World Health Organization

REGIONAL OFFICE FOR Africa

MINISTRY of HEALTH
REPUBLIC OF BOTSWANA

WHO COUNTRY COOPERATION STRATEGY 2014 - 2020

BOTSWANA

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List of Abbreviations

AC	Assessed Contributions
ACSSD	Accelerated Child Survival Strategy and Development
ACHAP	African Comprehensive Partnership on HIV/AIDS
AFP	Acute Flaccid Paralysis
ANC	Antenatal Care
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretrovirals
ASRH	Adolescent Sexual and Reproductive Health
BAIS	Botswana AIDS Impact Survey
BBSS	Biological and Behavioural Surveillance Survey
BFHS	Botswana Family Health Survey
BHP	Botswana Harvard Partnership
BNTP	Botswana National TB Control Programme
CAH	Child and Adolescent Health
CBO	Community-Based Organization
CCA	Common Country Assessment
CCG	Component Coordinating Group
CCS	Country Coordination Strategy
CDC	Centres for Disease Control and Prevention (USA)
CEDAW	Convention on the Elimination of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CPT	Co-trimoxazole Prophylaxis
CSO	Central Statistics Office
DHMT	District Health Management Team
DOTS	Directly-Observed Treatment Short-course
DPC	Disease Prevention and Control
DR-TBS	Drug Resistance Tuberculosis Survey
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme on Immunization
EU	European Union
FAO	Food Agricultural Organization
FHP	Family Health Programme

GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS TB and Malaria
GMAP	Global Malaria Action Plan
GoB	Government of Botswana
GOB-UNPOP	Government of Botswana UN Programme Operational Plan
HIMS	Health Information Management Team
HIP	Health Information and Promotion
HIV	Human Immuno-deficiency Virus
HR	Human Resources
HRH	Human Resources for Health
HQ	Headquarters
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IHS	Institute of Health Services
IHSP	Integrated Health Services Plan
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IOM	International Organization of Migration
IPT	Isoniazid Preventive Therapy
IST/ESA	Intercountry Support Team for East and Southern Africa
JICA	Japan International Cooperation
MARPS	Most At Risk Populations
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistance TB
MLHA	Ministry of Labour and Home Affairs
MLG	Ministry of Local Government
MMR	Maternal Mortality Ratio
MHSA	Mental Health and Substance Abuse
MoE	Ministry of Education
MoH	Ministry of Health
MPS	Making Pregnancy Safer
MPR	Malaria Programme Review

MTR	Mid-Term Review
NACA	National AIDS Coordinating Agency
NCC	National Coordinating Committee (Polio)
NCD	Noncommunicable Diseases
NDP	National Development Plan
NGO	Non-governmental organization
NHA	National Health Accounts
NPEC	National Polio Expert Committee
NPOs	National professional officers
NSF	National Strategic Framework
NSPR	National Strategy for Poverty Reduction
NTF	National Task Force for Polio Certification
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan for Aids Relief
PER	Public Expenditure Review
PHC	Primary Health Care
PLWH	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
PNC	Postnatal Care
POW	Plan of Work
PSI	Population Services International
RBM	Roll Back Malaria
REC	Resource Mobilization, External Relations and Cooperation
RED	Reaching Every District
RHR	Research and Programme Development in Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child And Adolescent Health
RO	Regional Office
RTA	Road Traffic Accidents
SADC	Southern Africa Development Community
SARN	Southern African Regional Network
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
SIDA	Swedish International Development Agency
SSA	Special Service Agreement

SRH	Sexual and Reproductive Health
STEPS	STEPwise Approach to Surveillance
STD	Sexually Transmitted Disease
STP	Short-Term Professional
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UMR	Under-five Mortality Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USA	United States of America
USAID	United States Agency for International Development
VC	Voluntary Contributions
VCT	Voluntary Counselling and Testing
WCO	WHO Country Office
WHO	World Health Organization
WR	World Health Organization Representative
XDR-TB	Extensively Drug Resistant TB

Map of Botswana

Foreword

The WHO Third-Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthening WHO capacity and making its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, and aims at achieving greater relevance of the organization's technical cooperation with Member States while focusing on identification of priorities and efficiency measures in the implementation of WHO Programme Budget. It takes into consideration the role of different partners including non-state actors in providing support to governments and communities.

The third-generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy (policies, plans, strategies and priorities), and the United Nations Development Assistance Framework (UNDAF). The CCSs are also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Rome (2003), Paris (2005), Accra (2008), and Busan (2011) declarations on aid effectiveness. Also taken into account are the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the decision-making capacity of governments to improve the quality of public health programmes and interventions.

The document has been developed in consultation with key health stakeholders in the country and highlights the expectations of the work of the WHO Secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in the country, formulate the WHO country workplan, advocate and mobilize resources. Also, it is intended to be used to coordinate with partners as well as shape the health dimension of the UNDAF and other health partnership platforms in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, particularly WHO country representatives to double their efforts to ensure effective implementation of the programmatic orientations of this document for improved health outcomes which contribute to health and development in Africa.

Dr. Matshidiso Moeti
WHO Regional Director for Africa

Executive summary

The WHO Country Cooperation Strategy III (CCS III) represents the medium-term strategy for the work of WHO in Botswana for the period 2014-2020. It is anchored on the 12th General Programme of Work (GPW 2014-2019) which is the strategic vision for the work of the WHO Secretariat globally as well as the Ministry of Health's Integrated Health Services Plan (IHSP): a strategy for changing the health sector for a healthy Botswana (2010-2020). The vision articulated in the IHSP is to provide an enabling environment whereby all the people living in Botswana have the opportunity to achieve and maintain the highest level of health and well-being. The document is built around 6 goals as follows:

1. The goal of service delivery is the attainment of universal coverage of a high-quality package of essential health services;

2. The goal for human resources is ensuring an adequate, motivated, and skilled health work force is in the right places and at the right time;

3. The health-financing goals are three-fold: to raise sufficient resources to ensure that all citizens have access to a range of cost effective interventions at an affordable price; to ensure financial incentives and systems are in place to deliver services efficiently with a particular focus on the needs of the vulnerable groups;

4. The goal for improving procurement and logistics is to ensure the effective and efficient delivery of health services to all people living in Botswana;

5. The health information and research goal is to create an enabling environment for efficient monitoring and evaluation of the implementation and achievements of the integrated health service plan and to provide the basis for evidence-based decision-making;

6. The leadership and management goal is to ensure strategic guidance and oversight in the regulation and implementation of all health related services.

The CCS will therefore provide a medium for responding to the goals identified by the Government of Botswana, acknowledging that as an upper middle-income country (MIC), Botswana will provide the bulk of its own resources for implementation of programmes, while partners bring technical expertise to the table. Where the country office has limitations in terms of human resources with the requisite expertise to answer to the country needs, the other levels of the organization will be mobilized to provide the necessary support. The UN system, in its analysis of the MIC status of Botswana, has identified its role as that of upstream advocacy and normative processes rather than implementation as the UN endeavours to Deliver as One, while still supporting the country to get better value for its money. Principles of equity, gender and human rights will be followed.

Botswana played a pivotal role in the discussions on health in the post-2015 era, the outcome of which has identified achieving universal health coverage (UHC) as central to reducing inequities in health service delivery. The country had already adopted the concept of UHC as stipulated in goal 1 above and is emphasizing the integration of services.

In terms of health and development, Botswana has made strides in improving geographical access to health services, including almost universal access to provision of antiretrovirals (ARTs) and prevention of mother to child transmission (PMTCT). It has qualified to be one of the countries earmarked for elimination of malaria, among other achievements. Progress has been made towards achieving most of the MDGs, the greatest of which is in millennium development goal 4 (MDG4). The MoH is now focusing on improving quality of services in the next National Development Plan, and strengthening of all the pillars of the health system will be crucial, while tackling the dual burden of communicable and noncommunicable diseases.

A lesson learnt from the implementation of the previous CCS is that tackling too many areas of focus with a limited human resource and financial base in the country office, reduces the impact on the ground. This CCS therefore attempts to focus support to the areas of critical need.

The CCS was developed through a consultative process involving the WHO country team, national counterparts from the Ministry of Health and other partners in the health sector. To demonstrate country ownership, the stakeholders' meeting was chaired by the Deputy Permanent Secretary, with a robust discussion by programme managers as well as partners from within and beyond the UN system. Building on the country achievements, country priorities and expectations of the Ministry and other stakeholders, strategic priority and focus areas were identified to guide the work of WHO at country level for next 6 years. Cognizance was also taken of the global obligations and action plans for various diseases such as the eradication of polio and malaria elimination, among others.

The overall objective of this CCS is to ensure that all necessary actions are undertaken for the attainment of the highest possible level of health as reflected in the aspirations set out in the national strategic documents on health.

The strategic priority areas to be supported by WHO are the following:

- reduction of communicable diseases such as HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine-preventable diseases;
- reversing the rising burden of noncommunicable diseases through promotion of healthy lifestyles;

- promoting health through the course of life with special emphasis on reducing neonatal and maternal mortality as well as addressing determinants of health;
- health systems strengthening, with a special focus on Health financing and human resources planning;
- epidemic preparedness and response, with special attention given to implementation of the International Health Regulations (IHR 2005).

Chapter 1: Introduction

The WHO Country Cooperation Strategy III (CCS III) is a medium-term strategic document that defines a broad framework for WHO's work, at all levels, with the Government of Botswana and all health partners for the period of 2014-2020. This third generation of CCS will be harmonized with the national processes as it comes at a time when the Government of Botswana is preparing to craft the National Development Plan 11 (2017-2024) and the Vision 2035. Botswana's overall development is guided by the Vision document with health goals set in the National Development Plan (NDP). The discourse around the post-2015 agenda also influences the strategic directions informing these two major documents of the Government as the strategic development goals (SDGs) will be captured therein. Greater advocacy will be needed to place health at the centre of sustainable development. Botswana played a pivotal role in the discussions on health in the post-2015 era, the outcome of which has identified achieving universal health coverage as central to reducing inequities in health service delivery.

The CCS document will be aligned to the Integrated Health Services Plan (IHSP): a strategy for changing the health sector for a healthy Botswana (2010-2020) and the National Health Policy. The IHSP and the revised National Health Policy (2011) are the flagship documents of the Ministry of Health. The National Health Policy was reviewed due to the recognition of changes in the health status of the nation, the organization of the health sector as well as to make social health determinants a central theme for health development. The National Health Policy stipulates that, "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 strategic focus areas within the CCS will therefore show WHO's response to the national policy and plan, while at the same time being anchored on the 12th General Programme of Work and will translate that corporate framework into country priorities.

The plan of the current United Nations Development Assistance Framework (UNDAF) which expired in 2014 has been extended to 2016 to align with the NDP 10 (2010-2016) document. The CCS will therefore align to the extension and inform the development of the successor UNDAF which, in turn, will translate the Sustainable Development Goals (SDGs) agenda into action at country level.

The biennial budgets and plans for the country office will be guided and informed by the CCS III. The CCS was developed through a consultative process involving the WHO country team, national counterparts from the Ministry of Health and other partners.

Chapter 2: Health and development situation

2.1 Main health achievements and challenges

2.1.1 Macroeconomic, political and social context including social determinants of health

Botswana is a landlocked country with an estimated population of 2 038 228 persons enumerated during the 2011 population and housing census, compared with 1 680 863 enumerated in 2001. According to the Botswana Population & Housing Census, the population growth rate between 2001 and 2011 is 1.9%. This gives further evidence of the country's diminishing population growth rates. Population growth rates based on decennial censuses held from 1971 to 2001 were 4.6, 3.5 and 2.4% respectively. With 3.5 inhabitants per km2 and having only 22% of the population living in urban areas, Botswana is one of the most sparsely populated countries in Africa.

Botswana is one the most developed countries in Southern Africa and the estimated GDP (purchaser's prices) was US$ 14.79 billion for 2013 and GDP per capita (purchasing power parity) for 2012 and 2013 was US$ 14 707 and US$ 15 675 respectively (*World Bank World Development Indicators*). Real GDP went up by 4.5% in the second quarter of 2014 compared to 7.3% accrued in the same quarter in 2013 (*Statistics Botswana, GDP 2nd Quarter of 2014 Release*).

According to Botswana financial statistics (*CSO 2011*), the composition of the 2009 GDP was dominated by mining, at 30.3%; general government (central and local government) services, at 17.7%; banks, insurance and services, at 12.8%; and trade, hotels and restaurants at 11.3%. The remaining sectors of agriculture, manufacturing, construction, and other were less than 10% (*NHA 2012*).

The country's impressive track record of good governance and economic growth supported by prudent macroeconomic and fiscal management, stands in contrast to the country's high levels of poverty and inequality and generally low human development indicators. Unemployment in Botswana is distributed unequally among different social groups, generally being highest for youth, women, and in rural areas. High poverty rates exist where unemployment is highest. According to the UNDP Human Development Report of 2014, Botswana's human development index (HDI) is ranked number 109 out of 187 countries assessed. The country has a HDI of 0.683 which lies in the range of medium human development countries. It is one of the most unequal countries with a coefficient of human inequality of 36.5. Botswana is ranked number 100 out of 187 countries assessed in Gender Inequality Index. With a Gini coefficient of 0.645 Botswana is among the most unequal countries in the world, and among the upper middle-income countries (UMIC) it compares with Namibia and South Africa. Poverty and unemployment contribute to this inequality and the country is looking at

pursuing inclusive growth and employment creation, while implementing a number of social safety nets to cushion the disadvantaged.

