World Health Organization

Country Cooperation Strategy at a glance

Botswana

This map is an approximation of country borders.

Population	1,700,000
Poverty rate (% of pop below PDL)	23.4
Underweight children (under 5, %)	57.1
Net enrolment rate, primary school (%)	98.5
Literacy rate, 15-24 year olds (%)	93.9
Ratio of males to females in primary schools	0.98
Ratio of males to females in secondary education	1.07
Infant mortality rate (per 1000)	56.7
Under five mortality rate (per 1000)	74
Children immunised against measles (%)	90
Births attended by skilled personnel (%)	96
Maternal mortality rate (per 100 000)	193
HIV prevalence among adults (%)	25
Access to ART (% clinically eligible)	95
TB notifications (per 100 000)	620
Proportion of population without access to safe drinking water(%)	4%

HEALTH & DEVELOPMENT

Socio-economic situation and Determinants of Health

The stable democratic governance coupled with the natural endowment with mineral resources is facilitating very high rates of economic growth in Botswana, which is classified as a middle-income country. In the period 1999/2000 and 2004/2005, the total GDP grew at an annual rate of 8%. However poverty rates are fairly high for a country of Botswana's income level and income inequality is also high. Nationally, 23.4% of the total population lives on less than a dollar a day. The percentage ranges from 5.1% of cities/towns, to 19.3% of the urban villages and as high as 36.1% of the rural populations.[1] Nevertheless, poverty rates have been falling steadily as the economy has grown. Unemployment also remains high for a middle-income country. About 23.8% of the labour force in Botswana was unemployed in 2002/2003. These included 60.4% of the senior secondary school leavers (aged 20 to 24 years)[1]. It was also reported that the number of unemployed graduates is on the rise. The Government encourages private sector development in its efforts to create job opportunities. There is however the need to collect up to date data on poverty and unemployment so as to accurately assess the *rate* of poverty reduction, which is the measure related to MDG 1 (Eradicating extreme poverty). The national literacy rate in 1993/94 was 68.9%, and increased to 81.2% in 2003/04. Botswana's education policy has focused on achieving universal access to primary education, and more recently on providing ten years of universal education. It has also aimed at eliminating gender disparities in educational access and on providing the skills needed to meet the demands of a modern economy. Considerable progress has made with regard to gender equality, in that many previously discriminatory laws have been reformed and women enjoy reasonably equal access to jobs, education and health care. Nevertheless, women experience higher poverty rates than males, higher unemployment, lower pay for similar work, and are victims of violent crimes (rape and femicide), partly because cultural attitudes that hinder women's progress are changing more slowly than the formal legal environment. Therefore attaining MDG 3 (Gender Equality) in Botswana requires more to be done with regard to female empowerment in the economy and decision-making. As in 2007 about 90% of the rural and all the urban populations have access to improved drinking water supply. Improved sanitation coverage is 60% in the urban and 30% in the rural areas. Vulnerable populations in Botswana include people with disabilities and orphans; the latter increasing rapidly as a result of HIV and AIDS. However, Government programmes to support orphans and those caring for them appear to have been effective at reducing, although not eliminating their vulnerability to poverty and abuse. More generally, opportunities for the youth are limited once they leave school, resulting in twin problems of youth unemployment and rising crime rates.

Development Policies and the MDGs

The overall guiding document for national development in Botswana is Vision 2016, a broad based national approach adopted in 1996 focusing on the aspiration of Botswana towards the 50th anniversary of their Independence. Vision 2016 comprises seven pillars that resonate strongly with the Millennium Development Goals. The principles and objectives of Vision 2016 guide the formulation of revolving 6-year National Development Plans (NDP). The current NDP 9 expires in 2009, and the follow up NDP 10 is being formulated. Strategic and annual performance plans are developed towards attaining the health goals set in the National Development Plans. The process of revising the national health policy commenced with WHO technical support, and more support is required for its completion. A formal assessment of Botswana's progress towards the Millennium Development Goals was conducted in 2004 in line with the Vision 2016 objectives. It was noted that the country was making good progress towards achieving the MDGs (UNDP & GoB, 2004). The monitoring of progress towards some of the MDGs is hampered by data inadequacies.

Health Systems issues and challenges in organization and management

The Ministry of Health (MoH) is responsible for the formulation of Policies, norms, standards and guidelines for health services delivery as well as the provision of secondary and tertiary care whiles the Ministry of Local Government (MLG) is responsible for the delivery of Primary Health Care services through District Health Teams. In addition 2 Departments of MoH (Public Health and AIDS Prevention and Care) manage programmes that are largely implemented at the District levels and have to deal directly with District staff. Thus the responsibilities of the 2 Ministries can be said to meet at the Districts. The precise roles and responsibilities and coordination between the two Ministries are however still not clearly defined at the operational levels.

