



UNIVERSITY OF CAPE TOWN  
FACULTY OF HEALTH SCIENCES

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*A study to explore the role of community disability workers in facilitating livelihood opportunities for disabled youth in rural areas of Southern Botswana*

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A minor thesis submitted to the Faculty of Health Sciences, University of Cape Town, in partial fulfilment of the requirements of the degree of Master of Philosophy in Disability Studies.

**February 2015.**

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M Phil Disability Studies, 2015

### Declaration

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Date

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### *Abbreviations & definition of terminology:*

BNPD	Botswana National Policy on Disability
BNYP	Botswana National Youth Policy
CBR	Community Based Rehabilitation
CDW	Community Disability Worker
CHW	Community Health Workers
DHMT	District Health Management Teams
HEA	Health Education Assistant
HREC	Human Research and Ethics Council
HRU	Health Research Unit
ICF	International Classification of functioning, Disability and Health
RNYP	Revised National Youth Policy
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WB	World Bank
WHO	World Health Organisation

### *Definition of terms:*

Kgotla	A <i>kgotla</i> is a public meeting, community council or traditional law court, especially in villages of Botswana, usually referred to as a customary court. It is usually headed by the village chief or headman, and community decisions are always arrived at by consensus ( <i>Ref: en.wikipedia.org/wiki/<b>Kgotla</b></i> ).
Livelihoods	A component of the CBR Guidelines and comprises five key elements namely, skills development; self employment; wage employment; financial services; and social protection (WHO, 2010b).

## *Abstract:*

**Purpose:** This study aimed to explore the role of Community Disability Workers (CDWs) in facilitating livelihood opportunities for disabled youth in rural Southern Botswana. The CDWs in the study worked in Community-based Rehabilitation (CBR) programmes. The elements of the Livelihood component of CBR Guidelines include skills development, self employment, waged employment, financial assistance and social security. In particular, the study presented the knowledge, skills, practices (activities and methods), and strategies used by CDWs to facilitate access to the livelihood opportunities for disabled youths in rural areas.

The **literature review** explored CBR as a strategy for addressing the needs and demands of people with disabilities. Botswana has implemented a CBR programme which is co-ordinated at the Rehabilitation Division of the Ministry of Health and involves disabled people, health professionals, the community and Non-Governmental Organisations (NGOs). Community health workers coordinate disability activities in rural as well as urban areas and comprise a range of health care practitioners namely physiotherapists, social workers, rehabilitation technicians, rehabilitation officers and health education assistants. In this study, community health workers were referred to as CDWs and only those with tertiary qualifications (certificate, diploma or degree level of training) were used as participants.

**Methodology:** A qualitative research approach using a case study design was adopted. Purposive sampling was used to select seven participants from districts in the southern part of Botswana to participate in the study.

The unit of study were the practices of the CDW in facilitating access to livelihood opportunities for disabled youth. Qualitative data was collected through semi-structured interviews with the CDWs. Interviews were digitally recorded and later transcribed verbatim. Analysis of data involved coding for themes and categories emerging from the data in the context within which it appeared. The environmental chapters of the International Classification of Functioning, Disability and Health (ICF) were used for data interpretation.

**Findings:** The findings of the study illustrated the role of CDWs in facilitating livelihood opportunities for disabled youth. Five themes that

emerged were related to CDWs' own experience of disability and rural environments, their knowledge and experience in facilitating livelihoods; their practices and strategies; the barriers to participation experienced by disabled youth; and lastly, the CDWs' suggestions for increasing participation and inclusion of disabled youth in livelihood opportunities.

The findings established that CDWs were involved in facilitating access to health facilities and assistive devices as well as education and skills development. Some strategies used were advocacy, networking, information dissemination, role modelling and follow-ups on former students. The barriers identified were inadequate disability policy; absence of disability friendly public facilities and transport; a poorly resourced public education system and inaccessible job markets. Suggestions made by CDWs included having inclusive policies and structures; addressing educational and training needs; accountability regarding employment; and community sensitisation and mobilisation.

The **Discussion** chapter interpreted the findings in terms of current literature and developed two further themes. One addressed the environmental factors impacting on disability and the other one addressed successful strategies to enhance livelihood opportunities in light of these environmental factors.

**Recommendations** included facilitating information on accessibility of assistive devices; minimising barriers to natural and made-made changes to the environment; building a network of supportive relationships; changing attitudes of community as well as government leadership; and facilitating implementation of inclusive services, systems and policies.

In **Conclusion**, CDWs are well placed to facilitate accessibility of livelihood opportunities for disabled youth. However, they need to be empowered with necessary resources such as disability inclusive policies, systems and services, attitudinal changes and revision of their training modules.

## Chapter One: Introduction

### *Introduction: Study Background*

Botswana has an estimated population of 2.1 million and a disabled population of about 73,500 people, 3.5% of the total population (Population Census, 2011). The country faces a wide range of challenges, such as unemployment, HIV/AIDS and poverty. The most affected section is the youth as they constitute a significant percentage of the population at 38.4 % (Population Census, 2001). The high unemployment rate is a key challenge to the Botswana government. According to the Botswana's Revised National Youth Policy (2010:2), "youth unemployment is a problem because of the general economic factors which include low economic growth and lack of growth in labour intensive sectors and this result in inadequate job creation".

Unemployment is much more severe for disabled youth. In an exploratory analysis study of CDWs' potential to alleviate poverty and promote social inclusion of disabled youths in three Southern African countries, Van Pletzen, Booyens and Lorenzo (2014) established that there was enough evidence to conclude that disabled people have less access to education, less employment and earning opportunities, increased expenditure and less access to basic resources. Conversely, poor access to health services, environmental inaccessibility and poor housing could lead to disability (Van Pletzen et al., 2014).

Given the socioeconomic vulnerability of disabled youth, it is important to find ways of ensuring that as many disabled young people as possible are equipped with skills that would enable them to contribute to their own livelihood and achieve at least some degree of economic independence.

An important development strategy for integrating disabled people into society is Community-based Rehabilitation (CBR). The World Health Organisation's (WHO) CBR Guidelines presents five key components within which disabled people should be included. These components are Health, Education, Livelihoods, the Social domain and Empowerment (WHO, 2010b).

Community-based workers are the backbone of CBR programmes. There are a range of workers in Botswana that do community-based work: family welfare educators; rehabilitation officers or technicians; social workers, physiotherapists

and occupational therapists. In this study they will be referred to as Community Disability Workers (CDWs). The CDW has been described as “a multi-skilled public servant” fulfilling, brokering and linking roles between individuals, communities and social institutions (Van Pletzen, Booyens & Lorenzo, 2014:1534). With specific reference to the livelihoods domain, Lorenzo, Motau and Chappell (2012:46), suggested that “CDWs are well positioned to be critical catalysts in accessing resources to mainstream livelihood opportunities of disabled youths”.

This study investigates the extent to which the practices and activities of CDWs could facilitate the access of disabled youth to livelihoods. The study includes the five components of the Livelihood domain in the CBR guidelines (WHO, 2010b): skills development, self-employment, waged employment, financial assistance and social security. It will explore whether CDWs in Botswana see themselves as “critical catalysts” in the way described by Lorenzo et al. (2012). The study will analyse their descriptions of the work they perform and whether it enables disabled youths to access livelihood opportunities.

## *1.2 The Youth of Botswana*

Botswana’s Revised National Youth Policy (RNYP, 2010) defines youth as individuals between the ages 15 and 35 years old. The RNYP is a framework for youth development which endeavours “to ensure that young women and men are given every opportunity to reach their full potential, both as individuals and as active citizens” (Botswana Government, 2010:1). The policy is intended to guide all national efforts in the development and implementation of youth programmes such as mobilisation of resources, strengthening implementation mechanisms and improving overall coordination within the youth sector (RNYP, 2010). Participation in education and training is considered important because it provides an essential foundation for developing life and vocational skills. According to the RNYP (2010), there is a high unemployment rate among the youth, which poses a key challenge. Youth unemployment is high, particularly among females (45.9%), while the figure for males is 36.0% (Botswana Government, 2004). Disabled youth are listed among vulnerable or risk youth groups and the RNYP (2010:12) states that “the policy will pay special attention to these groups”. The quality of life for disabled youth in particular remains a major challenge and the government of Botswana is committed to enhance their independence, self-reliance, participation and access to national resources through empowerment (RNYP, 2010).

Through its national policy on disability, the Botswana Government (2011:15) states that “ensuring and improving access to health and rehabilitation services, education, training and skills development, employment and recreational services” are priorities. Education is seen as a pillar of social development and securing livelihoods for disabled youth. In this respect, disabled youth should have an equal right without discrimination and on the basis of equal opportunities to realize their maximum potential. On work and employment, the Botswana Government (2011) promotes the right for disabled youth “to work on an equal basis with others and the opportunity to gain a living by freely choosing or accepting work in a labour market and work environment that is open, inclusive and accessible” (2011:32).

### *1.3 Contextual information of the study areas*

Kweneng District is home to the Bakwena people and is about 40kms west of the capital city, Gaborone. It has a lot of villages scattered all over. Some of the villages are Molepolole, Mogoditshane, Thamaga, Gabane, Letlhakeng, Kopong, Mmopane, Lentsweletau, Mmankgodi, Metsimotlhaba, Kumakwane, and Khudumelapye. Most community services are clustered in semi-urban areas or larger villages like Molepolole. Environmental factors encountered by disabled youth in this district include an inadequate physical infrastructure, geographical asymmetries and inaccessible transport (Levers, Magweva, Maundeni & Mpofu, 2008).

Kgatleng is home to the Bakgatla people and located 40kms to the north of Gaborone. The capital of the Kgatleng District is Mochudi. The local government in Kgatleng has programmes for disadvantaged groups such as the Destitute Person’s Programme and the Orphan’s Programme. These are provided to beneficiaries regardless of disability (Levers et al., 2008). Transportation and building structures are some of the environmental factors that do not accommodate disabled youth in the district. Levers et al. (2008:51) point out that “discrimination is a problem for family members in the district, who often feel embarrassed by their disabled family member”.

The South East District surrounds Gaborone. The village of Ramotswa is the administrative capital for the South East district. Environmental barriers similar to the ones found in Kweneng and Kgatleng districts are also encountered in this district.

According to the Botswana Government (2003), Kweneng had about 3.4%, Kgatleng 3.65 % and South-East 2.84% of the disabled population during the 2001 Population and Housing Census. The types of disabilities commonly found in the youth in Kgatleng, Kweneng and South East districts were blindness, deafness and physical disabilities such as muscle weakness, amputations and spinal deformities. Resources are distributed to disabled people by CDWs working in CBR programmes, introduced as part of this study in the next sections.

#### *1.4 Research Problem*

Many youth with disabilities do not have equal access to health care, education, and employment opportunities. They do not receive the disability-related services that they require, and experience exclusion from everyday life activities (WHO & WB, 2011). Youth in rural areas, especially disabled youth, are often more disadvantaged than those who live in urban areas (Botswana Government 1996). Therefore, the research problem is to investigate the role of CDWs in facilitating access to livelihood opportunities for disabled youth. The study also undertakes to explore the extent to which CDWs are prepared for and able to identify deficiencies in practice and identify successful strategies.

#### *1.5 Research Question*

To what extent can CDWs play a role in facilitating the participation of disabled youth in opportunities for skills development, self-employment, wage employment, financial services and social protection in rural areas of Southern Botswana?

Sub questions

- 1) What knowledge and skills do CDWs have to facilitate the participation of disabled youth in livelihoods opportunities?
- 2) What are the practices (activities and methods) of CDWs in accessing livelihood opportunities for disabled youth?
- 3) What strategies do CDWs use to facilitate the participation of disabled youth in livelihood opportunities?
- 4) What suggestions do CDWs make to improve participation of disabled youth in livelihood opportunities?

## 1.6 Rationale and Purpose

Disabled youth and their families constantly experience barriers to the enjoyment of their basic human rights and to their inclusion in society. Their abilities are overlooked, their capacities are underestimated and their needs are given low priority. Yet, the barriers they face are more frequently as a result of the environment in which they live than as a result of their impairment. Children with disabilities face barriers to education which means youth with disabilities face barriers to training and adults with disabilities face barriers to decent work (WHO, 2010b). The International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) describes environmental factors that either facilitate or obstruct the social inclusion of persons with disability. These are environmental accessibility, the provision of assistive devices, family and community support and relationships, alienating attitudes and the need for disability-inclusive services, systems and policies.

Van Pletzen et al. (2014) found that CDWs' knowledge and experience of the general vulnerability of family life in rural economies enabled them to devise appropriate strategies for accessing livelihood opportunities for disabled youths. However not much is known about these strategies. It is an important role of CDWs to facilitate livelihood opportunities for disabled youth. So far, the work activities of CDWs in the Livelihood domain have not yet been sufficiently explored and documented.

## 1.7 Research Aim

The aim of this study is to explore the extent to which CDWs play a role in facilitating the participation of disabled youth in livelihood opportunities in their communities.

## 1.8 Research Objectives

- 1) To describe the demographic profile of CDWs
- 2) To determine their knowledge and experience in facilitating the participation of disabled youth in livelihood opportunities.
- 3) To describe the practices (activities and methods) of CDWs in facilitating access to livelihood opportunities for disabled youth.
- 4) To identify the strategies of CDWs to facilitate the participation of disabled youth in livelihood opportunities.

- 5) To explore CDWs' suggestions for enhancing the development of these strategies and to make recommendations for strengthening their capacity to facilitate access to livelihood opportunities for disabled youth.

In summary, this chapter introduced the problem, rationale and purpose for the study. Disabled youth do not have equal access to health care, education and employment opportunities. Therefore, the research aim focused on exploring to what extent CDWs are able to facilitate access to livelihood opportunities for disabled youth. Background information on disabled youth, contextual information on the study areas as well as the research question were presented in Chapter 1.

Chapter 2 will present literature relevant to the research aim and objectives.

## *Chapter Two: Literature review*

### *Introduction*

This chapter starts off by reviewing literature on the relationship between disability and poverty and subsequently looks at literature on the impact of environmental factors on the livelihood opportunities of disabled youth, especially as these factors interact with disability in a context of poverty. The section draws on interpretations of The International Classification of Functioning, Disability and Health (ICF) (WHO, 2001). The chapter next explores literature on Community-based Rehabilitation (CBR) as a broad strategy for poverty reduction and social inclusion. It ends by reviewing literature on the role of community disability workers (CDWs) in facilitating access to livelihood opportunities for disabled youth.

### *2.1 Relationship between disability and poverty.*

Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions (WHO & WB, 2011). Although the definition of disability may vary from country to country, there is a general consensus in the world that the disabled population represents a special category of people needing important economic and social support (Mukamambo, Shaibu & Lesetedi; 2003). The social model of disability has increased awareness that environmental factors to participation are major causes of disability. This social interpretation of disability relocates the 'problem' from the individual to society. With this shift in analytical focus, disability can be seen less as a medical and more of a social problem, caused by social processes (Priestley, 2006).

