Occupational Health and Safety Legislation for the Health Sector in Southern African Development Community: The Case of Botswana and South Africa

Güney Afrika Kalkınma Topluluğunda Sağlık Sektörüne Yönelik İş Sağlığı ve Güvenliği Mevzuatı: Botsvana ve Güney Afrika Örneği

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ABSTRACT

Occupational Health and Safety (OHS) legislation, regulation, and enforcement for workers in all sectors worldwide still need to be improved and require a radical and systematic approach to foster development. However, the advent of the COVID-19 pandemic has shed light on the great need for OHS legislation in every sector, with health at the forefront. Some nations in the Southern African Development Community (SADC) region need more organizational and legislative structures in OHS, particularly in the health sector. Literature on OHS in the Southern African region is scarce because it is still in its infancy and greatly underdeveloped. The purpose of this study is to conduct a traditional review of the structure of OHS legislation in the SADC region, specifically in Botswana and South Africa's health sector. In conclusion, Botswana and South Africa have reached different levels in developing legislation frameworks that govern workplace health and safety, with South Africa having a highly developed system compared to Botswana. Human resource shortage and a lack of OHS expertise are significant challenges in implementing and adhering to workplace health and safety programs in both countries. The development of occupational health, specifically in the health sector in both countries, the Southern African region and other developing countries, could be aided by a focus on developing specific policies and legislations and providing training and education in OHS.

Keywords: Legislation, Health Care Sector, Occupational Health and Safety, Botswana, South Africa

ÖZ

İş Sağlığı ve Güvenliği (İSG) mevzuatı, düzenlemeleri ve dünya genelindeki tüm sektörlerde çalışanlara yönelik yaptırımlar hala eksiktir ve kalkınmayı teşvik etmek için radikal ve sistematik bir yaklaşım gerektirmektedir. Ancak COVID 19 pandemisinin ortaya çıkması, sağlığın ön planda olduğu her sektörde İSG mevzuatlarına olan büyük ihtiyaca ışık tutmuştur. Güney Afrika Kalkınma Topluluğu (SADC) bölgesindeki bazı ülkeler, başta sağlık hizmeti işkolu olmak üzere, İSG alanında sınırlı organizasyonel ve yasal yapılara sahiptir. Güney Afrika bölgesinde İSG konusunda bilgi kıtlığı var çünkü hala emekleme aşamasında ve büyük ölçüde az gelişmiş durumdadır. Bu çalışmanın amacı, Güney Afrika Kalkınma Topluluğu bölgesinde özellikle Botsvana ve Güney Afrika'nın sağlık hizmeti işkolunda İSG mevzuatlarının yapısının geleneksel bir incelemesini yapmaktır. Sonuç olarak, Botsvana'ya kıyasla oldukça gelişmiş sistemlere sahip Güney Afrika ile her iki ülke de işyeri sağlığı ve güvenliğini yöneten mevzuat çerçeveleri geliştirmede farklı seviyelere ulaşmıştır. İnsan kaynakları eksiklikleri ve uzmanlık eksikliği, her iki ülkede de işyeri sağlığı ve güvenliği programlarının uygulanmasında ve bunlara uyulmasında büyük zorluklar olarak gösterilmektedir. Her iki ülkede, Güney Afrika bölgesinde ve diğer gelişmekte olan ülkelerde özellikle sağlık hizmeti işkolunda iş sağlığının geliştirilmesine, belirli politikaları ve mevzuatlarının geliştirilmesine ve ayrıca İSG konusunda eğitim ve öğretim sağlanmasına odaklanılması yardımcı olabilmektedir.