Restructuring of the Ministry of Health

WHO has provided both financial and technical support to the restructuring of the Ministry of Health to address the changing health environment and improve performance. Intense advocacy was also provided for the adoption of the revised structure. The Ministry of Health now has six Departments (each comprising of Divisions and some having Units), all headed by Directors. *(The Department of Policy, Planning, Monitoring and Evaluation; Department of Health Sector Relations and Partnership; Department of Clinical Services; Department of Public Health; Department of HIV & AIDS Prevention and Care; Department of Ministry Management).* The two new Departments are vital in coordination and monitoring of wider stakeholders in health development. However two years following the recruitment of Directors the creation of appropriate structures at the Departmental level, particularly in the new ones, is yet to be realized.

Access and quality of health services:

In addition to an extensive network of 101 clinics with beds, 171 clinics without beds, 338 health posts and 844 mobile stops PHC services in Botswana are integrated within overall hospital services, being provided in the outpatient sections of Primary, District and Referral hospitals. These facilities should be enough to provide optimal services for the population however factors affecting access and quality include unequal distribution of health facilities per population, low 'after hour' services, and variable utilization of services (bed-occupancy, length of stay for in-patients etc). In addition the commodity supply chain has also been problematic and stock outs of various commodities have been experienced. There is a need to establish set norms for distribution of PHC and hospital facilities and their use per population. This will be done within the context the comprehensive integrated services delivery plan that is currently under development. The availability and management of staff, mix of skills, equipments, medical supplies and the referral system are among the other issues that need to be addressed to improve access and quality of services.

Human resources

Shortages of Human Resources for Health remains one of the major "bottle necks" in health improvement as it is a cross-cutting issue that influences the delivery of services. Despite government's efforts in increasing the capacities of health training institutions, human resources for health have been in short supply largely to work conditions of health staff, attrition is thought to be high (precise data on the rate of national attrition is not available) and some de-motivating factors affecting skilled staff. The Government has begun to address these issues. There are also increasing demands on the already over-stretched skilled work force due to HIV/AIDS. A long term Master Plan for Human Resources for Health has been finalized. Efforts will now be directed towards the implementation of the Plan in a sustainable manner by the full participation of all relevant stakeholders.

Health financing

National Health Accounts has been developed for the identification and monitoring of public, private and donor health financing so as to assess efficiency, effectiveness and equity. A National Health Accounts Report for based on data up to 2002 has been produced. The report highlighted the need to diversify the sources of funding for sustainability. A large proportion (Over 80% of Total Health Expenditure (THE) is provided by the Government. THE as a percentage of Gross Domestic product gradually increased from 6.43% in 2000, to 9.27% in 2001 and 10.54% in 2002[1]. Current reports indicate that Government spending has exceeded the 15% set by the AU during the 2001 Abuja Summit. Government funding for health in 2002 is delivered through the Ministry of Health (56%), Ministry of Local Government (7.88%), National AIDS Coordinating Agency (9.42%) and Ministry of Education (2.96%), the rest received by private health financing agents, (Insurance schemes, Household, NGOs and private firms). In the public services, a cost recovery system has recently been increased from P 2 per person per visit to P 5 for Botswana. Foreigners pay more, depending on the services. Services such are ART services are offered free to citizens, but foreigners are expected to pay. The international agencies contribute modestly but growing amounts to health care in Botswana

Health Management Information Systems

The paucity of relevant health information necessary for planning, timely interventions and monitoring and evaluation remain a big challenge in the Health Sector. Progress has been made in some programmes, particularly HIV/AIDS, but generally there is low articulation and use of data, which results in inadequate evidence-based planning monitoring and evaluation. In addition there are inconsistencies in the health information, particularly related to the main indicators, reported by different programmes and partners, including the UN agencies. Generally there is shortage of skilled staff in data management in all sectors and low capacity in the Health Statistics Unit. The partnerships in health development and the current momentum for scaling up of interventions towards achieving the set targets of the health related MDGs provides good opportunities for improving health management information systems.

Major Disease Problems

Health in general and HIV/AIDS in particular are exerting a considerable impact on the social and economic fronts of live in Botswana. This is due to the disease burden and its impact in terms of costs for management of the diseases problems as well as the impact on overall wellbeing of the people. In addition, there are emerging health problems such as drug resistance TB and non-communicable diseases that will continue to strain the health care delivery system. Threats of emerging diseases of international importance such as pandemic influenza and climatic change related health impacts require further strengthening of the capacity of health services for timely response and containment.

A number of malaria control interventions have been implemented over the years however challenges still remain in achieving the coverage targets for pregnant women and children under five. Botswana's aim is to move from malaria control to elimination by 2015. Therefore the focus in the coming years should be on development and implementation of a comprehensive malaria elimination strategy. Maternal mortality related to complications of child birth and cervical cancer is quite high. In addition, there are gaps in terms of reaching all children with the child health services, including malnutrition contributing to child mortality. The focus in the coming years will be to implement the road-map for Reduction of Maternal and Newborn Mortality and move towards attainment of MDG 5; and strengthen the implementation of reaching every child (RED) with immunization and IMCI services. Another key observation is that in recent years there has been a steady increase in non-communicable diseases, namely, hypertension, cancers and diabetes. Oral health, mental health, injuries and disabilities are also becoming problems.

The major challenge is to get a clear understanding of the magnitude and types of these diseases and to begin to systematically address them at national and community levels as priority areas in the national health agenda.

