GOVERNMENT OF BOTSWANA

MAPPING EXERCISE ON ACCOUNTABILITY EFFORTS FOR UNIVERSAL HEALTH COVERAGE IN BOTSWANA

MINISTRY OF HEALTH AND WELLNESS
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DISCLAIMER

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EXECUTIVE
SUMMARY

The mapping exercise for accountability for Universal Health Coverage (UHC) study is conducted as part of the USAID's support to the Government of Botswana through the Ministry of Health and Wellness, the Department of Policy Planning & Research and Development. The study is conducted through the technical support from Amref Health Africa on behalf of the African Collaborative for Health Financing Solutions (ACS) project. ACS is a five- year (2017-2022) USAID-supported project with the overarching goal of advancing implementation of health financing policies that support movement towards Universal Health Coverage (UHC) in Sub-Saharan Africa (SSA). ACS offers the technical support, facilitation, and coaching to countries that need to make progress toward universal health coverage. It is led by Results for Development in partnership with the Duke Global Health Innovation Center, Feed the Children, Amref Health Africa, Synergos, RESADE and CERRHUD. The findings of this exercise will be used to inform capacity building efforts for UHC in Botswana and the SSA region.

More specifically, the mapping exercise sought to:

i.   Identify the key stakeholders (Government, Private Sector, CSOs, Youth, etc.), networks and movements involved in promoting accountability within the health sector in Botswana.
ii.   Identify the strategies, approaches as well as platforms that have and/or can be (successfully) used to promote accountability.
iii. Identify existing gaps in promoting accountability by the various stakeholders' capacity to promote accountability through the various platforms.

According to the World Health Organization (WHO) "Universal Health Coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care" (https://www.who.int/health-topics/universal-health-coverage#tab=tab_1). Against this definition, the Internal Health Partnership (2018) asserts that Universal Health Coverage (UHC) can therefore be seen as a "social contract between the state and population", whereby "governments are accountable to their populations for delivering on the right to health". This assessment focused on establishing accountability strategies and process in Botswana with regard to the third Sustainable Development Goal (SDG 3) which seeks to **"ensure healthy lives and promote wellbeing for all at all ages".**

Findings indicate that various accountability strategies and process are in place in Botswana. At policy level, parliament has a history of allocating significant portions of the budget to the health sector. It also has a Public Accounts Committee that scrutinizes public spending. The Ministry of Finance and Economic Development (MFED) has seconded officers to MOHW to ensure compliance with planning and budgeting regulations. This is also meant to ensure an inclusive planning and financial management processes as health experts engage directly with planners and budget specialists in health programme development. MFED hosts consultative forums with private sector, civil society and the general public at strategic intervals to establish national development planning priorities as well midterm reviews to gauge performance and remediate. The National AIDS and Health Promotion Agency (NAHPA) conducts joint planning sessions with all stakeholders that are held annually and synchronized with the government financial year. This is meant to identify programming priorities and gaps and direct resource allocation. These strategies and processes notwithstanding, a few gaps were observed. There is need to conduct periodic policy evaluations in order to strengthen the effectiveness of parliamentary accountability structures.

At programme level, District Health Management Teams (DHMTs) were found to have strong accountability processes such as weekly and monthly reporting from health facilities they manage. Reporting lines and expectations are clearly spelt out and observed. This however was not replicated upwards, ie between districts and the national level where routine programme performance reporting is weak due to a centralized monitoring and evaluation (M&E) system that struggles to service all programme areas. As a result, some programs produce their own reports, which are not based on clear M&E plans.

Civil Society Organizations (CSOs) are involved mainly in community mobilization, and advocacy. Most of them are dependent on donor and government funding for their operations, which has the potential to compromise their role in advocacy and accountability, by extension. To play more fully their role in advancing accountability, CSOs need to minimise reliance on donor and/or government funding. This can be achieved by strengthening resource mobilization efforts and expanding their revenue streams.

Regarding media, although some work has been done to sensitize media practitioners on health strategies and priorities the impact of the work is not evident. There is an adversarial relationship between the media and the state. Media faces a challenge with access to information, especially in government domain. This is attributed to the absence of Freedom of Information law. Information is shared at the government's discretion, and further enquiry is met by a lot of bureaucracy. This compromises media's role and accountability as a public watchdog.

At the community level, the Village Health Committee (VHC), made up of volunteers from the community around a clinic or health post, serves as an extension of the health system especially in identifying needy home-based care patients and basic health promotion, with the recent outbreak of COVID 19 as a case in point. VHCs interact with political leaders such as Councillors and Members of during community level meetings and advocate for health-related issues to be prioritized. VHCs are a viable support system for the health system provided their capacity is built in order to ensure adequate grasp of health concepts and issues.

