

BOTSWANA FEDERATION OF TRADE UNIONS (BFTU)



POLICY ON HEALTH & OCCUPATIONAL SAFE ENVIRONMENT IN BOTSWANA

Published by
The Botswana Federation of Trade Unions
(BFTU)
March, 2007

Publication supported by



Copies of this publication be obtained from
Botswana Federation of Trade Union
(BFTU)
Tel/Fax: 3952534/39520013

BOTSWANA FEDERATION OF TRADE UNIONS
(BFTU)

POLICY ON HEALTH & OCCUPATIONAL SAFE
ENVIRONMENT IN BOTSWANA

TABLE OF CONTENTS

| | |
|--|----|
| Foreword | 3 |
| Acknowledgements..... | 4 |
| Introduction | 6 |
| Background Information..... | 6 |
| Philosophy of Botswana National Health Policy..... | 7 |
| Health Delivery System..... | 8 |
| Program Integration and Human Resources Management..... | 9 |
| Health Promotion | 10 |
| Health Sector Reform | 13 |
| Occupation Safety and Health issues | 14 |
| HIV/AIDS | 22 |
| BFTU Concerns on Health | 36 |
| BFTU Policy Position on Health and Occupational Safe Environment..... | 37 |
| References | 41 |

FOREWORD

Health care is fundamental to the workers continued supply of labour. An unhealthy workforce is unlikely to be a productive workforce. It is for this reason that issues of health, occupational safety, HIV/ Aids are central to the Botswana Federation of Trade Unions (BFTU). The Health care system in Botswana is based on the principles of Primary Health Care (PHC) as contained in the Alma Ata Declaration of 1978. The Government shall, when planning its activities, put health promotion and care and disease prevention, among its priorities, the basic objectives of which shall be access by all citizens irrespective of their financial resources or place of domicile. As workers we advocate that HIV/AIDS must continue to be accorded the highest priority at the national and local levels. Sufficient Human and capital resources must be mobilized to implement health programmes as envisaged in the Alma Ata Declaration of 1978. This would pave way for a healthy nation and a productive workforce.

This policy paper articulates a unified labour perspective on health and puts forward policy guidelines of how the labour movement can deal with the challenges of integrating health issues in the labour trends in Botswana.

It is my sincere hope that this policy document will not only raise the threshold of labour concerns but also enhance constructive engagement with government and other relevant stakeholders in making health key to the labour force in the country.

Long Live the Workers Struggle, Victory is Certain!

Henry Tebogo Makhale
SECRETARY GENERAL

March, 2007

ACKNOWLEDGEMENTS

The Botswana Federation of Trade Unions (BFTU) would like to thank all individuals and organizations that contributed to the success of this document.

Special thanks to Mr. Trywell Kalusopa and Dr. Kholisani Solo, Labour Researchers and facilitators for the preparation, compilation and presentation of this policy paper as well as the Reference Group which comprised the following labour organizations: Botswana Diamond Sorters & Valuers Union (BDSU), Botswana Telecommunication Union (BOTEU), Botswana Teachers Union (BTU), Central Bank Union (CBU), Botswana Secondary School Teachers Union (BOSETU) and Trainers and Allied Workers Union (TAWU) for the valuable insights and suggestions raised during the discussions and consultative meetings that enriched the document.

The BFTU also extends gratitude to the following affiliates and associations that participated in the consultative workshop to shape the document: Air Botswana Employees Union (ABEU), BDVSU, Botswana Public Employees Union (BPEU), Botswana Hotel Tourism & Travel Workers Union (BHTTWU), Botswana Housing Corporation Staff Union (BHCSU), Botswana Bank Employees Union (BOBEU), Botswana Meat Industrial Workers Union (BMIWU), Botswana Primary Schools Teachers Association (BOPRITA), BOSETU, Botswana Mine Workers Union (BMWU), Botswana Postal Services Workers Union (BPSWU), Botswana Power Corporation Workers Union (BPCWU), Botswana Unified Local Government Staff Association (BULGSA), Botswana Savings Bank Union (BSBU), BTU, Botswana Railways Workers Union (BRAWU), Botswana Wholesale Furniture and Retail Workers Union (BWFRUWU), CBU, Maranyane Staff Union (MSU), University of Botswana Non-Academic Staff Union (UBNASU), Trainers and Allied Workers Union (TAWU).

The BFTU wishes to thank the Friedrich Ebert Foundation for the generous support that enabled the consultation, preparation and publication of this policy document.

The BFTU wishes to thank the Friedrich Ebert Foundation for the generous support that enabled the consultation, preparation and publication of this policy document.

1.0 INTRODUCTION

- 1.1 This document is the BFTU policy paper on health in Botswana. The policy paper arises out of the methodical engagement of the BFTU affiliates and represents a unified position regarding the health and occupational safe environment in Botswana.
- 1.2 The development of the paper involved research work and consultations with a sample of BFTU affiliates and other key stakeholders in the health sector.
- 1.3 The policy paper is conceptually from a labour perspective and presents policy guidelines on strategies for integration of the health sector with the productive labour systems/trends in the country. This is because the need to align health to employment policies is of critical focus for the BFTU.

2.0 BACKGROUND INFORMATION

- 2.1 Botswana's population rose from 550,000 in 1966 to 1.6 million according to the 2001 National Population and Housing Census. The population is expected to reach the 2 million mark by 2015.
- 2.2 Due to improvement in the performance of the economy, life expectancy rose steadily from 46 years in 1965 to 56 in 1981 and then 62.5 in 1991. Crude death rates per 1000 people fell from 20 in 1960 to 10 in 1991.
- 2.3 This situation is expected to drastically change due to the impact of HIV/AIDS. In 2000 for example, an estimated 19% of the total population was infected with the HIV virus. Infections are very high at 36% adults (estimates derived largely among expectant women) aged 15- 49 years (GOB/UNDP, 2000). These are said to have reduced to

17.2% for the overall population and 32.4% among expectant women aged 15-40 years according to preliminary health survey of 2006.

3.0 PHILOSOPHY OF BOTSWANA NATIONAL HEALTH POLICY

- 3.1 The health care system of Botswana is based on the principles of Primary Health Care (PHC) as contained in the Alma Ata declaration of 1978. The Government shall, when planning its activities, put health promotion and care, and disease prevention, among its priorities, the basic objectives of which shall be access by all citizens of Botswana to essential health care, whatever their own financial resources or place of domicile, and the assurance of an equitable distribution of health resources and utilization of health services. (NDP 9)
- 3.2 PHC in Botswana emphasizes and ensures community participation inter-sectoral collaboration and equity. It also ensures that health care is affordable and accessible to the people. Further Botswana's commitment to social justice and equity lends itself to the operationalization of the PHC concepts. (Owolabi and Shaibu 1999)
- 3.3 Health services shall be structured and operated in such a way that they shall be linked with each other as well as with social services, and, together with available resources, shall be managed in such a way as to derive maximum social benefit therefrom, with minimum of waste.(NDP 9)
- 3.4 The development of the private health sector shall be supported, and in particular the cooperation of such sector with the public sector shall be encouraged.

