



Sexual Reproductive Health: Improving Child Survival Initiatives in Botswana

Ogar Rapinyana, (RN. RM, MSc)¹, William Baratedi (RN. RM, D. Lit et Phil)²,
Naomi Mmapelo Seboni, (RN. RM. PhD.)³

^{1,2,3}University Of Botswana

Corner of Notwane and Mabutho Rd, Private Bag 00712, Gaborone, Botswana

ABSTRACT: Improving maternal and child survival it's an important integral part of health care. A large number of deaths in Africa emanate from preventable diseases and largely in the first month of life. Majority of deaths were from preventable causes such as pneumonia, diarrhea and malaria and all accounting to 14.9%, 9.2% and 7.3% respectively. In an endeavour to the prevent and promote healthcare system, the government of Botswana came up with a special programme geared toward protecting the locals against common diseases. The government of Botswana, through the Ministry of Health (MoH), introduced the Accelerated Child Survival and Development (ACSD) strategic plan intervention with a specific focus on reducing the 'under five mortality rate' (U5MR). One of the high-impact interventions for reducing the U5MR is the Integrated Management of Childhood Illness (IMCI) strategy. The strategic goal of IMCI is to reduce death, illness, and disability and to promote improved growth and development among children under 5 years of age. Child welfare clinic and Nutrition has been discovered as one of the strategy to promote child's growth and development. This strategy can be effective if it is implemented with IMCI and Immunisation.

KEY WORDS: Botswana; Child Survival; IMCI, Nutrition and Child Welfare; PMTCT.

INTRODUCTION

Improving maternal and child survival has become an important integral part of the health care system in recent years. The reason for this is that maternal, perinatal and under-five morbidity and mortality are some of the formidable development challenges in Africa. The disturbing part is that the large number of deaths amongst children is due to preventable causes, (UNICEF 2004). Forty-three percentage (4.6 million) of the childhood deaths occur in the African region with about one quarter of these occurring in the first month of life. UNICEF (2004) further attest that in 2013, an estimated 6.3 million children worldwide died before the age of 5 years due to some infectious diseases that accounted to 51.8 percent. Majority of the death were from pneumonia, diarrhoea and malaria all accounting to 14.9%, 9.2% and 7.3% respectively. In line with these deaths, UNICEF and the World Health Organization (WHO) issued two reports on the global Action Plan for the prevention and control of Pneumonia and diarrhoea, all calling for the implementation of a package of interventions across the promote-prevent-and treat continuum, (Katahoire et al 2015). In the past four decades, HIV and AIDS has also taken toll in the increase of the mortality and morbidity of the people. By the year 2011 approximately 34 million people were living with human immunodeficiency virus (HIV) and 3.3 million of these were children under 15 years. Majority of these children live in Sub-Saharan Africa, (Argel et al. 2018).

The WHO (2004) purported to reduce the maternal mortality ratio in Africa from between 500 and 1 500 to 228 per 100 000 live births for the continent to meet the target of reducing it by three quarters, between 1990 and 2015. The second target of Millennium Development Goal (MDG) 5 called for the achievement of universal access to reproductive health by the year 2015, while the MDG 4 requires Member States "to reduce the under-five mortality rate by two thirds between 1990 and 2015. The MDG 4 and 5 have been therefore used as a standard to measure the human development level of any countries, region or continent, (Campbell & Graham 2006)

BACKGROUND

At its independence in 1966 Botswana was one of the poorest countries in the world. The health care system prior to independence catered for colonial governors and its staff. Mission hospitals provided services to Batswana, and trained nurses and midwives as far as 1926 up to date. Thus majority of Batswana did not access health care. Following Independence, Botswana invested heavily



in health infrastructure and training of personnel. One of the investments went into developing an extensive primary health care outreach system in order to serve the relatively small population distributed over a wide geographical area. The health care system has now expanded and are delivered through a hierarchical network of health care facilities ranging from National referral hospital to district and primary hospitals, clinics, health post and mobile stops. As a result of this investment in the health sector, 84 percentage of the population is living within 5 km radius from the nearest health facility while 95 % of the population lives within 8km radius from the nearest facility

The modern family planning services were introduced in Botswana in 1967 following the visitation of the IPPF staff. This initially started with the supply of family contraceptives. Furthermore, In 1969, maternal and child health/family planning (MCH/FP) was piloted in the country in Serowe. Courses were conducted and trained the first six (6) family welfare educator's (FWE'S) mainly for health promotion in the communities. The training included; immunisations, breastfeeding, nutrition, child and maternal care, prevention of some major diseases. After training, they were employed to educate and inform villagers on the availability and the use of health services (Khupe, 1993). In 1970 and beyond the health system was re-directed to focus on prevention and health promotion particularly in the rural areas where majority of people lived source. The health care system was designed to cater for men, women and children in health post, clinic, and health centre. The focus was health education, nutrition, and hygiene and disease prevention (Mogobe & Ncube, 2005).

