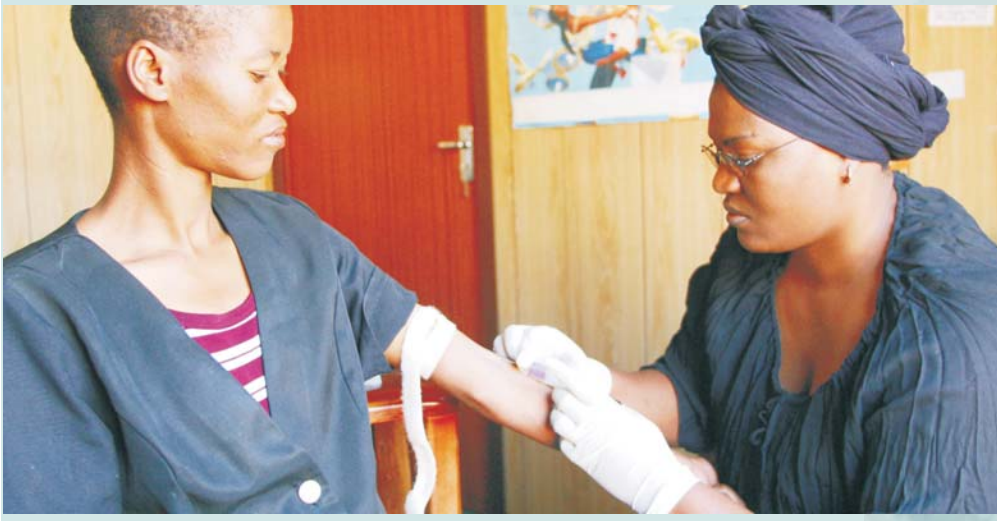
Goal 5



Maternal Health

> *The prevailing high fertility rate, the youthful structure of the population, and high maternal mortality pose serious challenges to Botswana. One of these is to eradicate preventable diseases such as measles, tuberculosis by 2016. Many of the clinics and health posts across the country do not have well-trained staff nor adequate equipment. Many people have had to travel long distances to obtain health care, especially in the remote settlements. This is a challenge that Botswana will have to meet by the year 2016.*
>
> Quote from Vision 2016

Targets (Targets are those set by the Botswana Government)	Will target be reached?	Conducive Environment?
13. To reduce the maternal mortality rate from 326 deaths per 100 000 live births in 1991 to 150 by 2011	Potentially	Strong

Data on maternal mortality are not complete. The most up to date measure of the maternal mortality rate is for 1991, so it is not clear how much progress has been made on this crucial development indicator since then. However, difficulties in reaching this goal derive from the impact of HIV/AIDS, whose prevalence is highest amongst young women in the reproductive ages.

1. What is the Situation like?

Childbirth is a serious health risk for women but data constraints make it difficult to understand the trend paths of the indicators that would help determine the nature and extent of the problem of maternal mortality in Botswana. The risks are more serious for young mothers because they have a higher propensity towards unsafe and illegal abortions and a higher risk of complications at birth due to physical underdevelopment. About 300 in every 100,000 pregnant women die during delivery.

Maternal Mortality Rate

Botswana's maternal death rate is high even though the overwhelming majority of expectant women in Botswana use preventive health services such as prenatal care and are assisted by trained health professionals during delivery. In 1996, a trained midwife assisted 94 out of 100 pregnant women during delivery. This ratio improved to 97 in year 2000. About 85% of all recent mothers received formal postnatal care.

Incidence and main causes of maternal death by age	
15-19 (18.5)	Sepsis
20-24 (22.2%)	Sepsis
25-29 (19.8%)	Toxaemia
30-34 (19.8%)	Haemorrhage

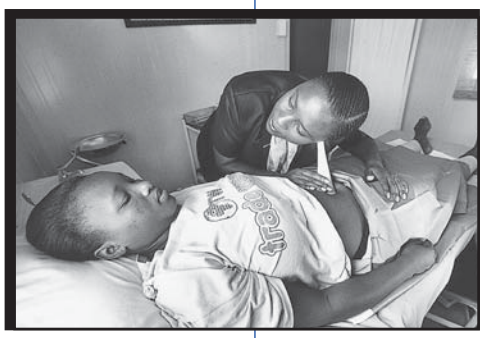
Although skilled/trained midwives attend to most normal deliveries, capacity to deal with obstetric emergencies is generally weak since most health facilities have neither the facilities nor the personnel to handle obstetric emergencies. A study based on obstetric records showed that screening tests to detect high-risk pregnancies were not performed on all pregnant women receiving antenatal care and that in cases where tests were performed and problems identified, the required action was not always taken. Furthermore, there were instances of patients being brought to the clinic/hospital late. In the case of complicated cases that have to be referred to bigger facilities, this could be fatal.

Analysis of the Botswana AIDS Impact Survey of 2001 indicated that 70 out of every 100 pregnant women attended antenatal care either in the second or third trimester. Another study found that many health facilities, especially clinics and health posts, lacked essential equipment and frequently ran out of essential supplies.

