

Integrating social  
determinants  
of health in all  
public policies:  
The case of health  
development  
in Botswana



World Health  
Organization

REGIONAL OFFICE FOR Africa



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Botswana

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An earlier draft of this case study was included in a special collection of global experiences on intersectoral actions which was widely disseminated during the World Conference on Social Determinants of Health held in Rio de Janeiro, Brazil in 2011. At the country level, the review process leading to the finalization of the case study generated multi-stakeholder policy and strategy discussions on implementing intersectoral actions to address social determinants of health.

The final product is a result of collective efforts of many individuals and organizations. However, the drafting team included Dr Edward T. Maganu, Consultant (Botswana); Mr Moagi Gaborone (WHO, Botswana) and Professor Germano Mwabu, University of Nairobi (Kenya). The overall guidance and technical inputs to the project from WHO Regional Office for Africa are gratefully acknowledged, namely: Dr Tigest Ketsela, Director Health Promotion Cluster; Dr Davison Munodawafa, Programme Area Coordinator, Determinants and Risk Factors; Dr Chandralall Sookram and Mr Peter Phori; and Dr Eugenio Villar, SDH Coordinator in WHO HQ, Geneva. We are indebted to the many people who made valuable inputs throughout the process who cannot be mentioned by name. Last but not least, we express great appreciation for the support received from the Government through the Ministry of Health to conduct this activity.

## Abstract

This paper examines the extent to which government policies, strategies and regulatory frameworks in Botswana incorporate social determinants of health (SDH) in their formulation and implementation. This is an important issue because the conditions in which people are born, live and work determine the level and distribution of health in the population. There is no systematic information available regarding the extent to which the government in Botswana or elsewhere in Africa has used existing knowledge on social determinants to improve health and well-being.

To address the above issue, a desk review was done to obtain information from the available literature and from relevant government documents on social determinants of health and primary health care. The review revealed that social determinants of health are covered in government documents in Botswana but inadequately. Moreover, different sectors in the country are carrying out their respective mandates but not with the explicit purpose of improving health. Furthermore, the review found that the health consequences of the sectoral mandates currently being implemented by government ministries and departments are not well understood.

There is evidence that the Government of Botswana has embraced the multisectoral approach to health development and accepts the concept of social determinants of health. There is, however, a need to develop mechanisms for strengthening the implementation of the new approaches. It is recommended that the WHO Regional Office for Africa (AFRO) and other partners should support studies similar to the present one in other Member States. Such cross-country studies can provide evidence on factors that facilitate or hinder the incorporation of social determinants of health into national development policies in the African Region.





# 1. Introduction

## Country profile

Botswana is a landlocked country in southern Africa with a population of 2.038 million<sup>1</sup>. The annual population growth rate between 2001 and 2011 was 1.9%. It is estimated that in 2010, 32.9% of the population was under 15 years of age, while the population over the age of 65 years was estimated at 6.8% and 5.1% for females and males respectively<sup>2</sup>. The GDP per capita in 2009 was estimated at US\$ 5959.5<sup>3</sup>. Due to the skewed distribution of wealth, 28% of the population lives on less than a dollar per day<sup>4</sup>.

The national literacy rate in 2003/4 was 81.2%, with a higher literacy rate for females at 81.8% compared to males at 80.4%<sup>5</sup>. Unemployment remains high and was estimated at 17.8% of the labour force by the Botswana Core Welfare Indicators Survey of 2009/10<sup>6</sup>. Females have higher unemployment although they have higher literacy.

The life expectancy at birth is estimated at 54.4 years (48.8 for males and 60 for females). Both the morbidity and mortality for all ages are still dominated by infectious diseases with HIV/AIDS and other communicable diseases causing about half the deaths<sup>7</sup>. Botswana has an established generalized HIV epidemic with an estimated prevalence of 30.4% in the 15-49-year-old antenatal population<sup>8</sup>.

## Purpose of the review

This exercise was undertaken to assess the level of integration of select intersectoral actions into government policies, regulatory frameworks and strategies. The aim was to examine the application, if any, of intersectoral approaches in the areas of leadership or stewardship roles in the Ministry of Health; health equity in all the policies; governance in the health sector in general; the building of partnerships and alliances; health information systems; and community participation and empowerment. This automatically led to the examination of equity in relation to the utilization of the health workforce and to health financing, especially the allocation of resources.

## The problem

The bulk of the health problems that the Ministry of Health deals with originate outside the health sector. Current development policy frameworks in different sectors do not address social determinants of health, and, therefore, miss out on the opportunity to impact on health. This results in the health sector having to deal with health problems created by other sectors.

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<sup>1</sup> Government of Botswana 2012. Statistics Botswana. Preliminary figures 2011 National Population and Housing Census.