In addition to the preventative and promotive healthcare system, the government of Botswana came up with a special programme geared toward protecting the locals against common diseases. This programme incorporated the antenatal, maternity, postnatal and children's immunisations. Emphasis was on children's welfare based on the premises that the children's health is a future investment of the country (Khupe, 1993). The health care system ensured availability of family planning services in all healthcare centres to facilitate planned and wanted pregnancies, child spacing and to have a desired number of children. As the economic status improved, the health facilities increased and are now located at a radius of 5 to 8km from where the people live source.

In line with the United Nations Millennium Development Goals (MDGs) (UNDP 2014), Botswana developed its Vision 2016, which articulates the country's developmental aspiration, Towards Prosperity for All. This vision is guided by seven pillars, which articulate the MDGs. Vision 2016's third pillar, which seeks to build a compassionate, just, and caring nation, cites health, among other things, as one of its priorities. It is within this third pillar that MDG4 is addressed (UNICEF 2015). MDG4 focuses on child mortality, which has been a major public health challenge from time immemorial, (Mupara, & Lubbe (2016).

The government of Botswana, through the Ministry of Health (MoH), has also introduced the Accelerated Child Survival and Development (ACSD) strategic plan intervention with a specific focus on reducing the 'under five mortality rate' (U5MR). One of the high-impact interventions for reducing the U5MR is the Integrated Management of Childhood Illness (IMCI) strategy. The IMCI strategy was formulated by the WHO and the United Nations Children's Fund (UNICEF) and was presented to the world in 1996. Many member countries including Botswana adopted it as the principal strategy to reduce child mortality and improve child health (Fujimori et al 2013). The strategic goal of IMCI according to (UNICEF 2013) is to reduce death, illness, and disability and to promote improved growth and development among children under 5 years of age. Its objectives are to:

- Reducing infant mortality
- Reducing the incidence and seriousness of illnesses and health problems that affect boys and girls
- Improving growth and development during the first 5 years of a child's life

The WHO further calls for inclusion of the IMCI in the medical and paramedical curriculum (Paranhos, Pina, & De Mello, 2011). However, Botswana is still to introduce this in her medical curricula except teaching the in-service personnel. During its inception, majority of nurses and Doctors were trained to reduce the infant, child mortality. According to Tjirare and Tlale (2021), about 90% of districts in Botswana are implementing the strategy, with about 60% trained health workers. However, there are challenges which have been identified as retarding progress: insufficient financial resources; lack of training, mentoring and supervision (Tjirare and Tlale, 2021). There has been an ongoing IMCI training since 1996 till to date. Despite the training, five preventable and treatable childhood conditions are still eminent and remain the main causes of childhood Mortality in Botswana (Mupura & Lubbe, 2016). There is need for comprehensive child care processes that encompass effective interventions applicable in the health care system. There should also be an integrated approach put in place with a view to reduce child morbidity and mortality. The main challenge with IMCI lies with its implementation of set guidelines by health worker. Therefore, this calls for the policy makers to pay more attention on the registered nurses/health workers performance in order to lower the child mortality. Secondly on the implementation



of IMCI. The implanters feel that it consumes time, as compared to the old way of doing things. They believe that clients waiting time is too long and some clients end up returning without consultation. Child welfare clinic and Nutrition has been discovered as one of the strategy to promote child's growth and development. This strategy can be effective if it is implemented with IMCI and Immunisation.

The Botswana government adopted the primary health care (PHC) and was adopted as a strategy and philosophy in 1978. Since then the government established in the department of Primary Health Care to family planning along with MCH services the local communities (Lesetedinyana et al. 1989). Before 1984, when the MCH/FP services were fully integrated, each of the services -- such as antenatal care, postnatal care, and immunizations -- was offered on different days of the week. Since then, family planning services have been available daily at the vast network of health facilities, particularly at the lower level health facilities (CSO, MOH 2007). The Ministry of Health in Botswana kept on improving the health care services with an aim of reducing childhood mortality and in 1997, the National Population Policy was developed, the aim was to reduce the total fertility rate from 4.0 in 1996 to 3.4 by 2011 and this goal was achieved in 2009. In 2002, the department of Public Health was reorganised to include the Sexual and Reproductive Health Division and Adolescent Sexual and Reproductive Health within the MCH/FP division and the implementation Strategy was formulated in 2003. The aim of the programme was to improve the lives of women, men and adolescent in Botswana by reaching out to adolescents/youth and men and establish youth friendly services, as well as, gender sensitive issues (MOH, 2008). The government of Botswana further realised that comprehensive quality health care could be realised by improving the quality of life of Botswana and making their services accessible (MOH, 2008).