Stable democratic governance coupled with a rich endowment of mineral resources accounts for the country's very high rates of economic growth and classification as an UMIC. While Botswana's economic progress over the past 40 years has transformed living standards for many, with poverty rates declining from over 50% at independence to just above 19% in 2011, significant and stubborn pockets of poverty remain, especially in rural areas. Education expenditure is among the highest in the world, at around 8% of GDP. While significant achievements in the education sector have been attained, including the provision of nearly universal and free primary education, the sector has not created the skilled workforce Botswana needs to diversify its economy. Unemployment has remained at nearly 20%, and as a consequence, income inequality in Botswana is among one of the highest in the world. The HIV/AIDS pandemic has further exacerbated the situation. At a prevalence rate of 18.5% (*Botswana AIDS Impact Survey- BAIS IV 2013*), the country suffers from the third highest HIV/AIDS adult prevalence rate in the world, contributing to education and health outcomes that are below those of countries in the same income group (*The World Bank, Botswana Country Overview Update, 16 April 2014*).

Botswana has made commendable progress towards achieving the MDGs. Life expectancy at birth stands at 68 years compared to 55 years in 2001 (*2011 Census*).

Starting with 47% of the population living below the poverty datum line in 1993, this variable stood at 30.6% in 2003 and further decreased to 19.3% by 2010. Botswana achieved the global target of halving the proportion living below the line before 2010. With the current aggressive abject poverty eradication project driven at the highest political level of the land, the 19.3% figure is most likely to have decreased further (*Botswana Millennium Development Goals Status Report 2013*).

The national adult literacy rate in 2003-2004 was 81.2%; it increased to 85.1% in 2013-2014 (*UNDP, 2014 Human Development Report, and Botswana*). Botswana's education policy has focused on achieving universal access to primary education and more recently has extended universal education to ten years. It has also aimed at eliminating gender disparities in educational access and on providing the skills needed to meet the demands of a modern economy. Literacy rates for women have consistently been higher than those of men from 1990 to 2015.

Botswana has a youthful population constituting 49.3% (10-35 years) of the population in 2011. The proportion of women (15-49 years) rose from 40.8% (1981) to 45.5% (1991) and 52.0% (2001) to 54.4% (Census 2011). Botswana has committed itself to the implementation of a number of declarations and protocols aimed at full realization of all human rights and fundamental freedoms. The country has also repealed national laws, ratified international and regional instruments supporting gender equality/equity; e.g. Citizenship Act (1995, 2003); Abolition of Marital Powers Act (2004), Convention on

the Elimination of All Forms of Discrimination Against Women (CEDAW), etc. However, Botswana has not ratified the Convention on the Rights of Persons with Disabilities

Considerable progress has been made with regard to gender equality: many previously discriminatory laws have been reformed and women enjoy reasonably equal access to jobs, education and health care. Nevertheless, women experience higher poverty rates, higher unemployment and lower pay than men. Women are victims of violent crimes (rape and murder), partly because cultural attitudes that hinder women's progress are changing more slowly than the formal legal environment. Therefore, attaining MDG 3 (gender equality) in Botswana requires more efforts to enhance the economic empowerment and decision-making roles of women.

Vulnerable populations in Botswana include orphans and people with disabilities. According to the Ministry of Local Government report the number of orphans dropped from 46 451 in 2009/2010 to 39 451 in 2013/2014. Government programmes to support orphans and their care-givers appear to have been effective at reducing, although not eliminating, their vulnerability to poverty and abuse. However, opportunities for the youth are limited once they leave school, resulting in the dual problems of youth unemployment and rising crime rates.

In 2011, the population using improved drinking-water sources was 99% (urban), 93% (rural) with a national average of 97%. Improved sanitation is experienced by 78% in urban areas and 42% in rural areas.

A formal assessment of Botswana's progress towards the Millennium Development Goals was conducted in 2004, 2010 and 2013, in line with Vision 2016 goals. It was noted that the country was making good progress towards achieving the MDGs. The monitoring of progress towards some of the MDGs was, however, hampered by data inadequacies. Botswana's 2014 Millennium Development Goals Report confirms a familiar story, namely in many ways the country is undergoing development success. Official data show that as early as 2009, Botswana had achieved the MDG target of halving poverty between 1990 and 2015. Furthermore, it reduced extreme poverty by almost 73% between 2002 and 2009 alone. This is enough reason to be optimistic that the country could eradicate extreme poverty by 2016. Poverty trends indicate this, but the more emphatic evidence lies in progress on other dimensions of human development. On education, health, gender equality and access to basic services, including water and sanitation, Botswana has either met or is on course to meet the relevant MDG targets. Recent data show that even maternal and child mortalities, identified as problem areas in the 2010 report, are improving fast. Hence, with just a little over a year left before the end of the MDGs, Botswana has a good MDG story to tell. However, the work is far from finished specifically on MDG 4 and 5.

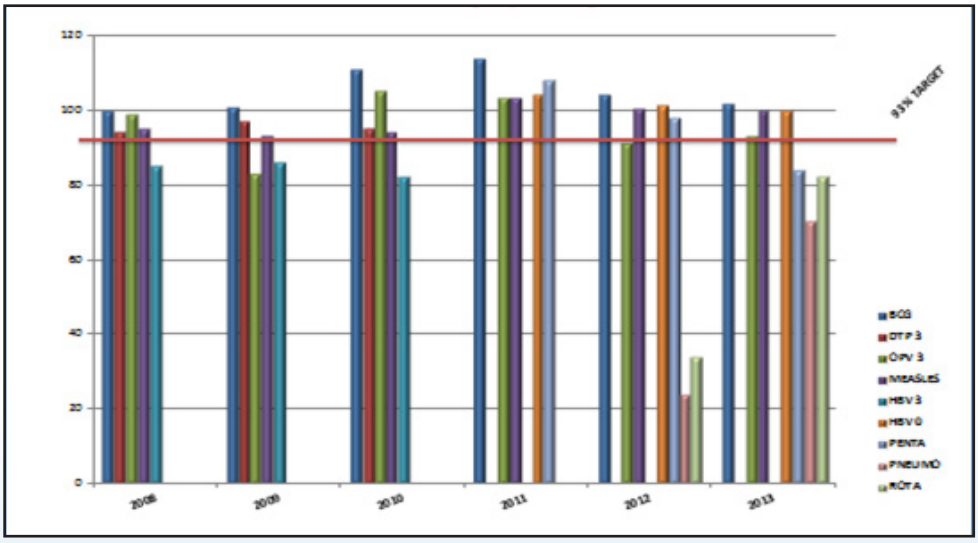
2.1.2 Health situation analysis

Expanded Programme on Immunization

Immunization services are presently delivered through a total of 24 districts (670 health facilities and 1000 mobile stops). The immunization programme achieved over 90% coverage in most antigens in the past three years (2010-2012); however, the same cannot be said of the newly introduced vaccines whose uptake had been slower (Fig 2). The programme introduced a number of vaccines such as Haemophilus influenzae type b (Hib) vaccine contained in the pentavalent vaccine in 2010; measles second dose (MCV2) introduced in 2011; pneumococcal (PCV13) and Rota virus (Rotarix) vaccines introduced in 2012. Despite the high coverage, there are hard to reach areas as a result of geographical limitations and hard to reach populations for reasons of cultural norms, values and religious beliefs. This has contributed to high numbers of un-immunized children in some districts.

The following is a reflection of the good performance of the immunization programme in Botswana as shown by the dropout rates of less than 10% in all antigens (BCG to Measles DOR = 2%, Penta1 to Penta3 = 2.9%, Pentavalent 1 to Measles = 1.3% and OPV1 to OPV3 = 1.1%).

Figure 1: Botswana national immunization coverage, 2008-2013



Source: MOH Routine Immunization Data 2013

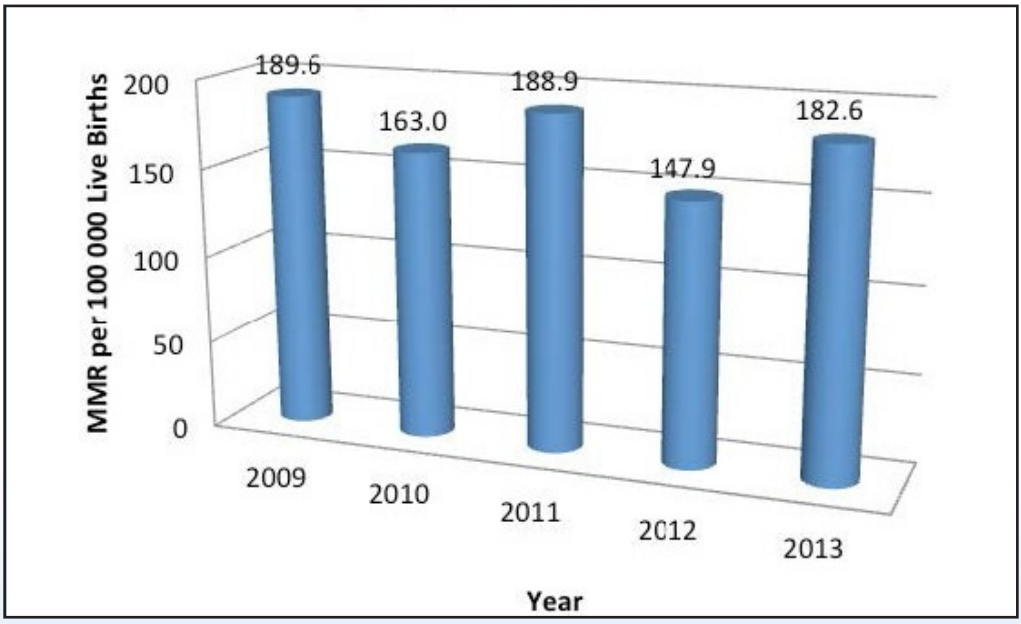
Reproductive maternal, newborn, child and adolescent health (RMNCAH)

Maternal mortality remains a major challenge in the country with Statistics Botswana estimating that 182.6 women die from pregnancy-related causes for every 100 000 live births in spite of ANC and PNC attendances being 97% and 85.2% respectively with an estimated 95 per cent of all births occurring in health facilities, (BFHS IV 2007). All maternal deaths reported occurred in health facilities as a result of preventable causes (75%). Major causes of maternal deaths were haemorrhage 28%, hypertensive disorders of pregnancy 17%, HIV related infections 17% and abortion 15%. Monitoring of maternal mortality is very strong and it is done through the performance of maternal death surveillance and response (MDSR), however, achieving MDG 5 target of 82 deaths per 100 000 live births by 2015 is unattainable.

Census data has revealed reduction in total fertility rates over time from 6.5 in 1971 to 2.7 in 2011 owing to high utilization of family planning services with CPR standing at 55% (BFHS 2007). However, there are recorded repeated pregnancies among HIV+ women indicating that access to contraceptives by these women may be a challenge.

The graph below depicts a picture of maternal mortality in the country over the years.

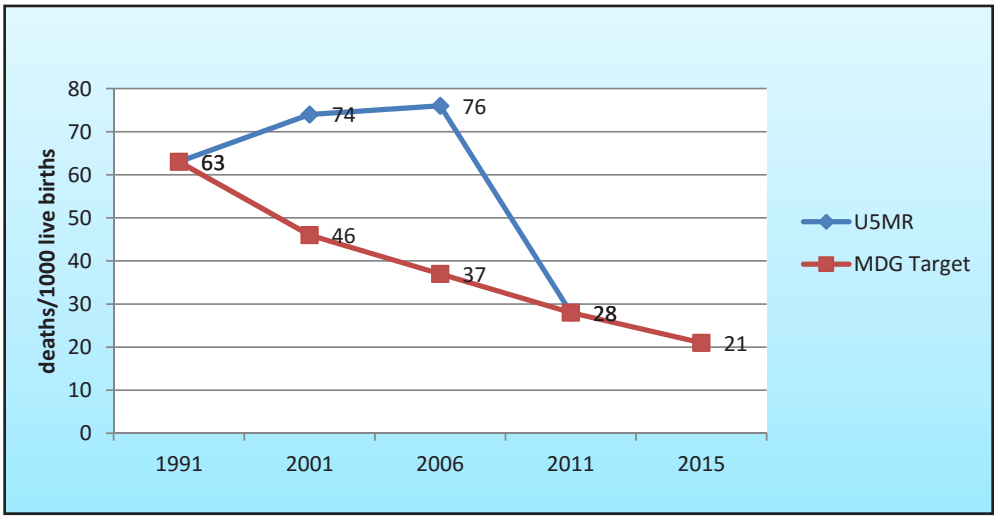
Figure 2: Botswana maternal mortality ratio, 2009-2013



Source: Statistics Botswana 2013

Infant and under-five mortality has since been reduced to the levels close to the achievement of MDG 4 targets that the country had set itself. This is due in part to the reduction of mother–to–child transmission of HIV to as low as 2.1% according to 2013 programme data, the high coverage of immunization, the implementation of Accelerated Child Survival and Development (ACSD) Strategy 2009/10-2015/16 which covers a wide range of high impact interventions for child survival. The same reduction in mortality cannot be said of the newborn as inadequate data in this area hampers performance measurement. This is shown in Figure 3 below.