Many persons with disabilities live in extreme poverty, especially in developing countries, without education or employment opportunities (WHO, 2004). As disability is a consistent feature of disabled people's lives the world over, it is a major concern for most user-led disability organisations in rich and poor countries alike (Barnes & Sheldon, 2010). Disability can prevent disabled youth from attending school as well as prevent them from working or restrict them from the type or amount of work they can participate in (Mitra et al., 2011). The WHO (2004:4) argues that "there is a strong correlation between disability and poverty as poverty leads to increased disability and disability leads to increased poverty".

Chappell & Lorenzo (2012:20) state that “given the complex struggle between poverty and disability, access to employment should always be considered essential for people with disabilities”.

According to the Botswana Central Statistics (2001) survey on the magnitude and range of disabilities, 3.5 % of the total population had a disability and 87.6 % of the disabled population lived in rural areas. The Botswana National Policy on disability (2011:32) comments on disabled youth’s livelihoods and states that “people with disabilities have an equal right to work on an equal basis with others, including the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible”. The policy further states that disabled youth should be enabled to have access to general technical and vocational guidance programmes, placements services and vocational and continuing training (NPD, 2011).

Poverty is a contributing factor as well as an effect of disability. It is estimated that 10-12 % of the world population has some kind of disability, and 82 % of people with disabilities live below the poverty line (Handicap International, cited in Levers et al., 2008). Poverty may lead to a health condition which might result in disability. It may also increase the likelihood that a health condition might result in impairment, activity limitation or participation restriction. Poor access to health care and rehabilitation, education, skills training and employment contributes to the vicious cycle of poverty and disability (WHO, 2004). Levers et al. (2008: 13) added, “the consequence of living in poverty with a disability is inadequate access to health services; resulting frequently in serious secondary conditions and general deterioration of the quality of life”.

## *2.2 Environmental factors and livelihood opportunities*

The ICF (WHO, 2001) was developed from the international classification of impairment, disabilities and handicaps, which was criticized for not allowing the measurement of environmental and social barriers and facilitators in the process of disablement (Bickenbach et al., cited in Maart, 2007). It is a comprehensive system that lists all known health and health-related states that could be experienced by individuals in their societies, firstly in terms of their bodily systems and structures, and secondly in terms of their functioning (activities and participation), from both an individual and a societal perspective. The ICF goes on to list the environmental

factors that impact on individuals' functioning. In this classification system, therefore, disability becomes a complex product of the interaction between the health conditions of persons with disability, their activity limitations and the environmental factors that they encounter in their daily existence.

A person's environment has a huge impact on the experience and extent of disability. Inaccessible environments create disability by creating barriers to participation and inclusion (WHO & WB, 2011). Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives (WHO, 2001). Environmental factors of the ICF can be classified as either barriers or facilitators and either way affect disabled youth participation in the community. These factors are divided into the following categories: products and technology, the natural environment and human-made changes to the environment, support and relationships, attitudes, and services, systems and policies (WHO, 2001). Whiteneck, Harrison-Felix, Mellick, Brooks, Charlifue and Gerhart (2004) state that the ICF makes it clear that environmental factors are common to all people, whether they are disabled or not. The difference is that the factors interact with individual health conditions, thereby resulting in different disability situations. According to Schneider et al. (cited in Maart, 2007), "the ICF provides a framework for describing and analyzing the interaction between a person's health condition and the context in which they find themselves". They conclude that the experiences of impairment should not be a barrier to participation if the environmental factor has been addressed. This participation would be achieved when the physical environment is accessible, social attitudes and norms are positive, and policies and services are inclusive in their approach. In the paragraphs that follow, each of the environmental factors will be discussed in more detail, and their potential impact on disabled youth's livelihoods will be reviewed.

Products and technology according to the WHO (2001) can either be natural or human-made products or systems of products, equipment and technology in an individual's immediate environment that are gathered, created, produced or manufactured.

These included assistive devices, which the World Report on Disability (WHO & WB, 2011: 101) defines as:

Any item, piece of equipment, or product, whether it is acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities.

The WHO & WB (2011) states that assistive devices have been recommended to reduce disability and may substitute or supplement support services. Products and technology could greatly facilitate livelihood opportunities for disabled youth, for instance by increasing their mobility. This environmental factor interacts closely with the second factor, the natural environment and human-made changes to the environment (WHO, 2001). Handicap International (2008) states that accessibility is a prerequisite for inclusion. The report further states that comprehensive accessibility would ensure that buildings, products, services and information were designed in such a way as to be accessible, usable, understandable and comfortable for all people, without discrimination. Together, these two sets of factors are of great importance to facilitating livelihood opportunities for disabled youth, as can for instance be seen in the discussion by Jovia (2006) of the difficulties created for people with disabilities by hilly terrain, lack of ramps and narrow roads, as well as by inappropriate assistive devices such as callipers and wheelchairs on steep slopes or crutches in narrow lanes which create obstacles for people with disabilities trying to access areas of self-employment like markets or other places of employment in Uganda.

The environmental factor concerning support and relationships focuses on the amount of physical and emotional support persons (or even animals) provide to the disabled person (WHO, 2001: 172). Physical or emotional support can be provided by groups such as immediate family, extended family, friends, neighbours and community members. Others are strangers, domesticated animals and health care providers. Jang et al. (cited in Cramm et al., 2013) found that the support from family, friends and neighbours is thought to enhance well-being by creating a sense of coherence and belonging and may have a substantial role in improving or maintaining the well-being of disabled youth. However, family relationships can also create barriers for disabled youth exploring livelihood opportunities. Singal and Jain (2012: 171) found that disabled youth in India also stated that “families were their greatest source of strength and support”; but these authors also report that families frequently lack faith in disabled family members’ abilities in the workplace, thus undermining their confidence and even at times preventing them from exploring livelihood opportunities or participating in employment.

The attitudinal environmental factor is described in the ICF (WHO, 2001: 176) as the “observable consequences of customs, practices, ideologies, values, norms, factual and religious beliefs”. It is stated that these attitudes influence individual behaviour and social life at all levels, from interpersonal relationships and community associations to political, economic and legal structures. For instance, in a comparison of disabled and non-disabled youth’s access to livelihood assets at nine sites in five South African provinces, Lorenzo and Cramm (2012) found that taxi drivers’ and fellow passengers’ attitudes were significant barriers to accessible public transport for disabled youth. Lack of affordable transport could impact on disabled youth’s livelihood opportunities. Singal and Jain (2012) broadly attribute unemployment and underemployment of young people with disabilities in India to issues of stigma and discrimination.

The ICF (WHO, 2001) describes the environmental factor titled services, systems and policies as being constituted by rules, regulations and standards. It is established by governments or other recognised authorities to govern and regulate systems that organise, control and monitor services in various sectors of society. Services provide benefits, structured programmes and operations in society that are designed to meet the needs of individuals (WHO, 2001). These can have a profound effect on disabled youth’s livelihood opportunities. Lorenzo and Cramm (2012) found that disabled youth had significantly less access to services such as labour, banks, internet cafés, all of which could assist in livelihood opportunities.

In its focus on functioning and on contextual environmental factors in the classification of different forms of disability, the ICF (WHO, 2001) supports the social model of disability. As stated in the ICF (WHO, 2001: 7), this system “offers a conceptual framework for information” that is widely applicable to health care, “including prevention, health promotion, and the improvement of participation by removing or mitigating societal hindrances and encouraging the provision of social support and facilitators”. In this respect, the ICF (WHO, 2001) can also be seen as an important planning tool for CBR programmes based on the social model of disability, in that it provides systematic information on the possible environmental barriers and facilitators that may interact with people’s bodily structures and systems, either impairing or enhancing their abilities to function (act and participate) at both a personal and societal level. In this respect, the ICF provides a foundation from which to develop community-based strategies for poverty reduction and social inclusion.

### *2.3 CBR as a strategy for poverty reduction and social inclusion:*

In the past 30 years, CBR has developed from being mainly a service delivery strategy to being “a multisectoral strategy to address the broader needs of people with disabilities, ensuring their participation and inclusion in society and enhancing their quality of life” (WHO, 2010a: 1). It has become a strategy for inclusive development which works towards mainstreaming disability in development initiatives, and which in particular works towards reducing poverty (WHO, 2010a: 12). This current form of CBR has been strongly influenced by the United Nations Convention on the Rights of Persons with Disabilities adopted in 2006, the purpose of which is to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (UN, 2006). The areas covered by the Convention are also those that CBR builds on: “accessibility, personal mobility, education, health, rehabilitation, employment” and the “measures State Parties must undertake to ensure the rights of persons with disabilities are realized” (WHO, 2010a: 22).

The Spastics Society of Tamil Nadu (cited in Lang, 1999) defined CBR as a process to bring about a transformation in the community (change in attitude, knowledge and skills), to enable community members to have a better understanding of disability services (medical, preventive, psychological, economic, socio-cultural, educational, etc.) and to improve the quality of life of persons with disability. The World Health Organisation (WHO) advocates for CBR as an approach for providing services to disabled people in general. The CBR guidelines have five major domains: health, education, livelihood, social and empowerment. The WHO and World Bank (WB) (2011) reports that more than 90 countries around the world continue to develop and strengthen their CBR programmes and that, “through an ongoing evolutionary process CBR is shifting from a medical-focused, often single-sector approach, to a strategy for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of people with disabilities” (p13).

The aim of CBR is disability inclusion, to achieve equal opportunities by and for disabled people and their families. The CBR framework is relevant to this study as it focuses on livelihoods and empowerment through facilitation and participation of disabled youth, their families and communities in all developments (WHO, 2010b;

Ned-Matiwane, 2013). The goal of CBR programmes should be to empower disabled youth to control their own lives and play a key role in services for themselves (Miles, 1996 cited in Rule, 2004). The economic empowerment of disabled youth is key to independent living and sustainable livelihoods. They should be able to gain a livelihood, have access to social protection measures and be able to contribute economically to their families and communities through their earned work wages (WHO, 2010b). Empowerment involves being capable of fighting for one's rights and being recognized and respected as equal citizens and human beings with a contribution to make in the community (Chappell & Lorenzo, 2012). Disabled youth and their families need to start shifting their mindset from being passive receivers to active contributors so as to overcome attitudinal, institutional and physical barriers in the community (Ned-Matiwane, 2013).

There are five key components in the CBR livelihood domain namely skills development, self employment, wage employment, financial services and social protection (WHO, 2010b). According to the WHO (2010b:1), livelihood is part of CBR because "it is essential to ensure that both youth and adults with disabilities have access to training and work opportunities at community level". Hartley and Okune (2006) state that CBR is a strategy for addressing the needs and demands of disabled people and their families in less-developed countries and has become the most accepted approach. The WHO (2010b: 1) argues that "a CBR programme that does not address the skills development and livelihood needs of youth and adults with disabilities in a community is incomplete and limits the sustainability of other efforts".

#### *2.4 CDWs as agents for facilitating disabled youth's livelihood opportunities*

There is no single accepted definition of a community-based health worker. Witmer, Seifer, Finocchio, Leslie and O,Neil (1995) defined community health workers broadly as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. According to Sunil, Kumar, Ortali and Pupulin (2011), the need for a new cadre of worker in the rehabilitation field was advocated for by the WHO in 1981. With this cadre, the needs of people with disabilities were supposed to be

met in their own environment, with involvement of family members and the community.

The community disability worker (CDW) has been described as a “multi-skilled public servant fulfilling, brokering and linking roles between individuals, communities and social institutions” (Van Pletzen, Booyens & Lorenzo, 2014:1534). In one of the pilot CBR training programmes in South Africa, CBR mid-level trained workers were known as community rehabilitation facilitators (CRFs) and were employed to provide services that included community development, physical rehabilitation, social integration and the equalisation of opportunities (Rule, Lorenzo and Wolmarans, 2004). The multi-skilling of community workers plays a critical role in offering integrated services to disabled people and their communities (Rule et al., 2004). CDWs are the main agents for the promotion of community awareness, involvement and mobilization around disability (Como & Batdulam, 2012). Van Pletzen et al. (2014:1525) stated that “an important vehicle for CBR programmes are community-based workers who engage people with disabilities, their families and communities in a range of rehabilitative, educational and advocacy activities, frequently aimed at increasing social participation and inclusion”.

In Botswana, community health workers (CHWs) comprise physiotherapists, social workers and rehabilitation technicians and rehabilitation officers. They have two-year certificates, three-year diplomas and 4-year degree qualifications and a background in social development studies. CHWs are employed in CBR programmes by either government ministries or NGOs and for this study will be referred to as community disability workers (CDWs). This is a term embracing all different community health providers working in CBR programmes. The other group of CDWs in Botswana is the health education assistants (HEAs). These are usually selected from within the communities and undergo six months of training in basic community work. The work of CDWs in under-resourced rural settings is overseen by District Health Management Teams (DHMT). In this study, only CDWs with tertiary qualifications were used as participants. The experiences of HEAs could be researched in a subsequent study.

As multi skilled community workers, CDWs are catalysts ensuring that there is collaboration across sectors by making information on services and resources

accessible to disabled youths and their families (Lorenzo et al., 2012). CDWs identify disabled youths in villages who are in need of service and based on their assessment, coordinate the information with various stakeholders, including the District Health teams, for appropriate intervention. They are also involved in other activities such as training and work placements, information dissemination on basic health related issues, destitute and orphans care programmes etc.

In conclusion, this chapter reviewed literature on the relationship between disability and poverty and the role of environmental factors as either facilitators or obstacles in the manifestation of disability. It looked at CBR as a vehicle for change and the role of CDWs to facilitate livelihood opportunities for disabled youth.

The next chapter will discuss the methodology that was used in this study.

## *Chapter Three: Methodology*

### *3.1 Introduction*

This chapter discusses the rationale for using a qualitative research design, the methods of data collection and data analysis, the study population and ensuring rigour and trustworthiness. Ethical considerations are also included.

### *3.2 Study Design*

A qualitative research approach using exploratory case study design was adopted for this study. This design was preferred because “it provides an insight into how people make sense of their experience that cannot be easily provided by other methods” (Rice & Ezzy, 2000:4). This dimension is important in assisting us to understand the knowledge, skills and work activities of the research participants in facilitating the participation of disabled youth in livelihood opportunities. Babbie and Mouton (2009:278) suggest that “qualitative research focuses its emphasis on studying human action in its natural setting and through the eyes of the actors themselves, together with an emphasis on understanding phenomena within an appropriate context”. The main characteristic of an exploratory case study is the emphasis placed on an individual unit. The unit of study was the practices of the CDW in facilitating participation of disabled youth in livelihood opportunities. Qualitative research can also play an important role in facilitating the dissemination of research findings as data can be turned into stories for easy understanding (Rice & Ezzy, 2000).

