Specialized medication

The data from the participants also show that specialized medication, such as insulin for people suffering from diabetes, is not available in local clinics hence they have to go to larger urban centres. They reported that they only received tablets in local clinics and that these were sometimes not available. In addition, the participants claimed that their treatment depended on the amount of money available. The majority of the participants said that they normally budgeted R300 for medication and the treatment that they got with this amount was not satisfactory. Below is an extract from an interview with one of the participants, explaining her experience;

I get treatment from the clinic, but you know our clinics these days there is no medication. Most of the time I don't receive the whole treatment so I have to go and buy medication from the pharmacy. If I can estimate, I use R300 monthly to get medication (Participant 9, October 2016).

However, the participants said that the nurses and doctors treat them with courtesy and respect. This is evident in the views expressed below:

Nurses in the clinic are so disciplined; I don't stand in the queues when I visit the clinic or hospital. Some community members understand, but others can be cruel and they argue that they were there first (Participant 4, October 2016)

The elderly and persons with disabilities often do not stand in queues when they visit clinics and hospitals, among other service provision centres in South Africa.

4.4.2 Main theme 2: Health facilities

The other theme that emerged from the data was the issue of access to health facilities. Some participants said that they stayed a long way from the hospitals and thus they have to walk long distances. A few complained about the quality of treatment that they received. A common complaint among the physically disabled was the inadequate provision of facilities such as wheel chairs. Last but not least, the participants pleaded with the government to subsidise the health sector. Therefore, two sub-themes emerged from the data, as follows:

- Ease of access to medical care
- Provision of health facilities

4.4.2.1 Subtheme 1: Ease of access to medical care

Some participants reported that they walked long distances to the hospitals to access medication. Others complained that they have to also wait long queues in the hospitals. Others were complaining that they use public transport which they said is very expensive for them. The researcher asked them if it was easy to access health facilities and medical care and they gave the following responses:

I have to hire public transport to take me to the hospital; I can't walk as I am in a wheelchair" (Participant 5, October 2016).

We actually have our local clinic but sometimes they refer us to cities as far as East London. As such, the transport costs are very high because I have to also pay the fare of the person who accompanies me (Participant 15, October 2016).

The above responses show that the participants sometimes travel long distances to access medical care. Significantly, the data obtained from the participants also shows that the specialized medication required by the disabled is not available in local clinics, thus compelling them to spend money on transport to obtain it.

4.4.2.2 Subtheme 2: Provision of supplementary health facilities by government

The other important issue raised by the participants was that they lack health facilities such as wheel chairs. One of the participants said that the wheel chair that she used was very old, and that it moved slowly because some of its parts were broken and she could not replace them. She said she would have preferred the newly introduced wheel chairs that were automatic, as she sometimes would like to go to town alone, but she cannot do this, because she needs somebody to push her wheel chair. In other words, she is dependent on the willingness of others to push her in order to be mobile. Below are the responses given by participants:

It is difficult for me to go to town or hospital alone, the wheelchair I am using is very old. I need the assistance of the other person to push the wheelchair (Participant 1, October 2016).

My brother is looking after me, since I have an old wheelchair he is the one who is pushing me around but I have to pay on my pension day. If I had the automatic one I would be saving a lot of money (Participant 4, October 2016).

One other important issue that emerged from the interviews with participants is that the government should subsidise the health sector and ensure the provision of quality medical care and facilities to the disabled. The participants acknowledged the support provided by the disability grant, but they mentioned the need for medical facilities such as new automated wheel chairs which would enhance their independence and social mobility.

4.5 To find out if the disability grant helps in social relations and enhances support to beneficiaries.

Table 4.5 below presents main themes, subthemes and issues raised emerging from data on whether disability grant helped in social relations and enhanced support to beneficiaries

Table 4.5: Main themes, subthemes, and issues raised

Theme	Sub-theme	Issues raised
Social relations	Support from the family and community	Families helped the disabled to manage stress and this strengthened emotional well-being.
	Household assistance and care giving	The majority of the participants reported being independent in the home environment. However, there was a single case where one disabled participant had to pay for someone to assist with some household tasks.
	Friends, community and family relations	The families, friends and community relations helped in strengthening the disabled people's emotional well-being, and their connections to the important people in their lives.
	Family relations in decision making	Family members, mainly mothers and beneficiaries, collaborated on how to use the money.
	Challenges in decision making on the use of grants	Conflicts mainly emanated from households that made decisions to use the grant money in a way the beneficiaries felt was inappropriate and unsatisfactory.
	Family advice in making decisions on the use of disability grant	The beneficiaries or recipients of the disability grant were often advised on how to use the money by their family members. This helped some of the disabled participants who could otherwise not maximise the financial potential of the grant. However, sometimes family members misused the money received by the disabled.

Discrimination within the community	Equal rights	A few participants mentioned that they were sometimes discriminated against in their communities. However, the majority of them said that they were well respected as much in the community as in their homes.
	Stigma	Just as above, data from the participants shows that the disabled were not stigmatized by community members. Instead, the disabled were well respected and taken care of by the people around them.

