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IMPLEMENTATION OF DISABILITY PREVENTION
AND REHABILITATION IN BOTSWANA

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INTRODUCTION

The World Health Organisation has defined rehabilitation as "the combined and co-ordinated use of medical, social, educational and vocational measures for the training or retraining of the individual to the highest possible level of functional ability."

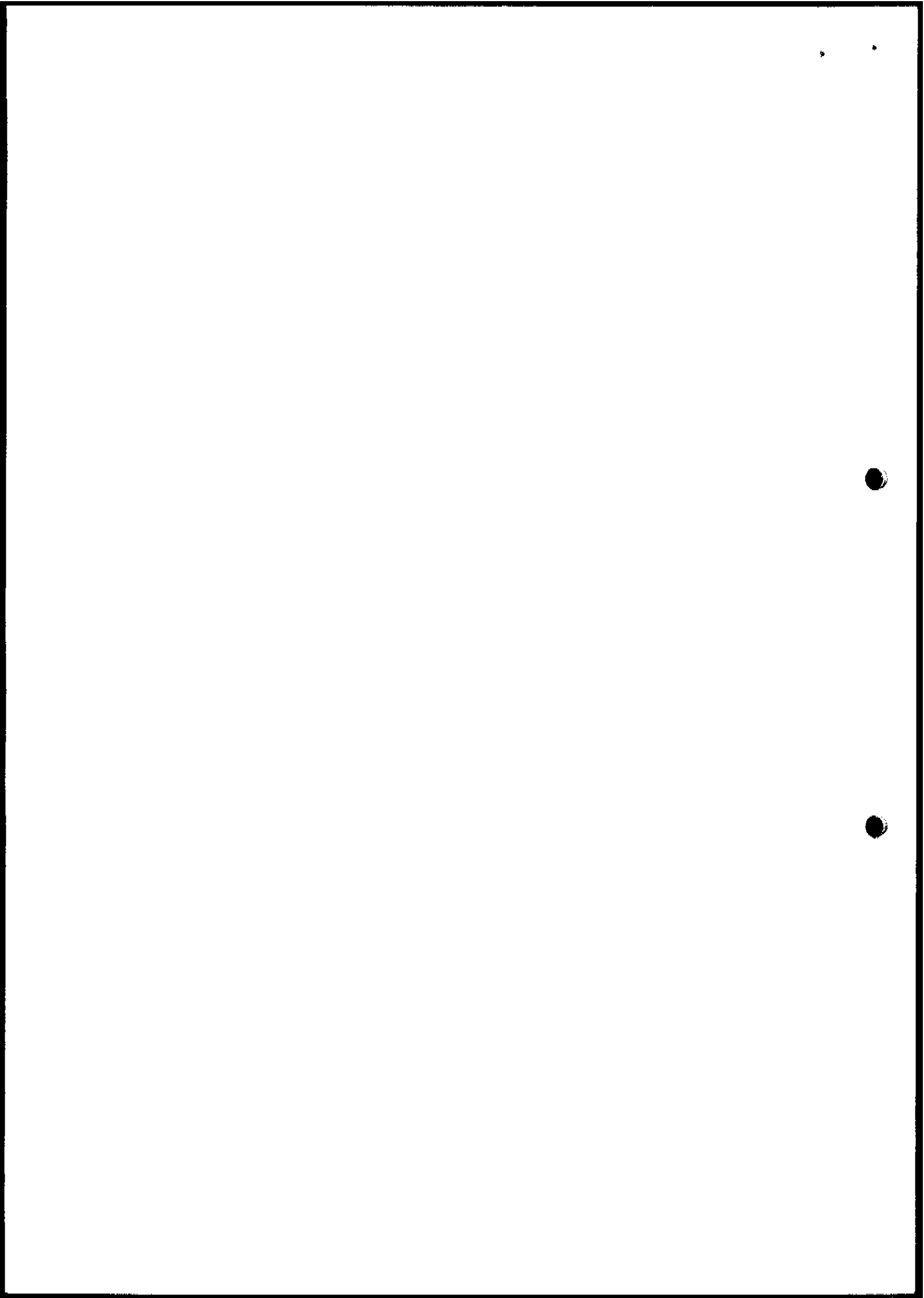
Humanitarian and economic considerations of rehabilitation dictate that every disabled person is a consumer and many of them can become producers and taxpayers if given the opportunity for training and employment. Through rehabilitation the handicapped individual can be prepared to share in family and community development. The Botswana National Development Plan 1973 - 78 declared that: "insufficient attention has been paid to the special problems of the handicapped in Botswana. It is the intention of the Government to seek assistance in the preparation of a programme of detection, care, training and rehabilitation of the disabled or handicapped given the restriction imposed by shortage of personnel and finance."