### *3.3 Study Sample*

The study population was 26 tertiary trained CDWs working in CBR and development programmes in rural areas of Botswana. Brink, van der Walt and van Rensburg (2011: 123) defines a research population as “the entire group of persons or objects that is of interest to the researcher.”

### 3.3.1 *Sampling Strategy*

This study adopted a purposive sampling method to select seven participants from three districts in the southern part of Botswana to participate in the study. According to Brink et al. (2011:133) "Purposive sampling is based on the judgment of the researcher regarding subjects or objects that are representative of the study phenomenon, or who are especially knowledgeable about the question at hand". The aim of using purposive sampling was to select cases likely to provide rich information about a phenomenon under investigation (Krueger & Neuman, 2006). It involved searching for individual CDWs with characteristics in keeping with the inclusion criteria described in section 3.4. Information-rich participants who have the experience to contribute to the research question were eligible for selection (Welman & Kruger 1999). The potential participants were all known to the researcher through interaction in their professional work. The researcher works as a prosthetist/orthotist at the main referral hospital and interacts with many CDWs. As such the researcher was located well to do purposive sampling.

### 3.4 *Inclusion Criteria*

The criteria for participation in the study were that the CDW must:

- 1) Have at least 5 years' experience in addressing economic and livelihood problems facing disabled youth;
- 2) Have at least 5 years' experience working in the rural areas of Botswana;
- 3) Could be either male or female;
- 4) Could be either disabled or non-disabled;
- 5) Be working for either government or NGO;
- 6) Be conversant in English language.

### 3.5 *Process of accessing participants.*

Potential participants identified by the researcher were contacted telephonically requesting for their voluntary participation in the study. The researcher then

physically visited the potential participants to discuss their participation in the study and seek permission from their supervisors and arrange appointments for the interviews. A letter explaining in detail the purpose of the study and the participant's role (see appendices 1 and 2) was hand delivered to the participants and their heads of departments. Those meeting the selection criteria and willing to participate in the study were invited to participate. Appointments were made for the individual interviews with the CDWs at their appropriate available time.

### 3.6 *Data Generation*

Data was generated through individual interviews using an interview guide consisting of open ended questions (see appendix 3). The exploratory questions from the one on one in-depth interview with the CDWs provided the research with a rich base of information and valuable insight. The choice of using interviews as a data collection strategy was influenced by the research aim and objectives. The researcher designed an interview guide with questions intending to answer the research question. Furthermore, in order to address the research question, the research aim provided guidance as to the intention of the study. The research objectives facilitated the detailed components of the questions in the interview guide. The individual interview is one of the most frequently used methods of data gathering within the qualitative approach. Babbie and Mouton (2009:289) describes a qualitative interview as "an interaction between an interviewer and a respondent in which the interviewer has a general plan of enquiry but not necessarily a specific set of questions that must be asked in particular words and in a particular order". Probes were used to increase detailed exploration during the interviews. Probes generate further explanation from research participants if the initial response is unclear or requires expansion. However, probes might also provide disadvantages to the researcher due to inconsistencies in the probes with other participants. The researcher might also pose leading or hint questions to the participants.

The interviews, lasting approximately 60 to 90 minutes, were conducted by obtaining responses from a participant in a face to face encounter. Participants attended two in-depth interviews. Permission was requested from the participants to audio tape the interview (see appendix 1 and appendix 2). The interviews were conducted in English as all the participants are articulate in English and the researcher does not speak the local languages fluently. The interviews were

conducted at a place convenient to the participants, which were mostly at their place of work. All interviews were transcribed in English.

### 3.7 Data Analysis

Thematic analysis was used for this study. It emphasizes pinpointing, examining and recording patterns within the collected data. Data analysis started at the beginning of the study with the first interview and subsequent verbatim transcription (see appendix 4). The collected data was shared with the researchers' supervisors and gaps identified were then worked on before the subsequent interviews. According to Rice and Ezzy (2000), qualitative data analysis should start at the beginning of the study. They claim that it should be part of the research design, literature review, theory formation, data collection, filing, reading and the writing process. The unit of analysis was the experience of the CDW. The unit may be meanings, practices, encounters, narrative structures, organisations or lifestyles (Rice & Ezzy, 2000: 192). Data consisted of verbatim transcripts of audio taped interviews. Manual analysis involved a thorough review of all recorded information that the researcher collected during the course of data collection. The data was coded and categorised and themes emerged from both the categorised data and from the investigator's prior theoretical understanding of the phenomenon under study.

This qualitative analysis approach included reflecting on the possible meanings and relationships between codes and between categories for possible themes by making memos about the similarities and variations. Brink et al., (2011) recommend verifying the selected themes through reflection on the data and discussion with other researchers. Ryan and Bernard (2003) suggest that repetition is one method to identify themes. An analysis of transcripts was conducted to check for word repetitions, key indigenous terms, and key-words in contexts. Some of the most obvious themes in a corpus of data are those "topics that occur and reoccur" (Ryan & Bernard, 2003: 91). In addition, the method of identifying themes involved searching for similarities and differences by making systematic comparisons across units of data.

### 3.8 Establishing rigour

Establishing rigour in qualitative research ensures the quality of the findings and evidence that the data accurately portrays the participants' views (Babbie & Mouton (2009). It also ensures that the findings are worthy of the attention and confidence of the reader. Babbie and Mouton (2009: 276) state that "the basic issue of trustworthiness is simple: How can an inquirer persuade his or her audience (including him or herself) that the findings of an inquiry are worth paying attention to or worth taking account of?" The researcher believes that the trustworthiness of qualitative research lies in proving that the credibility, transferability, dependability and confirmability criteria are established. The researcher has put a sample of transcript in the appendix (see Appendix 4) to show how decisions related to the identification of categories and themes were made. The researcher established rigour following the guidelines of Babbie and Mouton (2009).

#### 3.8.1 Credibility was established through the following methods:-

- *Triangulation* by collecting information from different sources, which included information from the CDWs and also my own observations. The interview the researcher conducted with two CDWs from Non-Governmental Organisations also produced a different perspective of data.
- *Peer debriefing* was done with a similar status colleague who is outside the context of the study but has a general understanding of the context of the study. The colleague provided checks and balances to the research.
- *Member checks* – I met for a second time with each CDW or emailed the transcript to the CDW and followed up with a phone call to check both the data collected and the interpretation. This process allowed me to assess the intention of the participants and I was able to check for errors and to ask for any additional volunteer information. The researcher also conducted a stakeholders' workshop after transcription of data. All participants and research supervisors were invited and findings were discussed with participants as part of member checks.

**3.8.2 Transferability** refers to the extent to which the findings can be applied in other contexts or with other participants (Krefting, 1991). Transferability was achieved as I presented sufficient descriptive data which allowed comparison. The demographic profile of participants, study contexts as well as interview guides were all used for comparison. In this way I addressed the problem of applicability.

**3.8.3 Dependability** of this study was achieved by checking that there was a clear connection between the research purpose and the research design. The exact methods of data gathering, analysis, and interpretation of the study have been described. The study was simple and offered direct outcomes that can easily be followed.

**3.8.4 Confirmability** was ensured by showing how data interpretations were arrived at in the study. Babbie and Mouton (2009) state that confirmability is concerned with the neutrality of the researcher and the manner in which the findings and conclusions achieve the aim of the study. I guarded against my own biases towards the study in terms of my prior assumptions and preconceptions. The role of triangulation in promoting such confirmability to reduce the effect of investigator bias was followed.

### **3.9 Ethical considerations**

The researcher was granted permission to conduct the research by the University of Cape Town's Faculty of Health Sciences Human Research Ethics Committee (*Ref No. HREC REF: 301/2013*). (See Appendix 5). The researcher then applied to the Health Research Unit (HRU) in the Ministry of Health in Botswana for permission to conduct the study in the 3 districts of Botswana. Permission was granted from the HRU of Botswana (*Ref No. PPME-13/18/1 Vol. VIII (215)*). (See Appendix 6). All ethical principles of conducting qualitative research were followed by the researcher as outlined below.

#### **3.9.1 Autonomy**

The researcher informed participants that participation in the study was voluntary and at any moment they wanted to discontinue, they were allowed to do so without any adverse effect on them or their work.

### 3.9.2 Confidentiality

Participants' confidentiality was protected by not revealing their names or other identifiable aspects in any documentation. Instead, pseudonyms were used with no direct link to the participants. (See appendices 3 and 4 for informed consent)

### 3.9.3 Beneficence and Non-maleficence

Risks and benefits of the study for participants were considered and there was no foreseeable harm or risk. The researcher ensured the wellbeing of the participants at all times during the research process. He carefully structured the questions and monitored the participants for any sign of distress. Participants were also informed that there was no direct benefit from participating in the study.

### 3.9.4 Justice

The researcher selected the participants for reasons directly related to the study problem and not because they are readily available or can be easily manipulated as stated by Brink et al. (2011). The participants' right to privacy was respected as they determined the extent to which private information could be shared or withheld from others.

### 3.9.5 Referral

Before the start of interviews, the participants were informed that if they became distressed and needed assistance, they would be referred for proper counseling with a professional Counselor or Psychologist.

### 3.9.6 Declaration of Helsinki (2013)

This declaration safeguards the safety and well-being of trial participants and provides important guiding principles for the ethical conduct of clinical research. The Researcher promised to abide by the declaration.

## *Conclusion*

This chapter discussed the methodology used in the study. A qualitative research design using an exploratory case study was adopted. CDWs working in Government or NGOs with at least five years experience were eligible to participate. A purposive sampling method to select seven participants was used. Data was generated through individual interviews using an interview guide consisting of open-ended questions. Thematic analysis of data which consisted of verbatim transcripts of

audio taped interviews was conducted. Permission to conduct the study was granted from both the UCT's Faculty of Health Sciences Human Research Ethics Committee (see appendix 5) and the Ministry of Health Research Unit of Botswana (see appendix 6). All ethical requirements were met namely, Autonomy, confidentiality, Beneficence and Non- maleficence, Justice, Referral and Declaration of Helsinki.

The next chapter will present the findings of the study.

## Chapter Four: Findings

This chapter presents the findings that emerged from the data analysis. The chapter first provides demographic information of the CDWs who participated in the study and goes on to present their knowledge and experience. CDW practices that relate to factors that facilitate the livelihood opportunities of disabled youth are next described. Subsequently, common strategies employed by CDWs in their practice as well as barriers which hinder disabled youth from participating in livelihood opportunities are reported. Finally, the chapter captures the suggestions made by participants for developing further strategies for facilitating livelihood opportunities for disabled youth.

### *4.1 Theme 1: Demographic profile, knowledge and experience of participants*

*Table 1* below gives demographic information of participants including their sex, age, years of training, employer at the time of the study, job title, experience in years, and their own disability status as well as that of their immediate family. Pseudonyms have been used to ensure confidentiality and to protect the identity of the participants.

As can be seen in *Table 1*, participants in the study were employed in CBR programmes by either government ministries or NGOs, and they all had substantial experience, ranging from 7 to 18 years, with an average of 13 years. Four of the participants had experience with disability through their siblings and one had a disability herself. The participants were selected purposively from the 3 districts of Kgatleng, Kweneng and South East in Botswana.

Table 1: Demographic profile and experience of participants

<i>Participant number</i>	<i>Pseudonym of participants</i>	<i>Sex</i>	<i>Age</i>	<i>Training</i>	<i>Employer</i>	<i>Job title</i>	<i>Experience (in years)</i>	<i>Disabled</i>	<i>Disability in family</i>
1	<b>Masego</b>	F	46	4 years	MoH	Rehabilitation Officer	13	No	Daughter blind, in wheelchair, intellectually disabled
2	<b>Gil</b>	M	36	2 years	NGO	Rehabilitation technician	12	No	Father had stroke
3	<b>Kgomotso</b>	F	45	4 years	MoH	Rehabilitation Officer	17	No	Child with convulsions for first 3 years of life; blind cousin (fully integrated)
4	<b>Kefilwe</b>	F	31	3 years	MoH	Social Worker	7	Yes	No
5	<b>Lefika</b>	M	42	4 years	NGO	Physiotherapist	18	No	No
6	<b>Naledi</b>	F	32	4 years	MoH	Social worker	9	No	Yes- 2 cousins from same family have physical disabilities
7	<b>Malebogo</b>	F	40	4 years	MoH	Rehabilitation Officer	16	No	No

The study data further make it apparent that participants acquired their knowledge and skills to work in the area of disability in two main ways. In the first place they all underwent professional training, which included basic training as well as specialized and follow-up training. In the second place, participants also acquired knowledge and skills related to disability through their experience of growing up and working in rural communities.

The participants all had a tertiary level qualification ranging from a two-year Rehabilitation Technician certificate course, three-four year diploma/degree in social work to a four-year degree in rehabilitation as well as physiotherapy. Their professional training was quite diverse: *Gil* trained as a Rehabilitation Technician,

*Lefika* trained as a physiotherapist focusing on community development, and *Malebogo* trained as a rehabilitation officer majoring in disability and rehabilitation. *Masego* and *Kgomotso* were trained as rehabilitation officers and *Kefilwe* and *Naledi* as Social Workers.

Participants' knowledge and skills were, however, not only derived from professional training. Several of them displayed a deep understanding of the cultural traditions and ways of living of rural communities, having been brought up in these environments themselves. *Kgomotso* narrated that rural dwellers in her experience refused to seek western medical attention, preferring traditional treatments in keeping with their beliefs, which often included strongly stigmatizing beliefs about the origins of disability:

*A lot were suffering out there in the bush without help, refusing to go to the hospitals, believing that they can sort their disabilities by curing them traditionally to get rid of witchcraft or whatever they believed in. (Kgomotso, first interview, 11/11/2011)*

*Gil* confirmed the stigma frequently attached to disability in rural communities. He explained that he himself at one point in his childhood believed that disabled people were cursed:

*I...had even this stigma because when I grew up...the place was, you know, the place has some superstitions. Some beliefs are that if somebody is disabled maybe they are cursed, something like that. (Gil, first interview, 11/11/2011)*

Even though participants reported the regular stigma attached to disability, *Gil* also described the 'Ubuntu' often found in rural communities. He stated that rural communities were 'well-knit' and if there were someone with a disability, everyone would know that person because he or she would be part of the community's life.

Despite the knowledge and skills gained either through training or through growing up and living in rural communities, one of the participants felt that the skills acquired during training were not sufficient to help her meet the challenges of her work. *Naledi* stated that during her training, Disability Studies were not part of the Social Work

syllabus that she studied. Instead, she only learnt through work experience how to deal with disability issues. She suggested that Disability Studies needed to be included in the training of social workers.

#### *4.2 Theme 2: Practices of CDWs that facilitate livelihood opportunities for disabled youth*

Participants in this study clearly recognized important areas of work that could facilitate securing livelihoods for disabled youth and they showed how their practices were shaped by these facilitators. The main practices they described related to helping disabled youth get access to health facilities, especially to assistive devices, recognizing the importance of access to education and training, and a range of further practices making it more possible for disabled youth to participate in livelihood opportunities such as being involved in self-employment projects, becoming more competitive in the wage employment market, and accessing financial or social protection schemes.