The comprehensive programme approach used in the National Strategic Framework for HIV/AIDS in Botswana is already paying dividends as the prevalence of HIV in young women attending ANC (aged 15 – 19) has dropped from 24.7% in 2001 to 17.5 in 2006; and the coverage of essential HIV/AIDS treatment, care and support services such as ART, PMTCT, HIV testing and counseling, food baskets for orphans and vulnerable children have all exceeded 80%. There are indications that mortality due to HIV/AIDS has declined since the introduction of HAART and that the HIV transmission from mother to child is down from 20 – 40% to 4 – 6%. The all inclusive approach created an opportunity for government to engage partners from a multidisciplinary and multi-sectoral perspective. However, the HIV/AIDS disease burden and its impact on health systems and national development in general are still immense. For example, the last two decades saw a resurgence of TB related to HIV co-infection as well as the deterioration of the TB programme performance indicators, complicated recently by the emerging of drug resistant TB, requiring the strengthening of the implementation of the DOTS strategy. Of particular concern is the still large number of new HIV infection which if not effectively addressed will continue to undermine all the gains made through HAART, PMTCT, and other programs. The critical focus in HIV/AIDS will be the implementation of a comprehensive HIV prevention strategy that addresses all the key drivers of the epidemic including the associated socio-economic and gender factors.

There is a steady increase of noncommunicable diseases, namely, hypertension, cancers and diabetes in Botswana. Oral health, mental health, injuries and disabilities are also problems in Botswana. The major challenge for the Government is to get a clear understanding of magnitude and types of these diseases and to begin to systematically address them at national and community levels as priority areas in the national health agenda.

PARTNERS

With its rating as an upper middle income country, Botswana has seen the reduction in the number of development partners. The few that have remained have mostly concentrated on supporting in the area of HIV/AIDS, and more recently also in TB. The largest external donor in the health sector is the United States of America through PEPFAR and CDC (BOTUSA), Bill and Melinda Gates Foundation (ACHAP), the European Commission, UN agencies (especially UNICEF and UNFPA); Japan (Japan International Cooperation Agency (JICA) and the GFATM. The partners are coordinated through the Ministry of Health and the National AIDS Coordinating Agency (NACA) for the HIV/AIDS related activities.

In terms of health financing, the Government provides over 90% of the overall expenditure on health. Other major contributors are the US Government and ACHAP.

OPPORTUNITIES	CHALLENGES
• High political commitment to addressing the health challenges of the country • Availability of national financial resources • A well developed primary health care system and health services infrastructure with good road network	• Geographically large country with small/sparse population making it expensive to deliver services • Inadequate clarity in roles and responsibilities in delivering decentralized health services • Ensuring sustained provision of quality HAART services to all those in need • Addressing emerging diseases such as NCDs, drug Resistant TB • Strengthening Health Systems, particularly in terms human resources for health & supply chain management for all health commodities

WHO STRATEGIC AGENDA (2008-2013)

Overall Goal
The overall goal of WHO's work in Botswana is to ensure that all the necessary actions are undertaken for the attainment of the highest possible level of health as reflected in the national aspirations set out in the national strategic documents on health. The strategic agenda for meeting the goal is based on the analysis of the health situation in Botswana and on the identified gaps and challenges. Further it focuses on what WHO at all the 3 levels can effectively contribute to the national health agenda within the existing resource capacity constraints and recognizing the roles and contributions of other partners at national level. The strategic agenda is modeled along the overall WHO strategic objectives as set out in the organization-wide Medium term Plan 2008 – 2013.

Strategic Approach
WHO's strategic approaches for attaining the set agenda will be through the provision of long-term and short-term technical assistance for policy development, planning, monitoring and evaluation of evidence based interventions in the health sector; development and dissemination of technical guidelines, modules and training materials adapted to the local context; Capacity building for implementation including training and exploration of innovative approaches such public private partnerships and task shifting; documentation and sharing of best practices nationally and internationally; and strengthening partnerships to ensure building of synergies for optimal provision of good health care. WHO will play a leading role and collaborate with other partners in the provision of support to government In addition, WHO will ensure the availability of at least all the staff complement as reflected in the WCO Human Resources plan 2008 – 2013.
In delivering on the strategic agenda WHO will work primarily through the Ministry of health, but also with other government departments such as NACA and Ministry of Local Government and with partners: NGOs and Civil Society, UN Family, CDC/BOTUSA, ACHAP and BHP.

ANY OTHER ISSUES
The country has a small UNCT with 5 resident agencies (UNDP, UNICEF, UNFPA, WHO and FAO). The country is in the process of developing the UNDAF for the period 2010 – 2014, aligned to the UNDP 10. The WCO has actively participated in the process especially in articulating the Health and HIV/AIDS thematic group.
The WCO has developed the CCS for 2008 – 13. This has also informed the development of the UNDAF.
The UNCT is proposing to go for a one UN programme approach starting from 2010. Discussion on this are on-going.

ADDITIONAL INFORMATION

WHO country page **http://www.who.int/countries/bwa/en/**

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