<sup>2</sup> United Nations Statistics Division Economic indicators 2010 (<http://unstats.un.org/unsd/pocketbook/PDF/Botswana.pdf>)

<sup>3</sup> Ibid

<sup>4</sup> Government of Botswana, National Health Policy; Towards a Healthier Botswana. Ministry of Health 2011, Government Printer, Gaborone (quoting UNDP 2007).

<sup>5</sup> Report of the Second National Survey on Literacy In Botswana. CSO 2003. quoted from the National Health Policy 2009.

<sup>6</sup> Government of Botswana (2012). Central Statistics Office. Statistics Briefing Key Indicators January 2012.

<sup>7</sup> Government of Botswana, National Health Policy; Towards a Healthier Botswana. Ministry of Health 2011, Government Printer, Gaborone.

<sup>8</sup> Botswana Government (2011). 2011 Botswana Second Generation HIV/AIDS Antenatal Sentinel Surveillance Technical Report.

All sectors have an impact on health. However, frameworks for intersectoral action are not well-articulated in sectoral policies and implementation frameworks. The consequences on health of the various policies are not well-understood. That is why integration is the key.

There is a need to identify ways of working across sectors. Every sector needs to integrate elements of social determinants of health in its work. This can only work when workers understand integration. Clear policy statements on social determinants of health need to be incorporated into all sectoral policies. Specific actions can then be included in the implementation frameworks.

## 2. Hypothesis

The hypothesis of this paper is that social determinants of health are not integrated into Botswana's development policies. This hypothesis is, however, rejected. Integration is happening but at a very low level. The evidence available is not in support of the hypothesis; for example, all the five categories of determinants of health are covered in development policies but at a low level. These categories are: i) early childhood development and education; ii) places where people live; iii) work environment; iv) social protection across the life course; and v) universal health care.

The health consequences of development programmes are not well-understood by the different sectors and therefore activities in these sectors are not specifically aimed at improving health. If they were understood there would be better health outcomes from the activities.

If there was a comprehensive mechanism for assessing the health impact of the activities, the health outcomes emanating from them would be enhanced. Hence, consideration needs to be given to conducting an Health Impact Assessment (HIA) before undertaking some development activities, possibly as a stand-alone detailed part of the Environmental Impact Assessment (EIA), resulting in an Environmental and Health Impact Assessment (EHIA). The Environmental Impact Assessment is already a requirement by law, especially for major development projects but subsumes health impact under the social impact component. As a result, health impact generally gets a passing mention in EIA reports.

## 3. Background

Botswana has a long history of making policies in the health sector that aimed at targeting the poor. The Basic Health Services (BHS) approach that was part of the Accelerated Rural Development Programme (ARDP)<sup>9</sup> that was launched in 1972 aimed to give the whole population access to health care and to services that impacted on health status and well-being. Hence, the ARDP included the construction of clinics, water supplies, schools, roads and other services in villages all over the country according to specific qualifying criteria, especially population and remoteness.

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<sup>9</sup> Republic of Botswana (1972) *Rural Development in Botswana*, Government Paper No. 1, March 1972. Gaborone: Government Printer.

The Basic Health Services (BHS) approach in Botswana transformed into the Primary Health Care (PHC) approach following the Declaration of Alma-Ata in 1978<sup>10</sup>, which articulated the concept of primary health care more clearly<sup>11</sup>. The PHC approach had two elements that expanded the Basic Health Services approach; intersectoral collaboration and community involvement and action. Subsequent policy and planning documents of the Ministry of Health always attempted to include strong elements of intersectoral collaboration and community involvement. The PHC approach was strongly associated with the social goal of Health for All by the Year 2000 (HFA 2000)<sup>12</sup>.

However, the social goal of HFA 2000 was not achieved in most countries in the African continent for various reasons. In many countries it was because of economic collapse, but in Botswana and some other countries, HFA 2000 failed largely because of the HIV/AIDS pandemic. In the case of Botswana, the pandemic reversed the major achievements that the country had achieved in the field of health; mortality rates (crude, infant, child, maternal) which had declined very quickly and drastically with the implementation of BHS and PHC strategies started rising again and reached pre-independence levels before declining again after the general application of antiretroviral therapy (ART).

The economic problems and the HIV pandemic, and the consequent failure of HFA 2000, resulted in new initiatives that eclipsed the PHC approach. The health sector reforms of the 1990s shifted emphasis to efficiency, cost-effectiveness and other elements that emphasized health financing and economic fundamentals, and the two important pillars of PHC, i.e. intersectoral action and community involvement, fell by the wayside. For example, many countries in the African Region have developed health policies in the past decade as well as health sector strategic plans, but most of them hardly mention PHC or the two concepts of intersectoral collaboration and community involvement. This historical background is meant to put things in perspective.

According to the WHO Commission on Social Determinants of Health, the social determinants of health are the conditions in which people are born, grow, live, work and age, and the systems put in place to deal with illness (the health systems)<sup>13</sup>. These circumstances are shaped by a wider set of forces: economics, social policies and politics.

