UHC COUNTRY FOCUS GROUPS - Botswana

Six consultations between April and July 2022

A total of 39 community members participated in preliminary consultations from a mix of peri-urban and rural areas. A further 8 key respondents were identified and targeted from CSOs working in areas of public health (HIV, SRHR). These were directly engaged on the UHC consultation template and further evidenced by the attendance registers/travel reimbursement forms. A further 40 community members were engaged on the margins of an existing SRHR campaign on knowledge dissemination on SRHR issues to ensure inclusion of diverse groups inclusive of representatives from disability, indigenous, ethnic minority, LGBTI and sex work communities. The Country Director of UNAIDS and National Coordinator of the National AIDS and Health Promotion Agency provided key remarks after several panels that included insights from diverse community members, guidance & counselling teachers in junior high schools and CSO leaders at the final validation session. The final consultation and validation session had 94 attendees from District Health Management, Ministry of Education, Tribal Administration, Elected Political Representation councils, CSO Networks working on HIV and Key Populations issues and other community based organisations. It was co-chaired by Nothing Without Us Society, which is a grassroots sex worker led and serving organisation in the North East region.

Some priority areas for follow up action noted at the validation session include:

- Manufacturing of own medications and vaccines in collaboration with the Harvard university.
- Improve measures of taking services to the people rather than people to services, for example, providing health education at kgotla (traditional governance platforms) meetings
- Sensitize health care workers when dealing with LGBTQ community
- There must be comprehensive sex education in our education system especially with regards to the particular challenges of the LGBTQ community.
- In order to facilitate universal health coverage, individuals in remote areas can be attended to by emergency medical services, while collective communities may be attended to by mobile clinics since it is an indicator of growth in demand.
- Provision of specific communication tools for people living with disabilities, for example; provision of sign language interpreters and braille keyboards for the visually impaired.
- Inclusion of people living with disabilities in all matters that affect them including, budgeting, monitoring and evaluation.

CATEGORY 1: ENSURE POLITICAL LEADERSHIP BEYOND HEALTH

Question	Summary Feedback
Does your government have a coordination government agency/mechanism/department that engages across sectors for the specific purpose of improving health or advancing UHC? If so, how well is this mechanism or department functioning?	A couple have been identified. The first, is The National AIDS and Health Promotion Agency (NAHPA) as the leading body having initially focused on the HIV/AIDS response, with an expanded mandate for non-communicable diseases under the Office of the President of Botswana. Most notably, using the human rights approach through eliminating various barriers impacting health outcomes.[1] The second is the Country Coordinating Mechanism (CCM) of the Global Fund to end AIDS, Tuberculosis and Malaria (The Global Fund), which NAHPA, Ministry of Health and civil society are a part of among other stakeholders. Although focus is not on UHC, there is a wide-reaching acknowledgement for integrated services and standard service provision within the public and community health systems. The first is a fully fledged body that operates and functions well, notably within the HIV response and as a fiduciary for Global Fund resourcing and

[1] One participant cited the country's strategy for removing human rights barriers: **https://www.theglobalfund.org/media/10418/crg_humanrightsbotswana2020-2025_plan_en.pdf**

	related technical working groups across the health spectrum. These are however, centered in the capital city and on the general public, with most programming and policy formulation targeting urban and peri-urban areas. A few responses identify the Ministry of Health as the foremost agency that engages across all sectors. Its primary mandate, policy and programming advance health with some gaps in strategic information sharing and implementing coordination within and outside the ministry (with other ministries, community health organisations and other social participation mechanisms). There are clear examples of consulting different stakeholders in policy and programming design; in HIV prevention cascading, integrated health, unintended pregnancies strategies and mitigating substance use campaigns among others.
If you primarily conduct health advocacy, have you engaged with other government ministries or departments beyond health in your advocacy efforts? How so?	Sex work CSOs have not acknowledged engaging other government ministries beyond health, whilst one has not had the opportunity to. Some youth-led organisations have previously engaged the Ministry of Finance Population Development Unit, Parliamentary Caucus on Women, Ministry of Education (on comprehensive sex education), Police Service, Directorate of Public Prosecutions and several human rights organisations have engaged the Ministry of Presidential Affairs, Ministry of Justice and Ministry of Education focusing on key populations. Most notably, other engagements have been towards treaty body, special procedure and international mechanisms. There are other mechanisms such as multistakeholder forums targeting Gender Based Violence, Child Protection and Gender Equality issues that some community health partners are a part of. Some issues are presented using the rights-based approach to health, such as advancing access to safe abortion services or improved service delivery for diverse grpups. Others target nuances/influences that impact health outcomes such as the decriminalization of sex work.
During the COVID-19 pandemic, has your government made UHC a high priority?	There is an overwhelming no from CSOs and public health officials; particularly because the government focused on COVID-19. Most notably in rural areas North of the country. Although UHC language and framing has been noted as insufficient, there are some perceptions of some policy progress being made towards UHC in light of the pandemic.
How have new health policies and programmes during the pandemic changed the path towards UHC?	No. Although there have been some health policy reviews, they are not participatory or inclusive of civil society. One CSO leader called for more education on UHC to hopefully lead to more efforts. Another shared that they believe there is some concession on improving PHC.

CATEGORY 2: LEAVE NO ONE BEHIND

Question	Summary Feedback
a. Which groups of people in your country struggle to gain access to health services? What are the main barriers for them to access health services? b. Considering the needs of the groups identified above, what are the specific health services that are under-prioritized?	a. Children, Adolescents, Sex workers, LGBTI, people with disabilities, migrants, indigenous people, the elderly, neurodivergent, people living with NCDs, ethnic minorities, and those based in highly dense urban areas or impoverished rural areas. These different groups experience challenges with accessing health services. Stigma and discrimination, ambiguous or restrictive laws, affordability, lack of political will for enabling infrastructure and harmful culture norms impede access. b. These vary from co-infection (STI and TB), Malaria, palliative care, maternal care, harm reduction programmes, substance abuse programmes, TB screening and treatment, menstrual health, commodity provisions, sign language accessibility, braille displays, audio descriptive accessibility, health service sin rural areas, stigma free environments, parental consent for contraceptives, sex education, safe abortion provisions, dental health to mental health provisions.
Are there laws and frameworks in place in support of vulnerable groups accessing essential health services they need? How well do they work in practice?	No. The right to health is not guaranteed in Botswana's constitution. Similarly, socioeconomic rights are not justiciable in Botswana, meaning no legally binding instruments to challenge accountability or the lack thereof. However, a court petition resulted in non-national prisoners (and essentially non-imprisoned migrants) receiving ART treatment for free. There are no clear frameworks for persons who inject drugs due to limited data.
a. Does your country have a policy or program to reduce or eliminate patient fees (out-of-pocket spending on health)? b. Who is most impacted or what health services are most negatively impacted by out-of-pocket payments?	a. Most stated that there is none. However, one CSO leader did note that there are subsidies for citizens. However, there was consensus that costs are most notably higher for migrant patients. Out of pocket spending is universal across the country, with those in more rural areas having to spend more due to poor infrastructure (public transport, logistics value chain for medicines, specialist skills, and in some instances basic equipment, etc.) b. Most residents who do not have medical aid. Those who receive some social programme benefits similarly cannot afford. Foreign nationals are the most negatively impacted as they are charged different/higher rates.

CATEGORY 3: REGULATE AND LEGISLATE

Question	Summary Feedback
Do you feel that UHC laws/policies/strategies that exist in your country are being adequately implemented?	No laws or policies. There are some avenues for potential through integrated health service provisions. However, this would address shortcomings in primary health care.

Do you know of any accountability or monitoring mechanisms for UHC in your country? If yes, please explain your answer.	Most could not articulate/identify. However, one based in the North, mentioned District Health Management. Other possibilities include the parliamentary Joint Oversight Committee and the Parliamentary Public Accounts Committee. International Cooperation/Development partners further support in data building and technical assistance on different health outcomes/targets/strategies. Notably, the Integrated Patient Management and Patient Information Management Systems launched in 2016 have been identified by a local District Health Management representative.
Are there laws and policies in place to ensure that people can engage in planning, budgeting and monitoring of health plans and budgets?	None could identify. However, a CSO leader noted that some consultations are only made after decisions are made and programming initiated.

CATEGORY 4: UPHOLD QUALITY OF CARE

Question	Summary Feedback
a. Do you think that health services in your country are of good quality? Can you elaborate and give examples? b. What health services and what communities/population groups experience the gaps in quality?	a. There were mixed responses. Generally, there are some parts of health services that are quality for the general population. For many other groups, including those identified in category 2; quality in health service is often compromised. There are missing elements of care in provision of services and enough medicine inventory, these affects quality. There are often long lines, even longer referral dates to see specialists or to undergo procedures. Stigma and discrimination continues for most Batswana and not just vulnerable groups, particularly around sexual and reproductive health needs. b. As per category 2 above.
Does your country have adequate health workers, especially at the primary health care level? Are community health workers part of the health staff roster and are they paid adequately?	No. Health workers are in shortage, with further risk of shortages due to opportunities to emigrate to developed countries (more notably the United Kingdom). Health workers in some rural settings (Muchenje, Mabele, Kavimba, Kachikau, Satau, Parakarungu, Shakawe, Gumare, Chukumuchu, Mohembo, and Pandamatenga) are forced to work without resources (medicines, equipment, understaffed) needed to provide services. Although there are instances where the Ministry of Health engages community health workers under specific campaigns (anti-substance use, tobacco awareness, non-communicable disease awarnesss), they are not part of regular staff appointments/recruitment. Community health workers mostly serve under community based or led organisations. They are paid independent of public health provisions/infrastructure. Thus payments are subject to external resourcing and the competitive funding landscape, meaning inconsistency, short-term and no social protections for many.

CATEGORY 5: INVEST MORE, INVEST BETTER

Question	Summary Feedback
Where do you think your government should be spending more in terms of achieving UHC?	Investing in health infrastructure is key, for example rebuilding health posts to clinics, transforming clinics to provide 24 hour services, increasing bed capacity (including ICU), psychosocial service infrastructure (including in-patient facilities), increasing the number of hospitals across the country and the workforce (including specialists spread/rotating across the country). Other investments should be in localised intellectual property, operational research infrastructure and manufacturing of commodities or generic medicines. This aligns with social contracting and transitioning out of Global Fund related financing and the country's aspirations moving from a higher middle-income country to a high-income country and knowledge-based economy. There should be increased investments (in lieu of bilateral or external donor funding) on availing safe sex commodities (dental dams, condoms, finger cots and lubricants) and contraceptives. All health workers (including security, support, and administrative staff) should be trained on different community issues to enable better and stigma-free access to health for diverse groups. There is a need to improve sexual and reproductive health services for diverse communities.
a. Is the government spending enough on health services and is this increasing? b. If the government is not increasing its spending on health services, what is preventing your government from investing more in health services?	a. No, it has declined in line with donor funding over the last decade, compared to the previous decade at the height of the HIV response. b. Lack of political will, unmet health related commitments (such as the Abuja declaration), maladministration, waste (from the Auditor General report) and corruption allegations, particularly since the COVID-19 pandemic.

CATEGORY 6: MOVE TOGETHER

Question	Summary Feedback
a. At the national level: are there opportunities for people, civil society organizations, and the private sector in your country to be engaged in planning, budgeting, monitoring and evaluating the health sector? i. If so, what are those opportunities and are they effective and efficient for the engagement of civil society, in particular, of the most vulnerable and marginalised populations and communities?	a. No. However, the HIV sector has opportunities for domestically funded CSOs contributing towards monitoring and evaluation and planning. b. No. Although in some urban areas there are consultations made, however there are no set processes or accountability measures in place for communities.

b. At the community level: Are communities engaged in local level health planning, budgeting and accountability processes? i. If so, how are they engaged?	
a. Are there civil society forums or constituencies in your country to engage with decision-makers on health-related issues? b. If so, how well does the existing civil society coordination function and what can be improved?	a. CCM, however it is largely exclusive and not consultative of broader domestic funding beneficiary CSOs/partners and others within the community health infrastructure. District AIDS Multi Sectoral AIDS Committees, District Health Management Teams and Village Development Committees have also been identified with some elements of civil society participation that varies according to the organ. In addition, there are Ministry of Health technical working groups on specific thematic or programmatic issues (comprehensive condom programming, key populations, human rights etc.). b. There are power dynamics that impede meaningful participation. This is further aggravated by lack of effective coordination for social participation on the part of government.

CATEGORY 7: GENDER EQUALITY

Question	Summary Feedback
a. Can you identify some of the major challenges for women and girls in their access to health services? b. What kinds of health services are most challenging for women and girls to access? c. What are the primary challenges to access health care services for individuals who are non-binary?	a. Stigma and Discrimination, harmful gender norms, child marriages within ethnic minority groups, access for those in rural areas, limited SRHR policy framework, pre and post-natal care, along with an overall lack of bodily autonomy and integrity for women and girls in their diversity in the public health system. This is further aggravated by variant forms of violence that compromise their health and wellbeing. In more rural locations they live in hard to reach areas, where in some instances there is no infrastructure for public transport and/or even vehicles for service providers to reach communities. There are gender disparities in service providers that impact how women and girls seek services – for example, being attended to by male doctors impacting how and what they can share on consultation. There are cultural dynamics that have similar impacts, for example younger women and girls having to request contraceptives from more elderly service providers; limiting how they can reveal full symptoms, needs and desires. Confidentially remains a challenge in remote villages due to the social relations that are often in close proximity among residents. Thus, this can create an atmosphere of assumptions and gossiping – impacting health seeking behaviour. b. The most notable include family planning, cervical cancer screenings and support, securing justice from variant forms of violence (notably sexual violence), safe abortion, stigma and discrimination.

	Female sex workers cannot easily access STI prevention or treatment commodities and services due to the logistical/administrative/psychological burden/cost. c. Similar to the above, further aggravated by inaccessibility (language, gender affirmative healthcare, enrolment, use of pronouns, lack of LGBTI specific knowledge by service providers, etc.)

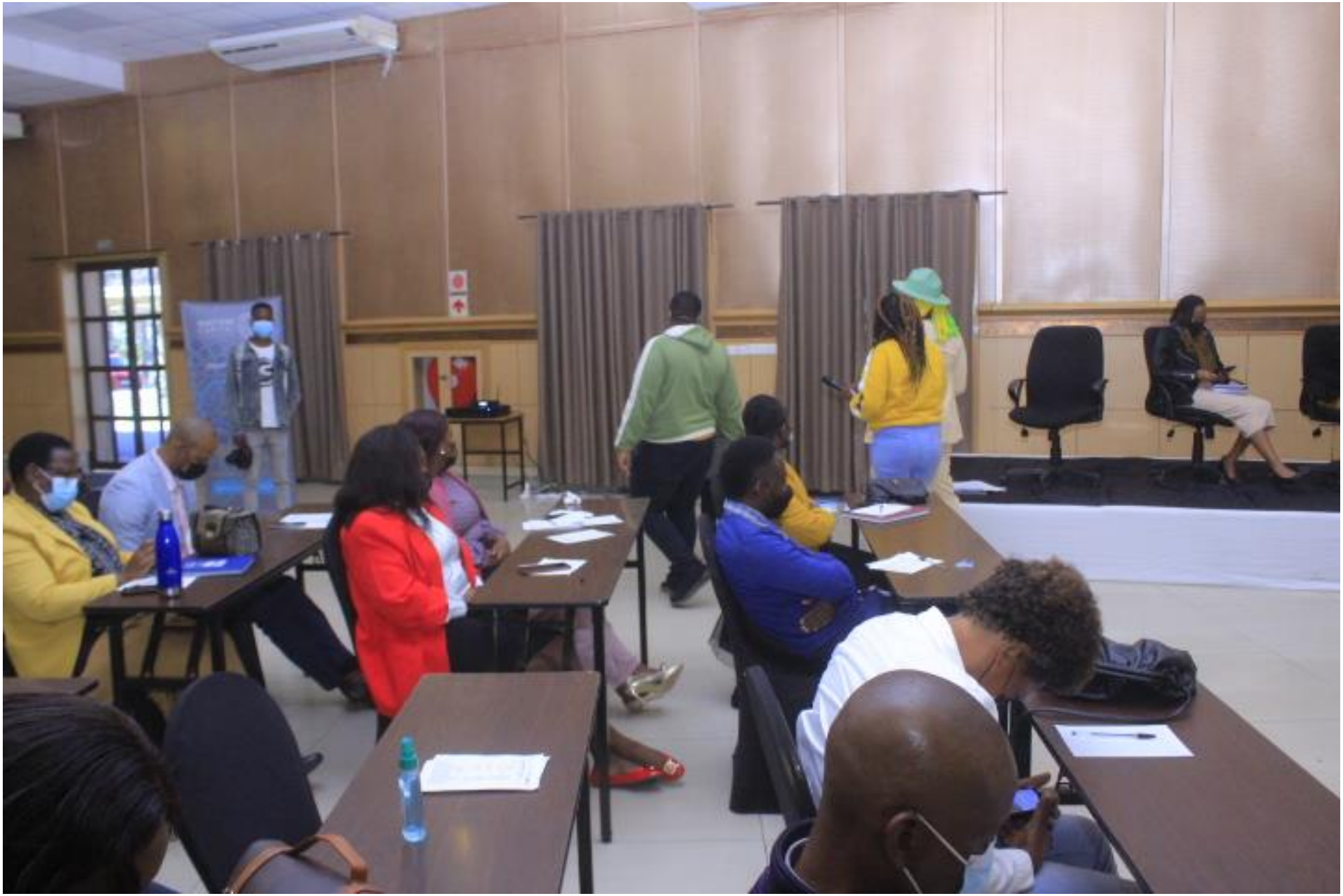
CATEGORY 8: EMERGENCY PREPAREDNESS

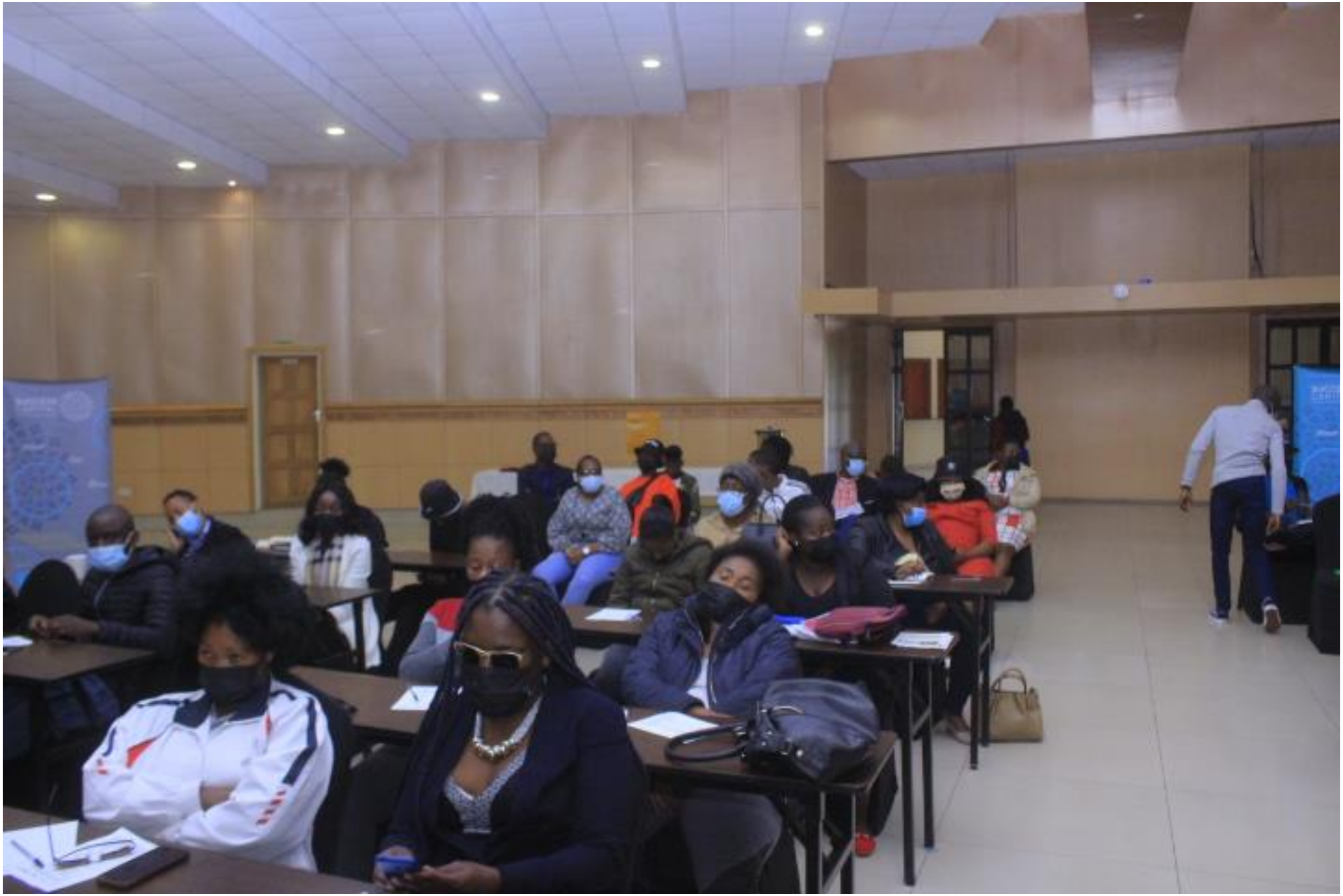
Question	Summary Feedback
a. How has the primary health care system been affected by the ongoing COVID-19 pandemic? b. How do you think that PHC can be improved/evolved to be better prepared for future pandemic and other health emergencies?	a. A lot of focus and funding shifted to the COVID-19 pandemic response negatively impacting availability of basic medicines and safe sex commodities, including in the private health sector. Dispensing of medicines has been extended to private sector pharmaceuticals, increasing out-of-pocket expenses for those in rural/underserved areas. In addition, there have been staff shortcomings (personnel, skills). In addition, movement restrictions impacted provision and delivery of services whilst some departments such as psychosocial support and sexual reproductive health were shut down. b. There is a challenge for many to answer given the very limited parameters for understanding the health landscape of the country. However, the strengthening of integrated health services is seen as a key enabler for PHC. In addition, strengthening community health systems, the health care workforce and skills thereof. Another improvement is educating the public towards more proactive health seeking behaviour and ensuring the inclusion of community health infrastructure in state spending.

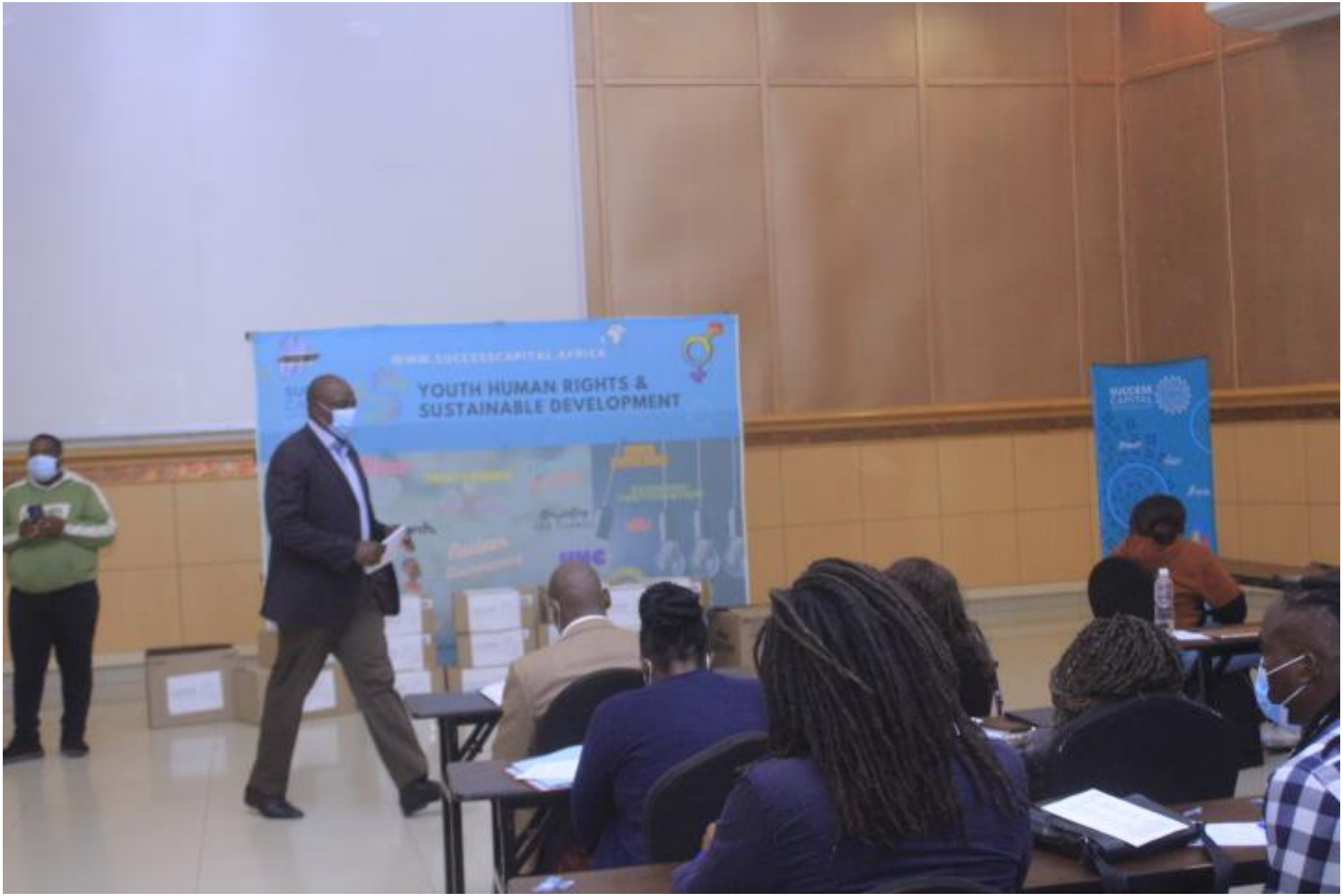
CATEGORY 9: LOOKING TO 2023

Question	Summary Feedback
Is there another element of UHC and the distribution of health services in your country that was not covered in the discussion today?	Referral services including law enforcement, social work and traditional leadership should have better coordination, diversity and inclusion provisions – especially in instances of GBV survivors that need to report cases, have specimens taken for evidence and follow up on the different stakeholders for healing and justice. Furthermore, social contracting should be accelerated and expanded to enable community health organisations to provide health services and care.
What is the main request you have for your Head of State about the state of health care (access, quality, and cost) in your country?	Eliminating stigma and discrimination in the public health system for all Batswana and migrants. Prioritise CSO participation in health service provision and care.