In pursuance of this objective the Government of the Republic of Botswana commissioned three consultancies in Rehabilitation Services in Botswana. The first of these was by the Assistant Director (Overseas) of the Royal Commonwealth Society for the Blind, Mr. G.E. Salisbury, MBE who compiled a report entitled "Plans for the Handicapped in Botswana" 1975. The second report: "Planning of Community-based Rehabilitation Services in Botswana" was by a WHO Rehabilitation Consultant, Dr. Einar Helander MD., in 1977. The final one was prepared by Mr. Henry Brown, ILO Regional Adviser in Vocational Rehabilitation who presented a report in 1978 entitled "Proposal for a Pilot Programme of Vocational Rehabilitation Services."

2. DISABILITY PROBLEMS

2.1 Size of the Problem

The incidence of disabling conditions in Botswana is not yet accurately known. It is however estimated that about 10% (80 000) of the population of Botswana has medical, social and economic



problems related to disability. During 1976 to mid-1978 the Special Services Unit of the Ministry of Health carried out registration of the handicapped in some areas of Botswana in order to reveal the extent of the problem. The registered cases were broken down into age and sex groups as shown in Table 1 and 2. Analysis of the Tables shows that more men than women were registered, that people over 45 years of age form almost half of the group and that major groups are the physically handicapped 31% and blindness 24%.

The exercise was latter suspended because after sensitizing the people and raising their hopes the Ministry of Health was unable to satisfy their high expectation due to limited facilities, inadequate specialised equipment, financial constraints, insufficient trained manpower to deal with problems of the disabled in the country.

Table 1

Sex and Age Distribution of Registered Handicapped

Age Group	Male	Female	Total	% Distribution
0-5	38	21	59	7
6-14	82	69	151	18
15-18	33	19	52	6
19-30	53	42	95	11
31-45	73	37	110	13
Over 45	206	182	388	45
TOTAL	485	370	855	100
	57%	43%	100%	

Table 2

Registered Handicapped by Group

Group	Male	Female	Total	% Distribution
Blind	153	161	314	24
Deaf	25	47	72	6
Physically Handicapped	236	173	409	31
Mentally Handicapped	116	101	217	17
Dumb	24	12	36	3
Multiple Handicap	137	123	259	20
TOTAL	691	616	1307	100
	53%	47%	100%	

2.2 . Causes of Disability

From the study of the available health statistics and other information the main causes of chronic impairment and disability in Botswana are:-

- (a) Congenital deformities and perinatal disease/Trauma - 1%
- (b) Communicable disease - 3%
- (c) Non-Communicable disease - 2%
- (d) Functional psychiatric disturbances, chronic alcoholism and drug abuse - 2%
- (e) Mental retardation - 1%
- (f) Trauma and injuries -1%
- (g) Other causes - malnutrition, under-nutrition and social derangement (as % of total population involved).

2.3 Future Trends of the Disability Problem

In view of the inadequacy of health statistics and accurate population figures in Botswana any discussions of future trends will have to be based on rough estimates.

Studies done elsewhere show an interrelationship between disability and socio-economic inequities like poverty, lack of education, unemployment, poor environmental conditions social prejudices.

The Botswana Government Strategy for development is based on four main planning objectives viz:-

- rapid economic growth
- social justice
- economic independence
- sustained development.

This strategy has been very successful in generating financial resources which have been reinvested in schools, health services, water supplies, roads and housing. The latest 1979-85 National Development Plan emphasis the complementary themes of employment creation and rural development.

All this development should lead to a decrease in morbidity from communicable diseases and a reduction in the number of disabled persons resulting from diseases like polio, tuberculosis, trachoma, malaria etc.

Modernization with its increasing urbanization and industrialization, as well as socio-cultural derangement should lead to increased disability problems resulting from functional psychiatric disturbances like neurosis, psychosomatic disorders, alcoholism and drug abuse.