4.5.1 Main theme 1: Social relations

Social relations and support to beneficiaries entail a good relationship between the two parties, i.e. the beneficiaries of disability grant and the family members in terms of giving each other emotional support, love and care. Thus, the researcher was interested in understanding the nature of family relations and support from the participants' point of view.

4.5.1.1 Subtheme 1: Support from the family and community

At every stage of life, our relationships and families present us with both joys and challenges. Learning to manage stress, to understand our own emotions and behaviour and to communicate effectively can help strengthen our own emotional health, as well as our connections to the important people in our lives. As such, the researcher asked the participants about the nature of their family relations. They gave the following varied responses, which indicated both exceptional support and complete absence of support from members of the extended family:

My family is very supportive; their support is amazing. I do not feel that I am on wheelchair they do everything for me. Sometimes I get worried that I am too much but the love and dedication to do the job is extraordinary (Participant No. 4, October 2016).

I get all the support I need from my family they treat me as an old person who cannot do anything for himself. And they never get tired of me. I really feel that I am being respected as an old person (Participant 5, October 2016).

I get all the support I need form my wife and kids. As for my family I don't see them the last time I saw them I was coming back from hospital. They did not even visit me from the hospital (Participant No. 9, October 2016).

As a family, we all make collaborative efforts to treat our disabled family member properly (Participant 11, October 2016).

My son cooks for me, cleans the house and washes the dishes. Basically he does everything except for washing myself I can do that I was trained when I was in King Williams' town in those schools for people with disabilities (Family member 9, October 2016).

The majority of the disabled participants testified affirmatively that they got adequate family support of both an emotional and practical nature. This is extremely important, as confirmed in the literature by Murphy et al (2007) who state that emotional as well as practical support is essential in helping the disabled individual cope with his or her disability. Opportunities to connect socially with families and friends remain central to the lives of people with disabilities. The physical environment is also important for quality of life for people with a disability. The care environment also matters as people with disabilities must be empowered, provided with a choice, and given independence over their lives in both community and residential care settings (Murphy et al, 2007: 26).

4.5.1.2 Subtheme 2: Household assistance and caregiving

Half of the participants were independent in the home environment. However, there was one case where a single male who had multiple physical disabilities had to pay someone to assist him with some household tasks.

I have to pay people to help me – even at home. I don't have a wife at home to help me, so I have to pay someone to clean the house (Participant 6, October 2016).

Few participants mentioned directly paying for caregiving services. Rather, there was a sense of increased independence on receipt of the grant, which enabled the disabled to pay for goods and services themselves. Some participants relied on indirectly-remunerated help from family members for a few tasks, such as collecting water from the river, because the terrain made the river inaccessible. One participant did not directly pay for help, yet those who assisted him directly benefited from the disability grant being used to cover household expenses. This can be linked to Frieg & Hendry's (2002) findings that where people with disabilities needed care from a family member, this person was often not employed, indicating possible reliance by the helper on the disability grant. For many beneficiaries, the people at home help with minor duties such as washing, cooking and other miscellaneous tasks in the home environment. This also resonates with findings by Vorster et al (2006), who established that 84% of disability grant beneficiaries did not specifically pay for care, but excluded mention of unpaid care or indirect payment through contributions by the recipient of the grant to household expenses.

4.5.1.3 Subtheme 3: Family, friends and community relations

The families, friends and community relations help in strengthening the disabled people's emotional health, as well as their connections to the important people in their lives. As such, the researcher asked the participants about the nature of their friends, community and family relations. They gave the following responses

I have a strong relationship with my friends, my community and my family (Participant 9, October 2016).

There is a lot of stigma when it comes to disability. Some disabled persons are abused by their own families (Social worker 2, October 2016).

I have good communication with community members and friends (Participant 14. October 2016).

I am not good in socializing with others so I don't have much social relationship except for my neighbours who are very nice people. (Participant 11, October 2016).

I have a good bond with my community members, neighbours and friends (Participant 5, October 2016).

The responses above show that the participants generally have good relationships with their family members. According to Maslow's hierarchy of needs, the next level over and above physiological needs and the need for security is to feel loved and accepted by others. People desire communication and attachment and seek out opportunities to relate meaningfully with others, especially with family members. Relationships such as friendships, romantic attachments, and families help fulfil this need for companionship and acceptance, as does involvement in the activities of social, community and religious groups.

4.5.1.4. Subtheme 4: Family relationships in decision-making

There are many existing debates on the issue of decision making in the use of social welfare grants. Some empirical studies yield the findings that the decisions on the use of grants are made by the beneficiaries themselves, while other studies contend that the elders in the household determine the use of grants, since the beneficiaries may be immature or unable to decide on their own. To this end, the researcher asked the beneficiaries who made decisions on the use of the disability grant. Below are the responses from the participants.

We all discuss together as a family how to use the grant money (Family member 4, October 2016).

My mother decides for me how to spend the money and her advice is good (Participant 2, October 2016).

My mother and I decide together on how to use the money (Participant 6, October 2016).

