

National Health Policy

“Towards a Healthier Botswana”

Ministry of Health, Gaborone
December 2011

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The revised National Health Policy:

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Foreword

The first National Health Policy for Botswana, formulated in 1995, guided the development of the health sector. Since the policy was adopted, many changes occurred in epidemiological, socio-economic and demographic situations as well as health technology development. The most important epidemiological change affecting Botswana is the advent of the HIV/AIDS epidemic and related opportunistic diseases.

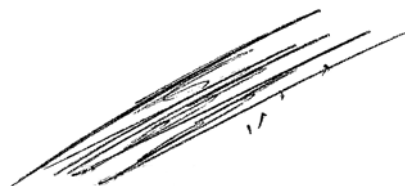
In order to improve access to quality health care, the Government of Botswana invested substantially in building health facilities all over the country. However, quality of health care and service utilisation remain a challenge as a result of inadequate skilled health professionals.

While the Ministry of Health is the steward in the provision of quality health care to the nation, social and economic policies have a determining impact on health. The overall development of Botswana can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided to the disadvantaged as a result of ill-health. The policy thus encompasses all the social determinants which impact the health of the nation.

This National Health Policy bears the slogan '*Towards a Healthier Botswana*', implying that the provision of health services is not just merely curing the sick but also promoting healthy lifestyles in order to prevent diseases/ill-conditions for all people living in Botswana.

The Policy covers all the six building blocks of health systems, with specific direction for each of them. It also provides the platform for well-coordinated planning, financing, monitoring and evaluation. The Policy will be implemented through an Integrated Health Sector Plan which will incorporate not just the public sector's effort but also those of the non-government organisations, community based organisations and the private sector.

The National Health Policy is the product of several stakeholder consultations which makes it more comprehensive. Similarly, it also provides for stakeholder involvement in the continuous monitoring of the implementation of the Policy as well as its future revision.



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Minister of Health

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Antiretroviral Therapy
BDF	Botswana Defence Force
BNDP	Botswana National Drug Policy
CBO	Community Based Organisation
CSDH	Commission on Social Determinants of Health
CSO	Central Statistics Office
DHB	District Health Board
DHMT	District Health Management Team
DPHC	Department of Primary Health Care
DRSA	Drugs and Related Substance Act
DRU	Drug Regulatory Unit
EDL	Essential Drug List
EHSP	Essential Health Service Package
EIA	Environmental Impact Assessment
GDP	Gross Domestic Product
HHA	Harmonisation for Health in Africa
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
IMR	Infant Mortality Rate
ITN	Insecticide Treated Nets
IHSP	Integrated Health Service Plan
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MFDP	Ministry of Finance and Development Planning
MIS	Management Information System
MJDS	Ministry of Justice, Defence and Security
MLG	Ministry of Local Government
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MRSA	Medicine and Related Substance Act
MTI	Ministry of Trade and Industry
NACA	National AIDS Coordinating Agency
NDP	National Development Plan
NGO	Non-Governmental Organisation
NHP	National Health Policy
NHC	National Health Council
PHC	Primary Health Care
SRG	Stakeholder Reference Group
TB	Tuberculosis
THE	Total Health Expenditure
TOR	Terms of Reference
TT2+	Tetanus Toxoid 2+
U5MR	Under-Five Mortality Rate
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHC	Village Health Committee
WHO	World Health Organisation

Chapter 1: Introduction

1.1 *The Need to Revise the National Health Policy (NHP)*

- 1.1.1 The enjoyment of a level of health that allows every citizen to lead an economically and socially productive life is widely accepted as a basic necessity in any population. The World Health Organisation (WHO) defines health as “*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity*”. Botswana has been trying to attain this level of health status through improvements in the health sector over the years. Since 1995, the first National Health Policy has guided the health sector towards attaining of the highest level of health status for all people living in Botswana.
- 1.1.2 Since the development of the first national health policy, there have been major changes in both health status and in the organisation of the health sector in the country. Changes include the disease burden, demographics and the socio-economic determinants of health. The recognition that health is a right to be enjoyed by all Batswana has also grown over this period.
- 1.1.3 A major reorganisation of the Ministry of Health, as well as the management of Primary Health Care within the Ministry of Local Government, began in 2002 and is still in progress. Since the last national health policy was developed, the number of health sector stakeholders has increased, the population has grown and lifestyles have changed. There have also been many changes in health technologies for health promotion, prevention and treatment and the rehabilitation of people - including those with disabilities.
- 1.1.4 These developments and changes have rendered the 1995 national health policy outdated and have necessitated the need for a review and revision of the policy to make it more relevant and responsive.

1.2 *National Context for Health Development*

The overall guiding document for national development in Botswana is Vision 2016, a broad-based national approach adopted in 1996 which focusses on the aspiration of the Nation. The principles and objectives of Vision 2016 guide the formulation and implementation of revolving 6-year National Development Plans (NDP). In pursuit of Vision 2016, health-related goals are set which contribute to the national development of Botswana, mainly through one of the pillars ‘*A compassionate, just and caring nation*’.

1.3 *Global Context for Health Development*

- 1.3.1 The international community has adopted eight Millennium Development Goals to be achieved by the year 2015 through the 2000 United Nations Millennium Declaration¹. In the African context, the Ouagadougou Declaration on Primary Health Care and Health Systems²

1. UN, Millennium Declaration.

2. WHO, Ouagadougou Declaration.

emphasises better health in this millennium beyond attainment of the health MDGs. In order to increase the pace toward the attainment of the health MDGs, the Paris Declaration³ urges countries to ensure aid effectiveness through country ownership, harmonisation, alignment and mutual accountability, and to focus on measuring results. Harmonisation for Health in Africa (HHA)⁴ ensures that all partners support countries in the sector through a single policy, a single national plan, a single implementation framework, and a single monitoring and evaluation framework under the leadership and ownership of government.

- 1.3.2 Recognising that social and economic determinants of health go beyond the health sector, the Commission on Social Determinants of Health (CSDH)⁵ has published a report proposing multisectoral interventions that can help reduce the negative impact of social stratification, illiteracy, insecurity (food, material, financial and otherwise), unemployment, poor housing, social exclusion, deprivation, malnutrition, addiction, poor working environment and lack of social support on health. This National Health Policy recognises the need for working closely with other sectors so as to ensure better and sustainable health status through concurrent and consistent strategies that will impact on the key social determinants of health in Botswana.

1.4 Brief Description of the Process of Policy Review

- 1.4.1 Taking into account the country, regional and global contexts, the Ministry of Health, in collaboration with all the health stakeholders, mapped out a process to develop this revised policy. It started with a situational analysis of the current health status, health determinants, and organisation, management and functionality of the health system. Based on the results of the situational analysis, a framework was prepared to assess the gaps within the 1995 National Health Policy.
- 1.4.2 The policy review process was done through a management structure consisting of the Stakeholder Reference Group (SRG) and six thematic groups (Leadership and Governance; Health Service Delivery; Human Resource; Health Financing; Health Information; and Health Technologies; Medicines and Vaccines). The thematic groups suggested what policy options could be included in the new policy. These options were also discussed and consensus built through national stakeholder and regional consultation meetings.

3. Paris Declaration on Aid Effectiveness, 2005.

4. UN Agencies, WB and AfDB, HHA.2. WHO, Ouagadougou Declaration.

5. WHO and CSDH, Closing the Gap in a generation, 2008.

Chapter 2: Situation Analysis

2.1 *Geographic and Demographic Features*

- 2.1.1 Botswana is a landlocked country situated in the centre of southern Africa, sharing borders with South Africa (to the south and east), Namibia (west), and Zimbabwe and Zambia (north). It is a semi-arid country of 581,730 square kilometres. The Okavango River from Angola flows through Botswana, creating the Okavango Delta (swamp) in the Okavango District. The Delta fills Lake Ngami and the Thamalakane River in Ngamiland, and Chobe River in the Chobe District. The most common natural hazards include drought, floods and veldt fires.
- 2.1.2 Botswana has a relatively small population, estimated in 2008 at 1,802,959⁶, giving a total population density of 3 persons per sq. km., making Botswana one of the most sparsely populated countries in the world. There is an uneven distribution of the population geographically, with the four western districts (Kgalagadi, Ghanzi, Ngamiland and Chobe) accounting for 61% of its surface area but only 13% of the population - and a collective population density of 0.6 persons per sq. km. Approximately 34% of the population is under the age of 15 years and 6% are over the age of 65 years. Just over a quarter (27%) of the total population are women of child-bearing age while children under five years constitute 12% of the population. The annual population growth rate stands at 2.4%⁷ and the total fertility rate is 2.9.⁸

2.2 *Social Determinants of Health*

- 2.2.1 The conditions in which people are born, grow, live, work and age, including the health system, determine the level of health enjoyed by the people. These conditions are referred to as social determinants of health and are shaped by the distribution of wealth, power and resources at national and local district levels. These in turn are influenced by policy choices in the different sectors involved. This revised National Health Policy attempts to address health inequities seen within and between communities and districts in Botswana. It is important to ensure improvements in all the social determinants of health so that the health system can successfully share its health resources with all people living in Botswana equitably, and hence improve their overall health status and life expectancy in a sustainable manner.
- 2.2.2 Health care is only one social determinant of health. Among others are individual's social and physical environment, and genetic endowment. Policies, programmes or services aimed at groups in society or an entire population may be as important as those aimed at individuals. Lifestyle changes also impact on the health of a population. There is a considerable homogeneity amongst different ethnic groups, and most are changing their

6. Botswana AIDS Impact Survey, CSO 2008.

7. Botswana Demographic Survey, CSO 2006.

8. Botswana Family Health Survey, CSO 2007.

lifestyles rapidly. Recent surveys⁹ show that factors like alcohol and drug abuse, tobacco smoking, unhealthy food habits and inadequate physical activity are common amongst adults in Botswana.

