The profile of disability grant applicants in Bishop Lavis, Cape Town

[a] **Govender T,** MBChB, MFamMed [b] **Mji G,** HED, BSc, MSc
[a] Family physician, Private practice and former postgraduate student, Stellenbosch University, Division of Family Medicine [b] Centre for Rehabilitation Studies, Stellenbosch University
Correspondence to: Dr T Govender, e-mail: thiru_govender@hotmail.com
Keywords: disability grant applications; adults profile; Bishop Lavis; ICF

Abstract

Background: Disability grants in South Africa increased from 600 000 in 2000 to almost 1.3 million in 2004. This rise can be attributed to the HIV/AIDS epidemic, South Africa's high rate of unemployment and possibly an increased awareness of constitutional rights. The Western Cape, which has a disability prevalence of 3.8%, has also experienced an influx of applications. The study was conducted at Bishop Lavis Community Health Centre (BLCHC) in the Cape Town Metropole, Western Cape.

The primary aim of this study was to establish the profile of adults applying for disability grants at Bishop Lavis. The secondary aim was the determination of the degree of activity limitation and participation restriction by means of the International Classification of Functioning, Disability and Health (ICF) shortlist of activity and participation domains.

Methods: A descriptive study was conducted with emphasis on identifying and quantifying the relevant factors. The population studied included all prospective adult (18–59-year-old females and 18–64-year-old males) disability grant applicants in Bishop Lavis over a two-month period (April–May 2007). A structured, self-compiled questionnaire was administered during face-to-face interviews with applicants. The questionnaire included the demographic details of the applicants, disability/chronic illness/condition, educational level and social/living conditions. The second part of the questionnaire was based on the ICF shortlist of activity and participation.

Results: There were 69 respondents over the period of data collection. Of the 69 applicants who participated in the study, 45 (65%) received a temporary disability grant, 6 (8%) received a permanent grant and 18 (26%) applications were rejected. The results demonstrated that most applicants were females over the age of 50, were poorly educated with chronic medical conditions and were living in formal accommodation with good basic services but with minimal or no disposable income. The ICF questionnaire responses showed that the majority of respondents had no difficulty in most domains, except for the general tasks and demands (multiple tasks), mobility (lifting and carrying, fine hand use and walking) and domestic tasks domains, which showed high percentages of severe to complete difficulty. However, further statistical analysis showed no association between degree of difficulty in the above domains and eventual outcome of type of grant received.

Conclusions: This study confirmed that unemployment and a lack of income are the factors influencing patients to seek assistance in the form of disability grants. Most applicants had a chronic medical condition and reported functional restrictions but only received a temporary grant. This may be an indication that most patients require further evaluation before a final decision can be made. There is a need for a standardised, objective assessment tool for disability grant applications. A campaign to educate patients about disability grants could save patients and hospital medical services time and money.

Ⓟ **This article has been peer reviewed.** **SA Fam Pract 2009;51(3):228-236**

Introduction

The World Health Organization (WHO) defines disability as "any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". The WHO defines impairment as "any loss or abnormality of psychological, physiological or anatomical structure or function".[1]

In South Africa, the following definitions of disability are applied:[2]

- *The Employment Equity Act (55 of 1998)(Section 1)* – People with disabilities are those "who have long term or recurring physical or mental impairment which substantially limits their prospects or entry into, or advancement in, employment".[3]
- *The South African Social Cluster Programme* – "Disability is moderate to severe limitation in functioning (activity) or participation restriction that is permanent. Disabilities are normally classified as physical, sensory, communication, intellectual and mental. The activity/functional limitation or participation restriction needs to exist after correction or control of impairment."[4]
- *The Social Assistance Act (13 of 2004)* – A person with a disability is someone "who has attained the prescribed age and is, owing to his or her 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".[5] This is the definition that will be used in this study.

A review of the literature produced three recurring themes [6-8]:

- The difficulty in assessing disability due to a lack of guidelines and inconsistencies in definitions
- Unemployment and poor economic climates forcing people to seek assistance in the form of disability benefits
- Mental disorders being among the leading causes of disabilities

A study to establish the disability profile of grant recipients was undertaken in a semi-rural area of the Western Cape in June 1999. This study found that almost a third of the respondents had been disabled since birth and the majority (86%) had disabilities in more than one category.[9]

The determination of impairment, functional capacity and disability requires knowledge that most medical practitioners are unfamiliar with or are not adequately trained for. In assessing disability, the extent of a person's impairment has to be judged in the context of the environment, the activities of daily living, as well as social and work functioning. Focussing only on the inabilities of people inadvertently leads to stigmatisation and categorisation.

This is one of the major reasons the WHO formulated the ICF.[1] It places emphasis on health and functioning as opposed to disability. The ICF provides a "standard language and framework for the description of health and health-related states". It is therefore taken as a universal classification of disability and health. The health-related domains help describe "changes in body function and structure, what a person with a health condition can do in a standard environment (their level of capacity), as well as what they actually do in their usual environment (their level of performance). These domains are classified into physical, individual and societal perspectives by means of two lists: a list of bodily functions and structures, and a list of domains of activity and participation".