CHAPTER 1:
METHODOLOGY

INTRODUCTION

Botswana is a landlocked covering an area of 582,000 square kilometers, bordered by Zimbabwe, South Africa, Namibia and Zambia. The 2011 Population and Housing Census projected that in 2020 the population would be 2 383 118 (Statistics Botswana, 2015), with a Sex Ratio of 95.5 Males to 100 Females and a Life Expectancy of 68 years (70 for females and 66 for males). The population of Botswana is relatively young, with 52.9% aged 24 years and below. The country underwent consistent and somewhat rapid urbanization since independence in 1966, with the percentage of population living in urban areas increasing from 9% in 1974 to 64.1% in 2011 (Statistics Botswana, 2014).

Botswana experienced impressive economic growth from the 1970s to the early 2000s, but since then performance has been declining. While the Gross Domestic Product (GDP) rate of growth averaged 9.2 percent up to 2007/2008, it fell to 3.3 percent thereafter. Although the share of the mining sector in GDP has been gradually declining over the past 30 years, the sector remains important in the economy. Mining (especially diamonds) is the single most important sector for foreign currency earnings in Botswana and exports of diamonds accounted for about 90% of the country's total exports in 2019. Tourism is also an increasingly important industry in Botswana, accounting for almost 12% of GDP in 2019, as one of the world's unique ecosystems, the Okavango delta is located in Botswana (NDP 11). A significant portion of Botswana's population lives in rural areas and depends on subsistence crop and livestock farming. Agriculture contributes about 2.8% to GDP—primarily through beef exports (African Development Bank, 2016).

Figure 1: Map of Botswana

ABOUT THE ACCOUNTABILITY MAPPING EXERCISE

The study is conducted by the Ministry of Health and Wellness, Department of Policy Planning & Research with support from Amref Health Africa under the African Collaborative for Health Financing Solutions (ACS) project. One of ACS' aims is to strengthen accountability so that UHC health financing solutions are designed, implemented, and tracked through a process that is evidence-based, transparent, and accessible. The project's accountability pillar seeks to promote learning about accountability for informed action and progress towards UHC.

The country mapping exercise is a first step towards gathering evidence on the status of accountability for UHC in the region. The multi-country exercise sought to map out the key stakeholders involved in accountability for UHC, the approaches being employed to promote accountability in different settings across Africa, and identify gaps in actors' capacity to promote accountability around UHC. The findings of this mapping exercise will be used to inform capacity building initiatives to reinforce the capacity of stakeholders, particularly youth and CSO movements, to play an active role in promoting accountability for UHC.

The mapping exercise seeks to:
i.   Identify the key stakeholders (Government, Private Sector, CSOs, Youth etc), networks and movements involved in promoting accountability within the health sector in Botswana.
ii.   Identify the strategies, approaches as well as platforms that have and/or can be (successfully) used to promote accountability.
iii. Identify existing gaps in promoting accountability by the various stakeholders' capacity to promote accountability through the various platforms.

The study was guided by the following research questions, based on the above study objectives:
a.   Who are the major actors working towards greater accountability in the health sector in Botswana?
  i.   How are these actors organized, what platforms exist and how inclusive and representative are they?
  ii.   What type of structures, policies and institutional arrangements do these actors target to seek change on with their activities?

b.   What strategies are employed towards the push for greater accountability?
  i.   How relevant and applicable have these strategies been in achieving desired change?

    ii.   What other viable strategies could be used to improve and maintain citizen awareness, empowerment and engagement around accountability for UHC?

c.   What gaps (capacity, political, resources etc.) exist in pushing for the accountability agenda?

    i.   What are the root causes of these gaps?

    ii.   What are some of the feasible methods of addressing these gaps especially capacity gaps?

    iii.   What are some of the preferred ways of filling the gaps identified?

STUDY DESIGN, SCOPE AND LIMITATIONS

The study used key informant interviews (KII) almost exclusively, with only one focus group discussion (FGD) being a Village Health Committee. To this extent a list of potential respondents was developed in collaboration with ACS and the MoHW.

