The status of health promotion in Botswana

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Abstract

Health education and promotion remains an integral part of public health. This paper details health promotion activities in Botswana since the establishment of the profession in 1988. It further describes health promotion infrastructure, investment in health promotion, human resource training and collaborations within the country. Infrastructure and services for health promotion in the country are mainly provided by government through educational institutions, faith based organizations, non-governmental organizations, general medical practitioners and mining companies complementing the Ministry's efforts. More than 1000 health promotion cadres have been trained at certificate, diploma and degree levels by Boitekanelo College and the Ministry of Health through Serowe Institute of Health Sciences.

Introduction

Although significant strides have been made worldwide in terms of screening, diagnosis and treatment of various diseases, the burden of disease is still huge with low-income settings being disproportionately affected. This realization calls for an urgent need to shift our focus from solely pursuing medical interventions but to also tackle social and environmental determinants of health. According to World Health Organization,[1] Health promotion is a process of enabling people to increase control over, and to improve, their health. Thus, health promotion as a discipline seeks to address social issues outside of the biomedical approach. According to Sharma[2] the Ottawa Charter on health promotion sought to enhance health and well-being of populations through building healthy public policies, reorientation of health services, creating supportive environments, strengthening community action and developing personal skills.[2] In Botswana, communicable diseases such as AIDS and tuberculosis are the major causes of illness and deaths.[3] Effective anti-retroviral therapy has resulted in the decrease of mortality in the past few years.[3] The life expectancy stands at birth males/females (years, 2015) 63/68, while the maternal mortality ratio is 151.6 per 100,000 live-births.[4]

Country profile

Botswana is an upper middle-income country that attained independence from Britain in 1966. The country has also enjoyed a stable democracy since Independence. Geographically, it is a land-locked country in Southern Africa. It is bordered by Namibia to the west and North West with a short border with Zambia in the north, by South Africa to the south and by Zimbabwe to the east. The total population of Botswana is estimated at 2,024,904 with an annual growth rate of 1.9%.[5] Women in Botswana constitute 52 percent of the country's population.[5] The Gross Domestic Product per capita is 7080.12 United States Dollars (USD).[6]

Structure of education

Early childhood education starts at 0-6 age group, followed by Primary education for seven years for those aged between 6 years and 12 years. Junior secondary education begins at 13 years and lasts for 3 years, senior secondary begins at 16 and lasts for two years before one can enroll into Tertiary education. The current literacy rate is 90%.[4]

Health services

Health system in Botswana is delivered through a decentralized model with primary health care being the pillar of delivery system. Botswana has an extensive network of health facilities (hospitals, clinics, health posts, mobile stops) in the 27 health districts. In addition, there is an extensive network health facilities where there are a total of 101 clinics which can cater for inpatients, 171 clinics without beds, a further 338 health posts and 844 mobile clinics. Public Sector healthcare services are almost free for citizens whilst foreigners pay a subsidized fee. Primary Health Care services in the country have been integrated within the overall hospital and healthcare services, and are provided in the respective outpatients departments of hospitals. It is through these structures that a complement of preventive, promotive and rehabilitative health services as well as treatment and care of common problems are provided. Although not part of the modern health care system almost all traditional health practitioners (95% of 3100 registered as complementary/alternative medical professionals under the Medical, Dental, and Pharmacy [Amendment] Act of 1987) reside in rural areas where they command a lot of influence and respect among the majority of the rural populace.[3]

Administrative political structure

The country is divided into twenty-seven health districts. The government through the Ministry of Health is the principal health care provider. The Ministry of Health is responsible for the national health including policies, goals and strategies for health development and delivery. The districts and local authorities are responsible for the delivery of primary health care services through health posts, which serve remote and rural areas, clinics, primary hospitals, and district hospitals. The central government provides referral services at Princess Marina in Gaborone and Nyangabgwe Hospital in Francistown. Hospital care, medications, and laboratory tests are free for all citizens in public sector

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Key words: Botswana; health promotion; training.

Funding: No direct funding was obtained for the research.

Contributions: the authors contributed equally.

Conflict of interest: the authors declare no potential conflict of interest.

Received for publication: 6 May 2017.
Accepted for publication: 1 July 2017.

