

# A Transect Walk to Establish Opportunities and Challenges for Youth with Disabilities in Winterveldt, South Africa

Theresa Lorenzo<sup>1\*</sup>, Jane Motau<sup>2</sup>

1. University of Cape Town, South Africa

2. Odi District, Department of Health, Gauteng, South Africa

## ABSTRACT

*Winterveldt was one of the 9 sites included in a national study to determine the livelihood strategies of youth with disabilities, undertaken by the Occupational Therapy Departments of 6 Universities in South Africa. Community-based rehabilitation (CBR) programmes were initiated in Winterveldt in the 1990s by non-governmental organisations and the Occupational Therapy Department at the University of Limpopo - Medical University of South Africa (MEDUNSA).*

**Purpose:** *This paper describes the use of a Transect Walk to identify aspects of context that contribute to the vulnerability of youth with disabilities with regard to their livelihood strategies.*

**Method:** *Transect Walk was employed as a participatory rapid-appraisal tool to gather data. Convenience sampling was used to identify 11 participants, including three youth with disabilities. Field notes and observations were analysed deductively for themes related to the 5 categories of livelihood assets.*

**Results:** *The findings describe the natural and built environment, the access to health, educational and financial services, and the social attitudes of people in this community towards youth with disabilities. The discussion uses the 5 CBR components as a framework to explore strategies for enhancing the assets of youth with disabilities, namely, empowerment, social, health, education, and livelihood.*

**Conclusions:** *There is significant development that could be maximised if youth with disabilities were aware of their rights and were able to access services and resources. The implication for local government is to create an inclusive environment in which youth with disabilities are able to participate in mainstream youth development opportunities.*

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\* **Corresponding Author:** Theresa Lorenzo, Department of Health and Rehabilitation Sciences, University of Cape Town, South Africa. Email:Theresa.Lorenzo@uct.ac.za

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## INTRODUCTION

The African Youth Charter provides policy structures for youth development and seeks to lift youth out of poverty (African Union, n.d.). Yet, the voice of youth with disabilities is absent. The National Youth Policy outlines a youth development strategy for South Africa, but again the voice of youth with disabilities is not represented (The Presidency, 2009). In 2009, the government established the Ministry for Rural Development and Land Reform, which provides an opportunity for youth with disabilities to lobby for inclusion in development opportunities. Community-based rehabilitation (CBR) has shifted from service delivery to community development, in recognition of the link between poverty and disability (WHO, 2010). It has promoted the use of local resources in improving quality of life and development opportunities for people with disabilities, through a multi-sectoral strategy to facilitate their participation in community-based inclusive development and in reducing poverty (WHO, 2010). The reality is that in the context of poverty and underserved areas, youth with disabilities have to construct livelihoods in many ways. The livelihood strategies used by youth with disabilities in Winterveldt are not known. CBR is a practical strategy to implement the UN Convention on the Rights of Persons with Disabilities by developing and monitoring local action plans. This paper reports on the findings of a Transect Walk done in Winterveldt, to establish the contextual vulnerabilities of and the existing opportunities and challenges for youth with disabilities in relation to their ability to sustain their livelihoods. The Transect Walk is a participatory tool that local government can use to facilitate community participation in the development of action plans and in monitoring their implementation.

### Context of Winterveldt

Winterveldt is a large area in Odi District of the North West Province, one of the 9 provinces in South Africa. In many ways, the community is typical of informal settlements on the periphery of a major 'core' metropolitan area. During the 1960s and 1970s, refugees from neighbouring countries such as Mozambique, Botswana and Zimbabwe moved to the area, hoping to find work in Pretoria. Since the change of government in 1994, significant changes have taken place; so much so

that Winterveldt is no longer considered 'rural', but has become an urban area, with government structures in place for service delivery and development.

In 1996, Nelson Mandela who was the then President, donated a substantial amount of money to Winterveldt for development. The community has changed spectacularly since then. Tared roads are being constructed and 11 public schools were built, including one for children with intellectual disabilities. Fresh water was supplied for the first time; previously, people had to buy water for 20 cents per litre. Now, common water points are available for everybody to access water (Vivian, 1997). Gardens and parks were developed, businesses started up, and people began to see purpose in their daily lives – even crime and violence began to decrease (these are personal experiences of both the authors who have worked in Winterveldt since 1992, and one of whom also lives here).