- 3.5 In pursuance of some of the above objectives, special measures may be taken in respect of high-risk groups, such as children adolescents, pregnant women, the elderly, disabled persons, and workers whose occupations or professions justify such measures.(NDP9)

4.0 HEALTH DELIVERY SYSTEM

- 4.1 The Botswana Health Care (BHC) delivery system comprises government health institutions, missionary, mine and private-commercial health institutions. The Government, through its Ministry of Health, is the main provider of health care. The health care delivery system, which is arguably one of the best in Africa, is based on the principles of Primary Health Care (PHC) as described in the Alma-declaration of 1978 (Ministry of Health, 1996).
- 4.2 The National health care system is organized hierarchically into Mobile stops at the bottom, Health posts, Clinics, Primary Hospitals, District hospitals, and Referral hospitals at the apex. While the Referral hospitals are located in the two cities of Gaborone (the capital) and Francistown, the district hospitals are located in the headquarters of the 11 districts and town councils. The Primary Health Care (PHC) system is mainly run by the Ministry of Local Government through the Council Health Departments. (Owolabi and Shaibu 1999) The lower the level of the health care system, the smaller is the population it is serving. For instance, while each health clinic serves households within a kilometer radius, health posts serve those residents in remote areas, and in cattle posts.
- 4.3 The health and medical personnel are also evenly distributed across these tiers of health care organization with, specialized professionals being located mainly at the referral (apex) hospitals, while the general medical and other health professionals are located in the district and primary hospitals.

(Owolabi and Shaibu 1999) The clinics, health posts and mobile stops are manned mainly by experienced registered nurses, midwives and family welfare educators. The PHC system is periodically supervised and monitored by the District Health Team (DHT), which is set up by the Local Government Council Health Department. The DHT are composed of multidisciplinary health professionals including medical officers, environmental health officers, nutrition officers, health educational officers and others.

- 4.4 The curriculum of nursing education and preparation in Botswana, particularly at advanced level courses, includes the diagnosis of, and prescription of treatment for the common infectious and non-infectious diseases. (Owolabi and Shaibu 1999). The nurses, who form the backbone of the health care delivery system, are thus adequately and technically prepared for the services in the PHC system. This is more so when there is a big shortage of qualified medical and other health professionals. For instance, while the ratio of qualified physicians to the population is 1:4130, that of nurses is 1:401. These values are however, substantially better than the sub-Saharan Africa average (18,488 & 6504) respectively and all developing countries average (5,767 & 4,715) (UNDP, 1996) respectively. There is however plans underway to expand both the infrastructure and human resources to bring health care, even closer to the people. (Owolabi and Shaibu 1999)

5.0 PROGRAM INTEGRATION & HUMAN RESOURCES MANAGEMENT

- 5.1 The PHC delivery system is decentralized. Each level of the PHC system is semi-autonomous, particularly at the district level with the central Ministry of Health playing supervisory and coordinating roles, in addition to formulating the national policies on health care. The Ministry of health also

defines the relationship between itself and district and town councils.

- 5.2 The health services provided by mission hospitals, hospitals and private-commercial hospitals are governed by relevant legislation and their relationship with the Ministry is well-defined (Ministry of Health, 1995). The Ministry of Health is in firm control of the PHC system, despite the decentralization. The available medical and health professionals are equitably distributed among all levels of the PHC system. The decentralization process ensures that every ill patient at grassroots receives prompt medical attention while at the same time, problems unique to particular regions are collated and referred to the district Health teams and the central administration at the Ministry of Health. National health policies are actually based on the communications between the regional health offices and the central Ministry of Health. (Owolabi and Shaibu 1999)
- 5.3 The consolidated model of health planning and delivery is adopted in national health manpower planning. The integrated model promotes cooperation between all government branches providing health services, provide opportunities for service rationalization in order to minimize duplications and provide for re-investments in program expansion or new program development, promotes ownership by local authorities, increases compliance and maximizes achievement of targets. (Owolabi and Shaibu 1999)

6.0 HEALTH PROMOTION

- 6.1 Health promotion is a major aspect of health care in Botswana. Every level of health care delivery has a component of health promotion. Health promotion and avoidance of ill health, through behavioral modification service, include health education, environmental sanitation,

and disease prevention, care of vulnerable groups and maintenance of special disease control. Health counseling is a standard service usually given to patients and their relations. This is with a view to changing the behavior of the people away from a risk-inducing one. Data collection, evaluation, and epidemiology are parts of community health services, with each district having health education officers and nutrition officers. The high emphasis on health promotion in the PHC delivery system is premised on the Governments concession that Botswana may still be at a level of development where the disease pattern is predominantly determined by poverty, poor nutrition, low levels of education, and undesirable environmental conditions such as poor sanitation. However, Botswana seems to be undergoing an epidemiological transition characterized by chronic illness related to changes in lifestyle, particularly among urban dwellers. These diseases may include chronic stress, hypertension, obesity and diabetes (NDP8) (Ministry of Health 1996). The Ministry of Health further has a department of Family Health Education, which is specifically involved in health promotion of the individuals, families, and communities. (Owolabi and Shaibu 1999)

- 6.2 The involvement of the communities in health care delivery is a major key to the identification of cultural attitude and practices, which may hinder the success of the health promotion program. Such health-hindering cultural practices are normally dealt with through cultural brokering and re-patterning.
- 6.3 Corporate health fitness programs are almost non-existing although some private employers provide recreational facilities for their employees use in the evenings and at weekends. Even, in these few cases, there is no corporate policy compelling or encouraging employees to participate in recreation. It is left to individual worker's decision. Alcohol consumption is very prevalent. It, in most cases, takes the

form of social drinking and is fast becoming a regular cultural celebration every weekend from Friday to Sunday. This appetite for alcohol, which appears to be enjoying some cultural acceptance, is fast degenerating into cases of alcohol abuse and alcoholism. In fact, many of the social problems rampant, particularly among the youths, are being traced to and blamed on alcohol misuse and abuse. These problems include juvenile delinquency, drug abuse, auto-mobile accidents, and early sexual intercourse, and teenage parenthood, wife-bashing and criminal tendencies like burglary, rape and vandalism (Owolabi & Kalui, 1997).