##### *4.2.1 Facilitating access to health facilities and assistive devices*

Assistive devices are important as a means of facilitating participation and access to livelihoods for disabled people as these devices increase independence and improve the possibility of participation in the community. CDWs in the study networked with other healthcare workers as well as their contacts at health facilities to facilitate access to assistive devices. *Gil* explained how an assistive device was a powerful first step to independence and mobility, which is important for securing a livelihood. One of his activities was therefore to solicit donations for wheelchairs for the disabled youth in his community '*who were just crawling in the village*' (*Gil, first interview, 11/11/2011*). He also told the following success story:

*We organized to go to Main Hospital and [the Prosthetist] performed miracles on that particular guy. [The Prosthetist] gave him prosthesis and that person is even driving his own taxi. (Gil, first interview, 11/11/2011)*

This is a striking example of how an assistive device could help a disabled person secure economic independence through self-employment.

#### 4.2.2 *Facilitating access to education and skills development*

Participants recognized the important role that education could play in enabling disabled youth to acquire the knowledge and skills necessary to access livelihood opportunities, particularly those involving self- or wage employment. Participants also recognized that there was limited availability of schools and vocational institutions for disabled youth in Botswana.

Despite this, participants gave hands-on practical assistance to place disabled youth at educational institutions and they also liaised with training centers and educational institutions to facilitate admission of disabled youth who met admission criteria in spite of their impairments. *Malebogo* commented that although spaces were limited, institutions such as technical colleges, private as well as public universities, had started admitting youth with disabilities and providing special services for them. She referred specifically to a system of government that assisted more disabled youths to be admitted to training institutions by reducing the number of points required for a disabled youth to be admitted to tertiary education:

*Yes the government has come up with a system where their ... the point system, how you qualify to go for tertiary. If you are disabled, your point system has to be deducted like five....yah...five I think....you don't have to be with the same points like an able-bodied person (Malebogo, first interview, 2/12/2013).*

Another participant, *Kgomotso*, explained the process of checking the examination results and entry points of young disabled clients. If learners met the entry points of educational institutions, CDWs helped them with application processes.

Participants found their activities in the educational domain both successful and rewarding. *Masego* described the gratitude shown by disabled youth when they were placed in schools: *'And even finding them some school placements, to some it's like I did something very remarkable for them'* (*Masego, first interview, 12/11/2011*). *Kgomotso* expressed equal job satisfaction at managing to place disabled youth in schools, even those that managed to complete only primary school. Although they had gone back to live a rural life, *'being able to find skills training for them was a positive thing for me'*

(Kgomotso, first interview, 11/11/2011). Gil described the success of a youth who used to be a student at their local centre and eventually went to Australia to pursue a degree in social work. After graduation, he returned to the same centre:

*Okay, our social worker here is totally blind; he grew up here and went to Australia to do his studies, yes he holds a degree and he is working here. He is an example to all our children (Gil, second interview, 30/06/2013).*

This is again a striking example of the impact that education could have on a disabled youth's ability to become an established professional and develop economic independence.

#### *4.2.3 Assessing and creating access to livelihood projects, programmes and careers for disabled youth*

CDWs explained that they kept a database of disabled people in their districts in order to provide accurate information on any of them. Naledi stated that

*If...there is a disabled person maybe who is applying for an empowerment scheme or a project, maybe at the youth department, they will want clarification from my office that.....in fact this is a person with disability... (Naledi, first interview, 12/11/2013)*

Gil explained that CDWs assessed the economic potential of disabled youth and that this included

*helping people to come up with income generation projects and also educate disabled people about the government programmes. (Gil, second interview, 30/06/2013)*

Participants were also involved in the practice of assessing livelihood projects for disabled youths. They offered career guidance and disseminated information on livelihood projects run by the government or Non-Governmental Organizations (NGOs) specifically for disabled youth. Gil described organising workshops for people with disabilities and arranging for the National Youth Council to go and

*educate the people with disabilities about the programmes that they give so that at least they could benefit from the government (Gil, second interview, 30/06/2013).*

As far as facilitating wage employment was concerned, *Lefika*, who worked for an NGO, mentioned that they had a job placement programme at their centre where 'We identify ... disabled youth and refer to potential employers and they do accept them' (*Lefika, first interview, 13/09/2013*).

#### *4.3 Theme 3: Strategies of CDWs to facilitate livelihood opportunities for disabled youth*

CDWs used many different methods and strategies in their daily practices. These included:

- 1) Advocacy to facilitate livelihood opportunities;
- 2) Networking to facilitate participation and access to livelihoods;
- 3) Using the media and village [*Kgotla*] meetings to disseminate information on available resources for disabled youth;
- 4) Role modeling to promote the employability of disabled youth;
- 5) Follow-up visits on former students to monitor their livelihoods.

Advocacy and networking were powerful strategies used by CDWs to facilitate participation and access to livelihoods. Various media such as the radio were used for advocacy purposes and to disseminate information. CDWs' networks included fellow professionals in communities, health facilities, schools, government departments and NGOs. They also used role models as a strategy to inspire disabled youth and follow-up strategies to monitor the success of former students or livelihood projects.

#### 4.3.1 *Advocacy to facilitate livelihood opportunities*

One of the most prevalent methods used by participants in this study was to advocate on behalf of disabled youth. Participants' account of their work showed that advocacy formed part of their every activity, involving many stakeholders and sites. *Masego* stated: *I advocate for disabled people in my everyday life and work' (Masego, first interview, 12/11/2011)*. *Gil* explained that advocacy was done through the community, the traditional Chiefs and in the *Kgotla* meetings. He concluded that as community-based workers, CDWs 'should always advocate for those people [disabled youth]' (*Gil, second interview, 30/06/2013*). *Kgomotso* gave an example of her advocacy work involving the government and potential wage employers of disabled youth:

*So what we have done, we have applied with them, they have submitted their names to Office of the President and Office of the President has a liaising Officer or human resources officer at [name of] supermarket headquarters. So after submitting, what we do is we keep phoning them, "how far, have you not secured a place somewhere where you can put our clients who have applied with your office?" (Kgomotso, second interview, 30/06/2013)*

CDWs also did their advocacy work at workshops that they organized or at the hospitals and clinics in communities that they visited.

#### 4.3.2 *Networking to facilitate participation and access to livelihoods*

Participants were engaged in internal and external networking to facilitate livelihoods for disabled youth. In this study, internal networking involves interacting with fellow CDWs and staff at health facilities, while external networking involves interacting with local government, staff at the Disability Desk in the Office of the State President, donor communities, various ministries such as Health, Transport, Lands and Housing, taxi drivers, traditional leaders, supermarket owners and local parliamentarians, collaborating to achieve a common goal. The CDWs in this study assisted in creating opportunities of mutual benefit for both the disabled youth as well as the prospective employers. *Lefika* acknowledged that he had seen a positive response from employers wanting to engage more disabled youth in waged employment. He stated that:

*To me, that has been very good and companies keep coming to say now we are opening, like when these diamond polishing companies were being established, they would say we want so many people with visual, with hearing impairment, to be part of our team. And to us it was really someone....some people who had really seen the benefits of employing people with disabilities (Lefika, First interview, 13/09/2013)*

Networking with professional staff at health institutions facilitates access to assistive devices and enables disabled youth to function independently in accessing livelihoods. Activities of soliciting for mobility aids by the participants assisted disabled youth in accessing schools and work places, as Gil narrated:

*What basically happened is that the child was my client at the centre I was working. So we did everything possible, going to sometimes referring the child to Marina Hospital for orthopedic you know, appliances sometimes referring that child for orthopedic reductions. So that kid basically grew up in my hands. And to see that particular child you know, going to school and eventually graduating from the University, it was something that really motivated me. And I can say it was a high point in my life because they even had to come to us to the centre and say your child has graduated. They had a party and I could see even the family, they were so happy. They even attributed that eh, success to us. And it, I can professionally wise I regard that as my high point. (Gil, first interview, 11/11/2011)*

The participants also discussed the successful experiences of networking amongst themselves, for instance in developing a system of collaborating between CDWs to disseminate information to disabled youth and their families about various institutions offering special educational services. Gil described the strengthening of the relationship between rehabilitation officers and social workers because

*social workers are the ones who are staying with the people....you know... they are at the grass root and more interactive with the community. (Gil, second interview, 30/06/2013)*

#### 4.3.3 *Using the media and structures to disseminate information on available resources for disabled youth*

Using the media to disseminate information and do advocacy work was found to be a successful strategy. *Gil* gave an example of successfully using the radio and Kgotla (Village) meetings to promote placing disabled youth in learning institutions. The radio in particular enabled them to cover a wide geographic area:

*We now have 75 children in our centre just because people are hearing us from the radio. (Gil, second interview, 30/06/2013)*

Even though he was excited that the strategy was working well because they were able to get clients, he however admitted that it was not enough, *'because it's difficult to cover the whole of Botswana through the media'*. (*Gil, second interview, 30/06/2013*)

#### 4.3.4 *Role modeling to promote the employability of disabled youth*

Role modeling was a strategy used by CDWs to promote the employability of highly skilled disabled youth to different companies. Because this is a result-oriented activity, its success depends on the extent to which the initial group of role models impressed the employers. *Lefika* gave a good example of using role modeling to promote disabled youth's employability in wage employment:

*He was amputated above the elbow.... He can write, he was answering phones and doing all those things, right now he is doing his degree in the United States. The company, after working with him and he was now going to school, they insisted on looking for someone with disabilities to say ....we have never seen productivity of this magnitude. (Lefika, first interview, 13/09/2013)*

Another example of using role models was given by *Gil*. He talked of going for outreach activities

*with educated, totally blind people, standing in front of people and telling them their experiences. So it has helped, it has helped a lot (Gil, second interview, 30/06/2013).*

Gil's narrative included the story mentioned earlier of the blind Social Worker who returned to inspire the youth as another example of a powerful role model.

#### *4.3.5. Follow-up visits on former students to monitor their livelihoods*

Another strategy which was used by participants was making follow-ups on former students. Following up former students enabled participants to assist those with challenges and to prevent them from dropping out. Gil narrated one of his experiences on the strategy of making follow-ups on disabled youth who had dropped out of school but were successful in a self-employment scheme:

*They graduated from here, and then they went to junior. They didn't do very well and then from there, they went to their homes. So we....we got a donor who was willing because we just said let us follow them to see what are they really doing. And unfortunately they are scattered and we provided them with chicken run, the chickens, even the feeds, just, just to start and they were doing quite well. We took five of them, three were totally blind and two of them are partially blind. And they are doing very well; yes with the help of their children, yah... but they are really doing well. It has boosted their confidence that 'at least I can do something'. It's not the end of the world, because they failed to go to senior secondary school and it was really affecting them. (Gil, second interview, 30/06/2013)*

#### *4.4 Theme 4: Barriers to disabled youth's participation in livelihood opportunities*

Participants mentioned a number of barriers that they felt were preventing disabled youths from accessing livelihood opportunities. These included:

- 1) Inadequate policy on disability;
- 2) Absence of disability friendly public facilities;
- 3) Poorly resourced public education system;
- 4) Inaccessible job market;
- 5) Alienating attitudes to disability related issues;
- 6) Poor dissemination of public information on disability.

#### 4.4.1 *Inadequate public policy on disability*

Most of the participants expressed displeasure with the available policies, saying that they are unclear on employment and education. Some also admitted ignorance of the existence of policies related to the two issues. The employment policy for disabled youth was one such policy that participants mentioned. As *Gil* explained:

*Mostly it's like [name of Supermarket], they have been employing people with disabilities. So we don't know whether it's a policy, deliberate policy by the government or it's just a company policy. (Gil, second interview, 30/06/2013)*

*Kgomotso* lamented about the unclear or unspecified policies available:

*Eeh.... I feel they [policies] are a bit fake really.... I feel they [policy makers] are a bit silent. If they can just come out clearly...eeh...and you know, compel or force the employers to do something. I mean even the education policy; we are talking about this accessibility, but if you look at the type of disabilities that they take, they take mild to moderate. (Kgomotso, second interview, 30/06/2013)*

Another participant, *Lefika*, felt that some policies like the performance-based reward system (PBRS) in schools may disadvantage disabled youths. Since the policy concentrates on high performance, the disabled learner is perceived as a slow learner and may be seen as retarding the performance average of the school. He felt there was a need to have disability friendly policies in schools to avoid discrimination of disabled learners:

*The school system itself you know with some of the policies put in like performance based management system... they feel that some of these children will delay implementation and then they take them out. (Lefika, first interview, 13/09/2013)*

#### 4.4.2 *Absence of disability friendly public facilities and transport*

Participants pointed out that there was no public transport which accommodated wheelchairs and other assistive devices. In order to access educational institutions and places of work, disabled youth had to get on special taxis which charged exorbitantly. *Lefika* talked of challenges of transport for disabled youth:

*Like at Moshupa, right now for example there is a problem of transport for people with disabilities. I have to struggle to take these people for medical check-ups, to schools at Maun, Otse, Mochudi (towns). That's where I have placed the youths but I struggle to find transport. (Lefika, first interview, 13/09/2013)*

Malebogo also stated that those who were using wheelchairs were complaining about buildings being inaccessible to those using assistive devices. This is an environmental barrier faced by most disabled learners:

*My class is upstairs and I cannot go for lectures. The lecturer has to come down after he has helped some other kids and I did not benefit like other students have benefited. Most surroundings are also unkempt, making mobility with assistive aids difficult. (Malebogo, first interview, 2/12/2013).*

Inability to access transport was also noted as a hindrance for CDWs themselves in facilitating livelihoods for disabled youth, especially in rural areas. As Gil pointed out:

*we do lack [transport]. So you find we go to our CBR maybe once in two months you know where as we are supposed to go on a weekly basis to go and monitor the projects. (Gil, second interview, 30/06/2013)*

The transport barrier thus led to unsupervised and unsupported CBR programmes.