Today, Winterveldt is divided into a rural northern half and an urban southern half (called Klippan). The population is approximately 800, 000 people (Stats SA Census, 2006), though local sources estimate it to be closer to 1 million. Population densities are much higher in the southern (urban) portion of Winterveldt. In 2007, it was made part of Gauteng Province.

### **Disability and Community-based Rehabilitation in Winterveldt**

Two government health clinics (Kgabo Health Centre and Dube Clinic) were provided with facilities for outpatient and maternity care, including ambulance service. Both facilities offer a fully comprehensive 24-hour service. Mercy Clinic is run by the Catholic Church, and receives a subsidy and medication from the government. Mercy Clinic offers medical services to people with disabilities, but no rehabilitation services. St Peter's Church initiated community-based rehabilitation (CBR) services in Winterveldt in 1990, and sent community members to training courses run by the Institute of Urban Primary Health Care (IUPHC) in Alexander, Johannesburg. The community-based rehabilitation facilitators (CRFs) worked alone until the coordinator at IUPHC approached the Occupational Therapy (OT) Department at the University of Limpopo – MEDUNSA campus. They established CBR services together with the final-year students (Shipham and Meyer, 2002). The lecturing staff assisted with the supervision of three CRFs during their training. The CBR programme addressed the need (of mothers of children with disabilities) for day-care centres, and the establishment of a self-help organisation for adults with disabilities (Shipham and Meyer, 2002). The vision of the programme was to improve the quality of

life of people with disabilities by improving service delivery as well as access to equitable opportunities that would promote and protect the rights of people with disabilities and their family members. Access to education and lifelong learning enhances the fulfilment of potential, promotes a sense of dignity and self-worth, and facilitates participation in society (WHO, 2010). The present CBR programme resources include an audiologist, an occupational therapist, a physiotherapist and three CRFs.

Meyer and Moagi (2000) identified the need for a study to determine the priority needs of mothers of children with disabilities. There seemed to be reluctance on the part of some mothers to participate in the management and running of the day-care centre programmes. The 3 priority needs identified (through use of Venn diagrams) were: education on handling children with disabilities, training in skills to generate an income, and day-care centres and employment. Support groups, sponsors and transport were also identified as 'real' and 'felt' needs. These needs reflect the extent of poverty and unemployment in the area. Meyer and Moagi (2000) found that the need for making money, though hidden, was present in all these needs, as the community had been neglected and deprived for years.

Barriers to participation usually lead to the social isolation or exclusion of those with disabilities. Maart et al (2007) did a study in rural and urban areas in the Eastern and Western Cape in South Africa, on how people with different impairments perceived environmental factors as a major cause of disability. The barriers identified in the urban areas were related to the 'products and technology' category, and the 'natural environment and human-made changes' category. Inadequate provision of mobility and communication devices, and seasonal changes in climate were identified as the most frequent barriers to accessing education and labour. Access to public buildings and housing were other specific barriers. Participants in the rural area experienced barriers in the attitude category with regard to friends, assistance, society and practices, and ideologies. There were an equivalent number of people in the two areas who identified barriers related to the services category. Access to transport was influenced by the nature of the environment: urban areas had roads, and rural areas were hilly and sometimes had rough terrain (Maart et al, 2007). A comparative study of communities in South Africa and India by Coulson et al (2006) identified the key challenge to be improving mobility in home and settlement environments. Affordability of public transport and empowerment of people with impairments who live in

poverty were identified as critical factors that influenced participation. The sustainability of community-based programmes has been influenced by partnerships between communities and higher education institutions in the development of services and related research (Shipham and Meyer, 2002; Lorenzo and Joubert, 2010).