Figure 3: Trend of under-five mortality rate in Botswana, (1991-2011)



Source: 2013 Census Report

Adolescent fertility rate on the other hand remains high despite the reduction observed over the years from 24%, 16.6% to 9.6% in BFHS1988, 1996 and BDS 2009 respectively. Median age at first pregnancy starts at 18 years with sexual debut at 17 years (BFHS 2007) while HIV prevalence among 15-19 years stands at 5.0% (BAIS 2013). These figures show that a concerted effort in addressing health issues of young people is crucial for their own health and as a strategy to tackle HIV/AIDS and maternal mortality.

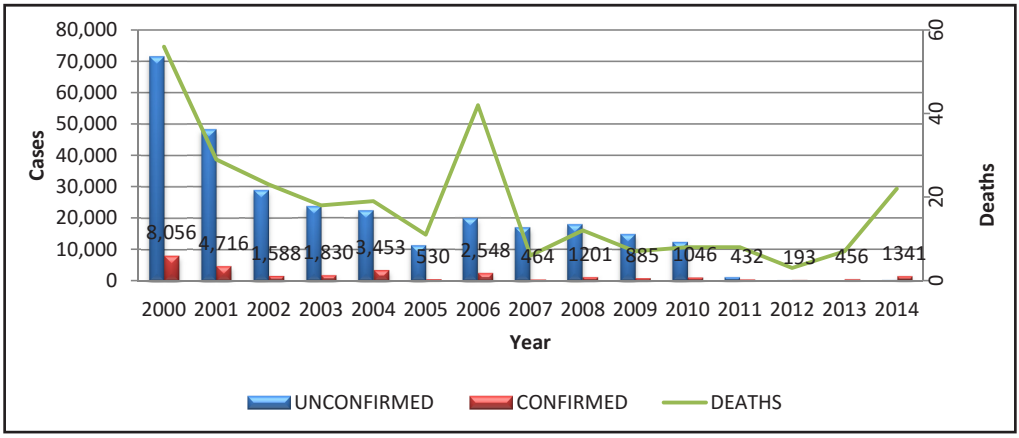
Malaria

In 2009 the National Malaria Programme conducted a comprehensive Malaria Programme Review (MPR) which indicated that Botswana is ready to move towards malaria elimination, defined as zero local malaria transmission. The MPR revealed that the country has achieved the goal of reducing morbidity and mortality with confirmed malaria cases and incidence reduced from 8056 cases (43 per 1000) in 2000 to 456 cases (0.23 per 1000) in 2013, translating to a 94% reduction. Malaria deaths reduced from 35 in 2000 to 7 in 2013.

The MPR made a series of recommendations that were to guide the country to achieve malaria elimination by 2015. The malaria strategic plan (2010 -15) was developed with objectives, strategies and activities aimed at achieving malaria elimination by 2015. The plan highlights the need for regional initiatives to reduce importation of malaria, strengthen cross- border initiatives, and to build a strong surveillance and prompt response system. Recognizing the operational and financial limitations, revealed by MTR in 2013, Botswana has extended the goal of malaria elimination to 2018.

Since the country's decision to move towards malaria elimination, intensified efforts in implementation of recommended interventions have resulted in a significant shift in the malaria epidemiology in the country as depicted in Figure 4 below.

Figure 4: Malaria trends; cases and deaths, 2000-2014

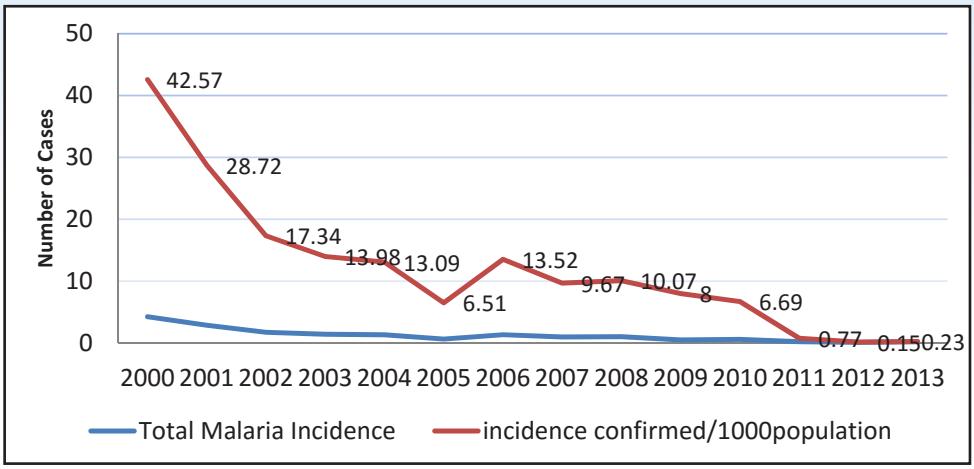


Source: Malaria Data Base, MOH 2014

Botswana has reduced the malaria burden through sustained political and financial support by government. The country's decision to refocus, redefine and intensify interventions resulted in the reduction of malaria cases from 19 099 to 311 and malaria deaths from 12 to 3 between 2008 and 2012. The adoption of the "test, treat and track" policy in 2010 resulted in a marked decline in unconfirmed cases which reflected a much lower burden. In 2012, all districts in Botswana were reporting less than one case per 1000 population, but increased dramatically in 2013 in Okavango and Chobe (highest risk areas), where outbreaks were not contained.

Figure 5 (below) shows the marked reduction in malaria incidence which is one of the critical milestones for elimination. This will be attained through concerted and intensified implementation of multi-pronged strategies which include integrated vector management (IVM) strategies, community mobilization, early diagnosis and treatment. It is expected that with further intensified efforts in implementing recommended strategies the country is on track to achieve the goal of elimination.

Figure 5: Total malaria and incidence of confirmed cases 2000-2013



Source: Malaria Data Base, MOH 2014

HIV/AIDS and STIs

Botswana faces one of the most severe HIV/AIDS burdens in the world with the national HIV prevalence estimated at 18. 5% (BAIS IV 2013). HIV/AIDS is the leading health and developmental challenge facing the nation. The epidemiology of HIV in Botswana can be considered as being generalised, with significant identifiable drivers of the epidemic. These drivers include, among others, sex workers with prevalence of 56% (*BBSS 2012*), multiple concurrent partnerships, and intergenerational sex. HIV surveillance of pregnant women indicates that prevalence peaked around the year 2000 to estimates of over 40%, significantly declined to 33.7% in 2007 and further came down to 30.4 by 2011 (ANC HIV Sentinel Surveillance 2011). This decline was particularly significant in the younger age group 15-24 years. The decrease in HIV prevalence in younger women suggests that HIV incidence is also falling. Though not statistically significant, incidence has also declined from 1.45 in 2008 to 1.35 according to the BIAS IV of 2013. However, prevalence in the general population has slightly increased. This is attributed to the success of the long standing ARV treatment programme.

At the peak of the epidemic around 2001, 300 000 people were estimated to be living with HIV/AIDS, and about 110 000 were in need of ART. The ART programme started in 2002 in two centres, Gaborone and Francistown, and was rapidly rolled out to other districts. In 2009, 139 643 people were on treatment, increasing to 161 219 by 2010, 178 684 by 2011, and 213 953 in 2013. This translates to 87.2% of those eligible for treatment at CD4 350/ml or based on WHO staging. The HIV testing rates have also improved over the years from 56% in 2008 (BAIS III) to 70.2% in 2013 (BAIS IV), especially after the establishment of community-based voluntary testing centres, and opt out policy on HIV testing in health facilities. Behaviour change interventions

informed by local data were implemented at national and district level e.g. campaign against multiple partner concurrency, while leveraging the role of community and civil society structures. The 2011 STI report on microbiological survey of sexually transmitted infections in Botswana revealed pockets of STI resurgence despite the country having adopted the syndromic management approach.

National response to HIV/AIDS

Botswana has mounted a broad multisectoral response to HIV/AIDS, encompassing interventions from both health and non-health sectors. The National AIDS Council chaired by the Vice-President guides the overall national response and its secretariat, the National AIDS Coordinating Agency (NACA), coordinates the action of all sectors and stakeholders. The Ministry of Health oversees all health sector interventions and the Ministry of Local Government coordinates the national response at district level. The national response was implemented in line with the Short Term Plan (1985-1988), the first Medium Term Plan (MTP 1, 1989-1993), MTP 2 (1997-2002), the National Strategic Framework (NSF) (2003-2009), NSF 2 (2009-2016) and the Health Sector HIV/AIDS Strategy (2003-2009). There is a positive enabling environment for national response in terms of political support, conducive response and financial support from the government and international donor community. Thus, there were a number of achievements during implementation of the first CCS as outlined below.

ART was scaled up from an initial four sites in 2002 to 32 sites by December 2004, and by November 2007, an additional 43 clinics were offering the treatment with over 90 000 patients taking ARVs. This represented 82% of all estimated patients needing ART. By June 2014, more than 520 health facilities were offering ARVs to more than 220 000 patients. Services for PMTCT were extended to all (634) health facilities with ANC and maternity in the country and were further strengthened in line with the goal of elimination of MTCT thereby aligning the country with 20 others that have signed up for the global agenda. An eMTCT uptake rate of over 90% was attained and mother-to-child transmission rates decreased from an estimated 40% in 2006 to about 2% by April 2014. Newer regimens for paediatric ART, including fixed dose combinations to enhance adherence, were adopted in 2012. Currently about 7 000 children are on treatment. Routine HIV testing and counselling were introduced in 2004, resulting in about 300 000 to 400 000 clients being tested through this programme annually. This initiative led to increased uptake of other HIV interventions such as eMTCT and ART.

The second-generation HIV surveillance system was adopted and syndromic management of STIs was extended to all health facilities. Innovative biomedical prevention services like safe male circumcision using devices and integrated early infant male circumcision (EIMC) will be rolled out once the evaluation of the pilot phase is completed; CD4 350/ml eligibility for ART treatment guidelines were adopted, ARV data audits were conducted to improve on the data quality, and the capacity of CBOs,

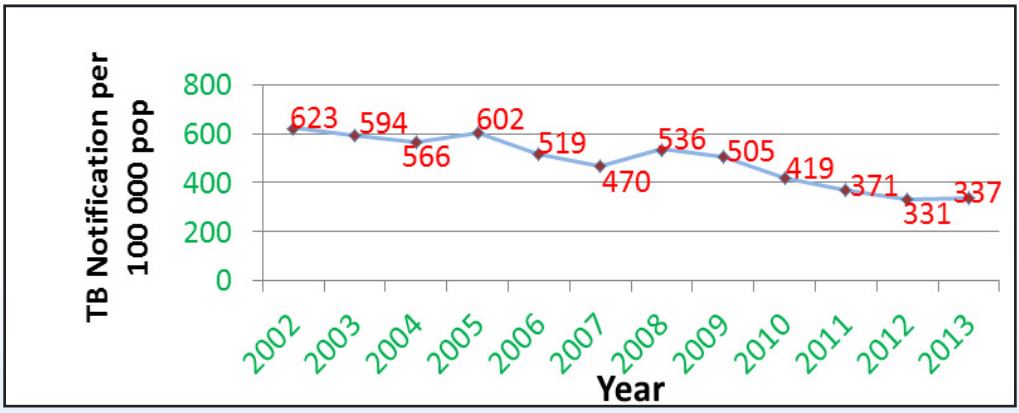
NGOs and other partners to implement HIV/AIDS services/activities at community and district levels was enhanced. The creation of the Department of HIV/AIDS in the MoH resulted in improved coordination and management of health sector responses to HIV/AIDS. The fight against HIV in Botswana is supported by high-level political commitment, relevant institutional structures and strong partnerships. Challenges remain in the scaling up of some HIV prevention interventions especially those that are related to behaviour change, sustainable quality ART services, and dwindling donor funding. Hepatitis disease as one of the co-morbidities, is also just being given the attention it deserves at country level owing to the rise in global epidemic status.

Tuberculosis

TB is a public health emergency and the most important opportunistic infection among people living with HIV in Botswana. The Botswana National TB Control Programme (BNTP) is being implemented through an integrated primary health care network supported by 52 diagnostic laboratories. The National TB Reference Laboratory is being upgraded in readiness for WHO and the Global Laboratory Initiative (GLI) assessment and accreditation to a supranational laboratory in the SADC region.

Despite clear signs of progress over the years, with sustained decline in notification rates, the estimated TB incidence was reported as 414 per 100 000 population in 2013, more than 3 times the global equivalent of 126. In 2013, registered notification rate of *348/100 000 population compared to 371/100 000 population in 2011* representing a decline of 6.2%. The estimated TB case detection rate increased from 75% in 2012 to 82% in 2013. See Figure 6 Below.

