Chapter 2

Botswana

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After reading this chapter you should be able to:

- Identify core strategies that are the focus of Botswana's workplace health promotion efforts
- Describe Botswana's historical evolution of workplace health promotion
- Explain the different approaches employed by corporate health promotion efforts throughout Botswana
- Review the central disease states and health issues driving Botswana's health promotion needs
- Name the components of, and the associated funding sources for, Botswana's healthcare system
- Discuss the impact of culture on Botswana's health status and health promotion efforts

Table 2-1 Select Key Demographic and Economic Indicators

Nationality	Noun: Motswana (singular), Batswana (plural) Adjective: Motswana (singular), Batswana (plural)
Ethnic groups	Tswana (or Setswana) 79%, Kalanga 11%, Basarwa 3%, other, including Kgalagadi and white 7%
Religion	Christian 71.6%, Badimo 6%, other 1.4%, unspecified 0.4%, none 20.6% (2001 census)
Language	Setswana 78.2%, Kalanga 7.9%, Sekgalagadi 2.8%, English 2.1% (official), other 8.6%, unspecified 0.4% (2001 census)
Literacy	Definition: age 15 and over can read and write Total population: 81.2% Male: 80.4% Female: 81.8% (2003 est.)
Education expenditure	8.7% of GDP (2007) Country comparison to the world: 10

continued

Table 2-1 **Select Key Demographic and Economic Indicators,** *continued*

Government type	Parliamentary republic
Environment	Overgrazing; desertification; limited fresh water resources
Country mass	Total: 581,730 sq km Country comparison to the world: 47 Land: 566,730 sq km Water: 15,000 sq km
Population	1,990,876 Country comparison to the world: 147
Age structure	0–14 years: 34.8% (male 352,399/female 340,058) 15–64 years: 61.4% (male 613,714/female 608,003) 65 years and over: 3.9% (male 31,155/female 45,547) (2010 est.)
Median age	Total: 22 years Male: 21.8 years Female: 22.1 years (2010 est.)
Population growth rate	1.937% (2010 est.) Country comparison to the world: 83
Birth rate	22.89 births/1,000 population (2010 est.) Country comparison to the world: 83
Death rate	8.52 deaths/1,000 population (July 2010 est.) Country comparison to the world: 92
Net migration rate	5 migrant(s)/1,000 population Country comparison to the world: 21 *Note:* there is an increasing flow of Zimbabweans into South Africa and Botswana in search of better economic opportunities (2010 est.)
Urbanization	Urban population: 60% of total population (2008) rate of urbanization: 2.5% annual rate of change (2005–2010 est.)
Gender ratio	At birth: 1.03 male(s)/female Under 15 years: 1.04 male(s)/female 15–64 years: 1.01 male(s)/female 65 years and over: 0.68 male(s)/female Total population: 1 male(s)/female (2010 est.)
Infant mortality rate	Total: 12.59 deaths/1,000 live births Country comparison to the world: 141 Male: 13.43 deaths/1,000 live births Female: 11.73 deaths/1,000 live births (2010 est.)

continued

Table 2-1 **Select Key Demographic and Economic Indicators,** *continued*	
Life expectancy	Total population: 61.85 years Country comparison to the world: 178 Male: 61.72 years Female: 61.99 years (2010 est.)
Total fertility rate	2.54 children born/woman (2010 est.) Country comparison to the world: 90
GDP—purchasing power	$24.14 billion (2009 est.)
Parity	Country comparison to the world: 111
GDP—per capita	$12,800 (2009 est.) Country comparison to the world: 86
GDP—composition by sector	Agriculture: 2.3% Industry: 45.8% (including 36% mining) Services: 51.9% (2008 est.)
Agriculture—products	Livestock, sorghum, maize, millet, beans, sunflowers, groundnuts
Industries	Diamonds, copper, nickel, salt, soda ash, potash, livestock processing, textiles
Labor force participation	685,300 formal sector employees (2007) Country comparison to the world: 151
Unemployment rate	7.5% (2007 est.) Country comparison to the world: 69
Industrial production growth rate	-19.9% (2009 est.) Country comparison to the world: 161
Distribution of family income (GINI index)	63 (1993) Country comparison to the world: 4
Investment (gross fixed)	26.7% of GDP (2009 est.) Country comparison to the world: 39
Public debt	17.9% of GDP (2009 est.) Country comparison to the world: 107
Market value of publicly traded shares	$4.283 billion (December 31, 2009) Country comparison to the world: 87
Current account balance	$-758 million (2009 est.) Country comparison to the world: 124
Debt (external)	$1.651 billion (December 31, 2009 est.) Country comparison to the world: 134
Debt as a % of GDP	———

continued

Table 2-1 **Select Key Demographic and Economic Indicators,** *continued*

Exports	$3.382 billion (2009 est.) Country comparison to the world: 120
Exports—commodities	Diamonds, copper, nickel, soda ash, meat, textiles
Export—partners	NA
Imports	$4.24 billion (2009 est.) Country comparison to the world: 126
Import—commodities	Foodstuffs, machinery, electrical goods, transport equipment, textiles, fuel and petroleum products, wood and paper products, metal and metal products
Import—partners	NA
Stock of direct foreign investment at	
Home	NA
Abroad	NA

