A different kind of family

Anushka Virahsawmy

CHAPTER 6

Health

Article 26

Shenaaz El-Halaabi, Deputy Permanent Secretary at the Ministry of Health.
Photo: Courtesy of Global Post

KEY POINTS

- The SGDI score for health is 76%, testimony to the country's massive 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.
- The CSC score is at 63%, lower than the 68% regional average.
- The maternal mortality rate increased to 160 per 100 000 from 139.8 in 2006, mostly due to deaths as a result of the HIV and AIDS pandemic.
- About 44% of the population have access to contraception.
- Abortion is illegal unless on specific medical grounds.
- Skilled personnel attend to 99% of births.
- About 95% of the population access safe water and about 60% access safe sanitation services.

Table 6.1: SGDI and CSC scores for health		
	SGDI	*CSC*
Scores	76%	63%
Ranks	5	12

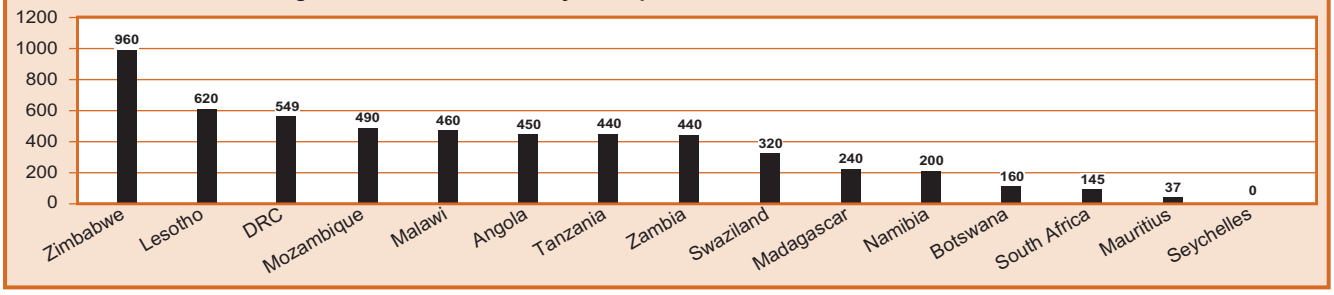
Table 6.1 shows that the SGDI score for Botswana is 76%, compared to 72% in 2012 and 2013. The SGDI is based on the following indicators: women aged 15-49 years who report using at least one form of modern contraceptive method; births attended by skilled personnel; maternal mortality rate; and coverage of sanitation. However, the CSC score dropped to 63% from a score of 75% in 2013. Overall, women (62%) scored their government lower compared to their male counterparts (65%).

Maternal mortality

The SADC Protocol calls on member states to reduce the maternal mortality ratio by 75% by 2015, in line with MDG-5.

The Maternal Mortality Ratio (MMR) 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.[1]