Traditionally, society has looked to the health sector to deal with its concerns about health and disease. Certainly, poor distribution of health care – not delivering care to those who most need it – is one of the social determinants of health. Action on the social determinants of health must involve the whole of government, civil society and local communities, business, global fora, and international agencies. Policies and programmes must embrace all the key sectors of society and not just the health sector.

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<sup>10</sup> Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978.

<sup>11</sup> As stated at Alma-Ata Conference: "Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

<sup>12</sup> The 30th World Health Assembly in 1977 agreed on the vision of Health for All by the Year 2000 as a major social target of governments, international organizations and communities. The Alma-Ata Conference in 1978 endorsed Primary Health Care (PHC) as the key strategy for implementation by all countries of the world in order to improve the health status of the people and lead to the achievement of Health for All by the Year 2000.

<sup>13</sup> CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

## **Main categories of social determinants of health (adapted from the WHO Commission on Social Determinants of Health – Final Report 2008)**

The categories below form a good framework from which to examine the extent to which the social determinants of health have been a consideration and how they are being approached in various government policies and strategies. They are used in this paper to analyse the situation in Botswana.

1. **Equity from the start:** Early childhood development and education are powerful equalizers. Education, preschool and beyond, fundamentally shapes children's lifelong trajectories and opportunities for health. Educational attainment is linked to improved health outcomes, partly through its effect on adult income, employment and living conditions.
2. **Healthy places-healthy people:** Why place matters for health equity? Where people live affects their health and chances of leading flourishing lives.
3. **Fair employment and decent work:** Employment and working conditions have powerful effects on health and health equity.
4. **Social protection across the life course:** The relationship between social protection and health. Poverty and living standards are powerful determinants of ill-health and health inequity.
5. **Universal health care:** The relationship between health care and health equity. Health-care systems are a vital determinant of health.

### **The evolution of the Botswana health care system**

Health policy in Botswana was for many years spelt out largely in its National Development Plans (NDPs). Its evolution can, therefore, be traced through the various NDPs, starting mainly from the early 1970s when the government started financing health care from mineral revenues. In addition, the policies and strategies of the other sectors whose work impacts on health status have also been historically laid out in the NDPs (e.g. Education, Water, Agriculture, etc.) However, in recent years, some individual sectors have also produced policies and strategies outside the NDPs. These have been included in the analysis where applicable.

The first such policy for the health sector was produced by the Ministry of Health in 1995<sup>14</sup>. The policy summarized the policies as they had been articulated in the NDPs up to that date and also had influence in subsequent policies. The 1995 policy stated that "Health care has been taken by Government to be part of overall socioeconomic development, as has been so clearly stated in Government Paper No. 2 of 1973 on Rural Development". The philosophy of the policy is also stated as being based on the principles of primary health care as contained in the Alma-Ata Declaration of 1978. The themes of decentralization, intersectoral collaboration and community involvement also underlay the policy.

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<sup>14</sup> Government of Botswana. National Health Policy, Ministry of Health 1995, Government Printer, Gaborone.

The current policy document was produced in 2011 (National Health Policy: Towards a Healthier Botswana)<sup>15</sup>. The policy recognizes the importance of the social determinants of health and their influence on health equities/inequities and that action needs to be taken. The policy also recognizes separately the socioeconomic determinants of health, which in reality are part of the social determinants. While not stating it explicitly, the policy has an overall aim of universal coverage with health care. The policy uses international frameworks as points of reference, notably the Millennium Development Goals (4,5,6) (UN 2000), the Ouagadougou Declaration on Primary Health Care and Health Systems of 2008, and the Commission on Social Determinants of Health (WHO 2008). The National Health Policy also recognizes and emphasizes the need for other sectors to work closely with the health sector to achieve the desired levels of health status.

The disease pattern of Botswana indicates that social determinants of health are very influential in relation to which diseases cause most morbidity and mortality. According to the National Health Service Situation Analysis Report of 2009<sup>16</sup>, communicable diseases still cause most mortality in both children and adults. Infant and childhood mortality rates are dominated by pneumonia, other respiratory diseases, retroviral infections (HIV) and septicaemia, in that order. Adult mortality is dominated by HIV-related infections, TB, other infections, cancers and anaemias (not necessarily in that order). These conditions also dominate inpatient morbidity. Estimation of maternal mortality ratio (MMR) has been fluctuating, mainly because of the methodologies used to measure it. It is probably between 150 and 200 per 100 000 live births, among the lower ones in Africa but high by international standards.

## 4. Methodology

This paper is a product of a desk review of the literature and of policy and strategy papers produced by the Government of Botswana. These documents were examined from the health point of view to determine if the social determinants of health were influential or were taken into account in formulating the policy documents. The final report of the WHO Commission on Social Determinants of Health of 2008 was used as the main framework for the analysis. The study draws heavily on that report.