Anahtar Kelimeler: Mevzuat, Sağlık Sektörü, İş Sağlığı ve Güvenliği, Botsvana, Güney Afrika

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INTRODUCTION

Protecting the health, safety, and welfare of those employed or working is the focus of OHS. [1] It encompasses employees' mental, emotional, and physical well-being and the achievement of organizational objectives.[2] The Joint International Labour Organization (ILO) /World Health Organisation (WHO) Committee on Occupational Health stated that the goal of OHS should be to promote and maintain the highest level of physical, mental, and social well-being for workers in all working sectors; to prevent health problems among workers brought on by their working conditions; to protect workers from risks resulting from factors that are harmful to their health; and to place and keep workers in work environments that are suitable for their physiological and psychological needs.[3] Strengthening an organization's OHS management system may help raise awareness while exhibiting motivation and commitment from all personnel.[4] As such, integrating OHS functions into the health sector structures is highly valuable.

Many people worldwide die daily due to illnesses or accidents at work. It is estimated that each year, exposure to 19 major occupational risk factors will result in 90 million Disability-Adjusted Life Years (DALYs) and at least 1.9 million deaths. Additionally, about 360 million nonfatal workplace accidents require more than four days off yearly.[5] All these risks have a colossal human cost. Occupation-related health problems, injuries, and illnesses create a lot of pain and cost a lot of money, both for the people who are afflicted and for the society at large.[6] The health and welfare sectors employ a sizable number of people. The combination of various dangers developing simultaneously, as well as the fact that this is a high-risk sector, has spurred debate about the need for a unique approach better to safeguard the health and safety of healthcare workers .[6]

Healthcare employees are exposed to a variety of major safety and health risk. “Bloodborne pathogens and biological hazards, potential chemical and drug exposures, waste anesthetic gas exposures, respiratory hazards, ergonomic hazards from lifting and repetitive tasks, laser hazards, workplace violence, hazards associated with laboratories, and radioactive material and x-ray hazards” are just a few of these hazards.[7] “Formaldehyde, which is used to preserve pathology specimens; ethylene oxide, glutaraldehyde, and peracetic acid, which are used for sterilizing; and other chemicals used in healthcare laboratories are also potential chemical exposures.”[7] Due to their employment and exposure to communities with high HIV and TB disease prevalence, healthcare workers, who are growing increasingly prominent in the South African workforce, are at risk of developing tuberculosis.[8] Occupational injuries and illnesses, such as biological, chemical, psychological stress, physical and ergonomically linked dangers, are common among workers.[9]

Occupational health services are estimated to be available to less than 10% of employees in Africa, with some countries, such as Tanzania, reporting notable lows of 5%.[10] OHS practice in SADC has been linked to a lack of integration into many SADC member nations' political, economic, and social environments.[11] In SADC member nations, there is a severe shortage of OHS professionals and almost no access to OHS services. Workers' access to OHS services has been hampered due to the SADC region's significant health personnel shortage, which has resulted in compromised health systems.[12] Despite the significance of workplace health and safety, only a small amount of empirical research has been carried out in the health sectors of South Africa and Botswana. This research aims to review OHS legislation, regulation, and enforcement in the healthcare sector in Southern Africa, specifically in Botswana and South Africa.

Demographic Profiles

Botswana, South Africa, the Democratic

Republic of the Congo, Madagascar, Malawi, Mauritius, Zambia, Mozambique, Namibia, Seychelles, Angola, Swaziland, Lesotho, Tanzania, and Zimbabwe are the 15 member states of the SADC.[13] Botswana is a sparsely populated landlocked upper middle-income country with slightly over 2 million people, or 3.5 people per square kilometer, according to the 2011 national census.[14] In 2050 and 2070, the population is expected to increase to 3.4 and 3.6 million, respectively.[15] With a GDP of $15.062 billion, it is one of the most prosperous countries in the world.[16] In 2014, Botswana had a 20% unemployment rate and 389,665 people employed in the public sector.[14] South Africa, like Botswana, is an upper middle-income country at the southern tip of Africa, with a population of 54 million people and a GDP of US$335.442 billion.[17,18] The country's labor force totals 20,228,000 people, with 4,909,000 unemployed and 2,448,000 working in the non-agricultural sector.[17] Between 2004 and 2010, the number of health professionals in the public sector expanded dramatically, from 153 383 in 2004 to 210 511 in 2010, with the nursing profession recording the most growth.[19]