This study will attempt to determine the degree of activity limitation and participation restriction of grant applicants using the ICF list of domains of activity and participation. The degree of impairment in relation to body function and structure and the environmental factors were not explored.

There are between 2.3 and 2.5 million people with disabilities in South Africa, comprising 5.7–6.1% of the total population.[10] Currently 22 million people in South Africa live below the poverty line and only 5.5 million receive state assistance.11 The social security budget comprises two main components: the old age pension (females ≥ 60 years, males ≥ 65 years) and the disability grant. Sixty per cent of the social security budget is allocated to old age pensions and 24% to disability grants.

Disability grant applications have increased rapidly in the last few years, not only in South Africa but also in other developed regions, in particular Western Europe and North America.[6,12-15] Disability grants in South Africa increased from 600 000 in 2000 to almost 1.3 million in 2004.[16] This rise can be attributed to the HIV/AIDS epidemic, South Africa's high rate of unemployment and possibly an increased awareness of constitutional rights.[16] The Western Cape, which has a disability prevalence of 3.8%, has also experienced an influx of applications.[14,17,18] However, many applicants upon investigation display no medical condition or disability. Poverty and unemployment appear to be important drivers for patients applying for financial assistance, especially in the Cape Flats community of Bishop Lavis. There are between 50 to 70 applications per week, placing an enormous strain on an already overburdened service. These issues of poverty and disability and the large number of applications motivated the investigation into the profile of disability grant applicants at Bishop Lavis.

The Western Cape Department of Health has been compelled to employ doctors, on a contract basis, to assist with the filling in of disability grant applications. However, the current system is fraught with problems. These include lack of a standardised assessment tool as well as a lack of training and experience in disability assessment. Moreover, the final decision is essentially at the discretion of the doctor concerned, whereas in the past it was the pension administrator who decided. The doctor can decide to award a temporary grant (awarded when the disability will continue for a continuous period of not less than 6 months and not more than 12 months) or a permanent grant (awarded when the disability will continue for more than 12 months) or to decline the application.

The grant is means tested, so a single applicant must have an income of less than R20 232 per annum and assets worth less than R266 400. For married applicants, combined income must be less than R37 512 per annum with assets worth less than R532 800. The means test does not take into account the value of the home when assessing assets on condition that the applicant is living in it.[5]

The primary aim of this study was to establish the profile of adults applying for disability grants at Bishop Lavis. The secondary aim was the determination of the degree of activity limitation and participation restriction by means of the ICF shortlist of activity and participation domains.

Methodology

Study design

A descriptive study was conducted with emphasis on identifying and quantifying the relevant factors.

Setting

The study was conducted at the BLCHC in the Cape Town Metropole, Western Cape. The BLCHC serves a population of approximately 44 000. Bishop Lavis has a predominantly coloured, Afrikaans population.[19] The health centre provides primary health care including rehabilitative services and dental services and has an adjoining maternity unit. Currently between 7 000 and 9 000 patients are treated per month (excluding maternity and dental patients).

The doctor currently tasked with filling in disability applications is a locum who only consults for three hours per week. A maximum of 15 patients are booked per week. Patients have to make an appointment to have their applications filled in. The disability doctor can refer patients back to the doctor treating the patient for optimisation of treatment or for explanations about management plans. Patients who require work assessments are referred to Tygerberg Hospital and their applications are thereafter reviewed.

Population

The population studied included all prospective adult (18–59-year-old females and 18–64-year-old males) disability grant applicants in Bishop Lavis within the period of data collection. Only first-time applicants were studied in order to ensure that their perceptions were not influenced by the disability grant doctor. The period of data collection was over a two-month period (April–May 2007).

Patients who made appointments for their grant forms to be completed were approached to participate in the study before the doctor handling the applications saw them. Those in agreement were interviewed immediately after consent was granted.

A research assistant, who was proficient in English and Afrikaans, was trained to collect data and a pilot study was done. The research assistant interviewed participants in the language of their choice although the questionnaires were in English only.

The participants in the pilot study were patients from the BLCHC who were applying for grants for the first time. The purpose of the pilot study was to ascertain whether the questionnaire was easily administrable and whether questions needed to be changed for a clearer understanding. Six pilot questionnaires were completed before the study proceeded further. The original questionnaire remained unchanged after the pilot study.

Assessment

A structured, self-compiled questionnaire was administered during face-to-face interviews with applicants. The questionnaire included the demographic details of the applicants, disability/chronic illness/condition, educational level, social/living conditions and questions about the eligibility requirements of the grant system (Appendix 1). The second part of the questionnaire was based on the ICF shortlist of activity and participation (Appendix 2). The degree of impairment relating to body function and structure was not investigated as more objective tools were needed for assessment and it was beyond the scope of this study to employ these.

