Investment Case Towards Ending Unmet Need for Family Planning

BOTSWANA
SYNTHESIS REPORT
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1. COUNTRY CONTEXT

Botswana is an upper-middle-income country with a population of about 2.2 million people. About 34.7 per cent of the total population is under the age of 15 and the percentage of females aged 15-49 years is 50.3 per cent.\(^1\) Over the past 50 years, the country has experienced a notable demographic transition.\(^2\) Total fertility rate has declined from 6.6 children per woman in 1960 to 3.1 children per woman in 2017. Under-five mortality has been reduced from 152 deaths to 48 deaths per 1,000 live births, while maternal mortality ratio has decreased from 151.6 deaths to 133.7 deaths per 100,000 live births over the same period.

Health services are provided through an extensive network of health-care facilities comprised of mobile health posts, health posts, clinics and hospitals, through which a benefit package of integrated services is delivered in line with the national policy. The least available sexual and reproductive health and rights (SRHR) services are related to post-abortion care and

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management of gender-based violence (GBV). These services are offered at about 42 per cent and 22 per cent of facilities, respectively.

Access to contraceptives in Botswana is high at 95 per cent of the population, which is enabled by the location of health-care facilities providing these services within an 8.0 km radius. Over half of the women surveyed in 2017 through the Botswana Demographic Survey (BDS) reported using male condoms (64.2 per cent), followed by injections (17 per cent), pills (12.6 per cent), intra-uterine device (IUD) 1.4 per cent, and female sterilization and Norplant at 1 per cent each (Statistics Botswana, 2018). Contraceptive prevalence rate (CPR) among married/in union women aged 15-49 is estimated at 67.4 per cent in 2017. Despite these encouraging statistics, the unmet need for family planning among the poor, least educated as well as among rural dwellers remains high, when compared to the rich, educated and urban dwellers. About 10.2 per cent of women with primary education use contraceptive methods compared to 89.5 per cent of women with secondary education. Similarly, 45.8 per cent of women residing in urban areas use contraceptive methods as opposed to 28.8 per cent of women in rural villages. Although knowledge of family planning is estimated at 98 per cent, there is only a limited range of contraceptive method mix in use. This is partly a result of weak commodity supply management and distribution, shortage of trained health workforce with skills to offer the method mix, as well as inadequate supervision and monitoring of integrated services for SRH and sexually transmitted infections (STI).

The family planning programme in Botswana has contributed to improved health outcomes and development over the years. This however, is not without some challenges. One of the main limitations to scaling up effective coverage of family planning services is the limited availability of disaggregated data on key SRHR indicators to guide targeted interventions. Botswana relies mainly on programmatic data for tracking progress of the family planning programme. Unlike in other countries where a comprehensive demographic and health survey is conducted every 5 years, in Botswana, survey data on SRH and family planning is collected once in 10 years. The 2017 BDS is the latest survey, which covered some aspects of family planning. It is worth noting that the survey did not comprehensively cover access to family planning and the full complement of method mix, thereby missing out key indicators required to guide planning and implementation of a robust family planning programme. Some of the key indicators not captured during the 2017 BDS are: adolescent birth rate (ABR), proportion of women aged 15-49 who are married or in a union who make their own decisions on sexual relations, and use of contraceptive and health-care. These are important data points that can help inform policy formulation and implementation for improved outcomes. This information is also

CONTRACEPTIVE PREVALENCE RATE (CPR) among married in union women aged 15-49 is estimated at 67.4% in 2017. The unmet need for family planning among the poor and least educated, as well as among rural dwellers, when compared to the wealthier, more educated and urban dwellers remains high. About 10.2% OF WOMEN WITH PRIMARY EDUCATION use contraceptive methods compared to 89.5% OF WOMEN WITH SECONDARY EDUCATION. Similarly, 45.8% of women residing in urban areas use contraceptive methods as opposed to 28.8% of women in rural villages.

critical going forward as half of HIV-infected pregnant women report incidents of unintended pregnancy, with 20.2 per cent seroconverting during pregnancy (Republic of Botswana, n.d).

1.1 Making a case for investing in transformative results

Family planning empowers individuals and couples to space pregnancies towards the desired number of children. Family planning also saves lives, promotes effectiveness of the health system by improving maternal health and child survival, prevents sexual transmission of HIV, and advances gender equality and economic prosperity through women and youth empowerment (Karra & Canning, 2020; World Health Organization, 2018). Starrs et al., (2018) demonstrated return on investment in family planning with improvements in health and well-being, improved prospects of gender equality, increased productivity, reduced poverty, and several multigenerational benefits for children, households and society.