The responses of the participants show that family members, mainly mothers of beneficiaries and the beneficiaries themselves collaborate on how to use the money. In support of the responses, the South African Social Security Agency (SASSA) and the United Nations Children's Fund (UNICEF) 2010 carried out a study on intra-household decision-making relating to the use of social security grants. The study, which was qualitative in nature, mainly focused on the grant use, improvements in the accessibility of grants and the misuse of grants. The results of the study were that decision-making concerning the use of grants mainly relies on the primary caregiver (usually a woman). However, many primary caregivers justified their sole control over the use of grants based on their superior knowledge of the grant beneficiaries' needs. In support of this, Doss

(2011) posited that the increased role of women in decision-making is expected by development practitioners to impact positively on the development outcomes of households, for example on the health and education of children and the general wellbeing of the entire household. In the backdrop of the increased gains from the increased women's bargaining power in the household, policy-makers and development practitioners find it critical to formulate and implement measures that foster women's bargaining power.

4.5.1.5 Subtheme 5: Challenges in decision-making on the use of grants

Although the previous section seemed to indicate that relationships are cordial and that there was shared decision-making, it was not always the case. Therefore, deciding on the use of the disability grant is not an easy endeavor, given that the money is just assigned to one individual, but due to poverty in some households, it ends up being stretched to meet the needs of all family members. Participants in this study highlighted that problems sometimes erupt in their households, causing family tensions.

In this respect, one participant responded by saying;

Every month when the grant money comes through there is stress and tension in the household as family members hope that they can get a share of the money so that they can use it for their own needs (Participant 8, October 2016).

This is expected, especially in households where there is little or no other source of income.

Tensions in families, therefore, increased the challenges faced by the disability grant recipients. In other circumstances, the conflicts involve the guardians of the grant beneficiaries. Another participant said;

When it comes to making decisions on the use of the grant money, there is always conflict between my guardian and myself as my guardian rushes to make decisions without asking me what I need as the rightful person who is entitled to the money. This tension has led to a strained relationship between me and my guardian (Participant 13, October 2016).

What worsens the situation of the beneficiaries in the case of these conflicts is the reality that the people with whom they end up having strained relationships are the same people who are supposed to accompany them to hospitals and other service provision centres, sometimes even to the collection of the grant money. Another participant added;

At the end of each month when the grant money comes home I find myself embroiled in a conflict with my guardian as I feel she is making inappropriate decisions with the money, for instance by spending the money on beer, when the money is meant to be for my nourishment as the primary beneficiary (Participant 4, October 2016).

Not all guardians and ordinary family members would want to use the grant money responsibly. This renders the grant money ineffective in improving the quality of life for the grant beneficiaries. Therefore, over and above the fact that the money is little and does not cover all the basics for the beneficiaries, inappropriate use and wrong decision in families of beneficiaries affect the quality of life of beneficiaries.

The social workers interviewed were aware of the problem of tensions and conflict that arose within the family over the issue of how the grant money should be spent, and had devised a strategy to address this. One social worker said; "*One of the problems is misuse of their disability grant by family members, who are supposedly taking care of them" (Social worker 1, October 2016)* while another said; "Yes, we do offer family counselling sessions and educational sessions on budgeting skills" (Social worker 2, October 2016). This information obtained from the participants points to the fact that there were difficulties and challenges in the process of deciding on the use of disability grants. From the perceptions of the participants it seems that conflicts mainly emanated from the households who made decisions to use the grant money in a way the intended grant beneficiaries, namely, the disabled, felt was inappropriate and unsatisfactory. Such decisions included, for instance, guardians deciding to use the money for alcohol or cosmetics. Beneficiaries of the disability grants were then affected by such decisions, which led to conflicts and tension in the family and households, particularly between the guardians and the beneficiaries.

The fact that the grant money is meant for the wellbeing and nourishment of only one person (the disabled person), is a source of challenges when it comes to deciding on its use. Most households where beneficiaries of the disability grant reside experience poverty, hence there is at least partial and in most cases total reliance on the social grant as a source of livelihood and survival for the entire household or family. Most of the members in families in this situation, according to the beneficiaries of grants in this study, look forward to the grant money being utilized to meet their personal and individual needs. This becomes a source of contestation because the grant money, despite being meant for the nourishment, improved welfare of an individual, is little in relation to the needs of an entire family. Guardians find themselves torn between decisions to satisfy the individual needs of one member of the household and of the entire household. The utilization of the disability grant by the entire family for a broader purpose has been corroborated in a study conducted by Gutura and Tanga (2014), where the findings revealed that social grants played a critical role in poverty alleviation in households. Their research established that the grant money was being used to buy food in poor households and that through this mechanism households managed to avert hunger, as food was made more accessible and available.

4.5.1.6 Subtheme 6: Family advice in making decisions on the use of disability grants

Advisers can play an important role in deciding on the use of money. The beneficiaries of the disability grant are usually advised on how to use the money by their family members, rather than external advisers such as social workers, and this can assist them, but not necessarily so. There is contradictory evidence in this respect, because some of the disabled participants welcomed the role played by family members in decision-making, while others resented this interference. In this regard, the researcher asked the participants about the people that the beneficiaries consulted when making decisions. The common response was along the lines of the following; *We do not seek advice from outsiders but we rather make our decisions as a family" (Family member 11, October 2016).* This shows that the families are self-reliant in terms of making decisions on managing their social welfare grants. This is supported in the literature by Nepal, Yai and

Fukuda (2005), who argue that a household, even if it consists of different individuals, acts as a single decision-making unit and that the household is the primary decision-making unit. Household members carry out household decisions by engaging in various activities. Decisions on whether or not to participate in different activities, as well as who participates in these, are a result of negotiation over roles, tasks and time allocation within the households. These decisions are derived from the pursuit of activities to satisfy household needs (Nepal, Yai and Fukuda, 2005).