During its epic in the period 1990s to 2005, HIV with its high rates posed an immediate threat to child survival as children born with HIV are vulnerable to both disease and death (Botswana Ministry of Health, 2011). Botswana started the Prevention from Mother to Child Transmission of HIV in 2002. The initial PMTCT program offered women voluntary HIV testing during pregnancy, with pre-test counselling provided by midwives during routine antenatal visits. The MOH provided expectant mothers access to all the services in one place by integrating PMTCT into routine maternal-child health services. Due to the program's perceived benefits, the PMTCT program was rolled out across the entire country by 2002, (Harvard Medical School 2011). This approach provides the basis for:

- Earlier ART for all HIV-positive pregnant women, benefiting both the health of the mother and preventing transmission to her child during pregnancy and in future pregnancies;
- Provision of antiretroviral (ARVs) to the mother to reduce the transmission during the breastfeeding period;
- Potential reduction of sexual transmission if the partner is HIV negative.

Alderman, Behrman & Hoddinott, (2004) reported that malnutrition among children is a major problem in Africa where approximately 45million children under the age of five years suffer from malnutrition. Botswana like other developing countries is also suffers malnutrition, (Nnyepi, Mmopelwa & Codjia, 2010). Botswana's feeding program is one of the world's oldest program. It started as a presidential initiative in 1965 by the government and 1966, the World food Program assisted the country by providing food commodities to both the health facilities and the primary school. There the government feeding programmes have a long history, and fall into two categories: school feeding and vulnerable group feeding. Under the school feeding programme, meals are provided to all children/pupil/students attending government schools. The other category is rationing all under-five children attending child welfare clinics (Moepeng 2016). The country's goal of feeding children is to respond to challenges of malnutrition and hunger following sustained droughts that are endemic to the country (African Union Development Agency-NEPAD 2018).

CONCLUSION

Botswana has achieved a lot since independence in 1966. The country has, by being a member state of the world community organisations gained a significant knowledge, assistances or donations and mentoring especially from the WHO, UNICEF, UNDP and African Union Development Agency. Botswana has benefited a lot in the adoption of the world's agenda such as the Millennium Development Goals, PMTCT, IMCI and Feeding school children. Furthermore, the country came up with initiatives that helped to improve and maintain the health of children. The country invested heavily in development of infrastructure and manpower.



Currently the programmes that are running and in full-force are prevention and management of childhood malaria in the north and North West of the country where malaria is common. This includes malaria prophylaxis in children in which intermittent preventative treatment is availed to children in affected areas. The maternal and child health (MCH) program is integrated in all primary health care services and has yielded results in monitoring the health of the pregnant mothers and the unborn child until the children are five years of age. The MCH is packaged such that it integrates the immunisations for both the mother and the child against childhood illness, it also includes child monitoring of growth and development as well as ensuring provision of feeds for the under five children.

Ever since the introduction of PMTCT, Botswana has achieved a comprehensive care of children infected and exposed to HIV infection. The administration of ARVs iron supplements and cotrimoxazole prophylaxis has helped to reduce child morbidity mortality significantly.

Other supplementation includes Vitamin A. The Intervention with vitamin A in neonatal period and in children older than six months of age has shown reduction in all-cause mortality and cause specific mortality of diarrhoea and measles. There is the use of zinc supplementation in children which has shown reduction of incidence of diarrhea in children.

RECOMMENDATIONS

Botswana is still a middle income country. The child morbidity and mortality is still worrisome and hence the country needs to extend its effort to ensure optimum coverage and consumption of all her projects to all members of the community.

The government, in collaboration with the Non-governmental organisations, the international agencies and the community could join hands and ensure that:

- There is improved access to comprehensive SRHR services with specific focus on child spacing and childrens health
- Strengthening the community's knowledge efforts for early antenatal care and attendance/ booking.
- Access to skilled birth attendants is ensured to every citizen irrespective of where they live.
- Ensure training of midwives and obstetrician to cater for all citizens by;
 - i. Training on Essential Steps in Management of Obstetric Emergencies (ESMOE) to doctors and midwives.
 - ii. Intensifying midwifery education and training.
- ensuring dedicated obstetric ambulances to every sub-district to ensure prompt transfer of women in labour and women and children with obsteric and neonatal emergencies to the appropriate level of care.
- Intensifying case management of sick children through:
 - i. Improving implementation of key family practices including diarrhoea
 - ii. Establishment of maternity waiting homes.

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