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REPRODUCTIVE HEALTH *at a* GLANCE

BOTSWANA

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Country Context

Botswana gained independence in 1966 and has transitioned from one of the world's poorest nations to one of the fast growing economies in the world, enjoying a growth rate averaging 13 percent, largely due to diamond mining. Botswana's steady economic growth has enabled improvements to infrastructure, health, and education programs.[1] Health facilities are located within 8 to 15 kilometers of all Batswana and 98 percent of the population has access to safe drinking water.[2]

Botswana's large share of youth population (34 percent of the country population is younger than 15 years old[3]) provides a window of opportunity for high growth and poverty reduction—he demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession and the country's exposure to high volatility in commodity prices.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[4]

In Botswana, the literacy rate among females ages 15 and above is 84 percent. More girls are enrolled in secondary schools compared to boys with a ratio of female to male secondary enrollment of 106 percent.[3] Three-quarters of adult women participate in the labor force.[3] Gender inequalities are reflected in the country's human development ranking; Botswana ranks 109 of 157 countries in the Gender-related Development Index.[5]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[4]

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Botswana: MDG 5 Status

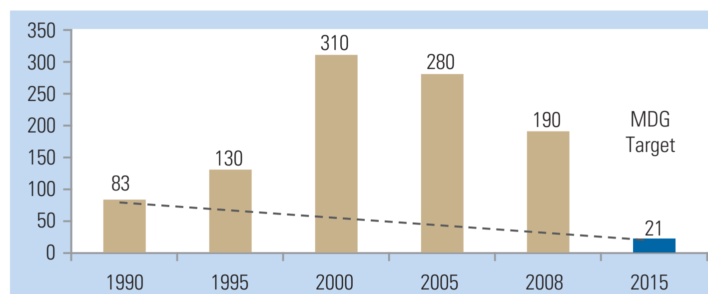
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	190
Births attended by skilled health personnel (percent)	94.6
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	52.8
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	51.4
Antenatal care with health personnel (percent)	94.1
Unmet need for family planning (percent)	—

Source: Table compiled from multiple sources.
[a] The Botswana Central Statistics Office estimate for year 2009 is 190.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Botswana has made insufficient progress over the past two decades in reducing maternal mortality and is not yet on track to achieve its 2015 targets.[6] The HIV/AIDS epidemic contributed to the increased AIDS deaths.

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Botswana

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2009 to 2013.

Current Project:
P102299 BW-HIV/AIDS Project SIL (FY09) ($42.4m)

Pipeline Project: None

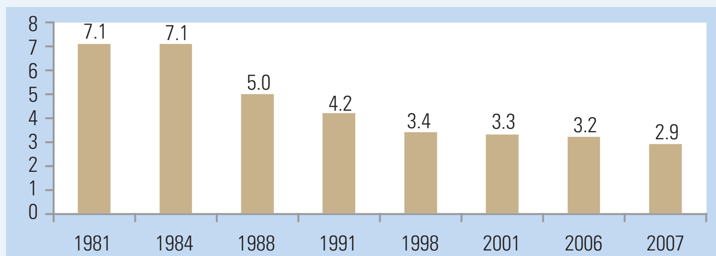
Previous Health Project: None

Key Challenges

High fertility

Fertility has been declining over time but remains high among the poorest. Total fertility rate (TFR) dropped significantly since 1981, from 7.1 births per woman to 2.9 in 2007—the sharpest decline in TFR in sub-Saharan Africa during that time period.[2] A main contributor to this decline was the country's strong national family planning program.[2] However, fertility remains relatively high among Batswana women with no formal education at 5.8 compared to 3.3 among women with secondary education and 2.6 for those with a university education. The TFR is also lower among city and town dwellers at 2.4, compared to 4.6 among rural women.[2]

Figure 2 ▪ Total fertility rate, 1981-2007 (selected years)