Source: CIA. (2010). *The world factbook*. Retrieved August 31, 2010, from www.cia.gov

Introduction

Botswana, a former British protectorate, became independent in 1966 and has since been a bastion and role model of democracy in Africa. Since independence, there has been uninterrupted civilian government, which prides itself on the rule of law and respect for human dignity. The main occupations are mining and agrarian farming. However, tourism is fast becoming a major income earner, with Botswana boasting of thousands of kilometers of nature reserves and wildlife areas.

While Botswana arguably has one of the highest rates of HIV and AIDS in the world (CIA, 2009), it has embarked on one of Africa's, if not the world's, most progressive, comprehensive, and ambitious programs in dealing with the pandemic. The healthcare system and the democratic system of governance have been described as an African success story and an enviable model by international organizations and acknowledged world leaders. The government of Botswana has made significant progress in its fight against HIV/AIDS. For example, Botswana was the first country in Africa to provide universal access to antiretroviral treatment and to implement routine HIV counseling and testing in all its health services. Not only are people living with HIV/AIDS being targeted and encouraged to use these services, but pregnant mothers are routinely tested and those infected are taken through prevention of mother-to-child

transmission therapy. For the last 15 years, HIV/AIDS has been the major issue, both politically and healthwise, in Botswana, and this is reflected in its central place in Botswana health care and workplace health promotion (WHP) issues.

Botswana is a landlocked country sharing international borders with Namibia, South Africa, and Zimbabwe. The climate is semiarid, and over 85% of the land lies within the Kalahari Desert. The population was 1.327 million in 1991 and 1.681 million in 2001, with females accounting for 52% of the population. The projected population for 2010 was 1.8 million (Botswana Central Statistics Office, 2009a).

Prevailing Health Issues and Risk Behaviors

Botswana is currently experiencing one of the most severe HIV/AIDS epidemics in the world. The country's adult HIV prevalence of 24.1% (UNAIDS, 2006) is arguably one of the highest in the world. According to the Second Generation Sentinel Surveillance 2007 results, HIV prevalence among pregnant women 15–49 was 33.4% (Botswana NACA, 2008). However, the 2008 Botswana AIDS impact survey III (BAIS) data indicated a national prevalence rate of 17.6% with females recording substantially higher rates than males as in the previous years. Also, the prevalence rates are higher among urban dwellers than among village dwellers. The incidence rate of new HIV and AIDS infections for the country is 2.9% (Botswana Central Statistics Office, 2009b). According to this recently released HIV and AIDS update, the HIV prevalence by age group ranged from 2.2% in the 1.5–4.0 years group to 40.6% in the 40–44 years age group. It was also observed that the prevalence increased with age and peaked between the 30 and 45 years (see Table 2-2).

Table 2-2 **Comparing BAIS* II of 2004 and BAIS III of 2008 Results**

	HIV prevalence (percent of total population by age)	
Age (yrs)	**2004**	**2008**
1.5–4.0	6.3	2.2
5.0–9.0	6.0	4.7
10.0–14.0	3.9	3.5
15.0–19.0	6.5	3.7
20.0–24.0	19.0	12.3
25.0–29.0	33.0	25.9
30.0–34.0	40.2	39.7
35.0–39.0	35.9	40.5

continued

Table 2-2 **Comparing BAIS* II of 2004 and BAIS III of 2008 Results,** *continued*

40.0–44.0	30.3	40.6
45.0–49.0	29.4	29.8
50.0–54.0	20.9	24.8
55.0–59.0	14.0	22.8
60.0–64.0	12.0	15.4
65.0+	6.8	10.4
Total	17.1	17.6

* BAIS: Botswana AIDS Impact Survey, a 3-year surveillance and evaluation (Botswana Central Statistics Office, 2009b).

Molomo (2008) aptly presented AIDS as a development issue because it reverses all the gains and projections of national development. The impact of HIV and AIDS on individual and national development in Botswana has been immense. One of the major effects of HIV and AIDS is on the population size. The projected population for 2021 is expected to be nearly 18% lower than it would be in the absence of the pandemic, and the number of deaths is expected to double (Government of Botswana Country Report, 2007). Accompanying the increased number of deaths would be an estimated fourfold increase in the number of orphans.