With more employment resulting in higher and regular earnings and more purchasing power for mechanical means of transportation has led to increased traffic accidents leaving more and more persons with serious injuries and permanent disability.

3. PRESENT REHABILITATION SERVICES IN BOTSWANA

Interest in the disabled in Botswana dates as far back as 1944. This interest largely concerned the blind. In 1946 the census returns included a section on the totally blind. Blindness and blinding diseases were continually under discussion as documented by a report by Dr. A. Jekl on ophthalmic surgeon, "on Eye Conditions in Northern Bechuanaland" in 1945, a report on "Rehabilitation of the Disabled in Colonial Territories 1945 and sample Surveys by the Royal Commonwealth Society for the Blind carried out in 1966. The deaf, mentally subnormal, the chronic sick or cripples were not mentioned or discussed at all.

Historically the initiative for rehabilitation services in Botswana was by non-governmental organizations which established several institutions for the disabled which were run with the help of foreign staff and funds e.g. School for the Blind in Mochudi, Rehabilitation Centre for the Physically handicapped in Tlokweng, Centre for the Deaf in Ramotswa and Camphill Community at Otse. In the rural areas with strong socio-cultural traditions a lot of time, energy, funds and other resources of family members and others in the community were diverted in order to care or compensate for the limitations of various types of disabled persons who were often hidden at home.

As mentioned previously the Botswana Government became concerned with the problems of the handicapped/disabled in the early 1970's and decided to seek some advice on the care of the handicapped. The Royal Commonwealth Society for the Blind on request appointed its Assistant Director, Mr. G.E. Salisbury as a Consultant with the following terms of reference:

- (a) Identify the main priorities in planning an overall scheme for the severely disabled,
- (b) make proposals which can be incorporated into the National Development Plan,
- (c) suggest the relationship between Government Ministries and Departments and set out ways of co-ordinating their

efforts,

- (d) to outline the manpower implications in the creation of a Cadre of staff capable of dealing with the disabled and to assess as far as possible financial commitments.

The Salisbury Report entitled "Plans For The Handicapped in Botswana" was presented to the Government with the following key proposals:-

- (i) That Government should accept that it has a responsibility for the severely disabled and should therefore allocate funds to assist them,
- (ii) that this responsibility be discharged by creating a co-ordinating body, an interministerial special services unit for the handicapped under the direction of a Commissioner preferably in the Office of the President but alternatively if this is not practicable, in either the Ministry of Health or the Ministry responsible for Community Development and Social Services. The report recommended staff training and establishment of the following pilot projects: Deaf Units, Blind Units, mentally handicapped units, physically disabled units, integrated vocational training - using Brigades and Botswana Enterprises Development Unit, an Orthopaedic Workshop to produce and service aids and appliances and an Audiological Centre.

The Report also emphasised that while Government can do much, the community and family of the severely handicapped had a major part to play as well. The Report further stressed that the prevention of disabling diseases was to be given top priority.

The Government accepted the Salisbury Report and at the beginning of 1975 a Commissioner for the Handicapped was appointed and a Special Services Unit for the handicapped was established in the Ministry of Health. Mr. G.E. Salisbury returned to Botswana for a further six months during which he trained ten social workers and oriented them to work with the handicapped including understanding classification of handicaps and their various causes. He also ran a one month course for six primary school teachers starting March 1976 - orienting them into special education of handicapped children, particularly education of the blind.

The work of the Special Services Unit as proposed by Salisbury Report and summarised in the Annual Report for 1976 is as follows:-

- a) Co-ordinate policy and ensure that every section dealing with the handicapped is aware of official line of approach,
- b) liaise closely with local organisation for the handicapped,
- c) maintain intimate contact with the disabled and parents of disabled children so that their views and feelings are considered,
- d) maintain contact with overseas organisations interested in the handicapped,
- e) maintain, in collaboration with the Health and Social Welfare authorities a register of the disabled.

Mr. Salisbury's Report had several useful recommendations which the Government of Botswana implemented. The establishment of the Special Services Unit in the Ministry of Health and under the direction of a Commissioner proved extremely useful in avoiding the usual division of the administrative responsibilities for the rehabilitation between a multitude of government ministries. His recommended division of responsibilities between the Ministries of Health, Education, Labour and Home Affairs, Commerce, Agriculture and Local Government and Lands underscored the complex multifaced nature of disability prevention and rehabilitation.