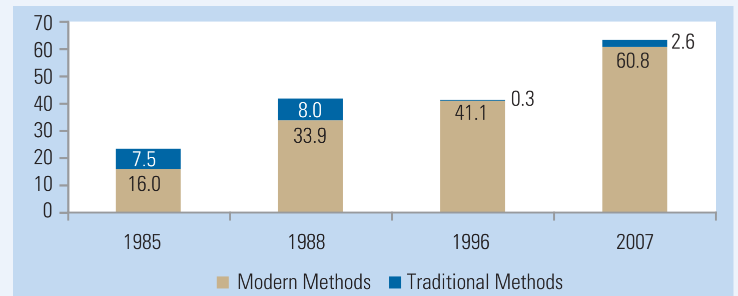


Source: Fertility Decline in Botswana report, 2010.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[4, 7] In Botswana, adolescent fertility rate is moderate at 51 births per 1,000 women aged 15–19 years.

Use of modern contraception is increasing. Because of Botswana's strong family planning program, use of modern contraceptives among all women 15–49 increased during the last three decades from 16 percent in 1984 to 29 percent in 1988, 40 percent in 1996, and 51 percent in 2007.[2] Use of traditional methods of contraception decreased from 7.5 percent in 1984 to 2.6 percent in 2007.[2] Male condoms are the most commonly used method of contraception (42 percent), followed by injectables (7 percent) and oral contraceptives (6 percent). Use of long-term methods such as intrauterine device and implants are negligible. The use of male condoms increased from 1 percent in 1984 to 11 percent in 1996 and 42 percent in 2007. This increase has been attributed to an effective multimedia dual protection HIV campaign.[2]

Figure 3 ▪ Use of contraceptives among married women by year



Source: Botswana Family Health Survey IV Report 2007.

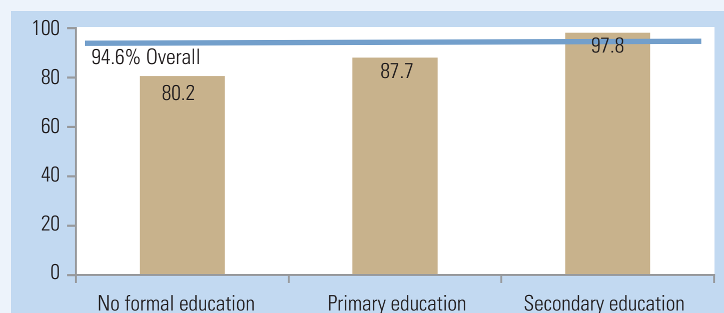
Abortion became legal in Botswana in 1991. It must be conducted by a medical doctor in a health facility during the first 16 weeks of pregnancy, and another doctor must also provide written consent. It can take place under one of three conditions: in cases of rape or incest, if childbearing poses a risk to the woman's physical or mental health, or if there is, or is a risk of, fetal impairment. Sixteen percent of maternal deaths in 2007 were caused by septic abortion. Unsafe abortions were a major cause of maternal mortality when abortion was illegal before 1991.[2]

Health problems and opposition to use are major reasons women not currently using contraceptives do not intend to use them in future. Twenty-three percent not intending to use contraception cited health concerns as the main reason while 5 percent expressed opposition to use, 5 percent expressed that the husband/partner disapproved, and 4 percent cited religion.[1] Cost and access are much lesser concerns, indicating further need to strengthen demand for family planning services.

Poor Pregnancy Outcomes

Majority of pregnant women use antenatal care and have institutional deliveries. Over nine-tenths of pregnant women receive antenatal care from skilled medical personnel (doctor, nurse, or midwife) with 73 percent having the recommended four or more antenatal visits.[1] 95 percent of women deliver with the assistance of skilled medical personnel. While 98 percent of women with secondary education delivered with skilled health personnel, 80 percent of women with no formal education obtained such assistance (Figure 4).[1] One fifth of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[8]

Figure 4 ▪ Birth assisted by skilled health personnel (percentage) by education level of mother



Source: Botswana Family Health Survey IV Report 2007.