The average life expectancy is declining instead of rising as projected. Although the average life expectancy of Batswana was expected to reach 67 years in 2000–2005, it was reprojected to fall to 41 years in this period (SADC, 1998). Indeed, average life expectancy fell from 66.8 years in 1996 to 47.4 years in 1999 (UNDP, 1999). Yet, in the last 15 years, Botswana has been one of the top countries in Africa with the highest and fastest growing economy and human development index (UNDP, 1999). According to Botswana NACA (2008), HIV and AIDS contributed 49% of the fall in national growth, with reduced productivity growth contributing 31% and reduced supply of labor, 20%.

Unfortunately, the people of Botswana do not seem to be reciprocating government efforts in combating the HIV and AIDS pandemic. Although government efforts and the provision of antiretroviral treatment have reduced the number of AIDS deaths by half (Botswana NACA, 2008), the current adult prevalence of 25.7% and the number of new infections still occurring every year pose serious challenges for the future. It would appear that young citizens, in particular, are finding it difficult to adapt their lifestyle, especially related to alcohol use and sexual relationships. However, the current estimate is a far cry from the prevalence of 36% in 2000. According to the *Daily News*, the official government daily newspaper, this put Botswana on top of the world's HIV/AIDS chart ("Residents welcome home based care programme,"

2000). The *Mmegi*, a Botswana daily newspaper, in its editorial opinion on World AIDS Day in 2009, lamented that challenges lie ahead in the country's seemingly endless battle against the pandemic ("Our anti-HIV/AIDS," 2009). It listed continuing alcohol abuse and high-risk sexual behavior as major challenges that need to be tackled from the bottom.

The Motswana, Physical Inactivity, and Productivity

The average Motswana is largely sedentary as an adult; most view physical activities as a child's preoccupation. Many observations and reports have been made on the low work output and productivity of Batswana workers (Lloyd 1999; Ministry of Health, 1996; Owolabi & Shaibu, 1999). The popular saying that "in Botswana, there is no hurry," aptly attests to this fact. It may indeed be a reflection or manifestation of the low physical fitness level of the average Motswana. Studies conducted on Batswana youths reported lower levels of physical fitness when compared with their counterparts in other countries (Corlett, 1984a, 1984b; Owolabi, unpublished data). This tendency not to want to exert oneself at work or to tire easily, although frequently attributed to a negative mindset toward work and poor motivation from within and without, may be caused by low physical fitness level more than other factors. In a recent study widely reported in national newspapers (Kesaobaka, 2009), it was found that Batswana citizens recorded worry and high levels of overweight and obesity. A study of public department employees who are at risk of metabolic syndrome also showed concerning results (see Table 2-3).

Table 2-3 **Risk of Metabolic Syndrome Among Sampled Government Employees in Botswana**

Variable	Benchmark	Male	Female	Total
SBP (systolic blood pressure)(mmHg)	> 140	25.1 (21.7)*	9.5 (18.4)	17.3 (20.05)
DBP (diastolic blood pressure) (mmHg)	> 90	25.0 (32.9)	14.3 (37.1)	19.7 (35.0)
Underweight	BMI = 18.00	0 (6.3)	0 (3.5)	0.0 (4.9)
Overweight	BMI = 25–29.4	31.2 (40.0)	33.4 (32.3)	32.3 (36.2)
Obese	BMI > 30	16.6 (9.1)	33.3 (34.9)	24.9 (22.0)
Waist circumference	M = 1.00 m; F = 0.87 m	20.1 (14.9)	38.1 (59.5)	29.2 (37.3)
% Body fat	M = 20; F = 25	12.0 (14.7)	15.2 (18.8)	13.6 (16.8)

* % of government employees (% of volunteer public samples 6 months earlier.

In a 3-year study by Owolabi and Keetile (2007), it was concluded that there was a high prevalence of overweight, obesity, and blood pressure among urban Batswana men and women. The females tend to be more obese, while the men tend to have higher systolic blood pressure. Waist circumference is highly related to BMI and blood pressure in both males and females ($p < 0.001$). Using the criteria of at least three cardiovascular disease risks, Owolabi and Keetile concluded that there is a low prevalence of metabolic syndrome.

In addition to lack of regular physical exercise and sports, the low physical fitness of the average Motswana might have been compounded by the popularity of excessive alcohol consumption as a recreational activity. In two studies (Kgosiemang, 2004; Ramatlala, 2002) carried out among university students, over 80% of sampled students across all age groups and gender viewed drinking alcohol and sexual activity as recreational. There is an urgent need for advocacy, legislation, encouragement, and enlightenment campaigns to promote physical activity for all.