Analysis

The results were summarised using frequency tables and histograms. For questions where more than one option could be selected, the number of selections for each option was counted and displayed on a column plot. Statistica 7.1 was used for the analysis. Other statistical tests included analysis of variance (ANOVA). The results were presented as confidence intervals with p-values of less than 0.05 indicating statistical significance.

Ethical issues

Participation in the study was voluntary and anonymity was emphasised. Codes were used for identification of those participating. Confidentiality was stressed as most patients were worried about their applications being jeopardised if they revealed personal information. Folder numbers, names or South African identification numbers were not used on the questionnaires. Participants were informed that all data obtained would be used for possible publication but without any identifiers. There was no communication with the doctor involved in disability grant applications at the hospital and the study was independent of the BLCHC's staff.

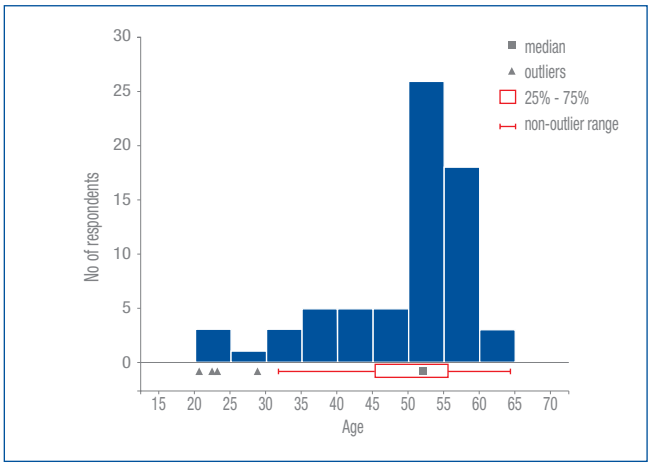
An informed consent document, which was available in English and Afrikaans, was signed in order to participate. There was an option to withdraw from the study at any point by contacting the interviewer or principal investigator. It had been decided not to provide any incentive to study participants.

Ethics approval was first received from the University of Stellenbosch Ethics Committee for Human Research prior to commencement of the study.

Results

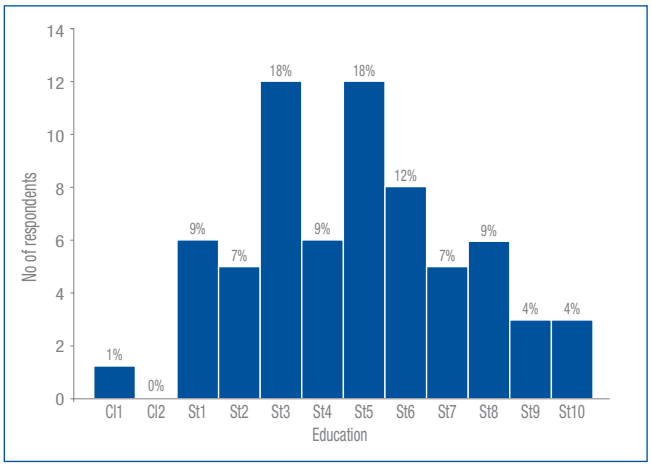
There were 69 respondents to the questionnaire – 23 male (33%) and 46 female (67%). Percentages have been rounded off. The age distribution, shown in Figure 1, includes a mean age of 49 years, a range from 21 to 64 years and high percentages in the 50–60 age group.

Figure 1: Age distribution of study participants n = 69



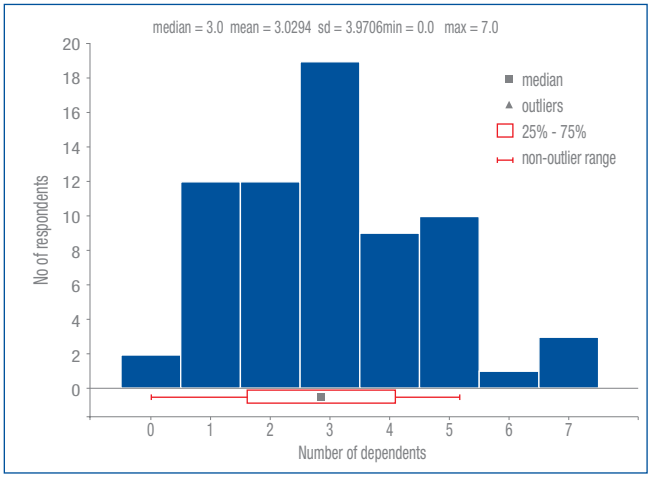
The educational levels of the respondents are shown in Figure 2. Most (62%) had only a primary school education.

Figure 2: Educational level of participants n = 69



The mean number of dependants was three with the distribution shown in Figure 3.