- 2.2.3 Although Botswana is committed to mitigating the effects of climate change, its impact is already noticeable. This is likely to have a direct impact on health: for example, prevalence of malaria is expected to increase as temperatures rise and conditions are more conducive for mosquitoes to breed during rainy seasons. Cholera is also likely to increase during the same period.¹⁰ With a reduction in rainfall, food production is likely to decrease and may lead to malnutrition in the longer term.

2.3 *Socio-Economic Determinants of Health*

- 2.3.1 Botswana has a total Gross Domestic Product of BWP 24.6 billion, representing a GDP per capita of BWP 14,232 (at the 1993/94 constant prices) for the year 2009/10. The composition of the GDP by sector is agriculture 1.8%, industry 59.5% (including 41.1% mining) and services 35.2%.¹¹ However, due to the skewed distribution of wealth, 28% (UNDP, 2007) of the total population live on less than US \$ 1/day. This disproportional distribution with the existence of *poverty* and unemployment may lead to alcohol and substance abuse, which impact negatively on the overall health status of the people. It is a challenge for the *health system* to ensure universal access to quality promotive, preventive, curative and rehabilitative health services among economically disadvantaged people.
- 2.3.2 There is universal primary *education* in Botswana which has a national literacy rate at 81.2% (2003/04), with a slightly higher literacy rate for females (81.8%) than males (80.4%).¹² Despite the reduction of school dropouts between 2005 and 2006 (by 14.8% and 5.1% for primary and secondary schools respectively), the rate of school dropouts is still significant – mainly due to desertion, pregnancy and illness.¹³
- 2.3.3 *Unemployment* remains high with 17.5% (for those actively seeking work) of the labour force in Botswana being unemployed.¹⁴ Despite being more literate, females (19.7%) suffer more unemployment than males (15.3%). An estimated 96,125 people are living with disabilities and may experience *social exclusion*.¹⁵ The number of registered orphans has increased over the years, mainly as a result of the HIV/AIDS epidemic. The number of orphans for the whole country was 41,592 at the end of December 2003, rising to 48,997 by the end of July 2008 (reports from 21 out of 27 districts).
- 2.3.4 Although most people live in habitable *housing* premises, there is still a sizeable number of people living in poor housing conditions. By 2006, 90% of the rural and 100% of urban population respectively had access to a *safe water* supply, while only 30% and 60% had improved toilet facilities and *sanitation* respectively.¹⁶

9. Chronic Disease Risk Factor Surveillance Report, 2008, MOH.

10. National Accounts Statistics, GDP: First Quarter 2010, CSO.

11. CSO, National Accounts Statistical Brief, . 2008.

12. CSO, Report of the Second National Survey on Literacy In Botswana, 2003.

13. Education Statistical Report, 2006.

14. 2005/6 Labour Force Survey, CSO.

15. Botswana Demographic Survey, CSO, 2006.

16. *ibid*, MOH, Environmental Health.

- 2.3.5 Botswana is capable of producing and importing enough food to ensure *food security* for every person. However, the skewed distribution of resources has resulted in over-nourishment and under-nourishment in different segments of the population.

2.4 Current Health Status in Botswana

The life expectancy at birth in Botswana is estimated at 54.4 years (48.8 males: and 60 females). The crude birth and crude death rates were estimated at 29.7 and 11.2 per 1000 respectively while infant and under-five mortality rates were 57 and 76 per 1000 live births respectively.¹⁷ The Maternal Mortality Ratio (MMR) is 193 per hundred thousand live births based on the CSO 2007 calculations. A total of 25.9% of the population are stunted, of which 16.8% are moderately stunted and 9.1% severely stunted.¹⁸

2.5 Major Causes of Disease Burden in Botswana

- 2.5.1 In Botswana both morbidity and mortality for all ages are still dominated by infectious diseases, with HIV/AIDS and other communicable diseases causing about half of the deaths. Due to an effective ARV programme, mortality due to HIV/AIDS has been declining over the past four years, but still is a major concern.
- 2.5.2 The Infant Mortality Rate (IMR) and under-5 mortality rate (U5MR) remain high with year-on-year fluctuations. More than two-third of these deaths is due to communicable diseases, with diarrhoea and pneumonia being the two main killers. More than 40% of infant deaths are within the first week of birth. The Maternal Mortality Ratio is also fluctuating. Although non-communicable diseases like hypertension, diabetes, etc. are not among the top ten causes of disease morbidity and mortality, the rates are increasing. Of these, cardiovascular diseases and cancers have been increasing alarmingly over the last decade.¹⁹ Tables 1 and 2 below indicate the major causes of mortality and morbidity in Botswana.

Table 1: Major causes of Mortality of Public Health Concern – 2006²⁰.

Diseases/Conditions	Numbers	Percentage
TB	731	6%
HIV	1,985	17%
Other Infectious	2,474	22%
Cancers	553	5%
Anaemias	401	4%
Endocrine, Metabolic & Nutritional	874	8%
Cardiovascular diseases	1,233	11%
Respiratory Diseases	1,448	13%
Digestive System Diseases	400	3%
Diseases of Nervous System	420	4%
Injuries/Trauma	324	3%
All Other Diseases	603	5%

17. Botswana Family Health Survey, CSO, 2007.

18. Botswana Family Health Survey, CSO, 2007.

19. MOH, Health Statistics Reports.

20. MOH, Health Statistics Report, 2006.

Table 2: Major Causes of Inpatient Morbidity (Excluding Neonatal Conditions) All Age Groups - 2006²¹.

Diseases and Conditions	Number	Percentage
Intestinal infectious diseases	9,409	9%
Tuberculosis	4,121	4%
Human immunodeficiency virus (HIV) diseases	2,965	3%
Other viral diseases	2,983	3%
Pneumonia and other ARI	8,133	8%
Pregnancy, Childbirth and the Puerperium	16,415	16%
Cancer	4,226	4%
Diseases of the Digestive System	5,219	5%
Diseases of the Circulatory System	6,298	6%
Injury, Poisoning and other external	10,853	11%
Total for the above	70,622	69%
Other Diseases and conditions	31,730	31%

2.6 The Organisation and Management of the Health Sector

Health service delivery in the country is pluralistic. There are public, private for profit, private non-profit and traditional medicine practices. Within the public sector, the Ministry of Health (MOH) is responsible for the provision of health services.

2.6.1 The Ministry of Health

The Ministry of Health is mandated with the overall oversight and delivery of health services for Botswana. It is responsible for the formulation of policies, regulations and norms, standards and guidelines of the health services. It is also a major provider of health services through a wide range of health facilities and management structures.

2.6.2 The Ministry of Local Government (MLG)

The Ministry of Local Government was mandated, until April 2010, to provide primary care through its network of clinics, health posts and mobile stops, as well as community-based preventive and promotive services, when those services were relocated to MOH.

2.6.3 Other Service Providers and Facilities

2.6.3.1 There are limited public sector health care services for targeted groups such as the Botswana Defence Force (BDF), Police and Prisons services. In the formal private sector, there are a number of private practitioners, including the mines, NGOs and missions facilities.

2.6.3.2 Although traditional medicine is widely used, there is no regulatory framework governing the practice. However, the Ministry of Health, in consultation with traditional health practitioners and other stakeholders, is in the process of formulating a bill to regulate traditional medicine.

²¹. MOH, Health Statistics Report, 2006.

2.6.4 Management and Coordination of the Health Sector

Until April 2010, the Primary Health Care Coordinating Committee at the national level and the District Primary Health Care Coordinating Committees at the district level were responsible for ensuring harmony and good working relationship between the MOH and the Ministry of Local Government. Over the years it became clear that there was confusion about the division of roles between MOH and MLG and also within various departments and divisions of each ministry. Thus Cabinet decided to relocate all health facilities to the MOH.

2.6.5 Regulation of the Health Sector

The public health services of the country are regulated by the Public Health Act 2002 (Chapter 63:01). However, with changes in the epidemiological scenario and technological advancements, the act is currently under revision. For both the public and private sectors, professionals are accredited by professional councils in accordance with the Medical, Dental and Pharmacy Act and the Nurses and Midwives Act. In addition to professional accreditation, the Ministry of Health is also responsible for the registration of private facilities through recognised standards.