Healthcare System

The Batswana government is the main provider of health services and facilities through the Ministry of Health, with missionaries, the mining industry, and private/commercial health institutions complementing government health care. Health care is delivered through a decentralized system. The healthcare system in Botswana is based on three tiers: primary, secondary, and tertiary. The primary and secondary levels are located across all villages, towns, and rural communities; whereas the tertiary level is comprised of referral centers located in the cities of Gaborone (the national capital) and Francistown. Botswana has an extensive network of health facilities comprising hospitals, clinics, health posts (local, village-based health centers), and mobile health stops, all spread around 24 health districts (Botswana Central Statistics Office, 2007). Nationally, 84% of the population is within a 5 kilometer radius from the nearest health facility, while another 11% is within a 5–11 kilometer radius. In the urban centers, however, 96% of the residents are within a 5 kilometer radius from the nearest health facility.

Botswana's government provides necessary services for communities. Both preventive and curative care is provided for every form of health problem—communicable and noncommunicable, prevalent and the rare—and for the risk factors of many diseases. In 2006, 7.2% of GDP was spent on health services (World Health Organization, 2006).

Considering that the majority of the adult population is employed, the government of Botswana is motivating public and private organizations to set up health and wellness units within their structures and to lead by example. The health and wellness units are staffed by qualified health professionals. Furthermore, most of these organizations organize regular workshops and symposia for the various cadres of employees, focusing particularly on how to reduce the rate of new HIV infections and motivating safe and healthy behavior. Health professional

associations have also been making a special contribution in this regard. Religious organizations and places of worship, such as churches and mosques, are also involved in the efforts of health promotion, particularly on matters relating to HIV and AIDS.

The government backs up its health efforts with legislation and policies, devoting a lot of its efforts and expenses on health promotion. This emphasis on health promotion percolates to every government department, as well as parastatals and private organizations. Most employers or corporate bodies tend to have a health and wellness, occupational health, or staff welfare department or unit, in addition to fully staffed and equipped medical facilities for first aid and emergencies. Furthermore, government and other employers contribute about 50% to the healthcare costs of individual employees and their families through a health insurance scheme. For some employing organizations, the contributions may be as high as 80%.

In the last 15 years, health promotion efforts have been put into education, community development, policy, and legislation. These efforts aim to prevent and control communicable and noncommunicable diseases. For example, to supplement internationally sourced funds in battling the HIV and AIDS pandemic, the Botswana government increased national funds from 165.0 million U.S. dollars in 2005 to 203.8 million in 2007 (UNAIDS, 2008).

Influence of Culture and Mentality

Democracy, respect for individual differences and limitations, and freedom of individuals are visible traits among the people of Botswana. It can even be argued that these commendable traits are sometimes taken to extremes, such as when parents frequently find it hard to scold or punish their erring children, particularly when they are over 12 years old. This lack of discipline coupled with misplaced respect can be argued to be the root cause of some juvenile, youth, and adult delinquencies in Botswana (Nolan, 2009; Orufheng, 2009). These delinquencies include excessive alcohol misuse and abuse and social problems.

Although there is government legislation controlling who can buy alcohol and where it can be drunk, it is rare that efforts are made to enforce the regulation. Even in the university setting, every attempt by the university administration to explore the restriction of alcohol purchasing or drinking hours was met with vehement opposition, not only from the students but also from the staff. Furthermore, President Ian Khama attempted to pass legislation through an act of Parliament restricting the hours of drinking alcohol and the operations of alcohol sale centers. There was widespread opposition from every sector of the society including from the Parliament itself. Yet, alcohol abuse has been implicated in several studies for the majority of delinquent behaviors among the people of Botswana ("Our anti-HIV/AIDS," 2009; Owolabi & Kalui, 1997; Owolabi & Mogotsi, 1999).

There still is a paucity of knowledge among the populace, particularly among students, about the factors related to safe and acceptable consumption of alcohol. The cultural factors that seem to be hampering the battle against the HIV/AIDS scourge in particular include:

- Low rates of marriage and unstable, multiple, concurrent sexual partners.
- Teenage pregnancy and motherhood.
- Single parenthood, consensual cohabitation, and lack of interest in marriage.

Khunwane (2009) reported that National Coordinator Molomo of the Botswana National AIDS Coordinating Agency lamented the high prevalence of HIV and AIDS among the citizens of Botswana despite the huge financial and human resources investments in the last 10 years, attributing the situation to the penchant for multiple concurrent partnerships. Indeed, both males and females across age groups pride themselves in the extensiveness of their sexual networks. Even married men and women seem to pride themselves on these health-hindering attitudes. Unfortunately, there is no deliberate social structure in place to formally and informally discourage these dangerous, disruptive, and destructive values. There are religious organizations such as churches that preach and counsel their members on the risks of sexual recklessness, the need to be faithful in marriage, and the avoidance of premarital sex. However, not all churches believe in these strict injunctions about sexual relationships before and during marriage.

A few years back, attention was shifted from the predominant slogan of "condomize" to an emphasis on abstinence. However, the Botswana NACA's 2008 progress report cited low acceptability of abstinence as a major obstacle to achieving prevention targets. The arguments against abstinence range from the unfairness of depriving sexually active adults to the difficulty in preventing youth from freely choosing their sexual lifestyle.