- 6.4 The absence of recreational opportunities has been implicated by researchers and sociologists, as a major contributor to the social problems. Most youths have also, often blamed the lack of recreational skills and facilities, as the major hindrances to their participation in sports and recreation (Masala *et al*, 1997). All the social problems traceable to lack of recreational skills can be directly and indirectly linked to the absence of Physical Education in the school curriculum. Empirical and well-designed studies have associated early exposure to Physical Education and physical activities with positive exercise habits throughout adult life (Trudeau *et al*; Taylor *et al*, 1999). Physical Education is not currently being taught as a formal subject in Botswana schools. Although Physical Education has since the last ten years always existed as a scheduled subject on the schools timetables, there is little or no evidence of its being formally and professionally taught due to various omissions in the implementation process (Owolabi & Sewane, 1998). The department of Physical Education at the University of Botswana only began offering Physical Education Programs at Certificate, Diploma and Degree level, four year ago. (Owolabi and Shaibu 1999)

7.0 HEALTH SECTOR REFORM

7.1 Health sector reform is defined as a sustained process in policy and institutional arrangements designed to improve the functioning and performance of the health sector and ultimately the health status of the population (NDP9). It involves changes in policies and institutions through which those policies are implemented. Reforms are primarily concerned with improving efficiency, equity, quality, cost effectiveness and consumer satisfaction. The most important underlying factor for reform is usually resource scarcity and the need for efficiency, as is the case for Botswana. (NDP9) It is essential to increase value for money especially in view of the long term sustainability of health expenditure under constrained national budgets in the coming years. Some health reform initiatives will therefore be undertaken during the Plan period. (NDP9) The purpose of the reform will therefore be:

- To ensure a more cost effective use of resources and improve the allocation and management of existing resources;
- To minimize wastage;
- To get users of the health services to contribute to their health care by exploring various ways of raising revenue through cost recovery techniques (e.g. user fees, various kinds of private or community based social financing, and insurance plans).(NDP9)

7.2 In order to strengthen health policy, a series of studies will be undertaken aimed at establishing the patterns of health expenditure (public and private), the ability and willingness of individuals and families to pay, the feasibility of a national health insurance scheme, etc. (NDP9) The studies will also aim at examining different ways of user contribution, such as user fees and risk sharing, like health insurance and prepayment schemes. Once these studies are completed, the appropriate essential package, which the

Government will guarantee to every citizen, will be put together, and policy will be made on the payment for services beyond the essential package. Government will decide to what extent it will subsidize any of the discretionary services for those who cannot afford them. (NDP9)

8.0 OCCUPATIONAL SAFETY & HEALTH ISSUES

- 8.1 Worker's Safety and Health are critical elements in every work setting. A safe working environment cuts absenteeism, companies' insurance bills and enhances productivity. The problem of occupational health and safety presents a serious challenge to most organizations in Botswana. Both Employers and Trade Unions must play a leading role in identifying hazards, educating members and helping in protecting their members against work hazards. Prevention of the workplace accidents and infections should be an integral part in an effective and coherent strategy for a number of reasons. This is in recognition of the fact that industrial accidents can have a negative impact both on the well-being or morale of employees and on the productivity of the workplace.
- 8.2 Research on occupational health practice in SADC countries reveal that "workers are... exposed to new chemical, psychosocial and physical hazards that are emerging from new forms of industrial processes and work organization" (Loewenson, 1998). Studies have also shown that occupational injury, illness and fatality currently accounts for significant losses, with over 3% GDP losses annually due to these causes. This means investments in occupational health and safety can thus bring gains in productivity and market access (Loewenson, 1998).

- 8.3 Document analysis indicates that several statutes exist on the question of accidents and compensation as the case may be. Thus, the employer has a common law duty to assess the work place in order to provide a safe working environment for his employees^[1]. Where an employee is injured at work and institutes a delictual claim against the employer, the employee will succeed if he or she can prove intent or negligence on the part of the employer or of a co-employee if the employer was to be found vicariously liable. Similarly, if an employee contracts a disease and it can be proved that the disease arose out of or in the course of his employment due to the nature of the work, he is engaged upon, the employer has a common law duty to compensate the employee for damages suffered in consequence of the disease. These actions were available at common law but now the state has intervened and passed legislation to enable persons who suffer from employment injuries and occupational diseases to be compensated by the employer. In Botswana, employment injuries and occupational diseases are compensated through the Workmen's Compensation Act scheme^[2]. What follows below is an account of how the Act operates.

Workmen's Compensation Act

- 8.4 Most social schemes will try to provide an income replacement for those persons affected by a loss of the ability to earn whether this is due to an accident or sickness. The need arises to wherever possible restore the status quo ante of the individual by either helping him to return to work or

^[1] Olivier M.P. et al. Social Security Law, General Principles. Butterworths. Johannesburg, 1999. pg 307.

^[2] Botswana Government: Workmen's Compensation, Chapter (47:03) Laws of Botswana. Government Printer. Gaborone.

provide for full or partial replacement of the individual's previous income.

- 8.5 Occupational accident and injury schemes are among the most widespread systems of social security^[3]. If various branches of social security from different countries are examined, it is clear that almost every country, regardless of continent, will be found to have an insurance scheme to cover these risks^[4].
- 8.6 In Botswana, there is a Workmen's compensation Act which is intended to provide for compensation of workers for injuries suffered or occupational diseases contracted in the course of their employment or for death resulting from such injuries or diseases. It applies to any worker employed by the Government, any local authority or statutory corporation in the same way and to the same way and to the same extent as if the employer were a private person^[5]. The employer will be found liable if the accident arose out of and in the course of a workers employment and resulting in personal injury^[6].
- 8.7 An employer whose worker suffers personal injury or an occupational disease arising out of and in the course of the workers in employment shall be liable to pay compensation in accordance with the Act^[7].

[3] Note 1 Ibid. Pg 312

[4] Note 1 Ibid. Pg 312

[5] Section 3(i) Workmen's Compensation

[6] Section 2 Workmen's Compensation

[7] Section 11 (i) Workmen's Compensation

- 8.8 An employer shall not be liable to pay compensation for any injury or occupational disease which does not incapacitate the worker to an extent that he is unable to work and earn full wages for any length of time or that has been deliberately self inflicted^[8].
- 8.9 According to Section 11(2), an employer shall not be liable to pay compensation for any injury or occupational disease;
- “(c) that is proved to have been caused by the workers willful misconduct such as
- i) being under the influence of intoxicating or narcotic drink, drugs or other substance;
 - ii) deliberate contravention of any law, regulation, or order, whether statutory or otherwise, expressly made to safeguard the health and well being of workers;
 - iii) the willful removal or disregard of any safety measures or other device which the worker knew to have been provided for the purpose of securing the safety of workers or;
 - iv) any other act or omission deliberately done contrary to given instructions; or
- (d) that can be proved to have been caused due to a health problem that worker has had an known about but had not disclosed to the employer^[9].”
- 8.10 Every employer is required to insure and to keep himself insured with such insurers as may be approved from time to time by the Commissioner for Workers Compensation in

[8] Section 11 (2) Workmen’s Compensation Act

[9] Note 8 Ibid

respect of liability under the Act to any worker employed by him^[10]. This does not however apply to Government^[11]. It is an offence for an employer to fail to insure or keep himself insured.