#### *4.4.3 Poorly resourced public education system*

Participants noted that there were no government owned schools for disabled youths. Almost all schools were run by NGOs, which was seen as a barrier in regulating education and skills development for disabled youths. Kefilwe stated that:

*Here in our country we don't have those institutions you can say this is for the government. Maybe if we could have that and maybe if we could have more like the government is building schools and local schools and secondary schools. They should look into that because there isn't any Institution which is solely the government institute for people with disabilities. (Kefilwe, first interview, 30/11/2011).*

Absence of trained special teachers was another barrier identified by the participants. It was noted that most of the available teachers teaching disabled youths do not have any training in special education. As *Kgomotso* explained:

*We have over 80 children currently, they have this teacher who is just from the main stream, she is not specialized in this area. (Kgomotso, second interview, 30/06/2013)*

Participants also discussed the low level and types of education commonly offered to disabled youth, which makes it difficult for them to progress to tertiary levels. *Kgomotso* said:

*I would say their level of education. They are a serious limitation to their progress really. As I have already mentioned that they cannot proceed to higher levels. (Kgomotso, second interview, 30/06/2013)*

This creates a barrier in accessing livelihood opportunities, as will be illustrated in section 4.4.4 below. Furthermore, training centres were found to be centralized mostly in urban districts. Participants pointed out that these few centres also lacked in a variety of courses to choose from. *Malebogo* observed:

*But then these vocational training centres also there are limited because the courses that they are offering are almost...almost the same for the whole country. (Malebogo, first interview, 2/12/2013)*

Another barrier mentioned was the loss of family contact when the disabled youth is admitted in an institutional training centre away from home. *Malebogo* noted that:

*There is no family bond for the whole term when the learners are in boarding institutions since they don't break until end of term and their families cannot afford costs of visiting them. (Malebogo, first interview, 2/12/2013)*

#### 4.4.4 *Inaccessible job market for the disabled youth*

Participants reported that job market challenges experienced by disabled youth were an enormous barrier in accessing employment opportunities. Several factors were identified such as being a developing country, poor infrastructure, a poor transport

network for disabled people, little or no attempt at making buildings disabled friendly, and the socioeconomic context which impacts badly on livelihoods for disabled youth. They also observed that accessing jobs after training was a challenge as the job opportunities were not aligned to the type of training disabled youth were offered. In their experience, young people were mostly trained in performing low to medium skilled activities like leather work, gardening and basket weaving which were supposed to lead on to self-employment. However, there seemed to be little opportunity of creating employment in these areas of training. *Kgomotso* and *Lefika* both stated that more often they found waged employment for disabled youth in small businesses like supermarkets. However, this is completely different from the training the youths had received:

*They have done textile in institutions that I have talked about, gardening, leather works. But now you see they are employed in a totally different area of operation (Kgomotso, second interview, 30/06/2013)*

Another barrier at the rural level was the rural-urban drift, which meant that rural areas lost capacity in disability services. *Lefika* pointed out that since economic activities at rural levels were affected, the young able-bodied who were supposed to: *'Push some agendas; they come to town to look for greener pastures'* (*Lefika, first interview, 13/09/2013*). This observation links up with the section below, as it highlights the alienating attitude that some prospective employers display towards disability.

#### *4.4.5 Alienating attitudes towards disability*

Alienating attitudes towards disabled youth were found to be a significant barrier impeding livelihood opportunities. Participants found that disabled youths experienced alienating attitudes even in the smallest community unit, the family. One of the participants, *Lefika*, mentioned barriers coming in the form of either *'overprotection'* or *'exclusion'* of the disabled family member:

*The type of provisions that are usually made to these people and because of these attitudinal barriers you find people are not much willing to engage these people in even at just family level. You would find a disabled child is not involved in the household chores. Even if they are able to they are not being sent. Either*

*it's overprotection on a...but the basic thing is they become excluded from family activities, something that they really would like. (Lefika, first interview, 13/09/2013).*

CDWs found alienating attitudes a major challenge in their society. They perceived that youth with disabilities were automatically equated to youth with special educational needs. Some people could not differentiate between various types of impairments. Thus, as long as you were wheelchair ambulant, the perception was that you also had intellectual impairment and therefore could not function, and if you could not function, then you were perceived as a burden. *Lefika* stated that:

*People with disabilities are treated as people with special educational needs, special learning needs. So no matter you are just in a wheelchair, looking to do academic things, they will feel you are a burden. (Lefika, first interview, 13/09/2013)*

*Lefika* also noted that some employers were unwilling to employ disabled youth, for various reasons:

*one, the type of support that people may need; two, the images....you know sometimes the reception work can be done by someone with disabilities but usually you know the culture, they want to put a nice looking lady at the reception and why, where would they put these ones who maybe are in a wheelchair with deformity? They say the image of the organization will be like that one or someone in a wheelchair and their attitude thereafter plays a significant role. (Lefika, first interview, 13/09/2013)*

These alienating attitudes unfortunately even extended to service providers and other health workers who were supposed to be well versed in disability issues. *Naledi* described this situation:

*Almost 90% of my work colleagues have an attitude, because like to tell you the truth, at the council, if they see somebody coming in a wheelchair or crutches or any type of disability, they will know that this person is going to see [me]. And you know what they will do; they will say to me your client is outside, even before listening to what the client wants. Like sometimes the client will not even*

*be looking for my assistance, he will be looking maybe for omang [identity card] office or looking for the District Commissioner's office, but they have this perception that if you see a disabled person ...aaah... he or she is looking for [me] even before listening to what the person wants. (Naledi, first interview, 12/11/2013)*

#### *4.4.6 Poor dissemination of public information on disability*

Participants stated that the Government was not doing enough to disseminate information on disability and youth disability programmes. This, they felt, affected their work in facilitating livelihoods as they were not aware of what the government had put in place and so could not sensitize communities. Gil stated that lack of information was a major barrier in disability. He pointed out that:

*The barrier, the main barrier really is lack of information. People really they do lack Information, starting from... from the councillors, schools...eem...parents, they ... they do lack information as far as disability ....is concerned. (Gil, second interview, 30/06/2013)*

Lefika aptly observed that even if the government reserved programmes for disabled people, without access to information disabled youth would not have access to those services. He questioned:

*Yah like Government programmes here they are there and they are there to benefit all but how many of those will be reserved, put aside for people with disabilities? And even if it's not put aside, how many people with disabilities have access to information and access to those services? (Lefika, first interview, 13/09/2013)*

Poor media coverage in rural areas was another barrier, even though participants found the radio an important way of disseminating information, as described in section 4.3.3. However, they found that some young people in remote areas could not access the Botswana radio network and therefore missed out on important information disseminated through the radio.

## 4.5 Theme 5: CDWs' suggestions for enhancing disability-inclusive livelihood opportunities

The participants made a number of suggestions which they felt would enhance the development of successful strategies for disabled youth's livelihood opportunities. These included:

- 1) Disability inclusive policies and structures
- 2) Addressing educational and training needs
- 3) Accountability regarding employment
- 4) Community sensitization and mobilisation

### 4.5.1 The need for disability inclusive policies and structures

The need for appropriate and clear disability inclusive policies and structures was noted to be an important tool in facilitating livelihood opportunities. *Malebogo* observed that without a proper structure, it would be difficult to implement disability policies. So she recommended having personnel, policies and structures. *Malebogo* stated her belief as follows:

*So I think all we need now is personnel and policies and structure because I believe where there is a structure, just like any other programmes that the Government has, it will work. But if there is no structure, it can't work. (Malebogo, first interview, 2/12/2013)*

### 4.5.2 Addressing educational training needs of disabled youth.

Training was emphasized and the absence of specialized training institutions wholly owned by the government was seen as a major obstacle in disabled youth's acquiring skills for livelihoods. Therefore one of the recommendations was for the government to have ownership of such institutions and to decentralize training to different regions of Botswana. *Gil* emphasized the advantages of decentralizing the training. He stated that:

*We would want to have those schools in each and every province so that at least every student will stay with their parent. (Gil, second interview, 30/06/2013)*

Participants also recommended the need for specialized, qualified teachers and consultation with disabled youth on their choice of training. Their voice should be heard and choices should not be made for them. *Malebogo* emphasized this point:

*...and also look at their interests, what are they interested in, because some of them you just take them and say go and do leather work after that they are not interested in leather work. (Malebogo, first interview, 2/12/2013)*

There was also a recommendation for the government to shift their focus from academic to skills training. It was agreed by some participants that most disabled youths were better at skills training than academic training.

#### *4.5.3 The need for government accountability on disabled youth employment*

On the job market, the participants recommended that government should be made accountable for employment of disabled youth. *Kgomotso* recommended that there should be more commitment from the government in terms of disabled youth employment. She suggested that:

*If the government can have a clause in this disability policy that binds both Government and non-governmental organizations to at least have each one of them employ maybe 5% of people with disabilities. (Kgomotso, second interview, 20/06/2013)*

*Kgomotso* also recommended the introduction of *sheltered employment*. She suggested having a skills training institution which would eventually employ some of the disabled graduates identified as unable to work independently:

*You train the youth and then from there you are sure they come and work here; supported employment where they will be having skilled personnel who will support them throughout because some of them even though they have been trained, you cannot do anything independent, they need to be guided. (Kgomotso, second interview, 30/06/2013)*

#### 4.5.4 Community sensitization and mobilization

Community sensitization and mobilization fall under the empowerment component in the CBR guidelines. The involvement of disabled youth is critical and must involve a mindset change from being passive recipients to active contributors. CDWs needed to motivate the disabled youth and connect them to their families and local communities and give them power to make important decisions which ultimately affect their lives. This is critical in order for CBR programmes to succeed. *Malebogo* talked of the need to:

*Empower people with disabilities to build their self esteem and all that. That's when we need skilled people for empowerment and advocacy. (Malebogo, first interview, 2/12/2013)*

Furthermore *Malebogo* emphasized the need for community awareness:

*We just need the whole community, for everybody to be aware of the problems that people with disabilities have, the barriers that make them not to achieve like other able bodied person because some of them are social, some are because of the environment that they live in (Malebogo, first interview, 2/12/2013).*

#### 4.6 Conclusion

In the preceding analysis of findings five themes emerged from the data.

##### *Theme 1: Demographic profile, knowledge and experience of participants*

Participants were employed in CBR programmes by either government ministries or NGOs and they all had substantial experience, ranging from 7 to 18 years, with an average of 13 years. All participants had a tertiary qualification.

##### *Theme 2: Practices of CDWs that facilitate livelihood opportunities for disabled youth*

Participants identified a number of elements that facilitated disabled youth's access to livelihoods. They then described a wide range of practices that they engaged in to facilitate livelihood opportunities for disabled youth. These included assisting young people to get access to health facilities, especially to assistive devices, recognizing the importance of access to education and training, and a range of further practices which give young people access to livelihood opportunities such as being involved in self-

employment projects, becoming more competitive in the wage employment market, and accessing financial or government social protection schemes.

*Theme 3: Strategies of CDWs to facilitate livelihood opportunities for disabled youth*

CDWs used many different methods and strategies in their daily practices. These included using advocacy to facilitate livelihood opportunities; using networking to facilitate participation and access to livelihoods; using the media and *Kgotla* meetings to disseminate information on available resources for disabled youth; using role modeling to promote the employability of disabled youth; making follow-up visits on former students to monitor their livelihoods.

*Theme 4: Barriers to disabled youth's participation in livelihood opportunities*

A number of barriers were identified: inadequate policy on disability; absence of disability friendly public facilities; a poorly resourced public education system; an inaccessible job market; alienating attitudes to disability and poor dissemination of public information on disability.

*Theme 5: CDWs' suggestions for enhancing disability-inclusive livelihood opportunities*

There is a need for disability inclusive policies and structures as well as to address the educational training needs of disabled youth. The government also needs to be accountable on disabled youth employment. Furthermore, community sensitization and mobilization were identified to be critical to CBR success.

The next chapter gives a detailed discussion of the study and recommendations.

## *Chapter Five: Discussion and recommendations*

### *5.1 Introduction*

This chapter gives a detailed analysis and interpretation of the findings presented in chapter 4. The findings showed that CDWs identified important facilitators to developing livelihood opportunities for disabled youth and that they engaged in varied practices to make these opportunities more accessible to disabled youth in order to increase their economic independence and participation in society. The findings made evident that CDWs worked in a multi-sectoral way, engaging in practices and activities in the education and health domains of CBR in order to strengthen disabled youth's participation in the livelihood domain (WHO, 2010b). In their daily work CDWs drew on strategies described in the CBR empowerment domain, such as advocacy, dissemination of information and community mobilization. The findings in the previous chapter also reported a number of barriers identified by CDWs in their work with disabled youth, and recorded their suggestions on how to overcome barriers and enhance facilitating strategies.

In light of current literature, the five environmental categories of the International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) provide a fitting framework for analyzing and interpreting these findings. The findings of this study showed that CDWs have the ability to engage with environmental factors over a broad range in order to enable disabled youth to be active citizens.

Two themes will be discussed in detail in this chapter, namely:

- Addressing environmental factors impacting on disabled youth's development of livelihoods;
- Successful strategies to enhance livelihood opportunities for disabled youth.

The description of the livelihood, health, education and empowerment domains and their constituent components in the CBR Guidelines (WHO, 2010b) were further used in discussing these themes. The CBR Guidelines in general aim to facilitate access for people with disabilities and their families to acquiring skills, livelihood opportunities, enhanced participation in community life and self-fulfillment (WHO, 2010b).

## 5.2: Theme 1: Addressing environmental factors impacting on disabled youth's livelihood development

The findings of this study revealed that the built environment presents many barriers for disabled youth with regard to mobility and accessibility (*Theme 4.4.2*). The barriers restricting accessibility identified by the CDWs in this study included sandy environments and uneven terrain, unkempt surroundings and most public buildings providing few design features to permit disabled youth ease of access.

These findings are in keeping with the literature. The WHO and the World Bank (2011) Report on Disability revealed that on-going environmental discrimination is the major limitation for people with impairment to access social services. An inaccessible environment leads to disabled youth not being able to access schools and healthcare facilities or to participate in any social activities in their communities. This factor results in disabled youth not being able to benefit from available services and systems that could lead to acquiring decent livelihoods.

The social model of disability focuses on the disabling environment rather than on the impairment of the person. On the one hand, environment refers to the physical environment, for instance availability of elevators and ramps to facilitate access to buildings. However, the concept of environment encompasses more than just the physical environment, in that it touches on several other issues such as family support, people's attitudes, and availability of policies that affect disability. Thus, the WHO (2001: 17) states that:

“Society may hinder an individual's performance because, either it creates barriers (e.g. inaccessible buildings) or it does not provide facilitators (e.g. unavailability of assistive devices)”.

It states that the social model of disability demands a political response, since the problems created by an unaccommodating physical environment are actually brought about by social attitudes and other features of the social environment, as will become evident in the discussion of different types of environmental factors encountered.

Facilitating access for disabled youth into and around the built environment is supposed to be an important function of the local authority. In a study conducted in Canada and the United States, Imrie and Kumar (1998:358) observed that “the built environment is hostile in that it is infused with able-bodied values, like steps or restrictions on entry to buildings, which serve to exclude or produce discomfort or nuisance”. A study conducted in Canada by Law, Petrenchik, King, and Hurley (2007) identified environmental barriers to recreational, community and school participation as being characterised by design and they also found that accessibility of home, school, and community environments can pose significant barriers to participation for disabled youth. Likewise, the CDW participants in the current study also identified barriers at schools, work places, health facilities, shops, community facilities as well as housing buildings.