Some of the main weaknesses of the Report concern the traditional establishment of separate comprehensive rehabilitation centres and specialised institutions for certain disability groups which may be needed only when the volume of severe or specialised cases in the population justifies such tertiary care; with its highly trained professional personnel. The exact budgetary implications of some of his recommendations seem to have been underestimated. Mr. Salisbury's guidelines for the long-term development also relate to institutional care, special education, specialists etc. which would involve very high costs indeed.

It was in this context that in 1977 the Botswana Government requested WHO to provide a consultant to:

- i) review the present facilities for rehabilitation in the country and their activities, and
- ii) prepare recommendations to guide the Government in improving and further developing the already ongoing activities in the field of rehabilitation.

The Government's favoured option was to provide care through a system of community-based rehabilitation, where the basic needs of most disabled persons can be met more economically through primary health care workers (F.W.E.) supervised and guided by multipurpose rehabilitation professionals integrated into local health teams and with emphasis on community and family participation. The WHO consultant, Dr. E. Helander, presented a Report entitled "Planning Of Community-Based Rehabilitation in Botswana" which outlined the details of the development of services, manpower and implementation of a community-based rehabilitation programme.

Dr. Helander's Report endorsed some of Mr. Salisbury's recommendation like the establishment of a Council for the Handicapped (Council for Rehabilitation) provision of orthopaedic corrective surgery. While recognising the need for development of referral services he however, departed from Salisbury Report in discouraging major expansion of specialised centres in view of their very high costs.

Dr. Helander suggested that in order to meet the specific needs of the country the rehabilitation officer should be trained in diagnostic, therapeutic, technical, educational, vocational and social skills and located at the village level so that he/she can train the disabled in the community and be able to make regular follow-up. In order to do this effectively there was a need for WHO to develop a manual for "Training The Disabled In The Community." Such a manual has been developed and Botswana was one of the countries where the manual was field tested.

In February, 1978 the Republic of Botswana became a full member of the International Labour Organisation. Towards the end of the same year Mr. Henry W. Brown, ILO Regional Adviser in Vocational Rehabilitation visited Botswana to assist the Ministry of Labour and Home Affairs on how

they can consolidate Vocational Rehabilitation of Disabled Persons in accordance with Recommendation No. 99 of the International Labour Organization concerning Vocational Rehabilitation of the Disabled (1955). Following a seminar attended by various interested groups on the subject Mr. Brown produced a report entitled "Proposal For a Pilot Programme of Vocational Rehabilitation Services" in Botswana.

One of the ILO Resolutions passed in 1975 urged Member States to provide for:-

- (i) The integration of disabled or handicapped persons in the general training or employment schemes,
- (ii) special services and support for the severely disabled or handicapped.

The proposals outlined in Mr. Brown's Report were intended to put into effect those parts of the above International Declaration which were not yet fully implemented in Botswana and particularly the provision of vocational and social guidance, vocational training, selective job placement and other rehabilitation measures.

The proposed scheme was to make maximum use of existing resources in the community such as training and employment facilities and consider new facilities only where non presently exist. It was to be a community-based programme of services starting initially in the capital city and extending throughout the Republic.

4. NATIONAL POLICIES AND PROGRAMMES

The Government considers it important to prevent disabling conditions and provide rehabilitation as part and parcel of primary health care and in such a way as to accomplish a meaningful integration of disabled persons into their society or community.

4.2 Preventative Measure

During the National Development III and IV the Ministry of Health's main objective was the strengthening of basic health services equitably distributed for all people, but with an emphasis on rural and peri-urban areas. In practical terms, this meant the establishment of a network of health facilities which could begin to provide comprehensive health service to the people throughout the country. This objective was achieved with a network of health posts, clinics,

health centres, and hospitals which provide reasonable access to health services to about 85% - 90% of the settled population of the country.

This was followed by more emphasis being given to the quality of the service provided which was achieved through the establishment of special programme units working together in a fully integrated pattern into the basic health services. To mention some of these units: Health Education Unit and MCH/ Family Planning, Nutrition Unit, Communicable Disease and Epidemiology, Environmental Sanitation, Prevention of Blindness, Dental Health, Mental Health and Occupational Health Programmes.