Drivers of Workplace Health Promotion

Before the HIV/AIDS crisis induced governmental efforts and encouraged private companies to protect their workers' health, many companies operating in Botswana, particularly those with parent companies in South Africa, already had informal work health promotion programs in place.

Indeed, almost every private and government corporation has a functioning health and wellness unit. These units—which come under other various names, such as welfare, occupational health, etc.—organize health and wellness seminars, workshops, and HIV/AIDS prevention discussions and activities at least once a year. They offer many services for their staff, including periodic counseling and health screening (e.g, testing for HIV), and free condoms. They all provide emergency medical care for their staff and cover part of their other medical expenses. Unfortunately, the focus of these health and wellness units seems to be mainly on HIV/AIDS prevention and care of the infected. One would, however, love to see these units expanded to take care of the myriad emerging health and wellness issues, such as metabolic syndrome, obesity, high blood pressure, diabetes, and cardiovascular health problems. Although a few of the workplace wellness units have incorporated exercise and physical activity into the workers' break and lunch periods, a large majority have limited their interventions and activities to

counseling and care of the workers when they fall sick during work hours. Going by empirical evidence from published studies (Fine, Ward, Burr, Tudor-Smith, & Kingdom, 2004; Linnan et al., 2008), it could be submitted that the most common obstacle to health promotion in the workplace is the employers' perception of the lack of benefits from health promotion.

In summary, through its open and collaborative efforts to combat the most current health problems, the government of Botswana is the main driving force behind workplace health promotion in Botswana. Public and private employers are encouraged to ensure a healthy working environment for their employees. Government departments and ministries lead the way by catering to their workers' health.

Programs

Although all government departments and private employers with more than 20 employees have a health and wellness unit, workplace health promotion programs are not formal or concrete. These units are staffed by special officers, but it is doubtful if such employees are adequately trained and qualified for implementing the workplace health promotion program. The driving force seems to be the urgency to deal with the rampaging HIV/AIDS scourge physically and economically pauperizing the population. Thus, a major focus is to assist the people living with HIV/AIDS to live a comfortable and integrated social life. This is done through periodic counseling and psychological support. Employees are also encouraged to seek free HIV/AIDS screening to determine their HIV/AIDS status whenever there is any inexplicable health problem or cause for concern. The health and wellness units in the various departments, both governmental and private, also supply free condoms. Their health/medical units give antiretroviral therapy or refer workers to antiretroviral therapy designated sites for free, regular dosage of drugs. Yet, the worksite has the potential to become a key channel for the delivery of interventions to reduce chronic and lifestyle-related diseases, particularly among the adult population. The worksite environment further encourages sustained peer support.

University of Botswana

During the 2008/09 session, the total student population at the University of Botswana was 15,000, while the staff population was 2,700. The staff population comprises 31.3% academic, 51.7% support staff, and 17% industrial workers. The university houses a health and wellness coordination center headed by a qualified officer. The University Health and Wellness Office caters to both staff and students as per its mission, but most of the university's health and wellness centers cater only to students. The university has various health and wellness delivery units (i.e., providing centers). These include:

- University Health Services, staffed by trained and qualified doctors, pharmacists, and nurses. Their core functions are the provision of general health care, including reproductive, counseling, health education, and consultation. They also produce a few leaflets and

pamphlets to educate students on contemporary health issues. Only in exceptional circumstances does University Health Services provide health care to staff. They keep data on students' health issues (from HIV/AIDS to pregnancy and other specific, common health issues); these data are used to counsel students and monitor emerging and acute health issues. Annual evaluation of performance is done in terms of students' attendance and the relative prevalence of a particular health problem.

- University Counseling Services. This service is provided by the Department of Career and Counseling. Full-time, professional counselors assist students and staff with their psychological problems. The center also trains students on peer counseling. The center's approaches include face-to-face meetings, seminars, workshops, the production and distribution of leaflets and pamphlets on contemporary issues, and online communications.
- Health education. Health education is provided by the health and wellness center through periodic workshops, seminars, the production of educational pamphlets, and peer education and other awareness activities. Issues currently covered include healthy nutrition habits, responsible alcohol use, balancing work and family life, responsible sexual activities and the advantages of abstinence, health relationships, and nurturing and caring for one's social, emotional, and spiritual health. The main focus is behavioral change among students. The evaluation of achievement on these services is left to reports by staff members and subjective measures of the effects of health educational efforts on students.
- Sports and recreation. These services are provided by the Department of Culture, Sports and Recreation, which has a full complement of qualified and full-time professionals. The university has extensive sports facilities including an Olympic-size swimming pool, 400-meter running track, indoor sports hall, and various other standard facilities for indoor and outdoor ball and team games. The department also sends out regular educational leaflets on the need for physical activities and recreation among students. In addition, there are occasional seminars and workshops to encourage student participation in sports and recreation. Less than 30% of the students make significant use of these facilities, and this number comprises mainly the university athletes. In theory, the facilities are available for both staff and students, but staff members rarely use these facilities, except for the occasional use of the swimming pool and tennis courts.