Health Sector Profiles

Botswana employs the primary healthcare model, a comprehensive healthcare approach. It has made significant progress in achieving universal access to healthcare, which has improved and elevated individuals' living conditions.[15] The government is a significant provider of health services, accounting for 65 percent of overall health spending.[20] All residents practically have free access to healthcare. The country's healthcare infrastructure is well-developed, with 95 percent of the population living within 8 kilometers of a healthcare institution (84 percent within 5 kilometers of the nearest healthcare facility).[21] Due to a high staff/patient workload, a lack of skilled staff remains one of the biggest impediments to the availability of quality healthcare in Botswana. Despite a rise in the number of health professionals in all categories, there are fewer doctors than nurses due to a lack of training and high turnover rates. According to a 2012 survey based on the Ministry of Health and Wellness database, there were 4.3 doctors and 41.3 nurses per 10,000 individuals. Furthermore, the allocation of health workers favors urban locations.[22]

The healthcare system in South Africa is built on a referral system. Patients' first point of contact is primary healthcare, which comprises of clinics and municipal-ward-based healthcare outreach teams. Primary, secondary, and tertiary public health services are provided by health facilities housed in and supervised by provincial health departments. As a result, the provincial departments are the direct employers of health workers, while the National Ministry of Health is in charge of policy creation and coordination.[23] Regarding the number of physicians, nurses, and midwives per 1,000 population, South Africa is among the top five African countries.[24] However, there have been multiple reports of severe staff shortages in the public health sector, particularly in rural and neglected areas.[25]

ILO estimates that 2.3 million men and women perish annually due to workplace injuries or diseases, which converts to over 6000 people daily. Around 340 million workplace accidents occur annually, and 160 million people experience work-related illnesses globally.[26] According to the Bureau of Labor Statistics (BLS), the US government had the highest incidence rate of accidents and illnesses among hospital employees, with 11.9 incidents per 100 full-time employees.[27]

According to the Australian Bureau of Statistics, 690,000 (6.4%) workers over a 12-month period suffered at least one work-related injury or sickness.[28] Whereas in South Africa, there were 725 injuries and illnesses per 100 000 healthcare workers between 2007 and 2010.[29] Over 19 years, 3,852,071 occupational accidents in South Africa's general sector were recorded for compensation consideration, with 3,808,177 being occupational injuries and 44,014 being occupational illnesses.[30] In Botswana, roughly 1000 job-related accidents resulting in more than three days off work are reported yearly, with about 60 deaths. Even though they are

considered to be ubiquitous, there are few reports of work-related illnesses. The bulk of work-related accidents are claimed to occur in places of employment where no occupational safety and health laws are in effect.[31]

Occupational Health and Safety Legislation and Governance

Even though the ILO has developed global OHS instruments, such as No. 81 (Labour inspection), No. 170 (Chemical Safety), No. 161 (Occupational Health Services), and No. 174 (Prevention of Major Industrial Accidents), No. 155 (Occupational Safety and Health), most of the SADC member states still lack a comprehensive OHS legislation, policy and the resources to implement it.[32,33] Most OHS legislation administration tasks are split across various ministries, yet there is a significant disparity in the management of OHS among ministries, resulting in fragmented systems.[34] Inadequate legislation in Africa to meet the requirement for a complete OHS paired with an emphasis on chemical risks exclusively, leaving out other essential hazard categories, as well as gender sensitivity and equity issues have been noted.[35]