4.3 Special Education Centres

a) Mochudi School for the Blind

The activities of the Centre started in 1969 and are administered by the D.R.M. Hospital in Mochudi. There are two types of activities; a school for the blind and a vocational training centre for blind adults.

As soon as the children have learnt Braille, they join normal school classes, and participate in these to a large extent,

b) Ramotswa School for the Deaf

Planning for the Centre started in 1972. They opened with six pupils in 1979. The Centre has an audiological technician and three teachers. Pupils receive pocket type hearing aids. The programme is run by the Ramotswa Society for the Deaf and is partly financed by Christoffel Blinden Mission in West Germany.

c) Camphill Community Rankoromane

The Centre opened in 1974 with 20 physically and mentally handicapped children. The activities closely follow the Waldorf System. The school follows the syllabus of ordinary primary schools and children live with able-bodied community members.

4.4 Vocational Guidance Institutions and Centres

The Botswana Red Cross Society has played significant role in Rehabilitation Services providing orthopaedic appliances etc. helping children with congenital heart defects.

Their Tlamelong Rehabilitation Centre caters for 20 physically disabled persons. The aim is to give them training in crafts so that at the end of two years trainees can find employment or set up their own workshops.

The Kanye Red Cross Branch has a similar programme in Kanye Village which caters for about 12 physically disabled persons.

The Society is planning to embark upon an impression community-based rehabilitation scheme in accordance with Government Policy and in collaboration with the League of Red Cross Societies and the Norwegian Red Cross.

4.5 Other Partners In Rehabilitation

- a) Barclays Bank of Botswana is willing to employ blind persons as telephonists if trained. The Bank itself has trained one in South Africa,
- b) The Lions Club has established a Crippled Children's Scholarship fund to pay school fees for children whose parents are unable to meet the school fees,
- c) Other Service Clubs like the Rotary Club have identified programmes for the disabled for their fund raising activities.

5. NATIONAL CO-ORDINATION AND FINANCING OF REHABILITATION SERVICES

The Botswana Government recognises disability as an economic and social challenge which demands action. It further supports the various Resolutions passed by the U.N. General Assembly and its specialised agencies like WHO and ILO on the Rights of the Disabled persons. It was in this context and in recognition of the Late President's great services to Botswana and in view of the expressed wishes of many people to donate money for a useful purpose associated with his name, that Government decided to open a Seretse Khama Memorial Fund whose proceeds will be used for assisting Batswana who are handicapped. As an indication of the importance that

Government attached to the Fund it donated P100,000 to open the Fund and since then donations have been pouring in from several quarters.

Although the primary responsibility for Disability prevention and rehabilitation was assigned to the Ministry of Health it was considered desirable to establish a National Co-ordinating body namely the National Council for the Handicapped which was formed in February, 1981. The Council acts as the overall co-ordinating body in all matters relating to the handicapped in Botswana. It advises the Government and non-governmental organisations on policies, programmes, plans and all matters affecting the welfare, education, training, rehabilitation, health and employment of the handicapped.

The membership of the Council consists of:-

- a) Ministries of Health, Education, Local Government and Lands and Home Affairs (Labour),
- b) the Special Services Unit for the Handicapped,
- c) such registered Societies or otherwise legally recognised Voluntary bodies, organisations or agencies whose constitutions or by-laws include direct services to the handicapped. At present in the Council these are:
 - (i) Camphill Community
 - (ii) Mochudi Resource and Rehabilitation Centre for the Blind
 - (iii) Ramotswa Society for the Deaf
 - (iv) Botswana Society of the Handicapped.

6. FIELD TESTING OF THE MANUAL "TRAINING THE DISABLED IN THE COMMUNITY"

Botswana started field testing the manual end of October 1979 - in Serowe and Palapye. The programme was introduced by a WHO consultant, Mrs. Padmani Mendis who is a tutor of physiotherapy in her home Sri Lanka.