2.7 Access and Utilisation of Health Services

- 2.7.1 Nationally, 95% of the total population (89% of the rural population) live within eight kilometres of a health facility.²² The public sector is the predominant provider of health care services in Botswana, with more than 80% of people receiving care from public facilities and programmes.²³
- 2.7.2 There is considerable disparity in the way health facilities are utilised. Some primary hospitals are utilised more than district hospitals, although there are fewer health workers in primary hospitals.²⁴ Although Botswana had achieved a national average of 2.06 beds per 1,000 population by 2009, there is marked inequality in the distribution of the beds by geographical area. This contributes to the underutilisation of available facilities. In addition, the bed occupancy levels in 82% of the hospitals, and the average length of stay levels in 69% of hospitals, are outside the optimal range (more than 70%) for developing countries.²⁵
- 2.7.3 Access to health facilities does not always translate into utilisation of high impact interventions. For example, insecticide treated net (ITN) use among pregnant women is at 15.4% while chemoprophylaxis against malaria is at 50%. Although ante-natal care (ANC) coverage is around 90%, Tetanus Toxoid 2+ (TT2+) utilisation among the same women is only 33%. However, in the context of providing services as a package, the lowest coverage of the high impact interventions is expected to be not less than 80%.

22. CSO, Statistical Brief No 2007/4. Access to Health Services in Botswana. August 2007.

23. CSO, Botswana Demographic Health Survey. 2006.

24. MOH, National Health Service Situation Analysis. 2009.

25. MOH, Human Resources Strategic Plan, 2008.

2.8 Human Resources for Health

- 2.8.1 Shortage of trained and qualified staff remains one of the major bottlenecks towards the availability of quality health care in Botswana. There are also increasing demands on the already over-stretched skilled workforce as a result of the addition of further programmes and projects, in particular those related to HIV/AIDS. Although the rate of attrition is negligible, there is a high turnover of staff at all levels of the health sector. Other challenges relate to inequitable deployment and failure to optimise the existing skill mix. An appropriate division of labour could contribute significantly to reducing the apparent shortage of staff.
- 2.8.2 The training of health care professionals is provided for by a combination of in-country and out-of-country institutions, with a heavy reliance on out-of-country arrangements. There are eight training institutes for nurses and some areas of health technologies only. In addition, the University of Botswana produces a limited number of nurses and some health technologists. The country's first medical school is currently under development. Due to this limited production of skilled health professionals, a large number of expatriates are deployed in the health sector.

2.9 Health Financing

- 2.9.1 According to the National Health Accounts Report, government contributed about 75% of total health expenditure (THE) in 2002, which represented about 9.2% of the total government budget. However, since 2004 the proportion of government budget allocated to health has reached the Abuja target of 15%.²⁶ The percentage of gross domestic product (GDP) spent on health gradually increased from 6.43% in 2000 to 9.27% in 2001 and 10.54% in 2002.²⁷ The share of out-of-pocket spending declined from 16% to 9% between 1995 and 2006, and the share of donor support increased from 4% to 7%, mainly due to increased funding for HIV/AIDS.
- 2.9.2 A nominal cost recovery system is in place for services in public facilities, with exemptions for vulnerable populations. Other additional charges include admission fees, ambulance charges, and charges for private patients and non-citizens. However, the extent to which these costs compromise the utilisation of essential services has not been assessed. It is generally believed that the cost of collecting is much higher than the funds collected. Alternative mechanisms for pre-payment, including social health insurance, are yet to be explored.

2.10 Medicines, Vaccines and other Health Technologies

2.10.1 Medicines, Vaccines and other Medical Products

- 2.10.1.1 The Botswana National Drug Policy (BNDP) and its implementation plan were adopted in 2002. Medicine regulation and control is mostly based on the provisions of the Drugs and Related Substance Act (DRSA) of 1992 and regulations thereto of 1993, which are

26. MOH, NHSSA, 2009.

27. MOH, Botswana National Health Accounts, 2006.

currently being amended to align them with the BNDP 2002 and other health related acts and policies.

2.10.1.2 There is a National Drug Quality Control Laboratory that tests medicines, condoms and gloves for conformity to specifications, but it is resource-constrained and not capable of satisfying public- and private-sector testing needs. The major challenges in the area of medicine regulation have been a shortage of staff at the Drugs Regulatory Unit to register medicines and conduct drug control activities; inadequate legislation to address importation and distribution of counterfeit medicines; prescribing and dispensing by unqualified people contrary to the provisions of the DRSA; and inadequate regulation and control of traditional medicines.

2.10.1.3 Supply chain management systems at all hospitals and clinics are weak, leading to erratic availability as well as shortage of essential drugs. There are attempts to reform the Central Medical Stores (government's drug provider) to improve its performance and ensure universal accessibility of essential medicines to all people living in Botswana.

2.10.2 Equipment

The government is equipping public health facilities with modern equipment, but they are not standardised to the level of the health facility. Staff at those facilities are not always trained or available to make optimal use of the equipment. The diversity of equipment poses a challenge to planned preventive maintenance and to effectively conducting an annual inventory of all equipment, including ascertaining its life span.

2.10.3 Infrastructure

2.10.3.1 Botswana has a good network of health infrastructure with adequate architectural designs. The earlier primary facilities (clinics) and some hospitals were not constructed to ensure patient flow and care. However, there are architectural, engineering, environmental, and safety standards employed to ensure the efficiency, durability and safety of the structures. Environmental Impact Assessments (EIAs) are done whenever infrastructure is planned for construction in accordance with legislation on EIAs. There is a waste management policy that covers issues related to waste classification, waste generation, waste storage, waste transportation and waste disposal. The Radiation Inspectorate of the Ministry of Information, Science and Technology has been established to ensure that harmful radioactive activity is detected and equipment is supervised for compliance.

2.10.3.2 However, there are no clear standards for the distribution and sizing of health facilities, and infrastructure development may not be linked to human resource availability. Because of this, some health facilities are currently under-utilised while others are over-utilised.

2.11 Health Information Management System

2.11.1 A well-functioning health information management system (HIMS) is critical for monitoring and evaluating the performance of the health sector. Currently, there are various challenges related to timely data collection, collation, analysis, interpretation and dissemination. Not all the health system data are captured and stored in a database. The weak referral and supervisory frameworks for health facilities and management units are

contributing to a failure to ensure the timely reporting, cleaning, analysis, interpretation and use of data.

- 2.11.2 Currently data use for planning purposes or programme improvement is limited, as different information systems (epidemiological, logistics, human resource, health statistics and finance) are incompatible and poorly coordinated. Lack of use of the information also undermines the quality of information. The existing monitoring and evaluation processes are fragmented.

2.12 Progress Towards Attainment of the Health MDGs

- 2.12.1 Different sources of data indicate that by 2006, none of the three health Millennium Development Goals (*1. Reducing the under-five mortality rate by two-thirds; 2. reducing the Maternal Mortality Ratio by three-quarters; and 3. halting the increase and begin to reverse the prevalence of HIV, Malaria and Tuberculosis by 2015*) were on track. However, as shown in Table 4 below, some health-related MDG targets, such as access to ART, access to safe drinking water and reduction of underweight among the under fives, are on track. Facility-based data shows a reduction of the prevalence of malaria in endemic areas. With increased access to ART, the target of reducing the HIV prevalence may be replaced with a more appropriate measure of incidence (a reduction of new HIV cases).

- 2.12.2 It is in this regard that it was found fit to revise the National Health Policy so as to address the changing demography and health profile, and also to incorporate the current perspectives of putting health on the national development agenda. The revised policy will therefore put emphasis on health system strengthening, integration and the coordination of existing policies and plans, to improve effectiveness and efficiency, foster partnerships and promote research to improve health system performance. Hence the focus is on the following Key Result Areas in order to maximise the impact on health status:

- Leadership and Governance;
- Health Services Delivery;
- lifestyle/behavioural Determinants of Health;
- Health Resources (Human Resources for Health, Medicines, Vaccines and Medical Equipment, Health Infrastructure, Health Financing); and
- Health Management Information System.

Table 4: Progress towards the MDGs – selected indicators.

MDG	1990-94	2002-06	Target (2015)
1. Underweight children under 5 (%) to reduce by half	17.0	5.9	8.5
4. Infant mortality rate (per 1,000) to reduce by two-thirds	48	56	16
4. Under five mortality rate (per 1,000) to reduce by two-thirds	63	74	21
4. Children immunised against measles (%)	74	86	100
5. Births attended by skilled personnel (%)	93	96	100
5. Maternal mortality rate (per 100 000) to reduce by three-quarters	326	150-190	81
6. HIV prevalence among adults (%)	NA	25	Falling*
6. Access to ART (% clinically eligible) universal.	NA	95	≈100
6. TB notifications (per 100,000)	200	620	Falling*
7. Proportion of population without access to safe drinking water (%) to reduce by half	23	4	12

Sources: CSO (2003a, 2004b, 2006a); CSO & GoB (2004); NACA & CSO (2005); GoB (2007b) CSO HIES 2002-2003.

* 'Falling' was used as a target because at the time of MDG target setting the baseline figures were not known. This also took into consideration the fact that cases may increase because of prolonged life due to better treatment.

Chapter 3: Vision, Mission and Guiding Principles

Botswana recognises health as a basic necessity and the need to promote health as imperative for social justice. This is best clarified through the following vision, mission and guiding principles.

3.1 Vision

An enabling environment in which all people living in Botswana have the opportunity to achieve and maintain the highest level of health and well-being.