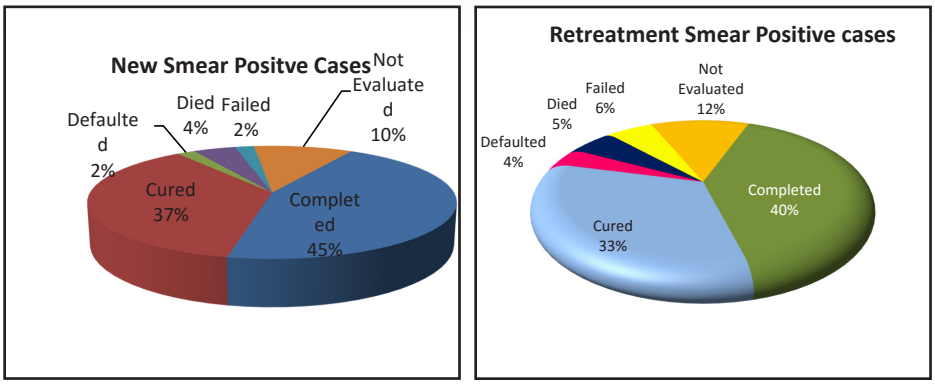
Figure 6: TB notification rates, Botswana, 2002-2013



Source: Electronic TB register, 2013 surveillance data

The proportion of TB patients with known HIV status is over 91%. Co-trimoxazole prophylaxis (CPT) and antiretroviral uptakes among co-infected patients have continued to move towards universal access, being 92% and 72% respectively. Intensified case search for TB among people living with HIV is however not optimal. Due to increasing drug resistant TB (prevalence of 2.5% among new cases- TB-DRS 2008) over years MDR-TB drug resistant TB surveillance system, has been established.

Figure 7: Treatment outcomes, new and retreatment smear-positive cases



Source: Electronic TB register, 2012 surveillance data

Treatment success rate among new smear-positive TB patients has sustained an upward trend. In 2012, the treatment success rate was 82% among new smear-positive patients while among retreatments it was 73%. The overall treatment success for all cases is 76%. Other outcomes are not favourable as depicted in Figure 7 above.

Engagement of other players in TB control is also gathering momentum through the implementation of the developed TB public private partnership (PPP) framework. The uptake of TB services in the private sector is however still small.

Challenges however still exist mainly with regard to TB/HIV co-infection and the rise in MDR-TB. The high rates of TB/HIV co-infection continue unabated, standing at 65% in 2013. The last TB Drug Resistant Survey (2008) reported a prevalence of 2.5% among new cases. Cases of confirmed extensively drug resistant XDR-TB have been reported as well. Some outcomes like cure rates are not favourable as depicted in Figure 7 above.

Neglected tropical diseases

Neglected tropical diseases (NTDs) of public health significance in Botswana include schistosomiasis (SCH), soil transmitted helminthiasis (STH), human African trypanosomiasis (HAT) and leprosy. This is based on routine health information system records. However, the magnitude needed to inform the national control programme is unknown. During the WHO Gaborone NTD Mapping Workshop in June 2014,

Botswana identified the mapping needs for four preventive chemotherapy (PC) NTDs namely SCH, STH, lymphatic filariasis (LF) and trachoma. The country is preparing to conduct a mapping of these diseases with the goal of eliminating them through mass drug administration (MDA).

Noncommunicable diseases

Noncommunicable diseases (NCDs) have emerged as a major public health issue for Botswana. This has effectively created a significant double burden of communicable and noncommunicable diseases for the country. In 2007, Botswana conducted her first STEPWISE (STEPS) survey to gauge the level of exposure to NCD risk factors among the population. This was followed by a Global Youth Tobacco Survey (GYTS) in 2008 to assess the level of smoking among school-going youth. Other assessments were done on alcohol consumption and other key variables. The country conducted another STEPS survey in late 2014. The results which will be published in 2015 will help refine strategies and actions contained in this document. Joint operational plans with the Government and other stakeholders will be formulated.

A synopsis of the various surveys/assessments was compiled by WHO into a Country NCD Profile for Botswana 2014. The profile indicates that Botswana has a fairly high level of per capita consumption of pure alcohol at 8.4 litres, current tobacco smoking rate of 22%, raised blood pressure of 32.9% and an obesity measure of 11.2 %. The profile also shows that NCDs account for 37% of total deaths in Botswana, with 18% of deaths due to cardiovascular diseases, 9% injuries, 8% other NCDs, 5% cancers, 4% diabetes and 2% chronic respiratory diseases.

In response to this situation, Botswana has put in place robust policy and legal frameworks, tools and mechanisms that include tobacco and alcohol legislation and policies. Key among these, are legislative instruments such as the tobacco and alcohol levies at 50% and 40% respectively in 2014. There is need for continued advocacy for more of the money from these levies to be dedicated to NCD prevention and control. Other complementary mechanisms and strategies include a population-based cancer registry. NCD management strategies as well as public education campaigns that promote healthy lifestyles. All these will help propel Botswana towards achieving the nine (9) voluntary targets of the Global NCD Action Plan 2013-2020.

Nutrition

Poor nutrition in children under the age of 5 years remains a challenge in Botswana. Re-analysis of the national household survey (BFHS 2007 and MICS 2000) using the 2006 WHO Growth Standard indicated that 31.2% of children under the age of 5 years were stunted, 11.9% underweight and 8.6% were wasted. Unfortunately very little information is available on micronutrient deficiencies in Botswana as the only available

data dates as far back as 1996 which revealed 35% of children under five were deficient in vitamin A. The BFHS 2007 also recorded 13.1% of newborns had birth weight of less than 2,500g suggesting that their mothers suffered poor health or nutrition during pregnancy.

According to the Lancet, (http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(13)70001-9.pdf) for Botswana, the estimated prevalences of anaemia within 95% confidence intervals are as follows: children 6-59 months: haemoglobin <110 g/L = 43% and haemoglobin <70 g/L = 0.7%; Women of reproductive age (15-49 years): haemoglobin <120 g/L for NPW and <110 for PW= 29% and haemoglobin <80 g/L for NPW and <70 g/L for PW = 1.4%; non-pregnant women (15-49 years) haemoglobin <120 g/L = 28% and haemoglobin <80 g/L = 1.5% and for pregnant women haemoglobin <110 g/L = 32% and haemoglobin <70 g/L = 0.5%.

HIV/AIDS may no longer be a major factor in child mortality owing to the reduction of mother-to-child transmission of HIV to 2.1%. However, particular attention is required in the infant and young child feeding practices. The aforementioned challenges show that under-five and maternal nutrition remains a cause for concern and government has as a result developed a strategy whose implementation the current CCS will support.

Gender-based violence

According to WHO (2013) estimates, globally 35% of women and in the African Region 45% of women have experienced intimate partner violence and/or non-partner sexual violence in their lifetime. In Botswana gender based violence is rampant with two thirds of women having experienced some form of gender-based violence in their lifetime (*Botswana Gender Based Violence Indicator Study, 2012*).

Violence has serious consequences for women's physical, sexual, reproductive and mental health. It also has adverse economic and social consequences for women, their children and families. In 2013, WHO published its first global clinical and policy guidelines for responding to intimate partner violence and sexual violence against women. These guidelines will be used in this CCS to provide evidence-based recommendations for providing clinical care, including for mental health, and for designing appropriate health services in response to violence.

2.1.2 Health systems and services

The organization and management of the health sector

With the relocation of primary health care from the Ministry of Local Government (MLG) in 2010, the MOH is now the principal public health care provider. The latter has taken steps to move to a sectoral decentralization model by empowering the District Health

Management Team (DHMT) and thus implementing a policy of provider/purchaser separation. The roles and responsibilities of the MOH and the DHMT will need to be reviewed and reorganized. The role of the private sector is growing, especially in urban centres.

Access of health services

There is an extensive network of health facilities including health posts, mobile posts, clinics and hospitals.

Table 1: Type of health facilities

Type of Facility	Government			Private		Mission	
	2007	2010	2014	2007	2010	2007	2010
Referral hospital	3	3	4	1	2		
District hospital	7	15		4*	4*	2	2
Primary hospitals	17**	17**					
Clinics	272	289					
Health posts	338	347					
Mobile stops	844	894					

Including three mine hospitals; **Including one military hospitals

Source: Master Health Facility List 2010

Regulation of the health sector

The Ministry of Health regulates and monitors private health facilities. The Public Health Act 2013 regulates both private and public health services in the country. For both the public and private sector, professionals are accredited by professional councils in accordance with the Medical, Dental and Pharmacy Act and the Nurses and Midwives Act. In addition to the professional accreditation, the Ministry of Health is also responsible for the registration of private facilities through recognized standards.

Access and utilisation of health services

Botswana has embraced the universal health coverage principles. Nationally, 95% of the total population (89% of the rural population) live within eight kilometres of a health facility (National Health Policy 2011). The public sector is the predominant provider of health care services, serving more than 80% of the population. However access to health facilities does not always translate into the utilization of high impact interventions. For example, although ante-natal care (ANC) coverage is around 90%, tetanus toxoid 2+ (TT2+) utilization among the same women is only 33% (revised National Health

Policy 2011). Patients only pay a nominal fee for services in the public sector and services are not denied to those who cannot afford them.

The revised National Health Policy (2011) places emphasis on health system strengthening through integration, and coordination of existing policies for the improvement of performance. Key result areas are leadership and governance, health service delivery, lifestyle determinants of health, health resources, and health management information systems.

Human resources

Human resource shortages negatively affect health improvement as well as the functionality of all programmes and projects at both central and district levels. Staff turnover is high; inequitable deployment and failure to optimize the existing skills mix present additional challenges. MOH is upgrading and equipping health facilities, but ensuring that they are staffed by appropriately skilled health workers remains a challenge. Despite government efforts to increase the capacities of health training institutions and work conditions of health staff, high attrition rates and some de-motivating factors affecting skilled staff still persist. In addition, there are increasing demands on the already over-stretched skilled workforce by the introduction of new programmes and projects especially those related to HIV/AIDS. Precise data on the rate of national attrition is not available.

The development of a long-term Master Plan for Human Resources for Health for Botswana was finalized in NDP 9 and its implementation initiated in NDP 10. However, during the development of IHSP, the master plan for human resources for health was revised and integrated into the plan and thus will be implemented as a package under IHSP.

During the lifespan of this CCS, Botswana will be assisted to do a proper workload analysis for all the cadres of the health workforce. This will help in formulating realistic staffing norms by level of facility.

Health financing

National health accounts have been developed for the identification and monitoring of public, private and donor health financing so as to assess efficiency, effectiveness and equity. Data from 2007 up to 2010 were collected, analysed and published in the NHA Report. It revealed that the health system in Botswana is funded mainly through government health budget and private health insurance. However, volatility in government revenue collection that largely depended on exploitation of mineral resources created certain challenges in sustaining the level of government spending on health. Therefore, the same as economic diversification, health financing in Botswana also needs diversification of the sources of funding for sustainability.

According to World Health Statistics 2013 (WHO), the government's per capita expenditure on health in 2010 was US$ 246 in comparison to US$ 216 for the global health expenditure; in Africa this was only surpassed by Seychelles (US$ 338) and South Africa (US$ 294). Government spending has exceeded the Abuja target of 15%. However general government health expenditure as a percentage of general government expenditure was 8%.

The Government of Botswana is the major source of health funds, accounting for 68.1% in 2009/10. Private sources came second at an average of 20.6% over the three years, while donors contributed an average of 11.5%. However, in the health sector, the Ministry of Health (MOH) was the major financing agent, controlling an average of 43.6% of total health expenditure (THE) over the three years. Medical aid schemes (namely, private insurance schemes), managed an average of 11.3% of THE. The National AIDS Coordinating Agency (NACA) controlled about 10.8% over the three years.

Over half of the total expenditure on health (58.6%) was spent on curative services while prevention and public health services consumed only 8.6%. This level of spending is not in line with primary health care principle adopted by the Botswana Government.

In public health services, a cost recovery system recently more than doubled health costs per person throughout the country, although in real terms this translates into half a US$ 1 for all services. Foreigners pay more, depending on the services.

Botswana's per capita health expenditure at US$ 380.53 in 2007/08 and US$ 444.66 in 2009/10 represents one of the highest health spending rates among Southern Africa Development Community (SADC) countries and World Health Organization (WHO) African Region countries. However the health indicators are not commensurate with the health expenditure, suggesting that Botswana may not be getting value for money for this remarkable investment. WHO could help the country to conduct further analysis to explain the mismatch.

Since the major source of revenue for health financing is the government, it could be further improved to ensure its sustainability. Government revenue collection could be problematic if there are external shocks to the macroeconomic environment, as Botswana heavily relies on external trade of minerals and agricultural products. Another important health financing issue relates to private health insurance which is poorly regulated and fragmented. As such, there is a need to strengthen prepaid and pooled financing arrangements through government health budget and private health insurance. One possible option is to develop alternative health care financing mechanisms such as national health insurance based on existing health insurance and community financing schemes. The NHA also found that households are the major source of the private health funds (65%) through their contribution to medical aid schemes, while private companies and parastatals contribute an average of 35%. These findings reinforce the government's desire to introduce national health insurance

under which all employers are mandated to pay health insurance contribution for their employees as part of their social responsibility (*National Health Account Report (2012) Ministry of Health*).

Health management information systems

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

Challenges in HMIS include untimely data collection, collation, analysis, interpretation, and dissemination of information. The situation is compounded by the existence of several databases (epidemiology, human resources, finance, etc.) existing in parallel. Monitoring and evaluation is fragmented; as a consequence, tracking health outcomes and measuring the impact of specific interventions is compromised. The weak supervisory framework for health facilities compromise timely reporting, cleaning, interpretation and use of data. There is need to improve the compatibility and coordination of the information systems. Monitoring and evaluation processes also need improvement. Currently MOH has put initiatives in place to improve monitoring and evaluation such as Integrated Patient Management System (IPMS) and Patient Management System (PMS) which are being rolled out nationally. A Monitoring and Evaluation unit, under the Directorate of Planning, will help harmonize all data collection tools and come up with a centralized M & E framework.