- 8.11 Workers enjoy a common law right to a safe work environment^[12] and the purpose of such social labour legislation (Workers Compensation) is to;

“... enlarge the common law rights of employees. This history of social legislation discloses that for a considerable number of years there has been progressive encroachment on the rights of employers in the interests of workmen and all employees. So much has been the purpose of social legislation that employees have been prevented from contracting to their detriment. They have been prohibited from consenting to accept conditions of employment which the legislature has considered too onerous and burden-some from their point of view.”^[13]”

- 8.12 It is in this light that whatever claim that may have accrued to the employer is replaced by insurance coverage. The Act makes it clear that failure to take insurance coverage for employees attracts a P5000 fine or a term of imprisonment of three years or both^[14]. Conviction for the offence does not absolve the employer from liability to compensate the worker in accordance with the Act.

^[10] Section 31 (I) Workmen’s compensation Act

^[11] Section 21 (2) Workmen’s Compensation Act

^[12] Note Ibid. Pg 325

^[13] R v Canqan 1956 (3) SA 355(E) 357 – 358

^[14] Section 31 (4) Workers Compensation

8.13 Notwithstanding the exclusion of liability as indicated in Section 11 of the Act, the Minister may, where the injury results in death or permanent incapacity, on consideration of all the attendant circumstances, award compensation to such extent as he may consider appropriate^[15].

8.14 Occupational diseases are listed in schedule 2 of the Act and workers are entitled to compensation should they contract such a disease. According to Section 21(I):

“A worker suffering from a scheduled disease or his dependants may obtain from a medical practitioner a certificate certifying that:-

(a) the worker is suffering from a scheduled disease causing incapacity or that the death of the worker was caused by a scheduled disease; and

(b) that such disease was due to the nature of the worker’s employment and was contracted within such period preceding the date of incapacity or death as may be prescribed in respect of that disease.”^[16]

8.15 The Act provides that where the Commissioner for Workers Compensation, appointed in accordance with section 4 of the Act, is satisfied that the allegations in the certificate are correct, the worker or his dependants if he is dead, shall be entitled to compensation as if such incapacity or death had been caused by an injury arising out of and in the course of his employment.^[17]

^[15] Section 11 (3) Workers Compensation

^[16] Section 21 (1) Workers Compensation

^[17] Section 21 (2) Workers Compensation

- 8.16 Employers are required to report injuries and occupational diseases within seventeen days of the date the injury occurred or disease diagnosed.^[18] Proceedings under the Act will not be maintainable unless notice of the injury or disease has been given by or on behalf of the worker as soon as practicable. This must be before the worker has voluntarily left the employment in which he was injured or at any rate within twelve months from the date it occurred or in circumstances where death is alleged to have occurred, within twelve months from the time of death.^[19]
- 8.17 The Act provides a no-fault compensation for employees who are injured in accidents that arise out of and in course of their employment or who contract occupational diseases.^[20] Employees who suffer temporary disablement, employees who are permanently disabled and the dependants of employees who die as a result of injuries sustained in accidents at work or as a result of occupational diseases are thus compensated for their loss of earning capacity.
- 8.18 A large number of persons have been excluded from the purview of the Workman's compensation Act. The excluded categories include domestic workers, the informally employed, the self employed and so called dependant contracts. The Act does not place much emphasis on prevention. The aim of such social labour legislation should have been prevention, reintegration, protection, regulation, inclusiveness and compensation. Be that as it may, the Act goes a long way as a social safety net for occupational diseases and accidents.

[18] Section 9(1) Workers Compensation

[19] Section 8(1) Workers Compensation

[20] Olivier M.P. et al; Introduction to Social Security, Butterworths, Duban 2004. Pg 326.

Factories Act

- 8.19 Apart from the Workman's Compensation Act there is also the Factories Act (Cap: 44:01) which provides for the regulation of the conditions of employment in factories and other places as regards the safety, health and welfare of persons employed therein and for the safety and inspection of certain plant and machinery and for purposes incidental to or connected with matters aforesaid.
- 8.20 The Act provides for the prevention of fire in that all inflammable substances should be kept in a fire resistant. It also provides that adequate means of escape should be provided in case of fire for persons employed in factories having regard to the circumstances of each case. The factories Act have welfare general provisions. An adequate supply of potable drinking water shall be provided and maintained at suitable points conveniently accessible to all persons employed. There shall be provided and maintained, so as to be readily accessible, a first aid box or cupboard.
- 8.21 In the case of any of the processes specified in the Act, suitable goggles or effective screens shall be provided to protect the eyes of the persons employed in the process. Where, in any factory, electric welding is carried on, effective provision shall be made, by screening or otherwise, to prevent persons employed (other than persons employed in the welding process) being exposed to the electric arc flash. Furthermore, where in any factory, workers are employed in any process involving excessive exposure to wet or to any injurious or offensive substance, suitable protective clothing and appliances, including, where necessary, suitable gloves, footwear, goggles, head or face coverings or any other necessary clothing shall be provided and maintained for the use of such workers.

The Minister is empowered by the Act to make regulations for the better carrying out of the objects and purposes of Act. Periodic inspections are envisaged by the Act.

Compliance with International Standards on OSH

- 8.22 Document analysis shows that Botswana has not acceded to any international instruments relating to occupational health and safety. These instruments include, Protocol to the Occupational Safety and Health Convention, 1981(Protocol 2002), Asbestos Convention No.162 of 1986, Occupational Cancer Convention 139 of 1974, Prevention of Major Industrial Accidents Convention 174 of 1993. It has also not acceded to Working Conditions (Hotels and Restaurants) Convention no.172 of 1991. Convention No.176 on Safety and Health in Mines of 1975 was ratified on 5th June, 1997 but has not been enacted.

9.0 HIV AND AIDS

This part discusses the impact of HIV/AIDS in Botswana with reference to three dimensions namely; the social policy, legal and economic and labour markets dimensions. Under the social policy perspective, it discusses the following: status of the HIV/AIDS pandemic; current responses and policy priorities; coverage of social security schemes; poverty implications and gender and vulnerability measures. The legal dimension on the other hand addresses some fundamental questions namely: the legal status of people infected and affected by HIV/AIDS; constitutional protection; equality and discrimination issues; the labour law paradigm and responses; role of international law and minimum standards, and the impact of law reforms. Finally, the economic and labour market dimension discusses; the macro-economic impact of HIV/AIDS, viability of schemes, financial support, and market responses. The section also

concludes by outlining some challenges and making recommendations for a way forward.