## METHOD

Participatory rural appraisal has been used for research on monitoring policy implementation and disability advocacy (Lorenzo, 2004; Lorenzo and Cloete, 2004). The use of participatory approaches involving community rehabilitation facilitators as research fieldworkers has been found to be valuable (Shipham and Meyer, 2002; Lorenzo, 2005; Lorenzo, 2010). Maart et al (2007) trained people with disabilities as enumerators for a study on environmental barriers to participation in rural and urban contexts. The sustainable livelihoods approach or SLA (DFID, 1999) is a way to understand the main factors that affect people's livelihoods, including the complexities of their environment and how this determines their ability to create livelihoods for their households. Livelihood factors include human assets of education, employment and health, natural assets, physical assets related to the built environment, social assets, and financial assets.

A Transect Walk is a participatory approach that enables the gathering of data, and is normally conducted by a group of local people and visiting professionals (Van Staden et al, 2006). It is a systemic walk along a predetermined route through areas, to gather information about things such as land use, social and economic resources or state of the environment. Chappel and Johannismeier (2009) used a Transect Walk in both rural and urban settings as one participatory method to evaluate the impact of CBR programmes on people with disabilities, their families and their communities in South Africa. They advocate for a participatory approach on the grounds that the needs of people with disabilities are often ignored.

In this study, the purpose of the Transect Walk was firstly to describe the prevailing social environment in Winterveldt and the public's awareness of disability and attitude towards youth with disabilities; and secondly, to identify the challenges and opportunities in the environment that would support the livelihoods of youth with disabilities in terms of natural resources, the built environment, access to services, and access to finances.

## Sample

Convenience sampling was used to select participants who were readily available along the main road, and who were willing to share their understanding of disability and explore the creation of jobs for youth with disabilities. Eleven people, including 3 youth with disabilities who had '*stalletjies*' (stalls selling goods) on the road, were approached by the researchers and agreed to be interviewed.

One limitation of the Transect Walk was that it was carried out in the rain, leaving little time to interview the participants in depth. Also, the sample of participants was limited to people who were on the street, excluding business owners or workers in businesses. 'Invisible' impairments such as youth with cognitive, communication or mental health impairments were not easily identified. Snowballing could be used as researchers could ask participants if they were aware of youth with such impairments. Their selection would be dependent on awareness in the community, as well as the accessibility of information and attitudes towards persons with these impairments.

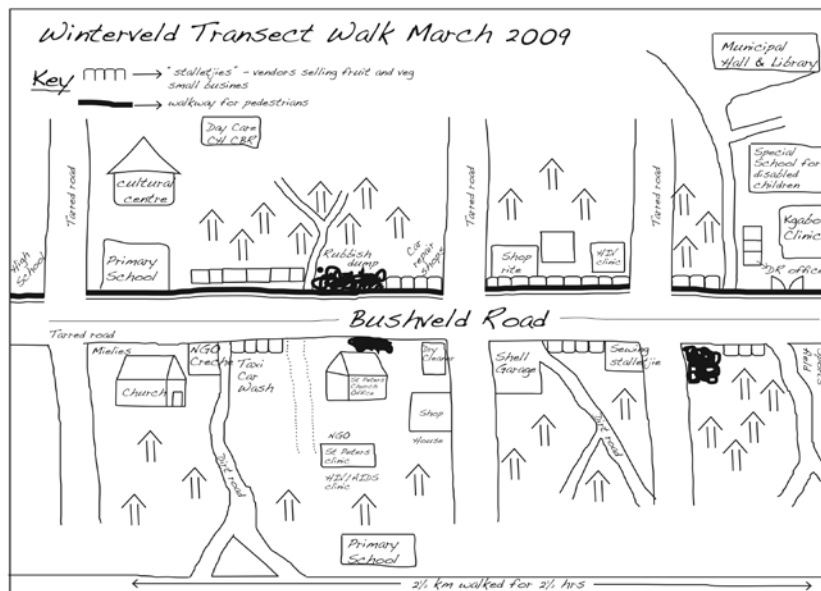
## Data-gathering Tool

Data gathering took place during the day. The process of data gathering stimulates awareness of disabling societal structures that require social change. The Transect Walk covered a distance of 2½ kilometres along the main road in Winterveldt, known as Bushveldt Road. This is a tarred road that leads to the R80 highway. The distance took the interviewers 2½ hours to walk. They were accompanied by 4 people with disabilities or their family members, who identified how communities had changed since the CRF had commenced working in the area.