Figure 3: Number of dependants n = 69

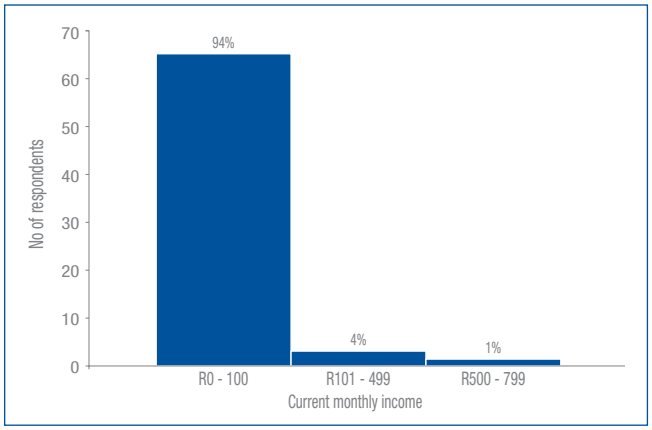


The question on marital status revealed that 30% of the respondents never married, 36% were married, 9% were separated, 13% were divorced and 12% were widowed. Ninety-three per cent of participants

were unemployed due to a health reason and 7% were unemployed due to other reasons, for example retrenchment.

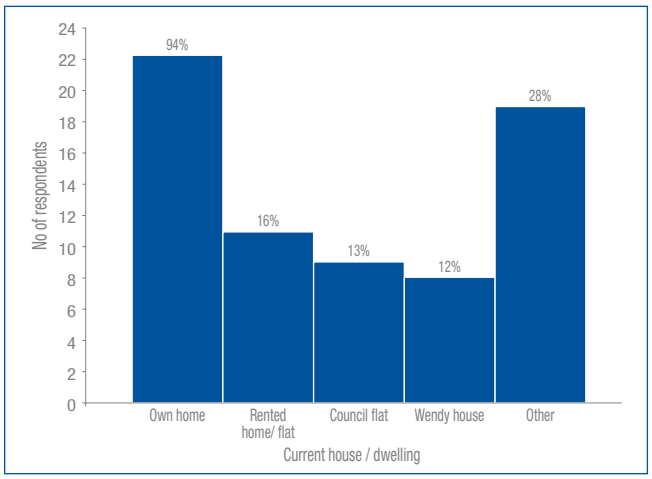
Figure 4 shows the current monthly household income of respondents. Ninety-four per cent survived on less than R100 per month.

Figure 4: Current monthly household income n = 69



The results for the type of current house or dwelling are shown in Figure 5. Sixty-one per cent had formal housing. The current dwelling of the "Other" 28% included shacks, tents and squatting with others.

Figure 5: Current house/dwelling n = 69



The question on basic services revealed that 99% of the respondents had water, 93% had electricity, 90% had a flush toilet and 86% had a refuse removal service. Seventy-eight per cent of respondents had other family members as their support system, 10% had friends or neighbours, 9% paid for help and 1% were supported by the church or a religious organisation. Support included assistance with shopping, hospital visits, as well as emotional and financial support.

Table I shows the positive responses to questions regarding hospitalisation, medication use, smoking, alcohol, rehabilitation, means test and whether the applicant would work again.

Sixty-seven of the respondents were on medication for their condition, but only eight were receiving physiotherapy. Of the 36% that answered yes to using assistive devices, all wore glasses. Although 4% were aware of the means test, they were all incorrect in their understanding of the actual criteria. Only nine respondents answered positively when asked whether they would resume work if their health status improved.

Table I: Key characteristics of disability grant applicants

Factor	n = 69
Hospitalised in past year	1
Uses medication	67
Receives physiotherapy currently	8
Receives occupational or speech therapy currently	0
Consults a traditional healer	0
Uses assistive device	24
Smokes	29
Consumes alcohol	5
Aware of means test for disability grant	3
Work again if health improved	9

Sixty-one per cent of respondents found out from the doctor or sister at the day hospital about the disability grant application, 13% could not explain how or where they had found out, 10% learnt from other sources, 7% from a friend in the same community, 6% from family, 1% from a friend in another community and 0% from the media.

Most respondents reported multiple chronic medical problems as shown in Table II.

Table II: Conditions listed as reasons for disability applications

Medical condition	n = 69 n (%)
Asthma/COPD	16(23)
Hypertension	35(51)
Epilepsy	11(16)
Diabetes	17(25)
Heart problem	9(13)
Depression	3(4)
Arthritis	28(41)
Back problem	3(4)
Stress	2(3)
High cholesterol	2(3)
Weakness	2(3)
TB	1(1)
Orthopaedic problem	2(3)
Schizophrenia	2(3)

Table II demonstrates that the majority of applicants had a chronic medical condition. Forty-five per cent reported applying for the grant because they had no income, 38% applied because they had no income and were sick, 6% applied because of illness, 1% applied because they were retrenched and 6% gave no reason except that they "cannot work". Eighty-seven per cent believed they would never work again, while 13% would work if their condition improved. The common recurring themes for not resuming work included having a chronic medical condition, old age and general poor health.