The same study also found that access to Emergency Obstetric Care (EOC) is uneven. In the Eastern and Southern region, the majority of clinics (28 out of the 34 sampled) were located 50 km or less from an EOC facility while in the Western region, the mean distance to an EOC facility was 181.25 km and no clinic was located less than 114 km. Another finding from this study is that despite the growing consensus based on evidence that 24-hour quality emergency obstetric care constitutes the most effective response to prevent maternal deaths and disabilities, there is evidence that not all the MCH/FP departments in Botswana's hospitals were open 24 hours, 7 days a week.

Although the average number of children born per woman has been declining steadily since the 1980s, trends in teenage pregnancies are still a serious public health problem. The average number of children born per woman declined from 6 children in 1991 to 3 in 2001. The percentage of teenagers who were mothers

rose from 15.4 percent in 1971 to 24 percent in 1988 before declining to 16.6 percent in 1996. Among 12-14 year old females, 12% had been pregnant in 2001 while 15-24 year olds had a pregnancy rate of 47.3%. Unplanned pregnancies are associated with illegal abortions, which in turn contribute to maternal deaths. It was found that sepsis accounted for 33.3% of the deaths among young women aged 15-19.



Family planning could reduce the maternal death rate by reducing the incidence of unplanned pregnancies, increasing that of planned and informed pregnancies, and reducing vulnerability to sexually transmitted infections, including HIV/AIDS.

2. Major Challenges

Improving access to professional and efficient reproductive health services in rural areas remains a challenge for delivery in the health sector. Access is constrained by, amongst others, inadequacies in the skills and numbers of health professionals relative to the complexities of obstetric and pregnancy complications; and the intermittent availability of required equipment and supplies at health facilities. This makes the management of obstetric cases difficult.

Improving access to emergency reproductive health services requires strengthening the referral system in Botswana. The facilities in rural areas cannot deal with obstetric complications since the referral system is not well resourced for emergencies due to deficiencies in skills, transport logistics and equipment. Also crucial is the management of the use of traditional medicine, which is a factor in both illegal abortions and health care outside the formal health system.

Managing and delivering quality of maternal health services

Substantial resources have been allocated to the health sector. Both access to, and the quality of, maternal health services have improved as a result. The incapacity to accurately capture the status of maternal mortality, however, remains a major weakness in evaluating progress on maternal health.

Maternal mortality is not directly measured in Botswana. There is no audit system to inform management of the service. Limited evaluations are conducted, leaving a gap in information. However, the next Botswana AIDS Impact Study (2004) is expected to generate information that will help determine the actual estimate of the Maternal Mortality Ratio.

Developing a System for Monitoring Maternal Mortality

Botswana needs to develop a comprehensive and reliable system for continuous monitoring of maternal mortality. The interface between the hospital records and the Civil Registration System should be improved to allow for continuous and timely delivery of data on mortality, including child and maternal mortality.

3. Support Policies and Programmes

The family planning programme in Botswana has since its inception embarked on an aggressive family health campaign, coupled with building the capacity of the health sector to provide a range of family planning services. Youth Friendly Services were introduced to cater for the needs of young people. These programmes are coordinated under the National Population Policy, summarised in the table below.

Key Policies and Programmes

The Instrument	Targeted Objectives
National Population Policy	♦ Reduce total fertility rate ♦ Reduce the incidence of teenage and unplanned pregnancy ♦ Reduce the incidence of maternal mortality including high risk pregnancies and births ♦ Promote youth, male and female shared responsibilities and participation in their reproductive and productive life ♦ Increase access to family planning
Youth Friendly Services Programme	♦ Improved adolescent knowledge, attitudes, values and behaviour on matters related to sexual and reproductive health issues; ♦ Increased utilization of sexual and reproductive health information and services with increased access to quality and cost effective adolescent sexual and reproductive Health (ASRH) information and services; ♦ Creation of a supportive political and community environment for ASRH

4. To Track Progress towards the Targets

According to the table, Botswana's capacity to follow trends in maternal mortality is weak. It is not immediately clear why this capacity was not developed along with that for monitoring child mortality. It is clear though that statistical capacity for tracking maternal mortality need urgent attention.

The solution to the problem of inadequate data on both child and maternal mortality lies in strengthening the vital registration system. Given the coverage of antenatal services i.e. more than 95% of all expectant women, an overwhelming majority of births and maternal deaths occur in hospitals.

Adequately documenting maternal mortality is thus largely a matter of feeding the necessary information from hospital records into the vital registration system. Looking at the vital registration system comprehensively, consideration should perhaps be given to enacting legislation that criminalizes failure to report births and deaths.

Table 16: Monitoring and Evaluation Capacities

Elements of Monitoring Environment	Assessment		
Data gathering capacities	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	**Fair**	Weak
Statistical analysis capacities	Strong	**Fair**	Weak
Capacity to incorporate statistical analysis into policy	Strong	**Fair**	Weak
Monitoring and evaluation mechanisms	Strong	**Fair**	Weak