The researchers were a senior lecturer and supervisor from the Occupational Therapy Department at the University of Limpopo - MEDUNSA, and the senior community rehabilitation facilitator from the Department of Health, who is a resident of Winterveldt. One researcher made field notes of responses given. Four pre-planned questions were identified, namely:

1. Are you aware of any youth with disabilities in Winterveldt, and of their disabilities?
2. Who cares for youth with disabilities? Where?
3. What does the government do for youth with disabilities?
4. What jobs do youth with disabilities do? Do they have the same opportunities as people without disabilities?

Figure 1



The researchers interviewed participants along the main road, which is well structured, with 'stop' signs, information signs and speed humps where necessary (See Figure 1). Along this road, there is an accessible cement side path for passengers and people using wheelchairs. Though this cement path is incomplete, there is ongoing construction work. This particular area of the main road was chosen because it is where most business takes place. It is also the most densely populated area. As it is the oldest section, many of the houses are still built of mud, though some rebuilding in brick has been started. Other information on natural resources, the built environment, access to services, and access to finances was gathered mainly through direct observation of accessibility via roads and entrances to buildings, environmental health risks, development initiatives, and the availability of services in the area where the walk took place.

## Data Analysis

Field notes and observations were analysed deductively for themes related to the 5 categories of livelihood assets. They were categorised into those that afford opportunities to youth with disability, and those that present barriers or challenges in terms of ability of the youth to sustain their livelihoods.

Ethical approval for the study was obtained from the Research and Ethics Committees of the Faculty of Health Sciences, University of Cape Town. To

ensure confidentiality, no particulars of the participants were disclosed. Verbal informed consent was obtained from them.

## RESULTS

There was general openness and a sympathetic attitude towards people with disabilities; no one expressed any aggression or intolerance towards them. Youth with disabilities seem to be known in Winterveldt despite the relative ambiguity of the term 'disabled'. Nearly everybody had seen someone in a wheelchair, walking on crutches, or those "*that are not right in their head*" (people with psychosocial disabilities), and some had seen blind people. Everyone knew of children with disabilities, but there seemed to be extensive ignorance about youth with disabilities. The 3 participants interviewed were youth with disabilities: 2 of them were clients from the CBR programme and knew about services of CBR; the third youth did not know about the available services, but had seen people go in and out of some homes, to take care of people with disabilities. Participants indicated that there is care for people with disabilities at Kgabo Health Centre. The other sources of care they knew about were the HIV/AIDS counselling clinic and NGO, and a special school behind Kgabo Health Centre.

The findings to the 4 questions that are elaborated on relate to the 5 livelihood assets of the sustainable livelihoods approach: natural assets; physical assets; human assets which cover education, health and employment; financial assets; and social assets.

### 1. Natural Assets

'Natural assets' are defined as resources available in the environment, such as land, vegetation, water, and natural energy sources (DFID, 1999). Land in Winterveldt still belongs to the plot owners. Roads become more difficult to use in rainy weather due to gravel and potholes in the few tarred roads. There is significant amount of waste in the environment and one person with mental health impairment was seen filtering through the waste. The water table is high, which provides a valuable resource for garden projects.

### 2. Physical Assets

'Physical capital' refers to infrastructure needed to support a person's livelihood (DFID, 1999).



Brick houses with lovely gardens and patches of lawn are in the majority. At the same time, there are some mud houses with outside toilets. In rainy weather, many of mud houses fall down. Water on tap is still a problem in Winterveldt. Water taps were noticed outside some houses, as well as old, unused water tanks. Water still needs to be carried to the house in containers, and people with disabilities need assistance to do this. In previous years, plot owners owned water tanks and would sell water to their tenants; some dug deep pits in their yards, to draw water. A number of illegal water connections were observed. Electricity is still a problem - there are some areas without this service. Access to services such as public phones was noted. It was evident that one public phone booth was not accessible to people with disabilities.