1. **Desk Review** of available literature – a list of policies, reports, scholarly materials, and gray literature were assembled and reviewed to develop formative impressions regarding the state of UHC and accountability in Botswana. Specifically, the literature search focused on identifying documents related to the country's commitment to the attainment of Sustainable Development Goals (SDGs), especially Goal 3: Ensure healthy lives and promote well-being for all at all ages and its Target 3.8: Achieve Universal Health Coverage. These documents are referenced in the Literature review and Findings chapters of this report and listed under References. They were also helpful in shaping KIIs that were conducted as the main source of data for this exercise.

2. **Qualitative data collection** was done through KIIs and one FGD. A list of key informants consisting of key stakeholders was provided. The list delineated six (6) distinct groups – policymakers, program managers, civil society, youth, development partners, and media. Each of these groups is treated separately under the findings chapter. Further, a FGD with a Village Health Committee was conducted with the support of Kgatleng District Health Management Team (DHMT).The study respondents were grouped under the following categories:

3. **Data analysis and report writing:** In order to analyze qualitative data, interview transcripts were read through, grouped thematically, and then analyzed to establish recurring patterns of interest. Views that did not align with dominant patterns within each theme were re-examined by re-reading the original transcripts, to ascertain the contexts in which the respondent expressed them.

4. **Limitations of the assessment:** This exercise was conducted under COVID-related restrictions. As a result, it was not possible to interview many potential respondents, notably private sector and academia as appointments could not be secured within the time allocated for data collection. This had the net effect of constraining triangulation of information obtained from the few interviews that were conducted. Also, due the peak of the COVID-19 pandemic, a time during which travel was restricted in Botswana, all interviews were done within Greater Gaborone thus depriving the assessment of views from other parts of the country. Where acceptable to the respondents, questionnaires were sent via email, and follow up made through phone calls and WhatsApp. While this approach yielded positive results in some cases, in others, respondents promised but never delivered.

CHAPTER 2:
ACCOUNTABILITY FOR UHC IN THE BOTSWANA HEALTH SYSTEM

THE STRUCTURE AND ORGANIZATION OF THE HEALTH SECTOR IN BOTSWANA

The health system is decentralized with primary health care being the pillar of health care. At national level, 84 percent of the population lives within a 5km radius of the nearest health center and a further 11 percent of the population lives within a 5-8 km radius, which translates into a total of 95 percent population within an 8 km radius (Statistics Botswana, 2017). The health care delivery system in Botswana has six levels structurally: national referral hospitals, district hospitals, primary hospitals, clinics, health posts and mobile stops. With the exception of the national referral hospitals, the Ministry of Health's delivery network is clustered as part of 27 health districts (World Bank, 2016), that are currently being restructured to form 18 health regions.

The country has a total of 1 454 clinics and health posts, of which 101 are in-patient clinics, 171 outpatient clinics, 338 health posts and 844 mobile clinics. In addition, there are three referral hospitals, strategically located in different parts of the country to facilitate accessibility. Further, there are 15 district and 17 primary hospitals spread across the country. In 2014, approximately 95% of the total population and 82% of rural population had access to a health facility within the 8km radius, showing fair accessibility of available health services (Setlhare, 2014).

Botswana is a signatory to the 2030 Agenda for Sustainable Development, adopted by the UN member States in September 2015 and that contains seventeen (17) Sustainable Development Goals (SDGs) and 169 targets geared towards addressing the unfinished business of the Millennium Development Goals (MDGs). The SDGs identify poverty eradication as their overarching goal captured through the five "Ps" of People, Planet, Prosperity, Peace, and Partnership.

To domesticate the SDGs, Botswana has aligned key development frameworks with the goals espoused in this global commitment. Of keynote are the eleventh National Development Plan (NDP 11), National Vision 2036, the third National Strategic Framework for HIV and AIDS (NSFIII) 2019 to 2023 and the revised National Health Policy. In these documents the country clearly spells out its development agenda, demonstrates how they are linked to the SDGs, based on the evaluation of performance of development programs pursued as part of previous development plans. For example, while the SDGs Goal 3 is to "Ensure healthy lives and promote well-being for all", the National Development Plan and Vision 2036 dedicates significant space to "Human and Social Development" and "Social Development" respectively, where national priorities that facilitate attainment of this global goal are identified and strategies mapped out. NDP 11 emphasizes that this synergy seeks to generate impetus "to help build national resilience through greater employment and livelihoods, more equitable access to resources, better protection against economic and environmental shocks, and a much stronger ability to prepare for, and deal with the consequences of natural disasters, especially as they are exacerbated by climate change". Key structures assigned responsibility to ensure implementation and accountability for these policies are identified. For example, a National Steering Committee on SDGs co-chaired by UN Resident Coordinator and Secretary for Economic and Economic Policy (a Permanent Secretary equivalent position) was established to drive the implementation of programs espoused in these policies as well as rationalize resource allocation.