The results of the ICF short list for activity and participation within the three domains of general tasks and demands, mobility and domestic life are represented in Table III as percentages. Respondents showed the most difficulty in these three domains but the complete table of results for all domains can be seen under Appendix 3. The other domains showed no difficulty in the majority of applicants.

Table III: Percentage of respondents having difficulty with general tasks and demands, mobility and domestic tasks according to the ICF n = 69

	No difficulty %	Mild difficulty %	Moderate difficulty %	Severe difficulty %	Complete difficulty %
General tasks and demands					
Single task	78	6	7	1	7
Multiple tasks	14	0	1	3	81
Mobility					
Lifting/carrying objects	4	0	1	10	83
Fine hand use	25	0	4	13	57
Walking	19	1	1	22	57
Domestic tasks					
Shopping	49	0	7	10	32
Cooking	52	1	10	13	20
Housework	43	0	3	12	41

Of the 69 applicants who participated in the study, 45 (65%) received a temporary disability grant, 6 (8%) received a permanent grant and 18 (26%) applications were rejected. The six recipients of permanent grants ranged from 23 years to 59 years in age. Medical conditions amongst the six who qualified for a permanent grant included epilepsy, arthritis, hypertension, diabetes, traumatic unilateral weakness, traumatic back problems and having only one arm (orthopaedic problem in Table II). All these applicants, with the exception of the epileptic, reported severe to complete difficulty with mobility, self-care and domestic life (see Appendix 3). The epileptic reported no difficulty in all domains but received a permanent grant.

Those applicants who were rejected were applying on the basis of a chronic medical condition.

The majority of the temporary grant recipients also had chronic medical conditions and were presumably awarded grants due to varying degrees of target organ damage. This could not be confirmed, as the doctor filling out the applications was not interviewed as part of the study. Their reporting of the degree of difficulty in the different domains was inconsistent with the nature of their illness, e.g. a patient who claimed to be unable to work due to severe arthritis had no difficulty in most of the activity domains.

The above domains (Table III) with the exception of the single task were analysed further in order to determine the strength of association between these domains and the different grant categories. No associations were found as all the p values were greater than 0.05 and indicated no statistically significant difference.

Further statistical analysis showed that there was no statistically significant associations between age ($p = 0.29$), education ($p = 0.31$), physiotherapy ($p = 0.16$), willingness to work again if condition improved ($p = 0.39$) and the different grant categories (temporary, permanent and rejected).

Discussion

It must be stressed that the results obtained in this study were based purely on what the applicants said and that no attempt was made to validate them through a review of medical reports or a medical examination of each individual. The examination conducted by the disability grant doctor was independent of the study.

The results demonstrated that most applicants were females over the age of 50, were poorly educated with chronic medical conditions and were living in formal accommodation with good basic services but with minimal or no disposable income. The type of grant received and certain characteristics of the applicants (age, education, physiotherapy and willingness to return to work) showed no significant associations after further statistical analysis. The ICF questionnaire responses showed that the majority of respondents had no difficulty in most domains, except for the general tasks and demands (multiple tasks), mobility (lifting and carrying, fine hand use and walking) and domestic tasks domains, which showed high percentages for severe to complete difficulty. However, only 8% received a permanent grant. Further statistical analysis showed no association between degree of difficulty in the above domains and eventual outcome of type of grant received.

It is important to note that disability grants are the only social grants available to adults of working age. As a result the unemployed rely on pensioners, on assistance from employed family members and on disability grants to survive. This trend is evident in this study. The reasons given for application of disability grants revealed that 45% were applying because of no income and only 6% because of illness, but all mentioned a medical condition when asked directly. This further strengthens the argument that unemployment and lack of income appear to be major factors in disability grants being used "as a form of poverty relief".[16]

Pressure on the social welfare system can also be seen to some extent in this study. Two-thirds (67%) of disability applicants were female despite Census 2001 statistics demonstrating that 7.62% of males and 4.14% of females were unable to work due to illness or disability in Bishop Lavis.[19] A possible explanation is that females are more likely to seek medical attention and therefore be diagnosed with an illness, which may possibly qualify for a disability grant.[20] In a similar study done in Kleinmond, 55% of applicants were male and 45% female with a mean age of 42 and a range of 18 to 64 years.[9]

The age distribution, shown in Figure 1, includes a mean age of 49 years and a range from 21 to 64 years. The range is understandable as current legislation awards disability grants to adults from 18 to 60 and 64 years for females and males respectively. The high percentages in the 50 to 60 age group is presumably due to the fact that this age group is more likely to have chronic medical problems and are less likely to find employment at this age.

The Census 2001 for over-20-year-olds in Bishop Lavis demonstrated that 3.41% had no schooling, 20.19% had an educational level between Grade 1 and Standard 4, 11.9% had completed Standard 5, 46.84% had completed Standard 9 and 16.2% had done matric.19 This contrasts with disability applicants in the study where 44% had completed Standard 4 and 4% Standard 10. Thus, those applying for disability grants in this community are generally poorly educated. The ICF shortlist assessment indicated no difficulty learning to read, write, calculate or solve problems. Questions on communication also showed that the majority of applicants had no difficulty on the ICF scale (Appendix 3).