What is one message you would share with world leaders at the United Nations if you were the Head of State presenting the state of health care in your country?	“We are all living in a world where we live with pandemics, we all need to develop a plan where we can all have a backup, if we face a health challenge globally.”, “Health services are free to all regardless of race, gender, sexual orientation etc.”, “More nurses, doctors, and compensated community volunteers”. “Key populations should play a role in decision making”. “Ensure that CSO are included and participate in pandemic preparedness, prevention and response interventions”.



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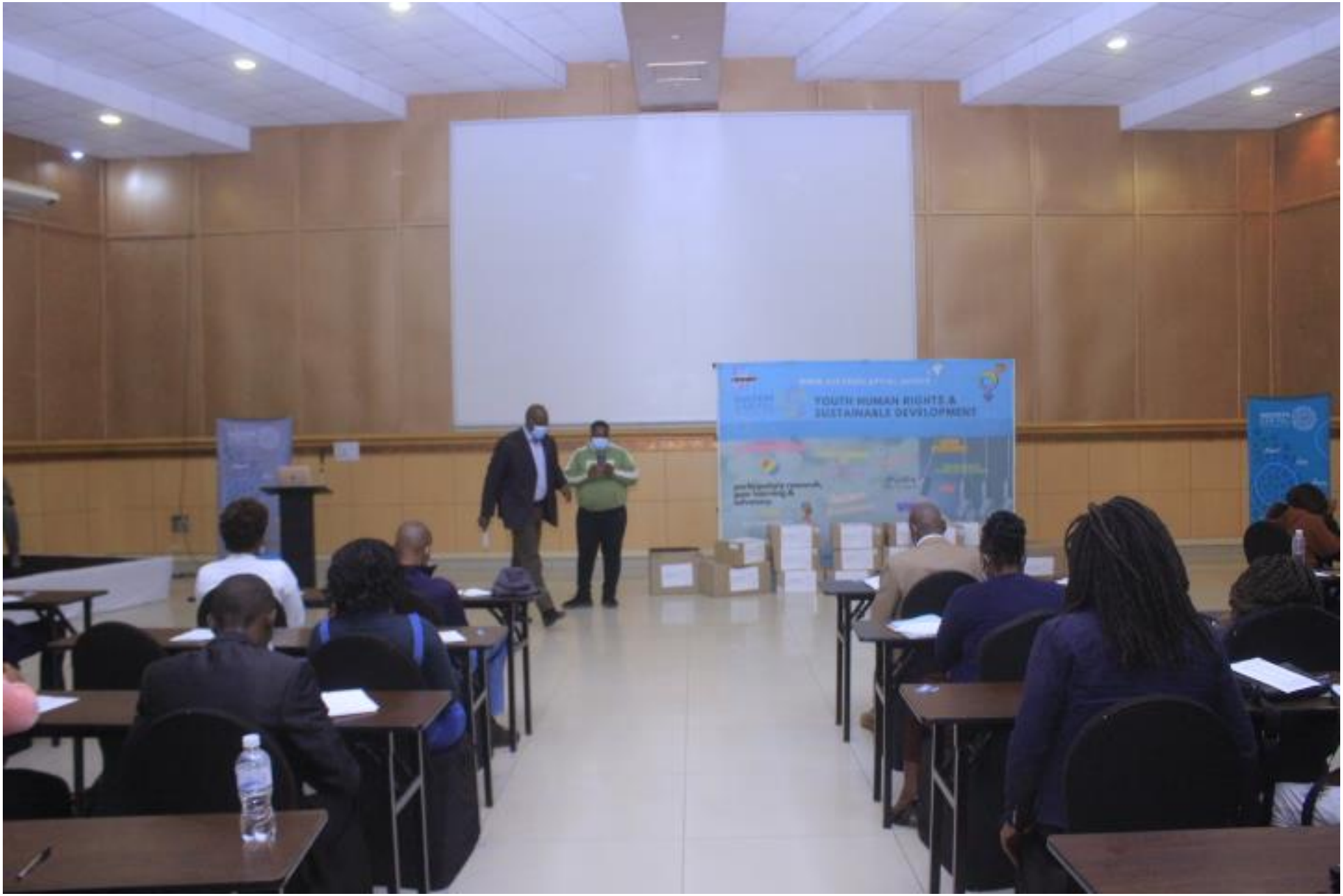
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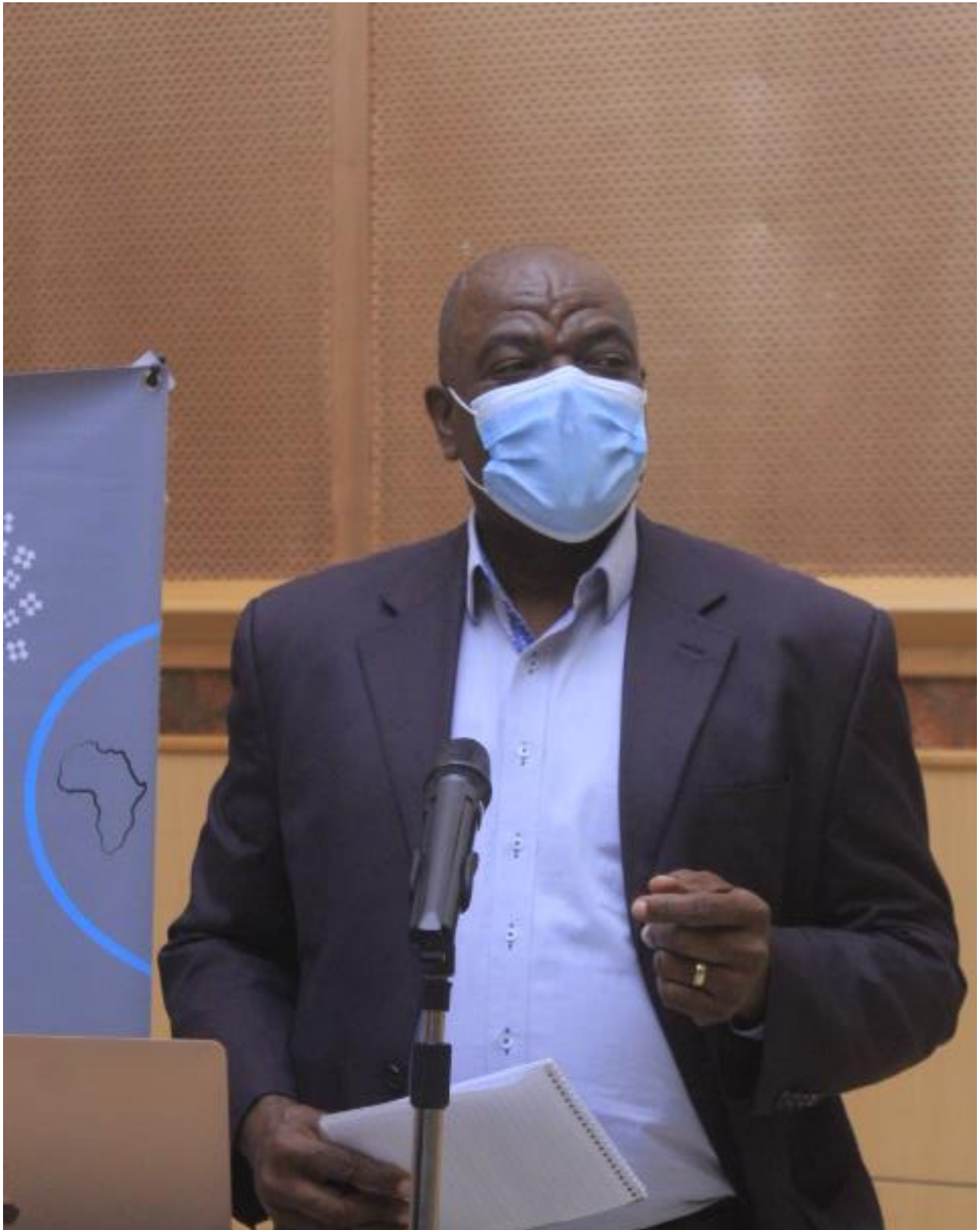

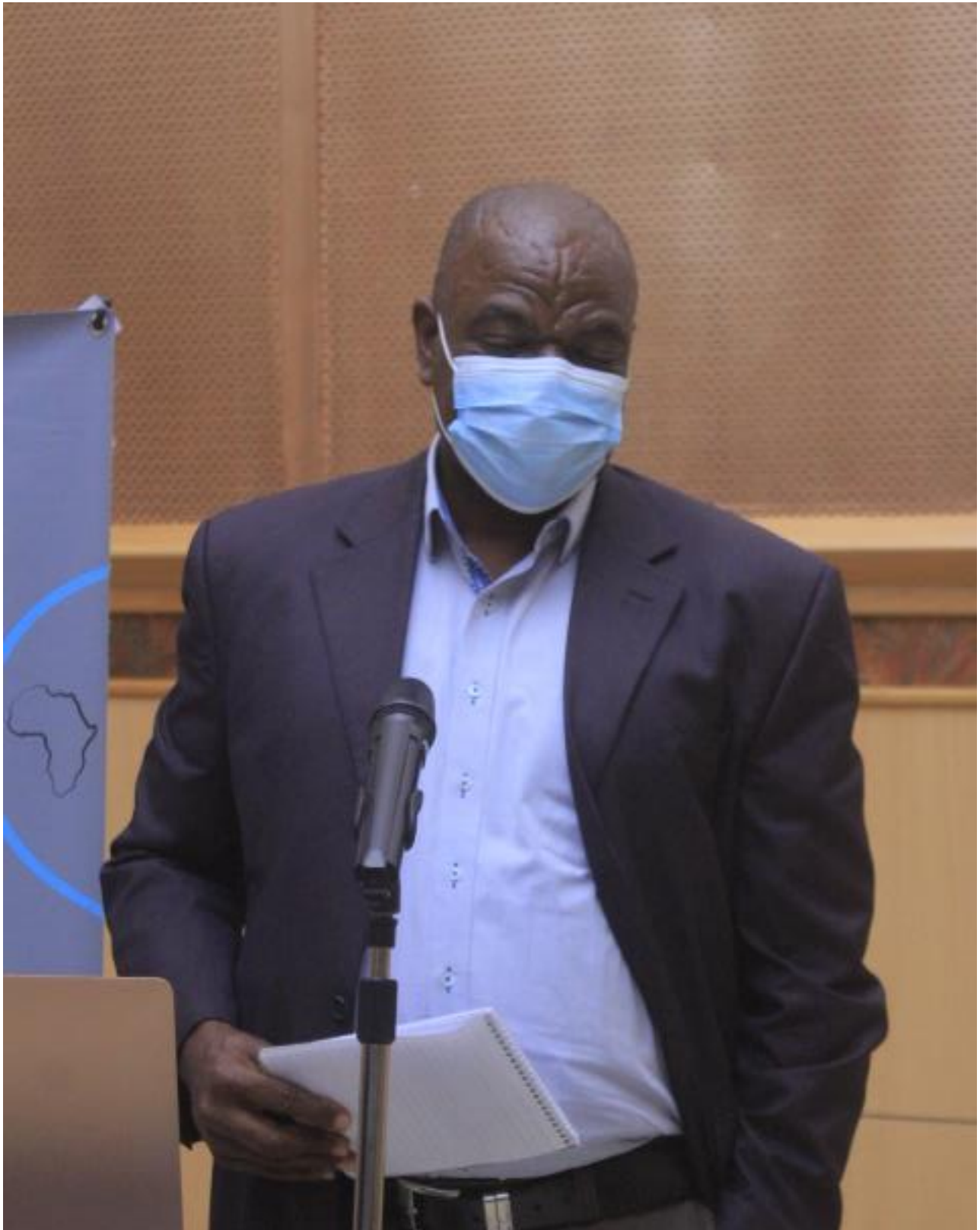

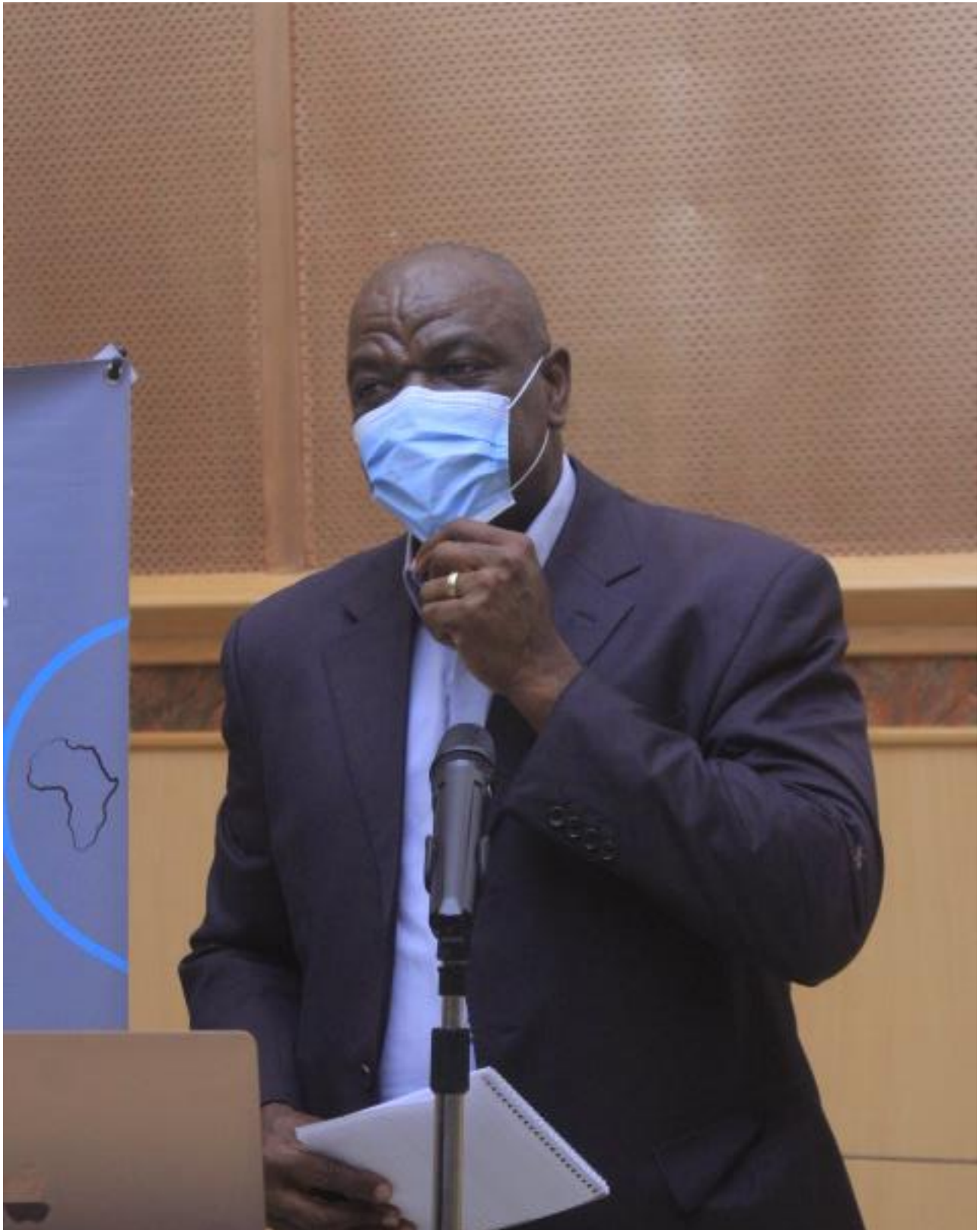

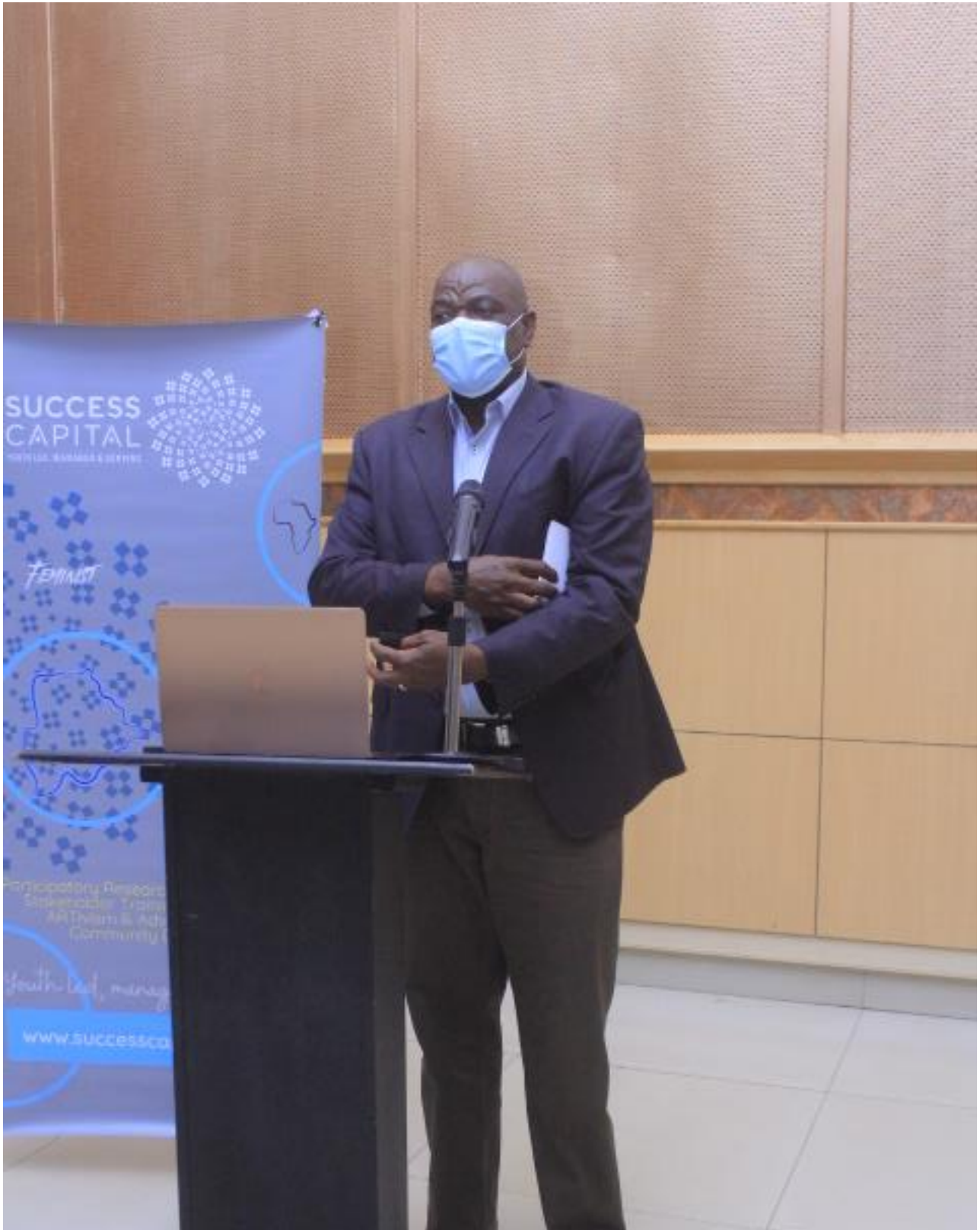
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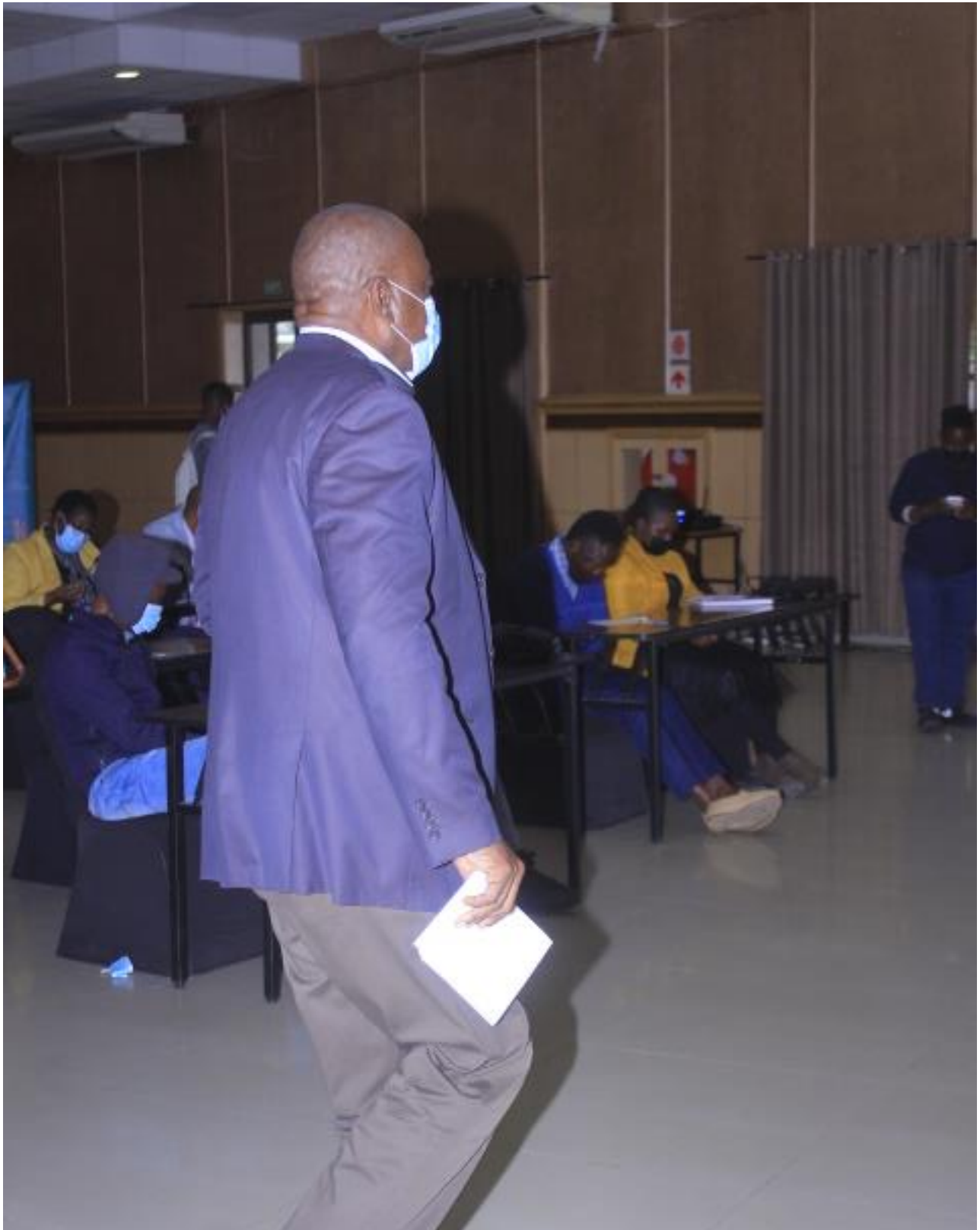