While CDWs knew that they should advocate for more accessible buildings, they seemed insecure to intervene in design and building processes. They recognized the importance of advocating for accessible built environments as part of facilitating independence, which could lead to increasing disabled youth’s ability to participate in society and to become more employable (*Theme 4.4.2*). Imrie and Kumar (1998:358) concludes that “disabled people’s needs are poorly articulated and/or represented in the design and development of the built environment while the regulatory controls which oversee disabled people’s access needs are weak”. While CDWs in the current study could articulate disabled youth’s needs, they did not seem equipped to intervene and represent their rights in the development of more accessible built environments.

### *5.2.1 Assistive products and technology increase independence and participation*

Assistive products and technology can be described in various ways. However, for the purpose of the classification of environmental factors, the WHO (2001) defines them as, “any product, instrument, equipment or technology adapted or specially designed for improving the functioning of a disabled person”. The CBR Guidelines (WHO, 2010b) furthermore document under the health domain that access to assistive devices are an important part of any development strategy and that without them, many people with disabilities would be unable to function independently or gain an education or employment, thus continuing a cycle of poverty.

The current study showed that with proper rehabilitation, disabled youth can access livelihood opportunities and even become economically independent and contribute positively to the community. The study also showed that CDWs played a crucial role in helping disabled youth access health services and assistive devices. After being fitted with a prosthesis, one disabled youth went into successful self-employment, driving a taxi and earning a livelihood.

However, careful assessment and education of every disabled youth has to be done in relation to the supply and usage of assistive devices, as some may not see the need for such. In a study on disabled persons' experience of dependence on assistive devices, McMillen & Soderberg (2002) stated that a device may only be accepted by the person who sees the aid as useful for his or her purposes. They further stated that "the incorporation of new equipment into one's life means pragmatic adaptation, emotional adaptation, a self-image and a body image that includes a wheelchair, for example" (2002:176).

Access to assistive devices may itself become a barrier, especially in developing countries. A study by Kahonde et al. (cited in Lorenzo et al., 2012) in informal settlements in Cape Town, South Africa, found that in some cases, people with disabilities did not receive devices due to poor human resource management. In this respect, the Botswana government has been very supportive of disabled youth to acquire assistive devices and other products and technology. In its circular of 2008, the government allowed free access to assistive devices for disabled children and youth aged from 1 day to 16 years. Disabled youth over the age of 16 have to pay a subsidized charge of 10%. Those who fail to pay are referred to the social welfare department for economic assessment, with the aim that those found genuinely unable to afford the charges, are assisted free of charge. The Botswana government also has social safety net programmes in place that have been used to redistribute resources to vulnerable groups in order to reduce chronic poverty or to protect them against risks to their livelihoods (Levers et al, 2008).

Despite these efforts, Botswana, with an estimated disability population of about 3.5% of a population of slightly over 2 million (Botswana Government, 2011), faces many challenges in addressing disability issues and bridging the gap between disabled and

non-disabled facilities. One of the challenges has been attributed to inadequate human resources specialised in disability practice and management. The experience of rehabilitation in Botswana is that the process of acquiring assistive devices at times takes long and therefore disadvantages disabled youth from accessing livelihoods. Assistive devices in Botswana are accessed mainly from the only referral hospital in the capital, Gaborone, which offers specialised services. It was evident from the findings that this centralized system for accessing assistive devices was a barrier as not every disabled youth could afford to travel long distances to access these services. However, CDWs were able to facilitate accessibility to assistive devices by arranging transport with the local district authorities and making all the necessary travel arrangements.

Although the literature and findings show that assistive devices have the potential to increase the independence of disabled youth and to facilitate their participation in accessing livelihoods, and although the Botswana government subsidises assistive devices, in reality there are many challenges obstructing the accessibility of devices. These challenges (as explained above) need to be addressed in order to have a smooth comprehensive rehabilitation system that will enhance livelihood opportunities.

### *5.2.2 Challenges with natural and human-made environmental accessibility*

The ICF identifies the natural environment and human-made changes to the environment as barriers to livelihoods for disabled youth (WHO, 2001). Some of the factors include the physical geography and the population. Other factors that fall under this category are the climate and natural events such as severe or violent weather conditions.

Botswana is a semi desert, with sandy terrain predominating, especially in rural and peri-urban areas. Using assistive devices in rural terrains would be a daunting task for disabled youth. From the researcher's knowledge of the study environment, most pathways and roads are not covered in tarmac and are sandy. There are hardly any disability-accessible walkways. The climatic conditions of Botswana are another barrier as the weather gets to extremes of cold and hot, making it unbearable for disabled youth, especially those who have to perform strenuous physical action in wheelchairs or on crutches.

In a study examining patterns of community participation and environmental factors for school-age children with and without disability conducted in the United States and Canada, Bedell et al. (2013:316) found that environmental factors are "often more frequently encountered and more challenging to predict and manage in the community than at home or school". They stated that inaccessible physical environments are usually the most commonly reported barriers to participation of children and youth with disabilities. Duncan et al (2011:30) have further shown that "people with disabilities who live in isolated rural areas in South Africa face a unique set of participation restrictions associated with their geo-social positioning". The studies mentioned above both discuss participation restriction of disabled people in the community. This is in keeping with the findings highlighted by the current study in *Theme 4.4.2*, where CDWs comment on the absence of disability friendly public facilities.

Buildings also present a barrier to disabled youth. Inaccessible public and private buildings were identified by CDWs as barriers that limited access to livelihoods. Many buildings, including schools and work places, did not have facilities for disabled youth, as they lacked necessities such as ramps and disabled parking areas. A report on a comprehensive study of safety nets for people with disabilities in Botswana by Levers et al (2008) found that building structures in Botswana did not accommodate people with disabilities. The Tanzanian National Policy on Disability (2004) also states that an inaccessible environment is a major barrier which excludes and discriminates against disabled youth where accessing social services as well as livelihoods are concerned. These statements are in line with the current study's findings in *Theme 4.4.2*, which report barriers to accessibility. They also support the recommendations of the current study on environmental accessibility.

### *5.2.3 Support and relationships for disabled youth when accessing livelihoods.*

The environmental factor concerning support and relationships focuses on the amount of physical and emotional support persons (or even animals) provide to the disabled person (WHO, 2001: 172). It refers to people or animals that provide practical, physical or emotional support, nurturing, protection, assistance and relationships to other persons, in their home or place of work, school or at play or in other aspects of

their daily activities. The family is seen as the central unit in the lives of most disabled people.

In the current study CDWs showed that there was minimal interaction between disabled youth and their families when they [disabled youth] were institutionalized in training facilities (*Theme 4.4.3*). CDWs expressed the need for the government to decentralise training facilities so that at least every district could have an institution. This decentralization could enable disabled learners to attend school from their homes or stay at the training centres but have more frequent visits from family members.

Even though institutionalised training created a barrier between disabled youth and their families, societal discrimination and negative attitudes may lead to a family opting for institutionalised training for their disabled child. For some it might be due to financial constraints as they find it difficult to manage with limited resources and opt for institutional residency (Groce, 2004). Other families may want to protect their children and thereby limit their independence. The over-protection can lead to low self-esteem and a poor sense of identity for disabled youth. This discourse might lead to disabled youth who want to remain dependent on others and lead to rejection or exclusion from community and young people who as a result end up being disempowered instead of empowered. WHO (2010c:3) states that many people with disabilities “may be rejected and excluded from community life because of stigma and discrimination”.

The CDWs in the current study demonstrated the ability to facilitate livelihoods for disabled youth but often experienced that disabled youth themselves were not empowered enough to meet the challenges. It emerged that they could not address issues directly and mostly went through the Disability Desk at the Office of the President. According to the empowerment domain of the CBR Guidelines (WHO, 2010c:3), “people with disabilities and their family members make their own decisions and take responsibility for changing their lives and improving their communities”. It also states that the role of the community disability practitioner is to contribute to the empowerment process by promoting, supporting and facilitating the active involvement of people with disabilities and their families in issues that affect their lives. The role of

the CDWs as a vehicle for facilitating CBR programmes, of which empowerment is one component, has been clearly outlined in this study.

#### *5.2.4 Attitudinal factors as a barrier to livelihood accessibility.*

Attitudes are described in the ICF (WHO, 2001: 176) as the “observable consequences of customs, practices, ideologies, values, norms, factual and religious beliefs”. The category on attitudes in the ICF environmental factors refers to people external to the person whose situation is being described. The ICF (WHO, 2001: 176) further states that “values and beliefs are not coded separately from attitudes as they are assumed to be the driving forces behind the attitudes”. These attitudes can either be from immediate family members, extended family members, friends, neighbours, personal care providers and health personnel.

Some of the health care providers in the study were reported to have a negative attitude towards disabled youth. This is alarming as the health care providers were supposed to be attending to the needs of the disabled youth and display positive attitudes as well as render emotional support where necessary. The major barrier in disabled youth’s access to livelihoods can be identified as peoples’ attitudes towards disability. Patterson et al. (cited in Chappell & Lorenzo, 2012:15) claims that “the attitudes of health workers towards people with disabilities are thought to exert a significant influence on the quality of client treatment”. Chappell & Lorenzo (2012) concluded that it was important for community disability practitioners to have the necessary technical skills, as well as the right attitude and good interpersonal skills in their work ethics. Van der Ploeg et al (cited in Maart et al., 2007) observed that other than impairment, the attitudes of society, family and health professionals could impact on the level of activity in the community for disabled youth. Said (2006) observed that family and community often look at people with disabilities as a burden and develop negative attitudes against them. As a result disabled young people lack support from the family as well as the community and cannot access social services that could lead to acquiring livelihoods.

Data showed that disability issues were given lower priority by communities, including policy makers (*Theme 4.4.5 & 4.4.6*). This finding was evidenced by the type or quality of support accorded to disabled youth. This barrier was found to cut across the

community, even extending to the family level where a disabled youth for example was not involved in household chores (*Theme 4.4.5*). The basic thing was that the youth were excluded from family activities that sometimes they would have loved to be involved in. This occurs because even some disabled youth and their families regard disability as something that incapacitates a person. Ned-Matiwane (2013: 101) observed that the attitude of “exclusion on the basis of disability had a profound effect on the self-esteem and confidence of disabled youth and their families, making them think they are incapable and incompetent”.

WHO (2010c) states that the negative attitude causes disabled youth and their families to feel disempowered and incapable. The theme on *Alienating attitudes (Theme 4.3.5)* revealed that a wheelchair was found to be a symbol of disability and every person using a wheelchair was perceived to have special educational needs. This extended even to some health care providers who would direct the disabled youth on a wheelchair or using crutches to the Disability Office without even enquiring the reason for their visit (*Theme 4.4.5*). According to Sapey et al. (2005: 493), “The wheelchair has long been viewed as a necessary, but undesirable piece of clinical equipment. It is the symbol of disability, despite the fact that only a minority (less than 10%) of disabled people are wheelchair users”. He argues that the dominant image of a person in a wheelchair is of someone who is dependent on others.

Traditional beliefs as well as religious systems also complicated the issues of disability for young people. Data showed that there were many traditional beliefs resulting in some youths refusing to seek help from hospitals (*Theme 4.1*). They believed that they could sort out their impairments by curing them traditionally in order to get rid of witchcraft that they assumed was the cause of their disability. In a study on livelihoods in South Africa, Maart et al (2007) also found that the beliefs and attitudes regarding the causes and nature of disability in a more traditional rural community could result in disabled people experiencing more barriers to participation.

Having discussed the alienating attitudes, CDWs need to be aware of disability services, systems and policies. This is an important ICF environmental factor in accessing livelihoods for disabled youth and is discussed in the following section.

### 5.2.5 CDWs' awareness of disability services, systems and policies.

Duncan et al. (2011:31) reports that “the intention of disability policy is to bring about progressive social change that promotes universal access to resources and opportunities for people with disabilities to participate in society”. Shumba and Taukobong (2009), in a study aimed at identifying policies and programmes that are helping children with special needs in Botswana, acknowledged that there was a policy on special education. However, for the policy and programme to function, there was a need for the government and all stakeholders (such as disabled youth, parents, teachers) to collaborate. There also seems to be a problem of ‘policy evaporation’. According to Albert and Harrison (cited in Ned-Matiwane, 2013:104), “policy evaporation is a problem of implementation and impact failing to reflect policy commitments as policy vanished somewhere between the organisational chain, from formulation through to implementation”. Another author, Dube (2006, cited in Ned-Matiwane, 2013) identified various reasons for poor implementation of disability-related policy at different levels of government. He named them as limited conceptual understanding, poor championship, inadequate arrangements and general lack of capacity. CDWs need to ‘push’ the government to revise the infrastructure and transport regulations and come up with policies that are disability inclusive. Another challenge is not having enough facilities offering rehabilitation services for disabled youth.

Data reported in *Theme 4.4.1* showed that most participants discussed the absence of disability inclusion in policies as a major setback in accessing livelihoods for disabled youth. The CDWs acknowledged that they were not aware of any policies that supported education or employment of disabled youth by the government. Some policies said to be in place were found to be disadvantaging disabled youth: one participant singled out the performance-based management system as one such programme in the policy which was being used by some teachers to discriminate against disabled youth (*Theme 4.4.1*).

Also in *Theme 4.4.3* data revealed that there was inadequate funding from the government to training institutions to enable them support disability training needs. There are however a number of training institutions that are run by NGOs that receive a government grant, such as Cheshire Foundation, Society for the Deaf and Camphill

Rankoromane which also assists disabled youths to gain workplace training and become financially sufficient (Shumba & Taukobong, 2009). Participants suggested that the government needs to increase funding to such NGOs who are partners in youth development that can then become inclusive.

Inaccessible public transport for the disabled population in general was identified as one of the major barriers to livelihoods (*Theme 4.4.2*). Transport is regarded as an important enabler in any effort to fight poverty through enhancing of access to education, employment and social services. The United Nations Children's Fund (UNICEF, 2007) states that public transport imposes limitations for disabled youth to access social services such as schools and employment. The World Report on Disability (WHO & WB, 2011) states that transport systems such as roads, buses, trains and terminals are inaccessible for people with disabilities in many countries. Inaccessible public transport was also identified as a barrier to social and economic development by disabled women in Khayelitsha, a township in South Africa (Lorenzo, 2008), as well as for disabled people who accessed supported employment opportunities in greater Cape Town metropolis (Engelbrecht & Lorenzo, cited in Lorenzo et al., 2012). Public transport, including buses and taxis, are not accessible for use by disabled youths and so many tend not to benefit from government programmes and just stay home (Levers et al., 2008). Many disabled youth have little option but to stay at home because the facilities to transport them either do not exist and/or are unaffordable (Imrie & Kumar, 1998).

Botswana does not have a public transport system that caters for disabled youth and as such disabled youth depend on either the good will of the community or they hire taxis at highly inflated charges. Visually impaired youth are also affected by transport problems as they need someone to guide them to school every day. In a report on a study for social safety nets for people with disabilities in Botswana, Levers et al. (2008) found that public transport, including buses and taxis, were not conducive to use by disabled youth. The report stated that because of this barrier, disabled youth tended not to benefit from government programmes in Kweneng district. It was very expensive for them to take special taxis, which meant they opted to just stay at home and this frustrated them extremely.