Poverty is common in the Bishop Lavis community, with 40% of the population living on less than R1 600 per month.[19] The majority of study applicants reportedly survived on less than R100 per month, with the mean number of dependents being three. Thus it is unsurprising that illness is also a significant motivating factor in attempting to gain social security benefits in this community. The literature shows that the current disability policy is creating incentives for people to become or remain ill.[16]

Despite the lack of disposable income, at least a third of applicants owned their home. The rest also had access to basic services e.g. water, electricity, sanitation and refuse removal. Support in the form of financial aid, emotional support, assistance with hospital visits and shopping was mainly from family members. One could therefore argue that the applicants were not destitute as compared to many South Africans.

Sixty-one per cent of respondents reported that they became aware of the grant application process from a doctor or sister at the day hospital. It would seem as if the staff at the day hospital is sympathetic to the social plight of their patients. The other issues that must be considered here are whether the staff is creating unreasonable expectations among patients in view of the small number that finally receive grants or whether grants are being allocated correctly, especially if no objective assessments are being done.

Only 13% of the respondents said that they would return to work if their health improved. Again one has to question why they were not willing to work if they were well and given an opportunity to do so. Perhaps the work that was manageable in the past might no longer be so as a result of current medical problems.

Most of the study participants listed multiple medical problems as the reason for their inability to work and earn an income. In the Kleinmond study 86% of respondents who received a grant had multiple disabilities based on the International Classification of Impairments, Disabilities and Handicaps (WHO, 1980).[9] One has to question whether multiple disabilities guarantees one a grant.

In the study a high percentage (41%, Table II) claimed to have arthritis (no type specified). According to the ICF shortlist of activity and participation domains (Table III), it can be seen that 93% had severe to complete difficulty with lifting and carrying objects, 70% had severe to complete difficulty with fine hand use and 79% had severe to complete difficulty with walking. Despite these high percentages only 12% received any rehabilitation in the form of physiotherapy. The assumptions are that the assessment/examination by the disability grant doctor refuted the subjective reporting of symptoms by the applicants; patients grossly overestimated symptoms of activity limitation or the doctor did not assess activity limitation. It was not established whether the temporary grant recipients were referred for further evaluation. Ideally an interdisciplinary evaluation of the patient should be carried out. This should include, amongst others, physiotherapy and occupational therapy evaluation, with a work assessment of the applicant being undertaken.

It is interesting to note that only a small percentage had listed a psychiatric illness as the reason for applying. It is quite possible that most patients with psychiatric problems are already receiving disability benefits.

The HIV/AIDS epidemic has been found to be one of the major reasons for an increase in disability grants, yet not a single applicant in the study applied for disability benefits due to HIV/AIDS.[16] The possible explanations include the stigma associated with HIV/AIDS, the prevalence of HIV being low in Bishop Lavis, underdiagnosis in this community or these patients not being aware that HIV/AIDS qualifies for assistance under certain conditions. The literature shows that nationally the number of disability grants for people suffering from 'retroviral disease' or who were 'immunocompromised' rose from 27% in 2001 to 41% in 2003.[16]

Most study participants (96%) were not aware of the means test. Those who claimed to be aware of it could not give any explanation of it. Therefore even if the doctor approves an application, the final decision to award someone a grant only occurs after the means test has been undertaken by the Department of Social Services.

The significance of this study is limited by a few factors. Firstly, the disability grant doctor was not interviewed to determine, among other things, his level of training in disability assessment and to understand his rationale for awarding grants or rejecting applications.

The ICF shortlist of patients' reporting of degree of difficulty in the various domains should ideally have been followed by an ICF-based clinical assessment. The degree of impairment relating to body structure and function was also not investigated.

The majority of the respondents in this study were coloureds living in an area with unfavourable socioeconomic conditions. If the study had used a more representative sample of the country's demographics, results may perhaps have been more reliable.

The past employment history of the participants was important information that was not collected. This omission limited the interpretation of results especially in relation to the ICF shortlist of activity and participation. The past employment history would have provided some insight into attitudes about work and the type of work that the participants could perform.

It would be interesting as well as insightful to undertake the study at several sites thereby obtaining a broader view of different communities with similar socioeconomic problems, their perceptions of illness and disability and their knowledge of the disability grant system. A bigger sample size would also be a recommendation for future studies. An objective assessment tool to complete disability grant applications that can be standardised should also be developed and researched.

Conclusion

This study confirms that unemployment and a lack of income are among the factors influencing patients to seek assistance in the form of disability grants. Most applicants had a chronic medical condition and were functionally restricted according to subjective evaluation. Most received a temporary grant. There is an obvious need for a standardised, objective assessment tool for disability grant applications. Interdisciplinary evaluation of patients should be undertaken to ensure that patients are not unfairly rejected.