Additionally, family planning increases young women’s years of education and earnings, household savings and assets, and subsequent increase in children’s years of schooling, with contribution to GDP growth. Kohler and Behrman, (2014) showed that for every $1 invested in family planning programmes, $120 is accrued in savings in public healthcare and economic opportunity costs in the long term. Similar investment returns estimates have been made by Starbird et al., (2016) who found that additional investment in family planning services would save developing countries in total over $11 billion each year in maternal and newborn healthcare costs. Among all the 169 SDGs targets, universal access to contraception has been cited to have the second highest return on investment.4

The above-cited studies support strategic investment in family planning as a means towards meeting the aspirations of Botswana to achieve its socioeconomic development goals such as reducing poverty and inequality, attaining universal health coverage (UHC) and financial risk protection for vulnerable population groups as well as achieving prosperity for all as a high-income country by 2036. This investment case defines the scale and scope of investments needed to provide family planning services in the country. It also provides information on high impact and cost-effective interventions required to accelerate progress towards ending unmet need for family planning in Botswana by 2030.

1.2 Priority health interventions

As the use of modern methods of family planning is anticipated to increase over time, it is also envisaged that the use of traditional methods would be decreasing. Currently, the prevalence of the withdrawal method is estimated at 0.5 per cent while the prevalence rates of prolonged abstinence, periodic abstinence and other traditional family planning methods are currently estimated at 0.5 per cent, 0.2 per cent and 0.3 per cent, respectively. By 2030, it is expected that the use of these methods would be reduced to ZERO PER CENT.

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The prevalence of female condom use is expected to increase from 1.1 per cent in 2020 to 1.9 in 2030, while the use of male condoms is estimated to increase from the current prevalence of 64.2 per cent to 64.6 per cent by 2030. Current efforts are underway to reposition male and female condom programming to increase community distribution. This intervention is expected to increase the community distribution points for family planning methods, which would ensure an increase in the use of female and male condoms by 2030.

Unmet need for family planning among all women in Botswana was estimated at 17.3 per cent in 2020 (United Nations, 2013). By consensus between the national Thematic Working Group (TWG) and Ministry of Health and Wellness (MoHW), the mid-term target to reduce unmet need for family planning (FP) was set from 17.3 per cent to 14 per cent by 2025 and the (longer-term) target was set at 8 per cent or below by 2030.

1.3 Scale of effective coverage of priority interventions

Different effective coverage scenarios of the priority interventions were developed in consultation with the Government and partners. The baseline was set at 2020 with projections for all scenarios into the SDG target year of 2030, with 2021 as the first year of impact. The “status quo” scenario assumes that the contraceptive prevalence rate (CPR) of 67.4 per cent will prevail over time and does not change. The scenarios show how scaling up the contraceptive prevalence rate (and modern CPR) will impact on unmet need for FP, unintended pregnancies, maternal deaths and unsafe abortions averted over time. The second scenario assumes that the current CPR of 67.4 per cent in the base year increases over time to reach a target of 75 per cent in 2030 – Botswana’s target for SDG 3 Target 3.7 for all countries. The third scenario assumes that current CPR increases over time to reach 80 per cent by 2030. The fourth scenario is an ambitious scenario that assumes contraceptive prevalence will reach 90 per cent by 2030.

1.4 Cost and impact of meeting the transformative results

The impact of increasing modern contraceptive rates (mCPR) across the different scenarios was estimated. The findings from the estimates show the significant impact of increasing mCPR and addressing unmet need for family planning in terms of reductions in unintended pregnancies, maternal deaths and unsafe abortions, as follows:

- An increase in mCPR from 64.52 per cent at baseline to 86.15 per cent by 2030 with a view to ending unmet need for family planning will increase the scale of impact on averting unintended pregnancies. In total 665,775 unintended pregnancies would be averted between 2020 and 2030 if mCPR of 64.52 per cent (baseline or status quo with a CPR of 67.4 per cent) is maintained. Scenario 2 (scaling up interventions to increase CPR to 75 per cent and mCPR to 72 per cent by 2030) would avert 703,992 unintended pregnancies by 2030. In scenario 3 (with a CPR of 80 per cent and mCPR of 76.58 per cent by 2030), the number of unintended pregnancies averted would increase to 729,173. This would increase to 779,482 under scenario 4 (with a CPR of 90 per cent and mCPR of 86 per cent by 2030).
• Likewise, increasing the CPR and mCPR will amplify the potential to avert unsafe abortions between 2020 and 2030. The number of unsafe abortions averted would increase from 139,014 (baseline or status quo scenario) to 146,994 under scenario 2; 152,251 under scenario 3; and 162,756 under scenario 4.

• The cumulative number of maternal deaths averted would increase from 993 under status quo scenario to about 1,050 in scenario 2; to 1,088 in scenario 3; and to 1,160 in scenario 4 (Figure 1).

• Maintaining current contraceptive prevalence rate between 2020 and 2030 will cost an additional $10.1 million. Scaling up contraceptive prevalence rate to 75 per cent, 80 per cent and 90 per cent in 2030 will require an additional $12.6 million, $14 million and $16.8 million, respectively (Table 1).