The current study's findings on the first theme revealed that there was a severe shortage of trained professionals, especially development practitioners, to attend to the needs of disabled youth through an inclusive approach. This absence is despite the effort made by the Botswana Government through the Ministry of Education to introduce a two-year diploma programme in special education for teachers (Shumba & Taukobong, 2009). This programme is one of many strategies in various ministries the Botswana Government is focusing on in an effort to mainstream disability issues and make them inclusive. In addressing disability inclusion, the Office of the President states on their official website page that "all national programmes and strategies in public and private sectors shall, where appropriate, demonstrate disability-sensitive programming, implementation, monitoring and evaluation so as to eliminate all forms of inequality and discrimination" (Botswana Government, 2015:1).

Despite the many challenges encountered by the CDWs, they were able to use and suggest successful strategies to enhance livelihood opportunities for disabled youth, which is discussed in the next section.

### *5.3 Theme Two: Successful strategies that facilitate livelihood opportunities for disabled youth.*

This theme discusses the effectiveness of CDWs' strategies in trying to facilitate livelihoods for disabled youths. CDWs seem to have effective strategies in some areas, but are not that effective in other areas. This points to important areas that need to be developed in CDWs' training programmes. For this reason recommendations are added at the end of this section on the kinds of training that could be included in CDWs' basic and ongoing training. As with the previous theme, the environmental factors of the International Classification of Functioning, Disability and Health (ICF) provide a framework for interpreting the findings related to successful strategies for enhancing the participation of disabled youth in livelihood opportunities.

#### *5.3.1 Increasing independence and participation through facilitating access to assistive products and technology*

According to the CBR guidelines health domain, access to assistive devices is an important part of any development strategy (WHO, 2010d). Provision of assistive technology is a national as well as an international responsibility and the use of

assistive technology can increase participation. However, in many countries such technology is not available (Borg et al., 2011).

CDWs seemed on the whole effective in facilitating access to assistive devices and a common strategy was to make use of knowledge of existing referral systems. However, they did not always seem to have sufficient knowledge and skills to identify the particular nature of impairments that could benefit from technological intervention. One CDW solicited for the donation of wheelchairs to her community because she saw “disabled youth just crawling in the village” (*Theme 4.2.1*). Yet, another solution for some of these cases might have been surgical intervention to release contractures instead of confinement to a wheelchair.

Making use of internal networks to facilitate access to assistive devices was another strategy used by CDWs. In this study, internal networking involves interacting with fellow CDWs and staff at health facilities, while external networking involves interacting with local government, staff at the Disability Desk in the Office of the State President, donor communities, various ministries such as Health, Transport, Lands and Housing, taxi drivers, traditional leaders, supermarket owners and local parliamentarians. While CDWs seemed to excel in drawing on internal networks, they did not seem to have the same confidence and capacity to interact with all external stakeholders, especially at the level of government. CDWs had challenges in handling external networking at policy levels where they did not seem to be well versed with policy issues. They were however able to interact well with other external stakeholders such as taxi drivers, supermarket owners and the traditional leadership. This inexperience in policy issues when dealing with external networks was evident in the data when CDWs described their difficulties with inadequate public policy around the employment, education or transport of disabled youth (*Theme 4.4.1*).

### *5.3.2 CDWs’ role in facilitating environmental accessibility.*

The Botswana National Policy on Disability (BNPD) states that “the conventional design of infrastructure and other facilities in the built environment, public transport ...hamper reasonable access by people with disabilities” (Botswana Government, 2011:24). The study context is a developing country where natural and human made features as well as rural/semi-rural/urban conditions of the environment are often

intertwined. Despite encountering challenges in facilitating environmental accessibility for disabled youth, the CDWs were able to succeed in building supportive relationships as shown in the following section.

### *5.3.3 Building supportive relationships for disability-inclusive livelihood development.*

One of the strategies in which CDWs were found to be most successful is in building relationships between disabled youth and their immediate families, communities and potential employers through interaction. CDWs were able to facilitate relationships at family and community levels by strengthening family bonds and combating stigma. These relationships were achieved by working closely with individuals and families, giving personal assistance and counseling where necessary and engaging the community (Van Pletzen, Booyens and Lorenzo, 2014). The CDWs' firsthand knowledge and experience of local rural communities equipped them well for this set of tasks (*Theme 1*).

Family members' attitudes of pitying disabled youth and leaving them out of family chores were noted in the findings (*Theme 4.4.5*). This exclusion was due to the perception that disabled youth could not do much and therefore family members needed to protect them. Families of disabled youth had limited knowledge of support services and development opportunities available. Meyiwa (2010) noted that minimal knowledge and information on available opportunities by family members, as well as inadequate skills and government support could limit families in their ability to offer support to their disabled children in accessing livelihood opportunities. Meyiwa's article (2010) and the current study show some similarities. They both show that families have inadequate skills in dealing with disabled youth, as well as limited knowledge about available opportunities and overcoming barriers against a background of inadequate government support. Apart from supporting families in how to deal with disabled youth, CDWs also need to encourage disabled youths to build relationships amongst themselves by learning from each other's experiences and building on positive experiences.

CDWs were successful in facilitating interactions between disabled youth and health-care professionals. Referrals for surgical intervention as well as physical rehabilitation were successfully carried out on various occasions and many of the disabled youth

who underwent the medical procedures were eventually economically empowered (*Theme 4.2.1*).

Building supportive relationships within the families and communities was one of the successes of CDWs. However, supportive relationships require an attitude change in order for the relationship to mature. Below is a discussion on changing attitudes for livelihood inclusion of disabled youths.

#### *5.3.4 Changing attitudes to enhance livelihood opportunities for disabled youth*

The attitudes of society, family and health professionals could impact on the level of physical activity of disabled youth (Van der Ploeg et al., cited in Maart, 2007). Traditional beliefs about disability have a direct impact on the community's behaviour towards disabled youth. The beliefs regarding the causes and nature of disability in a more traditional rural society could result in disabled people experiencing more barriers in terms of attitudes of society (Maart et al., 2007). These beliefs could also prevent disabled people from seeking help. Data from *Theme 4.1* showed that many disabled people were refusing to seek help from health facilities and instead believed that they could be cured through traditional intervention.

Levers et al. (2008) in their study in Botswana found that the social stigma associated with disability results in marginalization and isolation which can lead to the disabled youth begging on the streets as the sole means of survival. Attitudes can also lead to discrimination towards disabled youth that creates a problem for the family members who may feel embarrassed by the disabled family member (Levers et al., 2008).

*Theme 4.2.2* revealed how CDWs seemed to achieve success in building positive and supportive attitudes in families and communities about disabled youth's capacity to participate in education and work. They seemed particularly successful in changing attitudes in families and communities. While CDWs worked directly with family and community members to build up supportive attitudes, they also made use of the media [radio] and traditional leadership structures (e.g. *Kgotla* meetings) to reach families and communities (*Themes 4.3.1* and *4.3.3*).

### *5.3.5 Facilitating implementation of community services, systems and policies for livelihood development of disabled youth*

It is not mandatory for prospective employers to employ disabled people in Botswana. The Botswana Disability Policy is not specific on the employment of disabled people as it only mentions that administrative measures should be taken by various ministries to “employ people with disabilities in the public sector” and also to “promote the employment of people with disabilities in the private sector through appropriate policies and measures” (Botswana Government, 2011:32). CDWs in this study seemed to have some success in making possible job placements for disabled youths. One strategy is networking with various prospective employers that they have done either directly or through the Disability Desk in the Office of the President. The CDWs compile a list of names of disabled youths in each district for possible job placements as well as for government planning purpose (*Theme 4.2.3*). Once the names have been submitted to various prospective employers, the CDWs become the link between disabled youths, prospective employers and disability desk. They also make follow-ups to check on the employment status.

The strategy of facilitating provision of health and educational services to disabled youths through community systems has been a success (*Theme 4.2.1 and 4.2.2*). However, CDWs seemed less successful in facilitating services, systems and policies related to transportation and general social development services. Maart et al. (2007) established that the ability to access health and social services, school or work is largely dependent on the availability and the ability of a disabled person to access transport. Since most services and work opportunities are located in bigger towns, disabled youth found the transport factor to be a major barrier. The CDWs arranged buses to ferry disabled youth to their respective homes during school holidays and also arranged district council transport for referrals to health centres. For disabled youth in day schooling and employment, their families spend substantial amounts of money to meet transport costs by hiring taxis or go through the challenges of using public transport. The CDWs facilitated transport accessibility with limited resources that were availed to them by government or NGOs.

#### *5.4 Limitations of the study*

Due to financial and time constraints, this study was limited to three districts in the southern part of Botswana. The environmental factors might have been different from other regions of the country.

A second limitation is that CDWs tended to have been portrayed as a homogenous group in the study. The scope of the thesis did not allow the researcher to differentiate the roles or level of service of each cadre of worker. Future research should be undertaken to achieve this.

## *Chapter Six: Summary, Recommendations and Conclusion*

This chapter summarises, comes up with recommendations and draws conclusions on the research findings.

### *6.1 Summary*

The aim of this study was to explore the extent to which CDWs are prepared for and able to facilitate the participation of disabled youth in skills development, self-employment, wage employment, financial services and social protection in their work activities in rural Southern Botswana.

Information on disabled youth background, the study areas as well as the research objectives were presented. Literature was reviewed on the relationship between disability and poverty as well as CBR as a vehicle for change. It looked at the role of CDWs in facilitating livelihood opportunities for disabled youth and the barriers they experience in accessing livelihoods. Previous studies presented evidence that disabled youth do not have equal access to health care, education and employment opportunities.

A qualitative research design using an exploratory case study was adopted. CDWs working in Government or NGOs with at least five years' experience were eligible to participate. A purposive sampling method to select seven participants was used. Data was generated through semi-structured individual interviews using an interview guide consisting of open-ended questions. Thematic analysis of data which consisted of verbatim transcripts of audio taped interviews was conducted. The five environmental categories of the ICF, Disability and Health and the CBR livelihood components provided a frame work for analyzing and interpreting the findings. Permission to conduct the study was granted from the UCT's Faculty of Health Sciences Human Ethics Research Committee and the Ministry of Health, Research Unit of Botswana. All ethical requirements were met namely, Autonomy, confidentiality, Beneficence and Non- maleficence, Justice, Referral and Declaration of Helsinki.

In the analysis of findings, five themes emerged from the data and these were:

*Theme 1: Demographic profile, knowledge and experience of participants*

Participants were employed in CBR programmes by either government ministries or NGOs and they all had substantial experience, ranging from 7 to 18 years, with an average of 13 years. All participants had a tertiary qualification [certificate, diploma and degrees] in various health disciplines.

*Theme 2: Practices of CDWs that facilitate livelihood opportunities for disabled youth*

Participants identified a number of elements that facilitated disabled youth's access to livelihoods. They then described a wide range of practices that they engaged in to facilitate livelihood opportunities for disabled youth.

*Theme 3: Strategies of CDWs to facilitate livelihood opportunities for disabled youth*

CDWs used many different methods and strategies in their daily practices. These included using advocacy to facilitate livelihood opportunities; using networking to facilitate participation and access to livelihoods; using the media and *Kgotla* meetings to disseminate information on available resources for disabled youth; using role modeling to promote the employability of disabled youth; making follow-up visits on former students to monitor their livelihoods.

*Theme 4: Barriers to disabled youth's participation in livelihood opportunities*

A number of barriers were identified such as inadequate policy on disability; absence of disability friendly public facilities; a poorly resourced public education system; an inaccessible job market; alienating attitudes to disability and poor dissemination of public information on disability.

*Theme 5: CDWs' suggestions for enhancing disability-inclusive livelihood opportunities*

CDWs identified that there was a need for disability inclusive policies and structures as well as to address the educational training needs of disabled youth. The government also needs to be accountable on disabled youth employment. Furthermore, community sensitization and mobilization were identified to be critical to CBR success.

The Discussion chapter explored the factors necessary in facilitation of disabled youth's participation and inclusion in livelihood opportunities that would foster economic inclusion and independence, namely, environmental accessibility, the provision of assistive devices, family and community support and relationships, supportive attitudes and the need for disability-inclusive services, systems and policies. Successful strategies of CDWs for disabled youth's livelihood development that were identified were facilitating provision of health and educational services, making use of internal networks and building supportive relationships at community level by changing attitudes in families and communities.

It is evident that there is significant neglect in terms of government service provision for disabled youth in almost all areas of livelihood accessibility, especially skills development, wage employment and assistance with self-employment in rural areas. CDWs are well placed to become the driver to livelihood accessibility for disabled youth. They should be empowered with resources in advocacy and communication, community mobilisation and self-help groups in order to remove barriers to participation, especially barriers in the natural and built environment and the exclusion of disabled youth from services, systems and policies.

## *6.2 Recommendations*

In the following section, recommendations will be made on several attainable approaches for CDWs to be more effective in facilitating access for disabled youth to livelihood opportunities, comprising skills development, self-employment, wage employment, financial services and social protection and other CBR elements of Health and Empowerment.

Most generally, the Botswana Government is urged to enforce recommendations of UNCRPD (2006: 19, 20) article 27 on work and employment which states that:

State Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work

environment that is open, inclusive and accessible to persons with disabilities....

In particular, the following areas are singled out, with specific recommendations for added training for CDWs to enhance their ability to support disabled youth in accessing livelihood opportunities.

### *1. Facilitating information about and access to assistive devices and technology:*

CDWs should have modules in their training on identifying common impairments, appropriate referral systems and procedures in accessing various types of assistive devices. CDWs should also get exposure to advocacy work at government and policy levels during their training.

### *2. Minimising barriers to natural and man-made changes to environment:*

While CDWs seemed to realize the importance of advocating for accessible environments such as pavements with ramps, buildings designed with ramps and lifts, they do not seem to have the capacity to influence change at architectural designing level. Therefore they need to be empowered to discuss building requirements with local district council authorities and identify buildings which can be altered to become more accessible, for instance by fitting ramps. CDWs should have a community mobilisation module in their training. They need to receive training in how to educate members of the community such as local store owners to understand that ramps would make a big difference for their businesses – both in getting disabled clients access and making it possible for disabled people to work in the store. The local business owners can then make minor modifications to fit ramps to their buildings at their own costs.

The CDWS have been able to identify the barriers to participation in the natural and built environment. Their confidence to network with service providers who could address these barriers should be part of continuing professional development.

### *3. Building a network of supportive relationships*

CDWs should have modules on advocacy and communication in their training. They also need to advocate for disabled youth from different districts to meet and share

experiences and discuss possible solutions to common challenges. This strategy will be one way of building supportive relationships amongst disabled youth. They should also ensure that disabled youth have adequate information on how to access skills development and access self-employment and wage employment. This will enable them to make a contribution in the family so that they can inspire other disabled youth by being role models.