Occupational Health and Safety Legislation and Governance in Botswana

The regulation of OHS in Botswana is dispersed among several acts of parliament and is administered by several government ministries. OHS is overseen by Botswana's Ministry of Employment, Labour Productivity and Skills Development (MELPSD). This ministry is also responsible for disseminating OHS information and contributing to Botswana's National Health and Safety Standards development.[36] Botswana's situation is unique in that no OHS act has existed since its independence in 1966.[37]. Instead, there are several dispensed regulations divided over several statutes. As a result, the Ministry of Health does not have an Act or policy that specifically addresses OHS in health settings when it comes to healthcare workers in Botswana; instead, the following are some general legislative acts and regulations that are indirectly relevant to the health and safety of health service providers:

i.The Public Health Act 1981(Chapter 63.1): The Ministry of Health, through its public health division, provides specialist occupational health services under the Public Health Act of 1981 (Chapter 63.1).[38] Occupational health research, risk management, policy and standard creation, occupational health surveillance programs, and diagnostic occupational health services are among the services provided in his Act.[38]

ii. The Employment Act (Cap 47:01): is the primary employment law, establishing a "floor of rights" for the private sector, parastatal enterprises, and government employees, including basic minimum terms and conditions of employment. It spells out the parties' responsibilities to an employment contract, the maximum number of hours that can be worked, the rights to various types of leave, minimum salaries, and how contracts can be terminated.[39]

iii. The Workmen's Compensation Act of 1998: provides a comprehensive framework for compensating victims of workplace accidents and illnesses. Under this Act, accidents arising out of and in the course of employment that result in permanent disablement or more than three days of illness-related absence must be reported within 17 days of the date of injury.[40] The employer is responsible for compensating the injured under this act. Some exclusions from compensation eligibility include negligence or purposeful violation of any rule, regulation, or directive designed to safeguard workers' health and safety. The act also lists occupational disorders and impairment levels for anatomical losses in specific body parts.[31]

iv. The National Industrial Relations Code of Good Practice: provides day-to-day guidance on carrying out fair labor practices and good human and industrial relations in the workplace.[41] It was developed with the assistance of the labor advisory board and published under sections 49 and 68 of the Trade Unions and Employers' Organizations Act.[41] Employment discrimination, sexual harassment in the workplace, HIV/AIDS and employment, employees with disabilities, termination of employment, strikes and

lockouts, picketing, and collective bargaining are all covered by these codes. These codes apply to the OHS components for health service providers.[41] The codes summarize the law's requirements and provide good practice suggestions. If a conflict exists between these codes and the existing Acts, the Acts take precedence. [41]

Botswana requires an inclusive national OHS policy and must enlist concerted institutional support to create a framework for the long-term development of OHS.[42] The Department of OHS under MELPSD is developing an OHS policy to pave the path for legislative changes to address current concerns.[43] Standards for OHS have also been developed to serve as a basis for the reform of applicable legislation.[43]

Occupational Health and Safety Legislation and Governance in South Africa

More than 60% of the workforce in South Africa is involved in providing healthcare services to patients, exposing them to occupational hazards associated with patient care.[8] In South Africa, OHS law is spread over several ministries, resulting in overlaps, inconsistencies, duplication of activities, a lack of cooperation, and waste of essential resources across administering departments.[35] Three government ministries are primarily responsible for OHS governance and leadership: the Departments of Labor (DOL), Mineral Resources (DMR), and Health (DOH).[34] OHS is governed by a complex set of laws, regulations, and other policies. A few examples of these Acts include the Machinery and Occupational Safety Act no. 6 of 1983, the Health and Safety Act no. 29 of 1996 and Occupational Health and Safety Act no. 85 of 1993.[34] The Labour Relations Act 65 of 1995, the Employment Equity Act 55 of 1998, the Basic Conditions of Employment Act 75 of 1997, the Occupational Health and Safety Act 85 of 1993, the Protected Disclosures Act 26 of 2000, and the Compensation for Occupational Injuries and Diseases Act 130 of 1993, all protect healthcare workers, as do the Constitution and the National Health Act.[44]