The HIV/AIDS Center was set up to battle the scourge of HIV/AIDS on Botswana citizens. As a workplace health promotion unit, its major focus is to address the prevalence of HIV/AIDS among students and reduce the emergence of new cases. Its mission also includes educating noninfected students about HIV/AIDS and accepting, not stigmatizing, affected students. Very recently, an HIV/AIDS research center was established as part of the university's health and wellness efforts.

The staff are largely left to fend for their own health needs. There is, therefore, no formal workplace health promotion (WHP) program or policy in place for the over 2,700 staff members. The university staff sports association is a voluntary organization of staff members who

pay annual dues to sustain the association. This association meets only periodically to participate in competitions with staff of higher institutions from Botswana and abroad. Staff members also have some freedom to use university facilities outside of student use hours.

As a whole, the University's Center for Health and Wellness Coordination is striving to meet its objectives by coordinating the efforts of the various centers addressing health promotion, particularly among students. The center is trying to break down the barrier between positive attitude and safe practice. It is confident that over 90% of continuing students have all the knowledge they need for responsible and healthy living. The absence of specific, objective instruments to annually evaluate performance and achievements in the various health promotion services in the university is a major obstacle for the center.

The Botswana Police Force

The Botswana Police Force (BPF) has been very alert in identifying and appropriately responding to emerging staff health issues. Although the core duty of the BPF is crime prevention and reduction, the officers are aware that only police officers who are sound and sane in all aspects of health can carry out these duties effectively and efficiently. They are also aware that police officers and their families are exposed to various physical, social, emotional, and mental hazards in the performance of their lawful duties. Hence, the commitment of the BPF is to continually identify the workplace threats to the health of officers and their families and make efforts to prevent, neutralize, and/or control them. The BPF uses the integrated wellness approach through its Occupational Health, Safety, Chaplaincy, and Social Welfare (OHSCSW) unit.

The various sections within the OHSCSW unit are formally involved with WHP issues. Each section is headed by a health and wellness coordinator, who is a senior police officer. Every unit's health and wellness coordinator reports directly to the health and wellness coordinator at the Botswana Police Service headquarters in the capital city.

There are several divisions of the BPF spread across the country. The divisions are subdivided into smaller command groups called districts. The districts are further divided into stations or units. This hierarchy ensures effectiveness of police functions across the country. OHSCSW officers located in the headquarters and divisions take control of WHP issues in their divisions. In the districts, specially trained focal persons are appointed to monitor and implement WHP issues. At the station level, there are WHP assistants rather than OHSCSW officers. These assistants are inadequately trained but able to report on WHP issues to the focal persons and district officers, and where the issue is urgent enough, directly to the divisional officers or the coordinator at headquarters. The heads of the various sections also meet regularly to discuss health surveillance reports on the police force. The police health surveillance is crucial in monitoring the workplace health environment and quickly addressing any emerging health issue in the BPF. The focal persons in the districts send quarterly reports on their activities and observations to the divisional OHSCSW officers.

Each section of the WHP unit has a core of appropriate and trained staff at the OHSCSW and district levels including social workers, counselors, and psychologists. However, there is shortage of staff in the academic-intensive areas such as the forensic laboratory. Efforts are being made to identify and recommend appropriate staff for training among the police cadre.

Prior to 2000, the police devoted most of their WHP to the HIV/AIDS pandemic, which had a devastating impact on the force. Indeed, the first Botswana Police Service HIV/AIDS policy was published in March 2000 in response to a 1993 presidential directive (Botswana Police Service, 2000). The police service's HIV/AIDS mission statement states that "the Botswana Police Service will ensure that all its employees and their families are well informed and encouraged to take practical steps to avoid new infections and to provide adequate care and support services to the infected and affected" (Botswana Police Service, 2000). Although HIV/AIDS was the main focus, officers and their families raised other workplace health issues as well. Thus there was a need to expand the mission and policy from a focus on HIV/AIDS to a broader and more inclusive focus. In the year 2000, there was an unusually high prevalence of suicide cases among the staff of the BPF, and this necessitated the formation of a national committee to investigate various suicide responses, including a needs assessment survey and appropriate interventions. The committee's recommendations gave birth to the establishment of a chaplaincy and social welfare section within the OHSCSW unit in 2006. The formation of the chaplaincy and social welfare section was an appropriate response because many of the suicide cases had spiritual origins and implications. Although the police force has its cadre of trained pastors and reverends, they occasionally invite popular religious leaders to preach and spiritually counsel their staff in groups and individually, depending on the need.

