

Empowerment for the mitigation against the adverse effects of Disaster and HIV/AIDS among People Living with Disability in Botswana

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ABSTRACT

The global village is overwhelmed by disasters coupled with other threats such as HIV and AIDS which continue to challenge human populations, in particular people living with disability. This review explores ways in which this group of the population in Botswana can be empowered to mitigate the adverse effects of disasters. Evidence from the authors' work in this field as well as existing literature is used to support some of the arguments raised. The main tenet is that people living with disabilities in Botswana are secondary targets of services and programmes and they are not adequately empowered. The work highlights several methods of increasing resilience to disaster situations and related challenges for this population group to include among others the inclusion of people living with disability in disaster risk management to enable them to reduce their vulnerability and build their capacity. There is need for community based capacity building (special training), comprehensive disaster related information to suit people living with disability and HIV and AIDS, and designing relevant early warning systems.

Keywords: *Disaster, people living with disability, HIV/AIDS, empowerment*

INTRODUCTION

Disasters in general have become serious global threats that cannot be overlooked by any group of people. International and regional strategies, frameworks, and programmes have been developed to guide and build capacity against disasters. The United Nations Organization, the Red Cross and Red Crescent movements, and other organizations have taken the lead in building safety and resilience in threatened communities. These efforts, however, seem to marginalize special populations that are more vulnerable to disasters through circumstances beyond their control. People living with disabilities and chronic illnesses frequently find themselves in threatening situations. In this regard, disaster interventions cannot be considered as comprehensive and inclusive when some doubly vulnerable groups are excluded. Disasters affect all categories of people including the young, the elderly, the sick, women and children, people living with disability, and the economically deprived. The World Bank (2004) states that 600 million people worldwide were living with physical sensory (deafness, or blindness), intellectual or mental health impairment significant enough to make a difference in their daily lives. These individuals are not immune from disasters of whatever type in their communities. It is projected that 80

per cent of the 600 million live in developing countries (International Federation of the Red Cross and Red Crescent Societies (IFRC), 2007). By nature of their disability they are particularly vulnerable and suffer frequently serious harm from disasters that further complicates their socio-economic condition. Furthermore, HIV (which makes people more vulnerable to various health hazards) has affected 60 million people worldwide some of whom live with disability. In addition, over 95 per cent of people living with HIV and AIDS reside in low and middle income countries. Each day, it is estimated that 14,000 new infections occur worldwide of which more than 50 per cent are young people below the age of twenty-five (World Bank, 2003). HIV is a health hazard with the ability to decimate the workforce, create large numbers of orphans, exacerbate poverty and inequality, and put tremendous pressure on health and social services (World Bank, 2003). In Botswana, according to the 2008 Botswana HIV and AIDS Impact Survey III (BIAS III) conducted by the Central Statistics Office (2009), the national prevalence rate of HIV was 17.6 per cent compared to 17.1 per cent (BIAS II survey of 2004) while the national incident rate was 2.9 per cent. The BIAS IV survey is on-going and results are expected to be published soon. Therefore, disaster incidents increase the complexity of challenges faced by those who are HIV positive and living with disability. World Health Organisation (2005) states that the number of persons with disabilities is increased by new generations of survivors with amputations, spinal cord injuries, head trauma, multiple fractures, and mental illness. This study is hence designed to explore various ways people living with disability in Botswana can be empowered to mitigate against the adverse effects of disaster and HIV/AIDS.

The relationship between disaster, disability, and HIV and AIDS

Disasters, disability, and HIV and AIDS place humanity at varying levels of vulnerability within socio-economic environments. It is intriguing that the combination of these and the complexity that exists between them is taken for granted and remains subtle. Natural and human induced disasters cause irreparable psychological damage and injuries that result in permanent disfigurement and worsen conditions for those already disabled and living with HIV and AIDS (Harding, 2007). The common disaster hazards in Botswana are droughts, flooding, windstorms, wild land fires, motor vehicle accidents, structural fires, pest infestation, HIV & AIDS, animal diseases, other epidemics, and asylum seeker / illegal immigrants' influx, strong winds, and transport accidents (United Nations Development Programme, 2009; EM-DAT, 2009; International Resource Group, 2001).