How were the reviewed documents selected? International authoritative papers were purposely selected. The main ones were the final report of the WHO Commission on Social Determinants of Health of 2008 and the Alma-Ata Declaration on Primary Health Care. These documents are the most relevant and authoritative on the subjects of SDH and PHC respectively. The former was also used largely as a framework for the analysis undertaken in the report. A large number of country documents on policies, strategies and regulatory frameworks were also reviewed or used as references. The NDPs, especially NDP 10, were used extensively, as well as the national health policies, various legal statutes and regulations from the health and other sectors.

The evolution of the health care system in Botswana is treated extensively, starting with the historical developments. PHC, which has for a long time formed the basis of the health care system, is also treated extensively as well as recent developments of the policies

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<sup>15</sup> Government of Botswana, National Health Policy; Towards a Healthier Botswana. Ministry of Health 2011, Government Printer, Gaborone.

<sup>16</sup> Government of Botswana, National Health Service Situation Analysis Report, Ministry of Health 2009. Gaborone.

of the health sector. The approach to intersectoral action and integration of policies and activities in different sectors that impact on health forms the main thrust of the paper.

## 5. Findings: Social determinants of health in Botswana's policies and strategies

In dealing with this subject, it is important to note that the word “health” may not be mentioned in a policy or strategy, but the field and areas covered may be of great relevance to health. The major areas are treated in turn, examining particularly how they relate to health equity in Botswana.

### 1) Early childhood development and education

Education, preschool and beyond, fundamentally shapes children's lifelong trajectories and opportunities for health. Educational attainment is linked to improved health outcomes, partly through its effect on adult income, employment and living conditions.

The tenth National Development Plan (NDP 10)<sup>17</sup> that covers the period April 2009 to March 2016, in Chapter 7 (An Educated and Informed Nation), states that the plan's goal “arising from the Vision 2016 pillar of An Educated and Informed Nation, is to provide an adequate supply of qualified, productive and competitive human resources”. It also states that sectors contributing directly to this goal are Education, Public Service, Agriculture, Health, Youth, Labour and Finance.

The mandate of the Education sector is stated as being to produce skilled human resource through the provision of education and training opportunities. Health is not directly listed as a product. However, activities of the sector are known to be a major determinant of health even if it is not so stated in the plan. The goals of the sector in NDP 10 are:

- Goal 1: To provide accessible, equitable, quality education. This goal focuses on Botswana having full access to a high-quality education system at primary, secondary and tertiary levels.
- Goal 2: To provide globally competitive human resources to drive economic growth. Indicators that will be used for tracking this goal include unemployment rate, labour productivity index, the competitive index and the human resources development expenditure as a percentage of GDP.

The plan indicates that more attention will be paid to disadvantaged and vulnerable children (children with special needs, children in remote areas, and children with other social needs). The plan does not indicate commitment to early childhood development (ECD), which builds into formal education to provide a good basis for attaining health equity. Children who have attended preschool establishments perform better in school.

There are many ways in which education contributes to health outcomes. Many studies have also shown, for example, that there is an inverse relationship between infant and

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<sup>17</sup> Government of Botswana (2010). National Development Plan 10. Government Printer. Gaborone. (The document will be referred in this article as NDP 10).

child mortality and education of the mother; these mortalities decline with the higher the mother's education. Also, as stated above, education, by improving chances of better employment and income, contributes directly to health equity. Universal education, as advocated in the plan, also includes the girl child and contributes to gender equity, which is a great equalizer and contributor to health equity through various social determinants of health. Formal education also facilitates the acquisition of health knowledge, thus promoting the internalization of health messages and therefore the adoption of healthy lifestyles and positive health-seeking behaviours. This is crucial for the control of noncommunicable diseases as well as some communicable diseases, especially HIV/AIDS. So, education is a major social determinant of health, even though health is not directly mentioned as an outcome in the Education sector section of NDP 10.

The Children's Act (Cap 28:04) covers many important areas relating to the promotion and protection of the rights of the child. It has an extensive Bill of Child Rights. There are 17 rights listed. The most relevant ones to health are: (1) the right to life; (2) the right to know and be cared for by parents; (3) the right to health; (4) the right to shelter; (5) the right to education; (6) the right to leisure, play and recreation; (7) the right to protection against harmful labour practices; and (8) the right to protection against sexual abuse and exploitation. Each of these rights is elaborated upon, including the way it is to be enforced.

The implementation of the Act is supported by the "Children in Need of Care Regulations 2005". These regulations are meant to provide for the care and protection of particularly vulnerable children.

## 2) Healthy places - healthy people

Where people live affects their health and chances of leading flourishing lives. Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health equity. The following is an overview of the areas that have to be taken into account to make living areas healthy and improve levels of health equity, with a discussion of the current state of affairs in Botswana.

### ***Housing and shelter***

Shelter and housing are particularly important, especially in the context of rapid urbanization, which may result in slum conditions. Prioritization of provision of water and sanitation, electricity and paved streets for all households regardless of ability to pay is ideal.