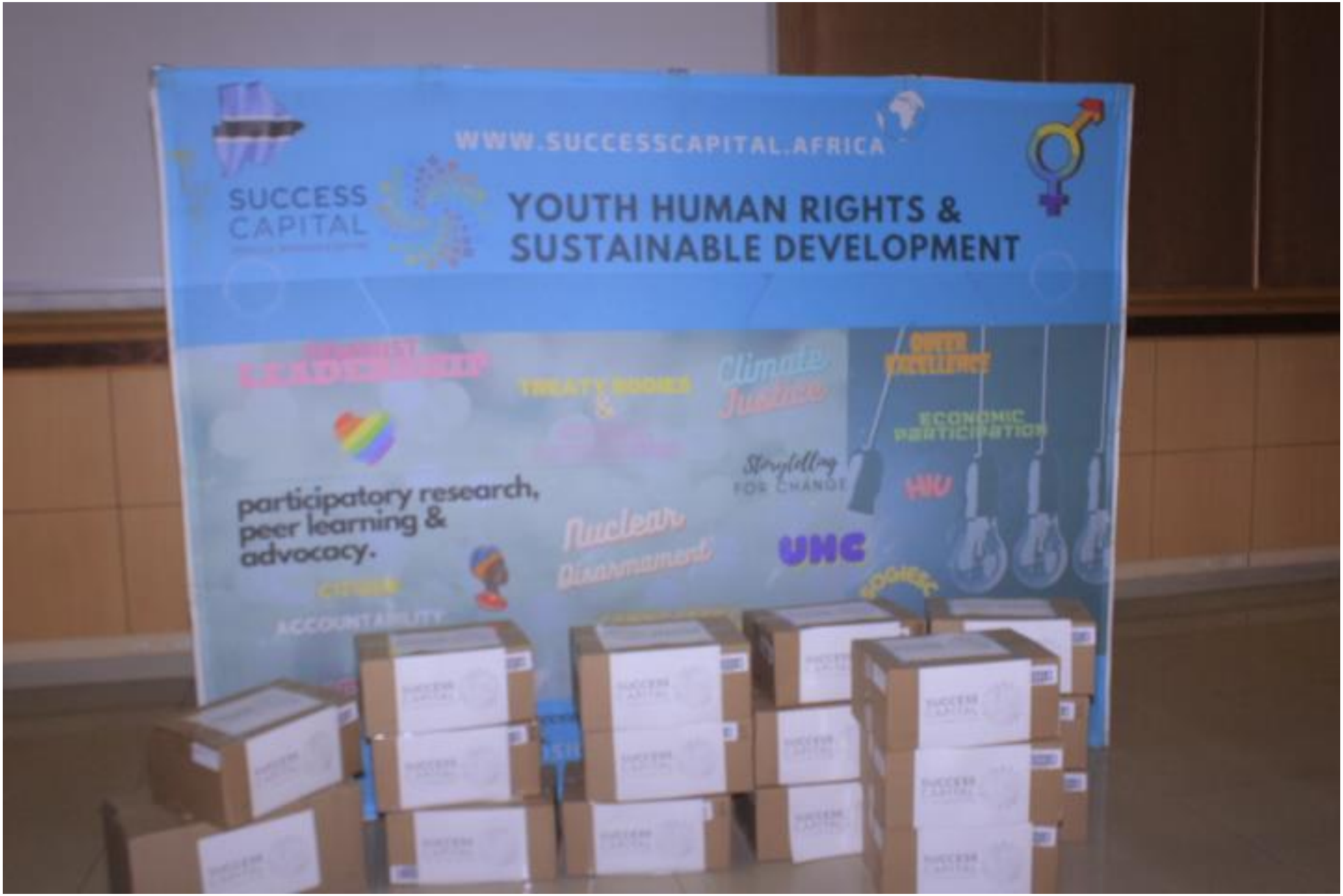
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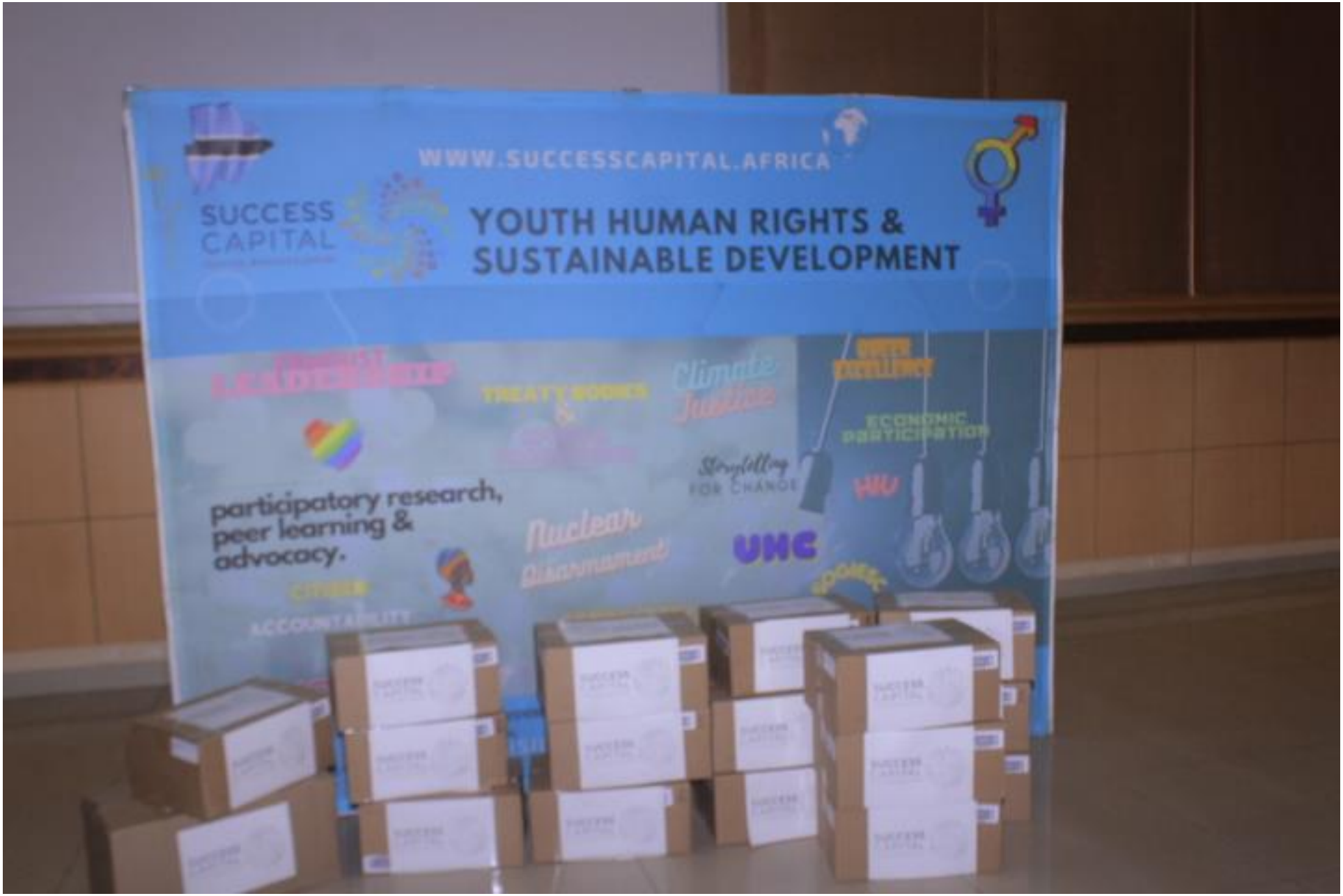
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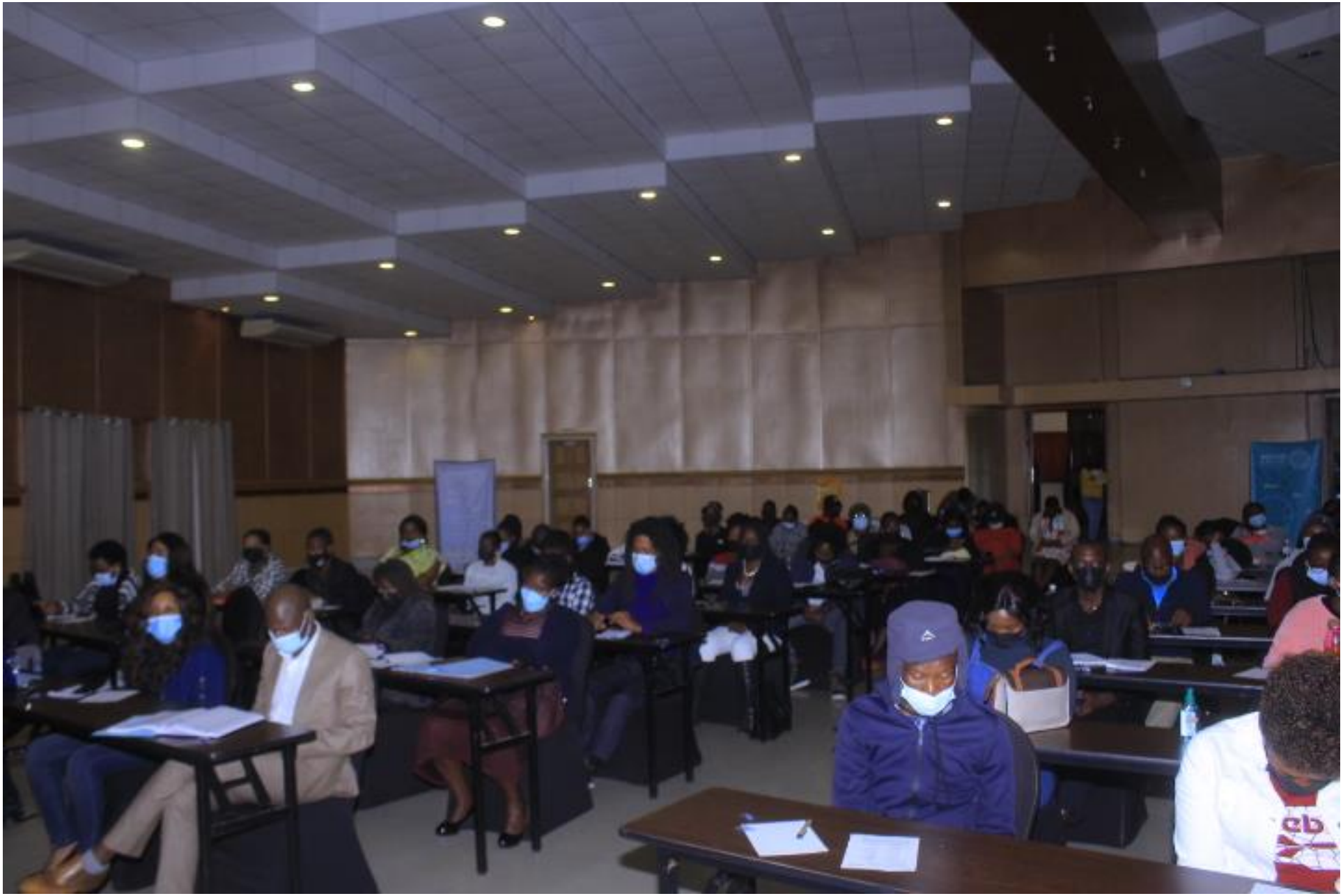