The Government of Botswana is responsible for universal health care for its citizenry. With adoption of the revised National Health Policy of 2011, Botswana committed itself to the attainment of universal care of a high-quality package of essential health services. In pursuit of this goal, NDP 11 espouses a need to establish a sustainable health financing system aimed at achieving the principles of financial protection, high efficiency levels, equity and quality as stipulated in the heath financing strategy (Health Policy Project, 2016) which are the objectives of UHC. The National Strategic Framework for HIV and AIDS III of 2018 also identifies sustainable health financing for HIV which is a major driver of health expenditure in Botswana as a priority.

TABLE 1 : KEY HEALTH FINANCING INDICATORS

Indicator	2009/2010	2013/2014
Total Population	1,776,496	2,101,741
Exchange Rate (BWP/ US $1)	6.6711	8.6822
GDP (in 2013/2014 real BWP)	68,507,360,119	124,223,200,000
GDP per capita (in 2013/2014 real BWP)	38,563	59,105
THE (in 2013/2014 real BWP)	4,339,196,344	7,801,524,020
Total current health expenditure	– –	7589480340
Total capital health expenditure	– –	212,043,680
THE per capita (in 2013/2014 real BWP)	2,443	3,712
THE per capita (at average US Dollar exchange rate)	366	428
THE/GDP	6.3%	6.3%
Total government health expenditure (in 2013/2014 real BWP)	2,954,820,995	5,103,432,920
Current government health expenditure	– –	4,909,702,640
Capital government health expenditure	– –	193,730,280
Government health spending as a percentage of total general government expenditure	17.8%	12.2%
HOW MUCH DO HOUSEHOLDS SPEND? (% THE)		
Total household spending (prepayments to medical aid and direct payments to providers)	18.5	11.5
Household OOP spending (direct payments to providers only) as a % of total health spending	4.4	4.2

Source: Botswana Health Accounts Report (2014)

From Table 1, Botswana had a GDP per capita of $6,897 in 2013. Total health expenditure (THE) per GDP in 2013, defined as the "sum of public and private health expenditure per GDP" was 6.3%, the same as that for 2009, 2.9% points lower than the global average of 9.2%. Public allocations to fund the health sector (Government Health Expenditure per GDP (GHE)) stood at 12.2% in 2013. This was a 5.6% decline from 2009 and a short fall from the 2012 global average of 15%. The Botswana health accounts reports (2014) illustrated a government health expenditure of 68% of THE in 2009 which declined by 3% in 2013, reporting a government expenditure of 65%. The remaining came from other partners such as donors (Health Policy Project, 2016). The Botswana Health Accounts report further states that the government of Botswana is the major source of financing with the report noting the government accounts for 65% of the spending as noted above, followed by employers at 16%, households accounting for 12% and lastly donors at 7%. However, the country experienced declining donor support in recent years despite increasing disease burden especially due to HIV and AIDS.

A nominal cost recovery system is in place for services in the public facilities, with a small consultation fee of $0.45 (BWP5) being charged and paid directly to the facility. Vulnerable population including people living with disability, citizen children up to the age of 16, destitute registered under the social welfare services, refugees in designated refugee camps, citizen and non-citizen prisoners and those in police custody pending trial, treatment of all diseases of public health concern to both citizens and non-citizens except for HIV treatment (of which ARVs are provided free to citizens & some non-citizens in the key populations category e.g prisoners), maternal and new born health services for citizens, child health services including immunization for both citizens and non-citizens etc. are however exempted from paying. General patients who cannot afford to pay this amount are not denied services.

As part of recommendations from the "Financing health services in Developing Countries: an agenda for reform" study, the World Bank (1978) suggested that countries should introduce healthcare charges. This encouraged the use of personal insurances to cover health risks (Akin, J. S., Birdsall, N., De, F. D. M., 1987). This was the beginning of private Medical Aid Schemes in Botswana. Even though government services were almost free, the private sector still charged for their health services, utilizing the private insurance schemes put in place by a handful of service providers as well as out of pocket payment. In 2016, about 17% of the population was covered by these Medical Aid schemes, which were 9 in total, with the largest 3 covering 88% of the beneficiaries (Health Policy Project, 2016). Private insurance schemes cover up to 80% of the client's bill. The remaining 20% which is paid directly to the service provider by the client makes up the out-of-pocket