4.5.2 Main theme 2: Discrimination within the community

Disabled people experience discrimination in all spheres of life. They are discriminated against through a variety of factors in societies across the world, in ways which include less access to education benefits, health, social life, and employment.

4.5.2.1Subtheme 1: Equal rights

An issue that emerged from the data was that of discrimination. A few participants mentioned that they felt that they were treated differently in their communities. However, the main area in which grant beneficiaries felt they did not have equal rights was in relation to access to employment. The majority of them said that they were not employed because employers thought that they could not do the work to the same standard as people with no disabilities. One participant said; "*In church we are not welcome ... we are perceived as if we cannot do anything for ourselves" (Participant 8, October 2016)* while Another sad; "*Not any work even the community cleaning we are not getting any place" Participant 11, October 2016).* This is in line with findings by Groce et al. (2011) who found that worldwide, the unemployment rate among persons with disability is up to 80%. This is higher in low-income countries (Wiggett-Barnard and Swartz, 2012).

According to Chalklen (2003:14), under apartheid the experiences of disabled people were also the experiences of people living in a deeply divided and unequal society. Black and white people were discriminated against and marginalized because of their disability. They had limited access to fundamental socio-economic rights such as employment, education and appropriate health and welfare services. This kind of discrimination and marginalization occurred because disabled people in general were seen as people who were sick or in need of care, rather than as equal citizens with equal rights and responsibilities (Chalklen, 2003:35).

Presently there is no Disability Act that protects the rights of people with disabilities in South Africa. The government is developing a national disability policy and a disability Act but there are still problems with the implementation of this Act. However, the rights of disabled people are protected within the Constitution. In addition to the protection of disabled people's right against discrimination in the Bill of Rights, the Constitution also provides a provision for the rights of disabled people in terms of Social Security. The Bill of Rights (Chapter 2) Section 27 (1) says "Everyone has the right to have access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance" (Child Health Policy Institute & South African Federal Council on Disability, 2001:12).

4.5.2.2 Subtheme 2: Stigma

The data obtained from interviews with the participants show that the disabled are not stigmatized by either the family or community members. Instead, the disabled are well respected and taken care of by the people surrounding them. Community members also run errands and deliver messages, and perform tasks relating to communication. One participant elaborated;

I have a great relationship with my community, I remember this one day we were in the fields and we asked a child to bring us water and when he came back he gave me the container with water and I couldn't handle it and he started to laugh with his friends. My friends called them but they ran away and [they] they chased after them and brought them back to apologize and I couldn't do anything, I just smiled and said silently forgive them Lord they are just kids. So, basically what I am trying to say is that this is the kind of good relationship that I have with my community members when kids try to tease me they would stand up for me (Participant 15, October 2016).

4.6. To explore the general life satisfaction and wellbeing of disability grant beneficiaries.

The table below engages with data from the interviews on the issue of general life satisfaction and wellbeing of disability grant beneficiaries.

Table 4.6 Main themes, subthemes and issues raised

Theme	Sub-Theme	Issues raised
Improved general life satisfaction	Living the same way as other people	Interviews with participants have shown that the lives of the disabled people have improved as a result of the disability grant. It emerged that the disabled people are now able to live a normal life and acquire basic items that are essential to cover their needs.
Improved welfare of the disability grant beneficiaries	No need to beg	Participants interviewed in this study said that they do not beg in the streets, because they receive the disability grant and do not need money from members of the public.
	Situation in the absence of disability grant	The participants indicated that the absence of disability grants would make their lives difficult. They specified that poverty and stress would overwhelm them since they did not have alternative sources of income.

4.6.1 Main theme 1: Improved general life satisfaction

The overwhelming majority of the participants (almost all of them) indicated that the lives of disabled people had improved because of the disability grant. It emerged from the participants that disabled people were able to live and lead a relatively normal life and acquire basic items. However, some of the participants said that they were not able to have three meals a day prior to receiving of the disability grant, indicating that previously they experienced deprivation and discomfort through hunger.

4..6.1.1 Subtheme 1: Live the same way as other people

The lifestyles of the disabled were reported to have greatly improved after the implementation of the disability grant in that they started having access to better quality food and medication, and their standard of living became the same as that of other people. In the post-apartheid era, the disabled were discriminated against and they lived in abject poverty as a marginalized group. During the interviews these sentiments were strongly expressed. One participant said;

I think my lifestyle has improved since I am sure that I get something at the end of every month. I was really in poverty before this grant money but now we afford to lead a basic life as a family (Participant 8, October 2016).

What is coming out of the excerpt above are disparities between life before and life after the commencement of the disability grant. This indicates that the grant has helped transform the lives of the beneficiaries. Participant 12 sums it up by saying; "*Our life has improved because we now have money to buy groceries and clothes. In other words, we live a normal life that can be compared to people who are working*". Data indicates that the grant has improved the lives of not only the beneficiaries as individuals but also their families and households.