In 2005, in response to identified needs, an occupational health and safety policy was launched. The major focuses of the policy included employee development on health and safety matters; provision of personal protective equipment; identification and assessment of potential hazards; installation of rapid incident response strategies; documentation and proper record keeping of occupational health and safety-related information; provision of first aid; management of communicable diseases, etc. The policy articulates the allocation of roles and responsibilities of different levels for workers' health and safety matters, from the commissioner of police to the last employee.

The occupational health and safety policy is reviewed every 2 years in order to assure its continuing relevance and suitability. Generally, the operational procedures to achieve the objectives of the department include health promotion awareness; health screening and counseling, both on an individual and group basis; occasional seminars and workshops; provision of health-promoting materials such as condoms and occupational safety materials; and an annual weeklong health and wellness program during which professionals are invited to lead the different aspects.

Police duties are physically demanding, with lots of emergencies in addition to daily duties; hence police officers are expected to be in top physical fitness condition at all times. There are several sports clubs in the BPS as with many other public and private employers. These clubs are open to those who are interested and have the requisite skills to perform at the elite level demanded by each sport. However, there is no policy on workplace health promotion of

physical activities and continuing physical fitness for police personnel. In the central Police College, regular physical activities and sports are part of the curriculum and are mandatory for all officers in training. There is no corresponding policy to ensure the continued participation in physical activities and sports after graduating from the Police College. The absence of a formal policy on regular participation in physical activity and physical fitness implies that the decision for personnel to participate is left to the heads of each police station/unit and is not mandatory. A formal WHP policy currently being formulated by the OHSCSW and the BPF will be presented as recommendations to the Botswana Police Service.

As with many WHP efforts in developing countries, there is no formal instrument or objective measurement criteria to evaluate the effectiveness and achievement of the WHP unit of the BPS at the end of each year. However, the unit relies on various reports from the divisions and districts to evaluate its successes and challenges and plan for the upcoming year. In most cases, these data are highly subjective and cannot be directly used to gauge the success of the WHP unit with any specificity.

Debswana Diamond Company

Some private companies, in addition to having robust and effective WHP programs targeted at preventing, controlling, and mitigating the impact of HIV/AIDS on the workforce, provide free antiretroviral therapy to their employees. One of these companies is the Debswana Diamond Company. The Debswana Workplace AIDS and Awareness Program was introduced in 1991 (Botswana NACA, 2008). This company was the first mining company in Southern Africa to provide antiretroviral therapy to its employees. The Debswana Diamond Company also has clearly defined workplace policies, an AIDS management system, and HIV/AIDS awareness and education and training programs, among other programs.

Outcomes and Indicators

Measures or specified outcomes to evaluate health promotion efforts and their effectiveness on workers' physical and mental health, regular attendance at work, and productivity are lacking. This may not be unexpected in the Botswana worksite environment as there is no trained leadership in occupational and worksite health and there are no occupational standards for workplace health promotion.

Existing Research

The severity of HIV/AIDS has been felt in the workplace as high rates of absenteeism, hospitalization, presenteeism, and even death. Hence, most of the efforts and studies on health promotion have been focused on HIV/AIDS.

For example, the Botswana government undertakes periodic HIV/AIDS surveillance in order to establish trends in HIV prevalence and new cases and also to gather information for developing policy and programs to stem the HIV and AIDS pandemic. It also conducts annual HIV/AIDs surveillance among pregnant women aged 15–49 years. The data includes both prevalence rate and behavioral patterns, in order to understand the underlying and immediate causes of the epidemic. The government also implemented periodic nationally representative behavioral surveys known as Botswana AIDS impact surveys (BAIS); the first was in 2001, the second in 2004, and the latest in 2008. The BAIS was initiated to regularly update information on prevalence, incidence, and behavioral patterns towards HIV/AIDS among the population (Montlane, 2009). This chapter's section, "Prevailing Health Issues and Risk Behaviors," presents details on the BAIS and other HIV/AIDS surveillance studies. The indifference of the average Botswana citizen to regular physical activity and sports is demonstrated by the results of the studies also referred to in this earlier section.

Workplace Health Promotion—A Survey Report

Owolabi conducted a study in 2005 (unpublished data) aimed at evaluating the relationship between employees' and employers' perceptions of the benefits of workers' participation in regular physical exercises and the provision of corporate fitness programs. Fifty companies employing from 20 to over 100 employees, across different types of industries, were used in the study. One hundred and sixty employees were sampled across all strata of management.