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Journal of Public Health in Africa 2018; 9:699
doi:10.4081/jphia.2018.699

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facilities. Hospitals and twenty-seven local districts administer local clinics. Each district has a district health team led by a public health specialist who is responsible for the administration and supervision of a number of public health orientated diseases such as Tuberculosis and HIV. Each district has an average of 3 or more posts for health promotion officers depending on the size of the district. In addition to government-sponsored institutions, faith based organizations, non-governmental organizations, and mining companies provide a parallel system of private health care through a complementary network of clinics and hospitals.[7]

Health education and promotion manpower

At the lowest level we have Health Education Assistants, who carry out health promotion activities. These cadres are certificate holders; during training they have 6 months classroom training followed by 6 months community internship during which they are attached to health facilities/communities. To date 600 HEAs/ CHWs have been trained at Boitekanelo College and have been absorbed by the Ministry of Health. Their main activity is to deliver basic health care guidance and health education information to homes and communities, to save lives through strengthening health-community linkages, improving health outreach to the hard to reach and upscaling the implementation of high impact interventions. There are only 2 institutions training diploma holders in Health education and promotion; Boitekanelo College (Private College) takes 2 years to train general diploma holders and Ministry of Health through Serowe Institute of Health Sciences (IHS) takes 3 years to train higher national diploma holders. The diploma holder specific duties involve planning, implementing, and evaluating health education activities for the promotion of health, prevention, and control of diseases. Degree level training is only done at Boitekanelo College where it takes 4 years to complete the program for those coming from high school whilst for the diploma holders it takes 2 years to complete the degree program. Degree holder's responsibilities involve the management of health education services at district level and those with Master's degree will coordinate health education services at National level. There are no institutions offering postgraduate training in health education and promotion in Botswana. Table 1 shows the total number of cadres who have been trained by the two Colleges.

The entry qualification of a health education and promotion officer is a College Diploma in Health education and promotion. Eighty six percent of Health educators hold a diploma, 1% masters and 13% hold a degree.

Coordination of health education and promotion programmes

Health education and promotion programmes are coordinated by the health promotion unit at national level under the department of Public Health, in the Ministry of Health. The Health education and promotion unit was created in 1988 under the department of public health with the mandate to: i) coordinate the development and implementation of health promotion and education policies, guidelines, legislation, regulations, standards and strategies relevant for public health; ii) develop, promote and sustain relevant health promotion and education interventions including new innovations and projects as a basis for building evidence based programming; iii) design, develop and disseminate health information and communications including print, television/video and computer based media in support of all health programmes and campaigns; iv) coordinate the development of community and other structures and processes that enhance community involvement and participation; v) build, coordinate, and facilitate implementation of a Comprehensive National School Health Programme in collaboration with relevant stakeholders; vi) monitor and evaluate health promotion and education programs and interventions in collaboration with the department of Policy, Planning, Monitoring and Evaluation; vii) identify research needs and implement research related to Health Promotion and education in collaboration with the department of Policy, Planning, Monitoring and Evaluation.; viii) provide technical support and guidance to the Government and non-Government organizations/agencies and other Implementing Partners on matters related to health promotion and education.

Professionalization process

There was a national consultative meeting of all Health Educators/Promoters, which led to the formation of the Botswana Professional Health Educators and Promoters Association (BOPHEPA) in Gaborone from the 16th to 18th November 1998. The purpose of the meeting was to bring all Health Educators/Promoters together and discuss professional and other related issues with a view to improve working relationships and form a professional body. Among other things discussed at the meeting included development of mechanism of collaboration between Health Educators/Promoters at DHMTs and government. Participants were also exposed to Participatory Hygiene and Sanitation Transformation (PHAST) initiative which is currently being adopted as a standard of practice in Botswana. It was on this meeting that the executive committee for BOPHEPA was selected and consultative meetings have been held annually until 2006 when Government stopped sponsoring the meetings and since then BOPHEPA has been struggling stay afloat.

Operational process for health education and promotion practice

The unit bases its activities upon the Ottawa Declaration (1986), which set down the principles guiding health promotion activities throughout the world. The Charter calls for a combination of five work strategies: construction of healthy public policy; creation of supportive environments; strengthening of community activity; strengthening of the individual's skills; and reorganization of health services.

In view of these principles of action, the Department acts in the following ways: i) legislation; ii) promotion of health policy;

Table 1. Number of graduates produced by the two Colleges.

College	Boitekanelo College	Institute of Health Sciences	Trained outside Botswana
Certificate holders trained	600	435	6
Diploma holders trained	259	184	0
Undergraduate Degree holders trained	30	None	35
Postgraduate degree holders trained	None	None	7

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iii) education and dissemination of information; iv) cooperation at the national and local level; v) media campaigns; vi) research and assessment; vii) professional development and training of persons engaged in the field of health promotion; viii) conferences and seminars.

Priority intensive programs

World Health Organisation has been instrumental in providing technical support for the development of the Tobacco Control Bill and policy, alcohol policy, Draft Health Promotion Policy, B.Sc. Health Promotion curriculum for Institute of Health Sciences, supported upgrading of Health Education Unit to Health Promotion and Education Division, and the school health policy and implementation plan.