• Given the available government resources, the funding gap to achieve the target coverage ranges from $12.3 million to $16.5 million based on all the scenarios between 2020 and 2030.

**Table 1: Summary of total estimated interventions costs between 2020 and by 2030**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>STATUS QUO</th>
<th>SCENARIO 2 (75 PER CENT CPR)</th>
<th>SCENARIO 3 (80 PER CENT CPR)</th>
<th>SCENARIO 4 (90 PER CENT CPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and supply costs</td>
<td>1,057,231</td>
<td>1,815,824.19</td>
<td>2,314,935</td>
<td>3,313,241.45</td>
</tr>
<tr>
<td>Labour costs</td>
<td>8,220,385</td>
<td>8,781,850.77</td>
<td>9,151,236</td>
<td>9,890,006.67</td>
</tr>
<tr>
<td>Other recurrent costs</td>
<td>265,587.3</td>
<td>456,558.64</td>
<td>582,219.5</td>
<td>833,591.59</td>
</tr>
<tr>
<td>Capital costs</td>
<td>906,612.2</td>
<td>1,558,289.86</td>
<td>1,987,093</td>
<td>2,844,853.74</td>
</tr>
<tr>
<td><strong>Total intervention costs in US$</strong> (conversion at $1 = BWP11.52)</td>
<td><strong>10,449,815.5</strong></td>
<td><strong>12,612,523.45</strong></td>
<td><strong>14,035,483.7</strong></td>
<td><strong>16,881,693.45</strong></td>
</tr>
</tbody>
</table>

**Figure 1:** Projected estimates of averted unintended pregnancies, maternal deaths and unsafe abortions by 2030

- Cumulative number of **UNSAFE ABORTIONS** averted due to modern method use
- Cumulative number of **MATERNAL DEATHS** averted due to modern method use
- Cumulative number of **UNINTENDED PREGNANCIES** averted due to modern method use
2. ACCELERATING COUNTRY STRATEGIES TO ACHIEVE THE SDGs AND ICPD25 COMMITMENT

Since 1973, the Government of Botswana has shown strong commitment to family planning by integrating and scaling up SRH and STI services in line with the SDGs and the International Conference on Population and Development (ICPD25) voluntary commitments. Women visiting public health facilities to utilize services such as antenatal and postnatal care, immunization and STI, are also offered free family planning services. Other key interventions deployed by the Government include pre-service and in-service training of providers to strengthen quality provision of integrated services, including family planning, as well as training community-based organizations. Family planning outreach to youth and increased community distribution points of family planning information and services have strengthened access to family planning in Botswana.

WOMEN VISITING PUBLIC HEALTH FACILITIES to utilize services such as antenatal and postnatal care, immunization and STI, are also offered FREE FAMILY PLANNING SERVICES.
The enabling policy environment is guided by the National Development Plans (currently NDP 11), Vision 2036, Adolescent Sexual and Reproductive Health Implementation Strategy (2010-2016), Botswana Integrated Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health, and Nutrition (RMNCAH&N) Strategy (2018-2022). In addition, the country has a national SRH programme which is aligned with these existing strategic policies. The SRH programme embraces equity, universal access, inclusiveness as well as human rights in supporting high-impact cost-effective interventions that inform policy.

To ensure accountability for results in the implementation of the policy frameworks, there is a need to strengthen evidence generation, monitoring, and evaluation for family planning programmes. The public health emergencies and disruptions presented by the COVID-19 pandemic and its far-reaching impact on lives, livelihoods and the economy, underscore the need for resilient health systems that can ensure continuity of essential services. It is important to note that COVID-19 lockdown restrictions disrupted many health services. Global estimates suggest that in 2020, about 47 million women in 114 low- and middle-income countries may not have been able to access modern contraceptives where restrictions persisted for up to six months, which could result in over seven million unintended pregnancies. It has further been estimated that if the lockdown continued, for every three months, an additional two million women may be unable to use modern contraceptives. This is important as Botswana considers resilience-building in its systems in preparation for future emergencies and disruptions.

GLOBAL ESTIMATES suggest that in 2020, about 47 MILLION WOMEN in 114 LOW- AND MIDDLE-INCOME COUNTRIES may not have been able to access modern contraceptives where restrictions persisted for up to 6 months, which could result in over 7 MILLION UNINTENDED PREGNANCIES.

5 UNFPA projections predict calamitous impact on women’s health as COVID-19 pandemic continues.
3. SUSTAINABLE FINANCING TOWARDS THE TRANSFORMATIVE RESULTS

3.1 Domestic resource mobilization landscape

Health-care in Botswana is primarily financed through the national budget allocations by the Ministry of Finance and Development Planning. In 2007-2008, total government expenditure was about BWP 2,079 million. It rose to BWP 5,103 million in 2013-2014. Between 2007-2008 and 2009-2010, total government health expenditure as a percentage of general government expenditure declined from 19 per cent to 18 per cent.