Access to police services was noted as there is one police station along the main road. Participants indicated that people with disabilities access their social grants at Winterveldt multi-purpose hall which is a pay point for South African Social Services Agency.

The section of road along which the researchers walked had a very good cement path, about 1½ metres wide, on which persons with wheelchairs or walking aids could travel without hindrance. This path is a few kilometres long and is in the process of being extended. The main road is tarred, but roads branching off from it are mainly uneven gravel roads, with a lot of potholes and sand in some areas, making it difficult for people with disabilities, including those with mobility problems who use wheelchairs and crutches. One person who was interviewed mentioned that the side streets are also not in good condition. Some streets are so narrow that vehicles cannot pass through them, and people with wheelchairs cannot move about freely.

Transport is still a major problem for people with disability. Accessibility of public transport presents a major barrier, specifically for those who need to go to clinics and hospitals.

Taxis were observed to be the most common means of transport but are difficult to access. Two participants who were taxi drivers said that they do stop to pick up persons with disability if required to; however, they charge a double fee for those with wheelchairs.

There is awareness of the need for accessibility among those working in or owning shops. On investigation it was found that a mobile ramp is available when needed, to negotiate the very high step at the entrance to the telephone

booth. At one of the plots where the shopkeeper was interviewed, there was even a ramp built at the entrance to the shop. A popular supermarket along the main road is also accessible to people with disabilities. It has made life easier for them as it means they can go shopping without using public transport. Public buildings along the road include a library and a public hall, both of which are accessible to people with disabilities.

Streets lights are installed along the main road; while some function well, there are others that do not. Legal, safe electricity installations for individual households have been available since 2007. Each household can apply for the installation from ESKOM, the national electricity supplier, at a cost of R500 (equivalent to approximately US\$60). This service has reduced the incidence of illegal connections. There appeared to be electrical connections to most houses seen on the walk.

Waste and refuse removal is a problem, even though the municipality delivers containers for storing waste. Garbage patches lie open along the main road; there are no communal containers for garbage. Goats, chickens, dogs and pigs feed on the garbage and wander freely across the busy road. Children also play in the open garbage; this could contribute to infection and disease. A well-known local man with a psychosocial disability has been known to feed himself from the garbage. Clearly, hygiene is still a concern.

There seems to be limited sewerage service. Public toilets have been built by the local government but have no steps, making them inaccessible to people with disabilities. Pit toilets were seen but most of them were also inaccessible. One youth with a disability reported that he could not use the toilet at his house. Only public facilities and registered crèches have flush toilets.

### **3. Human Assets**

'Human capital' refers to skills, knowledge, the ability to work, and good health. These are important for a person's access to income. Education and health are seen as important components of human capital (DFID, 1999). Along the main road, Manamelong primary and Lesolang high schools were noted. The researchers passed through Ratanang crèche and learned that they do accept children with disability. Outside the crèche good play equipment was noticed. Just behind Kgabo Health Clinic there is a special school for children with intellectual disabilities, and there is also a community library. Those who were

interviewed appeared to know about the special school. One of the researchers, a community rehabilitation facilitator, met a community person who knew her and who reported that her sister's child with cerebral palsy was not coping at school. An appointment was made to see the CRF at the clinic.

Regarding health assets, the presence of 5 herbalists were noted. The researchers visited one of them on the main road. He was chatting with his friend who was on crutches after a car accident. The herbalist reported that some people with disabilities consult him. The herbalist's friend reported that he had seen people visiting the homes of people with disabilities, and was aware of the physiotherapy and occupational therapy undergraduate students from MEDUNSA who do practice learning in the community, involving home visits and caring for people with disabilities. Good referral systems are in place, which enhances the wellbeing, trust and security that people with disabilities feel in accessing health services.

The other sources of help that people were aware of were the two HIV/ AIDS counselling non-governmental organisations, also located along the main road. Both offer the service of home-based care, give counselling and run support groups. One NGO is run by professional nurses and has a visiting doctor. The other clinic refers clients to the Kgabo Health Centre. Both dispense ARVs.