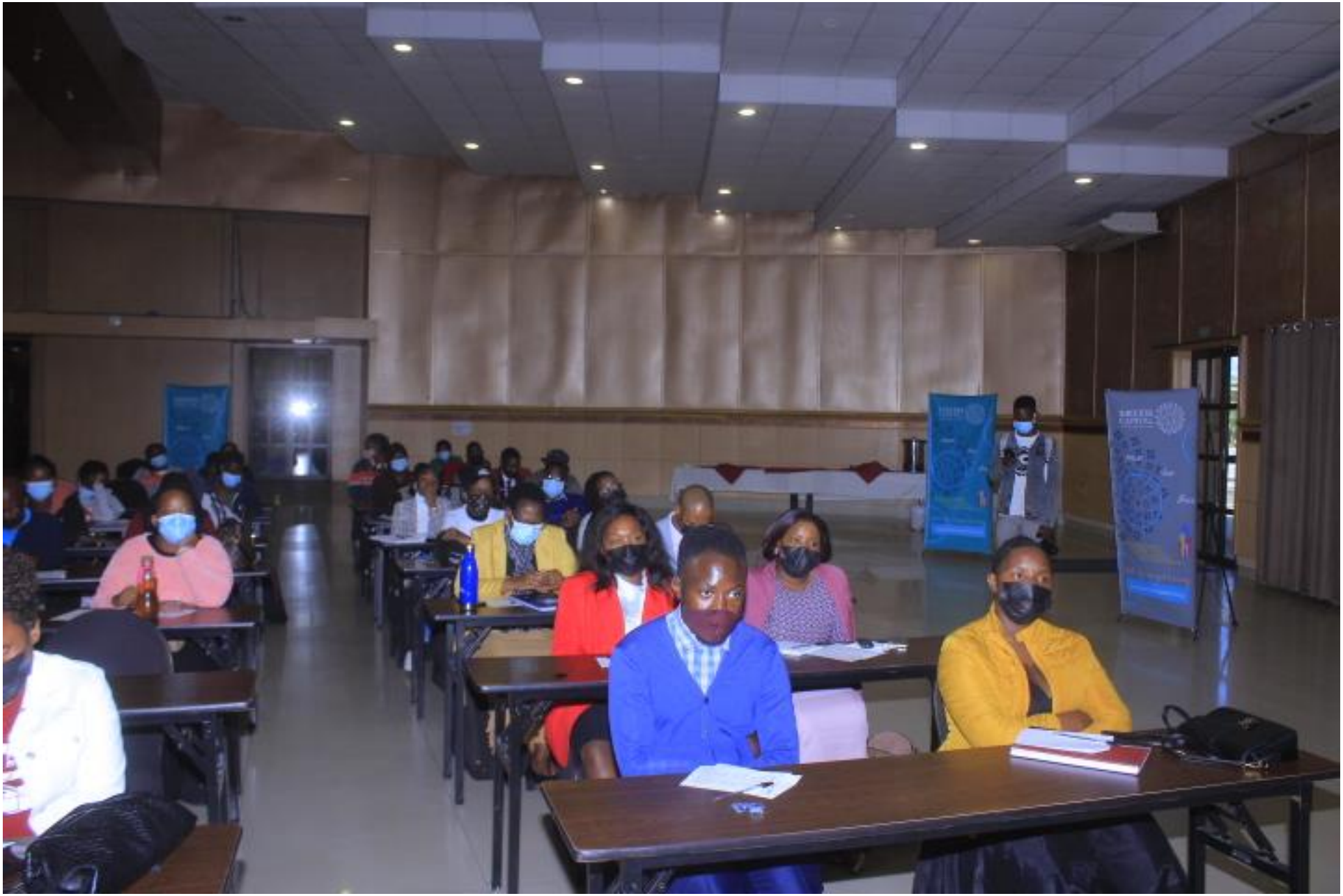

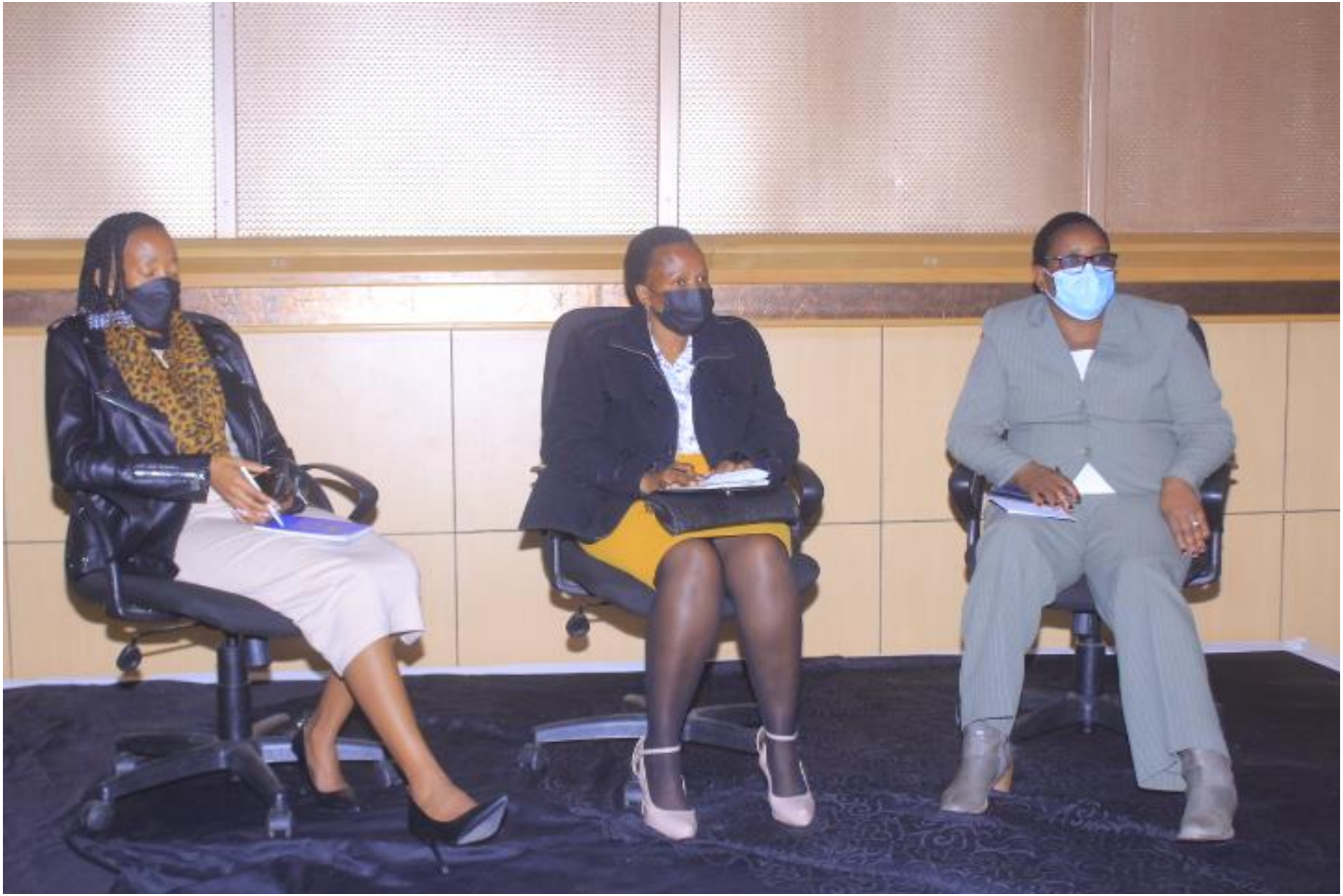

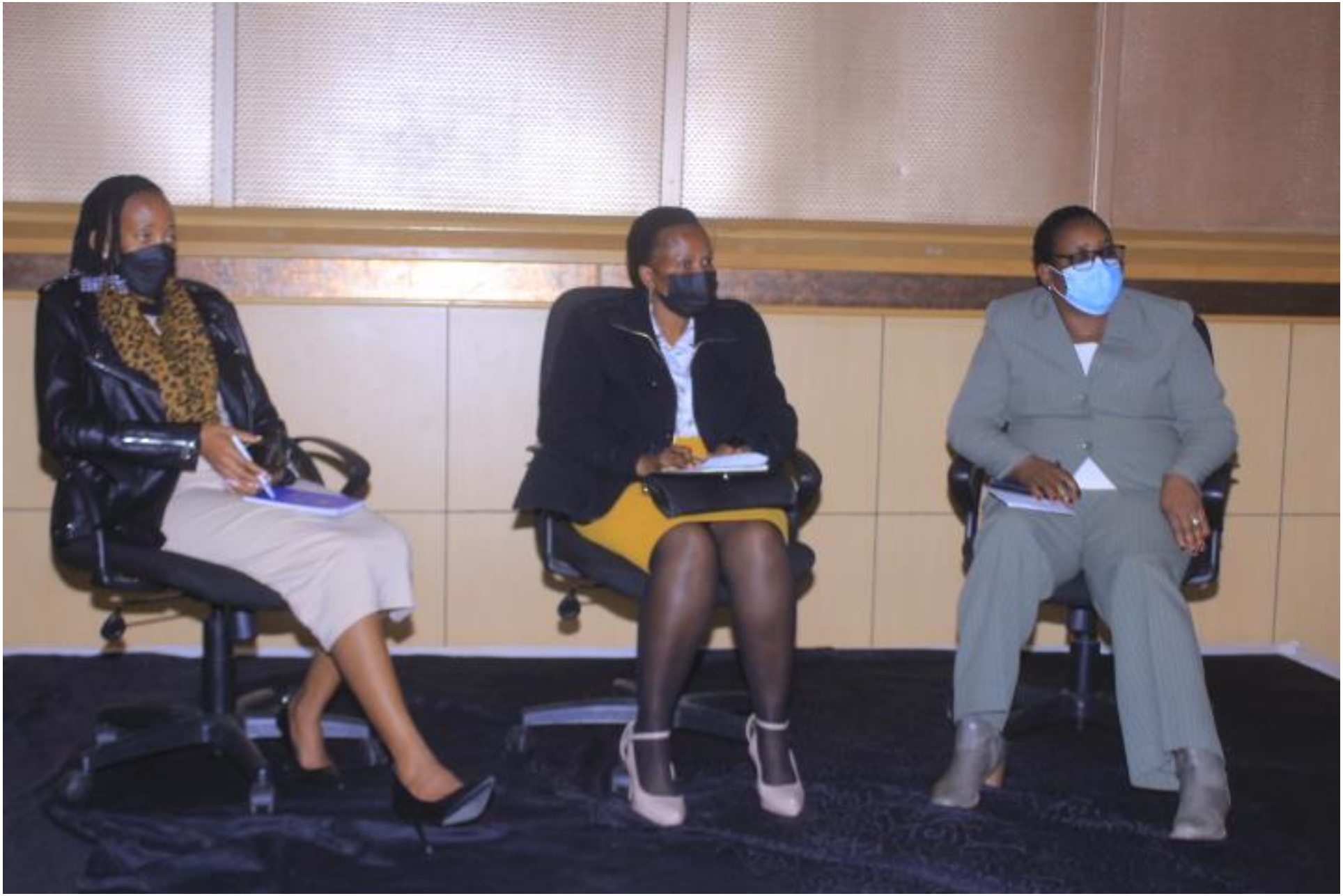

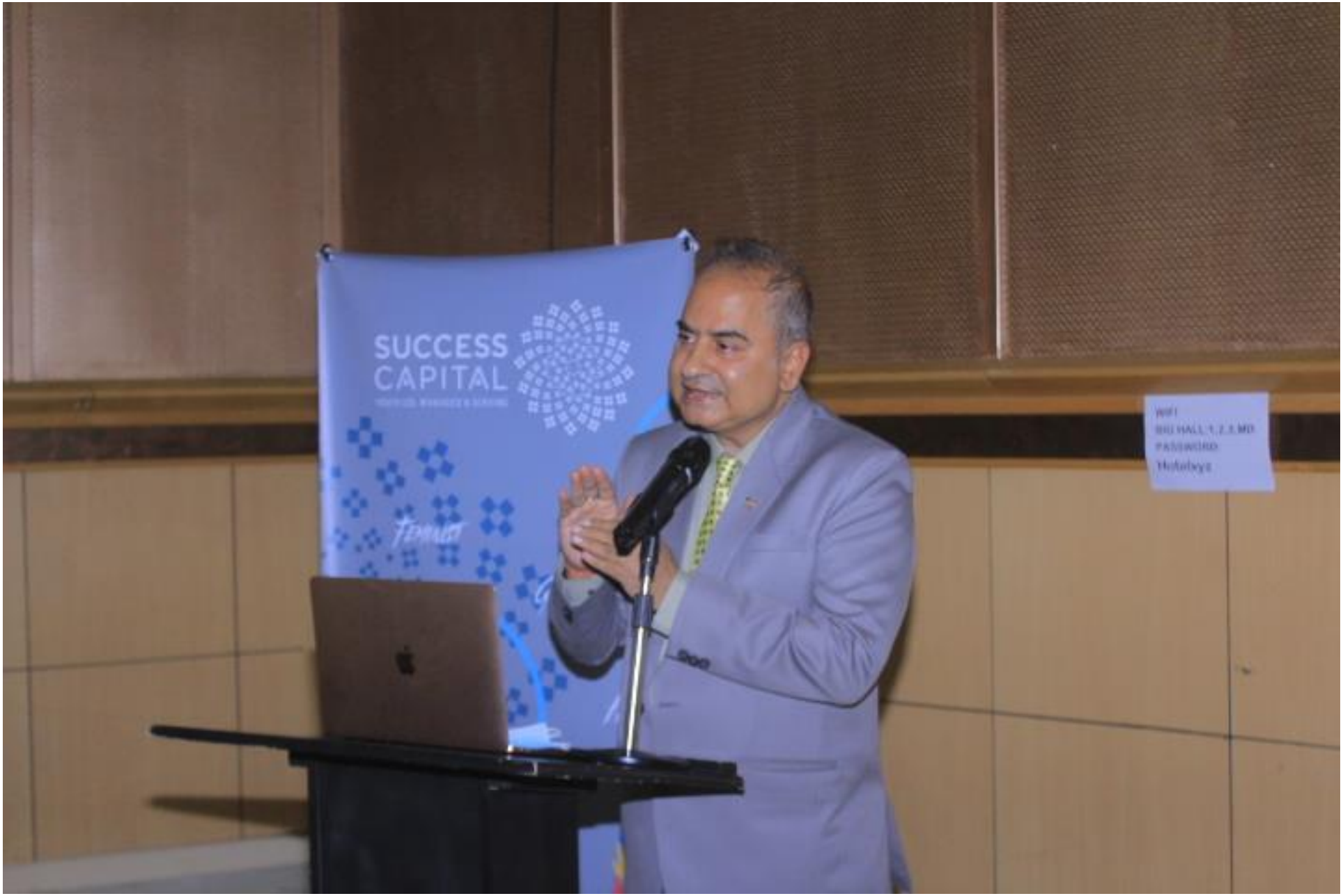
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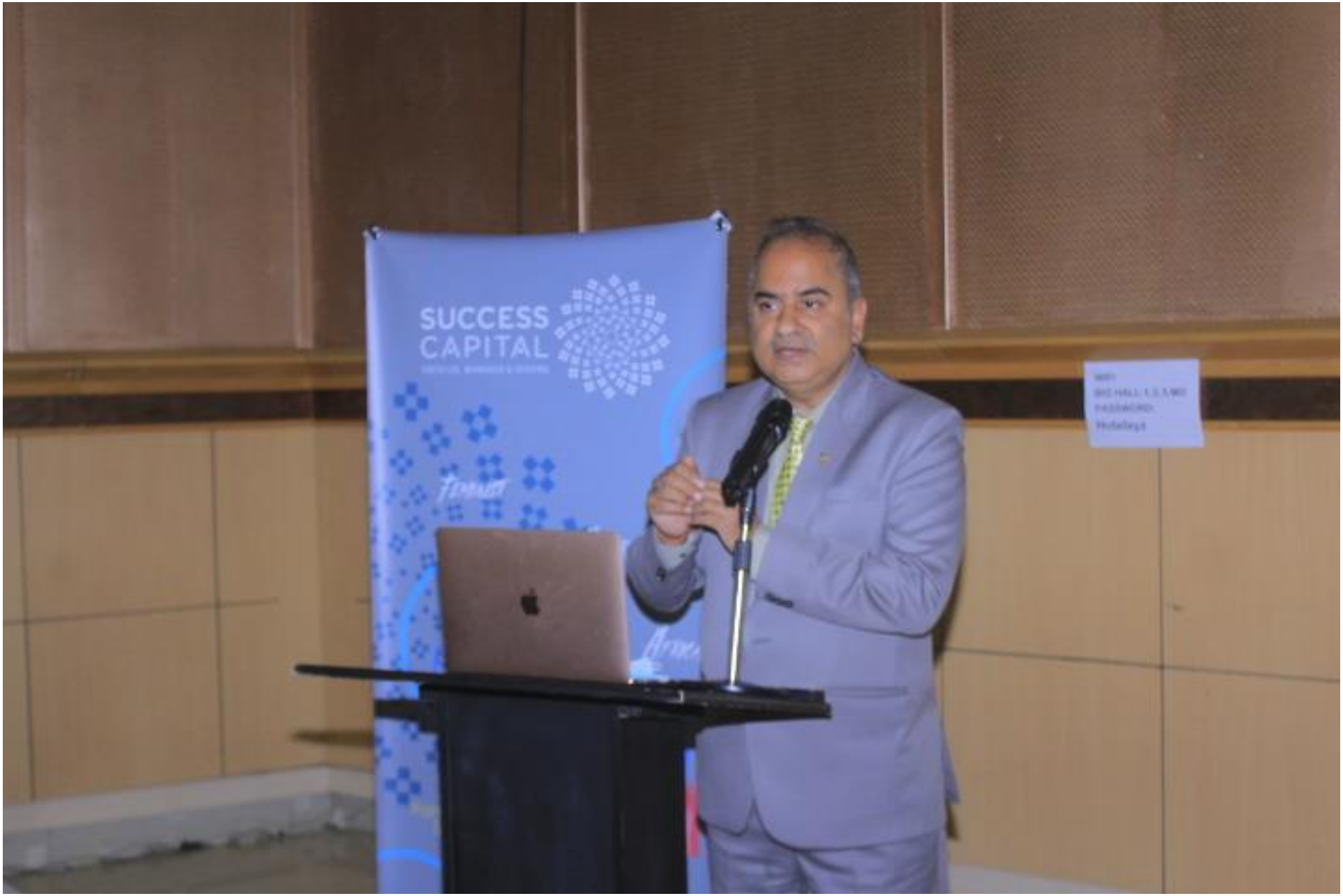
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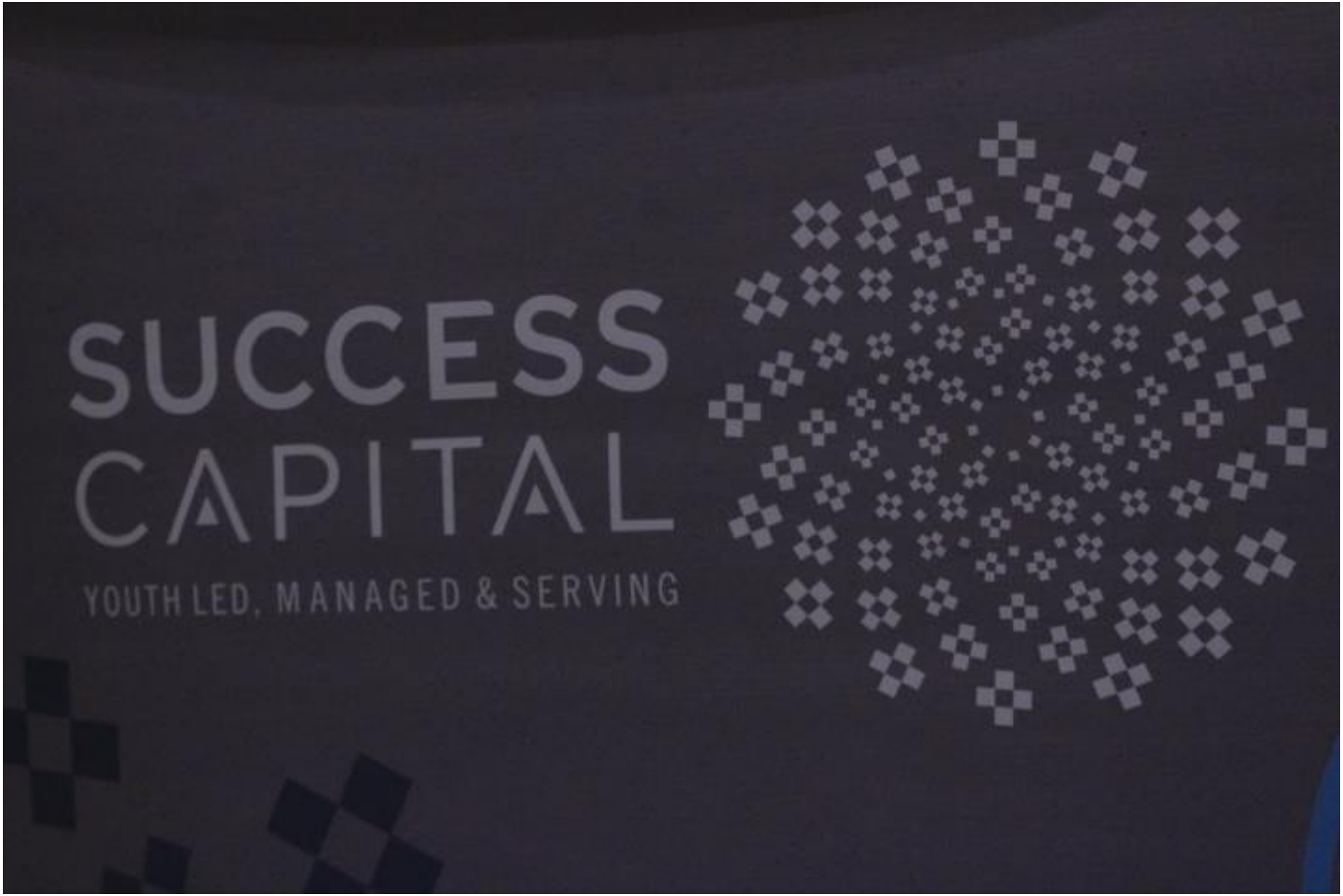
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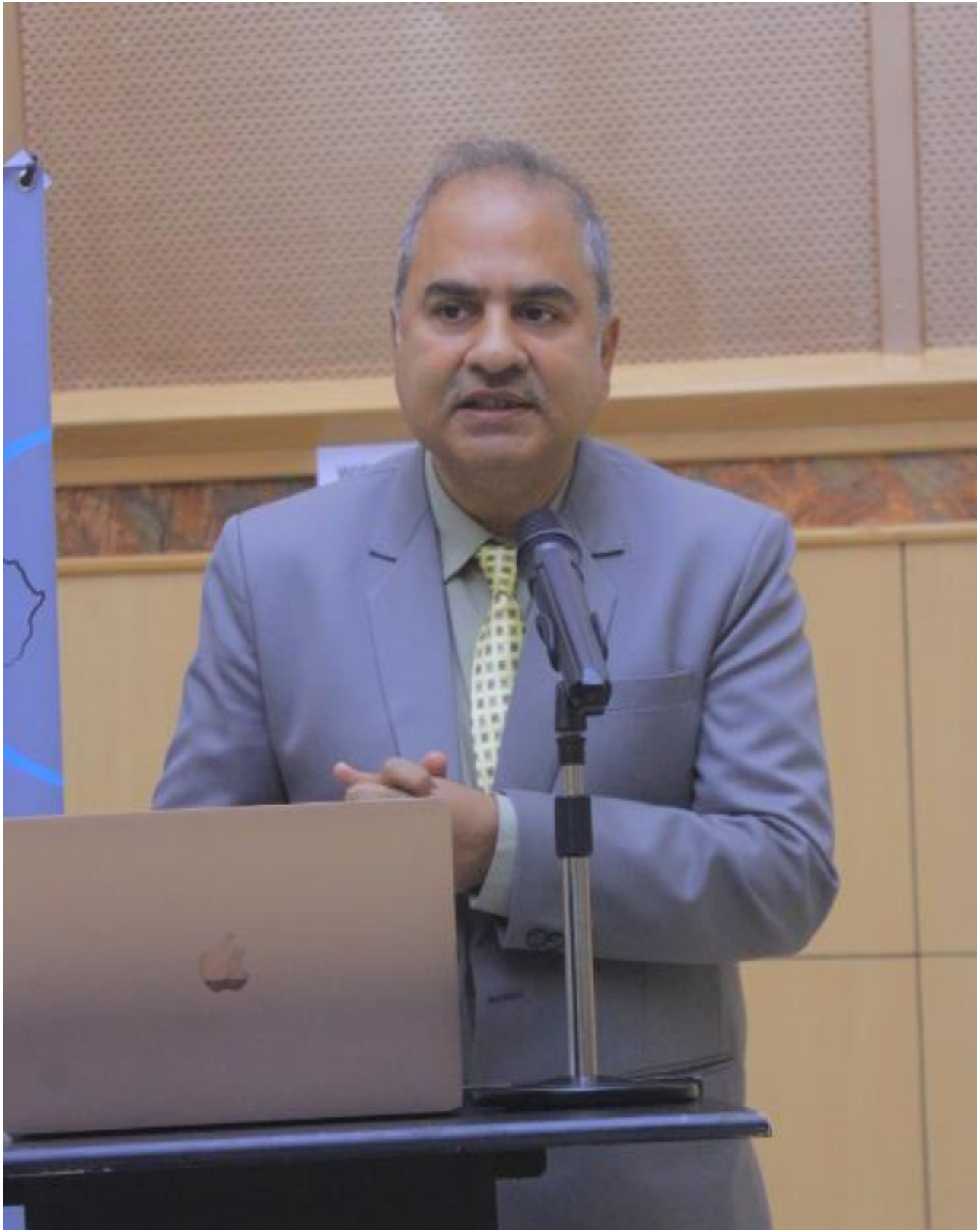

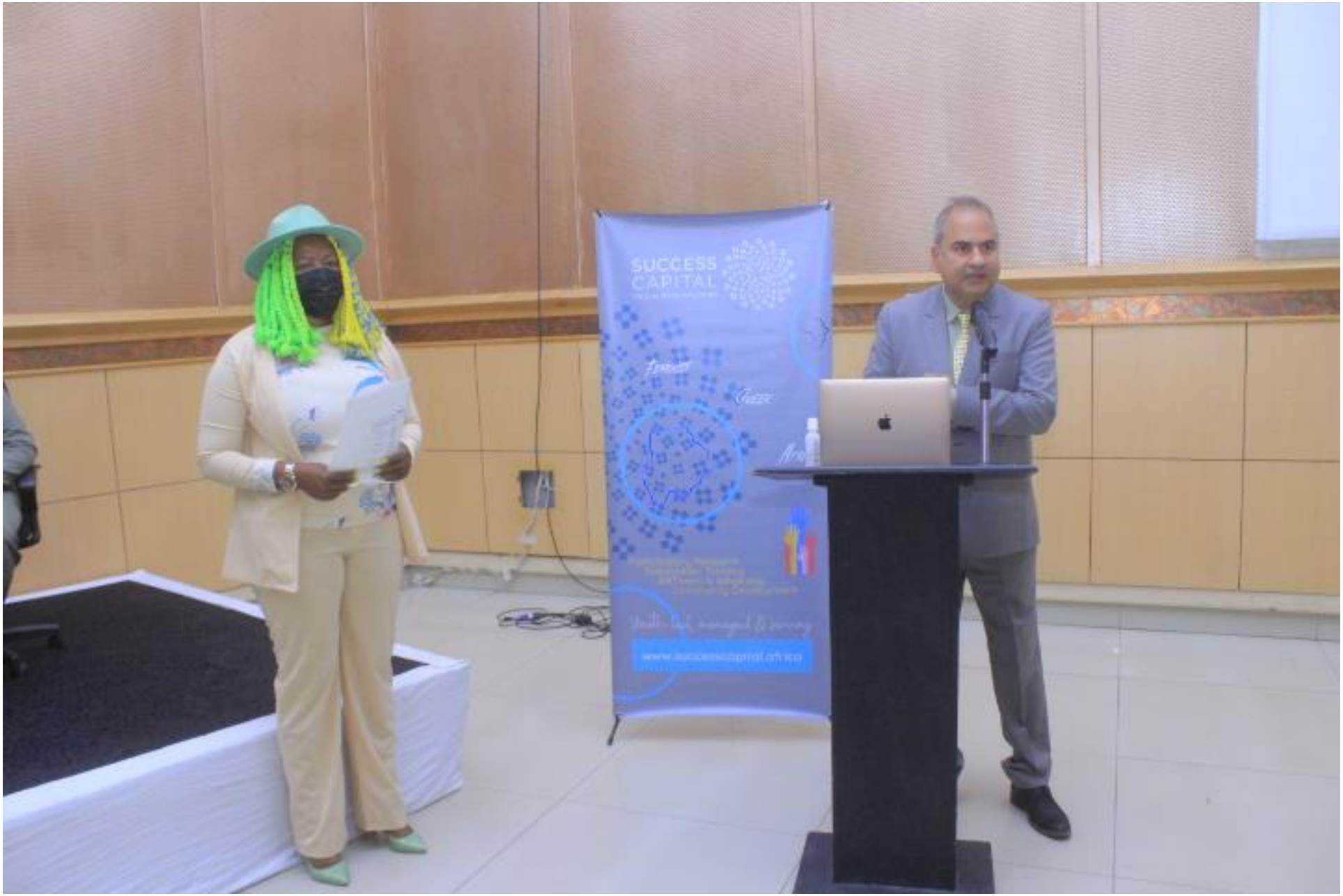