NDP 10 states that in order to restore the dignity of the poor, focus will be laid on improving the quality of basic shelter through schemes such as the Destitute Shelter Programme, the Self Help Housing Agency (SHHA)<sup>18</sup> and civil society schemes. Shelter is recognized as one of the major problems facing the majority of the people in Botswana.

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<sup>18</sup> SHHA is an acronym for "Self Help Housing Agency", a scheme by the government where loans are provided at low interest to low-income families to construct their own houses.

Decent shelter is a basic human need, and an important determinant of health. Therefore, every human being needs to have housing that maintains their dignity and protects them from the elements. Provision of shelter in Botswana is guided by the National Policy on Housing of 2000. The thrust of the policy is to facilitate home provision in partnership with stakeholders; channel more government resources to low and lower-middle income housing; promote housing as an instrument for economic empowerment and poverty alleviation; and to foster a partnership with the private sector and all major employers in home development. There are many schemes aimed at providing housing to citizens, but the SHHA is the major scheme aimed at the low-income groups. Other schemes are aimed at the poor. This should have an impact on health and well-being. Affordability is always a major issue in housing, in both urban and rural areas.

## **Environment**

Environmental issues are very broad and all have a bearing on health. However, some of them are usually directly associated with health, and these include waste management and pollution control. With regard to disposal of human waste, the government has programmes relating to latrines, e.g. change from pit latrines to water-borne systems in urban areas, or promoting more environmentally friendly VIP (ventilated improved) pit latrines in rural areas to avoid pollution of underground water as has occurred in some localities. Solid waste disposal is also progressively better managed with landfills. The Environmental Impact Assessment legislation is in place since 2005. There is a programme for environmental education and awareness which has focused on sustainable management of natural resources and prevention of environmental degradation. These are very important subjects for livelihoods and therefore are important social determinants of health.

The likely impact of climate change on the environment and therefore on health should be planned for. To that end the government has presented its proposals to the relevant UN body on the mitigation of the effects of climate change, and there are programmes for public education and awareness undertaken by various sectors. However, no comprehensive policy on climate change for the country has been elaborated yet.

## **Water**

Water is a major determinant of health. So, the supply of water to the population is a major responsibility of the government. Provision of water has always been a major component of rural development in Botswana. The government provides potable water to all recognized settlements and villages.

The NDP 10 goal for the water sector is “to supply adequate water efficiently of the required quality for different purposes (domestic, agriculture, mine, trade and industry)”. The first National Water Master Plan (NWMP) was completed in 1991. The plan provided guidance for water resource management and came up with a number of major recommendations. According to the National Water Master Plan Review of 2006 (NWMPR), substantial progress has been made on the implementation of the recommendations, with the exception of institutional and infrastructure development. Regular water quality monitoring and testing for chemical, physical and microbiological constituents were undertaken by



the sector to ensure compliance with the Botswana Standard for Drinking Water Quality Specifications (BOS 32:2000), and included water quality monitoring of dams and well fields. However, the quality monitoring for the rural villages water supply was not done on a regular basis due to shortage of manpower and logistical support. Plans are in place to remedy the situation.

In terms of water-borne diseases, the Botswana arid weather has been a blessing in disguise. The country has lower incidence of water-borne diseases than most other African countries. For example, it is probably the only African country that has not had transmission of cholera constituting an outbreak. The few cases that have occurred were all imported. The occurrence of typhoid has always been sporadic and the disease has virtually disappeared in recent years. This is due to the fact that there is little surface water in the country and most of the population depends on either deep underground water provided through boreholes or on dam water that has been treated. The problem of recurrent outbreaks of diarrhoea in children may be related to contamination in households more than to water sources, which is usually a result of poverty and poor living conditions.

### ***Urbanization/human settlements/rural development***

Urbanization is proceeding at a fast pace in Botswana. It is important when planning and designing urban areas to cater for physical activity, especially by the way transport systems are put in place. Retail planning could encourage healthy eating by facilitating access to food. Good environmental design and regulatory controls, including controls of the numbers and positioning of alcohol outlets, could also contribute to reduction in crime and violence. There are many laws and regulations in place to take care of these varying demands that are brought about by urbanization, and to also cater for human settlements in general. The following is a sample list of such laws and regulations - the list is by no means exhaustive.

- Local Government (District Councils) Act (Cap. 40:1)
- Town and Regional Planning Act (Cap. 32:09)
- Building Control Act (Cap. 65:02)
- Waste Management Act(Cap. 65:06)
- Industrial Development Act, 2006
- Road Traffic Act (Cap. 69:01)
- Liquor Regulations, 2008
- Control of Smoking Act(Cap. 65:04)
- Atmospheric Pollution Act (Prevention) (Cap 65:03)
- Control of Goods, Prices and Other Charges Act(Cap 43:07)

For rural areas, land rights are particularly crucial for livelihoods. Various laws deal with land administration in both urban and rural areas because there are differences between the two. Urban land is usually freehold or long-term lease, while rural land is usually tribal, largely accessible to residents but with limited security of tenure.