i. The Occupational Health and Safety Act (OHSA) Act 85 of 1993: is concerned with how the workplace affects employees' physical, emotional, and psychological health and well-being. This encompasses everything from the work itself to the materials and procedures used. The Act is founded on the premise that employees and employers should have control over their workplaces to reduce occupational illness and injury. To establish safer working conditions in various businesses, OSHA rules are revised regularly.[44] The OHSA Act No. 85 of 1993, as amended, is the principal Act that regulates OHS in South Africa's non-mining industries, including the health sector.[45]

ii. The National Health Act No. 61 of 2003: also covers OHS in South Africa. The Act mandates that healthcare facilities ensure that healthcare workers are not injured or have their property damaged. This means that healthcare professionals must be safeguarded from bodily damage, and their working environment must be kept safe and free of any potentially dangerous situations. The National Health Act established an Inspectorate for Health Establishments to guarantee that health establishments follow these policies. The National Health Act's provisions work in tandem with the OHS Act and labor laws that govern working conditions.[44]

iii. The Compensation for Occupational Injuries and Diseases Act (COIDA) of 1993: aims to cover compensation for mortality and disablement brought on by occupational accidents or illnesses that employees get while working. This aligns with the OHSA's adoption in the healthcare industry.[44] COIDA also complies with ILO Convention No. 121: Employment Injury Benefits, adopted in 1964.[45] The Act provides compensation for (a) any incapacity caused by work-related injuries or diseases; and (b) death caused by work-related injuries or diseases.

The Compensation Commissioner, rather than the employer, is considered liable for workplace injuries or illnesses under this Act. However, the employer is responsible for salaries and expenditures during the

employee's first three months off work.[44] Medical bills, wage replacement, and death expenses are among the benefits. Employees are not entitled to compensation for pain and suffering caused by this working occurrence.[44] Due to its riches, South Africa is one of the few African nations that can afford superior occupational health care compared to its neighbors, such as Botswana.[46] South Africa's healthcare system has been re-engineered, placing it ahead of its neighbors.[47]

iv. The National Public Health Institute of South Africa Act No. 1 of 2020: creates a single national public organization responsible for providing public health services, carrying out essential public health responsibilities, and requiring a high degree of coordination across activities such as monitoring and research. In line with the appropriate provincial health policy in the relevant province, it offers illness and injury surveillance, including occupational health services.[48]

Opportunities and Challenges

In Botswana and South Africa, OHS is governed by statutory law that sets a framework of norms and standards and mechanisms to avoid workplace injuries and illnesses. Some of these laws deal with national legal and regulatory frameworks, design, construction, and usage of facilities, the rights of health workers, research, and the monitoring of OHS control measures among health workers. As a result, these regulations create a "firm foundation" for future OHS legislation in the health industry. Furthermore, both countries' OHS legislation follows a systematic and user-friendly approach. Due to their well-organized approach, they are user-friendly, especially regarding enforcement and ligation procedures. South Africa and Botswana have also built compensation legislative frameworks in conformity with the ILO's Employment Injury Benefits Convention No. 121 of 1964.[49]

Botswana and South Africa are now struggling with various issues with their OHS regulations for healthcare practitioners. In certain nations, there is a lack of access to OHS services, complete national law, and OHS policies and procedures.[33,50] Some primary difficulties affecting the SADC area include OHS human resource capital shortfalls and a need for more extensive national OHS systems for the health sector. Botswana, for example, still needs to adopt a national OHS policy. Botswana must take a realistic, practical, and systematic approach to overcome these difficulties. OHS are only present to a limited extent in the SADC.[51] Even when such services are available, coverage is limited in terms of both OHS practitioners and OHS rules and procedures.[50]

Most OHS are in the hands of unqualified occupational medicine experts. A lack of training institutes has been blamed for the scarcity of trained occupational health practitioners in the SADC area.[11] Furthermore, in contrast to South Africa, where the Department of Health has a guideline on Occupational Health Services for healthcare that is followed by national health services across the country,[52] guidelines aimed at standardizing the operational practice of OHS in the healthcare sector are essential in Botswana.