The Kgabo Health Centre is the government clinic on the main road. All those interviewed were aware of health and rehabilitation services available at this clinic. Two of the participants were young people with disabilities who knew about the CBR services. One of them was on his way back from the CBR programme, after attending a support group for clients with mental health impairments. Another respondent did not know of any service in Winterveldt for persons with disabilities, but he had seen *"people go in and out of the homes to take care of disabled people in the houses. They were talking also to the families"*. Nearly all those interviewed were aware that rehabilitation services were available at the clinic "down there" (indicating the location of Kgabo Health Centre). People knew they could get medicine there. It is accessible to people with disabilities and to the broader community.

There is also a medical doctor in the same area, with a very busy surgery. This facility benefits those people who can afford to pay for a doctor.

A variety of active informal small businesses exist along the main road: public phones, TV and radio repairs, hair salons, panel beaters, brick-makers, a car wash, second-hand clothing sellers, a bakery, a butcher's shop, carpenters, and

several *spaza* shops (small grocer shops usually in a room or garage within a home). These businesses are accessible, but it is not known what opportunities exist for the employment of youth with disabilities. There are also many small '*stalletjies*'. These makeshift shops consist of wooden tables and corrugated iron or shade-cloth, set up on the pavement. Most of them sell fruit, vegetables and sweets. Some stall owners lay out their produce on plastic sheets on the ground.

The researchers also met 2 youth with disabilities. One was visiting his friend at a *stalletjie*, and suggested that *stalletjies* could be a source of job creation for youth with disabilities. The other has a *stalletjie* on the other side of Winterveldt. Both appeared very motivated to use this opportunity to provide finance for themselves. However, there were many young people loitering around the main road, apparently doing nothing. This indicates that in general, there are few job opportunities for the young population of Winterveldt. The data revealed that the participants did not really understand the question related to job opportunities for youth with disabilities. The researchers had to explain what was meant. Almost everybody answered that youth with disabilities could work if they acquired skills, though they were unsure about their participation in any high-level jobs.

#### 4. Financial Assets

'Financial capital' refers to access to cash or its equivalent for the purpose of engaging in livelihoods (DFID, 1999). Financial services are limited as there are no bank services, banks or ATMs in Winterveldt. However ATMS are available in certain shops such as U-Save Shoprite and there is one at the petrol station. For other transactions, people travel to Mabopane shopping complex, about 10 kilometres away. Taxi drivers said they would transport people with disabilities, but financial expense is sometimes a barrier. Participants are aware of the government social services (SASSA). They mentioned that people with disabilities access their money at the multi-purpose hall. All those interviewed said that the government gives money to those with disabilities: "*They go every month to the big [Winterveldt multi-purpose] hall behind the clinic to get their money*", and, "*That is a good thing*".

Government social services administer the provision of child care grants and disability grants, which helps enormously in changing the lives of individuals. It was evident that many teenagers live alone and carry adult responsibilities, as their parents have died. The public hall is used as a pay point for social grants and for running other multi-purpose tasks. The awareness events run in the

community include disability-awareness campaigns. Participants did not come up with any other suggestions regarding what the government should do for them, or what else is required by people with disabilities.

## 5. Social Assets

'Social assets' are support systems on which people draw in pursuit of their livelihood objectives or what a person relies on to survive, as well as how people make use of free time (DFID, 1999). People socialise in the streets and at the *stalletjies*, some of which are even run by people who have disabilities themselves. Several Pentecostal churches and a Catholic church were to be seen along the main road. Like other people, youth with disabilities also go to churches for support and to worship. The inaccessibility of the recreational facilities used by other people was a barrier for youth with disabilities. These facilities are minimal, which further limits their opportunities to socialise.

## DISCUSSION

The discussion reflects on the findings that emerged from the data gathered during the Transect Walk. The 4 questions proposed for the Transect Walk are explored in greater depth, using the 5 components of the CBR guidelines as a framework for interpretation to address implementation of programmes for community-based inclusive development. CBR is an intersectoral approach that involves health, education, social, livelihoods and empowerment (WHO, 2010). Focussing on these components will also contribute to the achievement of the millennium development goals for youth with disabilities, related to reducing poverty by improving access to health services, education and skills development for employability (Lorenzo et al, 2014).