Health equity between rural and urban areas can be promoted through sustained development in rural development addressing various causes of rural poverty. Botswana

has historically developed many policies and strategies for rural development generally, and for specific populations such as the Remote Area Development Programme. Indicators of development, such as levels of poverty and mortality rates, still show considerable inequities between urban and rural areas, with the remote areas, especially those in the western parts of the country, being the most disadvantaged. This also translates into poor health indicators. There is obviously a need to keep revisiting rural development, including allocating more financial resources to poor communities to promote equity in development in general and in health in particular. All rural development policies and initiatives for remote areas have strong health components, usually in the form of clinics, health posts or mobile stops, depending on population size.

### 3) Fair employment and decent work

Employment and working conditions have powerful effects on health and health equity. When these are good they can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards – each important for health. In addition to the direct health consequences of tackling work-related inequities, the health equity impacts will be even greater due to work’s potential role in reducing gender, ethnic, racial and other social inequities.

Employment Creation is mentioned as a major strategy in NDP 10 Goal 3, in Chapter 11, which is entitled “A Compassionate, Just and Caring Nation”. Equitable income distribution is Goal 2 of the same chapter. The background narrative explains that income inequalities remain considerably high in Botswana, and that compared to other middle-income countries, Botswana features among the ones with high inequality. The NDP 10 quotes CSO as estimating the value of the Gini coefficient<sup>19</sup> in Botswana as 0.573, with rural inequality at 0.515 being lower than urban villages (0.523), based on disposable income. The value in the cities was 0.503. The values were from 2002/03 and, for the national figure, showed a deterioration from 1993/94, which was 0.537. High unemployment is partly or even mainly responsible for this high income inequity. These values are similar to those of South Africa and Namibia.

The Decent Work Country Programme that the government espouses and is described in NDP 10 involves safeguarding workers’ rights, promoting social protection, social dialogue and employment creation. Effective social dialogue among workers, employers and government is to be established to address issues of common concern and resolve emerging issues amicably. An action programme on child labour will be developed to ensure compliance with international obligations on the minimum age for admission to employment, and the elimination of the worst forms of child labour convention. The Revised National Policy on Incomes, Employment, Prices and Profits introduced a minimum wage in the agricultural and domestic service sectors in order to further protect vulnerable workers from financial exploitation. The government plans to review the labour laws in the current plan period. The Labour Act was not reviewed by the authors.

Income inequity is a major determinant of health inequity. The government has put forward some strategies in NDP 10 to address this income inequity, which also has a gender dimension. These are contained in the National Strategy for Poverty Reduction and include

<sup>19</sup> The Gini coefficient measures the inequality among values of a frequency distribution (for example levels of income). A low Gini coefficient indicates a more equal distribution, with 0 corresponding to complete equality, while higher Gini coefficients indicate more unequal distribution, with 1 corresponding to complete inequality.

promotion of broad-based employment growth with extensive sectoral and geographical spread, assisting informal sector development as a source of entrepreneurial activity, and supporting informal sector enterprises to graduate to the formal sector.

Botswana is a food-deficit country. Although most people are employed in agriculture, the country does not produce enough basic foods to feed itself. This includes grain staples such as maize and sorghum. However, because of various government-supported schemes, food security at the household level is at a reasonable level. The government gives subsidies for food production and also has schemes of poverty alleviation as well as social safety nets that enable households to access foods. This has enabled the country to keep malnutrition levels low by African standards. Under-five children are provided with food in clinics to carry home, especially the ones that are underweight, and school-feeding is universal, all funded by the government.

The government has plans and strategies to promote more efficient technologies in agriculture and to support farmers to go into commercial farming. This is also meant to support agriculture as a major source of employment. It is, however, important that the government spells out the concept of household food security more clearly, including the role that small subsistence farmers can play in view of the arid climate. The cost of producing a bag of grain should not be more than the retail price of the same bag.

#### **4) Social protection across the life course: the relationship between social protection and health**

Poverty and living standards are powerful determinants of ill-health and health inequity. Social protection is covered in NDP 10, and is defined as the set of policies, programmes and strategies designed to reduce poverty and vulnerability by promoting employment opportunities, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against psychosocial and economic hazards and interruption or loss of income<sup>20</sup>.

Some areas of activity and initiatives include:

- Eradication of absolute poverty
- Equitable income distribution
- Adequate social protection
  - Social assistance and welfare service strategies for the most vulnerable groups
  - Enrolment on social safety nets.

A Revised National Policy on Destitute Persons of 2002 is referred to which covers support to destitute persons, the elderly (old-age pension), World War II veterans, community home-based care patients, needy children and remote area dwellers.