3.2 Mission Statement

A sustainable improvement in health status through progressive creation and maintenance of physical, mental, economic and social well-being.

3.3 Guiding Principles/Values

The following principles will guide the implementation of the Botswana National Health Policy:

Guiding Principle	Description
Ethics	Respect for human dignity, rights, confidentiality and cultural beliefs.
Norms and Standards	Good management practices and quality assurance in service delivery.
Equity	Equitable distribution of resources to guarantee accessibility to quality services at every point of demand, especially for the vulnerable, marginalised and underserved, irrespective of political, ethnic or religious affiliations and place of domicile.
Ownership	Involvement/participation of all stakeholders (providers and users) of health services in defining policy as well as the implementation framework.
Evidence-based	The policy will be based on evidence particularly pertaining to Botswana.

<p><i>Innovation</i></p>	<p>Continuous exploration of new ideas in health care delivery, e.g. geographical targeting, to benefit high priority areas; health insurance coverage for the disadvantaged sections of society; public-private partnership; demand-side financing; etc.</p>
<p><i>Gender Equity</i></p>	<p>Addressing gender sensitive and responsive issues, including the equal involvement of men and women in decision-making, eliminating obstacles (barriers) to services utilisation, and the prevention of gender-based violence.</p>
<p><i>Client Satisfaction</i></p>	<p>Ensuring efficient twenty-four hour quality health services that is more responsive and sensitive to Customer needs.</p>
<p><i>Skilled Staff Retention and Circulation</i></p>	<p>Attractive service conditions (package) and job satisfaction to encourage a net inflow of critically required skills.</p>
<p><i>Partnerships</i></p>	<p>Increasing community empowerment; active involvement of the private sector, NGOs, local government authorities and civil society, and effective development partner co-ordination.</p>

3.4 Duration of the Policy

The Policy will guide the health development of Botswana for the next 10 years. Continuous and rigorous monitoring and evaluation will be conducted regularly on the implementation of the Policy. The National Health Council may recommend to the Ministry of Health to revise its duration and review the policy depending on any changes in epidemiological or other factors affecting health.

Chapter 4: Policy Thrusts / Principle Areas of Action

In pursuing the vision and mission, and in line with the guiding principles set out above, the following principle areas of action and policy thrusts are identified, which collectively have the potential for a maximum impact on health status:

- Leadership and Governance;
- Health Service Delivery;
- Lifestyle/behavioural Determinants of Health;
- Health Resources;
 - Human Resources for Health,
 - Medicines, Vaccines and Medical Equipment,
 - Health Infrastructure,
 - Health Financing, and
- Health Management Information System.

4.1 *Leadership and Governance*

The performance of the health sector is dependent on the quality of leadership and governance. In the context of Botswana, **leadership** includes:

- The stewardship role;
- Inter-sectoral collaboration and coordination;
- Harmonisation and alignment; and
- Clarity of the roles and relationships between MOH, MLG, local authorities and other stakeholders.

Governance relates to:

- Setting a strategic vision with a timeframe;
- Inclusive participation and consensus around policy and implementation;
- Health legislation, regulation, standard-setting and enforcement mechanisms, including over-sight and supervision;
- Transparency;
- Responsiveness;
- Equity and inclusiveness for social protection and universal access;
- Effectiveness and efficiency through sound stakeholder involvement in strategic planning, priority setting and budgetary frameworks;
- Accountability;
- Information and intelligence; and
- Ethics.

4.1.1 *Goal*

Ensuring strategic guidance and oversight in the regulation and implementation of all health-related services.

4.1.2 Objectives

- To create a platform in the health sector for the provision of strategic guidance and oversight;
- To develop the National Health Strategic Plans to guide the implementation of the Policy;
- To clarify the roles of stakeholders;
- To ensure the functionality of all regulatory frameworks; and
- To separate the inspection and implementation roles within the health sector.

4.1.3 Policy Initiatives

- a) The Government shall form a National Health Council (NHC) to ensure strategic guidance and oversight, chaired by an Eminent Health Professional of Botswana and attended by Ministries of Health; Finance and Development Planning; Local Government; Education and Skills Development; Sports, Youth and Culture; Mineral, Energy and Water Resources; Environment, Wildlife, and Tourism; Agriculture; Transport and Communications; Infrastructure Science and Technology; Ministry of Defence, Justice and Security; and representatives of development partners, NGOs, the private sector, professional associations, notable health professionals as individuals and the Community (e.g., Kgosi, VDC representatives, community watch groups/VHC, etc.)
- b) The Government shall facilitate the establishment of bodies or associations of the users of health services responsible for representing and defending their interests and/or the general promotion and protection of health.
- c) MOH in collaboration with partners shall develop National Strategic Plans to facilitate the implementation of the policy.
- d) Cabinet, through the National Health Council, shall clarify the roles between different key players to ensure complementarities and synergies in the provision of continuous and sustainable health services for better health development.
- e) MOH shall facilitate the formulation of a Public Health Bill/Act and ensure its implementation and regulation. The Public Health Bill/Act will also incorporate the necessary and relevant international health regulations.
- f) MOH shall review, revise and develop norms, standards and legislative documents to harmonise and protect the quality of health services provided by all stakeholders in the health sector.
- g) The government shall encourage partnerships and the Ministry of Health shall lead and coordinate all partnerships in the health sector through the creation of different bodies for coordination at national and local levels.
- h) The government shall separate the inspection and implementation roles within the health sector by the creation of an autonomous Health Inspectorate.
- i) MOH shall adopt sector-wide approaches to harmonise and align planning, financing, implementation, monitoring and evaluation of the health sector.
- j) MOH shall from time to time review and revise its organisation and management structures to respond to new developments and challenges in order to gain and maintain high efficiency in the provision of health care.

4.2 *Service Delivery*

As a signatory to several international declarations and intents, Botswana is committed to ensuring quality health care services, that are affordable and accessible to all people living in Botswana. The government's focus is on improving health status and reducing health inequalities through expanding access to social safety networks, and on promoting affordable services for every household. For the poor and vulnerable, existing safety nets will be further improved and consolidated to ensure wider access to public health care services. The existing health infrastructure does not have facilities that adequately address the needs of people with physical disabilities. This will call for health infrastructure planning to be needs-based.

4.2.1 *Goal*

Attainment of universal coverage of a high-quality package of essential health services.

4.2.2 *Objectives*

- To scale up the utilisation of a well defined and comprehensive package of essential health interventions;
- To redefine existing service delivery levels and delineate types of health services for each of these levels of health care in order to ensure continuity and harmonised referral and supervisory functions;
- To increase and strengthen partnerships with the private sector and NGO's in attaining universal coverage of high quality essential health service package;
- To involve all community-based groups in order to ensure effective demand for health services; and
- To promote community participation in the planning and delivery of health services.

4.2.3 *Policy Initiatives*

- a) The MOH shall define a comprehensive set of essential health services with special emphasis on health promotion and preventive health care, using well articulated and transparent criteria based on the epidemiological, technological, geographical, economic and socio-political situation of the country. All cost-effective interventions in priority programmes as such as HIV and AIDS, Tuberculosis, reproductive and child health, accidents and emergency, and others shall be part of the essential health services package (EHSP).
- b) The MOH shall from time to time redefine the comprehensive essential set of health services, which include for promotive, preventive, curative and rehabilitative health care. This package shall be provided free of charge to citizens in all public health facilities and strategically purchased from private providers. Furthermore, diseases of public health importance shall be redefined from time to time and their treatment shall be provided free to all people living in Botswana.
- c) The MOH shall redefine the health care delivery levels into a five-tier system comprising individual/family, primary health clinics/centres, primary hospitals, district/secondary hospitals and referral hospitals.
- d) The MOH shall ensure that the comprehensive set of health services shall be provided as a package in all health facilities, including those owned by the mission, the mines,

the private sector and other government organs, taking into account continuity and harmonisation of referral and supervisory functions.

- e) The MOH and other partners shall establish a well functioning ambulatory care system, including air ambulance service, as well as a communication system for improved referral services.
- f) The MOH shall use appropriate approaches to effective private-public partnerships in health service provision in order to ensure universal access to essential health services.
- g) The MOH in collaboration with its partners shall ensure the provision of the set of comprehensive health services through an Integrated Health Services Plan (IHSP).
- h) The NHC shall establish a Clients' Charter, outlining the rights of clients in the process of health service utilisation and to health services, as well as their roles in taking responsibility for their own health.
- i) The NHC shall establish a Provider's Charter of rights and responsibilities outlining their obligations and responsibilities in the provision of health care as well their obligations in protecting the health and privacy of their customers.
- j) The MOH shall make provision for other services which are not incorporated in the essential package. The government shall partially share the costs of the services depending on the resources available.
- k) The MOH shall set an exclusion package of health services which will not be funded through the public sector.
- l) The government shall explore and establish Centres of Excellence so as to maximise health efficiency, reduce external referrals and attract medical tourism.
- m) The government shall provide the regulatory framework for alternative medicine²⁸ practice and create an enabling environment for the effective involvement of traditional practitioners, as well as for exploring traditional medicinal plants.
- n) The MOH in collaboration with relevant agencies shall ensure the proper screening of food, animals and animal products, and of persons entering Botswana through the provision of a Port Health Service.
- o) The MOH shall strengthen the public health laboratory services to support the priority disease control programmes, including the control of emerging and re-emerging diseases.