### Empowerment component – Public awareness of Disability

The empowerment component of the CBR matrix comprises 5 elements: advocacy and communication, community mobilisation, political participation, self-help groups, and DPOs (WHO, 2010). Although the community is aware that people with disabilities exist, they seem to take very little notice of youth with disabilities, appearing to be uninformed about their needs and challenges, and about the opportunities that could be provided for them to live in Winterveldt in a more sustainable manner. Using narrative action-reflection workshops in participatory research with women with disabilities in informal settlements in

Western Cape, Lorenzo et al (2002; Lorenzo, 2010) found that there is potential for raising awareness and networking to overcome a sense of isolation. Rule et al (2006) identified new challenges in implementing CBR, namely, intersectoral collaboration, the need for partnerships, the link between rehabilitation and community development, the nature of grassroots workers, and the need for monitoring and evaluation, and the dissemination of information. The findings of the Transect Walk revealed that these strategies are still relevant for this community.

It is encouraging that schools are integrating disability into their life-orientation curricula, through voluntary work with disabled people's organisations (DPOs) and with CRFs. The notion of citizenship and equal rights for youth with disabilities must be fostered. It is evident that there is a need to test the notion of reciprocal empowerment of stakeholders, rather than just assuming that youth with disabilities need to be empowered. In addition, CBR programmes need to facilitate the political development of youth with disabilities so that they may participate in the democratic processes of elections and advocacy for service delivery.

### **Health and Education components – Access to Clinics and Public Schools**

The health component of the CBR matrix consists of 5 elements: promotion, prevention, medical care, rehabilitation, and assistive devices (WHO, 2010). The findings showed that people are aware of health services available at Kgabo Health Centre. The CBR services seem to be known only to those clients who received or continue to receive rehabilitation. Several non-governmental clinics no longer operate in Winterveldt, including St Peter's, St Joseph's, and Thusong (a preventative clinic focussing mainly on persons with disabilities) which played a major role in rehabilitation of persons with disabilities. They were the first clinics to implement the CBR programme in Winterveldt by identifying persons with disabilities in the community and the need to send people to train as CRFs. Intersectoral collaboration with other units within the clinic should be facilitated. Although not recognised as formal service providers in the district health system, traditional herbalists play a significant role in the health and social support of people with disabilities; therefore it is important to build partnerships with them. The researchers identified the need to educate the medical and nursing fraternity about the needs of youth with disabilities and the importance of referral, as most youth with disabilities attend the clinic for consultations. This need for

continuing professional development was also identified across other sites in the study (Lorenzo and Cramm, 2012).

The 5 elements of the education components of the CBR matrix are: early childhood; primary schooling; secondary and higher schooling; non-formal education; and lifelong learning. The number of schools and crèches in Winterveldt and the facilities they offer have improved enormously. The researchers' findings were that children with disabilities are being integrated into crèches and schools. Provision of meals would also enhance the nutrition and wellbeing of the children, which demonstrates the close link between health promotion and disability prevention. Outdoor equipment adds to the development of children through play, but more needs to be provided in terms of toys for fine motor coordination, and the education of caregivers about the importance of play for development (Ramugondo, 2011). However, the uncertain electricity supply means greater challenges for further education and training of youth, which would generate more awareness and communication with other communities.

### **Livelihoods component – Employment Opportunities and Financial Services**

The 5 elements of the livelihoods cluster of the CBR matrix are: skills development, self-employment, wage employment, financial services and social protection (WHO, 2010). '*Stalletjies*' along the main road indicate that people have initiative and potential, as shown by the development of entrepreneurial opportunities. While youth with disabilities also operate *stalletjies*, most of them were run by adults from Mozambique and Zimbabwe, and only a few by local South Africans. The U-SAVE Shoprite is accessed by both persons with and without disabilities. Food is readily available, as well as hairdressers, shoe repairers, second-hand clothing sellers, car battery chargers, and radio repairers. Given the high rate of unemployment, youth with disabilities could be motivated to start their own small businesses. Different skills they have acquired could also provide other opportunities for employment, and the role of occupational therapists working together with the CRWs would be of great value in this regard (Lorenzo et al, 2014). These experiences confirm the findings of Meyer and Moagi (2000) concerning money being vital to all priority needs that were identified. They found that some families are supported by disability grants "*to have food to eat*". The community seems to have little idea of how they can use natural assets, such as energy sources and land, to benefit the economic empowerment and development of youth with disabilities through agriculture projects.