Figure 6.1: Maternal Mortality Ratio per 100 000 live births in Southern Africa

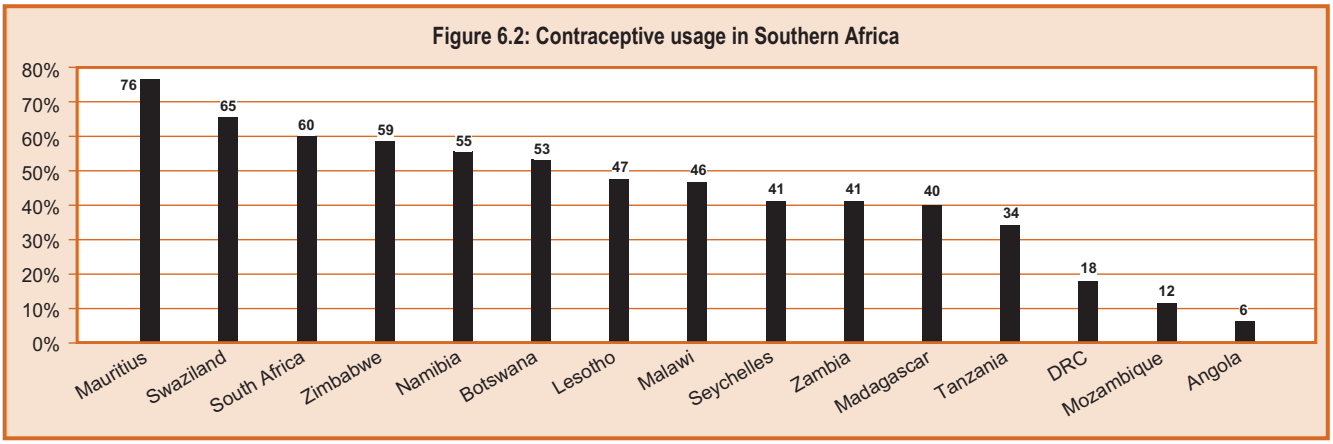


Source: Gender Links 2014 SADC Gender Protocol.

Figure 6.1 reveals high levels of maternal mortality throughout the SADC region. Botswana's MMR is at 160 deaths per 100 000 births. The percentage of births attended by a skilled health professional in Botswana is 99%. A comprehensive safe motherhood programme exists to strengthen, monitor and evaluate services.

[1] MMR definition.

Family planning and contraceptive usage



Source: Gender Links 2014 Gender Protocol Barometer.

Figure 6.2 reveals that contraceptive usage in Botswana is 44%. The United Nations Population Fund (UNFPA) has estimated that stakeholders could prevent a third of maternal deaths if all women had access to contraceptives. The maternal and child health and family planning 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, the Ministry of Health developed an Adolescent Sexual and Reproductive Health Implementation Strategy in 2003.

Research shows that, while 97% of women aged 15-19 years knew at least one modern method of contraception and where to get it, only 22% reported using it. Contraceptive use varied with the level of education. More than 40% of sexually active women with secondary or tertiary education used contraception, compared to only 17% of women with no education (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, at 97%, followed by the pill, at 87%. The data indicates that of those using contraceptives, a male condom is the most popular, at 95%, followed by the injection for women, at 73% (BFHS 2007).

Termination of pregnancy

Abortion is illegal in Botswana and only permitted on certain medical grounds, which include saving the life of a woman, to preserve physical or mental health or after a case of rape or incest. The abortion may only be carried out in the government or private hospital or clinic registered for that purpose. In addition, two medical practitioners must approve the abortion in writing. The provisions of the Penal Code of Botswana have governed abortion law since 1964.

It is illegal to perform abortions and women who consent to them have been imprisoned. The law set forth exceptions to the general prohibition against the performance of abortions. Botswana allows three conditions under the law:

- When the medical practitioner carrying out the abortion is satisfied that the pregnancy is the result of rape, defilement, or incest;
- When the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; and
- When established evidence shows a substantial risk that the child would suffer from or later develop such serious physical or mental abnormality or disease as to be severely handicapped.

A registered medical practitioner in a government hospital must carry out the abortion within the first 16 weeks of pregnancy or registered private hospital or clinic approved for that purpose. 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.

It is a violation of women's rights when they cannot obtain safe reproductive health services, including abortion. Sexual and reproductive health care should be accessible and affordable.

The government has widely distributed free condoms since the introduction of the female condom in 2002. However, 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 campaigns to promote the re-branded female condom, known as "Bliss," through road show and by distributing flyers and posters.

Herero women in traditional gear. *Photo: Google images*

Forced or arranged marriages

Children in Botswana remain highly vulnerable to the effects of arranged marriages, as they do elsewhere in SADC. Some Tswana societies regard children and women as inferior, with a lower status compared to men and boys. Arranged marriages remain common among the Herero and Ovambanderu. These involve child marriages and child betrothals. In most cases, families force girl children to marry significantly older men. Child brides usually have lower levels of education than girls who get married after childhood. When a girl marries early, it usually means the end of her education if she is in school and the end of her autonomy to make important decisions about work, her health and her wellbeing.

Abuse is common in child marriages and a lack of consistent marriage registration makes early and forced marriages difficult to track. Children sometimes run away from rural areas because of arranged and early marriages and end up on the street and/or in sex work. Arranged marriages infringe on the rights of the girl child and women; these rights include the right to health, education, full consent and the right to choose.

Male involvement increasingly important in sexual and reproductive health: The government, in collaboration with the UN, has identified male involvement as a critical area to mainstream in all sexual and reproductive health programmes. The health ministry has developed a policy guide to increase male participation in this area. It aims to make men share responsibility for sexual health and 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 a high number of pregnant women accessing antiretroviral drugs.