Human resources for maternal health are limited with 0.4 physicians per 1,000 population but nurses and midwives are more common, at 2.65 per 1,000 population.[3]

HIV prevalence is high in Botswana

HIV prevalence is high at 17.6 percent[9] and women are one of the most vulnerable groups. Nearly one-quarter of the population ages 15 and above is HIV positive. Of the HIV positive population, 61 percent are women of childbearing age.

Reductions in prevalence are most prominent in youth ages 15–19 and 20–24.[10] Prevalence has decreased in youth ages 15–19, from 6.5 percent in 2004 to 3.7 percent in 2008. Prevalence has also decreased significantly in the 20–24 age range, from 19 percent in 2004 to 12.3 percent in 2008.[11]

Due to free anti-retrovirals being made available since 2002, 91 percent of women living with HIV are now receiving the antiretroviral drugs necessary to help prevent transmission to their child. HIV/AIDS services have been integrated into family planning and maternal and child health services since the 1990's. Additionally, routine HIV testing has been available in all public hospitals since late in 2003.

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National policies and strategies that have influenced reproductive health

1973 The Maternal and Child Health/Family Planning (MCH/FP) Unit (under Primary Health care) is established. Family planning is integrated into maternal and child health from the outset.

1979 The MCH/FP Unit, along with the nutrition and health education units, becomes the Family Health Division.

1984 MCH/FP services begin to be offered daily at most health facilities.

1987 Family Planning Policy Guidelines and Service Standards are developed.

1988 Botswana Population Sector Assistance Project begins (runs through 1996).

1998 Family life education is introduced into the school curriculum.

1989 Family planning logistics manual (contraceptive commodities and drugs) is developed.

1989 National AIDS Control Program is established.

1991 Abortion is made legal through the Penal Code (Amendment) Act of 1991 in any of these three circumstances: rape or incest; to save a woman's life; or fetal impairment. Two doctors must consent, and the procedure must be done in the first 16 weeks of pregnancy.

1994 The Family Planning General Policy Guidelines and Service Standards are reviewed.

1997 National Population Policy is developed, with a goal to decrease the total fertility rate from 4.0 (in 1996) to 3.4 by 2011. (This goal was achieved by 2009.)

1996 Family Planning Procedures Manual is developed. 2000 Adolescent Sexual & Reproductive Health: A Trainers Manual is developed for service providers.

2002 Department of Public Health is reorganized. MCH/FP Unit becomes the Sexual and Reproductive Health Division.

2003 Adolescent Sexual and Reproductive Health Implementation Strategy is developed.

2001 Marriage Act 2001 is enacted, raising the legal age for marriage from 14 to 18 with parental consent and to 21 if there is no parental consent.

2006 Maternal death is classified as a notifiable event (recommendation submitted for Public Health Act).

2008 Family planning manual and family planning trainers manual (Adolescent Sexual & Reproductive Health) are revised.

2008 A strategy for reproductive health commodity security is finalized.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods. Make information, education and communications materials more available at MCH/FP clinics.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated. Strengthen the contraceptive logistics management information system.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.

Reducing maternal mortality

- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the Sexual and Reproductive Health Division's Monitoring and Evaluation (M&E) Unit. Ensure adequate staffing and training of the M&E Unit to produce timely reports and ensure accuracy and completeness of data on sexual and reproductive health.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Focus HIV/AIDS providing information, education and communication efforts on adolescents, youth, married women, and other high risk groups including IDUs, sex workers and their clients, and migrant workers.
- Strengthen the integration of sexual and reproductive health (including family planning) and HIV/AIDS services. These are coordinated by different departments within the Ministry of Health, and there is a need to strengthen their integration and collaboration.