Way Forward

Enhancing existing OHS regional and international programs and national investments in OHS education offer promising opportunities for driving the OHS agenda for the health sector ahead. The most efficient use of current regional and international programs can generate a critical mass of much-needed human capital. In most SADC member nations, including Botswana, a shortage of certified OHS practitioners with appropriate expertise in occupational health is a problem. Expert occupational medicine services staffed by qualified occupational health physicians are hard to come by in Botswana.[11] A new generation of highly skilled, autonomous, and dedicated OHS experts is a feasible goal that coordinated international activities may achieve .[50] Academic institutions of higher learning and polytechnic colleges in the SADC provide an essential foundation for developing strong OHS intellectual competence. Botswana and

South Africa have recently launched OHS certificate programs and bachelor's degrees to increase regional awareness of OHS issues. Essential occupational health human resources might be pooled using good knowledge management skills to build regional OHS training institutes.[11]

Establishing clinical occupational health services infrastructure and support organizations are required to realize the core occupational health services concept. Short occupational health courses and seminars for primary health care practitioners would be tremendously valuable in advancing the cause of workplace health. The responsibility for OHS administration in this study was discovered to be spread across several ministries, including health, labor, mining, and agriculture. The authors observed a significant disparity in OHS management among ministries, resulting in fragmented systems.[34]

CONCLUSION AND RECOMMENDATIONS

Employees in the healthcare sector are much more likely than those in other types of jobs to be exposed to illnesses and injuries associated with the practice of medicine. This necessitates a thorough understanding of OHS regulations in the healthcare industry and their implementation. The two countries under consideration have the essential legislative frameworks and organizational structures in place for OHS. Even so, healthcare workers' access to OHS services, like that of the rest of the globe, must be improved. In comparison to Botswana, South Africa has a complex legal structure that has evolved over time. However, both countries' legislations are complicated and fragmented, with most of them resting within three government departments or ministries, as well as various regulatory agencies. Collaboration between the authorities administering and enforcing OHS legislation could be more frequent.[45] Due to this, work is duplicated, and limited resources are spent inefficiently. In Botswana, health and safety legislative policies are similarly spread among various ministries and must be tailored to address health issues in health institutions. As a result, unless a specific legal approach in the form of a health policy or an Act exists, health personnel are in danger of experiencing occupational hazards.[53] Unlike the mining sector, which has applicable OHS legislation, the health sector in Botswana currently needs to catch up in developing and implementing specialized legislation and procedures. The need for human capital in OHS is another critical stumbling block in these two countries. Providing primary healthcare professionals with basic occupational health information would go a long way toward closing the present skills gap.

This article discusses the flaws and prospects for reforming OHS legislation relevant to Botswana and South Africa's health sectors. The review, however, has its own set of constraints. First, there is a lack of transparency, and it is challenging to obtain public documents, which might greatly aid future efforts to improve policies and harmonize what is currently a complex jigsaw. Second, the previous literature and the current study have left many questions unanswered regarding OHS laws in the healthcare industry in both nations. For example, there is still much ambiguity regarding what in all those policies is not working and what has to be altered regarding occupational exposure and safety. As a result, more study is required to create this understanding and supporting proof. Legislations are a tangible representation of leadership and governance that can improve OHS, particularly when they are evidence-based and rigorously applied or enforced.[54]

Despite these limitations, the study's key strength is that it is the first investigation of OHS legislation in the healthcare sector in Botswana and South Africa that we are aware of. The majority of the existing research is focused on mining, agriculture, and the informal sector. This emphasis may contribute to the corpus of information regarding the current condition and requirements of OHS laws in the SADC healthcare sector and

beyond. Finally, other topics not mentioned in this article that should be incorporated in OHS legislation in the health sector require more research.

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