Analysis indicates that the disability grant has added meaning and value to the lives of those who receive it as some have even bought valuables. For example, one participant indicated that;

Ever since I started receiving the money, at least my life has changed. There are household goods that belong to me that I have bought with the money, even though these days it's difficult because everything is expensive (Participant 4, October 2016).

In line with the above, quality of life means a life that allows a human being to experience pleasure from being alive, over and above basic survival. A good life can be considered as experiencing quality of life. 'Quality of life' is a concept that identifies what is important, necessary and satisfying in human existence. Quality of life comprises a number of objective factors such as state of health, level of education, income, property, relationships with others or economic situation of the country (Ventegodt et al, 2003).

4.6.1.2 Subtheme 2: No need to beg

None of the participants interviewed in this study said that they did not beg in the streets, thanks to receiving the disability grant. In most African countries, the disabled people are mostly beggars, because they do not receive grant money. An elderly physically disabled woman said that;

I can afford to buy all what I want and I am no longer begging as I used to do in the olden days before I was receiving this grant money (Participant 14, October 2016).

This is in line with Varney's (2013:129) argument that people with disabilities tend to be disempowered and deprived of economic and social opportunities and security because of social and physical barriers in society. Furthermore, they are also under-served by most public and private institutions and services. As a result, people with disabilities tend to be the poorest of the poor. Women with disabilities in particular are vulnerable to poverty because they often have fewer economic means and may resort to begging for survival (Elwan, 2000: 56). The disability grant has helped remove persons with disability from the streets, where they were often victims of abuse.

4.6.1.3 Sub theme 3: Possible outcome situation in the absence of the disability grant

One of the most important issues that emerged from the participants is the kind of situation they could face in the absence of the disability grant. The researcher asked them how the participants would feel if the grant was to be taken away from them. One participant had this to say;

I will die because of stress; I won't be able to do all these things that I am managing to do with the money. And I will die of hunger as I have mentioned that my daughter is unemployed and I lost my son who was taking care of me (Participant 3, October 2016).

Generally all the responses pointed at the possibility of their situation becoming deplorable were the grants to be scratched off. The response; *"It won't be good; we won't survive because I will not be able to do the things that I used to do before" (Participant 6, October 2016)* indicates that this would not only affect the grant beneficiaries but also their families and households since, as another participant indicates, *"it [the grant] is the only source of income (Participant 10, October 2016*). The above sentiments expressed by the participants show that the absence of disability grants would make their lives difficult and stressful. They emphasized that poverty and stress would overwhelm them since they did not have alternative sources of money.

4.7 Conclusion

This chapter presented and analysed data, leading to key findings of the study. In general, the findings point to the fact that the living standards of the beneficiaries have greatly improved because of the disability grant. However, the participants mentioned that the disability grant was not enough to meet all the fundamentals of their daily lives. This state calls for the government and other relevant stakeholders to seriously re-examine the plight of the disabled in South Africa. It is against this background that the next chapter proffers recommendations in relation to solutions to the challenges reflected in the findings. The following chapter also provides the conclusion of the study.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the study on the extent to which the disability grant is able to offer quality of life to disability grant beneficiaries in two villages in the Raymond Mhlaba Municipality. These villages are Magaleni in Fort Beaufort and Debe Nek in Middledrift. The fundamental purpose of this chapter is to respond to the research objectives and to attempt to critically justify them in accordance with the results obtained. The most significant aspects of the findings are discussed, giving particular attention to the financial satisfaction of the disability beneficiaries, the effects of the disability grant on the physical health of beneficiaries, the nature of social relations between the disability grant beneficiaries and their families, and, in addition, the general life satisfaction and wellbeing of disability grant beneficiaries. Finally, recommendations are made in relation to the findings

5.2 Summary of the findings

This section presents the summary of the findings based on the data collected, divided according to the categories of questions used in the interviews. The purpose of the summary is to briefly provide the findings on the quality of life of the disabilities, based on issues around financial satisfaction and improved welfare of the disabled; due to the provision of the disability grant, as well as the use of the grant money for health purposes, and, finally, the nature of their family and social relations. The overall findings concurred with the existing literature, in that the provision of the disability grant covered the basic needs of both the grant beneficiaries and their families. However, the contribution of the findings is that the disability grant contributes to the quality of life of grant beneficiaries, although there are certain significant gaps, which will be discussed below. This section commences with the aspect of disability grant and poverty alleviation.

5.2.1 Disability grant and poverty alleviation

The results of the study have shown that the disability grant is making a meaningful contribution to poverty alleviation in terms of covering all the immediate needs of beneficiaries themselves, such as food and clothing, whilst, in addition, some households were able to pay their water and electricity bills using the grant money. This shows that the participants are living above the Poverty Datum Line (PDL).