Yet another major problem facing youth with disabilities in Winterveldt is the inadequacy of financial resources, which is compounded by the inability to gain employment. For a long time, poor people in this community have depended on handouts, creating a culture of dependency.

There is recognition that the government plays a major role by issuing social grants, because the findings showed that people are aware of a pay point behind Kgabo Health Centre for those who receive these grants. Lorenzo et al (2014) found that youth with disabilities have more sources of income compared to youth without disabilities. Issuing of social grants contributes to the alleviation of hunger, which was confirmed through the personal experiences of the researchers who had worked in the community. They found that families with social grants were better off than those without, especially if there was no source of income in the family. In addition, the disability grant is difficult to access, and is inadequate to facilitate economic development (Sierlis and Swartz, 2006; Swartz and Schneider, 2006; Watson et al, 2006).

While it is encouraging that there is an awareness of disability among taxi drivers, who indicated their willingness to accommodate youth with disabilities, the high cost of public transport makes it inaccessible. Lorenzo (2008) reported on how women with disabilities in informal settlements had mobilised to achieve a public transport system that would increase their participation in social and economic development.

### **Social component – Family Life and Community Living**

The 5 elements of the social component of the CBR guidelines are: personal assistance; relationships, marriage and family; culture and arts; recreation, leisure and sport; and justice (WHO, 2010). It is surprising that the Transect Walk revealed so little about the social assets that are accessed by youth with disability. Faith-based organisations and churches provide opportunities for socialisation, especially to find comfort while so many people are dying from HIV/AIDs. The researchers did not sense the nature of the support of family, neighbours and friends. Maybe other participatory methods such as Venn Diagrams and the Wheel of Opportunities would be better to elicit information regarding these assets.

The provision of housing is essential for youth with disabilities to feel part of the community. It is a natural transition for youth to aspire to moving out of the



family home and to start up on their own. Local and provincial governments are providing resources, but they need to be aware of the housing needs of youth with disabilities and their vulnerability in poorly-constructed houses. While Coulson et al (2006) found that water supply is more accessible, sewerage is largely by means of pit latrines which are inaccessible to some youth with disabilities, while others manage somehow.

## CONCLUSION

There is scope in Winterveldt to achieve significant development by maximising whatever assets are already there. Public awareness campaigns, especially about CBR as a strategy for community-based inclusive development, must be organised to facilitate access to schools and health services. Youth with disabilities should be empowered to understand and know their rights, so that they will be able to influence local government to utilise natural resources such as land and accessible water for their development. Inaccessibility of toilets, housing and transport as physical assets must be addressed through infrastructure developments. There is little information about how to engage youth with disabilities in social activities. Recreational facilities need to be made accessible, to accommodate their needs. Attention must be paid to the role of occupational therapy students as part of the CBR team. The findings of this study show that the community has little knowledge about the financial needs of youth with disabilities.

## Implications

A strategy of communication – between the community, key role-players, local government services and development programmes – should be put in place in order for youth with disabilities to be heard and given opportunities to participate in decision-making processes. While the community is aware of youth with disabilities, campaigns should be organised to achieve the continued participation and involvement of all stakeholders in disability issues. The CRFs need to take a lead in this effort. The CRFs need to take a lead in this effort by participating in community stakeholder forums involving the departments from local government together with DPOs and families. They need to organise and take leadership in capacity building to understand disability inclusion as part of community development, with a specific focus on youth with disabilities. More job opportunities should be created and made equally available to youth with disabilities. Accessible public transport needs to be provided to increase participation in all facets of family and community living.

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