Health standards

In order to keep up with the complexities of diseases and ailments that are becoming more complex, as well as growing awareness of the public on their rights, improving quality and safety of health services has become more imperative. The MOH developed and launched the national health quality standards in 2013, followed by development of a national health quality policy. These standards define boundaries for health practices through prescribing minimal and acceptable levels of performance on the expected outcomes in the health care delivery. The standards further provide a nationally consistent level of care consumers should expect from health services and health providers.

Medical products and technologies

In 2009 the Ministry of Health revised the Botswana National Medicines Formulary. The Medicines and Related Substances Act was endorsed by Parliament in 2013. The WHO and other UN agencies will support the implementation and review of pharmaceutical policies and programmes to ensure rational selection and use of high quality essential medicines.

According to the IHSP 2012 supply chain management systems remain weak, resulting in limited availability and regular stock-out of some essential drugs and related medical supplies. In 2013 a Supply Chain Management Strategy was developed by the Ministry of Health working in collaboration with Supply Chain Management Systems (Botswana), UN agencies and other major stakeholders in the health sector. Furthermore the Ministry of Health and the major stakeholders have formed a sector wide logistics committee to meet quarterly to review the performance of the public sector medical supplies system and ensure regular availability of essential medical supplies.

Additional costs on health commodities arising from emergency procurement are incurred at more expensive prices than the regular CHAI benchmarked prices for generic drugs. Partners such as the USG have previously supported the PCSM system, including the setting up of the LMIS system. Given that this support is coming to an end, this is an area that WHO suggests other partners who have the competency and resources, pick up urgently to help with making the LMIS more functional all the way to the facility level.

Health system strengthening and support for UHC, SDH and SDGs

The vision of the Ministry of Health is to create an enabling environment that will ensure that all the people living in Botswana achieve and maintain the highest level of health coupled with a mission of sustainable improvement in health status through promotion of universal health principles, SDGs and Health for All. Guiding principles are ethics, norms and standards, equity, ownership, evidence-based care, innovation, skilled staff retention and circulation, partnerships, and client satisfaction (*Botswana National Health Policy, 2011*).

Challenges

There is an unequal distribution of health services by population: low after-hour services, variable utilization, bed capacity, and length of stay. Other challenges include weak supply chain management with shortage of commodities, staff and equipment shortages as well as poor skill mix of health workers. Weak health management information systems necessary for planning and timely interventions as well as monitoring and evaluation remain a challenge. Generally, there is low capacity in health statistics as evidenced by the late publication of the Health Statistics Report.

International health regulations

The implementation of IHR 2005 in Botswana is still at its infancy as not all laws, regulations, administrative requirements and policies have been put in place. The country still has to conduct core capacity assessment which is a prerequisite for full implementation of IHR. Some activities are however on-going. The National IDSR strategy was adapted in 2003 and followed by the development of the plan and tools. The Integrated Disease Surveillance and Response programme is functional and serves to coordinate all outbreak response activities. It is supported by relevant structures like National Emergency Preparedness and Response Committee and IDSR Coordination Committee. Routine data collection (weekly and monthly) is in place and the quarterly IDSR bulletin is being published as feedback on diseases status and the performance of districts on diseases reporting.

The human resource capacity has been improved through training of district level staff on field epidemiology, epidemic preparedness/response and prompt reporting. Port health has been established and staff deployed in most entry ports for surveillance of diseases of major concern. Structures need to be put in place to legislate for and direct how the MOH, other department or institutions as well as a broad range of stakeholders collaborate on IHR implementation.

2.2 Development cooperation, partnerships and contributions of the country to the global health agenda

2.2.1 Partnerships and development cooperation

Most of the health budget in Botswana is financed by the government. In the 2014/2015 financial year, 15.7 % of the total national budget was allocated to the Ministry of Health (*Budget Speech of 3 February 2014*).

With its rating as an upper middle-income country, Botswana has experienced a reduction in the number of development partners. The few remaining partners have concentrated their support on HIV/AIDS. The major external donor in the health sector is the United States of America through PEPFAR and CDC followed by the World Bank, the European Union, ACHAP, UN agencies, Japan (JICA), and People's Republic of China. The partners are coordinated through the Ministry of Health and the National AIDS Coordinating Agency (NACA).

Development partners

Development partner support in health is concentrated mostly on TB and HIV/AIDS prevention, treatment, care and support through provision of financial and technical assistance.

The Ministry of Finance and Development Planning (MFDP) is the principal recipient of all donor funds, including those for the implementation of HIV/AIDS programmes in the public sector. Whereas the Ministry of Health manages implementation of the overall health budget, NACA manages a good proportion of the HIV/AIDS donor funds and subcontracts civil society organizations for implementation. NACA and Ministry of Health, on behalf of the government, reports to donors through periodic financial and narrative progress reports on funds disbursed and programmes implemented. All donor-funded projects are implemented in accordance with the signed memoranda of agreement between the donor and the MFDP (on behalf of the government), the project document and the annual work plans.

Global Fund to Fight AIDS, Tuberculosis and Malaria

The GFATM has revised its funding model and Botswana is eligible to apply for TB/HIV/malaria as well as health systems strengthening. Botswana has already been allocated a total of USD28.5 million for the four components stated above for the years 2015-2017.

The mapping below takes cognizance of the fact that partners have different areas of interest and focus. However what is not reflected in table 2 is generally funded by the government. WHO has assisted the latter to leverage resources especially from the Global Fund and will continue to advocate more resources for unfunded programmes.

Table 2: Health partners in Botswana

	Areas of support										
Partner	HIV & AIDS	TB	GBV & Human Rights	RMN-CAH	NCDs, Mental Health & Injuries	Nutri-tion	PHE	Mala-ria	EPI	Health Promo-tion	HSS
CDC	✓	✓		✓							✓
EU	✓		✓	✓					✓		
World Bank	✓	✓	✓						✓		
China											✓
ACHAP	✓	✓									
WHO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
UNAIDS	✓	✓									✓
UNFPA	✓		✓	✓		✓					
UNICEF	✓		✓	✓		✓		✓	✓		
UNDP			✓	✓			✓				
UNHCR	✓		✓	✓							
UNESCO	✓		✓	✓							
Global Fund	✓	✓						✓			✓

2.2.2 Collaboration within the UN system at country level

The United Nations agencies in Botswana consist of UNDP, UNICEF, UNESCO, UNFPA, UNAIDS, UNHCR, FAO, IOM and WHO as resident agencies with a number of non-resident agencies. Collaboration within the UN system at country level is geared towards promoting multisectoral partnerships to address UHC, SDH and SDGs. The work of the UN in Botswana is guided by UNDAF (2010-2016). UNDAF identified five thematic outcome areas for UN focus namely:

- economic diversification and poverty reduction;
- governance and human rights;
- health and HIV/AIDS;
- environment and climate change;
- children, youth and women empowerment.

The Component Coordinating Groups (CCGs) based on the thematic areas above are co-chaired by UN heads of agencies and senior managers of government.

The strategic priorities in the thematic outcome areas were guided by the 2012 Mid-Term Review (MTR) of the GoB-UNPOP 2010-2014. The MTR of the GoB-UNPOP took into account the developments in the country, progress made as well as challenges and opportunities. The key findings included the following: that Botswana made significant progress and is on course to achieve the majority of the Millennium Development Goals and that the work of the UN in Botswana is aligned to national priorities but may need to be a bit more strategic, particularly given Botswana's economic status as an upper middle income country. Several observations were made on programme focus design, management, monitoring and evaluation and the need to report better on results achieved.

The UNDAF is implemented through the Government of Botswana-United Nations Programme Operational Plan (GoB-UNPOP 2010-2014) which has been extended by 2 years to align it to NDP 10. The GoB-UNPOP is a result of the UN on-going reforms and the goal of Delivering as One. The revised Standard Operating Procedures (SOPs) for countries adopting the Delivering as One approach has been signed by the Secretary-General and the Principals of all the UN agencies demonstrating the full commitment and support for the UN system to work better together and be 'fit for purpose' beyond 2015.

Within the Health and HIV/AIDS thematic area, the GoB-UNPOP have facilitated increased collaboration between UN agencies and have provided a framework for delivering outcomes.

Coordination within the United Nations

In addition to the theme groups referred to above, a number of working groups were formed, including the Programme Coordination Group, the Joint UN Team on AIDS, MDG working group and the UN Cares. The Joint UN Team on AIDS operates through three key strategic areas: "3 ones", HIV prevention, and HIV care and support. WHO chairs the working group on HIV care and support, while UNAIDS coordinates the whole Joint UN Team on AIDS.

The small size of the UN team in Botswana has meant that most individual staff members belong to more than one working group or theme group. This situation together with requirements for supporting the government's programmes has affected the operations of both the theme groups and the technical working groups.

Partner coordination

International partners providing support to health are coordinated through the Ministry of Health. With support from WHO, a Health Partners forum was formed, bringing together all key stakeholders in health. The Health Partners Forum conducts an annual Health Sector Review to assess progress on key indicators. It is also underpinned by the Health Partners Group which meets on a quarterly basis to share information and discuss issues pertinent to the health sector in its entirety. WHO co-chairs the Health Partners Group while NACA chairs the HIV/AIDS partners' forum.

Another mechanism of coordination is the GFATM country coordinating mechanism (CCM) that oversees Global Fund processes including resource mobilization and implementation oversight. Various stakeholders are represented as constituents of the CCM.

2.2.3 Contributions of the country to the global health agenda

The following research studies in Botswana have contributed to the WHO recommendations: The 36 months IPT trials informed the development of the 2013 IPT guidelines; the MASHI study contributed to the formulation of infant feeding practices for PMTCT; the *Mmabana* study informed the recommendations on dual versus triple ARV prophylaxis in HIV-positive pregnant women.

Chapter 3: Review of WHO's cooperation over the past CCS cycle

The second-generation Country Cooperation Strategy for Botswana was informed by the WHO global and regional strategic documents and orientations, key national documents such as the Ninth National Development Plan (NDP 9), the National Health Policy, and the Human Resources for Health Plan, the UN Country Cooperation Strategy, and the UNDAF (United Nations Development Assistance Framework).

The CCS was developed through a participatory process involving primarily the Ministry of Health senior management and counterparts. Information collected for the Common Country Assessment (CCA) of the UN, NDP 10, and the Human Resources for Health Plan provided much of the material for the situation analysis.

The strategic agenda was put together bearing in mind the existing partnerships, financing constraints of the health sector, and the constraints of the WCO in terms of limited staffing and funding. The latter was exacerbated by the upper middle income status of the country, which meant that there were few international partners or donors supporting the country. The priority areas in the CCS were presented in line with the organization-wide strategic objectives 1-12.

3.1 The strategic agenda of the CCS II, 2008-2013

The strategic agenda of the CCS under review focused on the following areas:

1. strengthening health systems, in particular supporting the development and revision of national health plans, policies and legislation, as well as supporting their implementation, monitoring and evaluation;

2. supporting the development and review of programme-specific implementation plans in all key health programmes to ensure that they address the real health needs of the country and are in line with international standards and best practices;

3. strengthening health sector responses to HIV/AIDS towards universal access and sustaining the efforts;

4. scaling up interventions for malaria prevention and control towards the goal for elimination;

5. intensifying efforts for TB control in terms of expanding DOTS and minimizing the emergence of drug-resistant TB;

6. ensuring coordination and collaboration among programmes- HIV/AIDS, TB, malaria, and sexual and reproductive health services;

7. strengthening epidemic preparedness and response, including implementation of the International Health Regulations and pandemic influenza preparedness;
8. building upon and sustaining the successes achieved in addressing vaccine-preventable diseases and other efforts;
9. increasing access to sexual and reproductive health, and maternal and child health, in order to attain overall improvements In people's health;
10. building capacity in all health programmes for leadership, coordination, management and delivery of services at national and local levels;
11. supporting the implementation of the Human Resources for Health Plan;
12. involving all health sector stakeholders in the planning, implementation, monitoring and evaluation of health initiatives;
13. advocating hitherto neglected areas such as occupational health, noncommunicable diseases, oral health, food safety, mental health, environmental health and social determinants of health.

In this CCS, WHO committed itself to playing an active role in the UN reforms and participating in the various UN theme groups.

3.2 External review of the CCS II Implementation

WHO in Botswana commissioned an independent evaluation of the CCS II, through documents/reports review, interviews with Ministry of Health officials, development partners as well as staff of the country office in Botswana. The interviews focused on finding out partners' knowledge on the work of WHO in Botswana, perceptions of what went well and what did not, as well as expectations of what WHO should focus on.

Results of interviews with partners

The CCS II was largely appreciated as a document by the partners and stakeholders. However, a substantial proportion of interviewed partners, both in the UN and among other cooperating partners, stated that they had never seen the document until they were invited to take part in this current review. This may partly be due to the fact that some of the partners, e.g., some UN Heads of Agencies, were assigned to the country when the CCS document had already been produced, and partly to the fact that the CCS is a strategy and not an operational document, and therefore is not referred to frequently.