The two challenges that face the government in implementing these programmes are selection of beneficiaries and sustainability. These are exacerbated by the apparent dependency syndrome that the programmes seem to encourage. Ipelegeng, the labour-

<sup>20</sup> Government of Botswana (2010). National Development Plan 10. Government Printer. Gaborone.

based programme, is controversial because some regard it as causing dependency and inhibiting initiative. Some criticize it because they feel the sustainable option is the creation of permanent well-paying jobs. The question is how to create such jobs in the economy of Botswana with its small size and structural problems. The government needs to continuously look for more sustainable solutions to these problems.

## 5) Universal Health Care: The relationship between health care and health equity

Health care systems are a vital determinant of health. This has been well recognized in the relevant documents in Botswana, such as the National Development Plans, health policies and health sector strategic plans. Inequitable distribution of health care is a major challenge in many countries, and it is particularly so in Botswana, where the country is large geographically and the population is unevenly distributed.

The health care system is more than just the treatment of disease. Health care systems offer benefits that go beyond just treating illness; this is especially so when they are integrated with other services, such as early childhood development (ECD). They can protect against sickness, generating a sense of life security, and can promote health equity through attention to the needs of socially disadvantaged and marginalized groups. Health care systems contribute most to improving health and health equity where the institutions and services are organized around the principle of universal coverage, i.e. extending the same scope of quality services to the whole population, according to needs and preferences, regardless of ability to pay. Health care systems, therefore, have to be built on the basis of the principles of equity, disease prevention and health promotion. It is crucial therefore that health care system financing be equitable. One way of ensuring this equity is for user contribution to be based on pre-payment, such as social health insurance rather than fees at the point of service.

The health workforce is a very important component of the health care system. Its capabilities therefore have to be built and strengthened, as well as expanded to be able to act on the social determinants of health.

The current National Health Policy<sup>21</sup> has attempted to address these issues. It has followed the WHO framework on health systems and has sections on (1) Management and Coordination of the Health Sector (Governance), (2) Access and Utilization of Health Services (Service Delivery), (3) Human Resources for Health, (4) Health Financing, (5) Medicines, Vaccines and Other Health Technologies, and (6) Health Information System.

In relation to universal access, the policy document notes that, nationally, 95% of the total population and 89% of the rural population live within 8 km of a health facility<sup>22</sup>. The public sector is also stated to be the main provider of health care services, providing about 80% of all health services through public facilities and programmes.

Regarding health care financing, the Botswana government has been estimated to contribute 68.1%, private sources 20.6% and donors 11.6% of the total health expenditure

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<sup>21</sup> Government of Botswana, National Health Policy; Towards a Healthier Botswana. Ministry of Health 2011, Government Printer, Gaborone.

<sup>22</sup> 8 km has been used since the beginning of health planning in Botswana as the maximum distance from a health facility to attain for the rural population. This is in recognition of the very scattered nature of the population, especially in the western parts of the country.

in 2009/10. Most of this spending is on curative services, indicating inequity in funding and distribution of services across needs. (Ministry of Health, Republic of Botswana. 2012. Botswana National Health Accounts for Financial Years 2007/08, 2008/09 and 2009/10. Gaborone, Botswana.)

Individual cost of health care in the public sector is heavily subsidised by the government. A nominal cost recovery system through a fee at the point of service applies in the public system, with exemption for vulnerable populations (children, pregnant mothers, the aged and specified communicable diseases). The extent to which these charges affect access has not been assessed. The policy indicates that alternative methods of payment such as social health insurance are yet to be explored but does not propose concrete steps to go in that direction. Private insurance in the form of medical aid, usually subsidized by the employer by paying a proportion of the subscriptions, is available for those earning appropriate income. There is a large Medical Aid Society for public servants (BPOMAS) and a few societies for the private sector (BOMAID being the biggest). It can be argued that these insurance schemes promote health inequities because they are based on affordability and can only be accessed by middle- and high-income groups. The members are able to have access to high technology care in the private sector, which is also more efficient. It can also be argued that because the middle level and senior level civil servants generally subscribe to medical aid and have access to private care, public health services tend to be neglected. The government is also subsidizing those who earn good incomes in the public service to access elite medical care.

In NDP 10, Goal 4 of Chapter 11 (A Compassionate, Just and Caring Nation), every citizen is entitled to “Affordable and Quality Health Care Services”. Here, the government/ Ministry of Health reiterates that the health care delivery in Botswana is anchored on the PHC strategy as articulated in the Alma-Ata Declaration of 1978. If indeed this is the case it needs to be emphasized in the National Health Policy as well. The NDP reiterates that through successive NDPs, Botswana has successfully created a solid foundation of health care provision by, in addition to strengthening health care provision, also collaborating with various sectors and partners in different capacities to ensure the multisectoral approach. The plan states that 80% of the population is within 5 km of a health facility.