A campaign to educate patients that chronic medical illness per se does not qualify for disability grants and that disability or impairment must prevent one from earning a living in order to receive a grant may go a long way in easing the current burden on the health and social services. As most applicants were made aware of the grant process by medical staff, the educational campaign should begin at the health centres. There is always the risk that patients may decide to default on treatment in order to exacerbate their condition and thus qualify for benefits.

In the absence of comprehensive unemployment benefits or a universal basic income grant, poor unemployed people are likely to continue applying for disability grants if they have a medical condition.

Acknowledgements

I would like to express my sincere gratitude to the following people who assisted me in the completion of this study: Professor Bob Mash, Ms Gubela Mji, Dr Martin Kidd and my husband, Richard, and my daughter, Leia, for all the support, love and coffee while I toiled at the computer.

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Appendix 1

Table 3- ICF Shortlist of activity and participation domains.

Domains	No	Mild	Moderate	Severe	Complete	Not specified	Not applicable
	%	%	%	%	%	%	%
Watching	91	0	1	3	4	0	0
Listening	97	0	1	0	1	0	0
Learning to read	70	0	1	6	22	0	1
Learning to write	64	0	3	9	23	0	1
Learning to calculate	84	0	3	1	10	0	1
Solving problems	85	0	3	0	10	0	1
Single task	78	6	7	1	7	0	0
Multiple tasks	14	0	1	3	81	0	0
Spoken messages	93	0	1	1	4	0	0
Non-verbal messages	94	0	0	3	3	0	0
Speaking	97	0	1	0	1	0	0
Conversation	97	0	1	0	1	0	0
Lifting/carrying objects	4	0	1	10	83	0	1
Fine hand use	25	0	4	13	57	0	1
Walking	19	1	1	22	57	0	0
Move with equipment	30	0	0	0	4	0	65
Use of transport	68	0	0	6	22	0	4
Driving	40	0	1	0	31	0	28
Washing	67	0	1	14	17	0	0
Caring for body parts	70	0	0	16	14	0	0
Toileting	93	1	4	1	0	0	0
Dressing	78	0	1	13	7	0	0
Eating	96	3	0	1	0	0	0
Drinking	96	3	0	1	0	0	0
Looking after health	94	0	0	4	1	0	0
Shopping	49	0	7	10	32	0	1
Cooking	52	1	10	13	20	0	3
Housework	43	0	3	12	41	0	1
Basic interpersonal interaction	86	0	4	3	7	0	0
Complex interaction	87	0	3	4	6	0	0
Relating with strangers	71	3	7	4	14	0	0
Formal relationships	94	1	1	1	1	0	0
Family relationships	88	0	1	3	7	0	0
Intimate relationships	90	0	0	3	7	0	0
Informal education	90	0	0	0	6	0	4
School education	82	0	1	3	10	0	3
Higher education	60	0	3	3	13	4	16
Paid employment	66	0	0	0	3	21	10
Basic economic transactions	68	0	0	0	7	18	7
Economic self-sufficiency	66	0	0	0	7	19	7
Community life	96	0	0	0	3	1	0
Recreation/leisure	97	0	0	0	3	0	0
Religion/spirituality	99	0	0	0	1	0	0
Human rights	87	0	0	0	10	0	3
Political life/citizenship	81	0	0	1	14	0	3

Appendix 2
DISABILITY GRANT QUESTIONNAIRE

1. Case number _____

2. Sex Male [ ] Female [ ]

3. Date of birth _____/_____/_____ **(year/month/date)**

4. Education Highest standard passed:

i) Class 1 [ ]
ii) Class 2 [ ]
iii) Standard 1 [ ]
iv) Standard 2 [ ]
v) Standard 3 [ ]
vi) Standard 4 [ ]
vii) Standard 5 [ ]
viii) Standard 6 [ ]
ix) Standard 7 [ ]
x) Standard 8 [ ]
xi) Standard 9 [ ]
xii) Standard 10 [ ]
xiii) Tertiary qualification [ ]
xiv) Other training/education [ ]

5. Number of dependants [ ]

6. Current marital status

i) Never married [ ]
ii) Currently married [ ]
iii) Separated [ ]
iv) Divorced [ ]
v) Widowed [ ]
vi) Cohabiting [ ]

7. Current occupation

i) Paid employment [ ]
ii) Self- employed [ ]
iii) Non-paid work e.g. volunteer/charity [ ]
iv) Student [ ]
v) Home maker [ ]
vi) Retired [ ]
vii) Unemployed (health reason) [ ]
viii) Unemployed (other reason) [ ]
ix) Other (please specify) [ ]

8. Current monthly income

i) R0 – 100 [ ]
ii) R101 – 499 [ ]
iii) R500 – 799 [ ]
iv) R800 - 999 [ ]
v) R1000 – 1999 [ ]
vi) R2000+ [ ]

9. Current house/dwelling

i) Own home [ ]
ii) Rented home/flat [ ]
iii) Council flat [ ]
iv) Wendy house [ ]
v) Other [ ]

10. Basic services

i) Water [ ]
ii) Electricity [ ]
iii) Flush toilet [ ]
iv) refuse removal [ ]

11. Support systems (e.g. shopping, hospital visits, etc.)

i) Family members [ ]
ii) Church/religious organisation [ ]
iii) Friends/neighbours [ ]
iv) Community-based carer [ ]
v) Paid help [ ]

12. What disability/ medical condition do you have?

13. Have you been hospitalised in the past year? Y/N

If Yes, please specify reason(s).