The major role that WHO plays as a technical agency of the UN in providing technical support and expertise to the health sector was acknowledged. This has a potential to play a major role in UN support to Botswana. The close relationship with the Ministry and the latter's confidence in it was an important factor in WHO's ability to exercise its leadership role.

WHO's role in supporting the conception and implementation of the sector dialogue in health (sector-wide approach or SWAp) in Botswana was well appreciated, where the Agency acted as a facilitator and honest broker, and its convening power was well demonstrated.

WHO was recognized as the leading partner in health in the UNCT. Its contribution to providing joint support to Government with other agencies was well appreciated and this is evidenced through WHO's active role in committees such as JUTA (Joint UN Team on HIV/AIDS) and other relevant UN Thematic Groups. WHO and other agencies have worked together in sexual and reproductive health (SRH), especially in maternal health, adolescent health and family planning (FP), as well as in areas of child health such as EPI and nutrition.

Other potential areas were suggested where WHO and its UN sister agencies could strengthen their support. For example UN partners could help the Government utilize its resources better. This is prompted by the view that health indicators in Botswana do not reflect the level of expenditure on health by the government, which is quite high. There is a belief that currently the health system in Botswana is not delivering value for money.

Because of the problems facing health in Botswana, such as the problem of implementation of many good policies, WHO should really take leadership in UN dialogue with the Ministry of Health and in research relating to problems in the sector such as noncommunicable diseases, infant feeding by HIV positive mothers and other areas. It was felt that WHO should use its convening power to discuss topical issues.

WHO's technical collaboration with other stakeholders in health such as CDC and ACHAP was acknowledged at global, regional and country levels especially in communicable diseases control, epidemic response as well as integrated disease surveillance and response.

Ministry of Health and other government departments or entities

Government partners are highly appreciative of WHO's contribution to health development through provision of technical support and expertise. The Ministry of Health (MOH) is the counterpart ministry to WHO, therefore the staff of the ministry and WHO work closely together on a daily basis.

Ministry of Health's executives and senior programmes staff (such as heads of programmes) were very familiar with the CCS, and they stated that it plays an important role of feeding into the making of biennial work plans. They were consulted when the CCS II was written and found it very useful.

The ministry's officials indicated that WHO provides support and guidance in virtually all programmes in the MOH. This is usually in the form of guidelines, i.e. helping the ministry to adapt WHO guidelines for local use, building capacity of local staff, harmonizing procedures with those of WHO, such as maternal mortality audits. They appreciated the expertise that is provided through consultants and WHO staff from the Region or headquarters, and sometimes also the limited financial support provided.

The ministry views its relationship with WHO as very important and would like to see the latter's work in the country strengthened. There was a suggestion that WHO should ideally have some international technical staff and send out the NPOs for capacity building when necessary, even if it is for a few months. Because of shortage of financial resources, it was pointed out that WHO technical staff cover too many areas, including areas that are not in their field of expertise.

The absence of an officer in the WCO responsible for health systems is of particular concern to the ministry since this has rendered support in the area weak. However the ministry appreciates the support provided by WHO in the formulation of the National Health Policy and the Integrated Health Service Plan. Of particular importance, the ministry is looking forward to more WHO support in IHR core capacity assessment, policy development in health systems, and research in areas such as inequities, to help prioritize areas such as NCDs and MDGs in view of inadequate resources. The Ministry of Health expressed concern at the low budget WHO allocated to the country, which is mainly attributable to the classification of Botswana as an upper middle income country.

Other government entities also look up to WHO for support. NACA for example expressed its appreciation of WHO guidelines, frameworks, technical information and inputs in planning.

While generally the ministry supports the "delivering as one" approach of the UN, they felt that this had reduced to some extent the direct contact with WHO. Annual work plans of WHO and MoH have been replaced by CCG work plans of the whole UN and the quarterly MOH/WHO meetings are no longer being held as they have been replaced by CCG meetings.

WHO capacity during the implementation period

During the implementation period the office operated with the following staff complement:

- 4 internationally recruited staff: The WHO Representative, medical officers in charge of HIV and EPI as well as the Administrative Officer;
- 6 national staff responsible for HIV, FHP, TB, malaria, HIP and disease prevention and control;
- 9 support staff: ICT, finance secretary, receptionist, 3 secretaries and 3 drivers.

By 2011, all the international staff had left except the WR; the DPC, one of drivers and the receptionist also left, thereby leaving the office quite lean on the ground to implement the rest of the CCS. The cluster approach that had been adopted in the Region could not be implemented in this country office with such few staff. The financial resources at the disposal of the country office during the three biennia that were covered by the CCS II are indicated below;

Table 3: WHO Country Office budget, 2008-2013

Biennia	Planned Total	AC Allocation	AC-HR	VC Allocation	VC-HR	Total HR AC+VC	% HR costs
2008-2009	4 385 000.00	2 134 000.00	1 770 000.00	2 566 684.00	1 295 000.00	3 065 000.00	69.90
2010-2011	4 336 000.00	2 078 000.00	1 618 000.00	1 805 000.00	1 134 000.00	2 752 000.00	63.47
2012-2013	3 883 000.00	2 078 000.00	1 626 000.00	1 805 000.00	1 134 000.00	2 760 000.00	71.08

AC – assessed contributions; VC – voluntary contributions ; HR – human resources

On average 31% of the country's budget was spent on activities across the 13 strategic priorities indicating the importance of the provision of technical assistance rather than funding in Botswana. The reduction of human resources in the country office due the global financial crisis and the subsequent organization-wide constraints impacted on the quality of support for the ambitious agenda that had been defined at the beginning of CCS II implementation. Since it is unlikely that there will be any budget growth during the lifespan of the 3rd generation CCS, the funding available for HR and activity costs will remain the same. The implication is that greater prioritization will be required as we identify strategic areas of support.

Implementation of the strategic agenda's priorities for WHO country cooperation

The technical staff in the country office felt that the "Delivering as One" approach of the UN country team had also brought changes to the way the UN operates at country level. On the other hand, the "the One UN Plan" emphasizes finance so much that only those activities conducted with other UN agencies appear in the UN Programme Operational Plan as they are fully funded. This makes it difficult to quantify and monetize the technical support that WHO staff bring to the table.

The WCO technical staff also gave the following as the problems encountered in implementing the CCS during this period:

i. slow response from MOH personnel and changing priorities;

ii. shortage of staff at WCO, who have to multi-task, covering many areas with resultant staff burn-out; and

iii. staff attrition attributed to global economic meltdown.

In spite of the above, the status of CCS implementation of the priorities, with both technical and financial support from other levels of the organisation, is as follows:

Communicable diseases

WHOs provided technical support for the Introduction of new vaccines funded by the government; capacity building and conducting of post introduction evaluation (PIE) following the introduction of the new vaccines. Support is also provided for AFP surveillance polio eradication committees (NCC, NPEC and NTF) vaccines stock management; development of measles strategy and the post Measles Campaign Immunization Coverage Survey. Botswana has maintained its polio eradication status by attaining AFP detection rate of 4.1/100 000 population. The latest administrative records show that stool adequacy is 100% for first and second quarter in 2015 compared to 52% in 2014. Botswana has not reported any positive case for measles since 2011 and has maintained measles eradication indicator of reporting at least one measles per 100 000 population per year (MOH, 2015).

In IDSR WHO supported field epidemiology training; conducted IDSR strategic plan review and provided technical support in the control of disease outbreaks as well as capacity building on the emergency preparedness for H1N1 and SARS.

HIV/AIDS

WHO supported the Ministry of Health in strengthening national policy and operational framework for comprehensive health sector response to HIV/AIDS through the adoption of WHO 2010 treatment guidelines; scaling up HIV prevention through establishment of the Safe Male Circumcision programme; sustaining the large number of patients on ART, ensuring continued quality ART and other HIV/AIDS treatment and care services; HIV/AIDS strategic information collection and use, including monitoring and addressing emergence of HIV drug resistance. This support contributed to the national roll out of comprehensive treatment services to more than 540 public facilities as well as to the reduction in incidence in HIV from 1.45 in 2008 to 1.35 in 2013.

Tuberculosis

Notable achievements in the TB programme include the development and revision of policies, strategies, standards and guidelines for the BNTP. Examples of these are the national TB/HIV policy, guidelines on community TB care, MDR/TB and infection control. MDR/T surveillance data base was developed through OPEN MRS web based model. Community TB care strategy has gained momentum with about 70% of patients currently accessing TB through the community-based model. WHO also supported the development of the 2008-2013 TB strategic plan; 2008 IPT evaluation; 2009 programme evaluation. The implementation of National HIV/AIDS policy has assisted to increase the uptake of ART among TB/HIV co-infected patients from 25% in 2005 to 75% in 2014. The TB incidence rate has also gradually declined.

Malaria

WHO supported the development of case based surveillance guidelines and tools, advocacy, IEC and communication strategy, development of laboratory QA/QC manual and SOPs, policy change on diagnosis, establishment of malaria elimination database, capacity for data management and mapping. Malaria Indicator and Parasite Prevalence surveys and evaluation of Vector Control programme were also supported. WHO and other partners such as (RBM/SARN) supported the development and midterm review of the malaria strategic plan 2010-2015 as well as the; malaria programme review (MPR). The development of key strategic documents and intensified implementation of interventions geared towards malaria elimination has accelerated malaria control in Botswana resulting in the reduction of malaria morbidity and mortality by over 75%.

Noncommunicable diseases, mental health, violence, injuries and disabilities

WHO supported the Ministry of Health to develop the NCD policy, Strategic Plan and Health Promotion Strategy; introduced WHO Package on Essential NCDs (WHOPEN); supported development of current disability policy, dissemination of last STEPS survey and preparations for successor survey.

Sexual and reproductive health

WHO supported the MOH health in the following areas: the development of Family Planning Procedures Manual. MOH adapted the WHO medical eligibility criteria for contraceptives; situation analysis of Cervical Cancer Programme which informed the development of the National Cervical Cancer Strategy. On the basis of these, the country is now rolling out visual inspection using acetic acid (VIA). WHO funded and provided technical support in conducting the situation analysis of SRH and HIV linkages resulting in the acquisition of funds from EU by MOH for the implementation of SRH and HIV linkage programmes. Following the successful pilot in three districts, the country is now ready to scale it up country wide.

Making pregnancy safer

With the support of WHO, the country reviewed, developed and implemented the following: the National Road Map for Reduction of Maternal and Newborn Mortality; strengthened auditing of maternal deaths and revised the system to incorporate maternal death surveillance and response (MDSR), developed the EmONC training manual and contributed to the development of newborn registers to facilitate data collection at facility level; supported the country to implement the recommendations of the Information and Accountability Framework on Women and Children's Health (CoIA). All hospitals are reporting maternal deaths while almost 70% of them are conducting maternal deaths audits. However, response to the outcomes of the audits remains weak and will be addressed in the current CCS.

Child and adolescent health

WHO supported the programme in periodic up-dates of the IMCI programme, initiated the training of health workers on emergency triages assessment and treatment (ETAT), and assisted the country to initiate early child development and care training also provided technical support for MOH to conduct IMCI Health Facility Survey. Currently, IMCI is implemented in all the districts while 18% of the facilities have achieved WHO targets 60% of trained health workers in IMCI. This has contributed to the reduction of under-five mortality which is currently at 28 per 1000 live births.

Health promotion

WHO provided technical support for the development of the Tobacco Control Bill and policy, alcohol policy, Draft Health Promotion Policy, B.Sc. Health Promotion curriculum for Institute of Health Sciences, supported upgrading of Health Education Unit to Health Promotion and Education Division, school health policy and implementation plan. WHO also supported implementation of Global Youth Tobacco 2008 Survey. According to the Department of Roads Traffic Safety annual report, there was a decrease in alcohol

related road crashes from 675 in 2013 to 643 in 2014 and a 12% reduction in per capita alcohol consumption since imposition of alcohol levy.This reduction is partly attributed to the alcohol abuse prevention campaign and implementation of reduced blood alcohol content in the revised Traffic Act.

Social determinants of health

WHO supported stakeholder workshop on social determinants of health (SDH) after the Rio World conference on SDH, supported survey of SDH in government policies and implementation frameworks and developed a case study for Botswana, Influenced inclusion of SDH as core approach in the revised National Health Policy and supported the launch of Decade for Action on Road Safety as well as development and implementation of National Road Safety Strategy 2011-2020.

Environmental health

WHO supported updating and implementing the national environmental health policy, water quality monitoring, situation and needs assessment (SANA) for the implementation of the Libreville Declaration; development of national plans of joint action for implementing Libreville Declaration development of chemicals management database, dissemination of information on IHR core capacity assessment on port health; development of port health strategy and establishment of port health services in selected ports of entry. The SANA report was used to guide the development of National Plans of Joint Plans for implementing the Libreville Declaration and the report will further used to guide the development of policies and guidelines on Health and environment.

Food safety and nutrition- growth monitoring

WHO supported MOH to adapt the child growth card using the WHO new growth standards and training of health workers on the new growth standards. Support was provided in the management of severe malnutrition implementation in all hospitals and the development of guidelines in collaboration with UNICEF. Implementation of the management of severe malnutrition is on-going in all hospitals. The implementation of the code on breast milk substitutes and the manual on nutrition and HIV was supported and monitoring of the code is on-going and will continue to be supported in the current CCS.