Although there are arguments surrounding the classification of disasters into two, man-made and natural, experts believe that all disasters result from human behaviour in related geo-physical environments. Therefore, a disaster occurs when natural or technological hazards have an impact on human beings and their environment (IFRC, 2000). Kellenberg and Mobarak (2008) argue that natural disasters worldwide killed an estimated 2.69 million people and caused US\$955 billion in economic damages between 1970 and 2001, with losses twenty times larger in developing countries. The most common disaster in Botswana is drought. However, in the year 2000 there was a cyclone which

originated from the Mozambique Channel that resulted in the heaviest floods ever recorded in the history of the country (International Resource Group, 2001). Continually, Botswana has experienced 14 natural disasters from the period of 1980 to 2010 with 95.5 per cent of the people reported to be killed by the epidemic while 4.5 per cent in that period were killed by floods. Similarly, 84.8 per cent of the people were affected by drought, while 12.4 per cent were affected by flood, and 2.8 per cent were by epidemics (EM-DAT, 2009.) The availability of economic and social resources in developed countries enables those affected to withstand more successfully the effects of a hazardous event or process than poorer populations in developing societies. Furthermore, the poor are vulnerable to disasters because they have fewer resources and less capacity to prevent or cope with the impacts (United Nations Environment and Policy (UNEP), 2002).

Disasters do not only cause economic hardship but also social and health related problems. Rock and Corbin (2007) argue that major disasters of any kind cause a multiplicity of social and economic difficulties and wreak havoc in the lives of individuals, families, and communities. This cannot be over emphasized for people living with disabilities who are HIV positive and already suffering prejudice, discrimination, and stigmatization. Disability includes mental retardation, visual and hearing impairment, communication disorder, learning difficulties, and cerebral palsy, which affect not only the person's physical and intellectual functioning but also their interaction with others (Armando, Morales and Sheafor, 2011). Disability makes people more vulnerable to hazards than those considered 'normal.' The vulnerability results from their physiological and intellectual limitations and their dependence on significant others for survival. Human vulnerability refers to a condition or process resulting from physical, social, economic, and environmental factors which determine the likelihood and scale of damage from the impact of a given hazard (United Nations Development Programme, 2008).

The situation in Mozambique, for instance, confirms that, though discrimination and stigma take their toll, poverty and disability reduce the dignity and the autonomy of the people (Disability and Development Partners, 2008). The concern is that discrimination of people living with disabilities multiplies the barriers they have to deal with in order to live a normal day-to-day life. Gender discrimination exposes women and children living with disability to suffer more from disasters and HIV and AIDS than other groups. The Botswana Millennium Development Goals (MDG) Report (2007) states that poor households are made vulnerable to hunger by inflation which erodes real incomes of farmers which enables them to subsist in poor seasons. Amongst the poor and vulnerable groups in Botswana are people living with disability as, according to Handicap International (2006), people living with disability are highly over- represented among the poor with about 82 per cent living below the poverty line.

The IFRC World Disaster Report (2007) states that disasters do not discriminate but affect minorities and majorities, the able-bodied and persons with disabilities, young and old, men and women. According to Kajeju (2013), in Botswana, the rate of people living with moderate or severe disability is estimated to be 11 to 15 per cent or 58,716 to 96,125 of the entire population of about 2 million. However, the effects on the disabled

exacerbate their already compromised situation. The World Bank (2004) finds that disabled persons are among the poorest and most stigmatized and marginalized of all the world's citizens. Furthermore, conditions related to poverty like poor nutrition and lack of access to health services or safe living and working conditions, create disabilities that can occur from birth to old age. As a result poverty is considered a cause and consequence of disability (Handicap International, 2006). Human immunodeficiency virus (HIV) that is spread most commonly by having unprotected sexual intercourse with an infected partner can enter the body through the lining of the vaginal, vulva, penis, rectum or mouth during sexual contact (Pelchen-Matthews, Kramer, & Marsh, 2003). There are several myths in Botswana regarding people with disabilities and the belief that they do not have sexual feelings, cannot lead a full and productive life, they are dependant, and always need help. As a result, there is a great deal of stigma and discrimination with the society.