(OOP) healthcare expenditure. Even though a good proportion of the population is aware of medical aid services, they choose to not enroll since it is not mandatory and government services are free. Failure or unwillingness to get cover is also attributed to the perception that schemes are designed to exclude the low-income group as well as the unemployed population, creating perceived discrimination and rejection to participate. This group then heavily relies entirely on sub-free government services (Mbogo & McGill, 2016)

PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE (UHC) IN BOTSWANA

While the primary health care approach has served the country well, the 2011 Botswana National Health Policy observes that the country still struggles with shortage of trained and qualified staff affecting the quality of health care in the country. Further, addition of programs and projects, particularly related to HIV/AIDS, increased demand on the already over-stretched skilled workforce. In response, Botswana has progressively pursued aggressive training of health care professionals - with eight nursing training institutes and one school of medicine. The country also sends many young citizens for training in other parts of the world, notably United States of America, UK and other European countries. Further, labor shifting strategies have been put in place in order to alleviate the situation (Roy, Sekis and James, 2017).

In order to objectively assess performance of the health system, it is fair to look at some key health indicators, over time and gauge their direction. The Government of Botswana, like other middle-income countries, faces the burden of providing medical assistance to people affected by non-communicable diseases, raising the health costs. Access to treatment of people affected by non-communicable diseases amounts to 85% while 15% percent are not receiving treatment, even while NCDs are well covered by medical schemes. To manage the financial burden caused by NCDs, the government has invested in preventive measures and developed several strategies. Health promotion and education has been a strategy used by the government of Botswana together with its partners (NGOs, CSOs, media, etc.) to educate the public on preventive measures for NCDs as well as other health issues attributed to lifestyle (Roy, Sekis and James, 2017). This is done through campaigns, walks, adverts in the media and IEC posters in the communities. These activities are also carried out for other disease areas to raise awareness and preparedness. They engage the communities (media, population, HCWs, etc.) and promote conversation surrounding the health care system which push the population to hold the government as well as NGOs and CSOs accountable to UHC.

Despite the country's outstanding access to health services, there is still room for improvement to attain UHC through the collaboration with the private sector and civil society as well as a modification of already existing interventions to promote access to the best quality care for every individual in Botswana.

Healthcare systems can be powerful equalizers to realize the human right to healthcare, can empower socially disadvantaged and marginalized populations, and can positively influence the broader socioeconomic and political determinants of health equity. Evidence and experience have shown that public resources are fundamental to ensuring efficient and equitable progress towards UHC. Commitment to UHC also means significant governmental fiscal commitment. An increase in healthcare finances alone will not necessarily achieve UHC, especially if it is not used effectively to ensure priority services and interventions to marginalized people. Central to the notion of strengthening accountability in the health sector is the necessity to ensure that resources are used prudently, accounted for and that tangible beneficial health outcomes are derived, especially for the most vulnerable and the marginalized.

HISTORY ON ACCOUNTABILITY EFFORTS IN THE HEALTH SECTOR IN BOTSWANA

The story of Botswana's rise from rags at independence in 1966 to riches following discovery of diamonds a few years later is well documented. The country had only three hospitals in 1966 (Nthomang, 2012) and all of them were established and run by missionaries. Under the stewardship of the first President Sir Seretse Khama, the country adopted a national development planning process which identified development priorities, which formed the basis for allocation of national resources. Using this approach, much of the newfound wealth was invested in infrastructures such as roads, telecommunications, schools, health facilities and others. From the early years post-independence, the health sector development was driven through two main instruments - the National Health Plan (1968 to 1969) and Rural Development Policy (1972 to 1980) both of which led to significant improvements in health infrastructure. In 1985 Botswana adopted the Primary Health Care Strategy, and aggressively extended the reach and coverage of health services. By the beginning of the 1990s it was estimated that 81% of the country's population lived within 10km radius of a health facility (Nthomang, 2012). Moreover, mobile health services were instituted to bring services to citizens further afield. These investments soon paid off as reduction in mortality and gains in life expectancy were recorded. For example, infant mortality rate declined from as high as 97 deaths per 1000 in 1971 to 48 deaths per 1000 live births in 1991 while Under 5 mortality declined from 152 deaths in 1971 to 65 deaths in 1991 (Statistics Botswana, 2018).