Health system strengthening

WHO supported MoH to conduct National Health Accounts and National AIDS Spending Assessments (NASA). Support was provided to develop the policy on HIMS, as well as on e-health; information for the country health profile that was published in the African Health Observatory. The NASA and NHA quantified resources for the health and HIV sectors and informed the formulation of the National Strategic Framework.

In research, WHO supported the development of health research agenda including the prioritization of areas of research. Development of policies, strategies and guidelines for conducting health research; strengthening the scientific and ethical skills of the Health Research and Development Committee.

Gender-based violence

WHO has worked with other partners to support MOH to develop “Protocols and Service Standards for Prevention and Management of Gender Based Violence for Health Workers (2011)”.

Chapter 4: Strategic agenda for WHO cooperation

The CCS II evaluation has indicated that WHO is perceived as a leader in health, a convenor, a facilitator and honest broker by different stakeholders. However partners felt that WHO should be more proactive in advising the government on how to use its resources more efficiently to get better value for its money and translate the massive health investment into better health indicators. Suggestions were made that WHO should also help guide the research agenda and ensure that planning in the districts and ministry is more evidence-based. In this regard, there is a need to match the country cooperation agenda with priorities of the Government of Botswana and expectations of other health stakeholders, while being cognisant of the existing WHO country office capacity.

The CCS III development comes at a time when the implementation of the WHO reform process has commenced. However the six co-functions that were articulated in the Eleventh General Programme of Work remain a sound basis for describing the nature of WHO's work globally. They are as follows:

1. providing leadership on matters critical to health and engaging in partnerships where joint action is needed;
2. shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge;
3. setting norms and standards and promoting and monitoring their implementation;
4. articulating ethical and evidence based policy options;
5. providing technical support, catalysing change and building sustainable institutional capacity;
6. monitoring the health situation and assessing health trends.

In this CCS, the WHO Country Office in Botswana will be guided by the same core functions listed above as well as the priorities of the Twelfth General Programme of Work (GPW) defined around six categories, (five programmatic and one corporate service) as follows:

i. **communicable diseases**: reducing the burden of communicable diseases, including HIV/AIDS, tuberculosis, malaria and neglected tropical diseases;

ii. **noncommunicable diseases**: reducing the burden of noncommunicable diseases, including heart disease, cancer, lung disease, diabetes and mental disorders, as well as disability and injuries, through health promotion and risk reduction, prevention, treatment and monitoring of noncommunicable diseases and their risk factors;

iii. **promoting health through the life-course**: reducing morbidity and mortality and improving health during pregnancy, childbirth, the neonatal period, childhood and adolescence; improving sexual and reproductive health; and promoting active and healthy ageing, taking into account the need to address determinants of health and internationally-agreed development goals, in particular, the unfinished business on health-related Millennium Development Goals which will be addressed through SDGs as the Post 2015 Agenda;

iv. **health systems**: support the strengthening of health systems with a focus on; governance and leadership; financing to achieve universal health coverage; strengthening human resources for health; health information systems; facilitating transfer of technologies; promoting access to affordable, quality, safe and efficacious health technologies; and promoting health systems research;

v. **preparedness, surveillance and response**: supporting preparedness, surveillance and effective response to disease outbreaks, acute public health emergencies and effective management of health-related aspects of humanitarian disasters in order to contribute to health security;

vi. **corporate services/enabling functions**: organizational leadership and corporate services that are required to maintain the integrity and efficient functioning of WHO.

The contents of these categories of work were translated into CCS III priorities, based on the Botswana Integrated Health Service Plan (IHSP) priorities, the Essential Health Package of Botswana defined in 2010 and the UNDAF, according to the following criteria:

i. national health challenges and the priorities;

ii. alignment of key stakeholders in health to support the areas of focus;

iii. internationally-agreed instruments that involve or impact on health such as declarations and agreements, as well as resolutions, decisions and other documents adopted by WHO's governing bodies at the global and regional levels;

iv. the existence of evidence-based, cost-effective interventions and the potential for using knowledge, science and technology for improving health.

The support WHO will give within the next generation of the CCS has to be responsive to the ministry's priorities and goals, such as Integration and universal coverage through the primary health care approach including Multisectoral collaboration to promote achievement of SDH and SDGs while being informed by the health situation in the country.

The ministry has defined 7 strategic goals of service delivery; human resources for health; health financing; procurement and logistics in service delivery; health information systems: monitoring and evaluation; governance, leadership and management of the health sector; operational planning and review.

The IHSP lists the following as principal issues likely to affect Botswana over the next 10 years:

1. high infant and child mortality including post-neonatal mortality;
2. high maternal mortality ratio;
3. high mortality and morbidity from communicable diseases (e.g. HIV/AIDS, diarrhoeal diseases, acute respiratory infections, etc.);
4. under nutrition of mothers and children;
5. high incidence of infectious diseases such as HIV/AIDS and tuberculosis;
6. increasing prevalence of noncommunicable diseases;
7. poor quality of care;
8. increasing number of injuries and accidents;
9. excessive shortage of skilled human resources;
10. poor quality management and regulation in both public and private sectors;
11. unhealthy lifestyles and widespread inappropriate health seeking behaviour;
12. weak sector-wide management.

The table below therefore links the CCS focus areas with the GPW outcomes as well as outcomes stipulated in the IHSP document in response to the principal issues listed above. The CCS thereby becomes the interface between Global and country results.

Table 4: linking CCS focus areas with GPW outcomes

CCS Strategic Priority	GPW Outcome	CCS focus Area	IHSP (2010-2020) Outcome
Reduction of communicable diseases such as HIV/AIDS, tuberculosis, malaria, neglected tropical diseases and vaccine preventable diseases	Increased access to key interventions for people living with HIV	Strengthened HIV/AIDS response through provision of normative guidance on legislative, policy and implementation of quality services surveillance, monitoring and evaluation; prevention and control of hepatitis, STIs and other co-morbidities	Increased access and utilisation of a quality essential health services package especially for the poor and vulnerable
	Increased number of successfully treated TB patients	Strengthened detection and treatment of both drug susceptible and resistant TB through new rapid diagnostic methods, integrating other co-morbidities with emphasis on key affected populations	Increased access and utilization of a quality essential health services package especially for the poor and vulnerable
	Increased access to first-line antimalarial treatment for confirmed malaria cases, strengthened malaria interventions for malaria elimination	Updated policies, guidelines and strategies to improve access to recommended medicines and diagnostics:, improved surveillance monitoring and evaluation, Vector control; capacity building for programme management, cross-border collaboration and BCC/IEC	Increased access and utilization of a quality essential health services package especially for the poor and vulnerable
	Increased vaccine coverage for hard-to-reach populations and communities	Strengthened implementation of the Global Vaccine Action Plan (2011-2020) by promoting equitable access to quality vaccines, monitoring and evaluation of adopted global immunization initiatives	Reduced child mortality
	Increased and sustained access to essential medicines for NTDs	Strengthened capacity for the elimination of neglected tropical diseases (NTDs) by 2020. focusing on preventive chemotherapy, intensified case management disease surveillance	Increased access and utilization of a quality essential health services package especially for the poor and vulnerable

Reversing the rising burden of noncommunicable diseases through promotion of healthy lifestyles	Increased access to interventions to prevent and manage noncommunicable diseases and their risk factors	Enhanced national capacity and intersectoral action for prevention, early detection and management of NCDs and to address determinants of NCDs in line with Global Action Plan for NCDs 2013-2020 Scaled up response to mental health, alcohol and substance abuse and injury prevention.	Reduced burden of NCDs
	Reduced nutritional risk factors throughout the life-course	Improved national capacity to address nutrition challenges in a multisectoral way; strengthened policy, guidelines and strategies to address food and nutrition throughout the life course; strengthened surveillance, monitoring and evaluation	Improved nutritional status among children and adults
Promoting health through the course of life with special emphasis on reducing neonatal and maternal mortality as well as addressing determinants of health	Increased interventions to improve maternal, newborn, child and adolescent reproductive health while promoting active and healthy ageing	Improved maternal, new-born, child and adolescent reproductive health while promoting active and healthy ages through evidence-based policies, guidelines and strategies Strengthened capacity for programme planning, organization, implementation of quality RMNCAH interventions	Reduced infant mortality rate Reduced child mortality rate Reduced maternal mortality ratio
	Increased intersectoral policy coordination to address social determinants of health	Strengthened health promotion, disease prevention, universal health coverage and entrenched Health in All policies while addressing the broader social determinants of health	Increased access and utilization of a quality essential health services package especially for the poor and vulnerable
	Reduced environmental threats to health	Strengthened policies strategies and, guidelines to address environmental risks to health, climate change including, improved information systems and mapping	More effective, efficient and decentralized health system

Health systems strengthening with special focus on health financing and human resources planning	Policies, financing and human resources are in place to increase access to people-centred, integrated health services.	Long-term sustainable and equitable financing of health through development of health financing strategy; monitoring health expenditure trends (NHA and NASA) and capacity building on economics and budget analysis to attain universal health coverage	Reduced household health expenditure among the poor especially for catastrophic illnesses
	All countries have properly functioning civil registration and vital statistics systems	Integrated health management information systems able to generate analyse, and evaluate information for evidenced based policy formulation and planning across the six pillars of the health system	More effective, efficient and decentralized health system
	Improved access to and rational use of safe, efficacious and quality medicines and health technologies	Strengthened national capacity for pharmacovigilance and drug regulatory mechanisms	Increased access and utilization of a quality essential health services package especially for the poor and vulnerable
	Policies, financing and human resources are in place to increase access to people-centred and integrated health services	Improved HRH production, development, retention and distribution to attain universal health coverage	Increased number of skilled human resources
Epidemic preparedness and response, with special attention given to International Health Regulations (IHR 2005)	No cases of paralysis due to wild or type 2 vaccine-related poliovirus globally.	Strengthened national capacity to implement the polio eradication and endgame strategic Plan through sensitive polio surveillance, polio virus containment and certification, introduction of inactivated polio vaccine (IPV) and oral polio vaccine (OPV) withdrawal and promoting; polio legacy planning	Reduced child mortality rate
	Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective response to major epidemics and pandemics	Strengthened country's capacity to respond to disasters, disease outbreaks and other acute public health emergencies including the implementation of the international health regulations and effective surveillance and preparedness	Compliance with international health regulations

The implementation of the strategic agenda will be a collaborative process between the stakeholders in the health sector primarily Ministry of Health, development partners, NGOs and CSOs as appropriate.

4.1. Validating the CCS strategic agenda with UNDAF outcomes

The UNDAF action plan was extended to 2016 and the Health and HIV CCG agreed to reduce the number of outcomes from the original UNDAF document to three with several outputs identified. The outcomes are mapped against the strategic priority areas of the CCS III as follows:

Table 5: linking CCS focus areas with GPW outcomes

CCS Strategic Priorities	UNDAF Action Plan Outcomes 2015 - 2016		
	3.1 Health System(s) at all levels strengthened to effectively provide integrated, promotive, preventative, curative and rehabilitative services in line with the IHSP 2016	3.2 Improved quality and access of Health Services by 2016	3.3 Strengthened community systems and actions for better health outcomes by 2016
Strategic Priority 1: Reduce the burden of communicable diseases	X	X	X
Strategic Priority 2: Reduce the burden of noncommunicable diseases	X	X	X
Strategic Priority 3: Reducing morbidity and mortality and promotion of health through the life-course while addressing determinants of health	X	X	X
Strategic Priority 4: Supporting the strengthening of health systems with a focus on the organization of integrated service delivery and financing to achieve universal health coverage	X	X	
Strategic Priority 5: Supporting the preparedness, surveillance and effective response to disease outbreaks			X

As and when the new UNDAF is formulated, it is expected that this CCS and the evolving health situation in the country will inform that process.

Chapter 5: Implementing the strategic agenda: implications for the entire Secretariat

This Country Cooperation Strategy sets out the strategic directions and medium term agenda of the work of the entire WHO secretariat in Botswana for the period 2014-2020. The Biennial Work Plan 2014-2015, despite being prepared earlier, shares the issues, challenges and orientations as outlined in this document. In addition, the two subsequent biennial work plans will be based on the strategic agenda.

The final CCS document will be shared and widely disseminated to the country office staff and national counterparts for constant use in planning and implementation of WHO programme of technical cooperation; for guiding technical backstopping from the other levels of the organization; for advocacy, resource mobilization and contribution to joint planning or programming with partners and other stakeholders, such as for shaping the health dimension of the forthcoming UNDAF. It is envisaged that there will be strategic realignment of the resources of the country office, particularly improving the technical capacity of the staff in order to respond to the areas of commitment under the strategic agenda for effective implementation. The implementation of the CCS will have certain implications for the Organization's work at all three levels.

5.1 The role and presence of WHO Country Office according to the strategic agenda

The WHO Country Office will continue to increase its role as a broker and advocate for health in Botswana. The core competencies required to deliver on this CCS include expertise in health systems, disease surveillance and control, programme management, advocacy for health, health promotion, maternal and child health. WCO will assist the country by providing the services of technical experts as and when required.

Where possible, the human resources available in the country office will be strengthened in terms of numbers and competences to be able to respond the requirements of the CCS.