9.1 Status of the Epidemic in Botswana

HIV/AIDS has become one of the most serious social, health, economic and development problems in most of the countries, particularly in Sub-Saharan Africa. In Botswana, the first case of HIV-related illness was first discovered in 1985. Since then, the virus has spread rapidly throughout the country. For example, data from the 2002 HIV Sentinel Survey carried out among pregnant women reveal that at the national level, the prevalence rate is 35.4%. The recent data collected by the Central Statistics office in collaboration with the National

AIDS Coordinating Agency (NACA) found that the overall HIV prevalence in the general population aged 18 months and older now stands at 17.1%²¹. Age groups 30-34 years is the highest with a prevalence rate of 40.7% followed by age group 35-39 at 36.9%, age group 25-29 at 33.0% and 40-44 at 30.5%.²² The highest proportion of HIV positive population was found among people living in towns (22.0%) followed by those living in cities (19.9%). The lowest prevalence was found among people living in the rural areas (15.8%)

In terms of the impact of the epidemic, the latest figures from the Central Statistics Office (CSO) reveal that about 18% of all deaths were attributed to HIV/AIDS.²³ Child survival indicators have deteriorated as a result of the epidemic. For example, infant mortality rate has increased from 48 in 1991 to 56 deaths per 1000 live births in 2001. The under-5 mortality rate increased from 62 to 74 deaths

²¹ CSO (2004) Botswana AIDS Impact Survey (BIAS II)

²² Ibid

²³ CSO National Census Report.

per 1000 live births in 2001. Further, death rates among the 25-29 age groups almost doubled from 7.3 to 16 deaths per 1000 people. This rate tripled for the age group 30-34 showing recorded deaths from 8.5 to 23.6 deaths per 1000.²⁴ It was projected that the total population (without AIDS) would rise from 1.327 million in 1991 to 2.648 million in 2021 (an increase of 2.8% per year). With AIDS, the total population is projected to rise to only 1.874 million in 2021, an increase of 0.9% per year.²⁵

9.2 Current Responses and Policy Priorities

HIV/AIDS has been accorded the highest priority at the national and local levels. For example, the national response to HIV/AIDS is coordinated by a multisectoral National AIDS Council (NAC) chaired by President Festus G. Mogae, with the Minister of Health as the Vice Chair. The Secretariat of the NAC is the National AIDS Coordinating Agency (NACA). At the government ministerial level, full-time AIDS coordinators have been appointed to coordinate, plan, implement, and monitor sector responses. In terms of national planning, HIV/AIDS is a cross-cutting issue in all the sectors of National Development Plan 9 (2003/4-2008/9).²⁶

Further, at the National Parliament level, a Parliamentary Select Committee on HIV/AIDS has been formed to enhance the capacity of parliamentarians across party lines and to able them to act as catalysts for information dissemination in their respective constituencies. The district response is coordinated through the District Multisectoral AIDS

²⁴ Republic of Botswana *Status of the 2002 National Response on HIV/AIDS* 16.

²⁵ See Republic of Botswana *Macro-Economic Impact of HIV/AIDS*, 5.

²⁶ See National Development Plan 9 (2003/4- 2008/9).

Committees (DMSAC) chaired by the district commissioners, while civil society efforts are coordinated by various agencies. These include the Network of AIDS service organizations (BONASO), Network of People Living with HIV/AIDS (BONEPWA), Network for ethics and law on HIV/AIDS (BONELA) and Botswana Business Coalition for HIV/AIDS (BBCA).

A National AIDS Policy was formulated in 1998 to guide the response of the above actors, including community organizations, parastatal and private sector organizations as well as the members of the community. The policy encourages these sectors to develop and implement their own prevention activities with some technical and financial support from government and development partners. The broad policy interventions include the following:²⁷

- the prevention of HIV/STD transmission;
- the reduction of the personal and psycho-social impact of HIV/AIDS and STD;
- the mobilization of all sectors, and communities, for HIV/AIDS prevention and care;
- provision of care for people living with HIV/AIDS;
- the reduction of the socio-economic consequences of HIV/AIDS and STD;

The policy underscores the need to utilize the social protection system to deal with the consequences of the pandemic. For example, section 4.13 of the policy calls for the revision of the criteria for eligibility for destitute support to enable families caring for people with AIDS and orphaned children to have access to support, in line with the National Policy on Destitute Persons. This section also outlines the need to provide welfare support to ensure that basic needs of children are met, including their health needs, and that sufficient resources are available to implement community

²⁷ See Botswana National Policy on HIV/AIDS, 4.

home-based programmes.²⁸ Besides provision of basic needs, the policy calls for the protection of the rights of HIV/AIDS-infected workers to enable them to lead normal productive lives.²⁹

The policy further acknowledges that in the long-term, HIV/AIDS will have a devastating effect on the social and economic development and therefore calls for an effective national response to militate against its impact. However, there is no specific mention of the impact of the pandemic on the social protection system, although this is implied in the general principles.

9.3 Community Home-Based Care

This programme was established in 1995 in response to increased illnesses due to HIV/AIDS. The aim of the programme is to ensure quality care from health facilities to the home setting. The programme is implemented through joint partnership between the Ministry of Health and Ministry of Local Government. In 2002, 6,380 patients were registered by social workers compared to 1058 in 2001.³⁰ Patients enrolled in this programme benefit from the clinical medical assistance as well as a food basket that is aimed at meeting the nutritional needs of the patients. Therefore, the Pula worth of the food basket depends on the nutritional needs of patients. For example, some patients receive as much as P397.00 worth of food, while others get P276.00 or less. Other assistance includes supplies such as gloves, mackintosh bedspreads, bedpans and disinfectants to protect both patients and care givers. Eligibility for assistance under this programme is not means tested.

²⁸ See National Policy on HIV/AIDS, 8.

²⁹ See the ethical and legal aspects, *Ibid* 11.

³⁰ Republic of Botswana *Status of 2002 Response* 25.

9.4 National Antiretroviral Therapy (ARV) Programme

Government is committed to providing ARV therapy on a national scale to all HIV-infected individuals. By 2002, only four sites were providing this service with an enrolment of 8,000 patients. Out of this number, 554 have died. Plans are underway to increase the number of sites to 13 by the end of 2003. Government has spent P12 million on ARV therapy in partnership with African Comprehensive HIV/AIDS Partnership (ACHAP).

9.5 The Legal Dimension

HIV/AIDS is not only a health issue; it is also a rights issue.³¹ The primary contention of human rights lawyers and organizations is that any HIV/AIDS policy and programme that does not incorporate the human rights dimension is inadequate.³² Disregard of human rights may make it difficult to contain the spread of the disease.³³

9.5.1 The role of International Law and Minimum Standards

There are several international instruments which have been formulated to protect human rights. These human rights instruments include the Universal Declaration of Human Rights (1948), The International Covenant on Civil and Political Rights³⁴ and the International Covenant on

³¹ Industrial Court Judge, Justice De Villiers. Mmegi 31 May – 06 June 2002.

³² Oagile KD *HIV/AIDS and the Law*. Printing and Publishing Company 1999, 5.

³³ Note 2 above, 5.

³⁴ 1966.