In recent years the focus has shifted from infrastructural development to improving performance of the health sector. In a document titled Integrated Health Service Plan (IHSP): A Strategy for Changing the Health Sector For Healthy Botswana 2010-2020 (Ministry of Health, 2010), the Ministry acknowledged that the country was not on course to achieve the Millennium Development Goals (MDGs) and identified i) shortage of trained and qualified staff ii) increasing demands on the already over-stretched skilled workforce as a result of additional programs and projects, in particular those related to HIV/AIDS iii) high staff turnover, iv) inequitable deployment and failure to optimize existing skill mix v) weak supply chain management systems resulting in limited availability and regular stock-out of essential drugs and vi) weak health information management leading to untimely data collection, collation, analysis, interpretation, and dissemination of information as key bottlenecks to optimal performance of the health system. While recognizing the importance of upgrading and equipping

health facilities, IHSP emphasizes addressing the above challenges in order to improve the quality of health services delivered to citizens. Another important dimension of the IHSP is its emphasis on cost effectiveness as a key aspect of health financing – whose objectives are "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 and with a particular focus on the needs of the vulnerable groups".

CHAPTER 3:
MAPPING FINDINGS

This chapter presents findings of accountability efforts for UHC in Botswana, first the accountability actors, their roles in accountability, status of accountability efforts and then recommendations moving forward. The second part highlights accountability approaches currently used by various stakeholders as well as challenges faced. A complementary literature review is also presented to provide further context for the findings.

ACTORS AND THEIR ROLE IN ACCOUNTABILITY

Policymakers

Policymakers' main role is to set the development agenda and formulate policies to drive the agenda. Their role also includes resource allocation to programs designed to operationalize those policies, usually in the context to shifting and competing development needs against scarce resources. Policymakers also carry the responsibility to evaluate policies in order to assess their relevance. Some of the critical findings that emerged from the exercise are:

- Parliament has a history of allocating significant portions of the budget to the health sector. It has a Public Accounts Committee that scrutinises public spending.
- Ministry of Finance and Economic Development has seconded officers to MOHW to ensure compliance with planning and budgeting regulations. This is also meant to ensure an inclusive planning and financial management processes as health experts engage directly with planners and budget specialists in health programme development.
- Ministry of Finance and Economic Development hosts consultative forums at strategic intervals to establish national development planning priorities as well mid-term reviews to gauge performance and remediate.
- Joint planning sessions between NAHPA and all stakeholders are held annually and synchronized with the government financial year. This is meant to identify programming priorities and gaps and direct resource allocation

Public providers and health managers

Health service providers are the drivers of health policy. Once adopted by policy makers, this group takes responsibility to implement policy by designing programs and projects that seek to actualize the policy objectives. Health service providers take the frontline seat in community engagement to promote uptake of programs and projects, monitor use, and propose financial resources required in order to ensure availability of and access to services. Some of the critical findings that emerged from the exercise are:

- From the interviews and the desk review, reporting lines between DHMTs and health service facilities are clear. Health facilities report weekly and monthly to the DHMTs. The disconnect seems to creep in between the programs and the policy makers. Specifically, routine programme performance reporting is weak, the reason being a centralized M&E system which struggles to service all programme areas. As a result, some programs produce their own reports, which are not based on clear M&E plans.

Community members, Community representatives

From one angle, the community is a recipient or beneficiary of government development services. From another angle, the community carries responsibility to define its needs and engage policy makers in order to ensure that their needs are taken into account into policy formulation processes. The community organizes itself to advocate for provision of services in line with its own priorities. In Botswana the community has played a leading role in decisions around placement of health facilities, lobbying for improvements in health service delivery, and increase in numbers of health care workers. Some of the critical findings that emerged from the exercise are:

- One of the structures that are used in most villages is the Village Health Committee (VHC), the lowest tier of local authorities – where the area Councilor sits at the top, the Village Development Committee (VDC) is next, and VHC is a sub structure of the VDC. VHC members are volunteers from the community around a clinic or health post. VHCs serves as an extension of the health system especially in promoting good health practices, including observing of COVID-19 protocols at the community level. VHCs are also active in finding and registering home based care patients.
- During Kgotla meetings addressed by political leaders such as Councillors and Members of Parliament, the VHC is normally allocated a slot to present their issues, and proceedings are documented, and action items assigned to various stakeholders. VHCs are a viable support system for the health system provided their capacity is built in order to ensure adequate grasp of health concepts and issues.

Civil Society Organisations

Civil society plays the role of extending government services to the community, beyond health facilities, for a reasonable fee. It identifies service gaps and engages government with a view to plug those gaps and bring health services within reach to those challenged by various factors to access health facilities. Some of the critical findings that emerged from the exercise are:

- CBOs are involved mainly in health service provision, community mobilization, and advocacy. Most of them are dependent on donor and government funding for their operations, which has the potential to compromise their role in accountability and advocacy.
- For most CBOs the protocols governing their reporting relationship with their funders is clear. Their role in accountability may be hampered by their reliance on the funders for sustenance.