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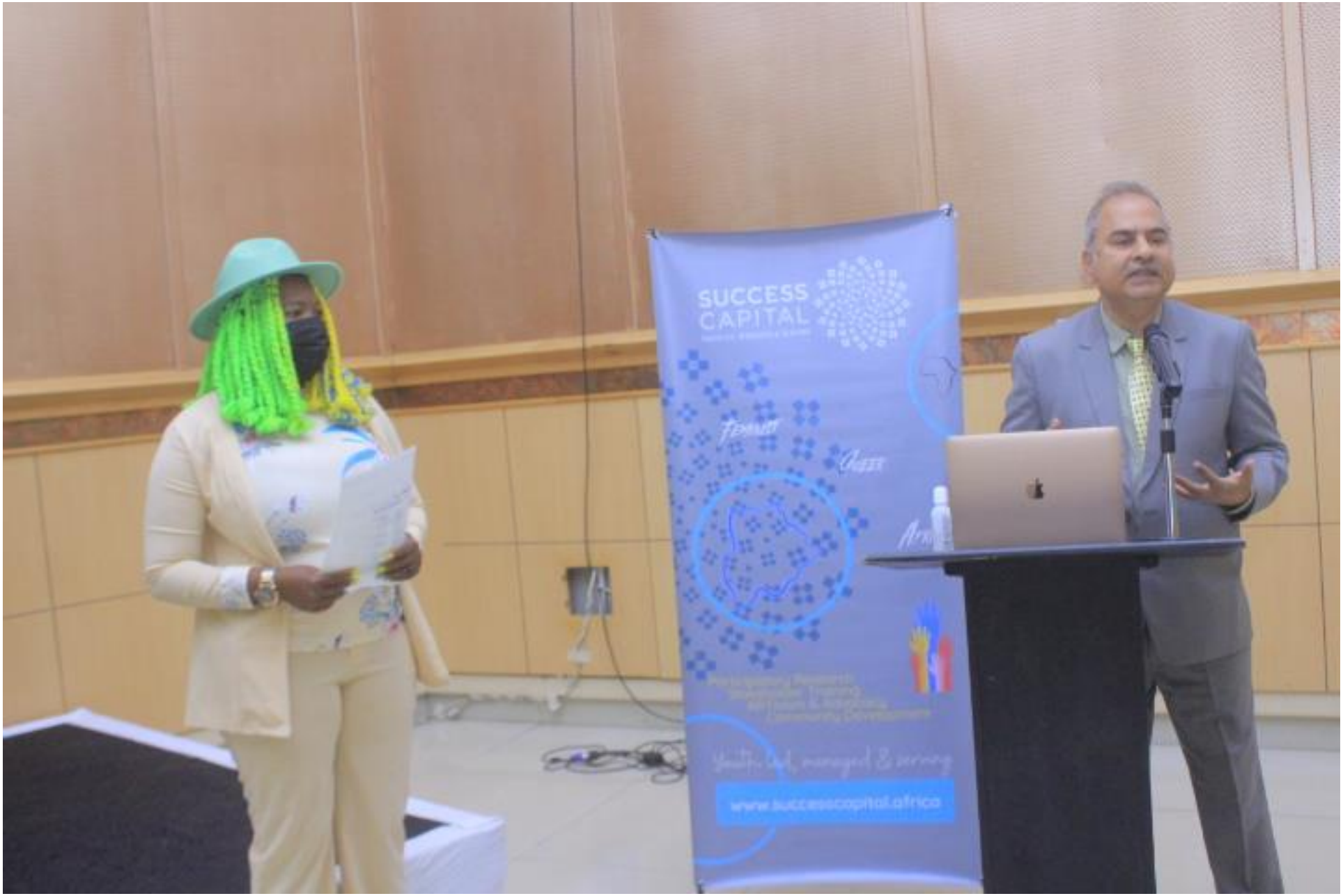
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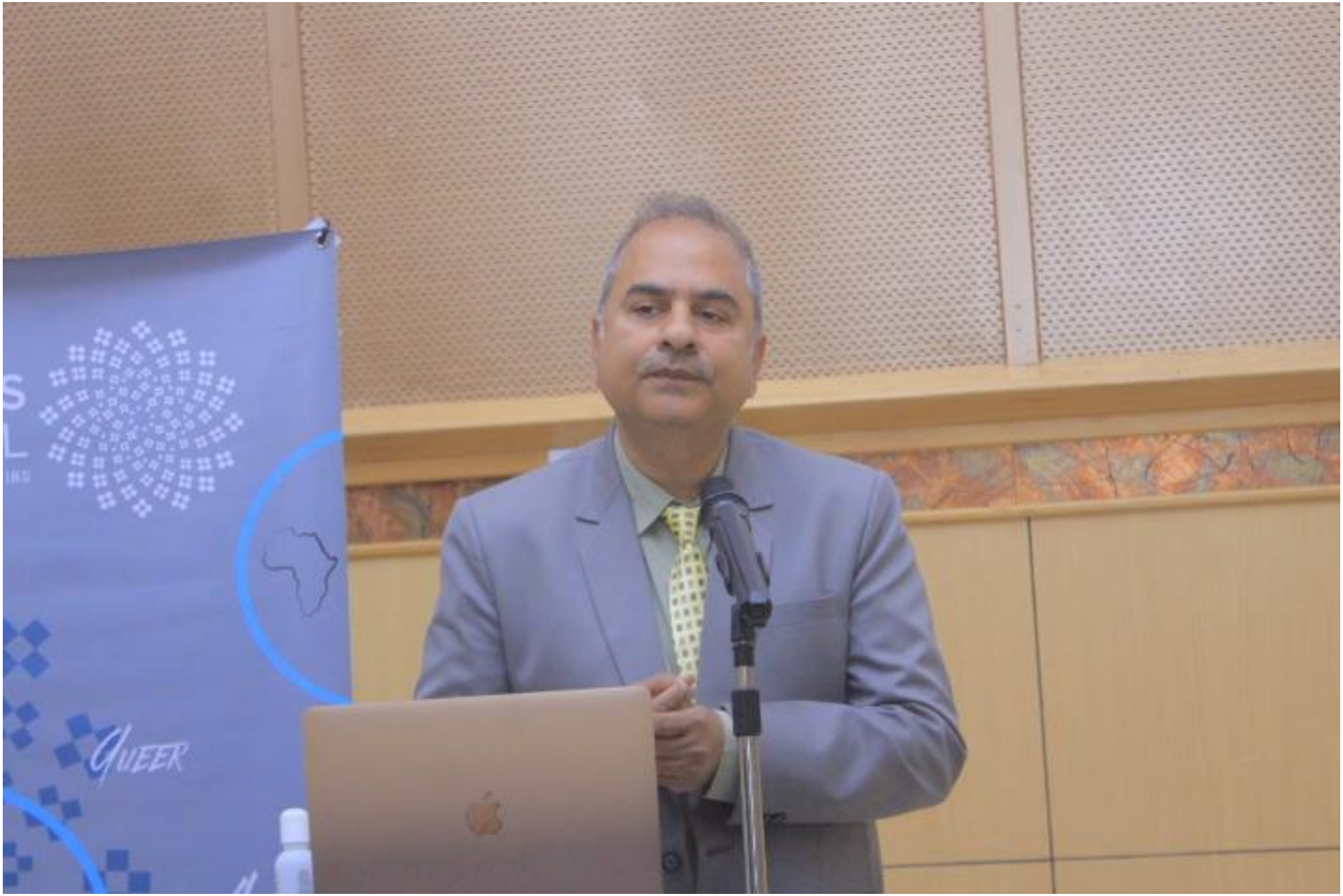
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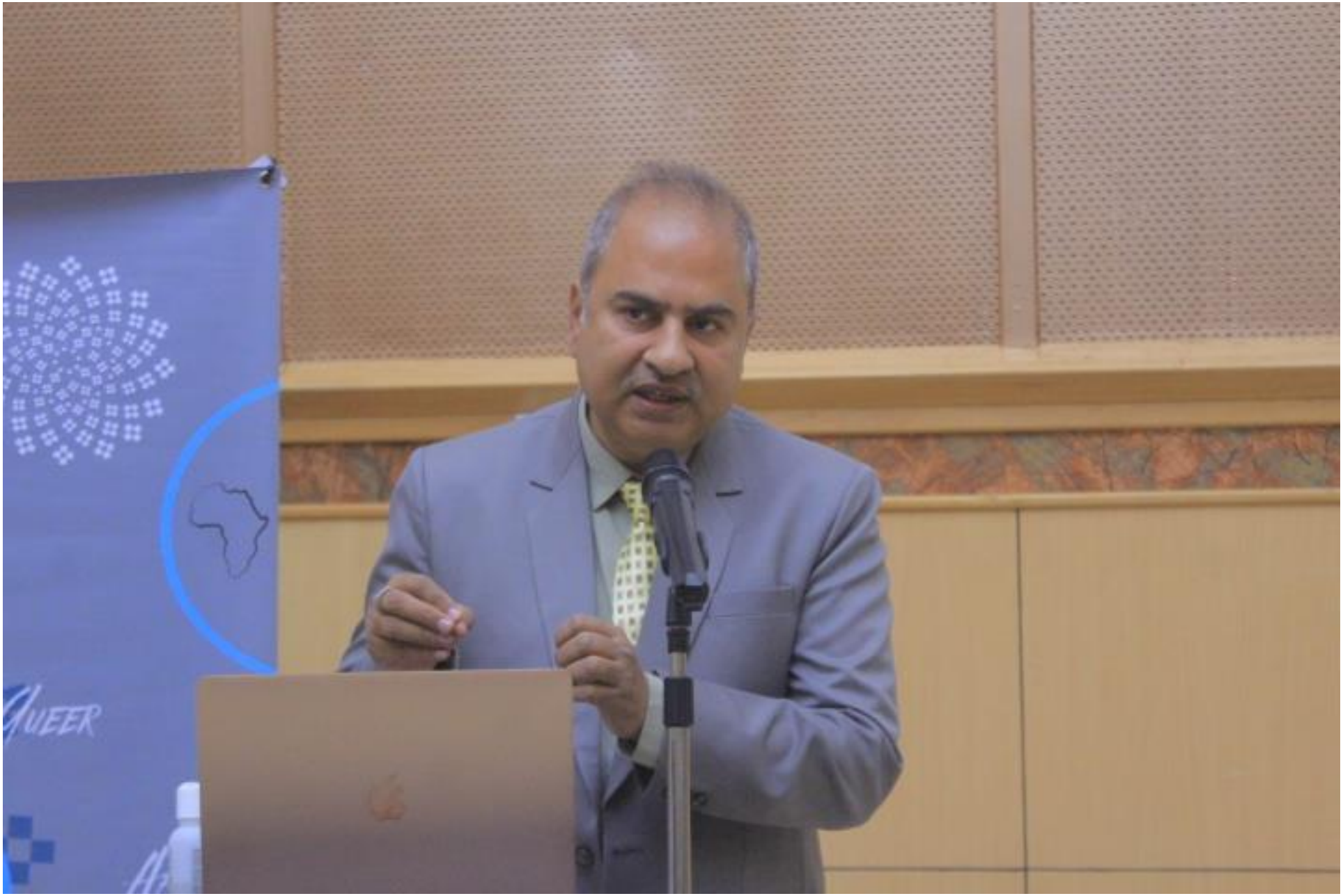
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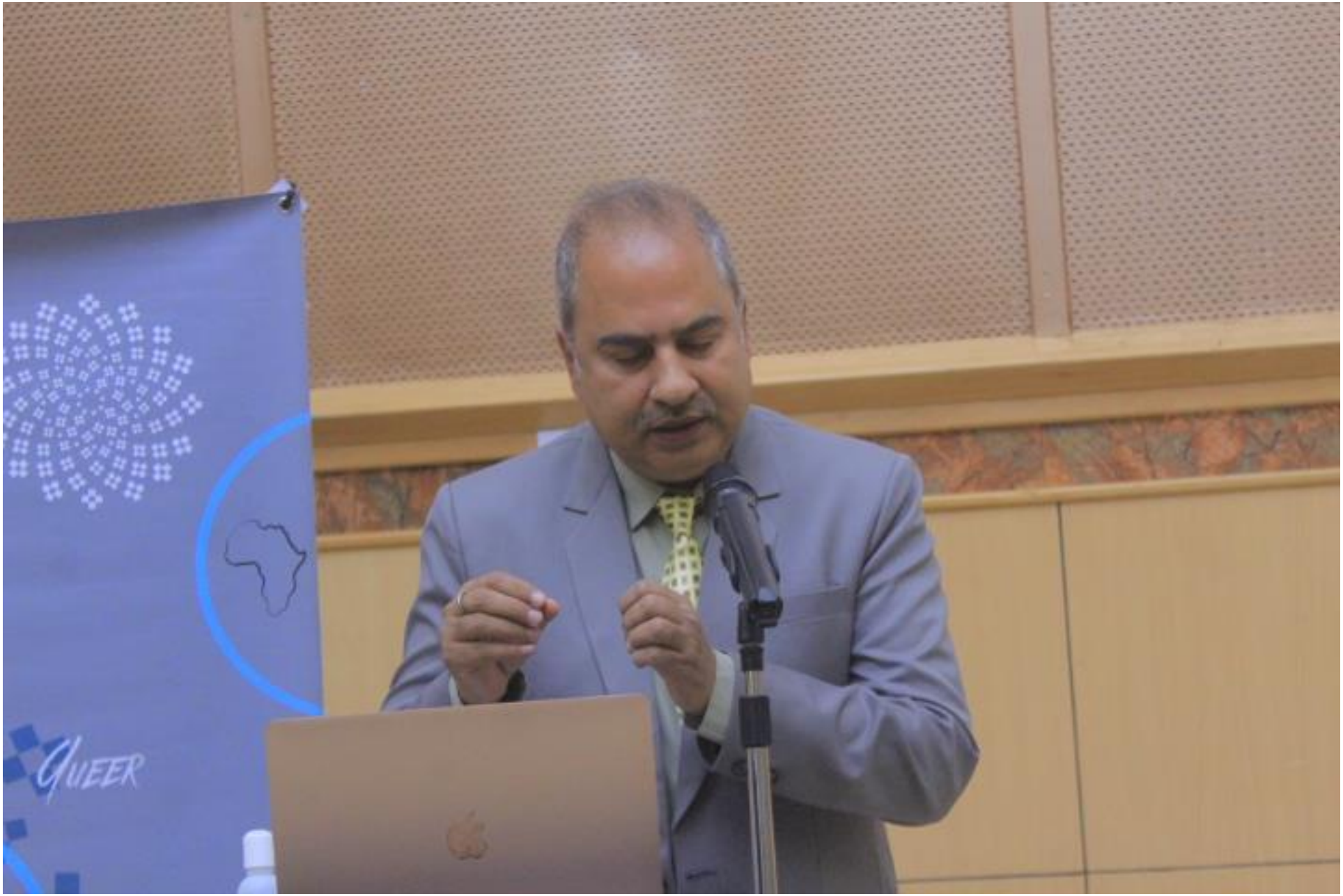
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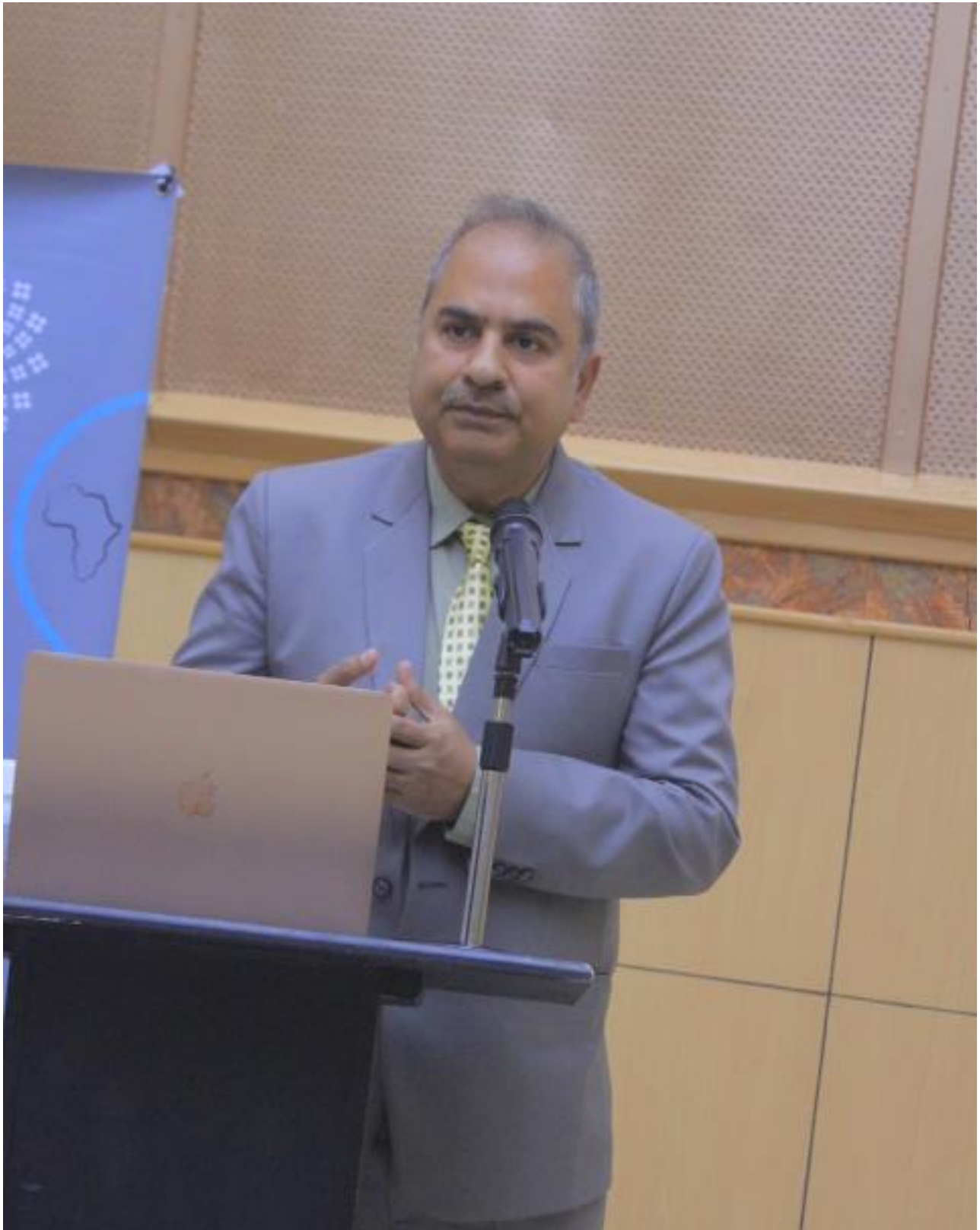