4.3 Human Resources for Health

Human resources for health (HRH) are the backbone of service delivery in the health sector. Creating an appropriately skilled, highly motivated, client-focused health workforce is critical for Botswana to attain its ambition of ensuring an enabling environment in which all people living in Botswana have the opportunity to reach and maintain the highest attainable level of health.

28. Alternative medicine implied here includes traditional herbalists, homeopathy and neo-herbalists.

4.3.1 Goal

Ensuring an appropriately skilled, motivated, well distributed and productive workforce for the provision of quality health services effectively and efficiently, delivered to all the people living in Botswana.

4.3.2 Objectives

- To strategically plan health workforce development for the sector;
- To develop and continuously review recruitment and retention strategies for the health workforce; and
- To strengthen the management of human resources through the development and implementation of performance standards and norms for efficient service delivery.

4.3.3 Policy Initiatives

- a) The MOH shall strategically forecast HRH needs, taking into account the multiplicity of professions and skills, service delivery facilities and providers (public, private and NGOs), population health needs and their growth, and geographical distribution.
- b) The MOH in collaboration with its partners shall develop and review health workforce strategic plans from time-to-time.
- c) The MOH in collaboration with the Ministry of Education and Skills Development shall ensure the equitable production of an adequate and appropriately skilled health workforce to provide health services at all levels of health care delivery.
- d) The MOH in collaboration with its partners shall harmonise the recruitment and deployment criteria of the health workforce to reduce turnover and ensure continuity of care.
- e) The MOH in collaboration with the Directorate of Public Service Management (DPSM) and other relevant government sectors shall periodically review the conditions of service (salary, housing, professional advancement, contractual obligations, involvement in decision-making, recognition of staff contribution and other incentives) and develop appropriate recruitment and retention strategies, both for national and expatriate health workers, within the public sector.
- f) The MOH shall ensure that all data generated in pre- and in-service training, recruitment, deployment and migration of health workers be captured, stored in a database, analysed and interpreted for decision-making, and to inform future national policy directions.
- g) The MOH shall ensure that the IHSP incorporates the Health Workforce Strategic Plan, such that the right number of staff with the right skills is in the right place to deliver the package of services.
- h) The MOH shall develop and periodically update the staff norms/skills-mix by care level based on research which includes users' views, to ensure well informed pre-service training and efficient recruitment and deployment of the health workforce, and to ensure an uninterrupted provision of essential health services.
- i) The government shall develop a regulatory mechanism for alternate medical (traditional - herbalist, homeopathy, etc.) practices, preferably in the form of an Act to be

administered by MOH and the Traditional Practitioners' Association through the creation of a registration system for alternate medical practitioners, in order to safeguard against malpractice and misconduct.

- j) The government shall promote the formation of and strengthen professional associations and unions to ensure well informed involvement in decision-making and the amicable settling of disputes.
- k) The MOH shall periodically review and update the Health Professionals Act and the Nurses and Midwifery Act in order to modernise the accreditation process (for instance, incorporating periodic testing for the continuation of professional registration).

4.4. Health Financing

The ways in which resources are raised, pooled and allocated, and the way services are paid for, all have a major impact on access to health care and, in turn, on efforts to alleviate poverty through attainment of the highest level of health status.

4.4.1 Goal

Raising and allocating sufficient resources and putting in place appropriate payment arrangements to ensure that all people living in Botswana have access to a range of cost-effective health interventions at an affordable price regardless of their economic status.

4.4.2 Objectives

- To raise sufficient funding to meet health needs of the people in a sustainable manner;
- To prioritise funding for the essential health service package (EHSP);
- To ensure efficiency in the collection and pooling, as well as cost effectiveness in utilisation of funds;
- To determine and periodically review the costing of health services by levels of health care; and
- To objectively undertake innovative measures to ensure social protection and universal access to essential health services.

4.4.3 Policy Initiatives

- a) The MOH shall develop a health financing strategy that will guide the financing of the entire health sector.
- b) The government shall ensure the availability of financial resources for a prepaid package of essential health interventions for all citizens of Botswana so that the services are available to the client free of charge.
- c) The MOH shall promote public-private partnerships in order to achieve universal coverage of the essential package services.
- d) The MOH shall partially finance limited interventions outside the essential package depending on the availability of resources.
- e) The MOH shall periodically review all its financial collection mechanisms in order to ensure the efficiency and cost effectiveness of service delivery.

- f) The government shall put in place mechanisms to strengthen health systems so that all services, including infrastructure, are provided in an efficient and cost-effective manner.
- g) The government shall ensure an increase in per capita allocation and expenditure of funds allocated to health to at least 15% of total government expenditure (Abuja Declaration target).
- h) The MOH shall embark on approaches to harmonise and align donor support of the health sector, for example a sector wide approach and health compacts.
- i) The MOH shall formulate and periodically review and revise resource allocation formulae for the equitable and timely disbursement of funds to all districts and health facilities as well as national health programmes.
- j) The MOH shall explore and develop contracting-out arrangements, based on agreed standards, with NGOs and the private sector for the delivery of EHSP, to ensure universal access.
- k) The MOH shall advocate for and introduce other prepayment mechanisms, such as social health insurance, to raise the level of revenue for health services outside the EHSP.
- l) The government shall introduce and periodically revise taxes and levies from cigarettes, alcohol, etc. to fund promotive and preventive activities.

4.5 Medicines, Vaccines and Health Technologies

Medicines, vaccines, equipment and infrastructure are very important health resources that need to be in place for the efficient provision, maintenance and utilisation of health services. The main issues here concern the availability, universal access and utilisation of appropriate medicines, vaccines and health technologies by those who need them, at the time and place where they are needed.

4.5.1 Medicines, Vaccines and other Medical Products

Medicines, vaccines and other medical products are fundamental resources in the provision of health care. There is already a comprehensive national drug (medicine) policy addressing such areas as selection, procurement, storage, etc. This National Health Policy will focus on areas that need further improvement and clarifying functions.

4.5.1.1 Goal

Ensuring the availability of medicines, vaccines and other medical products, which are of acceptable safety, efficacy and quality, to those who need them, at the time they need them, and ensuring the rational use of medicines, vaccines and blood products.

4.5.1.2 Objectives

- To ensure that there is universal access of essential medicines, vaccines, laboratory reagents and other medical products by the people living in Botswana;
- To ensure the use of safe, efficacious and quality medicines, vaccines, laboratory reagents and other medical products;

- To ensure adherence to norms and standards related to the use of medicines, vaccines laboratory reagents, prescriptions, and dispensing; and
- To strengthen regulatory measures in the prevention of drug misuse and abuse.

4.5.1.3 Policy Initiatives

- a) The MOH shall review from time to time the Essential Drug List (EDL) to match with changes in the EHSP, advancement in medical technology, and levels of resistance to available medicines.
- b) The MOH shall ensure the selection, forecasting and quantification of medicines and vaccines in collaboration with districts, facilities and other relevant stakeholders, to reflect the needs of the health services.
- c) The MOH shall develop and periodically review a National Medicine Formulary and Standard Treatment Guidelines, and impart training to encourage its rational use by health service providers and their clients at all levels in the health sector.
- d) The MOH shall explore the possibilities of outsourcing the procurement, storage and distribution functions, to ensure the equitable and timely availability and utilisation of essential medicines and medical products.
- e) The MOH shall develop a web-based tracking system for the drug/medicine management system.
- f) The MOH shall lead the review of the Medicines and Related Substances Act (MRSA) to update its relevance, and include new sections on blood and blood-related products, and the introduction of new medicines and medical products, in the country.
- g) The government shall explore, through a local preference scheme, possibilities for collaboration with other countries to promote, where feasible, the local production of medicines, vaccines and other medical products.
- h) The government, through re-engineering the existing Drug Regulatory Unit (DRU), shall set up an autonomous independent Medicine Regulatory Authority to institutionalise pharmaco-vigilance so as to ensure universal access to efficacious and safe medicines, vaccines, reagents and other medical products, by regulating the manufacture, import, export, distribution, sale and dispensing of medicines and the sale of related substances, including cosmetics.
- i) The MOH shall strengthen the National Drug Quality Control Laboratory and place it within the proposed autonomous Medicine Regulatory Authority to ensure that medicines, vaccines, reagents and other medical products produced, distributed, exported, procured and used in Botswana are tested for conformity to standards of quality recognised internationally.
- j) The MOH shall explore and promote the evidence-based utilisation of herbal and other alternate medicines through mutual collaboration with alternate health practitioners, and the establishment of regulatory framework for the regulation of alternate medicine practices.
- k) The MOH, in collaboration with Ministry of Agriculture, Ministry of Transport and Communications, Ministry of Infrastructure, Science and Technology, Ministry of

Environment, Wildlife and Tourism, University of Botswana, and Ministry of Trade and Industry, shall explore the possibility of encouraging the transformation of locally available medicinal plants into industrialised medical products.