Those living with disabilities who are HIV positive are marginalized or pushed to the extreme of communal living (IFRC, 2007). This is worsened by the fact of being poor and suffering the aftermath of disasters like windstorms and floods. Auxter (2008) states that people with disabilities are vulnerable to HIV because they are economically disadvantaged. Many of them do not work and are not provided with government assistance. Although there is a large amount of research on HIV and AIDS, there are limited numbers of studies on the effects of disaster, disability, and HIV on special populations. As a result there are no statistics in Botswana on people with disabilities who are HIV positive. There are two categories of people living with disability, which are, those who acquire HIV and need treatment and HIV positive people who acquire disability as a result of being infected. During a disaster evacuation, people living with disability who are HIV positive are usually not included amongst the most vulnerable. Their medication may get lost or omitted in the emergency list and they may not have access to food and water which may lead to poor nutrition and medication adherence failure (IFRC, 2007).

Due to their limited mobility they are most likely to be left behind due to inaccessible facilities and transportation systems that do not cater for their disability. As a result of family break up during disasters community home-based care and community-care rehabilitation become the only hope for the people living with disability who are HIV positive. Economic vulnerability is a major determinant of HIV and AIDS prevalence amongst people living with disability. Their possible low economic status and exposure to disasters and HIV are critical factors for consideration in risk reduction and need to be accordingly assessed and addressed. The susceptibility to poverty for disabled persons is related to barriers to knowledge and participation in the economic development of their communities. As such, there is an interface between discrimination and abuse because of gender, age, language, colour, race, culture, disability, disease (including HIV status), and geographic location (Asian Development Bank, 2005). Gender mainstreaming in poverty reduction is critical because poverty impacts differently on women and men, in particular when coupled with crises and HIV and AIDS. Vision 2016 Council (2009) expects Botswana, by 2016, to be discrimination-free society in relation to religion, language, ethnic origin, and disability or misfortune yet the policies are not reflecting the philosophical

principles. The reduction of risk and vulnerability to disasters and HIV for special populations increases their capacity and resilience to hazards that threaten their lives. The vulnerability is reduced by addressing gender discrimination and poverty while protecting those with special needs and providing education and awareness on how they could be supported. In this case, women living with disability who are HIV positive have special needs to a greater extent than men of the same status. This should be taken into account in the design of community based and national disaster programmes and services intended to build their capacity.

The challenges of disasters, HIV and AIDS, and disability

HIV and AIDS present a number of challenges to the infected and affected biologically, socially, economically, and technologically. This is worsened when the person is living with multiple disabilities and family members are ill-equipped to assist him or her to manage the challenge. At times, the condition may be economically draining, making it difficult for the family or carer to provide for other needs. Disability outside HIV is characterized by complex social and economic factors that the person should confront and overcome in a positive manner. For example, stigma, discrimination, illiteracy, poverty, unemployment, and marginalization are common features in society.

Wisner (2002) states that people with disabilities have additional situational characteristics that could increase their vulnerability to harm and loss in, for instance, an earthquake and its aftermath:¹ These include: lower income than the non-disabled; living in unreinforced, low-rental buildings near urban centres; and living outside care-giving institutions such as nursing homes or halfway houses with no legislated obligations to prepare for emergencies; living inside care giving institutions which may lack features designed to enhance the safety of residents such as provision for safe evacuation, non-structural hazard mitigation, reserve water, and power supplies; and living on their own. In consequence, they suffer the social distance or stigma associated with being labelled 'disabled' or 'sick' in a society valuing self-sufficiency and independence.