5.2.2 Inadequacy of disability grant to cover basic needs

The findings of the study have shown that the grant money was not entirely adequate, especially in the families without any other income besides the grant. As such, the study found out that there are very few families with supplementary incomes. Basic needs, from the participants' view, covered the whole family, and included health, education, food and clothing, electricity and water bills, as well as funeral cover, among other items. This was because the beneficiaries were all unemployed and did not believe they would be able to become employed, so they and their families relied on the disability grant. Discussions with the social workers, family members and the disabled indicated that the disability grant was not enough to cover all basic needs of beneficiaries and their families. The main reason given by the participants was that some families were very big and rely on solely rely on the grant money that is entitled to one recipient i.e. the beneficiary.

In sum, it is significant that disability beneficiaries considered themselves as sole providers, as the only source of income for the family, and they used the grant to pay for expenses of the family, such as food and school fees. Furthermore, the study found that the disabled people encountered many health problems, and that the grant was only partially able to address these, as infrastructural facilities such as specialised nearby clinics and wheelchairs were not always available. The grant was not always enough to cover medical needs such as special medication, for which they had to budget an average of an extra R300.

5.2.3 Results concerning social relations

The findings of the study have shown that the nature of social relations is one of the most fundamental aspects that determine the well-being of the grant recipients. It entails aspects such as support from the family and the community, household assistance and care giving, family relations in decision making, among others. The findings of the study have shown that the family members help the disabled to manage stress and offer moral support, strengthening their emotional health. The disabled participants acknowledged the presence of their family members and said that they shared their problems with them. Therefore, the study has shown that the support from the family and the community had a significant impact on the quality of life of the disabled.

However, the findings of the study have shown that sometimes conflicts may arise in the process of decision making on the use of grant money. Conflicts mainly emanate from the households who make decisions to use the money in a way the beneficiaries feel is inappropriate and unsatisfactory. In terms of relationships within the community, only a few participants mentioned that they were sometimes discriminated against. However, the majority felt that they were excluded from employment opportunities because of their disabilities.

5.2.4 Improved welfare of the disability grant beneficiaries

According to the findings, the welfare of the disabled had greatly improved in the sense of quality of life, which exceeded the mere covering of basic needs and included aspects such as sense of wellbeing and security in the family and the community. They have a sense of respect and independence, and they do not have to resort to humiliating activities such as begging in order to gain the money they need. However, contradicting the evidence of the participants, the researcher has nonetheless observed disabled people begging in the streets and in public places. This suggests that either the disabled are not comfortable disclosing that they do participate in the practice of begging, or that those interviewed do not do so.

5.3 Conclusions

At the outset of the study, four objectives were identified, reflecting the research goals. This section summarizes the conclusions that were reached in relation to each objective, as discussed above.

- The first objective was to investigate whether disability grant beneficiaries are financially satisfied with the money they receive from the government. In relation to this, the findings of the study indicated that whilst the beneficiaries appreciated the funds made available through the grant, these were not adequate in terms of satisfying their needs.

- The second objective was to explore the impact of the disability grant on the physical health of beneficiaries. Once again, the findings revealed that the grant only partially addressed the physical health requirements of the beneficiaries and there were significant gaps in relation to the cost of specialised medication and the provision of specialised facilities such as wheelchairs.

- The third objective was to find out whether the disability grant helps in social relations and enhances support to beneficiaries. The findings showed that the grant in itself played no role in improving social relations and enhancing support, as beneficiaries reported that they received support that was unrelated to the provision of funds. It was, however, reported by a few beneficiaries that use of the grant led to tensions within the families as to how the money should be spent.

- The fourth objective was to explore the general life satisfaction and wellbeing of disability grant beneficiaries. The findings pointed overwhelmingly to improvements in the general life satisfaction and wellbeing as a result of receiving a grant that allowed beneficiaries to lead a more dignified life in which their basic needs were met, even if not all of them were fully accommodated.

5.4 Implications for social work

The main findings of this study show that the disability grant is not completely adequate in relation to the needs of the disabled and also that the facilities and resources required by the disabled in order to enjoy quality of life are not usually available in the rural areas in which the research was conducted.

The implications for social work policy and practice are firstly, that the base on which the amount to be allocated to disabled people is decided needs to be reviewed; and secondly, their isolation from the facilities they need must be addressed by provision of appropriate transport and more accessible health facilities such as those provided by hospitals.

5.5 Recommendations

The recommendations arising from this research are as follows:

1. The government should provide more health care facilities to the disabled, since they are currently inadequate.

2. The government should appoint more social workers to deal with the issues affecting the disabled.

3. Social workers should revitalize their role as intermediaries between the government and the disabled, as this will enable the government to respond to the problems that are flagged by social workers timeously.

4. Provision of adequate and appropriate housing should also be ensured so that the disability grant money is utilised for other purposes than for installing the facilities that are necessary for the disabled in their homes.

5. In the interim, social work practitioners should improvise various coping strategies that the disabled people can adopt, so as to better cope with the challenges they encounter.

5.6 Suggestions for future research

Future researchers might wish to conduct similar research utilising triangulation in order to establish the validity of the data. A single research method, using only qualitative data may not be adequate to investigate and obtain all the desired information. Therefore, the combination of two or three research methods would be worthwhile and advisable. Future researchers should investigate the role played by development programmes in assisting the disabled people who are not able to work for themselves.