- l) The MOH shall set up a system within the Central Medical Stores to receive all donated medicines, vaccines, reagents and other medical products on behalf of all recipients in the health sector, including the private sector and NGOs. It shall establish an appropriate structure to ensure that the donated items meet set quality standards.

4.5.2 Equipment

The demand for medical equipment and maintenance services has increased dramatically over the past years as a result of advances in technology and the increased complexity and burden of medical conditions. Some equipment is expensive and may not be suitable for all countries. Currently, equipment is not universally standardised, nor based on the type of service, level of service delivery or disease pattern. Servicing and maintenance standards are also essential to increase the longevity of equipment.

4.5.2.1 Goal

Ensuring the availability, safety, durability, quality, cost-effectiveness and appropriate provision of medical equipment necessary for promotive, preventive, curative and rehabilitative health services.

4.5.2.2 Objectives

- To ensure the consistent availability of effective, safe and appropriate medical equipment;
- To ensure the standardisation and optimum use of medical equipment at all levels of health care provision; and
- To adopt planned servicing and maintenance practices for medical equipment at all public sector health facilities.

4.5.2.3 Policy Initiatives

- a) The MOH shall develop standardised criteria for medical equipment by level of care, type of health service and specification.
- b) The MOH shall explore different options, such as creating an appropriate organisational structure, outsourcing, etc., for the timely and effective preventive maintenance and repair of equipment at different health facilities.
- c) The MOH shall select, forecast and procure medical equipment based on standardisation criteria and health service needs at all health facilities.
- d) The MOH shall review the procedures of medical equipment procurement, to ensure that it entails appropriate training, maintenance and repair of the equipment by the supplier.
- e) The MOH shall establish an independent authority to receive equipment donations on behalf of all recipients (public or private) in the health sector in order to ensure that the medical equipment meets standard criteria.

- f) The MOH shall build the capacity of medical equipment users so as to attain maximum possible equipment benefits, life span, cost-effectiveness, and quality and safety of care.
- g) The MOH shall establish a periodic inventory of medical equipment to ensure effective planned preventive maintenance.
- h) The MOH shall develop cut-off points for the decentralisation of procurement and maintenance of some medical equipment in order to reduce inefficiency and the interruption of critical health services.
- i) The government shall explore the possibilities for collaboration with other countries to promote, where feasible, local production and/or assembly of healthcare technology, including medical equipment.

4.5.3 Infrastructure

Infrastructure refers to physical structures, management offices, staff quarters etc. The main emphasis is on the need to standardise health facility infrastructure by level of care and local need. It is also essential to ensure progressive continuity of care through effective referral systems.

4.5.3.1 Goal

Ensuring that the health infrastructure is adequate and equitably distributed to meet the unique needs of health services, taking into account architectural, engineering, safety and environmental standards as well as local needs.

4.5.3.2 Objectives

- To ensure that the health infrastructure meets the set quality standards regarding architecture, engineering, environment and safety, with consideration given to the efficiency of patient flow;
- To ensure that equal needs, levels and types of care are served with a similar nature of health infrastructure while adapting to local needs; and
- To address inequalities in the health care delivery system related to geographical access and vulnerability.

4.5.3.3 Policy Initiatives

- a) The MOH shall develop and periodically review standardisation that would ensure that health infrastructure meets architectural, engineering, environmental, and safety standards taking into account the special needs of different forms of health services and different levels of care.
- b) The MOH shall develop and periodically review transparent criteria for the distribution of health facility infrastructure based on the availability of resources, population, disease burden/pattern and geographical layout.
- c) The MOH in collaboration with the Ministry of Infrastructure, Science and Technology shall build internal capacity for the articulation and development of architectural, engineering, environmental and safety standards based on health service needs at all levels of care, ensuring their adherence in the public and private sectors.

- d) The MOH in collaboration with the Ministry of Infrastructure, Science and Technology shall ensure that all health facility buildings provide for the special needs of users with disabilities.
- e) The MOH shall collaborate with the Ministry of Environment, Wildlife and Tourism, the Department of Environmental Affairs and the Department of Buildings and Engineering Services in conducting Environmental Impact Assessments whenever health infrastructure is planned for construction.
- f) The MOH shall collaborate with the Ministry of Environment, Wildlife and Tourism and the Department of Buildings and Engineering Services to ensure adherence to policies and regulations related to environmental standards.

4.6 Health Information and Research

Health information concerns the availability, completeness and timeliness of data that is used for evidence-based policy planning and implementation. Data collection, collation, analysis and interpretation require norms, standards and guidelines for the data to be efficiently utilised. A viable information system is essential for the effective monitoring and evaluation of health services and programmes.

4.6.1 Goal

Ensuring the timely availability, accessibility, quality and use of health information for the sustainable improvement of the health status of the people living in Botswana.

4.6.2 Objectives

- To collect and analyse information about diseases and health, services, finances and workforce, medicines and medical products, infrastructure and equipment, from all stakeholders of the health sector;
- To clarify the roles and functions of different stakeholders in data management in order to minimise duplication and maximise the optimal utilisation of resources;
- To ensure timely, wide and need-based dissemination of data to all stakeholders;
- To develop and implement a research agenda in collaboration with relevant partners to support national policy development; and
- To develop and implement regulations regarding the mandatory reporting of defined information requirements.

4.6.3 Policy Initiatives

- a) The MOH shall ensure that all relevant health information regarding population dynamics, diseases, health services, health financing, health workforce, medicines and vaccines, infrastructure and equipment is collected from all the health stakeholders, including donors, the private sector and NGOs.
- b) The MOH shall develop the capacity and tools, including a web-based observatory, to ensure effective data collection, collation, analysis, interpretation and timely feedback and dissemination for improved evidence-based decision-making at all levels.
- c) The MOH in consultation with all stakeholders shall develop indicators for measuring performance in different policy areas and programmes.

- d) The MOH shall establish an institutional/organisational arrangement that will harmonise and link all the data management units with the aim of reducing the duplication and wastage of data, and of maximising its effective use through prompt reporting and feedback.
- e) The MOH shall develop a regulatory framework (norms, standard operation procedures, policy directives and laws) that will ensure that all data is collected and reported to the relevant data management units and shared with all the concerned stakeholders.
- f) The MOH shall, in collaboration with research institutions, develop a comprehensive research agenda to streamline areas that require new knowledge and provide guidance to the National Health Policy, plans and programmes.
- g) The MOH shall set up an autonomous National Health Research Council which will be responsible for ensuring adherence to scientific and ethical standards in the conduct of health research.

4.7 Lifestyle / Behavioural Determinants of Health

Botswana is undergoing an epidemiological transition in which communicable diseases decrease whilst a number of non-communicable diseases and conditions increase. Several lifestyle factors have major impact on morbidity and mortality.

While alcohol can be included within a healthy lifestyle, excessive drinking carries a heavy toll in illness, accidents, anti-social behaviour and criminal acts of violence, including domestic violence. The personal, social and economic costs associated with excessive and irresponsible drinking are high. Drug and substance misuse also exist within Botswana. It damages the health of individuals and communities. Steps to prevent drug and alcohol abuse (including effective treatment approaches) will benefit health directly and improve community safety and other factors underlying good health. The key approach for the reduction of morbidity and mortality will be to change harmful lifestyles through targeted and intensive health promotion. Industrialisation and urbanisation contribute to ill health by affecting environment and lifestyle.

4.7.1 Reducing Smoking

Worldwide evidence shows that tobacco smoking (active or passive) is the most important preventable cause of ill-health and premature death. Smoking, particularly amongst young males and women, is increasing thus making these groups more vulnerable to several non-communicable diseases, especially lung cancer.

4.7.1.1 Goal

Reducing the harmful health condition related to active and passive smoking.

4.7.1.2 Objectives

- To reduce the number of smokers;
- To prevent young adults from trying tobacco; and
- To reduce smoking among pregnant women.

4.7.1.3 Policy Initiatives

- The MOH in collaboration with the Ministry of Trade and Industry shall review the existing legislation in order to impose more stringent measures on tobacco control and marketing.
- The MOH shall enhance health promotion campaigns on the dangers of smoking as well as the ‘stop smoking’ strategy.
- The MOH shall take steps to introduce health services like counselling, stop smoking aids, etc. to help smokers quit.
- The Ministry of Trade and Industry with the Ministry of Labour and Home Affairs shall secure tougher enforcement of the law against the sale of tobacco to minors.

4.7.2. Healthy Food Habits and Increased Physical Activity

An imbalanced diet with high amounts of fat, salt and sugar, and low amounts of fibre is also a significant cause of poor health, contributing to a range of serious illnesses, such as coronary heart disease, certain cancers, strokes, osteoporosis and diabetes. The Government of Botswana is determined to encourage wider participation in physical activity, particularly by younger people. Moderate physical activity, in the form of everyday activities such as walking, also makes a vital contribution to positive health and active ageing. An increase in eating unhealthy foods has come with changes in lifestyle, contributing to obesity and other chronic diseases.

4.7.2.1 Goal

Increase access to affordable healthy food, and promote healthy eating habits and increased physical activity, in order to reduce malnutrition as well as preventing chronic diseases such as diabetes, cardiovascular disease, osteoporosis, etc.