Protocol @ work

Calling all men: sexual and reproductive health for all

The 1994 International Conference on Population and Development (ICPD) in Cairo stressed 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 highlighted the need to engage men in participating and bearing the burden of reproduction as equal partners. Gender empowerment, reproductive health and rights also proved critical areas for dialogue at the Beijing Platform for Action in 1995.

As part of the follow-up and implementation of the recommendations of the Cairo conference and Beijing Platform for Action, the Botswana government developed the National Population Policy in 1997. Speaking at the SADC Protocol@Work Summit in Botswana, Ministry of Health representative Kelebogile Motlhanka 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."

Men taking an active role in sexual and reproductive health. *Photo: Courtesy of PSI*

Through The National Implementation Plan of Action for the Population Policy and Programmes (NIPA), stakeholders implement the objectives and strategies of the policy in focused intervention programmes and activities with observable and measurable outcomes. Key thematic areas of action include sexual and reproductive health. Male involvement in sexual and reproductive health is an objective under this thematic area.

The Botswana government has affirmed its commitment to the international and regional declarations and

conventions that have addressed GBV such as the 1993 Convention on the Elimination of all Forms of Discrimination against Women (CEDAW). One aim of its programming 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 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 nurse's capacity on the clinical management of GBV;
- To build the capacity of health service providers to integrate male involvement in sexual and reproductive health and rights, and the prevention and management of GBV, STI, HIV and AIDS into health services; and
- To build the capacity of health workers to provide male-friendly services and to mainstream gender, male involvement in sexual and reproductive health, 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.

Sanitation

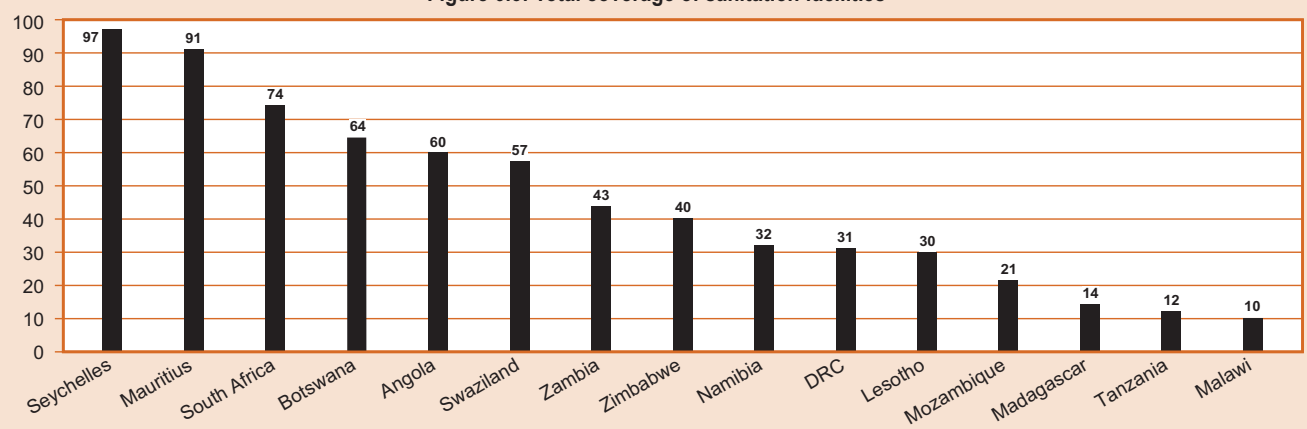
The SADC Protocol requires that, by 2015, member states ensure the provision of hygiene and sanitary facilities and nutritional needs of women, including women in prison.

The provision of sanitation and hygiene facilities is integral to improving women's health throughout the region. Poor sanitation results in the increased spread of communicable diseases. Furthermore, menstruation, pregnancy, and post-natal care prove more difficult for women without proper hygiene and sanitary facilities, as does caring for family and community members living with HIV and AIDS. According to the World Health Organisation, almost one tenth of all global deaths could be avoided by providing clean drinking water; better sanitation; improving water resources management in order 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 family 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 lessens when toilets and water supplies exist close to home, and where they do not have to leave their homes at night to access these.

