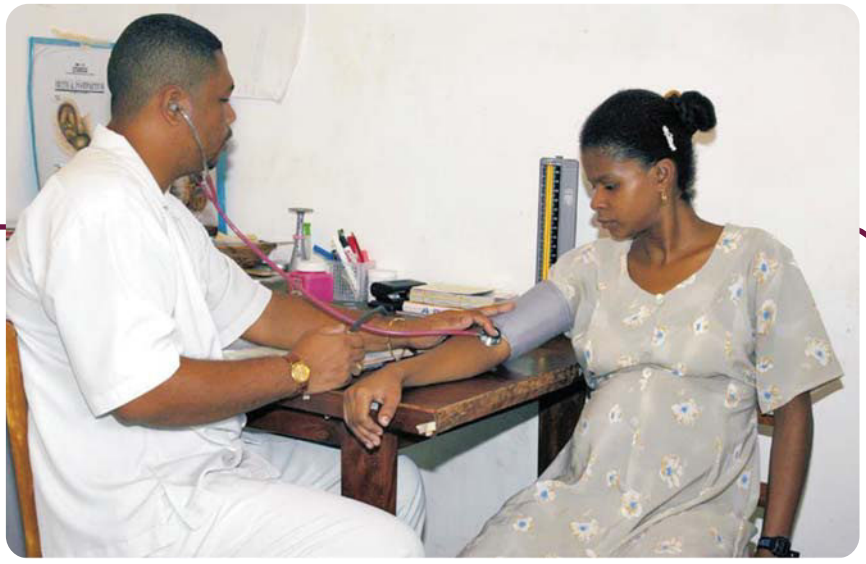
CHAPTER 6

Health

Article 26



No woman should die whilst giving birth. *Photo: Danny Glenwright*

KEY POINTS

- The SGDI score for health is 79%, testimony to the country's huge investment in the sector; ranking the country fourth in the region.
- Botswana has one of the best and most comprehensive health systems in Southern Africa. About 84% of the population is now within five kilometres of a health facility.
- CSC is less than the SGDI at 75%, but still marginally higher than the 68% regional average.
- The maternal mortality rate increased to 198 per 100,000 from 139.8 in 2006, mostly due to deaths as a result of the HIV pandemic.[11]
- About 44% of the population access contraception.
- Abortion is illegal unless on specific medical grounds.
- Skilled personnel attend to 99% of births.[12]
- About 95% of the population access safe water.[13]
- About 60% per cent access safe sanitation.[14]

[11] CSO 2009, MDG's report 2010.
[12] WHO 2012.
[13] UNICEF 2008.
[14] UNICEF 2008.

Table 6.1: CSC scores on health		
	SGDI	*CSC*
Scores	79%	75%
Ranks	4	4

Nurse Oaitse of Jwaneng Town Council (right), winner in the GBV support category during Botswana Local Government and Justice national summit in March 2012. *Courtesy Botswana Press Agency*

The SGDI score for Botswana is 79% compared to 72% in 2012. The SGDI is based on the following indicators: women aged 15-49 years who report to use at least one form of modern contraceptive method, births attended by skilled personnel, maternal mortality rate and coverage of sanitation.

On the other hand, the CSC has increased from 64% in 2012 to 75% in 2013. Overall, women (75%) scored their government higher compared to their male counterparts (73%). The high CSC scores points to the fact that citizens are more positive about the services they receive than the services actually delivered. This may reflect the way in which these services have been delivered and that they are probably delivered in gender responsive ways.