WHO also supported implementation of Global Youth Tobacco 2008 Survey. According to the Department of Roads Traffic Safety annual report, there was a decrease in alcohol related road crashes from 675 in 2013 to 643 in 2014 and a 12% reduction in per capita alcohol consumption since imposition of alcohol levy. This reduction is partly attributed to the alcohol abuse prevention campaign and implementation of reduced blood alcohol content in the revised Traffic Act.[8]

Ministry of Health through the Health Education unit has taken steps towards prevention and control of non communicable diseases. Various communication channels among others radio, and television are being used to sensitize positive eating habits and the importance of physical exercise.

HIV/AIDS and Tuberculosis are of paramount importance when it comes to Health Promotion response to public Health. Behavior Change Communication Unit within Department of HIV/AIDS Prevention and care is composed of ten Health Promotion officers who are assigned to programmes such as PMTCT, ARVs, and Counseling and Testing, STI unit, Safe Male Circumcision, TB/HIV/AIDS and Home based Care Unit. The role of Health Promotion Officers at these Units is to implement and coordinate behavior communication activities related to the assigned programmes or units at national level. Health Promoters use mass media, print media, workshops and seminars, Health Campaigns and use of interpersonal communication through volunteers at district level to sensitize community on HIV/AIDS and related programmes.

Child welfare services

Health Education Assistants are part of the health education cadres attached to all health facilities in Botswana to focus mainly on health education at grassroots level. One of the primary health services that health education assistants offer is nutritional surveillance and growth monitoring of all under five children and report to district health education office. As a way of strengthening child welfare services, growth monitoring and promotion policy and feeding policy for under-fives have been developed.

School health

School health programme is implemented using a holistic approach strategy to facilitate uniform provision of school health services to children. The school health team at DHMT is composed of the Health Education officer, Nutrition officer, Environmental Health Officer, Dental Therapist, Education officer and social welfare officer who on regular basis visit schools as a team and offer services as per their area of specialty.

Family planning

Formulation of Family Planning Policy Guidelines and Service Standard evolved from a recognition that family planning service delivery policy and standards are crucial factors in ensuring client safety, service accessibility and appropriate training of service providers. The Maternal and Child Health/Family Planning programme of the Ministry of Health was formally established in 1973 with the setting up of the MCH/FP Unit as an integral part of the general health services. Since then, the Government, under the guidance of the Ministry of Health, has been very supportive to family planning as reflected in the National Development Plans. Family planning services is an integral part of Primary Health Care in all hospitals and clinics in Botswana. Use of interpersonal communication, mass media, education and counselling has made family planning services highly acceptable by the public.

Seasonal campaigns

Ministry of Health through the department of Public Health conducts Malaria campaigns every year particularly on the northern part of Botswana where cases of malaria escalate during rainy seasons. Health promoters in malarial zonesplay a vital role of intensifying health information campaigns on prevention of malaria, motivating and convincing community members to allow spraying teams to have access in to their homes. They also educate and demonstrate the use of mosquito nets.

Epidemic campaigns

There have been sporadic outbreaks of measles and diarrhea among under fives and in schools.[9] Every year the Ministry of Health through District health management teams embark on national campaign on Vitamin A and Measles to immunize under five year old children. Health Promoters play a leading role in mobilizing resources, advocating for support from stakeholders, community leaders and the community itself. Health Promoters as members of rapid response teams at district level, coordinate the health information, and material distribution while at national level the Health Education unit engages multimedia to support health information dissemination at district level.

Challenges

Limited resources such as transport and financial resources is a major challenge affecting Health Education and Promotion activities across the country. Health Educators are limited when it comes to travelling to reach communities as well as financing health promotion activities. In most cases there is no specific budget for Health Education and Promotion activities at District level. Programmes such as TB, HIV/AIDS, PMTCT are allocated a very small Health Education budget. These budgets are then managed and controlled by coordinators who are clinicians and hence end up giving priority to curative services.

Lack of community based media platforms such as community or district radio and television stations limit multimedia campaigns as all government and private organizations compete for slots in the Government run media houses. Health Education material development remains centralized at national level. This hinders the district health education officers from developing education materials that best suits the culture and problems in their specific districts.

Professional development and identity remains a problem area. Since the inception of the professional body in 1998 health education officers have not fully developed the

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association to fully-fledged professional body that can stand for the professional needs and aspirations of Health Education officers. A staggering Health Education and Promotion professional body is not only a challenge but a threat to the integrity of the profession and officers. In the year 1998 to 2002 the intake of Health Educators was temporarily suspended at Gaborone Institute of Health sciences for no clear justifiable reasons and the professional body did very little to advocate for re-opening of the programme until government took a decision to open it again. Despite the challenges Health Education and Promotion remains the pillar of primary Health Care in Botswana.

Conclusions

In all the achievements in Public Health, Health Education and Promotion has played a pivotal role in creating awareness on public health services as well as promoting positive behavioral changes at national level.

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