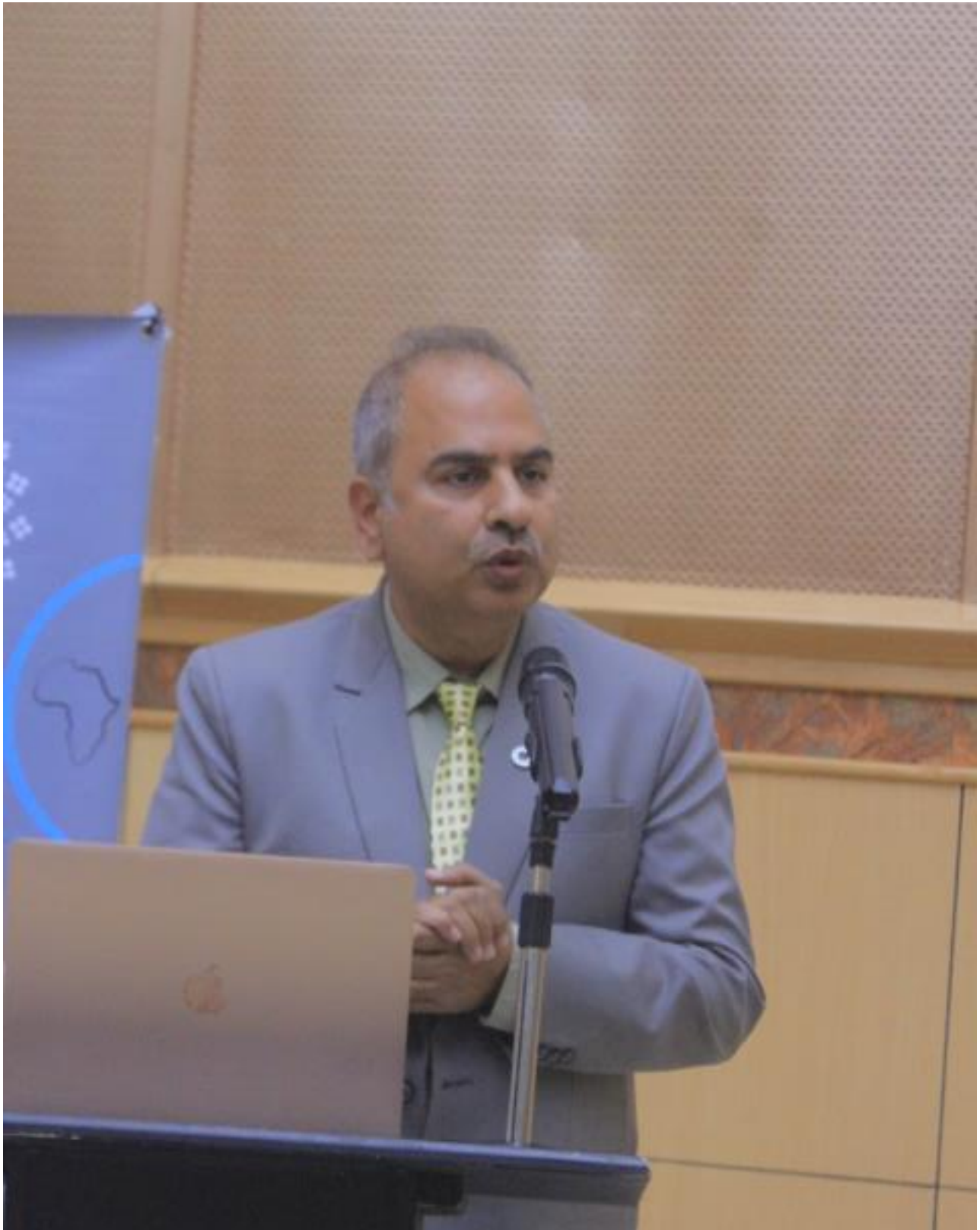

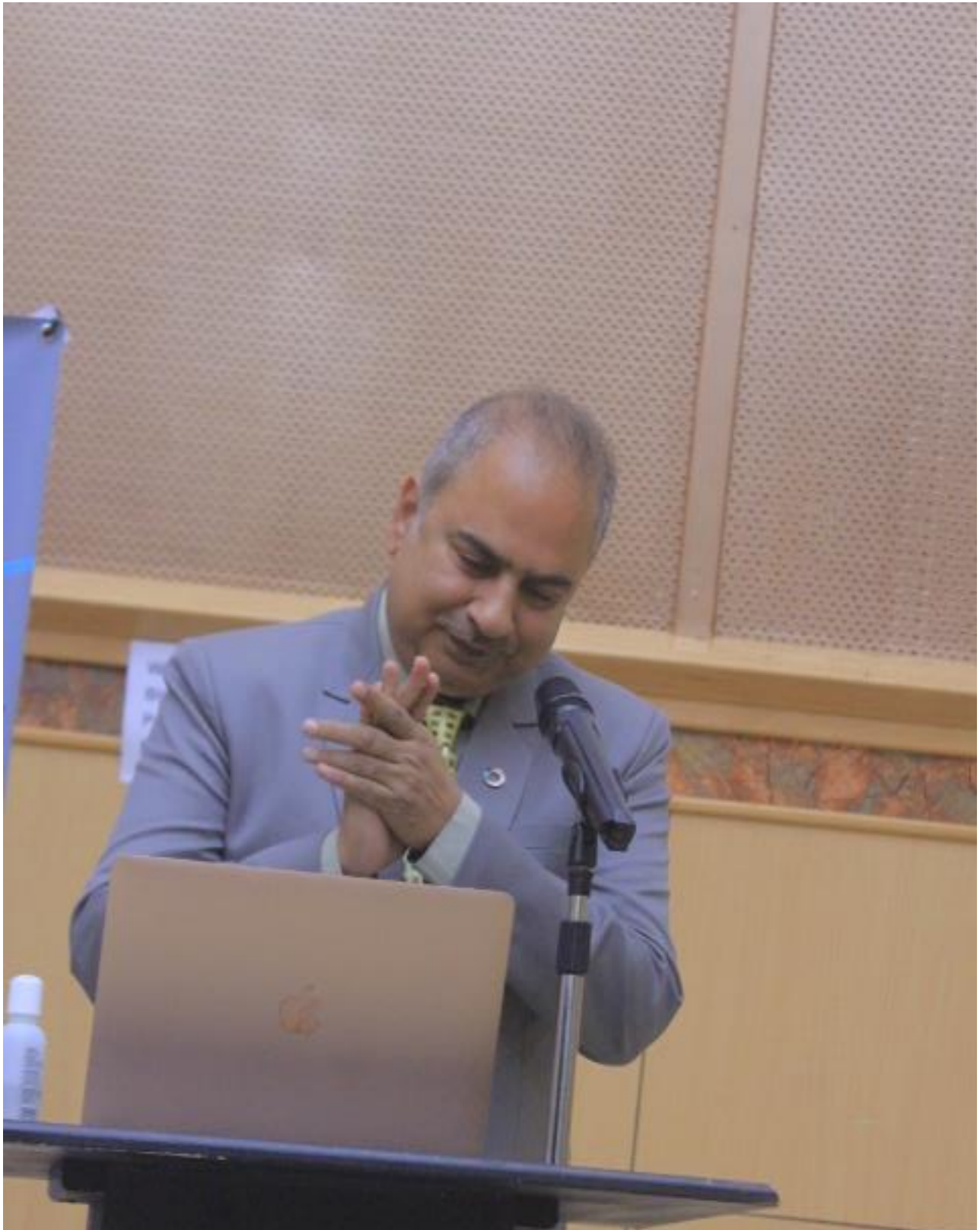

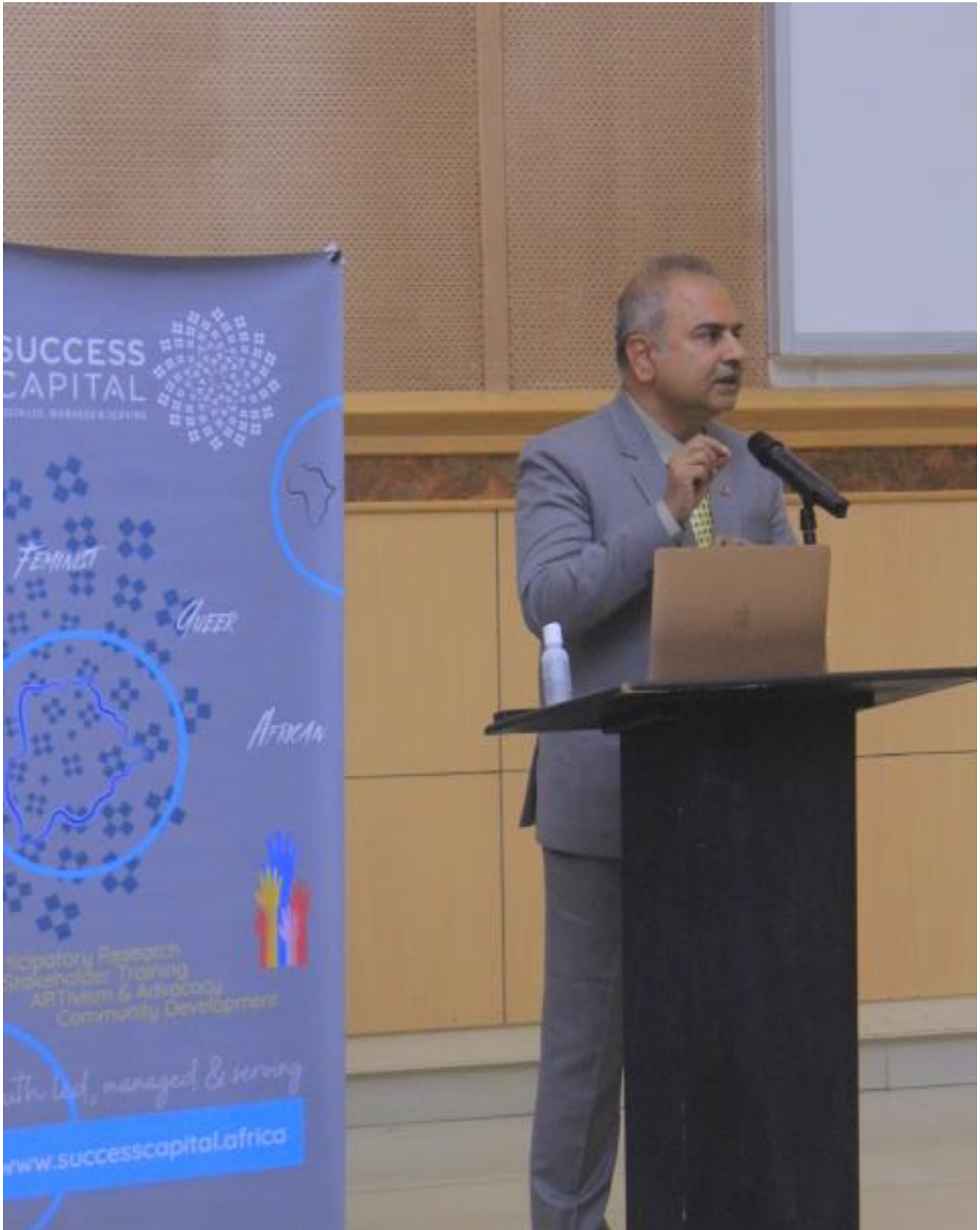
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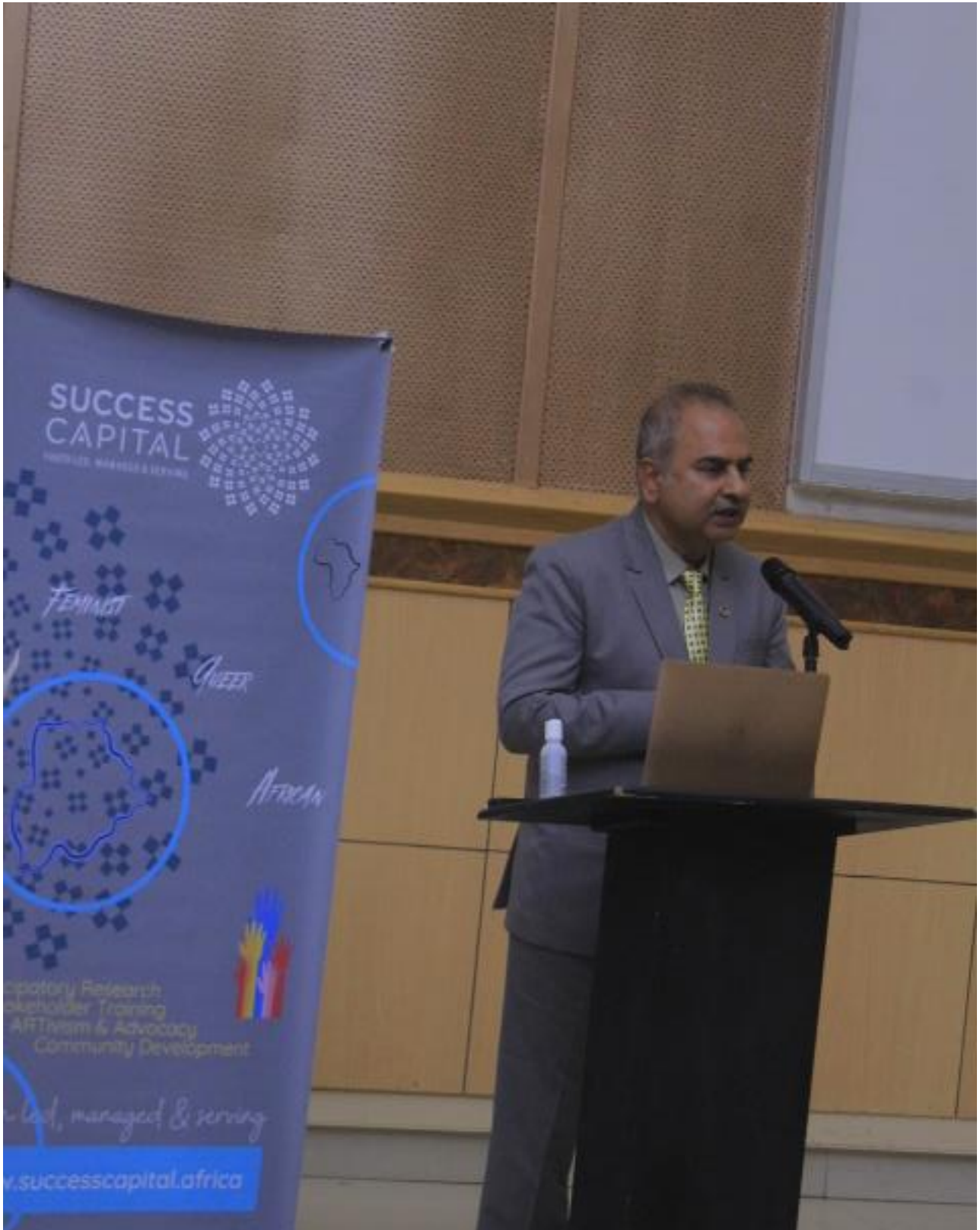
FEMINIST
QUEER
AFRICAN
www.successcapital.africa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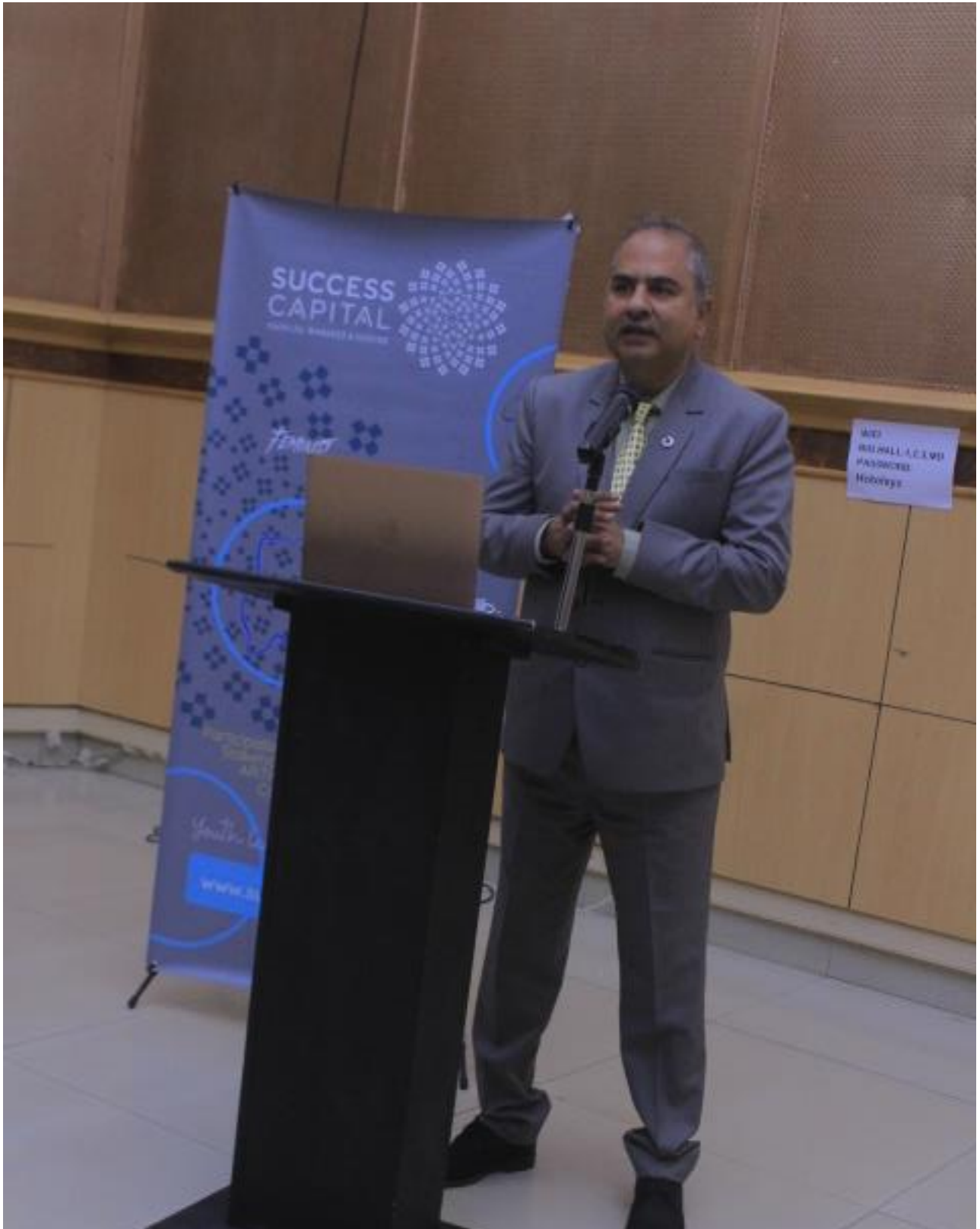
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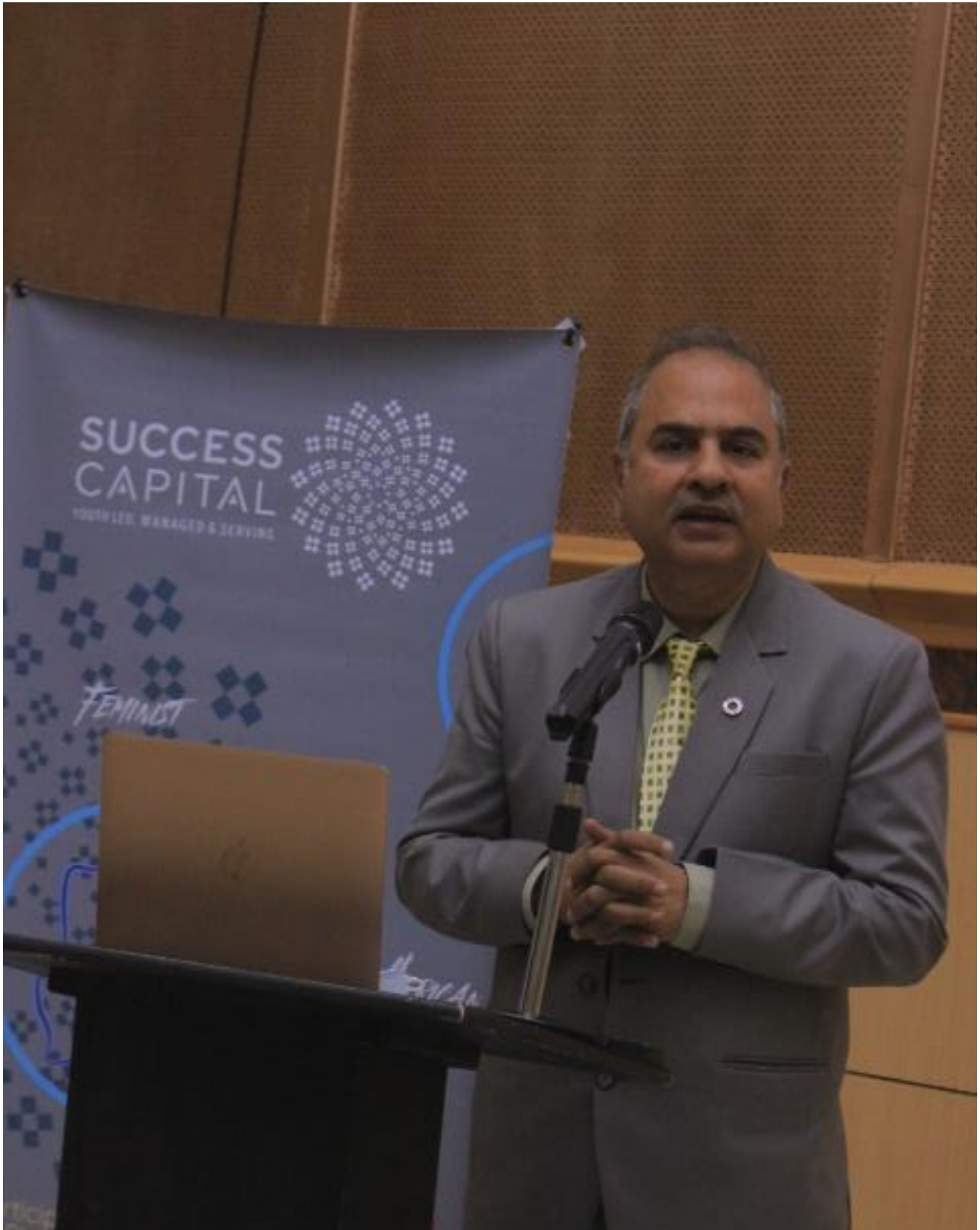
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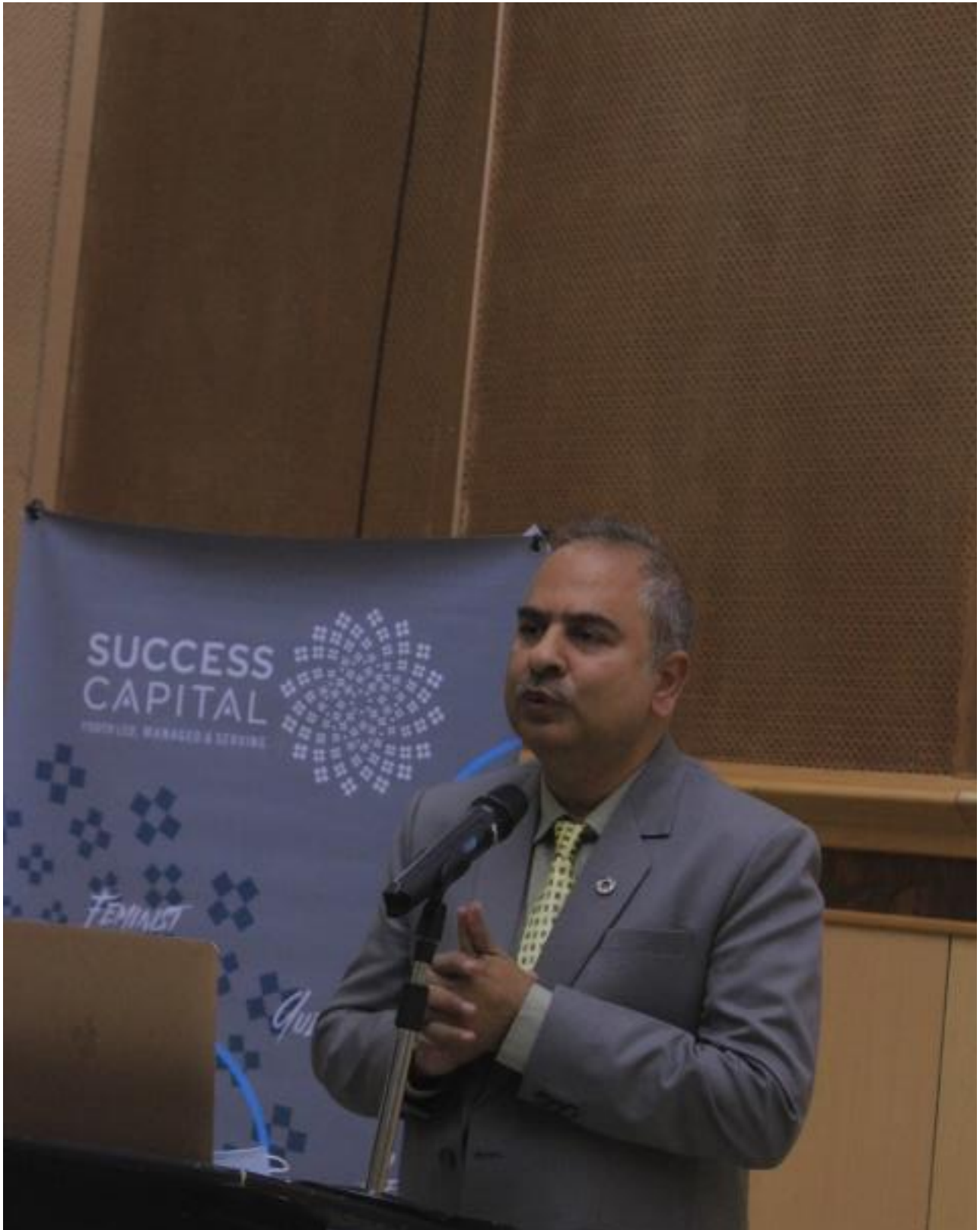
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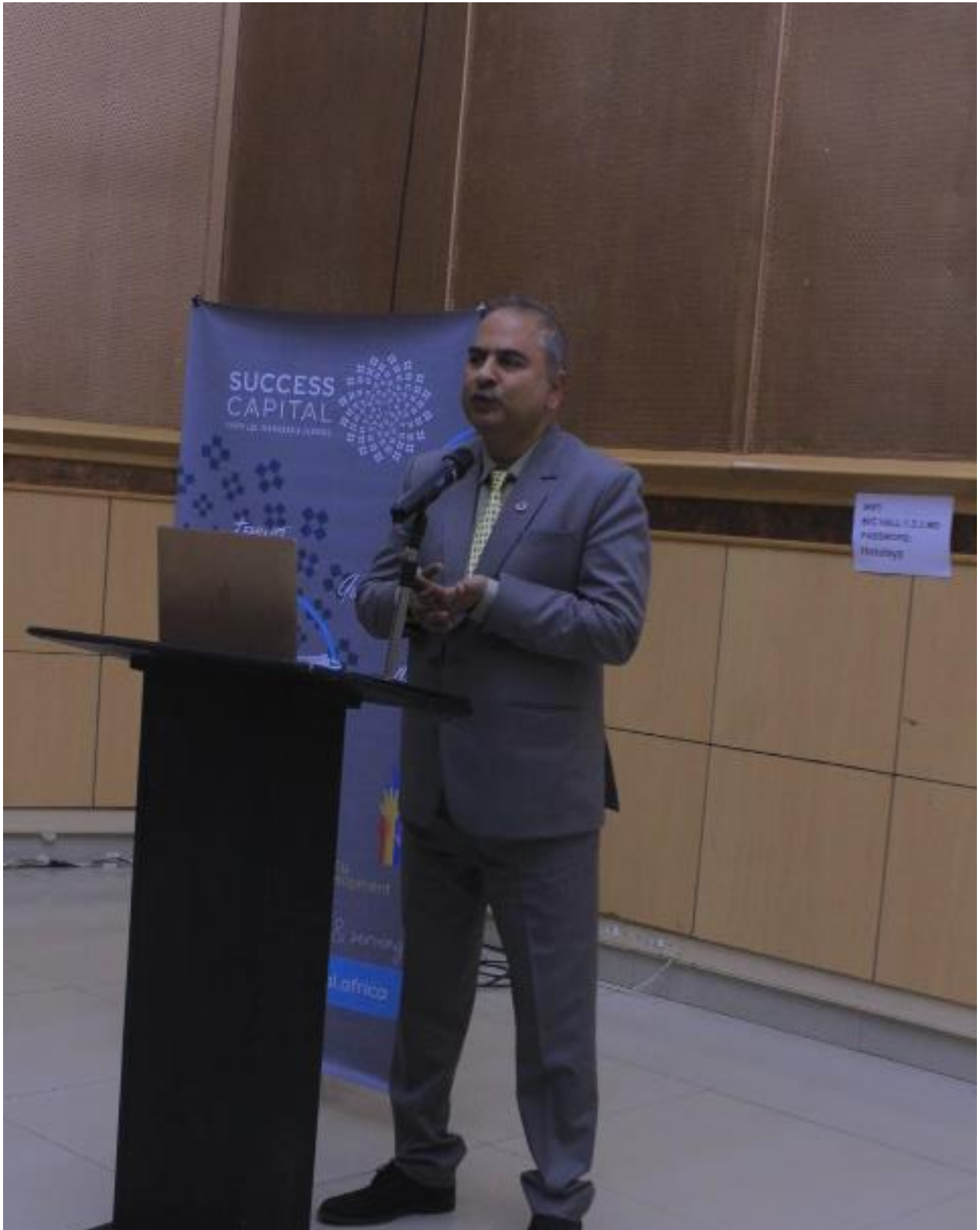
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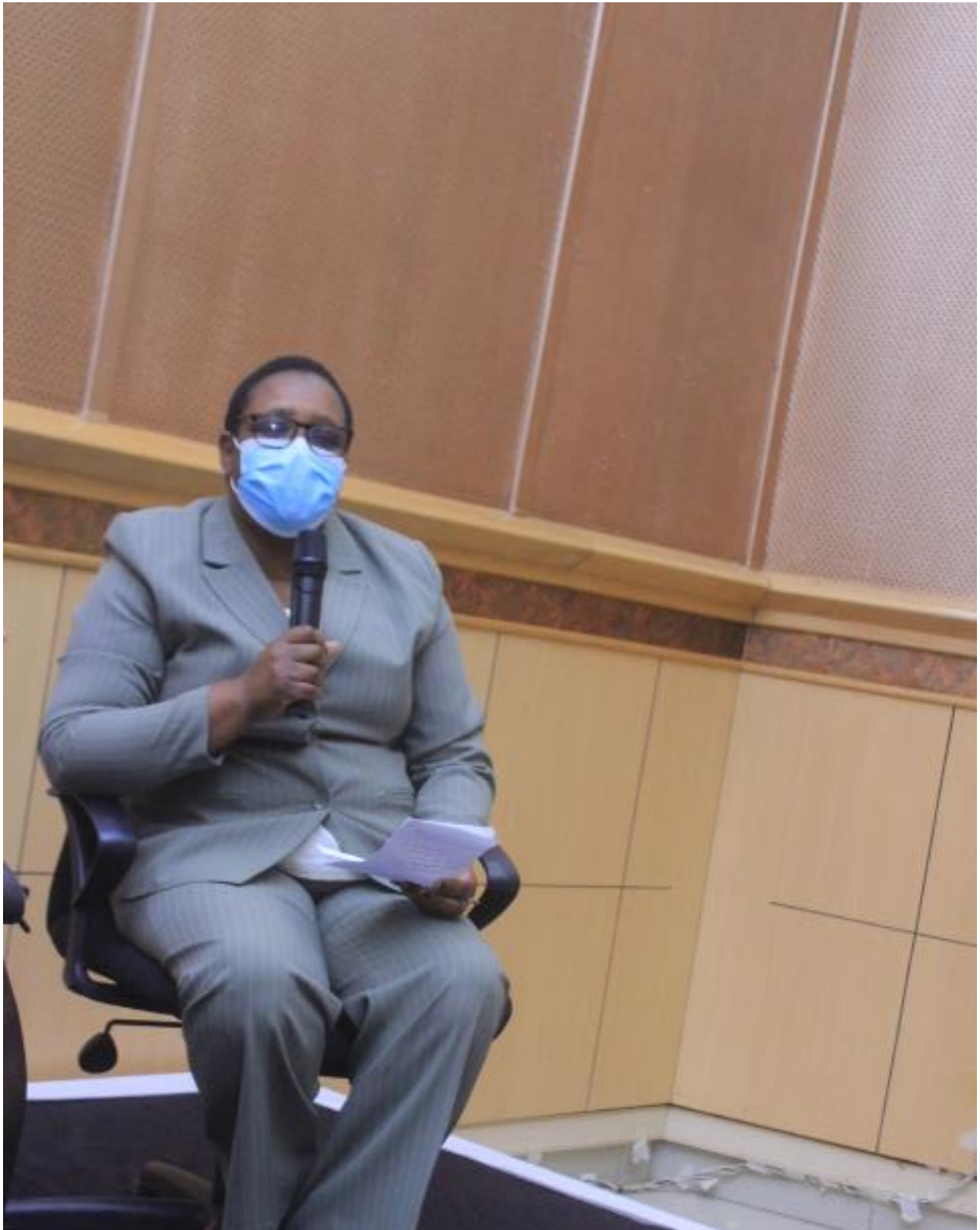

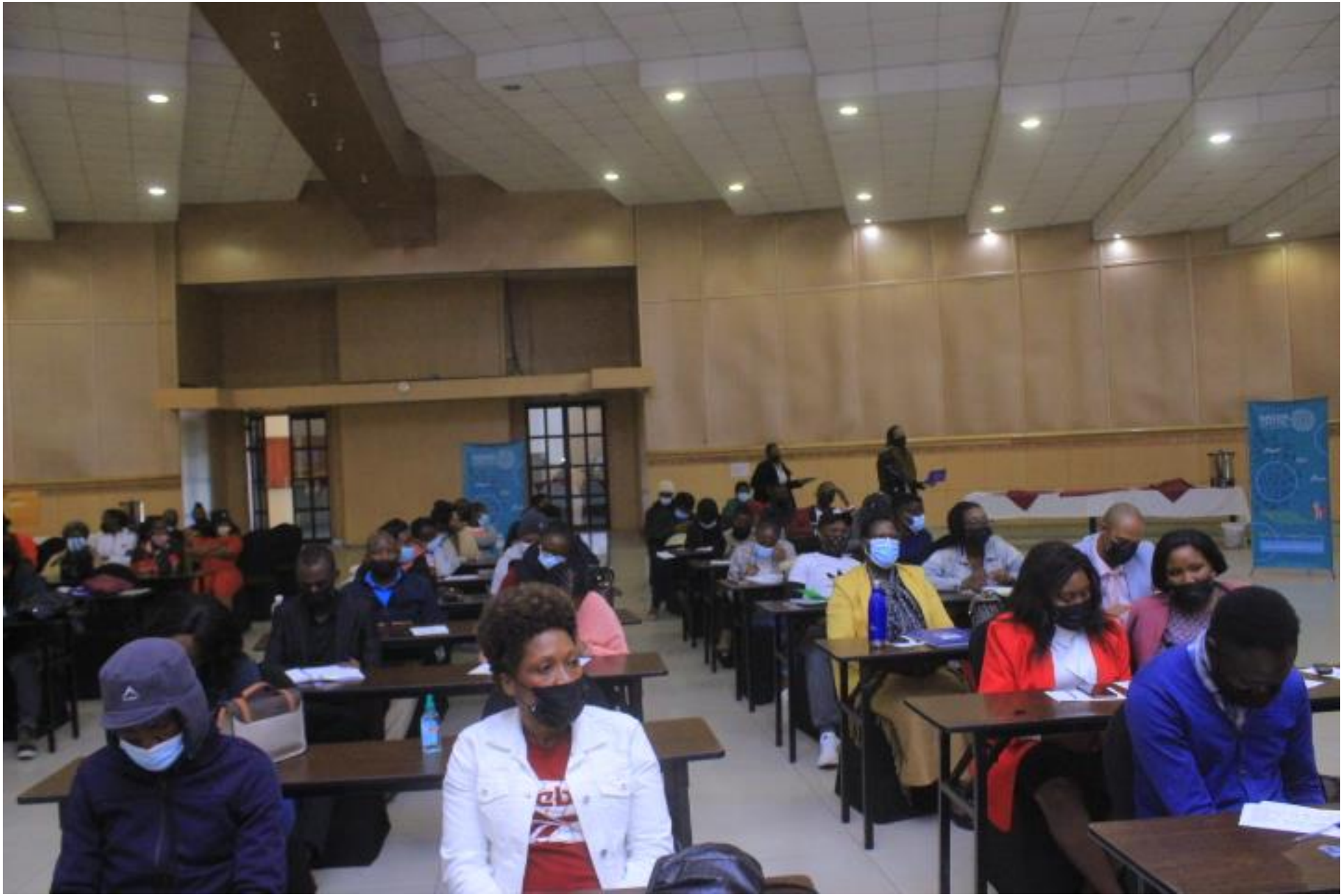

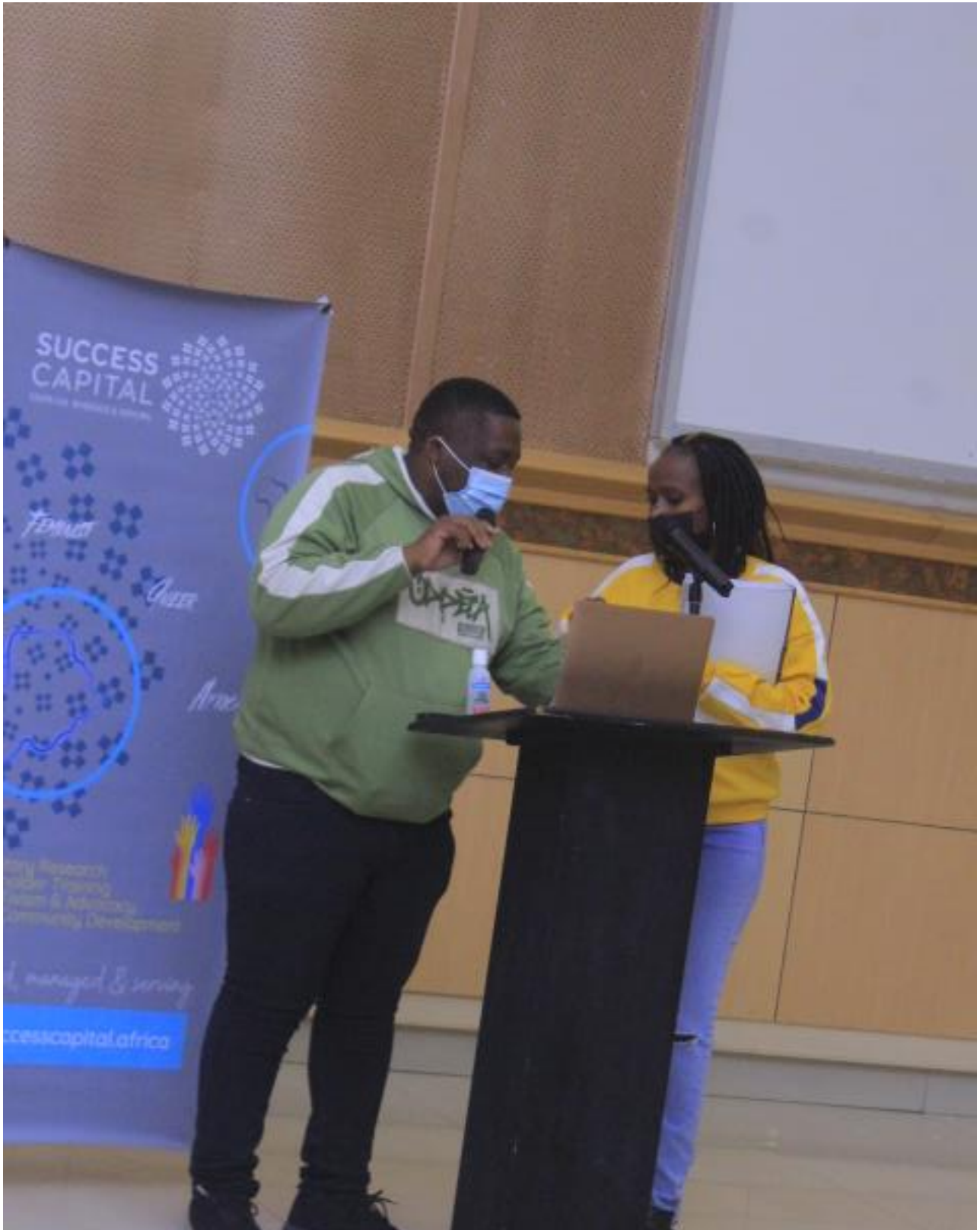
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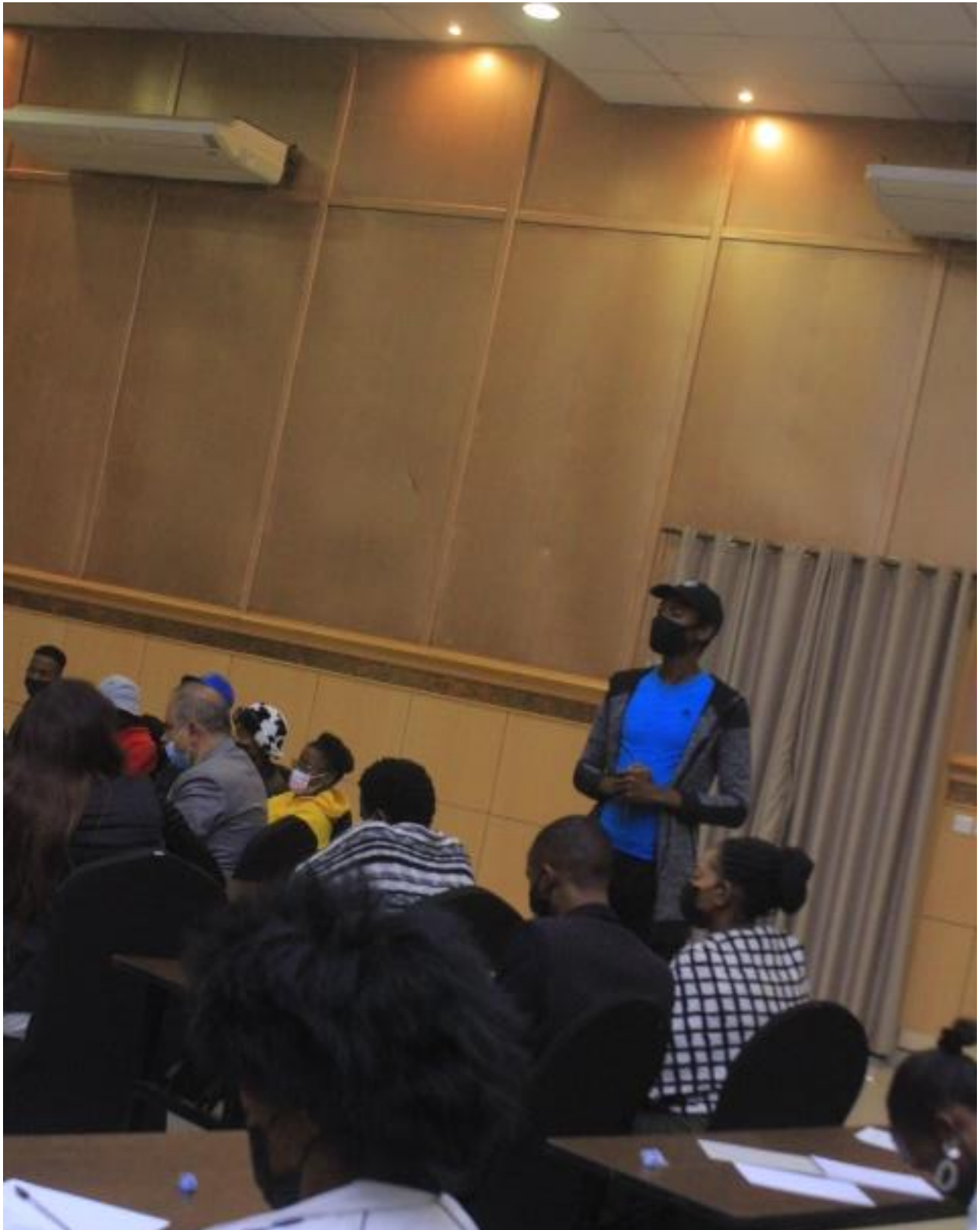