United Nations Office for the Coordination of the Humanitarian Affairs (UNOCHA) (2009) shows that in 2008 there were 104 internationally reported disasters and 99 % were climate related. In addition, the number of people in Africa affected by natural disasters annually doubled between 1988 and 2008 from 9 million to 16.7 million. Drought accounts for 75 per cent of these disasters on the continent and it decreases grain yields and causes the extinction of several plants and animal species. UNOCHA (2009) reported that floods washed away 230, 000 hectares of crops and left nearly 8 million people food insecure as well as at heightened vulnerability. In Angola, 60 people were killed, 220,000 affected, 81,000 displaced, and about 4,000 houses were destroyed. These reports do not show whether these people were living with physical or any other form of disability. In either case, it is difficult to know with certainty which population group was seriously affected because the figures put together people living with disability who are HIV positive and all others. Botswana formulated a disaster policy in 1996 with the mandate to provide guidelines for all sectors and institutional levels to implement disaster preparedness and emergency response. However, active participation of all the sectors including the private sector and

non-governmental organisations is a challenge. There is no specific legislation to support the implementation of disaster risk reduction (Office of the President, 2010) hence no measures and guidelines are in place to assist people living with disability who are HIV positive.

Empowerment Status for people living with disability in Botswana

Services to people living with disabilities were pioneered and provided by non-governmental and community based organizations supported by the Ministry of Health through the Botswana Council for the Disabled (BCD). One other measure that the Botswana Government took was the establishment of the Special Services Unit under the Ministry of Health which provided disabled people with: social welfare services such as community based rehabilitation in the form of wheelchairs, hearing tests and hearing aids, physiotherapy, and occupational therapy. Botswana adopted the 1982 World Health Organization Programme of Action Concerning Disabled Persons to “provide international and national measures to ensure the full participation of disabled people in social life and the development of their societies” with emphasis on prevention, rehabilitation, and equalization of opportunities. It encourages disabled persons to organize themselves in order to be heard according to Resolution No. 37/52 adopted by the General Assembly on December 3, 1982. A national policy on care for people with disability was approved and adopted by government in 1996 after the advent of HIV & AIDS. However, it does not cover issues of HIV& AIDS and disasters (Botswana Ministry of Health, 1996).

In addition, the Botswana Council for the Disabled was established in 1985 to coordinate services provided by the civic society organisations to people living with disability and to advocate on their behalf. According to University of Botswana (2009) the purpose of the council is the overall coordination of associations/organizations involved with the welfare of people with disabilities as well as the promotion of associations/organizations of and for people with disabilities and monitoring of their activities. Its objectives are:

- i To advocate on behalf of people with disabilities
- ii Promote standards within its member organizations so as to encourage quality programming for people with disabilities
- iii Undertake regular visits to its members to discuss, advise and assist where necessary
- iv Advocate to secure funding for its members from government
- v Publish a quarterly newsletter
- vi Organize workshops for its member organizations
- vii Undertake regular visits to its members to discuss, advise and assist

However, about 66.2 per cent of disabled people live in rural areas where services are limited or do not exist at all. In a report to the Southern Africa Federation, Obed (1998) states that although Botswana has a disability policy, the actual services did not reach people with disabilities because of inadequate resources. There is a need to consider treating psycho-emotional impairment arising from disaster, especially post-traumatic stress disorder (PTSD) (Davidson and McFarlane, 2006; Priestley and Hemingway, 2007). It is the key to effective recovery from disaster because of its link to physical safety and survival.

Disasters are events that challenge the individual's adaptive capacity often leading to adverse mental health outcomes. Moreover, taking antiretroviral therapy has been found to result in clinical fatigue which can cause depression complicated by the effects of being disabled. When disabled people are HIV positive and faced with disaster hazards, there is a heightened possibility of non-adherence to antiretroviral therapy (Rasmussen *et al.* 2011; Ferrando *et al.*, 1998). HIV & AIDS and disaster policies do not address challenges faced by those who experience disaster and public transport that does not accommodate people with disabilities. There are still architectural and design barriers, limited access to information for the visually impaired and the deaf, and no recreational and training facilities specifically for people living with disability to deal with disasters.

Pudulogong Rehabilitation Centre in Mochudi and Camphill Trust in Otse are two centres working with children with disability which were visited to obtain information about services for people living with disability. Podulogong is a rehabilitation centre for children living with disability, especially the blind and the deaf. It does not have a comprehensive disaster, disability and HIV & AIDS programme and a multifaceted policy to address the issues. However, it has a draft health and safety policy that focuses on domestic fire hazards and related risks but does not include other hazards like flood and heavy rain.