When the programme started, the Special Services Unit for the Handicapped in co-operation with the Serowe Regional Health Team organised a workshop for the WHO consultant to orientate those who were going to participate in field-testing the manual. It had been decided that the manual should be field-tested by Family Welfare Educators in Serowe and Palapye; also, with the active participation of the Social Welfare Officer for the handicapped in Serowe. A three days workshop was held in Serowe from

22nd to 24th October, 1979 - participants during the first day were: the Commissioner for the Handicapped, four Regional Social Welfare Officers for the Handicapped, one Psychiatric nurse, two Public Health nurses and one Physiotherapist; the Family Welfare Educators joined for the second and third days.

The manual consists of guides and booklets. The guides contain material for those who work with the handicapped/disabled in the community like local supervisors, community leaders and teachers. A guide for policy makers is not yet available. The booklets contain training material for the disabled or family members of the disabled prepared for people with:-

- fits

hearing difficulties
learning difficulties
moving difficulties
seeing difficulties
speech difficulties
strange behaviour.

The aim is to improve and promote physical, educational and vocational potentialities and independence for the disabled. The emphasis is on using family members to train their disabled; also, encourage community participation.

On the 30th November, there was a one day seminar to discuss the experiences on the programme. Since this was a new approach by family welfare educators, they found it a challenging task and felt it was too much for them. They spent more time on the handicapped cases selected (each family welfare educator was asked to select two cases to start with) than before because they had to explain what the programme was all about and to get trainers where a family member was not willing to do the training and where there was no family member to do it. They found all this time consuming, more so that they walked to do home visits and also do a lot of nursing care in the clinics, not exactly the purpose they are intended for. The language in which the manual is written discouraged some readers and beneficiaries. The Family Welfare Educators were asked to each take one new case every month and it was agreed that the evaluation of the programme should be six monthly.

On the 26th June, 1980, another evaluation meeting was held in Serowe. There were presentations on cases processed by Family Welfare Educators of Serowe and Palapye; also, those processed by the Social Welfare Officer for the Handicapped in Serowe.

The following were comments, suggestions and conclusions made:-

a) Problems Met

- i) Reading the manual by those who did not understand English, some of them felt it a strain and thus ignored it,
- ii) Finding neighbours or volunteers as trainers was not easy, most of them felt bothered,
- iii) Some family members also felt it a bother to be asked to train their disabled,
- iv) Self-pity from parents of disabled children with self-blame; also, traditional beliefs of not wanting to interfere with God's will "He has made him/her disabled, how can you change him?"
- v) Not finding trainers at times during home visits because they had gone to the lands or cattle posts. Transportation difficulties also facilitated this problem since trainers could not be followed up at the lands. Most families do not have telephones and therefore making appointments was not possible,
- vi) Rejection of handicapped children by some school teachers. Some schools accepted disabled children for this year 1980,
- vii) Poverty amongst families with handicapped persons. Although local authorities have poor relief funds, they cover very small numbers and there are no programmes for able-bodied destitutes where they could be employed or occupied to produce food for their consumption or earn some money for survival,
- viii) Tight schedules of Family Welfare Educators in the clinics.

b) Problems that could not be overcome

- i) Children who are severely mentally retarded could not be helped since there are no institutions for such cases in the country,
- ii) The life-styles of Batswana to go to the cattle posts and lands at seasonal intervals,

iii) Traditional beliefs - to change people's attitudes.

c) Suggestions to Overcome Problems Experienced

- i) Educational programmes for parents, teachers and the community. It was strongly felt that an element of special education be included in the teacher training,
- ii) Financial support to families with handicapped persons.
- iii) Emotional support to families with disabled persons to relieve them of the stress or tension of self-blame and other problems shouldered through regular visits and information to the public to motivate the community to participate in the care of the disabled,
- iv) Translation of the manual into Setswana. N.B. We have been notified that funds are available from WHO for the translation and printing of the manual but the money has not yet reached us,
- v) Increasing Family Welfare Educators so that they could visit their clients regularly. Also increasing Social Workers for the handicapped as they are secondary level supervisors,
- vi) Introducing parents support groups,
- vii) Availability of adequate transport.

d) Suggestions to Improve the Manual

- i) Placing more emphasis on the case or patient to first see a doctor, audiologist ophthalmologist or either specialist before training is begun,
- ii) Sign language should be more in cultural context.

7. CONCLUSION

This paper reviews the development of disability prevention and rehabilitation services in Botswana - their objectives, organisation, management and co-ordination.