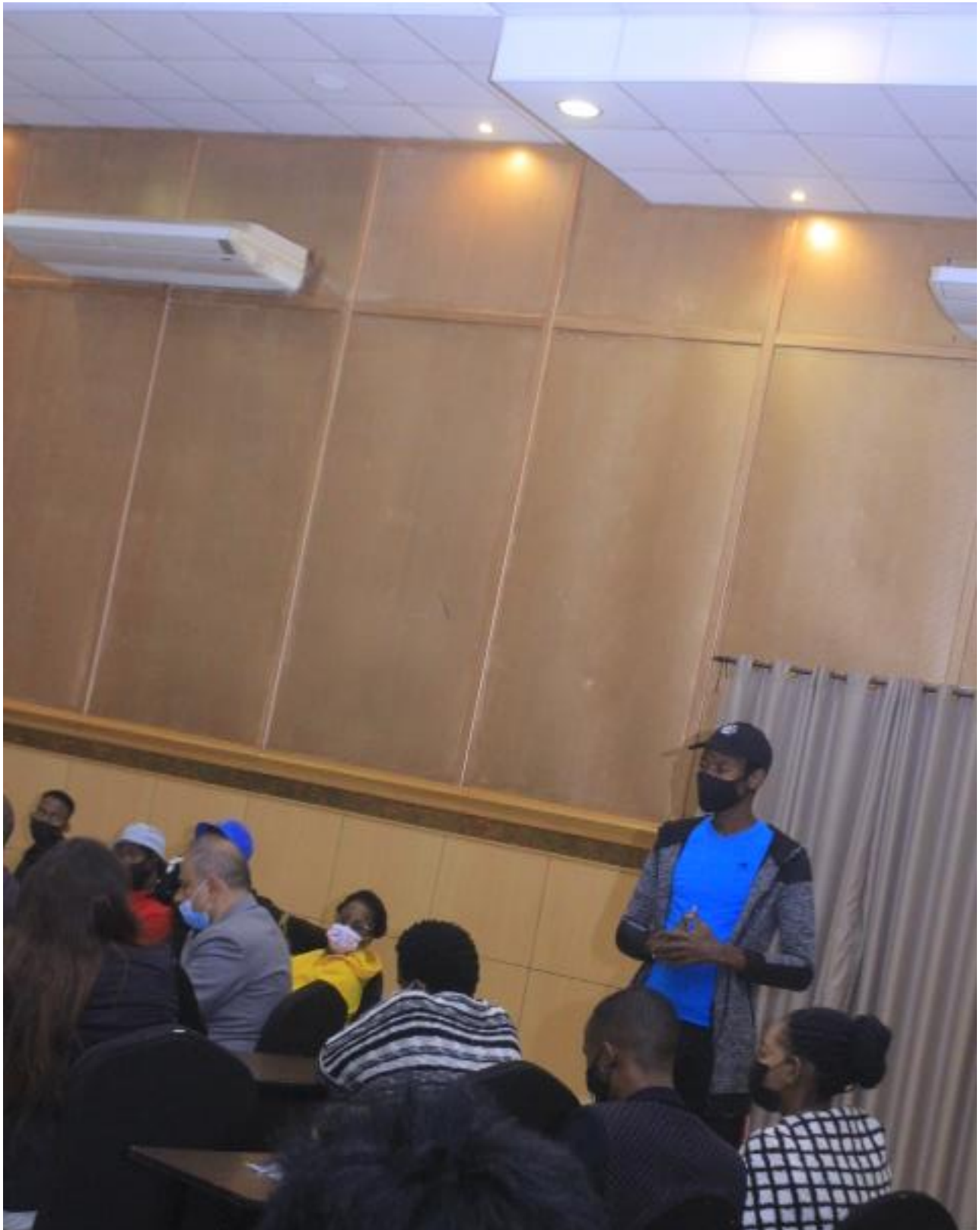

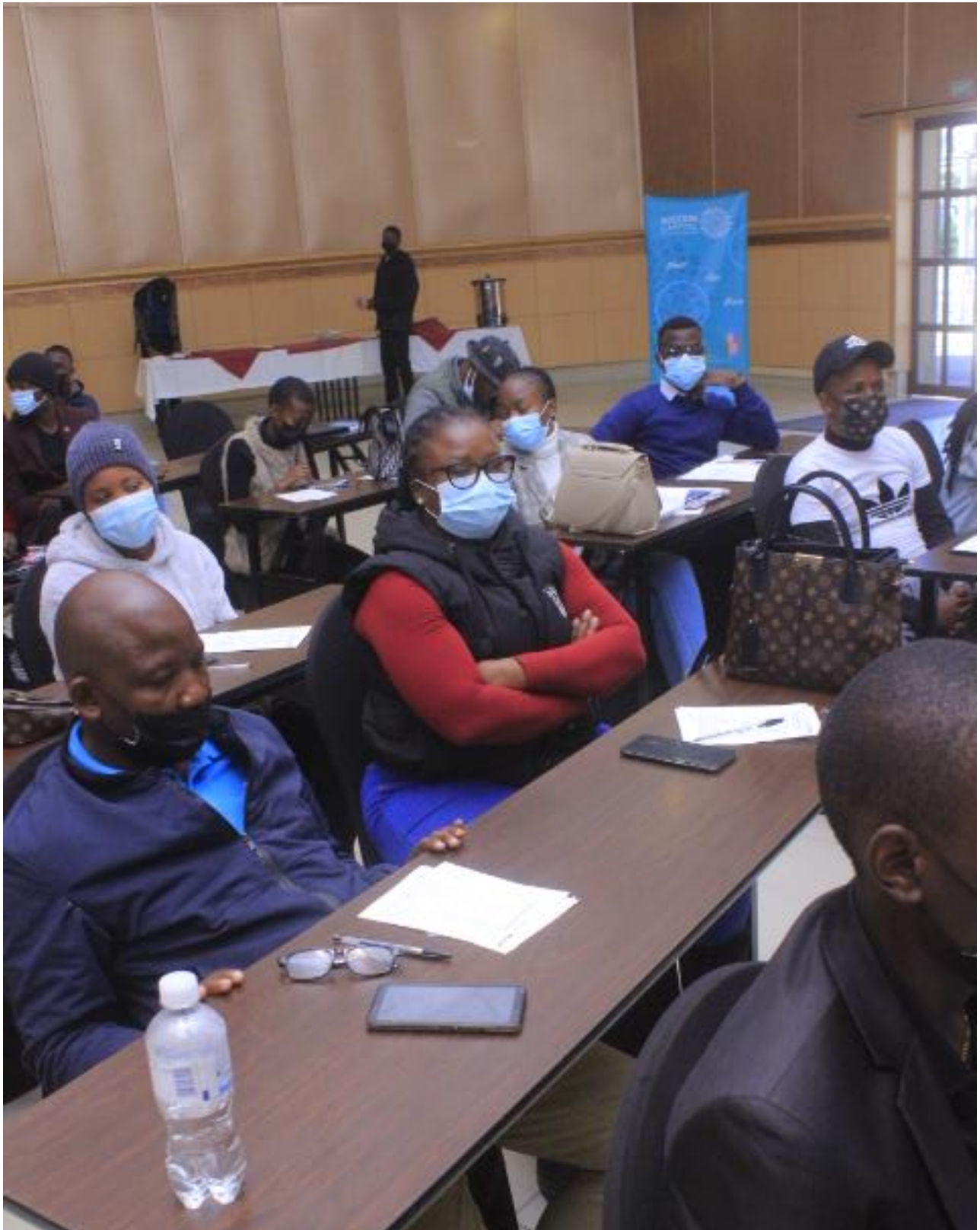

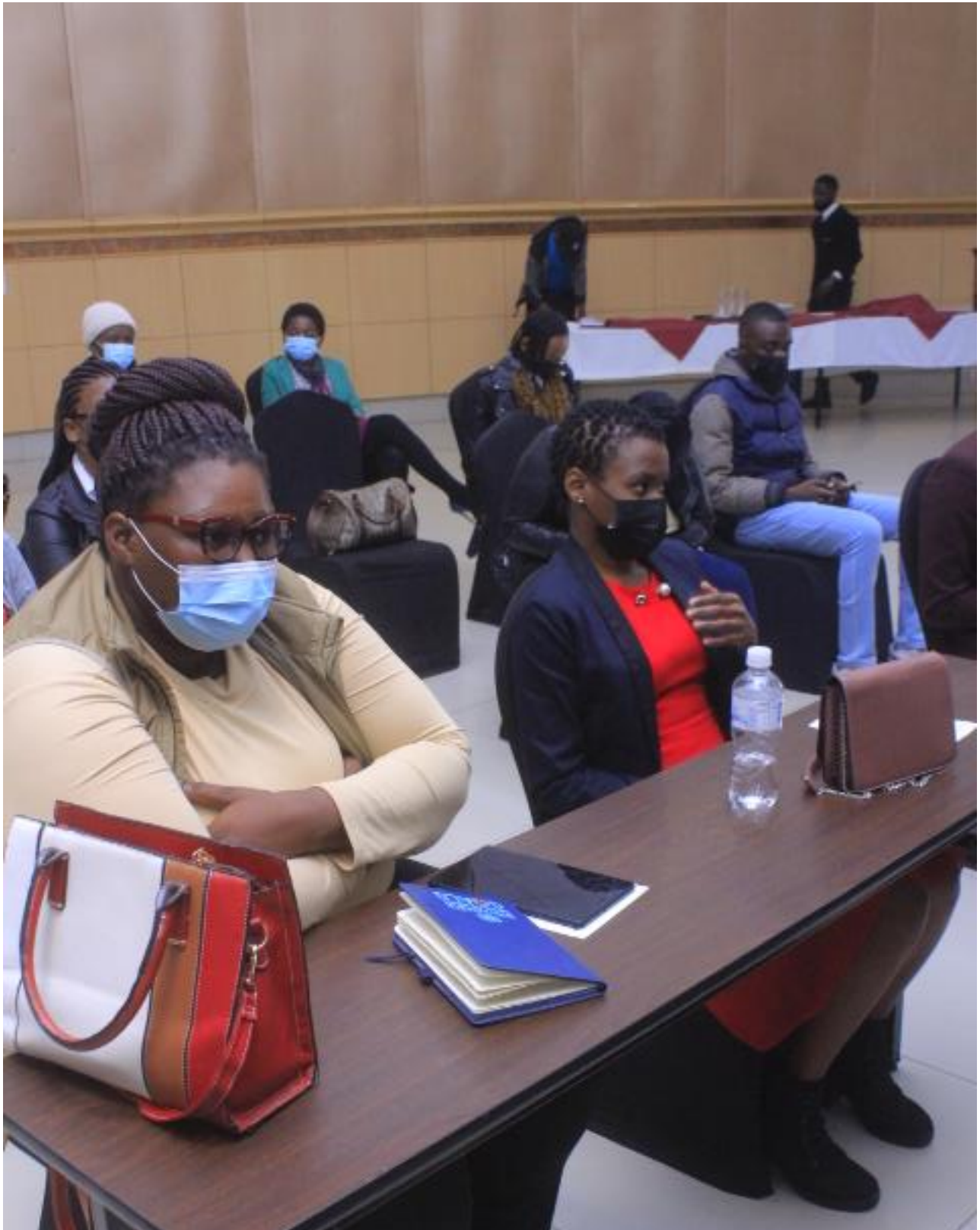

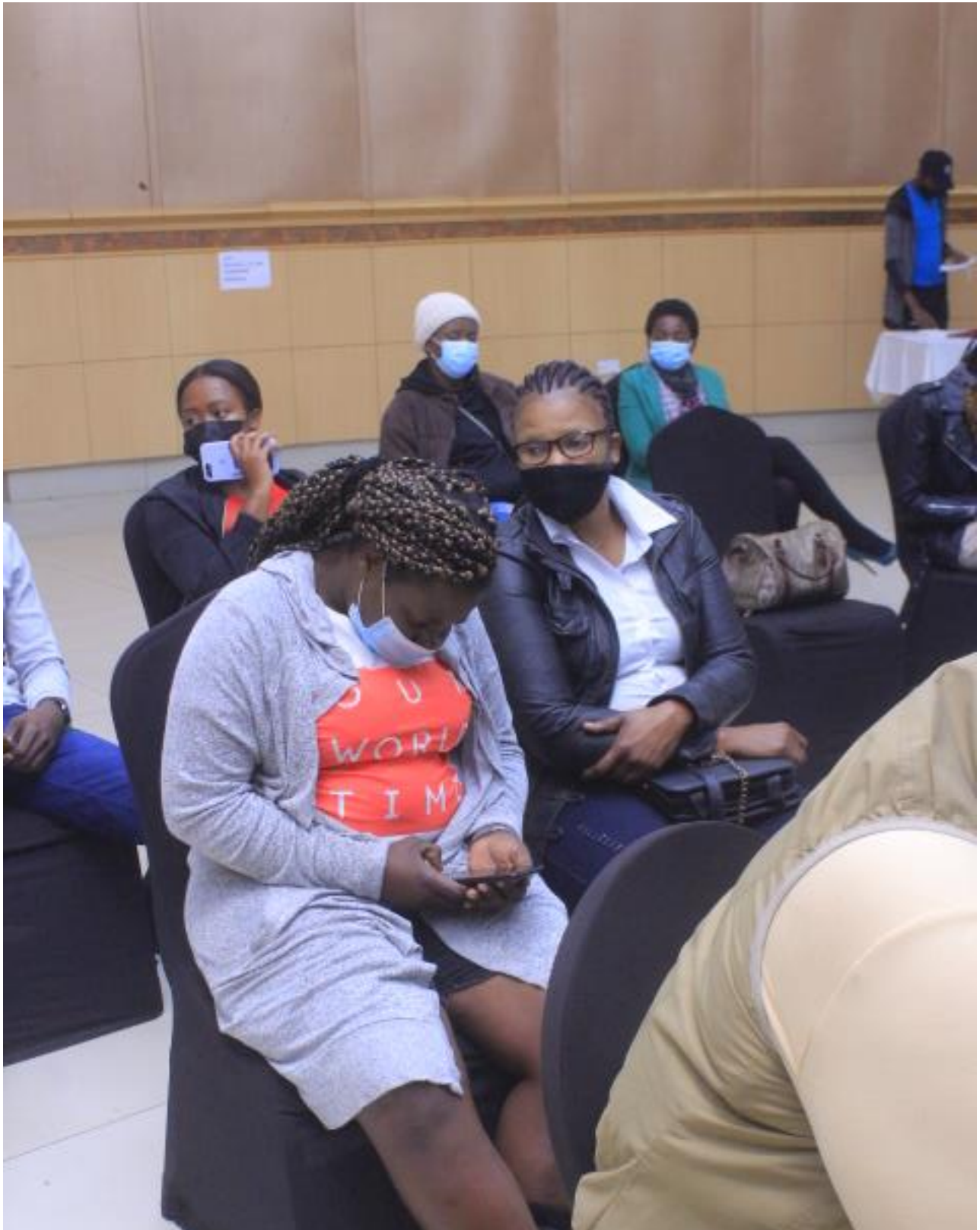

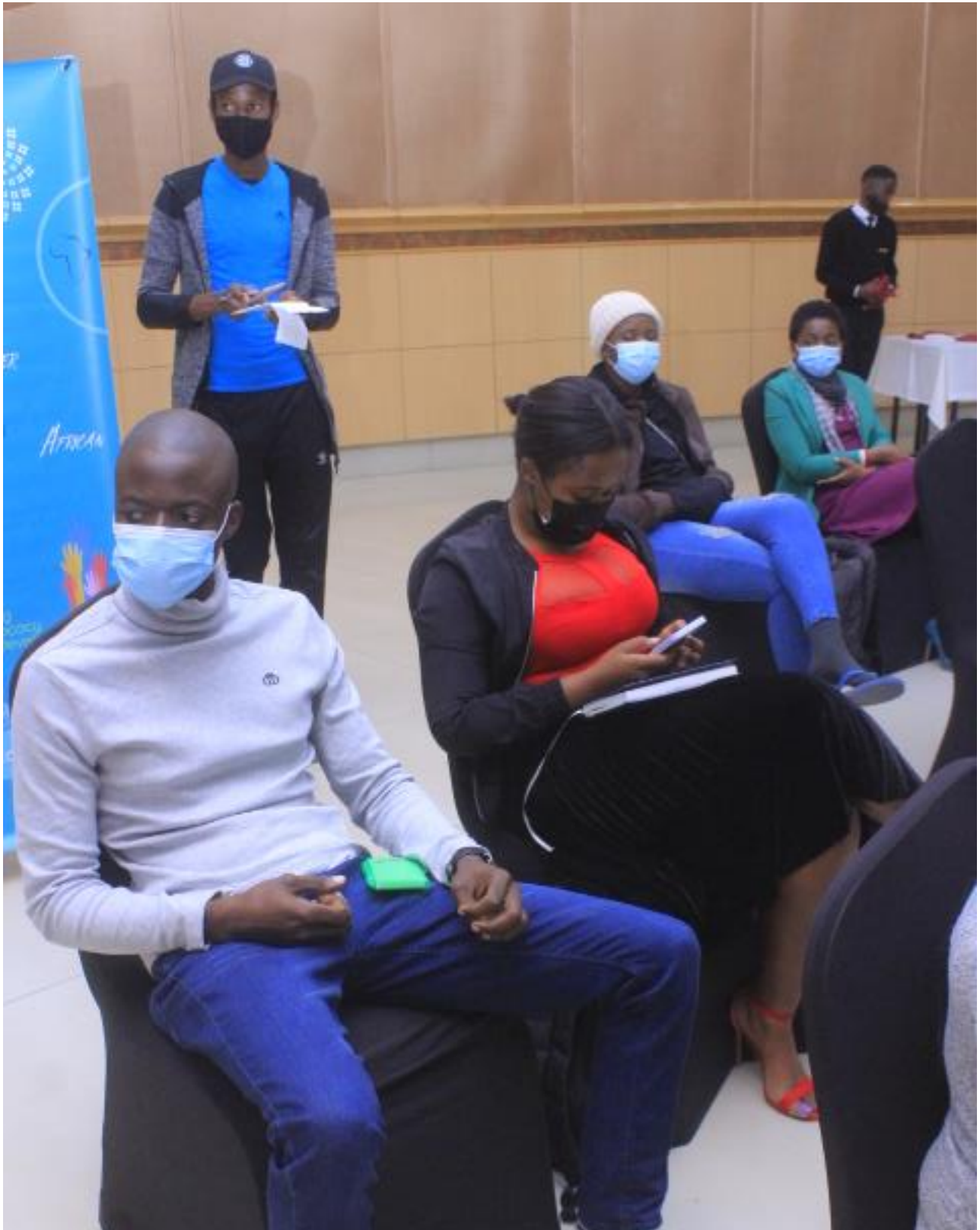

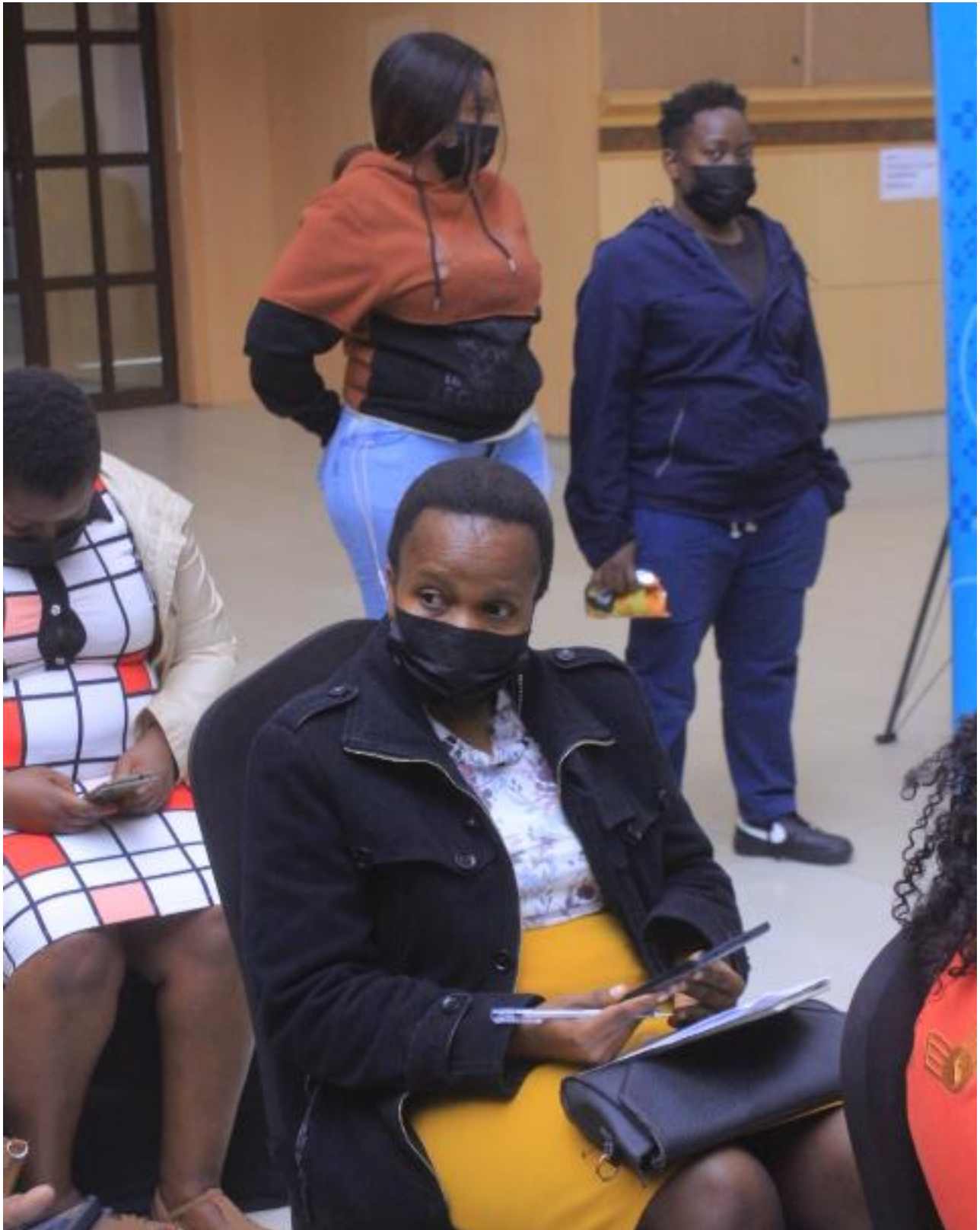

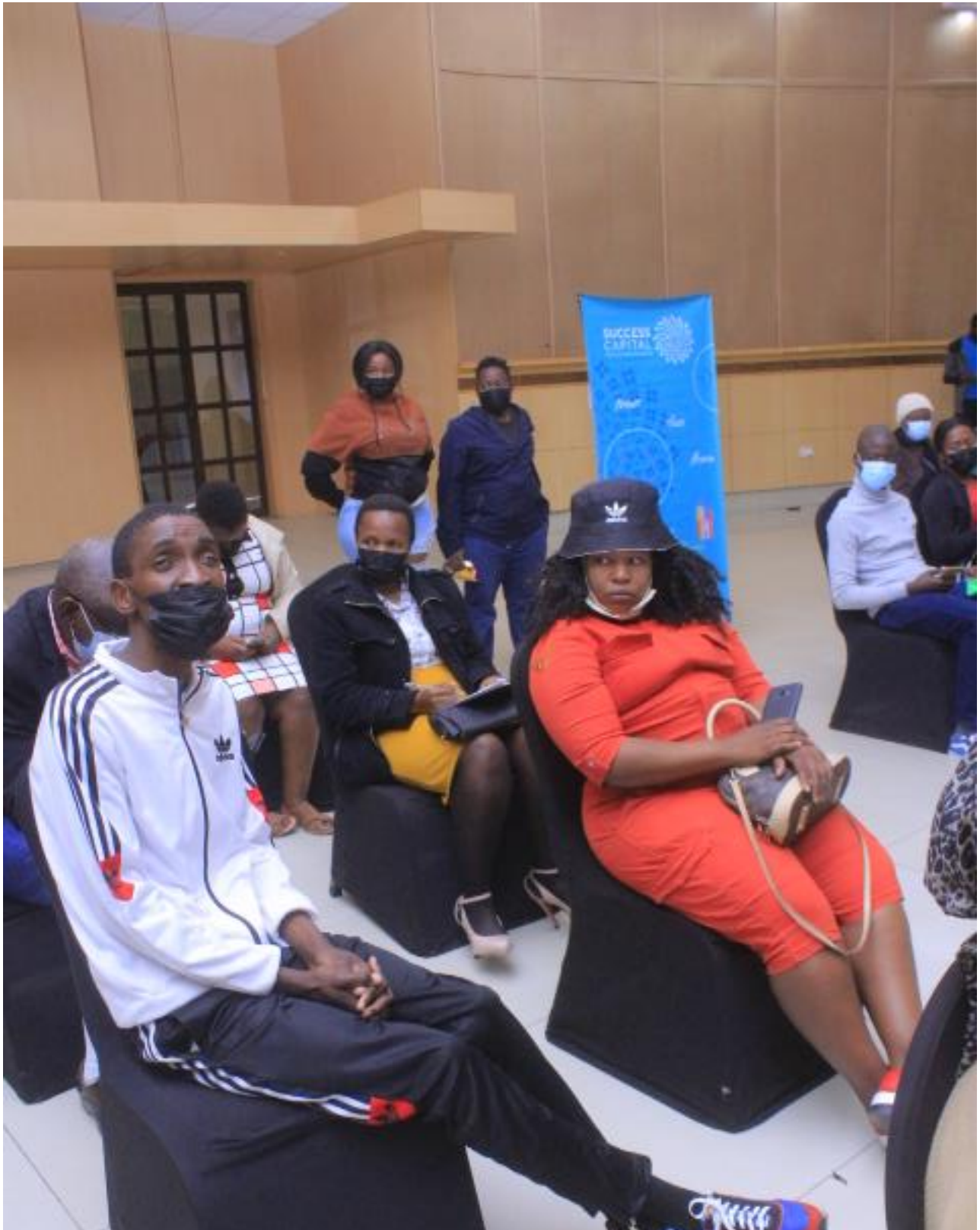