Future researchers should look at the basic skills that can be taught to the disabled so that they can be self-reliant in terms of providing for their basic needs themselves, rather than relying solely on the government. Last but not least, future researchers should undertake comparative studies that investigate the nature of disabilities and the lives of the disabled in Africa, in comparison with those in other continents (Asia, Europe, North and South America, Oceania).

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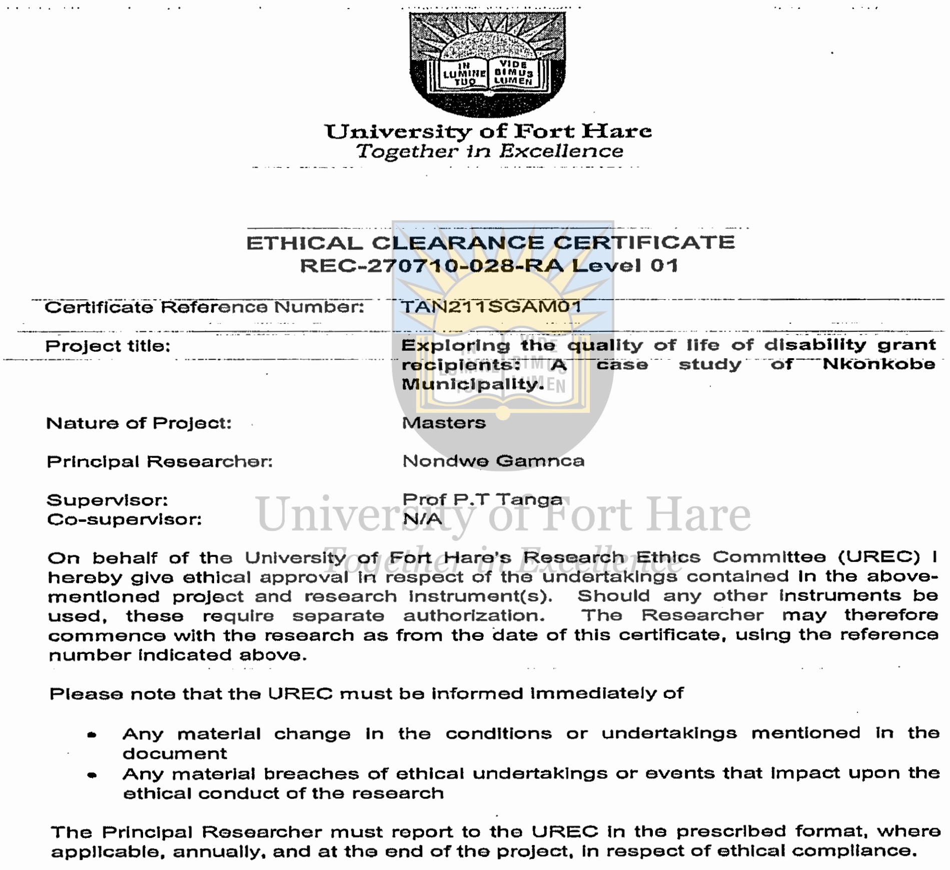
Appendixes

Appendix A: ETHICAL CLEARANCE



University of Fort Hare
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ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	TAN211SGAM01
Project title:	**Exploring the quality of life of disability grant recipients: A case study of Nkonkobe Municipality.**
Nature of Project:	Masters
Principal Researcher:	Nondwe Gamnca
Supervisor:	Prof P.T Tanga
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: Research that includes children as per the official regulations of the act must take the following into account:

Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
    - Any unethical principal or practices are revealed or suspected
    - Relevant information has been withheld or misrepresented
    - Regulatory changes of whatsoever nature so require
    - The conditions contained in the Certificate have not been adhered to
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Wilson Akpan
Acting Dean of Research

22 September 2016

APPENDIX B: INFORMED CONSENT

University of Fort Hare
Together in Excellence

INFORMED CONSENT

My name is **Nondwe Gamnca**. I am currently conducting a study **Exploring the quality of life of disability grant beneficiaries**. I am doing this in order to fulfil one of the requirements for the Masters degree in Social Work for which I am registered. May I kindly ask you to contribute in no more than 30 minutes of your time to answer my questions? **Please note that all the information collected will be treated as confidential.**

I hereby agree to participate in research regarding exploring the quality of life of disability grant beneficiaries. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop this interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally.

I have received the telephone number of a person to contact should I need to speak about any issues which may arise in this interview.

I understand that this consent form will not be linked to the questionnaire, and that my answers will remain confidential.

I understand that if at all possible, feedback will be given to my community on the results of the completed research.

……………………………………

Signature of participant **Date:** ……………………………………

I hereby agree to the tape recording of my participation in the study

……………………………………

Signature of participant **Date:** ……………………………………

APPENDIX C: INDEPTH INTERVIEW QUESTION

IN LUMINE TUO VIDEBIMUS LUMEN

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INDEPTH INTERVIEW QUESTIONS FOR GRANT BENEFICIARIES

SECTION A: BIOGRAPHICAL INFORMATION

1. Gender:

2. Age:

3. Marital status:

4. Employment:

5. Education:

6. Number of people in household:

7. How many other household members are receiving other grants?

8. Which type of grant if any member(s) are receiving social grants?

9. What is your household total monthly income?

SECTION B: Financial satisfaction with the money they receive from government?