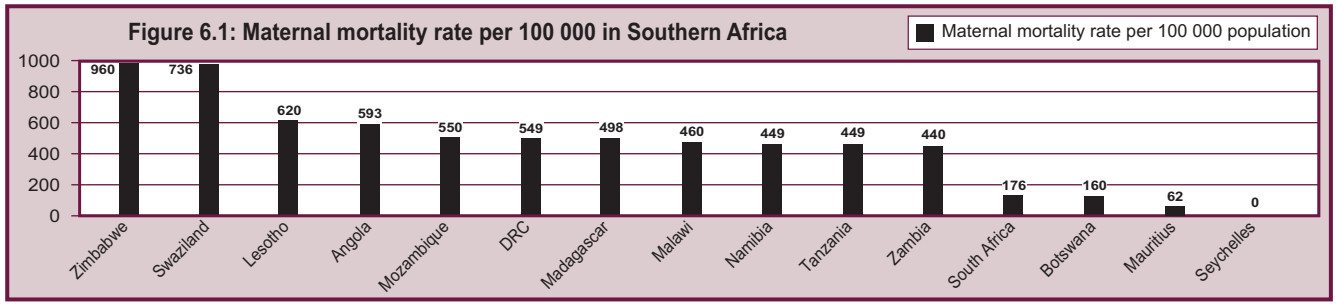
People are witnessing government's efforts to improve the health of mothers, young children and adolescents. Some initiatives have begun to target men more successfully too. However, citizens probably took into account some of the challenges. The SGDI does not take into account that abortion remains illegal in Botswana and permitted only on certain medical grounds. Two practitioners must approve abortion after rape or incest in writing. The written approval can take time leaving the girl and women more vulnerable to unsafe abortions.

Also, many women are unaware and do not have access to the female condom, particularly in the peri-urban and rural areas. It is expensive too.

Maternal mortality

The SADC Gender Protocol calls on Member States to reduce the maternal mortality ratio by 75% by 2015, in line with MDG 5.

The Maternal Mortality ratio is the number of women of child bearing age who die during pregnancy or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes per 100 000 live births.[15]



Source: 2013 SADC Gender Protocol Barometer.

Figure 6.1 reveals high levels of maternal mortality throughout the SADC region. Botswana's maternal mortality is at 160 deaths per 100 000 births.

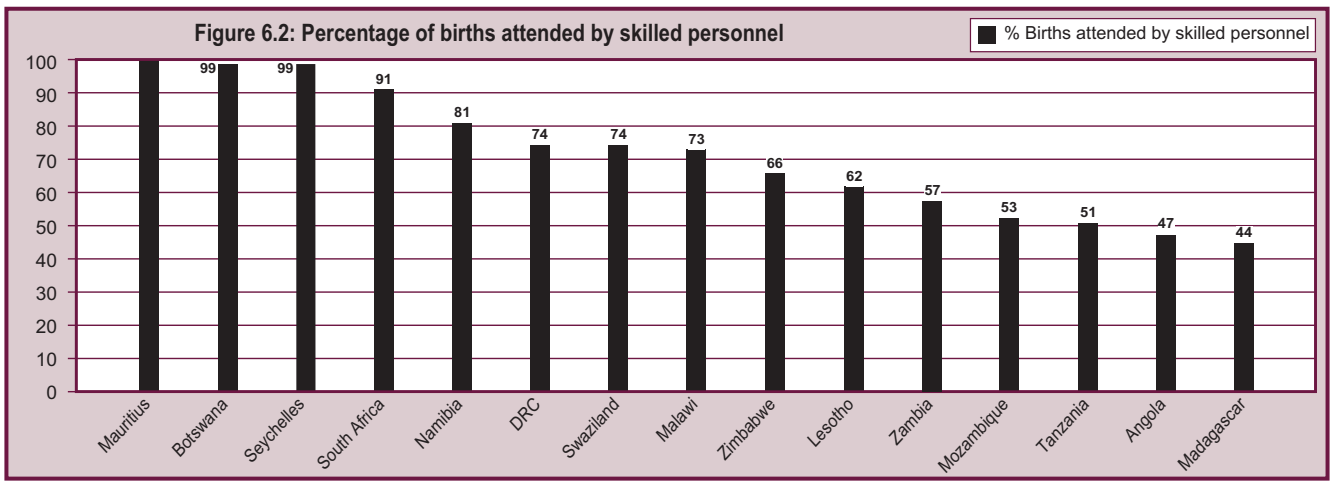
[15] MMR definition.

A comprehensive safe motherhood programme is in place to strengthen, monitor and evaluate services.

The BIAS 1V data indicates that the fertility rate has decreased significantly from five children in 1988 to about three children in 2007. The data also show that the medium age at first pregnancy is 18 years.