The centre has safety measures to improve signs to alert its community on hazards threatening their lives especially when such dangers arise within the school. It must develop protocols for travelling outside the centre which must be clearly communicated when students are on trips. The routes should be clearly marked so that they can be appropriately approved. The centre needs disaster risk management system and a preparedness plan. There is need for suitable signs for visually impaired people to indicate areas of potential danger and alert them when there are disasters on campus through use of a siren. However, these processes does not cater for students with hearing impairment and hence remain at risk to disasters.

The centre has an HIV & AIDS programme for people with disability which includes the AIDS club providing peer-to-peer counselling, male circumcision for students, and workshops supported by the National AIDS Coordinating Agency and the Botswana Family Welfare Association to educate both students and staff members on HIV & AIDS issues as well as sexual reproductive health; Translation of information from District Multi-Sectoral AIDS Committees and readable for students is made available; HIV & AIDS lessons are part of the school curriculums; and condom distribution on campus for students is provided. It was affirmed that 100% of students underwent HIV counselling and testing in the current year (2013). Camphill Trust has a school for young people living with physical disabilities and a disaster preparedness committee which was formed after a fire outbreak in the school kitchen in 2011. However, the committee is not trained on disaster risk reduction except for fire outbreaks. It does not have a disaster policy to guide action and preparedness, and lacks knowledge on related processes. Once in a while a fire drill is conducted and a whistle is blown to assess school responsiveness. In the past teachers and students used to respond to the whistle but currently they do not take it seriously. Some of the efforts include keeping updated fire extinguishers, classrooms equipped with

smoke alarms, and emergency exit burglar bars which are easily removable by children. However, only 4 of the 15 teachers had been trained in first aid in 2011. The school needs first aid and disaster risk reduction training. HIV & AIDS is included in the school curriculum as a topic unlike disaster risk reduction. Guidance and counseling classes extensively cover HIV & AIDS although there is little on HIV & AIDS and disability.

CONCLUSION AND RECOMMENDATIONS

Disaster risk reduction is meant to decrease people's vulnerability and increase their appreciation of self-worth and control of their own destiny. This can be done through community based disaster approaches. The approach should positively discriminate in favour of special populations because of their vulnerability. These are people living with disability who are HIV positive including children, the elderly, expectant mothers, and pregnant women. It should not be assumed that these people are immune from HIV and disasters. They are in fact, possibly more susceptible due to the circumstances of their lives. They need special preparedness and response packages which will include maintenance of healthy lifestyles. These interventions should seek to reduce the burden on people living with disability from societal and cultural practices that exacerbate their marginalization/vulnerability to disasters. There is need for educational awareness, training, and mitigation measures for this special population group based on their special needs. The educational material should be in a language that they understand and that enables them to act in a timely manner. This will reduce dependence and enhance life skills for those living with disability.

The inadequate levels of community preparedness for disaster in Botswana call for disaster profiling at local levels and a design of community based disaster risk reduction which will lead to capacity building at International Resource Group (2001). These initiatives must be inclusive of people living with disability to militate against disaster related challenges. A community based approach is appropriate for Botswana which works with the government to develop inclusive policies and practices. Disability is not an inevitable consequence of physical and cognitive impairment and, similarly, disaster is not an inevitable natural hazard (Priestley and Hemingway, 2007). There is need for a capacity building programme for disabled persons that prepares them to be resilient to disaster and to enhance their participation in community development. A community based approach considers the community as the primary focus of attention. It intends to correct the top-down approach in development planning and disaster risk management which incorporates knowledge of neglected local needs and appreciates the potential of indigenous resources and capacities (Mmatli, 2007; Maripe and Maundeni, 2010; Victoria, 2008). The inclusion of people living with disability in disaster risk management would enable them to reduce their vulnerability and build their capacity. There is a need for synergy between community home-based care, community-based rehabilitation, and community based disaster risk reduction to ensure that people living with disability who are HIV positive receive optimal service delivery.

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