Media

The media provides a platform for government/policy makers to "meet" the community, in a virtual sense. Policymakers are normally engaged on radio to explain government policy to the general public, which in turn is allocated time to contribute to the discussion by asking questions and expressing their concerns. Print media also has space reserved for health matters as a way of fulfilling its mandate of promoting accountability in health service provision. The study finding revealed that:

- Although some work has been done to sensitize media practitioners on health strategies and priorities, the impact of the work is not evident. There is an adversarial relationship between the media and the state.
- Information is shared at the government's discretion, and further enquiry is met by a lot of bureaucracy.

Recommendations

TABLE 2 : RECOMMENDATIONS FOR ACCOUNTABILITY ACTORS' ENGAGEMENT

Accountability actors	*Recommendations*
Policymakers	• Improve policy evaluations in order to strengthen effectiveness of parliamentary accountability structures • Tighten engagement between MFED and line ministries especially at programme level needs to ensure coordinated health programs evaluations
Public providers and health managers	• Decentralize the M&E department within the Ministry of Health in order to ensure reporting efficiency
Community members, Community representatives	• Improve capacity building to strengthen the skills base of VHC members
Civil Society Organisations	• Strengthen resource mobilization efforts and expand revenue streams to minimise reliance on donor and/or government funding
Media	• Enact Freedom of Information law to increase the answerability of governments through the creation of space for public authorities to render account

ACCOUNTABILITY APPROACHES AND TOOLS

During the mapping exercise, respondents pointed to a number of structures and approaches that have been successfully used to coordinate the country's development agenda as an indication of political, Performance and financial accountability in Botswana. Examples given were as outlined below.

TABLE 3 : ACCOUNTABILITY APPROACHES USED IN BENIN

Type of accountability	*Accountability approaches*
Performance	• Participatory policy formulation • Results Based Financing • Public media channels such as radio and print media • National and subnational joint assessment (through Health committees, National Monitoring and Evaluation System (NMES))
Political	• Public gatherings like Bogosi System, Kgotla System • Parliamentarian control (through Public Accounts Committee, Health and HIV and AIDS Portfolio Committee) • Participatory policy formulation like National Steering Committees on SDGs co-chaired by the UN Resident Coordinator and Secretary for Economic Policy, High Level Consultative Council (HLCC), Population Council, Rural Development Council etc
Financial	• Joint planning sessions with Health committees • Monitoring of Public Finance Management (PFM) processes' compliance

Bogosi Systsem

Bogosi is centered around Chiefs and provides a platform for ordinary citizens to engage with authorities on their health and other development needs. Major decisions that are made in Botswana emanate from intense consultation via the kgotla system whereby meetings are called by dikgosi (traditional leaders) and issues tabled to morafe (tribe). Evidence gathered indicates that historically dikgosi have always led their morafe on health matters among others like security. This is enshrined in the Bogosi Act of 2008 as one of the functions of dikgosi: "to exercise his or her powers under this Act to promote the welfare of the members of his or her tribe".

Kgotla System

Every Kgosi presides over a Kgotla (plural Dikgotla) a place of public gathering where community issues are discussed and resolved. There is a common saying that mafoko a kgotla a mantle otlhe – translated to mean "there is no wrong or right at the kgotla, which is meant to encourage everyone to speak their mind. The kgotla is also a point of entry for Government (Members of Parliament, Cabinet Ministers, Civil servants) to interact with and engage communities over matters affecting them, including health. Historically policy pronouncements were made at the Kgotla and community members would have opportunity to interrogate the policy so pronounced for better understanding.

Village Health Committee

Every health facility in the rural area can have a VHC, they are mobilised and organized by the health workers of the facility. These are a group of volunteers who assist health workers with health promotion activities at the community level. They capture communities' health needs to inform health policy development processes as they are afforded opportunities to engage civil servants, politicians or any other stakeholder during community dialogues such as kgotla meetings.

Botsogo Pitso

Botsogo Pitso is community health forum is gathering meant to promote engagement between government and the community. The DHMT in greater Gaborone have such gatherings on a regular basis. At these platform stakeholders discuss issues related to community health and give feedback matters discussed in previous meetings. These platforms could be extended to other areas

Media

Media plays a leading role in shaping public opinion and hence public response to societal issues. Although there are some programs in the state radio such as Dikgang tsa Botsogo (Health News) on Radio Botswana, more could still be done to engage the public on issues of accountability through the radio.