NDP 10 lists the areas where cross-linkages occur with other programmes as well as cross-cutting issues. The following cross-cutting issues are highlighted:

<b>Cross-cutting issues</b>	<b>Coordinating Agency</b>
Disaster preparedness: epidemic preparedness and response, disaster mitigation	NDMO
Environmental sustainability: waste management	MEWT
Gender and development: equitable provision of services	MLHA
Governance: review and development of policies and legislation	MSP
HIV/AIDS mitigation: treatment and support strategies	NACA
Human capital development: human resources development	MFDP/MESD
Information and communication technology: telemedicine, IT support	MCST

Cross-cutting issues	Coordinating Agency
Poverty eradication/Pro-poor interventions: accessible and quality services promote productivity	MFDP
Employment creation: public sector privatization and outsourcing of selected services	MFDP
Rural development: infrastructure development (hospitals, clinics and other facilities)	MFDP/MLG
Partnerships/PSP: strategic networks/linkages	MFDP

The summary above and the table shows that the health sector is committed to addressing the social determinants of health because it recognizes their importance in generally improving the health status of the people and in reducing health inequities, which are quite considerable in Botswana.

## 6. Discussion

Poverty is a major determinant of health. Although international literature tends to state that Botswana has low levels of poverty, official statistics show that there are still high levels of poverty in the country. According to various government documents, the population living below the poverty datum line was estimated at 30.3%, although latest releases by the government indicate that it has now fallen to 27%.

Health is a product of development but health is also a strong input into development. When a society is “developed”, what it really means is that the social determinants of health are favourable. It also usually means that the incomes are favourable and/or equitably distributed. It is now generally accepted, even by many economists, that the health sector is not a consuming sector but a productive one. Good health is essential for development. Healthy people are more productive.

The consequences of development policies, strategies, regulatory frameworks, etc., on health are not well-understood. Those who are not healthy do not enjoy the fruits of development.

People who undertake their own activities in their own sectors carrying out their mandate do not know that they are contributing to health. If they knew, their activities would have bigger impact. If they were to understand the impact of their activities on health, they would act even better. Some carry out work which has a negative impact on health but are not aware of it. There appears to be a general perception and expectation that the Ministry of Health is there to mop-up any incidental or negative health outcomes from other sectors.

This review has shown that the government of Botswana has many good policies and strategies that are conducive to and promote positive social determinants of health. Analysis of the health policies and strategies has generally showed a favourable picture. However, implementation is weak and there are structural attributes of society that make it difficult to achieve health equity. These generally relate to high levels of poverty and to highly skewed distribution of income. The situation makes it difficult to achieve health

equity and needs to be tackled. The government also needs to consider the feasibility of a social health insurance to avoid the situation that is currently prevalent where the elite that can pay the high fees demanded by the private sector, including those on medical aid, have access to more efficient services. By contributing to a medical aid scheme for the public servants, the government is actually spending more on health per capita on the already well off. Social health insurance would promote health equity.

The policies and strategies in other sectors are also generally supportive of positive social determinants of health. However, hardly any of them specifically mentions health. The positive impact of education on health is well-known and is discussed in the document - from early childhood development to tertiary education. The same applies to conditions in which people live - the importance for health of aspects such as good dignified shelter, access to water and sanitation, good balanced diets, electricity and communications. Government policies aim at extending these to as much of the population as possible. What needs to be explored is better and faster methods of achieving this. The same applies to employment and decent work. Policies and strategies have to be revised from time to time to achieve as close a situation to full employment as possible.

Botswana is renowned for its social welfare programmes, including social protection and social safety nets, and for its sound governance and development policies. What needs to be done is to strengthen these programmes while continuously examining their sustainability. Many of the programmes have large influence on the population's well-being as they target the poor and provide them with services needed to restore and maintain health.

The health sector has been extensively discussed. Policies and strategies are in place and are strong. The question of sustainability of some aspects of the policies and strategies needs to be continuously examined. For example, it is necessary to examine whether the technologies employed and the size and mix of the health workforce as proposed are financially sustainable.

## 7. Conclusions and recommendations

Since health is a fundamental enabler and poor health is a barrier to meeting policy challenges, the health sector needs to engage systematically across government and other sectors to address the health and well-being dimensions of their activities. For that reason, governments need institutionalized processes which value cross-sector problem-solving and address power imbalances<sup>23</sup>. This approach is now commonly referred to as the "Health in All Policies" approach. It is in this spirit that this paper has examined the extent to which social determinants of health are taken into account in various government policies and regulatory and implementation frameworks in Botswana and what can be done to strengthen intersectoral action for health.

The analysis of government policies and strategies has shown that while there is some intersectoral consideration in most of them, more needs to be done to address health and well-being in sectors other than health to address this dimension. Action to be taken to

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<sup>23</sup> WHO; Government of South Australia (2010). Adelaide Statement on Health in All Policies - moving towards a shared governance for health and well-being.

address the situation includes incorporating health outcomes in all government policies and strategies, such as those addressing poverty reduction and those dealing with early childhood development and education. This, in fact, is applicable to all development policies and strategies.











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