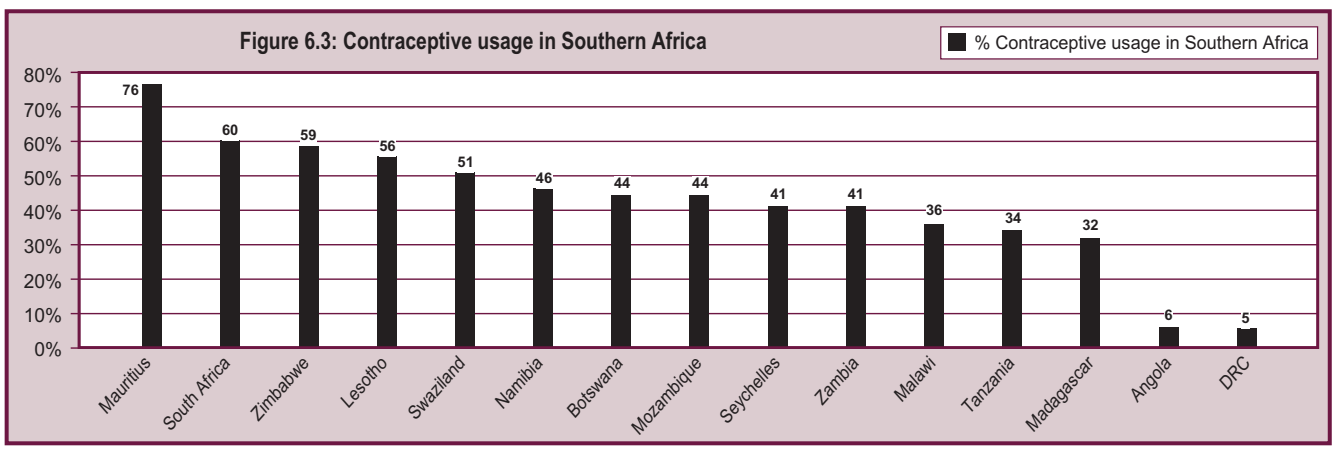
Some 95% of the population have access to safe drinking water and 60% have access to safe sanitation facilities (UNICEF 2008), which are impressive indicators and will contribute to a healthy nation as stated in NDP 10 and Vision 2016. However disparities exist with people in the rural areas and female-headed households having less access to social services.

Access to skilled health professionals



Source: 2013 SADC Gender Protocol Barometer.

Figure 6.2 shows that the percentage of births attended by a skilled health professional in Botswana is 99%.



Source: 2013 SADC Gender Protocol Barometer.

As can be seen in figure 6.3, contraceptive usage in Botswana is 44%. As the UNFPA has estimated that a third of maternal deaths could be prevented if all women were able to access contraceptives, this is obviously an area where much effort needs to be invested.

The maternal and child health and family planning (MCH/FP) approach mainly targets mothers and younger children and largely excludes the youth.

To address adolescents' needs, particularly the high rates of unprotected sex, HIV infections and premature parenting, in 2003 the Ministry of Health developed an Adolescent Sexual and Reproductive Health Implementation Strategy.

Research shows that 97% of girls aged 15-19 years knew at least one modern method of contraception and where to get it. About 44% of sexually active women were using contraception. (Ministry of Health, 2003).

Knowledge about family planning methods is high, with 98% and 97% of all women and men between the ages 15 - 49 years knowing at least one method of family planning. The most common known method is the male condom, 97%, followed by the pill, 87%. The data indicates that the male condom is the most popular, 95%, followed by the injection for the woman, 73%. However, use of contraception is much lower at 53% and 47% for female and males respectively (BFHS 2007).

The government distributes free condoms widely and introduced the female condom in 2002. Few women use the female condom due to lack of knowledge and access.

In 2008, between April and June, the government distributed almost 24,500 male condoms but only 4203 female condoms (Mmegi, 2008).

The Ministry of Health has mounted cam-paigns to promote the re-branded female condom known as 'bliss' through road shows, distributing flyers and posters, and is planning television advertisement.

Termination of pregnancy

Abortion is illegal in Botswana and only permitted on certain medical grounds, which include saving the life of the woman, to preserve physical or mental health or after a case of rape or incest. The abortion may only be carried out in a government or private hospital or clinic registered for that purpose. In addition, two medical practitioners must approve the abortion in writing.

Research shows that bureaucratic delays and limited access to health clinics are encouraging illegal backstreet abortions. Although official data is lacking, the UN reports that illegal abortions are common and physicians often refuse to authorise abortions that fall under the law.

There seems to be many obstacles in obtaining permission for an abortion. The absence of a clear definition of 'acceptable evidence' that a pregnancy is the result of rape or incest, poses a challenge. Few approved clinics for abortion exist and especially for rural women (UN 2009).