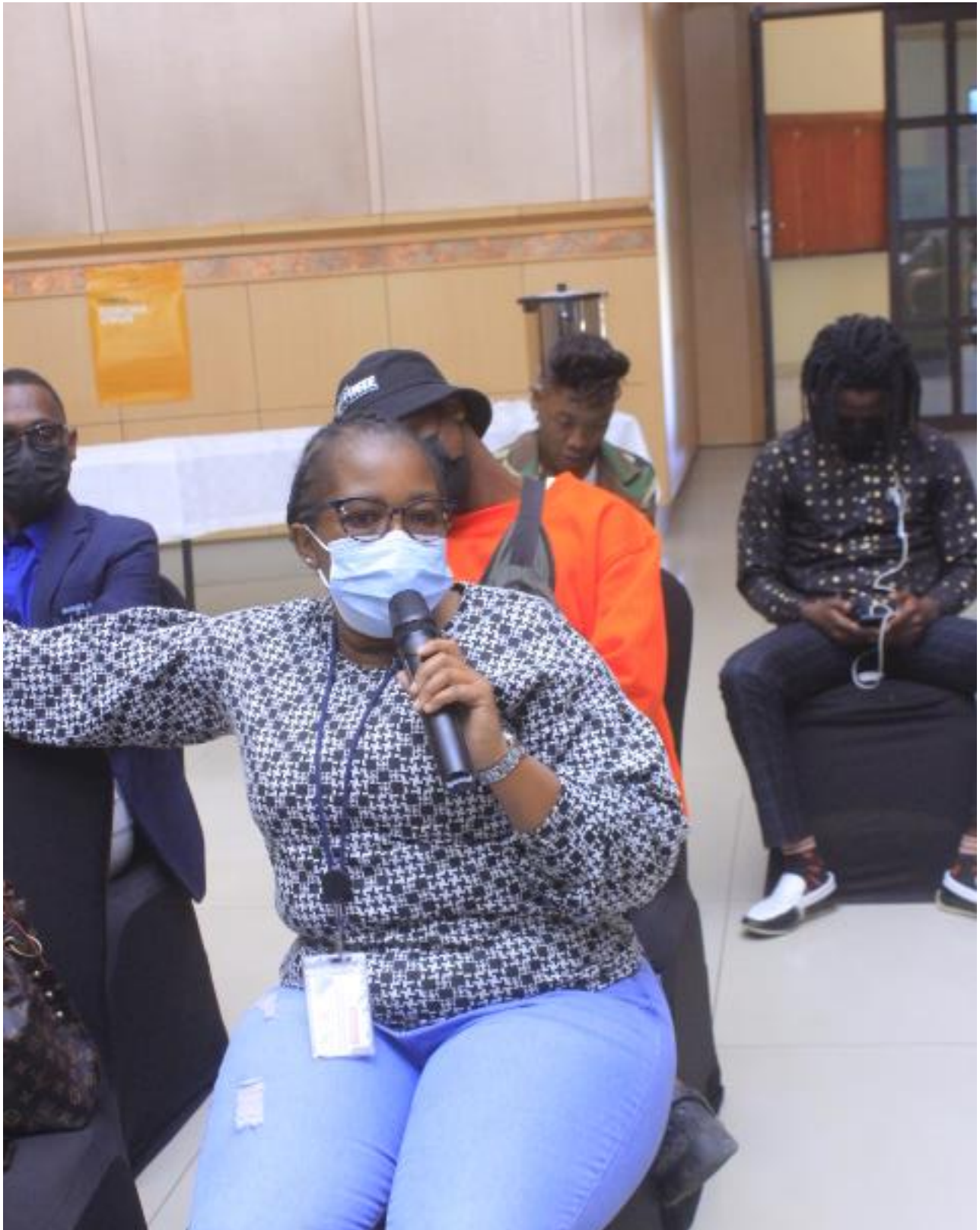

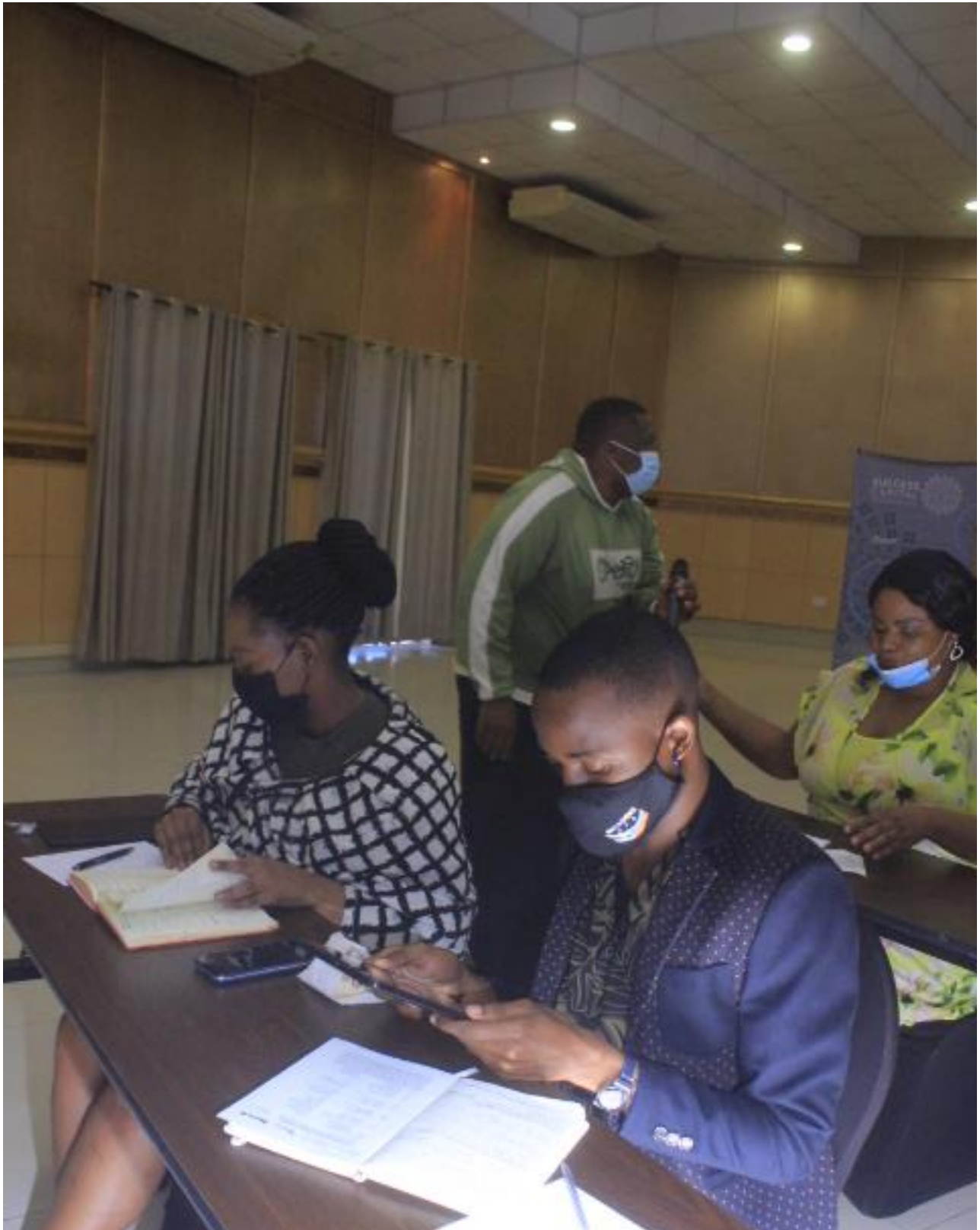

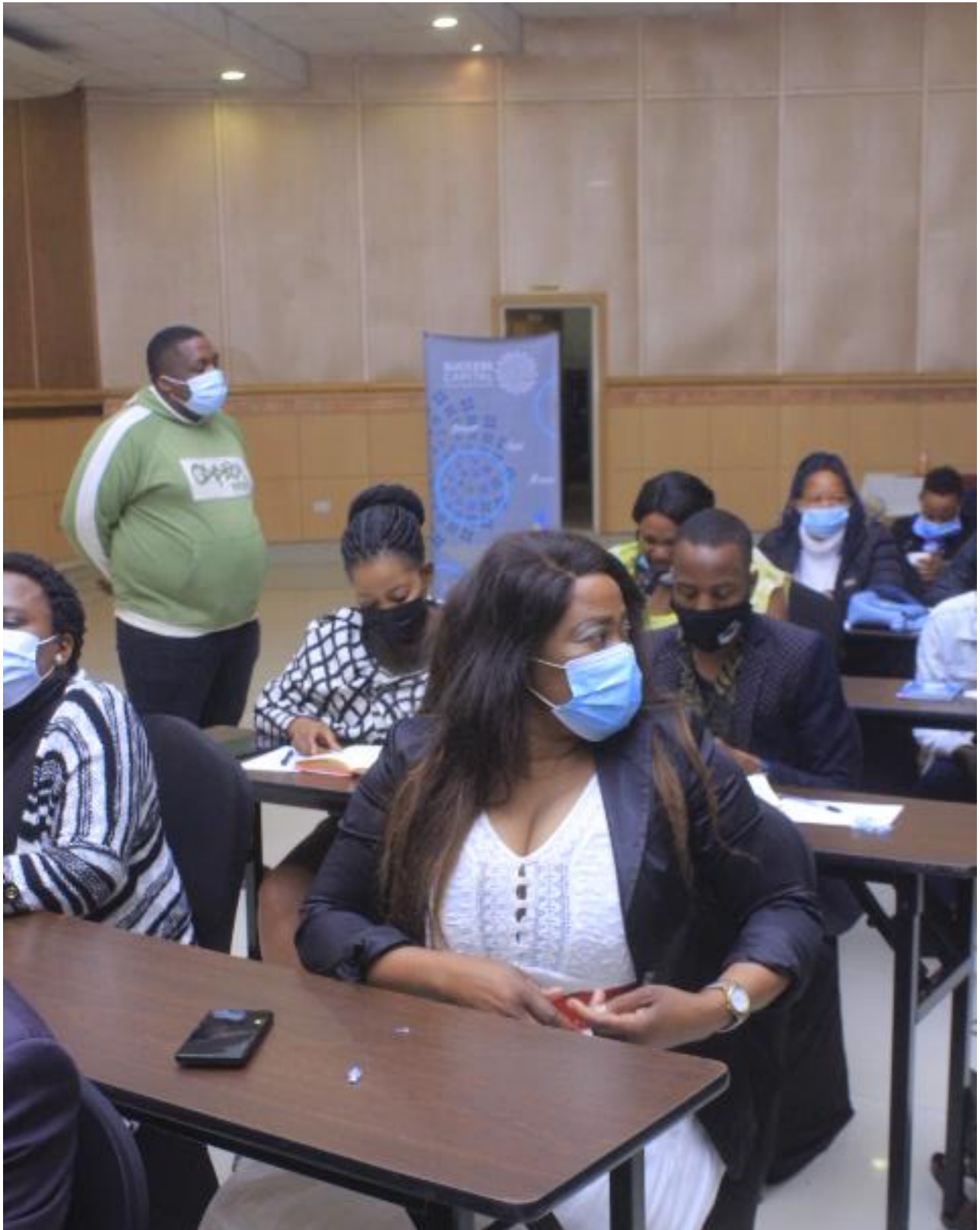

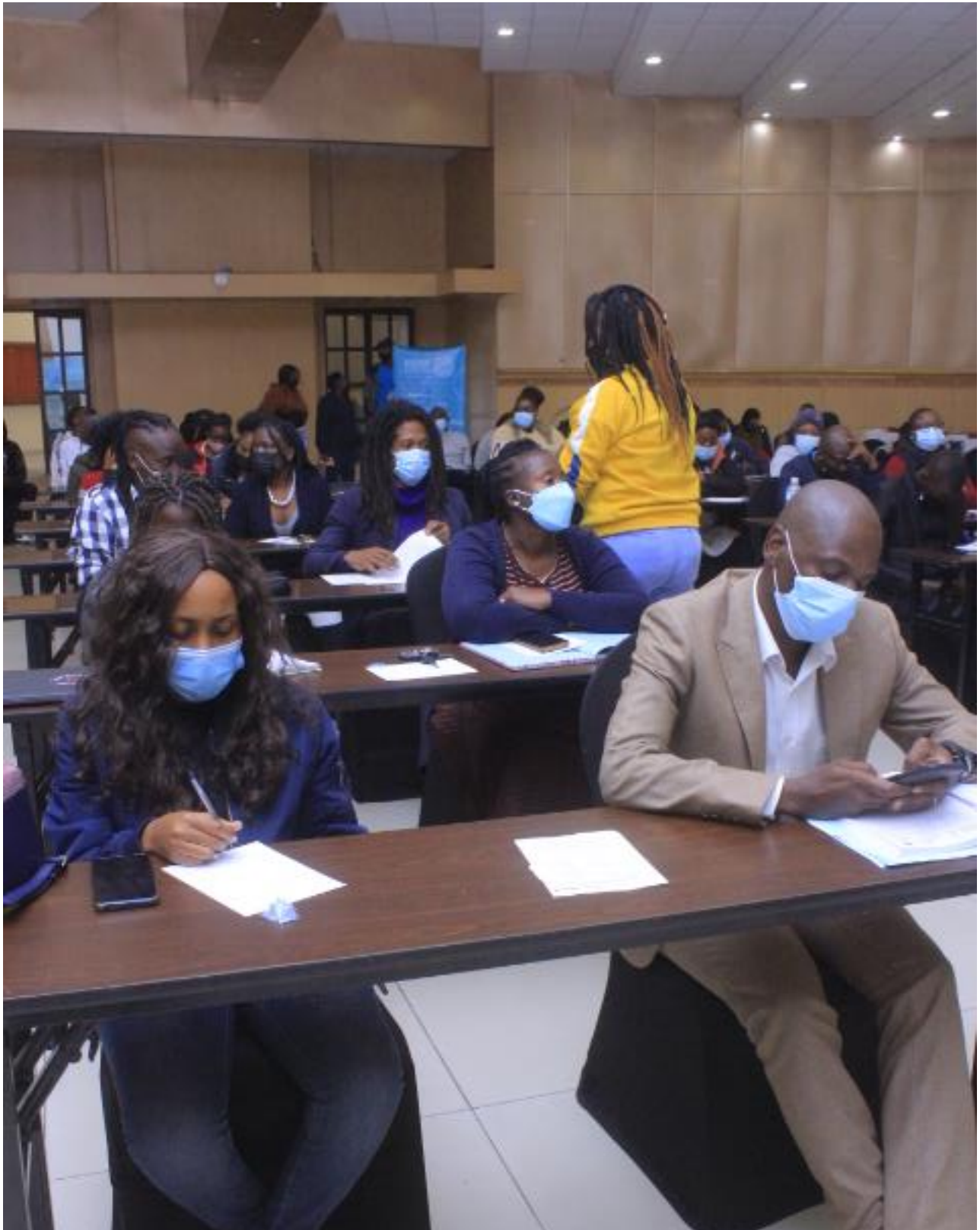

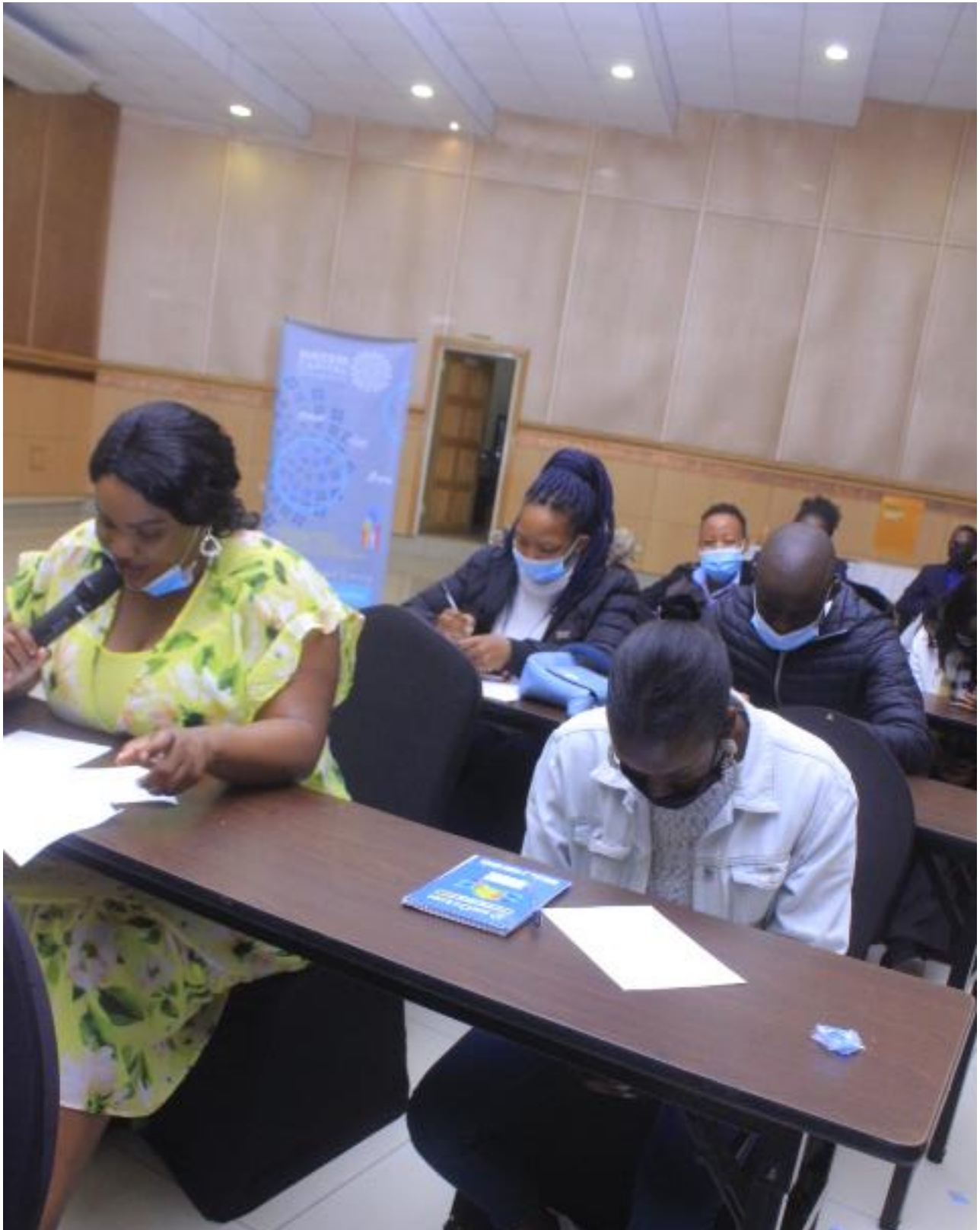

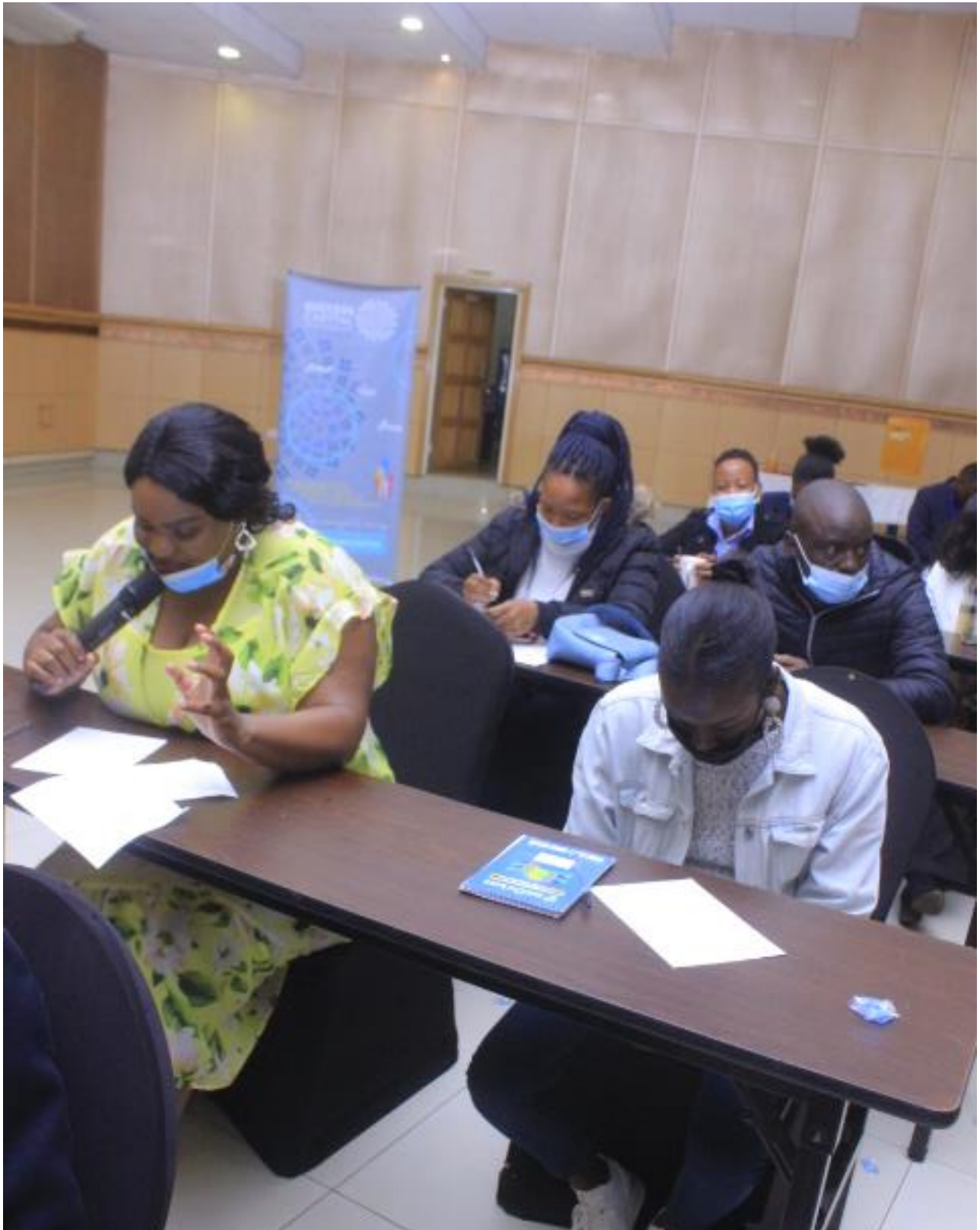


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