4.7.2.2 Objectives

- To reduce obesity;
- To prevent children from obesity and malnutrition;
- To increase accessibility to affordable, healthy foodstuffs by all people, particularly in deprived and rural areas; and
- To implement a physical exercise programme along with the health and wellness week in all work places and schools.

4.7.2.3 Policy Initiatives

- a) The MOH shall develop and disseminate national dietary guidelines to all Botswana residents.
- b) The MOH shall promote healthy eating habits through events, education, campaigns, etc.
- c) The Ministry of Local Government (Department of Social Services) shall assess food quality and provide subsidies for healthy foods, particularly fruits and vegetables, to vulnerable groups.
- d) The MOH and Ministry of Local Government shall promote nutrition education with

community support groups.

- e) The country shall observe a wellness week once a year for all lifestyle-related health conditions.
- f) The MOH shall lead a wider health promotion campaign for increased physical activity.
- g) The Ministry of Education and Skills Development shall increase activities on school sport.

4.7.3 Alcohol and Substance Abuse

Alcoholic beverages have been traditionally brewed and consumed in Botswana as part of cultural and social practices. In most communities drinking alcohol is culturally and socially acceptable. While the effects of alcohol are cherished by many individuals, the negative impact of harmful drinking can be devastating for individuals, families and nations.

Although the actual extent of abuse of medical drugs and illicit drugs like “dagga” is not documented, it is perceived that abuses are increasing. This in the longer term may have harmful effects on people’s health as well as that of the society.

4.7.3.1 Goal

Foster a healthy and productive nation through the reduction in mortality and morbidity, as well as of the negative socio-economic impact, of alcohol and substance abuse.

4.7.3.2 Objectives

- To promote and monitor public education and awareness creation on the harmful effects of alcohol and substance abuse, and guide the management of alcohol and substance-related harm;
- To facilitate a review of, and harmonise, regulations and control measures/ instruments;
- To strengthen the health sector response to alcohol and drug abuse through increased accessibility to user-friendly healthcare facilities;
- To regulate and monitor the formal and informal liquor sector/industry;
- To reduce the incidence of adults exceeding generally acceptable limits of alcohol consumption; and
- To ensure road safety.

4.7.3.3 Policy Initiatives

- a) The MOH, in collaboration with the Ministry of Trade and Industry and working with other stakeholders, shall formulate an alcohol and substance abuse policy.
- b) The MOH in collaboration with the Ministry of Trade and Industry (MTI) shall establish an inter-sectoral committee comprising key stakeholders to oversee and ensure strategic guidance, coordination and supervision of the alcohol abuse policy.
- c) The MOH shall incorporate strategies, in its sector strategic plan, to combat the ill-effects of alcohol and illicit substances on health.
- d) The MOH in collaboration with the Ministry of Local Government shall work with the Ministry of Trade and Industry and relevant partners to support communities in

monitoring both home-based and commercial sales and distribution systems through close working relations with the authorised officers.

- e) The MOH shall work with the Ministry of Trade and Industry and the Ministry of Labour and Home Affairs to address alcohol problems at the workplace through initiatives aimed at educating, protecting and assisting employees.
- f) The MOH in collaboration with the Ministry of Education and Skills Development shall develop curricula on substance abuse in general, and on the harmful use of alcohol in particular, to be integrated into primary and secondary school curricula.
- g) The MOH shall ensure the availability of counselling and interventions regarding substance abuse in health facilities, especially at primary care level, and in other settings such as social welfare and accident and emergency departments, workplaces, and educational institutions.
- h) The MOH shall ensure that people with alcohol-related problems in need of treatment and rehabilitation have access to non-stigmatised and confidential evidence-based treatments at user-friendly health facilities and community-based services.
- i) The Ministry of Defence, Justice and Security (MDJS) in collaboration with the Ministry of Transport and Communication shall plan and develop anti-drink driving initiatives aimed at educating, protecting, preventing and reducing alcohol-related road traffic accidents and injuries.
- j) The alcohol industry (including pub owners) in collaboration with MJDS shall develop an appropriate strategy for reducing driving under the influence of alcohol.
- k) The Ministry of Trade and Industry and the Ministry of Local Government shall review the existing marketing regulation structure(s) in order to implement a partial or complete ban on alcohol marketing practices, especially those targeting young adults and minors, and also to have statutory warnings on packaging.
- l) The government shall continuously review and revise taxes and levies on alcoholic beverages in order to control the consumption of alcohol and use additional funds for harm reduction and health impact programmes.

4.7.4 *Environment, Health and Safety*

Industrialisation and urbanisation contribute to ill health by affecting environment and lifestyle.

4.7.4.1 Goal

Ensure the protection of the environment, and the health and safety of employees, users and communities.

4.7.1.2 Objectives

- To strengthening occupational health services within the national healthcare delivery system;
 - To develop a strategic plan for the prevention and mitigation of environmental impacts on health;
- To promote and provide effective health education on safety at the workplace; and

- To formulate or review legislation on health and safety at work.

4.7.4.3 Policy Initiatives

- a) The MOH shall develop and implement a health and safety strategic framework for all sectors, especially the public and informal sectors.
- b) The MOH shall develop a monitoring and evaluation mechanism for the implementation of the health and safety strategic framework.
- c) The MOH, based on identified deficiencies and gaps, shall periodically review and update the Public Health Act to ensure that it targets key health and safety concerns.
- d) The MOH in consultation with employee and employer organisations, shall develop, monitor and review appropriate cost-sharing mechanisms for compensation with a view to placing the responsibility for occupational diseases and injuries in the hands of employers.
- e) The MOH shall train occupational health specialists specifically in health and safety, with a cadre created for them.
- f) The Ministry of Environment, Wildlife and Tourism in collaboration with MOH shall review the existing policies and legislation and update them in the current context.
- g) The MOH shall conduct long-term research to assess the impact of environmental changes on health and formulate a preparedness and mitigation programme as part of the national disaster preparedness and response plan.

Chapter 5: Implementation Framework

The implementation of the Policy aims at ensuring harmony, improving efficiency, clarifying the roles of relevant stakeholders and the effective involvement of communities, non-governmental organisations and development partners through the proposed structures.

The National Health Policy will be implemented through a ten-year National Integrated Strategic Plan, with agreed goals/targets that respond to the needs of essential health programmes and the population. There are a number of stakeholders whose policies and activities will directly or indirectly impact on the implementation of this Policy.

5.1 *Specific Roles and Responsibilities for Implementation of the Policy*

The roles specified and the stakeholders outlined in Table 5 below are not exhaustive. However, the implementation of the roles has a synergistic impact in improving both the health status of the people and overall government development.

Table 5: Stakeholder role in Health Policy

Sector / Body / Stakeholder	Roles
Office of the President	<ul style="list-style-type: none"> • Clarifying and setting mandates of the Ministry of Health. • Ensuring the implementation of health policies and programmes through different sectors.
Parliament	<ul style="list-style-type: none"> • Ensuring adequate funding for the health sector. • Reviewing the performance of the sector through the parliamentary committee on health.
Ministry of Health	<ul style="list-style-type: none"> • Overseeing and providing leadership in the health sector.
Ministry of Local Government	<ul style="list-style-type: none"> • Performing all the relevant tasks as stipulated in this Policy.
Ministry of Finance and Development Planning	<ul style="list-style-type: none"> • Supporting the Ministry of Health in creating the Health Sector Wide Approach pool of funds and other health financing mechanisms as stipulated in the Policy.
Ministry of Agriculture	<ul style="list-style-type: none"> • Ensuring food security (provision of affordable, nutritious and fresh food to all, especially the most vulnerable).
Ministry of Education and Skills Development	<ul style="list-style-type: none"> • Reducing levels of educational failure and promoting coping skills in education.
Ministry of Labour and Home Affairs	<ul style="list-style-type: none"> • Ensuring job creation and security. • Ensuring a harmonised vital registration system in collaboration with the Ministry of Health and Local Authorities.
Ministry of Lands and Housing	<ul style="list-style-type: none"> • Ensuring an equitable distribution of land and the introduction of innovations for affordable and quality housing for all people living in Botswana.