The public continues to debate abortion. Most Batswana agree with the current policy because they believe it is in line with Christian values and traditionally women are encouraged to have children.

Male involvement in sexual and reproductive health

The government in collaboration with the UN, has identified male involvement as a critical area to mainstream in all SRH programmes.

The MOH has developed a policy guide to increase male participation in sexual and reproductive health, which aims to make men share responsibility for sexual health and also to reduce GBV.

The increased level of awareness and participation of men in the prevention of mother to child transmission (PMTCT) of HIV programme has contributed to more pregnant women accessing antiretroviral drugs.

Male involvement in SRH in Botswana

The 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt, highlighted the significance of addressing the sexual and reproductive health needs of all as a core strategy in the population and development discourse. It emphasised gender equality, and within this framework, highlighted the need to engage the male sector of the population in participating and bearing the burden of reproduction as equal partners. It was also at this time that the case of "the missing male" was formally acknowledged, and nations were called upon to actively bring men on board and make them visible, first as beneficiaries in their own right, and as partners and decision makers. Gender empowerment, reproductive health and rights were also key areas of dialogue at the Fourth Conference on Women and became central to the Beijing Platform of Action in 1995.

As part of the follow up and implementation of the recommendations of the Cairo conference and Beijing Platform of Action, the Botswana government developed the National Population Policy in 1997. Speaking at the SADC Protocol@Work Summit in Botswana, Kelebogile Motlhanka from the Ministry of Health said the policy "addresses critical issues of concern with respect to the growth, structure and characteristics of the population of Botswana, and provides strategies to influence them in a manner conducive to the attainment of sustainable human development".

Through The National Implementation Plan of Action for the Population Policy and Programmes (NIPA) the objectives and strategies of the policy are put into operation in focused intervention programmes and activities with observable and measurable outcomes. Key thematic areas of action are, among others, sexual and reproductive health. Male involvement in sexual

Protocol @ work

and reproductive health (SRH) is an objective under this thematic area.

The Botswana government affirms its commitment to the international and regional declarations and conventions that have addressed gender-based violence (GBV) such as the 1993 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW).

The purpose of the programme is to strengthen institutions' programmes enhancing male involvement in sexual and reproductive health and the prevention and management of STI, HIV and AIDS and gender-based violence and:

- To build the nurse's capacity on the clinical management of GBV.
- To improve the quality of care given by individual health care providers and the overall service response of the Botswana Health Service to GBV.
- To build the capacity of health service providers to integrate male involvement in SRH, SRH rights, and the prevention and management of GBV, STI, HIV and AIDS into health services.
- To build the capacity of health workers to provide male friendly SRH services and to mainstream gender, male involvement in SRH, prevention and management of STI and HIV and AIDS and gender-based violence into the sexual reproductive health services.

The project targets health care service providers (nurses, doctors, health educators, health community, males, females, community leaders and religious leaders. Going forward, NGOs such as, BONELA and PSI should continue campaigns on condom use and particularly promote the use of the female condom; encourage more debate on abortion and advocate for the review of current legislation; and stakeholders need to encourage men to be more involved in reproductive health.

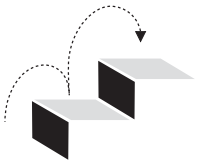
Sanitation

The SADC Gender Protocol requires that by 2015 member states ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

The provision of sanitation and hygiene facilities is integral to improving women's health throughout the region. Poor sanitation results in increased spread of communicable diseases which women are particularly vulnerable to. Furthermore, menstruation, pregnancy, and post-natal care are difficult for women without proper hygiene and sanitary facilities, as does caring for family and community members living with HIV. According to the World Health Organization, almost one tenth of all global deaths can be avoided by providing clean drinking water, better sanitation and improving water resources management to reduce the incidence of water-borne diseases and cases of accidental drowning.