References:

1. Central Statistics Office and UNICEF. 2007 *Botswana Family Health Survey IV Report*. 2009. Gaborone, Botswana.
2. Mills, Samuel, Leburu, Veronica, El-Halabi, Shenaaz, Mokganya, Lesego, and Chowdhury, Sadia. May 2010. *Fertility Decline in Botswana 1980–2006: A Case Study*. The World Bank. www.worldbank.org/population.
3. World Bank. 2010. World Development Indicators. Washington DC.
4. World Bank, Engendering Development: Through Gender Equality in Rights, Resources, and Voice. 2001.
5. Gender-related development index. Available at http://hdr.undp.org/en/media/HDR_20072008_GDI.pdf.
6. Trends in Maternal Mortality: 1990–2008: Estimates developed by WHO, UNICEF, UNFPA, and the World Bank.
7. WHO 2011. Making Pregnancy Safer: Adolescent Pregnancy. Geneva: WHO. http://www.who.int/making_pregnancy_safer/topics/adolescent_pregnancy/en/index.html.
8. Worldwide prevalence of anaemia 1993–2005: WHO global database on anaemia / Edited by Bruno de Benoist, Erin McLean, Ines Egli and Mary Cogswell. <http://whqlibdoc.who.int/publications/2008/9789241596657_eng.pdf>.
9. Central Statistics Office (CSO). 2008. Botswana AIDS Impact Survey III (BAIS III). Preliminary Results, Stats Brief, No. 2009/8, May 2009. Gaborone, Botswana.
10. Ministry of State President. National AIDS Coordinating Agency. Government of Botswana Country Report, General Assembly Special Session on HIV/AIDS. 2007.
11. Botswana AIDS Impact Survey III (BAIS III), 2008. 2009. Central Statistics Office. Gaborone, Botswana.

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BOTSWANA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2007	2.9	Population, total (million)	2008	1921122
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	51.4	Population growth (annual %)	2008	1.5
Contraceptive prevalence (% of married women ages 15–49)	2007	52.8	Population ages 0–14 (% of total)	2008	33.7
Unmet need for contraceptives (%)	—	—	Population ages 15–64 (% of total)	2008	62.6
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	3.7
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	59.8
Mean ideal number of children for all women	—	—	Urban population (% of total)	2008	59.6
Antenatal care with health personnel (%)	2007	94.1	Mean size of households	2006	4.2
Births attended by skilled health personnel (%)	2007	94.6	GNI per capita, Atlas method (current US$)	2008	6,640
Proportion of pregnant women with hemoglobin <110 g/L	2008	21.3	GDP per capita (current US$)	2008	6,982
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	83	GDP growth (annual %)	2008	2.9
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	130	Population living below US$1.25 per day	—	—
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	310	Labor force participation rate, female (% of female population ages 15–64)	2008	75.1
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	280	Literacy rate, adult female (% of females ages 15 and above)	2008	83.5
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	190	Total enrollment, primary (% net)	2006	89.5
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	21	Ratio of female to male primary enrollment (%)	2006	97.9
Infant mortality rate (per 1,000 live births)	2008	26	Ratio of female to male secondary enrollment (%)	2006	105.7
Newborns protected against tetanus (%)	2008	85	Gender Development Index (GDI)	2008	109
DPT3 immunization coverage (% by age 1)	2008	96	Health expenditure, total (% of GDP)	2007	5.71
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	53.9	Health expenditure, public (% of GDP)	2007	4.26
Prevalence of HIV, total (% of population ages 15–49)	2007	23.9	Health expenditure per capita (current US$)	2007	372
Female adults with HIV (% of population ages 15+ with HIV)	2007	60.7	Physicians (per 1,000 population)	2004	0.4
Prevalence of HIV, female (% ages 15–24)	2007	15.3	Nurses and midwives (per 1,000 population)	2004	2.65

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	BFHS	2007	—	—	—	—	—	2.9	—	—
Current use of contraception (Modern method)	BDS	2006	—	—	—	—	—	28.9	—	—
Current use of contraception (Any method)	BFHS	2007	—	—	—	—	—	52.8	—	—
Unmet need for family planning (Total)	—	—	—	—	—	—	—	—	—	—
Births attended by skilled health personnel (percent)	BFHS	2007	—	—	—	—	—	94.6	—	—