Economic, Social and Cultural Rights.³⁵ These international instruments, together with other United Nations declarations, resolutions and recommendations laid down the basis of modern human rights law. This human rights law at international level protects human beings, irrespective of whether they are HIV positive or not, and irrespective of whether they have AIDS or not. These afore-stated instruments not only protect both HIV/AIDS infected and affected persons, but also set acceptable minimum standards for the treatment of all human beings. In addition, there are many international declarations, resolutions and recommendations about international human rights which, although not legally binding, may have crystallized into binding rules of international customary law.³⁶ Civil and political rights include the right to life, liberty, security of the person, freedom of movement, the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment.³⁷ Economic, social and cultural rights include the right to the highest attainable standard of health, to work, social security, food, clothing, housing, education, amongst others.³⁸ Some of these rights are not only set as minimum standards at the international level but are actually protected and enforced at the municipal level or domestic law level. These instruments on human rights proclaim a catalogue of human rights, which apply to all human beings and therefore, implicitly, to HIV/AIDS infected or affected persons. In the case of Botswana, most of these instruments are reproduced in the constitution in the form of a bill of rights.

9.5.2 Regional Standards

Within the region, the Southern African Development Community (SADC) came up with a Code of Conduct on

³⁵ 1966.

³⁶ Note 2 *supra* 7.

³⁷ *Ibid.*

³⁸ *Ibid.*

HIV/AIDS and Employment.³⁹ This was developed and drawn up by governments, employers' associations and labour movements of the region, taking into account Member States' national codes and also reflecting principles developed by the World Health Organization and the International Labour Organization. The Code⁴⁰ does not only balance individual rights and social needs, but also provides a platform on which to build strategies for prevention and management of the epidemic. The Code represents the common standard by which the region deals with the rights and duties relating to HIV/AIDS and employment. According to the Code, it is based,⁴¹

“...on the fundamental principles of human rights and patient rights, WHO/ILO and regional standards and guidelines, medical and occupational health ethical principles, sound epidemiological data, prudent business practice and a humane and compassionate attitude to individuals. The approach aims to achieve a balance in protecting the rights of all parties, including those with and without HIV, employers, employees, state and others. This will include obtaining a balance between individual protection and cooperation between parties”.

The policy components in the SADC Code relating to education, awareness and prevention programmes, job access, workplace testing and confidentiality, HIV testing and training, managing illness and job security, occupational benefits and protection against victimization are in line with the Botswana National Policy on HIV/AIDS.⁴² This National Policy on HIV/AIDS is the only comprehensive document in Botswana dealing with HIV/AIDS. It is however in the

³⁹ Adopted by the SADC summit, September 1997.

⁴⁰ Code of Conduct on HIV/AIDS and Employment in the Southern African Development Community.

⁴¹ Note 10 *supra*, 4.

⁴² Approved and adopted by Government on 17th November 1993.

process of revision. It is anticipated that although it does not have the force of law together with the SADC Code, it will greatly impact on those infected and affected by the pandemic. It is expected that should there be litigation relating to HIV/AIDS issues, these would be resolved in the light of not only domestic law and policy, but also in the light of regional and international standards.

9.5.3 Constitutional Protection

The Constitution of Botswana⁴³ guarantees to all human beings, regardless of race, place of origin, colour, creed, opinion, political beliefs, including people infected with HIV/AIDS fundamental human rights in its bill of rights subject to respect of freedoms of others and the public interest.

9.5.4 The right to life⁴⁴

The right to life includes the right to live in dignity, freedom and safety. The constitution of Botswana prohibits subjecting any person to inhuman, degrading treatment or punishment. People living with HIV/AIDS have a right to be treated like any other person in the society. They have the right to a full life, respect and dignity regardless of their health status.

9.5.5 The right to security of the person⁴⁵ and protection by law⁴⁶

HIV/AIDS infected persons should not be segregated, condemned or shunned. They should rather be treated with compassion and respect. Their right to security will be breached if they are discriminated against and ridiculed. Like

⁴³ 1966 Constitution Chapter 01:01.

⁴⁴ Section 4 of the Constitution of Botswana.

⁴⁵ Section 7 of the Constitution of Botswana.

⁴⁶ Section 10 of the Constitution of Botswana.

everyone else, they are entitled to full and equal protection of the law.

9.5.6 The right to privacy⁴⁷

People living with HIV/AIDS are entitled to confidentiality in all matters relating to their health and HIV status. Shared confidentiality or openness about their status with family and trusted friends helps people living with HIV/AIDS, but is a matter of individual choice. Health care workers and other professionals such as counsellors may encourage people living with AIDS to be open about their HIV status but they have no right to breach the confidentiality of any person infected or affected by the disease.

Apart from the constitutional rights of infected persons, namely, the right to life, liberty, security of the person, privacy and non discrimination which, amongst others, are guaranteed by the constitution of Botswana, there is no law other than the Public Health Act dealing directly with the HIV/AIDS scourge.

9.5.7 Labour Law Paradigm and Responses

There is nothing specified in any of the laws of Botswana, such as the Trade Dispute Act, Employment Act and Public Health Act which specifically addresses HIV/AIDS issues. Section 5 of the Public Health Act⁴⁸ makes notification of notifiable diseases compulsory by a health officer to the Ministry of Health. HIV/AIDS is however not classified as a notifiable disease.

Section 11 of the Public Health Act provides that it is a criminal offence for any person, who while suffering from a

⁴⁷ Section 9 of the Constitution of Botswana.

⁴⁸ Chapter 63:01 of the Laws of Botswana.

communicable disease, willfully spreads the disease. HIV/AIDS, although not specifically stated, is a communicable disease.

According to the Botswana National Policy on HIV/AIDS, there should be no direct or indirect pre-employment testing for HIV. Employees should be given the normal medical tests for current fitness for work and these tests should not include testing for HIV.

There should be no compulsory workplace testing for HIV.⁴⁹ Voluntary testing for HIV on the request of the employee should be done by a suitably qualified person in a health facility with the informed consent of the employee, in accordance with normal medical ethical rules and with pre- and post-test counselling.⁵⁰

Persons with HIV/AIDS should have the legal right to confidentiality about their HIV status in any aspect of their employment.⁵¹ An employee is under no obligation to inform an employer of his or her HIV/AIDS status. Information regarding the HIV status of an employee should not be disclosed without the employee's consent.⁵² The principle of "shared confidentiality" should be applied, that is, those who need to know in order for appropriate health and social welfare care to be provided should be told.

HIV-infected workers who are healthy should be treated the same as all other workers, with regard to training and

⁴⁹ Note 1 supra 29. See further *Botswana HIV/AIDS Human Right Charter* September, 2002 5.

⁵⁰ Note 1 supra 29. See further *Botswana HIV/AIDS Human Rights Charter* September 2002 5.