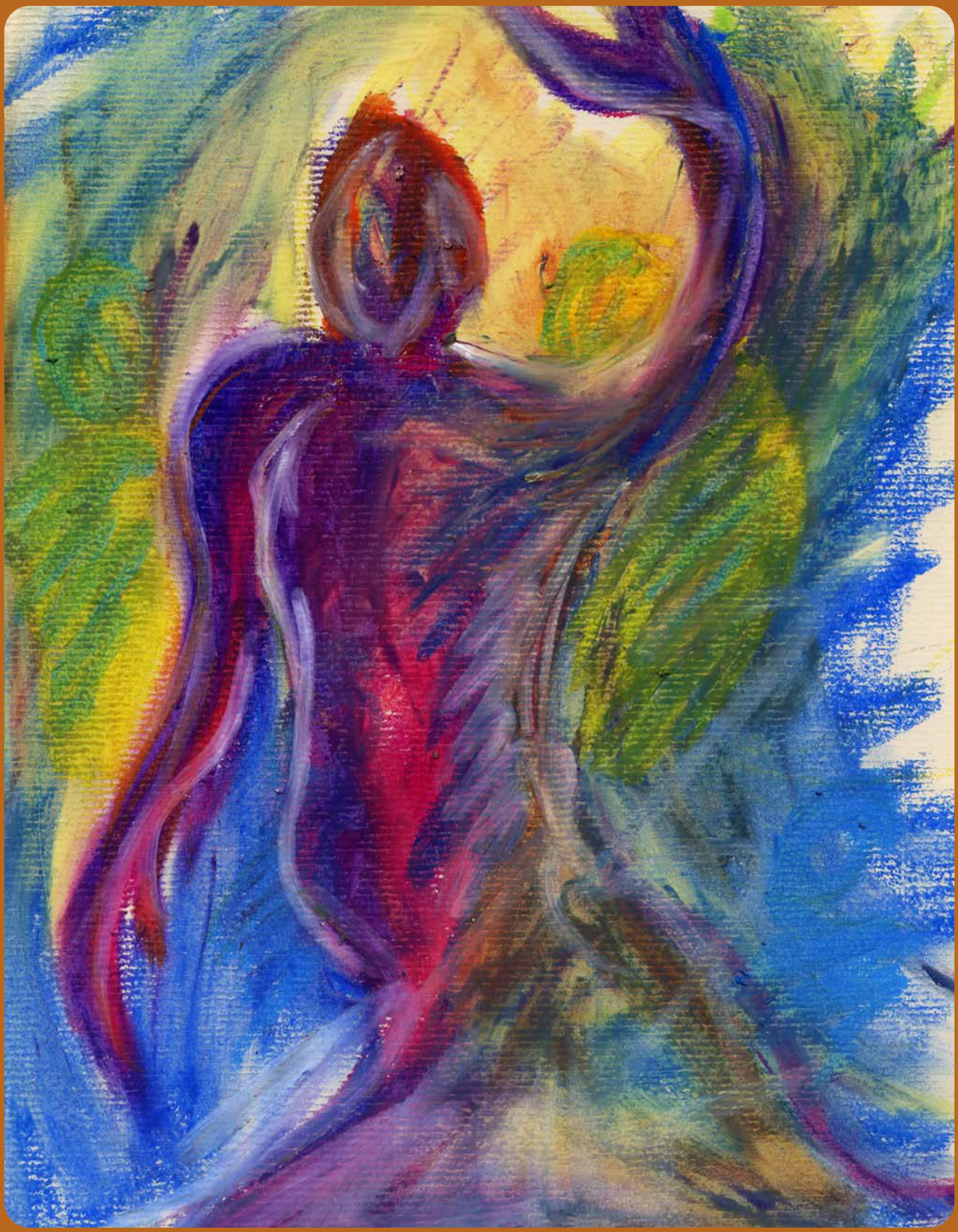
Household sanitation is everyone's responsibility, but the reality is that women, especially those in rural areas, bear a disproportionate burden of household responsibilities. Tasks such as cooking, cleaning, care giving and caring for children are easier where there is running water. Inadequate sanitation also influences women and girls' personal safety. Women's risk of experiencing rape and sexual assault are reduced when toilets and water supplies are located close to home, and where they do not have to leave their homes at night to access these. Women thus have a stake in ensuring that there are developments in sanitation in the countries, and their energies should be harnessed to implement national and community projects to improve sanitation. Although providing hygiene and sanitation facilities are provisions of the protocol, the developments have been slow.

WHO/UNICEF reports show that overall sanitation coverage is 62%; with rural coverage of 41% and of urban areas 75%.



Next steps

- Gender disaggregated research around sexual reproductive health practices and challenges of women and girls by governments.
- Promotion of sexual and reproductive rights for adolescents, men and women.
- Focus more attention on health services and sanitation for rural and lower income populations.



"Anita"

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