WCO will continue to play an active role in the formulation, implementation and review of UNDAF by participating in the UN thematic groups and meetings with other development partners, thereby strengthening collaboration with partners, minimizing possible overlap of efforts and opening new avenues for resource mobilization at the national level in Botswana. To ensure that national health priorities are adequately addressed, the Country Office will continue supporting the preparation of proposals for resource mobilization from GFATM, and other potential funding partners. Further, the WCO will assist in implementing, monitoring and evaluating various grants as required.

The country office will document results, including best practices, and demonstrate that WHO as an organization is making a difference in the health of the people of Botswana.

The role of WHO Regional Office

The WHO Regional Office for Africa will create an enabling environment that will facilitate organizational change and institutional development issues arising from the CCS. As a starting point, the Regional Office will review its support to Botswana and identify the implications of the new CCS on that support.

The Regional Office will disseminate the Botswana CCS document to divisional directors and regional advisers. This will create a better understanding among RO staff of the country's health system and its problems as well as improve the scope and quality of technical support provided to the country team. Bearing in mind the need for additional resources to support the implementation of the agenda of the CCS, the Regional Office will use the document to mobilize financial and technical resources for the country office. For this purpose, the CCS document will be disseminated to key donors and stakeholders in health.

The Regional Office will endeavour to provide adequate technical backstopping to the country office for implementing the agenda in a timely manner. In this regard the IST/ESA, Harare, will provide more immediate support and increase access to technical assistance.

The Regional Office will seek to increase allocation of resources to the Country Office in line with the priority areas identified in the CCS document. Decentralization of financial responsibilities has facilitated the work of the Country Office and should thus be sustained. In accordance with the principle of "One WHO", WHO headquarters will work with the Regional Office to mobilize resources and provide technical support for the implementation of the Botswana CCS, and to document lessons arising from the approach and its impact on WHO work as a whole as well as in individual countries

The role of WHO headquarters

Headquarters will continue to provide up-to-date technical information to countries, directly and through the Regional Office. Finally, headquarters will review the CCS document and use it as a basis for resource mobilization and revisiting the WHO reform agenda.

The table below outlines the technical/financial support that will be required by the country office from the other levels of the organization in order to deliver on the CCS focus areas

Table 6: Support required in order deliver on the CCS focus areas

CCS focus area	Support required from AFRO/HQ
Strengthen HIV/AIDS response through provision of normative guidance on legislative, policy and implementation of quality services surveillance, monitoring and evaluation; prevention and control of hepatitis, STIs and other co-morbidities	▪ Programme evaluations/ surveys (ART, STI, HTC, Drug resistance surveys) ▪ Conduct bio-behavioural surveillance studies for key affected populations ▪ Develop strategies
Strengthened detection and treatment of both drug susceptible and resistant TB through new rapid diagnostic methods, integrating other co-morbidities with emphasis on key affected populations	▪ Integration of TB/HIV/RMNCH and other co-morbidities ▪ Programme reviews/evaluations ▪ Adaptation of the post 2015 end TB strategy ▪ Monitoring of programmatic management of DR-TB
Updated policies, guidelines and strategies to improve access to recommended medicines and diagnostics:, improved surveillance monitoring and evaluation, vector control; capacity building for programme management, cross-border collaboration and BCC/IEC	▪ Update/review malaria strategic plan to align with the recommendations of the GTS for malaria 2016-2030 ▪ Strengthen national surveillance and response system including M&E and research to achieve malaria elimination ▪ Develop insecticide resistance management strategy and protocol for drug resistance monitoring ▪ Strengthen laboratory capacity on QA system
Strengthened implementation of the Global Vaccine Action Plan (2011-2020) by promoting equitable access to quality vaccines, monitoring and evaluation of adopted global immunization initiatives	Support for new vaccine introductions, routine immunizations, post Introductory evaluation, effective vaccine management assessment, data quality assessment and immunization coverage surveys
Strengthened capacity for the elimination of neglected tropical diseases (NTDs) by 2020. focusing on preventive chemotherapy, intensified case management disease surveillance	▪ Mapping of NTDs in the country ▪ Capacity building for NTDs control and response ▪ Post MDA surveillance
Enhanced national capacity and intersectoral action for prevention, early detection and management of NCDs and to address determinants of NCDs in line with Global Action Plan for NCD 2013-2020	▪ Develop strategies and guidelines on NCD's to align with Global Action Plan for NCDs ▪ Conduct tobacco surveillance

Scaled up response to mental health, alcohol and substance abuse and injury prevention	Develop community based rehabilitation services strategy
Improved national capacity to address nutrition challenges in a multisectoral way; strengthened policy, guidelines and strategies to address food and nutrition throughout the life course; strengthened surveillance, monitoring and evaluation	▪ Multi-nutrient Survey ▪ Improvement of nutrition data quality/surveillance
Improved maternal, newborn, child and adolescent reproductive health while promoting active and healthy ages through; evidence- based policies, guidelines and strategies	▪ Develop of the Road Map for Reduction of maternal and newborn mortality based on the outcome of the RMNCAH review (2015) ▪ Conduct bottleneck analysis of the newborn programme ▪ Develop every Newborn Plan
Strengthened capacity for program planning, organization, implementation of quality RMNCAH interventions	Programme policy, standards and guidelines updates
Strengthened health promotion, disease prevention, universal health coverage and entrench health in All policies while addressing the broader social determinants of health	Develop guidelines on entrenching health in all policies through multisectoral partnerships to achieve the health objectives of the SDGs
Strengthened policies, strategies and guidelines to address environmental risks to health, climate change including, improved information systems and mapping	▪ Update Port Health Strategy Environmental Health Policy, and water quality and chemical management guidelines ▪ Support the health sector in preparedness, response, and resilience by building capacity both at national and district levels through development and implementation of the Health National Adaptation to Climate Change ▪ Support the country's risk communication and community engagement as well as enhancement of intra-sectorial health coordination and cross-sectorial partnership in emergency preparedness and response to the public health consequences of Climate Change ▪ Ability to strengthen the country's capacity in information system and mapping health and environmental risks
Long-term sustainable and equitable financing of health through development of health financing strategy; monitoring health expenditure trends (NHA and NASA) and capacity building on economics and budget analysis to attain universal health coverage	Conduct NHA, NASA and budget analysis

Integrated health management information systems able to generate analyse, and evaluate information for evidenced based policy formulation and planning across the six pillars of the health system	▪ Develop the eHealth strategy ▪ Build capacity for data analysis and use
Strengthened national capacity for pharmacovigilance and drug regulatory mechanisms	Strengthen pharmacovigilance
Improved HRH production, development, retention and distribution to attain universal health coverage	Set up HRH observatory and develop retention strategy
Strengthened national capacity to implement the Polio Eradication and Endgame Strategic Plan through sensitive polio surveillance, polio virus containment and certification, introduction of inactivated polio vaccine (IPV) and oral polio vaccine (OPV) withdrawal and promoting Polio legacy planning	▪ Introduction of inactivated polio vaccine ▪ Evaluation of polio elimination endgame strategy ▪ Certification of polio eradication in the country ▪ Inventory/polio legacy planning
Strengthened country's capacity to respond to disasters, disease outbreaks and other acute public health emergencies including the implementation of the International Health Regulations and effective surveillance and preparedness	▪ Conducting core capacity assessment ▪ Capacity building for disaster preparedness and response

Chapter 6: Evaluation of the CCS

The monitoring of the implementation of the CCS will be through the semi-annual monitoring review, mid-term review and biennial evaluation of the programme budget. Indicators to be used will be specified in the biennial work plans.

The monitoring and evaluation reports of national health programmes supported by WHO and other partners will be used to complement the standard WHO reports as described above. The results of other national evaluation exercises such as censuses, surveys and research will also be used to evaluate the impact of the CCS.

Annexes

Annex 1: CCS stakeholders consultation meeting Venue: WHO board room; Date: 30 January 2015

#	Surname	First name(s)	Organization
1	JIBRIL	HARUNA BABA	MOH
2	NKOMO	BONAPARTE	MOH - DHAPC
3	SENGWAKETSE	THATO	MOH
4	BOTSANG	JOHN	MOH - DPS
5	ALFRED	JANE	MOH - HPDME
6	KEAKABETSE	TSHIAMO	MOH - DPH
7	MEDHIN	HELUF G.	MOH - DPH
8	ANDERSON	MARINA	MOH - DHPDME
9	GANESH	VIDHYA	UNICEF
10	MOKGANYA	LESEGO	MOH - DPH
11	GASENNELWE	SEADIMO	MOH - PHCSD
12	KHULUMANI	PILATE	MOH
13	ZIBOCHWA	PATRICK	MOH
14	KENOSI	ONALENNA	MOH
15	GABORONE	MOAGI	WHO
16	MAFENI	JEROME	ACHAP

17	GASENNELWE	BOINGOTLO	WHO
18	MAGANU	EDWARD T.	PRIVATE
19	KEAPOLETSWE	KOONA	MOH - DHAPC
20	MARIBE	LUCY S.	WHO
21	NTSUAPE	CONRAD	MOH
22	MALESELA	KEAGELAMANG	MOH
23	MWANGENI	FRANK	ACHAP
24	MADIDIMALO	TEBOGO P.	WHO
25	LA GRENADE	CHRISTINE	MOH
26	SEOBAKENG	MARINA	MOH/DPH/EPI
27	PUSOENTSI	MALEBOGO	MOH/DPH/NCD
28	SUN	GANG	UNAIDS
29	DIRIBA	MOSISSA	MOH
30	HALABI	SHENAAZ	MOH
31	PERDERSON	HARRIET	EU
32	MUDAMBO	KAKA T.S.	RBM/SARN
33	ZAWAIRA	FELICITAS	WHO

Annex 2: List of references

Government of Botswana; Ministry of Health; *Accelerated Child Survival and Development (ACSD) Strategy; 2009/10-2015/16*

Government of Botswana; Ministry of Health, (2014). Routine Immunization records

Government of Botswana; *National AIDS Coordinating Agency; Botswana Aids Impact Survey (BAIS) IV; 2013*

Government of Botswana; Ministry of Finance and Development Planning; Botswana *Millennium Development Goals Status Report; 2013*

Government of Botswana; Ministry of Finance and Development Planning; Botswana *Millennium Development Goals Status Report; 2014*

Government of Botswana; *3rd Budget Speech; February, 2014*

Government of Botswana, *Central Statistics Office Report, 2011*

Government of Botswana; *Statistics Botswana, GDP 2nd Quarter of 2014 Release*

Government of Botswana; *Botswana Gender Based Violence Indicator Study, 2012*

Government of Botswana: *IMCI Health Facility Survey 2012*

Government of Botswana; Ministry of Health; *Human Resources Health Plan, 2011*

Government of Botswana; Central statistics office *Multi Indicator Cluster Survey (MICS); 2000*

Government of Botswana; Ministry of Health; *Integrated Health Service Plan (IHSP); 2010-2020; 2010*

Government of Botswana; Ministry of Finance and Development Planning; *National Development Plan 9 (NDP 9)*

Government of Botswana; Ministry of Health*; National Nutrition Strategy; 2012-2016*

Government of Botswana; Ministry of Finance and Development Planning; *National Development Plan10 (2010-2016; 2012*

Government of Botswana; Ministry of Health; *5 years Maternal Mortality Report: Exploring Causes of Maternal Mortality; 2007-2010; 2014*

Government of Botswana; Ministry of Health; *National Health Accounts Report 2012*

Government of Botswana; Ministry of Health; *National Health Policy; 2011*

Government of Botswana; National AIDS Coordinating Agency; *National Strategic Framework for HIV and AIDS (2003–2009*

Government of Botswana; *Population and Housing Census: 2011*

Government of Botswana; Ministry of Health; *Report on Microbiological Survey of Sexually Transmitted Infections in Botswana, 2007-2008; 2010*

Government of Botswana; Ministry of Health; *STEPWISE Survey; 2008*

Government of Botswana; Ministry of Health; *TB Drug Resistant Survey Reported (2008)*

Government of Botswana; Office of the President; *National Aids Coordinating Agency; HIV/AIDS Mid-Term Plan1 (MTP 1), 1989-1993*

Government of Botswana; Office of the President; *National Aids Coordinating Agency; HIV/AIDS Mid-Term Plan 2 (MTP 2); 1997-2002*

Government of Botswana; Ministry of Health *Mapping, Size estimation, and biological and Behavioural surveillance Survey; 2012*

Government of Botswana; Ministry of Labour and Home Affairs; *Citizenship Act (1995, 2003)*

Government of Botswana; Ministry of Labour and Home Affairs; *Abolition of Marital Powers Act; 2004*

The World Bank, Botswana Country Overview Update, 16 April 2014

United Nations; Botswana *Common Country Assessment Report; 2007*

United Nations Development Assistance Framework (UNDAF) 2010-2016, 2009

United Nations Development Program; Botswana *Human Development Report; 2014 (Draft)*

United Nations Development Program; *Human Development Report; 2014*

World Bank; World Development Indicators for 2014

World Bank, Botswana Country Overview Update, 16th April 2014

World Health Organization; *12th General Programme of Work (GPW) 2014-2019; 2010*

World Health Organization; *Global Youth Tobacco Survey (GYTS) Report; 2008*

World Health Organization; *Global NonCommunicable Disease (NCD) Action Plan 2013-2020*