⁵¹ Note 1 supra pg 29. See further *Botswana HIV/AIDS Human Rights Charter* September 2002 5.

⁵² *Botswana HIV/AIDS Human Rights Charter* September 2002 5. See further, SADC Code *supra*.

promotion. As for workers with HIV-related illnesses and AIDS, they should be treated the same way as any other worker with an illness. HIV-infected employees should have access to and receive standard social security and occupational benefits.

If the employee has HIV/AIDS but is still fit for work and does his work up to the required standard, he cannot be dismissed from work because of his status. Like other workers, he must be given time off from work and sick leave if he is entitled to it. There may be a time however, when the HIV/AIDS-infected person reaches a stage when his health will inevitably have to affect his work performance. It is only then that he can justifiably be classified as a poor or unsatisfactory work performer.⁵³

9.6 Economic and Labour Market Dimensions, Macro-economic Impact of HIV/AIDS

The study on the macro-economic impact of HIV/AIDS in Botswana projects that AIDS will have an impact on GDP and average incomes, household incomes, and direct effects on government revenues and spending. The study predicts that the rate of GDP is expected to fall from the projected 3.9 per cent a year without AIDS to between 2.0 and 3.1 per cent with AIDS, and after 25 years, the economy is predicted to be 24 -38 per cent smaller with AIDS than it would have been without AIDS.⁵⁴ Further, GDP per capita growth will fall to 1 per cent a year, and average incomes will be 13 per cent lower after 25 years as a result of AIDS.

Household incomes will be negatively affected due to the loss of income if the breadwinner stops working as a result of sickness and death. Other factors affecting household

⁵³ Note 1 supra, 29.

⁵⁴ Republic of Botswana *Macro-Economic Impacts of HIV/AIDS* (2000) 35.

income include additional expenditures on health care, funeral costs and time spent providing emotional and psycho-social support. Overall, the direct effects of HIV/AIDS will worsen poverty at the household level. Finally, HIV/AIDS will have direct effects on government revenues and spending.⁵⁵ For example, government expenditure on health care is likely to go up and as a result government may be forced to impose taxes to increase revenues. The introduction of VAT in 2002 is one example of the indirect effects of HIV/AIDS. Due to increased expenditure on health care, training and sick pay, investments as well as savings will also be significantly reduced.⁵⁶

9.7 Labour Market Impact

The impact of HIV/AIDS on the labour market is expected to be negative. Due to predicted deaths of employees and frequent absenteeism, skilled labour will be relatively in short supply, with a predicted growth of only 1.2% a year. Seemingly, wages of skilled workers are predicted to rise relatively faster. On the other hand, supply of unskilled labour in the informal sector will be reduced, leading to a fall on employment level by 1% a year.⁵⁷

With respect to access to and exit from the labour market by those infected by HIV/AIDS, two scenarios are likely to occur, namely, rising morbidity (greater sickness) and rising mortality (higher death rates). Rising morbidity results in reduced productivity due to workers' time off to attend to personal health problems or looking after a sick relative and lower productivity at work, due to illness or worry. On the other hand, rising mortality means that there will be a smaller population and labour force, skilled labour will be

⁵⁵ *Ibid*, 35

⁵⁶ *Ibid*, 7.

⁵⁷ See *Study on Macro-Economic Impact of HIV/AIDS* 32

scarce and there may be a change in labour force participation rates.⁵⁸ Overall, predictions show that there will be higher productivity loss due to AIDS, higher HIV prevalence amongst skilled workers, and a slower growth rate of skilled workforce.

Caregivers who are in the labour market are also likely to be affected by these market forces. This will be in the form of absence from work to care for the AIDS patients on home-based care, absence attending funerals and also loss of time making phone calls to provide emotional and psycho-social support to family members. Income levels of these employees are also expected to be negatively affected because of medical and funeral expenses provided to a sick or dying family member.

Further, discrimination in the workplace is a likely outcome due to the stigma attached to AIDS. However, as mentioned in the section on the legal dimension, government has put some policy measures in place to address this issue. In addition, structures have been established in each Ministry to address issues of stigma and discrimination. Likewise, workplace HIV/AIDS programmes have been set up in private and parastatal organizations to raise the level of awareness and to offer a much more inclusive framework to ensure that an employee with AIDS can feel secure while he/she is still productive.

⁵⁸ Ibid, 7

10. BFTU CONCERNS ON HEALTH

While available indicators show that Botswana has made a phenomenal progress in provision of health care, this sector is facing a myriad of problems. The BFTU is thus concerned about, among others, the following challenges:

- Apart from the provisions specified under the discussion on the legal framework, there are no labour market regulations that deal with the impact of HIV/AIDS on the labour market or special provisions for those affected or infected by HIV/AIDS. Provision of social protection to affected and infected HIV/AIDS patients is thus lacking.
- There is the general shortage of critical trained health personnel to implement health programmes. For example, social workers carry heavy case loads and there is a high attrition of trained health care personnel due to lack of incentives;
- There are few counsellors that would make sure that every woman visiting the health care facilities has access to quality PMTCT counseling.
- There is inadequate infrastructure to implement ARV treatment programme.
- People are not coming forward to receive services as a result of stigma and discrimination attached to HIV/AIDS. Women in particular are not coming forward in large numbers to enroll in the PMTCT programme due to fear of cultural expectations to breastfeed and lack of support from partners.
- Civil society organizations are experiencing difficulties accessing HIV/AIDS funds as a result of

bureaucratic bottlenecks and procedures created by development partners.

- Despite numerous behavior change interventions put in place, new HIV/AIDS infections continue to be recorded.
- Most organisations do not have safety officers and the labour inspection lacks depth in the dissemination of information to trade unions through the tripartite structures so that workers are educated in the detection, prevention and control of hazards.
- Most organisations do not have adequate occupational nurses and doctors and that there are few medical surveillance checks. This means most organizations do not seriously consider monitoring the effects of employment injuries, disease and disabilities.
- There are gaps in term of human resource requirements for OSH, training and skills among the workers in most organizations.

11. BFTU POLICY POSITION ON HEALTH & OCCUPATIONAL SAFE ENVIRONMENT

The BFTU believe that the provision of health services is crucial in the improvement of the living conditions of Botswana. In the long term, such services if provided adequately can make a significant contribution to the reduction of poverty and other forms of suffering. Therefore, the BFTU advocates the following:

- The government should as matter of urgency put in place measures to recruit and retain health personnel. The need to create adequate incentives to retain

qualified professionals particularly doctors, nurses, social workers, counsellors and community home-based care volunteers is critical.