Some 95% of Botswana's population has access to safe drinking water and 64% have access to safe sanitation facilities (UNICEF, 2008): impressive indicators that 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 these services.

Figure 6.3: Total coverage of sanitation facilities



Source: Unicef progress on Drinking water and sanitation 2014 update.

Figure 6.3 shows that total coverage of sanitation facilities in Botswana is 64% this puts the country at fourth place in the SADC region.

SGP Post 2015

The health sector and post-2015

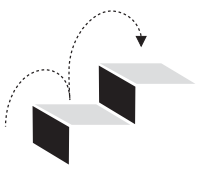
Momentum in this area has waxed and waned depending on competing priorities and lobbies. Capacity is required in technical skills, research, policy formulation and advocacy among health care providers.

Table 6.2: Proposed revised targets and indicators for health

Area of concern	Proposed post-2015 targets	Proposed post-2015 indicators	Priority indicators
Maternal mortality	By 2030, reduce the maternal mortality ratio to less than 70 maternal deaths per 100 000 live births (Draft SDG 3.1)	1. Maternal mortality ratio[2] (out of 100, 000)	Reduction in the barriers to access to sexual and reproductive health services particularly for young people and the most marginalised[3]
		2. Percentage of births attended by skilled personnel[4]	Percentage of access to safe drinking water (rural, urban, prisons, refugee camps)
		3. Percentage ante-natal care coverage	Percentage of women/girls accessing sanitary towels
		4. Percentage of men attending ante and post-natal care facilities	Proportion local councils that provide information or organise events to promote awareness of cancers and other health conditions
Sexual and reproductive health rights	By 2030, ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action (Draft SDG 5.6)	5. Contraceptive prevalence rate[5]	Existence and provisions of country policy on termination of pregnancy
	Ensure people, especially adolescents are educated about their sexual and reproductive health and rights	6. Reduction in the barriers to access to sexual and reproductive health services particularly for young people and the most marginalised[6]	
		7. Proportion of local councils that provide diverse and inclusive information on health and sexual reproductive health rights	
	Adopt and implement laws ensuring women's sovereignty and choice over their bodies and reproductive health choice right to life	8. Existence and provisions of country policy on termination of pregnancy	

2 WHO Health Demographic surveys.
3 WHO Development Indicators.
4 WHO Health Demographic surveys.
5 WHO Development Indicators.
6 WHO Development Indicators.

Area of concern	Proposed post-2015 targets	Proposed post-2015 indicators	Priority indicators
	By 2030, achieve universal access to safe and affordable drinking water for all (Draft SDG 6.1)	9. Percentage of access to safe drinking water (rural, urban, prisons, refugee camps)	
	By 2030, achieve adequate sanitation and hygiene for all, paying special attention to the needs of women and girls (Draft SDG 6.2)	10. Percentage total coverage (urban and rural) of sanitation facilities	
		11. Percentage of women/girls accessing sanitary towels	
Non-communicable disease	Ensure all citizens have access to information and facilities for testing for and treating cancers and other diseases, also early detection	12. Percentage men and women suffering from different cancers	
		13. Proportion local councils that provide information or organise events to promote awareness of cancers and other health conditions	
Healthy lifestyles	Promote healthier lifestyles among women and men, focusing on prevention to reduce ill health such as hypertension and diabetes	14. Prevalence of raised fasting blood glucose among women and men aged ≥ 25 years (percentage)	
		15. Prevalence of raised blood pressure among women and men aged ≥ 25 years (percentage)	
		16. Percentage of obesity rates among men and women	



Next steps

- Improve access to quality health care services.
- Improve government use of gender-disaggregated research around sexual reproductive health practices and challenges of women and girls.
- Continue to promote sexual and reproductive rights for adolescents, men and women.
- Intensify training of service providers (for example police, social workers, teachers, etc.) on sexual orientations and gender diversity.
- Since reproductive rights form an important basis for the enjoyment of other rights and freedoms and remain an integral part of attaining gender equality, Botswana should amends its policies and laws to recognise and protect women's sexual and reproductive rights.
- Work with the grassroots populations to change perceptions, attitudes and behaviours that condone and justify reproductive coercion.
- The Ministry of Health should take the lead in developing policy and ensuring that all HIV-positive women can obtain cervical cancer prevention and screening services.