Government's share of financing covered 67.3 per cent of total health expenditure (THE) in 2007-2008, 68.4 per cent in 2008-2009, 68.1 per cent in 2009-2010 and 65 per cent in 2013-2014. The private sector covered an increasing share at 18.7 per cent, 19 per cent, and 24 per cent in 2007-2008, 2008-2009 and 2009-2010, respectively. Donors accounted for a declining share of 14 per cent, 12.5 per cent and 7.9 per cent over the same period. In 2013-2014, the pattern was the same; the private sector (employers, both for-profit and parastatal) accounted for 16 per cent, while donors and NGOs each accounted for 7 per cent, and households accounted for 12 per cent of THE (Figure 2). 2017 studies reflect the same expenditure pattern.

Figure 2: Distribution of total health expenditure financing by source

Source: NHA 2007/07; 2008/09; 2009/10
The largest source of funding for reproductive health was from the Government, accounting for 92 per cent of total reproductive health spending (MoHW, 2016). Households and employers contributed 4 per cent each to the total reproductive health spending. The contribution of external sources of funding was very minimal (1 per cent), indicating minimum dependency on external funds to sustain success and growth in managing reproductive health programmes.

3.2 Financing gaps to meet the costs of getting to zero unmet need for family planning

Botswana prioritizes the attainment of universal health coverage (UHC) by ensuring financial risk protection for vulnerable households against catastrophic costs while seeking care. To scale up contraceptive prevalence within the context of UHC to meet zero unmet need for family planning, the country will require additional resources across the four scenarios. The additional resource requirements range from $12.6 million to $16.8 million to meet the estimated targets by 2030.

The National Health Accounts for Botswana provides estimates of the total share of government expenditure on health which was below the Abuja target of 15 per cent during the period 2000-2006, but surpassed the Abuja target by about 4 per cent in 2009-2010. The latest estimate, benchmarked from 2013-2014, showed a decline to about 12 per cent of the national budget. In 2013-2014, Botswana spent about 12 per cent of the total health expenditure (THE) on reproductive health. This was comprised of 78 per cent expenditure on maternal health, and 11 per cent each for perinatal conditions and family planning. There are significant gaps between projected expenditures and available government resources. The funding gap to achieve coverage ranges between $12.3 million and $16.5 million across the scenarios and over time. The estimates of funding gap include only public funding. Both private and donor funding are excluded in the computations. If donor and private funding were included, the funding gap would be reduced.

To ensure financial tracking for SRHR resources, the Government embarked on a fourth round of National Health Accounts (NHAs) in 2017, using the System of Health Accounts 2011 framework, which generated the baseline data for 2013-2014. Although this was the third round of NHAs, this was the first time the module on Reproductive Health was implemented.

There is also the need to allocate significant resources at the primary health-care (PHC) level, considering that most of the family planning services are provided and accessed at PHC facilities and mobile outreach. PHC accounts for about 24 per cent of total health spending as opposed to secondary and tertiary health-care, which accounts for about 44 per cent.

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CONCLUSIONS

THE BENEFITS OF FAMILY PLANNING include improving maternal health outcomes, child survival and HIV prevention, as well as reducing the proportion of unwanted pregnancies and unsafe abortions. Family planning also empowers women and youth with the agency and bodily autonomy required to advance gender equality, higher education, and active engagement in the labour market with contributions to economic growth.

THIS REPORT SETS OUT THE CASE FOR FURTHER INVESTMENTS TO END UNMET NEED FOR FAMILY PLANNING IN BOTSWANA BY 2030, WITH THE GOAL OF REACHING 90 PER CENT CONTRACEPTIVE PREVALENCE RATE (CPR). The scenarios modelled provide quantitative basis of the programme needs, impact and resources required for proven family planning interventions. This will contribute to decision-making to achieve the Sustainable Development Goals, in particular Goals 3, 5 and 10. The compelling results from all the scenarios justify the need to increase coverage of modern methods of family planning to avoid costs to society and the Government that would be far more than public spending on the provision of family planning services. The return on investments will also contribute to the realization of Botswana’s socioeconomic development vision to transition from an upper-middle-income country to a high-income country status.

Interventions such as integrating SRH and STI services, training of health service providers on family planning services, free provision of SRH and increased availability of health services underscore the commitment of the Government to meet national family planning needs. The country, through its family planning achievements, has also made great strides in empowering women with their agency and bodily autonomy on rights and choices. Women and girls who can decide when, if and how many children to have, tend to obtain higher education levels, thereby increasing their ability to harness productive assets and income-generating opportunities and contribute to inclusive economic growth.