- The government should improve service delivery through the decongestion of major public health facilities.
- To work with other relevant stakeholders to lobby and campaign for appropriate legislation to put in place to address issues of HIV/AIDS on the question of discrimination and social protection.
- There is need for conducting a comprehensive review of social security system to assess the impact of HIV/AIDS on these programmes.
- The government should enhance human resource capacity of key personnel. This means academic institutions should get budget support to increase enrolments in key fields and to offer relevant and appropriate courses in health.
- There is need to increase access to funding sources by NACA and development partners by simplifying procedures for applying for these funds.
- To work with relevant stakeholders in creating avenues for increasing the involvement of men in HIV/AIDS programmes such as PMTCT, orphan care, home-based care and burial societies.
- There is need for government to develop labour market regulations to deal with the impact of HIV/AIDS.
- The National Strategic Framework on HIV/AIDS provides a comprehensive response to mitigate the

impact of the pandemic. This plan must be fully implemented to ensure that resources are mobilized to finance social security programmes.

- There is need to encourage the integration of traditional medicine through more scientific research.
- There is need for a health regulator to provide oversight and standards in health care provision to deal with issues where the market fails to correctly ascribe benefits and costs to the consumer.
- The Labour Inspection should be beefed up in terms of human resources and be modernised so as to effectively monitor trends within the various sectors of the economy.
- Since there is shortage of inspectors in the country, inspectorate efficiency may be enhanced if there were greater proactive identification and promotion of accessible and appropriate safe technologies and procedures in work places.
- The Occupational Health and Safety (OHS) training should be standardized through a national standards system and professional body that will use OHS expertise to set and audit curriculum requirements, qualifications and competencies. Such standards shall, where relevant, be in line with international standards and draw input from international professional expertise. The Botswana Training Authority (BOTA) can be given the mandate to monitor such standards.
- The Workman's Compensation Act should thus be reviewed so that the social safety net is broadened. There is also the need to recast legislation to address

the prevention, monitoring and management of occupational risks and injury in the informal economy and to develop comprehensive systems for incorporating these into national programmes.

- There is need for the ratification and enactment of the international conventions that guarantee a safe working environment. Proactive approaches in promoting a health work environment need to be backed by improved legal standards. Thus, there is the need to address gaps in legislation relating to coverage of all workplaces, setting clear rights and duties for tripartite co-operation, explicitly enabling and setting procedures for the right to refuse dangerous work, overcoming the administrative fragmentation of enforcement systems and strengthening penalties. This means strengthening social dialogue on the ratification of ILO Conventions 155 on Health and Safety, 161 on Occupational Health and Safety Services, 170 on Chemicals, 184 on Health and Safety in Agriculture and the enactment of 176 on safety and Health in Mines.
- There is need to give greater profile to the link between productivity and investment, on one hand, and to improved occupational health standards and infrastructure on another. This calls for the systematic collection of information on how occupational health improvements have enhanced productivity and national development.

REFERENCES

BIDPA *Study on Poverty and Poverty Alleviation in Botswana* Ministry of Finance and Development Planning Gaborone 1997.

Dingake K *HIV/AIDS and the Law*. Gaborone Printing and Publishing 1999, Employment Act Chapter 47:01.

Fidzani H & Ntseane D *The Situation and Response Analysis of HIV/AIDS in South East District* UNDP Gaborone 1997.

Loewenson R (1998) Situation Analysis and Issues in Occupational Health & Safety in the SADC region. Paper presented to the SADC Employment and Labour Sector meeting in Mauritius.

Loewenson R (1997) Health impact of Occupational Risks in the Informal Sector in Zimbabwe, TARSC Report prepared for ILO, Harare

Mabua GN *Social Protection Programmes in Botswana* Paper Presented at the SADC Social Security Core Group Meeting held in Gaborone 18th Sept 2003..

Mmegi “Industrial Court Judge De Villiers” *The Reporter* Gaborone 2002.

Ministry of State President/NACA *Botswana 2002 Second Generation HIV/AIDS Surveillance: A technical Report* Gaborone 2002.

Ministry of Local Government and Lands *Revised National Policy on Destitute Persons* Gaborone 2002.

Ministry of Local Government and Lands *Short Term Plan of Action on the Care of orphans* Gaborone 1999.

Molebatsi C & Mogobe *Strategic Plan for Ngamiland District* UNDP Gaborone 1999.

Ngwenya BN *Gender and Social Transformation through Burial Societies in a Contemporary Southern African Society: The Case of Botswana*. (Unpublished PhD Thesis) University of Michigan 2000.

Motor Vehicle Accident Fund Act No.6 of 1998.

Ntseane D *Socio-Cultural Factors and the Spread of HIV/AIDS: Implications for Indigenous Social Work Curriculum* Paper Presented at the Joint University Council (JUC) Conference held at Oasis Motel, Gaborone, September 2001.

Ntseane D & Ncube E *The Situation and Response Analysis of HIV/AIDS in Serowe/Palapye*. UNDP, Gaborone 2001.

Ntseane D & Solo K *Social Protection in the SADC: Developing an Integrated and Inclusive Framework - the case of Botswana* CREDA 2004.

OATUU HSEP (1996) Chemical Safety Practice in Africa in OATUU HSEP Newsletter, No 4, Zimbabwe

Olivier M.P; et.al (1999).Social Security Law, General Principles. Butterworths. Johannesburg

Olivier M.P; et.al (2004).Introduction to Social Security Butterworths, Durban

Olivier M.P; Kalula E.R; (2004).Social Protection in SADC: Developing an Integrated and Inclusive framework Rand Afrikaans University, University of Cape Town

Olivier M.P et al. (2003) Social Security, A legal analysis Butterworths. Durban

Olivier M.P. et al; The extension of Social Security Protection in South Africa, A legal inquiry. Sibe Ink, Cape Town 2001.

Owolabi E and Shaibu *Health care and promotion in Botswana*
International Institute for Health Promotion, American University,
Washington D.C. 2002

Public Health Act Chapter 63: 01.

Republic of Botswana *National Development Plan 9. 2003/4 - 2008/9* Ministry of Finance and Development Planning, Government Printer Gaborone 2003.

Republic of Botswana/UNICEF/UNAIDS *Status of the 2002 National Response to the UNGASS Declaration of Commitment on HIV/AIDS* NACA Gaborone 2003.

Republic of Botswana *Macro-Economic Impact of the HIV/AIDS Epidemic in Botswana.*
BIDPA, Gaborone 2000.

Republic of Botswana *Botswana National Strategic Framework for HIV/AIDS 2003-2009* Pyramid Publishing Gaborone 2003

Republic of Botswana *Botswana National Policy on HIV/AIDS.*
Ministry of Health Gaborone 1998.

Republic of Botswana *Constitution of the Republic of Botswana,*
Government Printer Gaborone 1996.

SADC Code of Conduct on HIV/AIDS and Employment 1997.

Solo K, *Social Security and Rural People of Botswana*
(Unpublished).

Trade Dispute Act Chapter 47: 01.

UNDP *Botswana Human Development Report: Towards an AIDS Free Generation* Gaborone 2000.

Workmen's Compensation (Chapter 47:03) Laws of Botswana