#### *4. Changing attitudes of the community as well as government leadership:*

CDWs need to conduct community sensitisation and mobilisation regarding the nature of disability in order to change the mindset of people and remove the harmful beliefs about disability that create barriers to their inclusion. This will assist in changing the attitudes of society towards disability. Empowerment of disabled youth through advocacy and communication, community mobilisation, self-help advocacy groups should be encouraged by CDWs. CDWs also need to have access to platforms such as meetings/seminars where they can meet and advocate on disability issues with people in positions of authority. CDWs could also set up a committee that can have consultative meetings with various government ministries on issues pertaining to disabled youth livelihoods.

#### *5. Facilitating implementation of inclusive services, systems and policies:*

On transportation, CDWs are well positioned to identify disabled people with some economic independence to invest in a taxi service that is welcoming and friendly towards disabled people. Disabled youth can also form a cooperative and CDWs can assist in writing business proposals and applying to government for business funding for disability friendly transport businesses. The Botswana Government encourages such business ventures for its citizens through poverty eradication initiatives.

On policies, CDWs need to familiarize themselves with policy issues and assess existing policies, systems, services, and regulatory mechanisms, identifying gaps and priorities to improve provision (WHO, 2011). Where policies do not exist, CDWs should advocate for development of policies, legislation and regulatory mechanisms with relevant government authorities. They also need to have a comprehensive understanding of how to monitor livelihood opportunities for disabled youths. CDWs need to have the confidence or learn to engage with the employers, government leaders

and policy makers in order to make any significant changes in issues that they are failing to articulate. They need to be conversant with policy issues for them to discuss policy. All this can be achievable by tailoring training modules and according them exposure to advocacy work at government and policy levels during their training.

CDWs need to acquire skills of knowing how to remove barriers to participation and create an enabling environment for all to access economic development.

### *6.3 Conclusion*

The study used the ICF environmental factors and the CBR livelihood components as frameworks to discuss the findings. The factors necessary in facilitation of disabled youth's participation and inclusion in livelihood opportunities that would foster economic inclusion and independence are environmental accessibility, the provision of assistive devices, family and community support and relationships, supportive attitudes and the need for disability-inclusive services, systems and policies. Successful strategies for disabled youths livelihood development that were identified were facilitating provision of health and educational services, making use of internal networks and building supportive relationships at community level by changing attitudes in families and communities. The study identified that there is significant neglect in terms of government service provision for disabled youth in almost all areas of livelihood accessibility, especially skills development, wage employment and assistance with self-employment in rural areas. CDWs are well placed to become the driver to livelihood accessibility for disabled youth. They should be empowered with resources in advocacy and communication, community mobilisation and self-help groups in order to remove barriers to participation, especially barriers in the natural and built environment and the exclusion of disabled youth from services, systems and policies. Revision of the training modules for CDWs to include suggestions stated above is therefore recommended.

The Botswana Government is urged to enforce recommendations of UNCRPD (2008) article 27 on work and employment. A review of CDWs' training to incorporate modules such as disability policy, advocacy and communication strategies and community mobilisation is recommended in order for them to be more effective in their work. The WHO (2001) states that the effects that the environmental factors have on the lives of

people with health conditions are varied and complex and it is hoped that future research will lead to better understanding of this interaction.

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## Appendices

### Appendix 1: Information letter for participants

#### University of Cape Town, Faculty of Health Sciences



#### Participant Information letter:

My name is Bryson N. Kabaso. I am a student at the University of Cape Town in South Africa, studying for a Masters in Philosophy in Disability Studies degree. I am conducting a study to explore the role of Community Disability Workers (CDWs) in facilitating economic inclusion of disabled youths in Kgatleng, Kweneng and South East Districts. The aim of the study is to explore the training and work activities of CDWs in facilitating education and employment opportunities for disabled youths in order to identify skills and knowledge needed.

I am kindly asking you to participate in this study because I believe you have rich experience in my research topic. I will be asking you about your experiences as a CDW. If you agree, we will together arrange to meet for approximately one hour for the interview at your place of work or any place that is convenient to you. The interview will be tape recorded with your permission so that I can be able to keep the information without any additions or subtractions to it. If you decide to participate, kindly note the following important ethical considerations:

- There are neither risks nor direct benefits that you get from participating in this study but I hope that the information that you and others give will be useful in influencing policy regarding the work of community disability workers and service provision for disabled youths especially in rural areas.

- There is no remuneration for taking part in this study.
- The decision to participate in this research is entirely voluntary. If at any moment you want to discontinue, you are allowed to do so without any adverse effect on you or your work.
- Confidentiality of your responses will be strictly observed by ensuring that all the information provided is kept confidential and only accessible by me and my research supervisors.
- You have an opportunity to ask questions and have them answered to your satisfaction.
- You will be required to attend one in-depth interview of approximately 1 hour.
- You will also be required to meet with me at a later date for member check to ensure that interpretation of data collected is correct.
- Audio recording the interview is part of the research, and by consenting, you understand that it will be taking place. However, the audio-recording will be used only for the original purpose and will be dealt with the same confidentiality as described above.
- Audio recordings will be stored in the recorder which will be kept under lock and key in my cupboard. The audio recordings will be completely erased five years after completion of the study.
- The interviews will be conducted in English.
- If because of your participation in this assignment you become distressed and need help, proper counselling will be organised for you with a professional Counsellor or Psychologist.
- The audio-taped interview will be written down word-for-word as it happened and will be submitted to the supervisors as part of the research information. You have the right to request for a copy of the interview to read before submission. If for any reason there is information you would not like to be included in the interview anymore you can ask for it to be removed.

Approval for this interview as part of the study will be obtained from the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee telephone number 0027 21 4066338 and the Botswana Ministry of Health.

I have given you all the relevant information but please feel free to contact me or any of the following people in connection with this research;

**Student researcher:**

Bryson Nsama Kabaso (Tel: +267 71396066).

*Email address:* kabasobn@yahoo.com.

*Physical Address:* Princess Marina Hospital,  
Department of Prosthetics & Orthotics,  
Hospital Way, Gaborone. Botswana.

**Research Supervisors:**

1. A/Prof. Theresa Lorenzo. Tel: +27 21 406 6326/ 6534.

*Email Address:* theresa.lorenzo@uct.ac.za

2. A/Prof. Ermien van Pletzen. Tel: +27 21 650 5054

*Email Address:* ermien.vanpletzen@uct.ac.za

**Head of University of Cape Town Faculty of Health Sciences Human Research  
Ethics Committee:**

Prof. Marc Blockman

Tel: +27 21 406 6496

Email: marc.blockman@uct.ac.za

Thank you.

*Appendix 2: Informed Consent Form.*

**University of Cape Town, Faculty of Health Sciences**



**Informed Consent form**

The purpose of the interview has been clearly explained to me by the researcher and I have had a chance to ask questions and have them answered to my satisfaction. I have freely accepted to participate in the study. I am aware that I can change my mind about participating at any time and this will not have any negative effect on me or my work. I have been informed that agreeing to take part in this interview will not be of any personal benefit to me. I have also been told that any information I provide will remain confidential and that this consent form will not be linked to the answers I give. I have been given contact numbers that I may call if I have any questions or problems about the research.

**Consent for audio taping**

I have also been asked for my permission to allow the interview to be tape-recorded so that the researcher has a record of the information that I provide during the interview. I have had the procedures involved in the tape recording explained to me, including how the confidentiality of the information that I provide will be protected, and I am satisfied with the explanation. I therefore agree to give the researcher permission to tape record what I will be saying during the interview session.

_____	_____
Participant's name & signature	Date
_____	_____
Witness' name & signature	Date
_____	_____
Researcher's name & signature	Date

### *Appendix 3: Interview guide for CDW*

1. Please briefly tell me about the type of education and training you have attained as a CDW.
2. What is your knowledge of CBR in relation to supporting livelihoods for disabled youths?
3. What barriers do you encounter in rural environments to developing livelihoods for disabled youths?  
*Probe:* In your opinion, how can these barriers be overcome?
4. What opportunities are there for learning and employment for disabled youths in your rural environment?
5. What is your best experience of working with disabled youths in economic empowerment?
6. What is your worst experience of working with disabled youths in economic empowerment?
7. Kindly explain the skills that you think are required to achieve livelihood opportunities for disabled youths.  
*Probe:* Do you feel that you have been equipped adequately?
8. What influence do you think your role as a CDW has had on assisting disabled youths achieve livelihood learning skills?
9. Are you aware of policies which support learning and employment for disabled youths by the government?  
*Probe:* Are these policies fully implemented?
10. What would you recommend in order to empower disabled youths with skills necessary for achieving livelihood opportunities in your area?

*Appendix 4: Sample of interview transcript with CDW*

R. So really rehabilitation is quite a great great job I should say

*Gil.* And um, I have got... he's now a friend of mine he was involved in a car accident he is a taxi driver. And he had a below knee amputation. We organized to go to Marina Hospital and you performed miracles on that particular guy. You gave him prosthesis and that person is even driving his own taxi.

R. That's good

*Gil.* And every time if he meets me he says hello (laughs) .It motivates you it's even more than the salary! And you walk up tall, you show people aaaah this guy, you see this guy, he has got prosthesis and is walking.

R. Otherwise he could have been wheelchair bound or just seated at home

*Gil.* Yes, yes doing nothing

R. Um, what do you think has been the greatest challenge that you have had to deal with em..., concerning working on disability issues in the community?

*Gil.* Mhmm, the challenges are are are finances, they are finances. The organizations that we are working with they are not well... you find that they don't have the muscle power. You find that the medical equipment is too expensive, sometimes you would want to buy certain medical equipment- you want to use the medical equipment or the occupational therapy equipment it's damn expensive!

R. Mmmm, yes

*Gil.* So sometimes you just have to improvise so the challenge really has been that of finances. And you know with this Aids scourge, finances are being channeled, diverted to the Aids program. Even the government- so.....

Appendix 5: UCT Faculty of Health Sciences Human Research Ethics Committee – Letter of Approval

UNIVERSITY OF CAPE TOWN



Faculty of Health Sciences  
Human Research Ethics Committee  
Room E52-24 Groote Schuur Hospital Old Main Building  
Observatory 7925  
Telephone [021] 406 6338 • Facsimile [021] 406 6411  
e-mail: [shuretta.thomas@uct.ac.za](mailto:shuretta.thomas@uct.ac.za)  
Website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms)

29 May 2013

**HREC REF: 301/2013**

**Mr B Kabaso**  
c/o Prof T Lorenzo  
Health & Rehab  
OMB

Dear Mr Kabaso

**PROJECT TITLE: A STUDY TO EXPLORE THE ROLE OF COMMUNITY DISABILITY WORKERS IN FACILITATING ECONOMIC INCLUSION OF DISABLED YOUTHS IN KGATLENG AND KWENENG DISTRICTS IN BOTSWANA**

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

**Approval is granted for one year till the 15<sup>th</sup> June 2014**

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: [www.health.uct.ac.za/research/humanethics/forms](http://www.health.uct.ac.za/research/humanethics/forms))

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

**Please quote the HREC. REF in all your correspondence.**

Yours sincerely

Signed by candidate

**PROFESSOR M BLOCKMAN**  
**CHAIRPERSON, FHS HUMAN ETHICS**

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.

The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

*Appendix 6: Botswana Human Research Council Ethics approval*

TELEPHONE: 363 2766  
FAX: 391 0647  
TELEGRAMS: RABONGAKA  
TELEX: 2818 CARE BD



Republic of Botswana

MINISTRY OF HEALTH  
PRIVATE BAG 0038  
GABORONE

REF NO: PPME-13/18/1 Vol VIII (215)

23 September 2013

Health Research and Development Division

Notification of IRB Review: New application

Bryson Nsama Kabaso  
P.O. Box 258  
Gaborone

**Protocol Title:** A STUDY TO EXPLORE THE ROLE OF  
COMMUNITY DISABILITY WORKERS IN  
FACILITATING ECONOMIC INCLUSION OF  
DISABLED YOUTHS IN KGATLENG  
KWENENG AND SOUTH EAST DISTRICTS  
IN BOTSWANA

Protocol Sponsor: N/A  
HRU Approval Date: 23 September 2013  
HRU Expiration Date: 22 September 2014  
HRU Review Type: HRU reviewed  
HRU Review Determination: Approved  
Risk Determination: Minimal risk

Dear Sir/Madam

Thank you for submitting a new application for the above referenced study. This approval includes the following:

- Application form
- Proposal
- Data collection tools

This permit does not however give you authority to collect data from the selected sites without prior approval from the management. Consent from the identified individuals should be obtained at all times.

## Appendix 6: Botswana Human Research Council Ethics approval

The research should be conducted as outlined in the approved proposal. Any changes to the approved proposal must be submitted to the Health Research and Development Division in the Ministry of Health for consideration and approval.

Furthermore, you are requested to submit at least one hardcopy and an electronic copy of the report to the Health Research, Ministry of Health within 3 months of completion of the study. Copies should also be submitted to all other relevant authorities.

### Continuing Review

In order to continue work on this study (including data analysis) beyond the expiry date, submit a Continuing Review Form for Approval at least three (3) months prior to the protocol's expiration date. The Continuing Review Form can be obtained from the Health Research Division Office (HRDD), Office No. 9A 10 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). As a courtesy, the HRDD will send you a reminder email about eight (8) weeks before the lapse date, but failure to receive it does not affect your responsibility to submit a timely Continuing Report form.

### Amendments

During the approval period, if you propose any change to the protocol such as its funding source, recruiting materials, or consent documents, you must seek HRDC approval before implementing it. Please summarize the proposed change and the rationale for it in the amendment form available from the Health Research Division Office (HRDD), Office No. 9A 11 or Ministry of Health website: [www.moh.gov.bw](http://www.moh.gov.bw) or can be requested via e-mail from Mr. Kgomotso Motlhanka, e-mail address: [kgmmotlhanka@gov.bw](mailto:kgmmotlhanka@gov.bw). In addition submit three copies of an updated version of your original protocol application showing all proposed changes in bold or "track changes".

### Reporting

Other events which must be reported promptly in writing to the HRDC include:

- Suspension or termination of the protocol by you or the grantor
- Unexpected problems involving risk to subjects or others
- Adverse events, including unanticipated or anticipated but severe physical harm to subjects.

If you have any questions please do not hesitate to contact Mr. P. Khulumani at [pkhulumani@gov.bw](mailto:pkhulumani@gov.bw), Tel +267-3914467 or Lemphi Moremi at [lamoremi@gov.bw](mailto:lamoremi@gov.bw) or Tel: +267-3632466

Thank you for your cooperation and your commitment to the protection of human subjects in research.

Yours faithfully

Signed by candidate

P. Khulumani  
For Permanent Secretary