Sector / Body / Stakeholder	Roles
Ministry of Environment, Wildlife and Tourism	<ul style="list-style-type: none"> • Collaborating with the Ministry of Health and other ministries to implement environmental management programmes to reduce environmental related health risks. • Collaborating with the Ministry of Health in promoting and introducing 'medical tourism'.
Ministry of Transport and Communications	<ul style="list-style-type: none"> • Expanding the road network to ensure accessibility to all health facilities.
Ministry of Infrastructure, Science and Technology	<ul style="list-style-type: none"> • Expanding the telecommunication networks to ensure connectivity to all health facilities, and collaborating with the Ministry of Health in research on traditional medicinal plants.
Ministry of Trade and Industry	<ul style="list-style-type: none"> • Advocating for the improvement of international regulations on trade to encourage agricultural and industrial growth in Botswana. • Collaborating with the Ministry of Health to promote the establishment of pharmaceutical and biomedical manufacturing companies in Botswana.
Ministry of Defence, Justice and Security	<ul style="list-style-type: none"> • Enforcing regulations related to promoting and maintaining health. • Ensuring the security of all people living in Botswana and their property. • Provision of health services for targeted groups
Ministry of Presidential Affairs and Public Administration	<ul style="list-style-type: none"> • Support the Ministry of Health to ensure the attraction and retention of skilled health workers. • Promoting and introducing performance related reforms in order for the workforce to play a full and useful role in their sectors.
Ministry of Minerals, Energy and Water Resources	<ul style="list-style-type: none"> • Provision of safe water to all. • Provision of electricity to all health facilities.
Ministry of Youth, Sports and Culture	<ul style="list-style-type: none"> • Enhance the environment for healthy living with increased involvement of schools and colleges through sports. • Support behaviour change communication related to disease prevention.
Ministry of Foreign Affairs and International Cooperation	<ul style="list-style-type: none"> • Facilitate bi-lateral cooperation. • Address issues of cross-border cooperation for pandemics,
The Ombudsman	<ul style="list-style-type: none"> • Amicable settlement of all health-related disputes in line with the existing Act.
The National Health Council	<ul style="list-style-type: none"> • Overseeing and advising the health sector on: <ul style="list-style-type: none"> ◦ Policy concerning any matter that is likely to protect, promote, improve and maintain the health of the population; ◦ Legislation pertaining to health matters prior to such legislation being approved by Parliament; ◦ Norms and standards for the performance of the health sector; ◦ Implementation of the National Health Policy and the National Integrated Health Strategic Plan; and ◦ Coordinating and monitoring cross cutting health issues in all relevant sectors.

Sector / Body / Stakeholder	Roles
District Health Management Team	<ul style="list-style-type: none"> • Overseeing the provision of health care services and management of facilities (secondary and primary including the implementation of community-based health programmes) in their assigned districts. • Monitoring and evaluating the performance of all health care facilities in the district.
Referral Hospital Boards	<ul style="list-style-type: none"> • Overseeing the provision of health care services and the management of referral hospitals. • Monitoring and evaluating the performance of the assigned referral hospitals.
Health Inspectorate	<ul style="list-style-type: none"> • Provision of regulatory policies, standards and guidelines for monitoring the performance of the health sector. • Periodic auditing of health facilities, division/units and programmes to ensure adherence to norms and service standards. • Licensing of all health facilities and establishments.
Donors, Partners and NGOs	<ul style="list-style-type: none"> • Aligning programmes and projects to support the implementation of this Policy in a harmonised manner.
Private Sector	<ul style="list-style-type: none"> • Shall act as a partner in the provision of health services,
Community	<ul style="list-style-type: none"> • Articulate their needs, ensure that their voice is heard and participate in the financing, planning, monitoring and evaluation of the health care service delivery.

5.2 *Organisation and Management of Service Delivery*

- 5.2.1 The National Health Council will be the main coordinating body at national level. It will link policy directions in all sectors that impact on health, in order to address all the social determinants of health concurrently. Other coordination and partnership structures will be established at national, district and community levels to ensure the effective collaboration and efficient use of available resources. At national level, the structures will facilitate coordination and collaboration between the Ministry of Health, other public sector departments, central agencies, development partners, NGOs, and umbrella organisations for the private sector and civil society. At lower levels, it will be represented by the public sector departments, key NGOs and CBOs.
- 5.2.2 The existing management, planning and monitoring of health service delivery will be reorganised. In addition to the stewardship and oversight roles, the MOH will also be responsible for overseeing and coordinating health service provision. Through decentralised District Health Management Teams (DHMT) created by the Ministry of Health, health care services will be planned, implemented, monitored and evaluated for all services from the community level up to district hospitals. The strengthened District Health Management Team will also be responsible for the management and provision of health care services. The DHMT will be formed in all health districts (i.e. districts and sub-districts) and they will be decentralised. The Ministry of Health will establish decentralised Hospital Boards for referral hospitals. The revised management structure is shown in Figure 1.

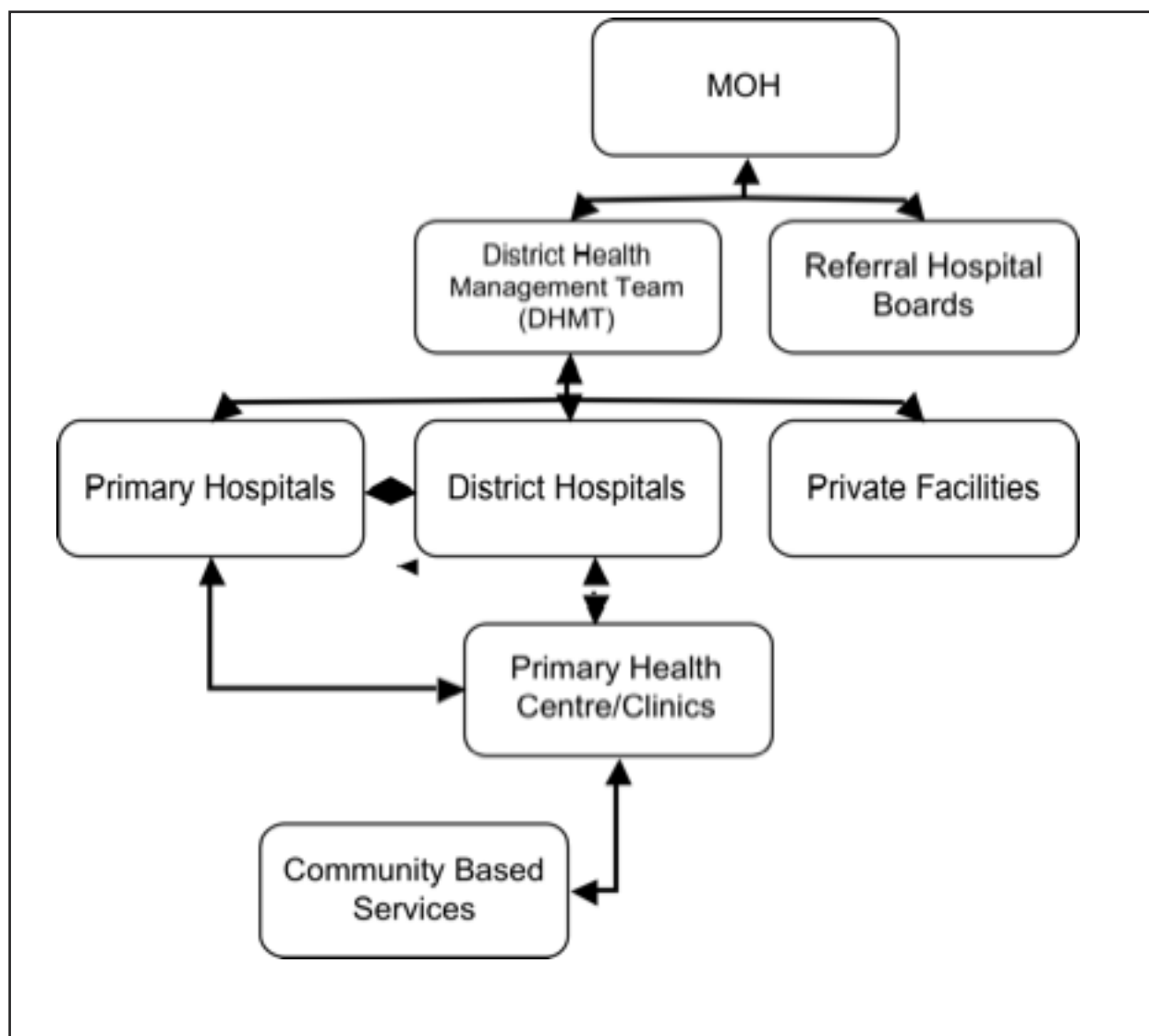


Figure 1: Organisation and management structure for health service delivery.

5.3 Planning and Budgeting

- 5.3.1 Through a sector wide approach, the development partners (including the UN organisations, NGOs, and the private sector) will work together and support the Ministry of Health in implementing a single health policy, a single integrated health strategic plan, a single implementation framework and a single monitoring and evaluation framework, in order to ensure harmonisation, alignment and ownership. The Integrated National Health Strategic Plan will be implemented through annual operational plans that will be jointly developed by all stakeholders in a bottom-up approach.
- 5.3.2 Each district will plan in alignment with the national targets and priorities, and negotiate budgets with the MOH annually. The districts' plans will be integrated for all programmes and priorities, avoiding vertical projects.

Chapter 6: Monitoring and Evaluation

- 6.1 The National Health Policy will be monitored using a comprehensive monitoring and evaluation framework based on the objectives as set out in the policy. This needs data collection, collation and analysis on diseases, health services, health finances, health workforce, medicines and medical products, health infrastructure and equipment from all stakeholders of the health sector.
- 6.2 Joint review missions, preceded by technical reviews, will be conducted bi- annually to assess performance and will involve all stakeholders. At the first review mission, priorities for the year will be identified while the second review mission will assess the progress being made. At the middle of each Strategic Plan period, a mid-term review will be undertaken to assess progress made towards set goals and to inform intervention measures for the remainder of the plan period. In the last year the strategic plan will undergo a final evaluation, and a new strategic plan will be developed.

National Health Policy

“Towards a Healthier Botswana”



MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