1. When was the first time you received your grant and how long have you been receiving it?
2. Who is making the decision about the grant?
3. Explain how you spend the grant money?
4. Explain how many people benefit from the grant money and in what way
5. What are the challenges you encounter as a disability beneficiary?
6. Explain how you have been positively affected since you started earning the grant?
7. Describe how the disability grant helps alleviate poverty in your household?
8. Tell me how you would feel if the grant was taken away from you?
9. Explain if the grant money is enough to cover your financial needs?
10. Tell me whether you are happy with the amount that you receiving?

SECTION C: Effects of disability grant on the physical health of beneficiaries?

1. What kind of physical disability do you have?
2. What specific medical issues affect you?
3. How much of the grant money do you use to buy medications for these medical issues?
4. How do you access health facilities?
5. How far is the health facility from your home?
6. What mode of transport do you use to go to health facility?
7. How much you use on transport?
8. How are you treated by nurses in the health facility?
9. How much of your medical bills does the grant cover?
10. How would you rate your physical health?
11. How satisfied are you with your physical health?
12. How does your health affect your quality of life and functional abilities?

Section D: Social relations and support to beneficiaries

1 Describe what social relationships you have?

2. What kind of support do you get from your family?

3. Which social organization are you a member of?

4. Tell me if whether you are happy with your neighbourhood as a place to live in?

5. Explain your relationship with community members?

Section E: General and Psychological Satisfaction

1. How satisfied are you with the housing situation?
2. What type of toilet system do you have?
3. Who pays for your electricity and water?
4. Tell me whether you like the food you eat?
5. How satisfied are you with the clothes you wear?
6. Tell me what your talents are?
7. Have someone ever complimented you on something you have done?
8. Is the something that you are interested in?
9. Describe the things that make your quality of life better or worse?
10. Generally, how satisfied are you with your quality of life?

APPENDIX D: FOCUS GROUP DISCUSSION

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FOCUS GROUP DISCUSSION OF FAMILY MEMBERS OF DISABILITY GRANT BENEFICIARIES

SECTION A: BIOGRAPHICAL INFORMATION

1. Gender:

2. Age:

3. Marital Status:

4. Employment

5. Education: 6. No of years receiving grant:

7. No pf people in the household:

8. How many other household members are receiving other grant:

9. Which type of grant if any members are receiving social grants:

10. What is your household total monthly income:

SECTION B: FINANCIAL SATISFACTION

1. What are the positive changes that have taken place since the beneficiary started receiving the grant?

2. To what extent does the disability grant assist your household inn poverty alleviations?

3. Who take decisions about the household grant?

4. How satisfied are you or other household members with the amount received by the beneficiary?

5. Explain if the disability grants meet financial needs of your household?

SECTION C: EFFECTS OF GRANT ON HEALTH

1. Explain if the beneficiary is treated with dignity in your local health facilities?

2. In what way does the grant money help you in accessing health facilities?

3. How do social workers help you in the health problems of the beneficiary?

4. How is the beneficiary treated and perceived by the community?

5. How satisfied are you with the treatment received by the beneficiary from your health facility?

6. Are you satisfied with the beneficiary's physical health in the past four weeks?

7. Generally how is the physical health of the grant beneficiary?

SECTION D: SOCIAL RELATIONS AND SUPPORT TO BENEFICIARIES

1. How is the relationship of the beneficiary with other household members?

2. How does the family support the grant beneficiary?

3. Does the beneficiary have friends in the community except those in the household?

4. How is the community behaviour or relationship towards the disabled?

5. What community programs is the beneficiary involved in?

6. If you are not available as the primary care giver who attends towards the needs of the beneficiary in the household, who perform this role?

SECTION E: GENERAL AND PSYCHOLOGICAL SATISFACTION

1. How are you affected by living with the beneficiary in the household?

2. How satisfactory is the housing situation for the beneficiary's needs?

3. How appropriate is the toilet system in your household for the beneficiary?

4. How healthy is the food provided for the beneficiary and to what extent does it cover his/her nutritional needs?

5. Generally what would you say about the quality of life of beneficiary ever since he/she started receiving the grant?

APPENDIX E: EDITING CERTIFICATE

B S
C C
BE STILL COMMUNICATIONS
For effective communication solutions
bestillcommunications@gmail.com
landamasuku@gmail.com
+27835841854; +27618043021

CERTIFICATE OF EDITING

This document certifies that the Masters Thesis whose title appears below was edited for proper English language usage, grammar, punctuation, spelling, and overall style by Dr Nhlanhla Landa whose academic qualifications appear in the footer of this document. The research content and the author's intentions were not altered during the editing process.

THESIS TITLE: Exploring the Quality of Life of Disability Grant Beneficiaries: The Case Of Magaleni And Debe-Nek Townships In Raymond Mhlaba Municipality, Eastern Cape Province

AUTHOR: **NONDWE GAMNCA (201101299)**

DATE: **18 JUNE 2017**

EDITOR'S COMMENT

The author was advised to effect suggested corrections with regards to clarity of terms and expression.

Signature

PhD Applied Linguistics (UFH), MA Applied Linguistics (MSU), BA (Honours) English and Communication (MSU)