The major findings were that despite the fact that 95% of the subjects perceived a corporate fitness program to be very important in improving the health and productivity of employees, only 10% participated in regular physical exercises of any form. Although 60% of the sampled companies had private fitness and sports facilities, none had a corporate health promotion policy or program. Furthermore, although all the companies had welfare managers, none of them had occupational health or corporate fitness personnel. It was found that the indifference of most companies to employees' fitness programs was due to the lack of commitment of the chief executive officers to workplace health promotion. The companies' workplace health programs were mainly in the form of facilities and recreation rooms, which workers patronized in the evening and Saturday after work hours. None of the 50 companies sampled had health and wellness activities within work hours. The motivation for WHP depended on the managing director of the company and his/her interest in health and wellness and perception of its value to workers.

Conclusion

Public health promotion is being largely propelled by the zeal and efforts of the government of Botswana. However, a large chunk of these efforts is directed to preventing and mitigating the impact of HIV and AIDS on the people of Botswana and on individual and national

development. Despite the billions of dollars and international collaborations toward fighting and preventing new HIV/AIDS infections over the last 15 years, the current prevalence and incidence rates are not commensurate or encouraging. It is hoped that the people of Botswana will soon begin to reciprocate government efforts in the seemingly endless battle against HIV/AIDS.

Workplace health promotion, though appreciated and perceived as very important in maintaining and improving the health, wellness, and productivity of workers, is not formally in place. Government also seems to be the main driver of WHP. The government's efforts in stimulating and encouraging WHP via the multifaceted approach to eradicating the HIV/AIDS scourge from Botswana are highly commendable. However, in most companies, there are no formal health policies, no formal and measurable WHP programs, and no means to measure the outcomes and impact periodically. Most of the companies have designated welfare or health and wellness managers, but none have qualified occupational health or corporate health and wellness personnel.

The indifference of most companies to WHP is due to the lack of commitment of the chief executive officers. Most efforts are reactive rather than proactive. It would be beneficial if employers in both public and private companies in Botswana initiated bold WHP programs based on urgent contemporary issues rather than waiting for high incidence in the workplace, and then chasing curative solutions. The University of Botswana and other higher institutions should implement policies that promote participation in sports.

Summary

Botswana is located in southern Africa, and it became independent from British protectorate in 1966. Botswana is arguably the role model of democracy in Africa. It has one of the highest rates of HIV/AIDS prevalence in the world, but the government has shown great determination in dealing with the scourge.

Botswana affords universal access to antiretroviral treatment and counseling. It also offers its citizens free HIV status testing and free condoms in all public places. Infected pregnant women are taken through prevention of mother-to-child transmission therapy. HIV/AIDS has been the main issue in Botswana discourse and its health focus since 1995. Because one cannot divorce the workplace health from community health, a large chunk of workplace health promotion (WHP) attention and activities are focused on preventing, counseling, and dealing with the HIV/AIDS issue.

The prevailing health issues and health risk behaviors include HIV/AIDS and its causes. Despite millions of dollars and the government's concentrated efforts in the last 10 years to reduce prevalence and new infections, at best the HIV/AIDS situation appears stabilized. The current prevalence rates range from 2.2% in the age group of 1.5–4.0 years to 40.6% in the age group from 40–44 years. There are several recorded negative impacts of high HIV/AIDS prevalence on the population and economy of Botswana.

Uninhibited alcohol use and uncontrolled and undisciplined sexual relationships have been found to fuel the HIV/AIDS prevalence. Physical inactivity and accompanying low productivity are other concerns for WHP.

Government is the main provider of health services and facilities, although missionaries, mines, and private commercial health institutions also provide services. Through government's motivation and its enthusiastic attack on the HIV/AIDS scourge, most public and private organizations set up health and wellness units/departments within their structures.

Government backs up its health efforts with necessary legislation and policies. A lot of effort is devoted to health promotion, which has been incorporated in education, community development, policy, and legislation. Culture and mentality play a big role in WHP issues in Botswana. These include low rates of marriage and unstable and multiconcurrent sexual partners, fairly high prevalence of teenage pregnancies and motherhood, single parenthood, and cohabitation.

Workplace health promotion in most employing organizations is not formal or clearly defined. The absence of specific, objective measuring instruments to annually evaluate performance and achievements is a major setback for the effectiveness and progress in WHP in Botswana. Furthermore, physical activity, which is a major platform in WHP to relieve workers' stress and enhance productivity, is glaringly absent in the WHP policy of most employing organizations in Botswana, including the Botswana Police Force.

Review Questions

1. Explain the impact of HIV/AIDS on the development of Botswana.
2. Describe the three tiers of the healthcare system in Botswana and what each provides.
3. What is the role of workplace health promotion programs in Botswana?
4. Choose one of the case studies of Botswana workplace health promotion and describe its impact on employee health.
5. How are research indicators affecting health promotion research in Botswana?
6. Consider the current status of workplace health promotion in Botswana and list three challenges to successful implementation of future workplace health promotion initiatives.

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