14. Are you taking any medication? Y/N

If Yes, please specify.

15. Are you receiving any help/rehabilitation for your condition/ disability?

i) Physiotherapy [ ]
ii) Occupational therapy [ ]
iii) Speech therapy [ ]
iv) Traditional healer [ ]
v) Other _____

16. Do you use any assistive devices such as glasses, hearing aid, wheelchair, etc?

If Yes, please specify.

_____

_____

_____

_____

17. Do you smoke? Y/N

18. Do you drink alcohol? Y/N

19. Why are you applying for a disability grant?

_____

_____

_____

_____

20. How did you find out you could apply for a disability grant?

i) doctor/sister from the day hospital [ ]
ii) family member [ ]
iii) friend in the same community [ ]
iv) friend in another community [ ]
v) media- TV, radio, newspaper [ ]
vi) self-initiated [ ]
vii) other [ ]

21. Are you aware of the means test for disability grant applicants? Y/N.

If Yes, what does it say?

_____

_____

_____

_____

22. Do you think you would be able to work again if your condition/ health improved? Give reasons.

_____

_____

_____

_____

Appendix 3

0 **No difficulty** means the person has no problem

1 **Mild difficulty** means a problem that is present less than 25% of the time, with an intensity a person can tolerate and which happens rarely over the last 30 days.

2 **Moderate difficulty** means that a problem that is present less than 50% of the time, with an intensity, which is interfering in the person's day to day life and which happens occasionally over the last 30 days.

3 **Severe difficulty** means that a problem that is present more than 50% of the time, with an intensity, which is partially disrupting the person's day to day life and which happens frequently over the last 30 days.

4 **Complete difficulty** means that a problem that is present more than 95% of the time, with an intensity, which is totally disrupting the person's day to day life and which happens every day over the last 30 days.

8 **Not specified** means there is insufficient information to specify the severity of the difficulty.

9 **Not applicable** means it is inappropriate to apply a particular code (e.g. b650 Menstruation functions for woman in pre-menarche or post-menopause age).

Short List of Activity and Participation Domains

d1. LEARNING AND APPLYING KNOWLEDGE

d110 Watching [ ]
d115 Listening [ ]
d140 Learning to read [ ]
d145 Learning to write [ ]
d150 Learning to calculate (arithmetic) [ ]
d175 Solving problems [ ]

d2. GENERAL TASKS AND DEMANDS

d210 Undertaking a single task [ ]
d220 Undertaking multiple tasks [ ]

d3. COMMUNICATION

d310 Communicating with -- receiving -- spoken messages [ ]
d315 Communicating with -- receiving -- non-verbal messages [ ]
d330 Speaking [ ]
d350 Conversation [ ]

d4. MOBILITY

d430 Lifting and carrying objects [ ]
d440 Fine hand use (picking up, grasping) [ ]
d450 Walking [ ]
d465 Moving around using equipment (wheelchair, skates, etc.) [ ]
d470 Using transportation (car, bus, train, plane, etc.) [ ]
d475 Driving (riding bicycle and motorbike, driving car, etc.) [ ]

d5. SELF CARE

d510 Washing oneself (bathing, drying, washing hands, etc) [ ]
d520 Caring for body parts (brushing teeth, shaving, grooming, etc.) [ ]
d530 Toileting [ ]
d540 Dressing [ ]
d550 Eating [ ]
d560 Drinking [ ]
d570 Looking after one's health [ ]

d6. DOMESTIC LIFE

d620 Acquisition of goods and services (shopping, etc.) [ ]
d630 Preparation of meals (cooking etc.) [ ]
d640 Doing housework (cleaning house, washing dishes laundry, ironing, etc.) [ ]

d7. INTERPERSONAL INTERACTIONS AND RELATIONSHIPS

d710 Basic interpersonal interactions [ ]
d720 Complex interpersonal interactions [ ]
d730 Relating with strangers [ ]
d740 Formal relationships [ ]
d760 Family relationships [ ]
d770 Intimate relationships [ ]

d8. MAJOR LIFE AREAS

d810 Informal education [ ]
d820 School education [ ]
d830 Higher education [ ]
d850 Remunerative employment [ ]
d860 Basic economic transactions [ ]
d870 Economic self-sufficiency [ ]

d9. COMMUNITY, SOCIAL AND CIVIC LIFE

d910 Community Life [ ]
d920 Recreation and leisure [ ]
d930 Religion and spirituality [ ]
d940 Human rights [ ]
d950 Political life and citizenship [ ]