Public dashboards

Public dashboards to engage and update the public on the performance of the fight against HIV / AIDS were cited as an initiative that had positive impact in engaging communities and rallying them behind a common course. These were erected at a central place like the Kgotla and action items agreed to in a meeting are posted for all to see. Updates and feedback are also posted publicly to ensure continued engagement.

TABLE 4 : RECOMMENDATIONS FOR ACCOUNTABILITY ENHANCEMENT IN BOTSWANA

Accountability approaches	Recommendations
Bogosi system	• Place Dikgosi at the center of interactions with communities especially in the epidemic control like that of on-going response to COVID-19.
Kgotla System	• Impartial moderation of the Kgotola system to solve subdued interrogation of accountability issues as a result of unspoken reverence to the kgosi and anybody in a position of authority. • Broaden HIV/ AIDS kgotla tenure to provide a voicing platform for all health-related issues.
Village Health Committees	• Advocate for motivation of VHCs as they play a key role in mobilising the community and act as a link between the community and health workers.
Botsogo Pitso	• Incorporate facilitation function in Botsogo Pitso initiative before country-wide scale-up.
Public dashboards	• Re-explore and resuscitate the initiative as a means of promoting accountability on health issues at the community level.

COMPLEMENTARY LITERATURE REVIEW

A literature review done before the mapping exercise revealed that Botswana has a long history of consultation between the government and citizens, founded upon the "kgotla system", a traditional meeting place that provides a platform for ordinary citizens to engage with authorities such as government officials of all levels including the President of the Republic on the national development agenda including health. Citizens use this platform to hold their representatives accountable on matters relating to social development among others. Broad-based participation is highly encouraged at this platform so that the community is free to air their views, usually expressing demand for services such as health facilities, improvement in quality of health service, etc. Respondents from the mapping exercise agreed that this system serves to guarantee members of the community an opportunity to not only express their needs and expectations but also hold those they elected to office accountable.

At the policy level, informants were confident that systems were in place to measure performance of Government's development programs, pointing to domestication of SDG Indicators and adoption of National Monitoring and Evaluation System (NMES), which aims to go "beyond the comprehensive M&E system and include: a policy framework and review guidelines; capacity building; harmonization of policies and strategies; and information dissemination" (NDP). The system was discussed in parliament recently as part of NDP 11 review and captured on the Botswana Daily News of 14th September 2020.

At the program level, and among civil society and development partners, there is a general feeling that Monitoring and Evaluation systems are not effective. Acknowledgement is made of the existence of the Department of Monitoring and Evaluation and Quality Assurance within the Ministry of Health and Wellness as well as at National AIDS & Health Promotion Agency (NAHPA). However, these are largely seen as centralized and lacking presence at program level. Cases of disbursement of funds to implementing partners, especially CSOs, without financial monitoring to check for compliance was also seen as a big concern especially by development partners.

CHAPTER 4:
RECOMMENDATIONS FOR ENHANCING ACCOUNTABILITY

LESSONS AND OPPORTUNITIES FOR STRENGTHENING ACCOUNTABILITY FOR UHC IN BOTSWANA

Based on the analysis, recurrent issues and trends have been extracted and are briefly discussed in this section, in addition to opportunities for strengthening accountability for UHC in Botswana.

1. There is need to improve policy evaluations in order to strengthen effectiveness of parliamentary accountability structures. Currently there seems to be a gap between policy decision making function of parliament and actual assessment of the impact of these policies.

2. The "Silo" approach to programme planning on one hand, and programme implementation in the other, need to be dismantled e.g. the Ministry of Finance and Economic Development (MFED) as the custodian of public coffers did not engage meaningfully with implementing departments within Ministry of Health and Wellness on budget processes, which led to perceived misallocation of resources, limits budget efficiency, constraints ministries' ability to track extensively and comprehensively funds utilization. Enhanced engagement between MFED and line ministries especially at programme level therefore needs to be strengthened.

3. There is need to decentralize the M&E within the Ministry of Health and Wellness in order to ensure reporting efficiency. The current arrangement whereby no M&E Officers are assigned to programs compromised programs' ability to account for their performance on a regular and predictable basis as the national M&E framework cannot be effectively operationalized.

4. On-going efforts to resuscitate Partnership Forum should be pursued with greater vigor so that partners within the health sector have a platform where scarce resources are rationalized and allocated in full transparency in order to maximize their benefit to citizens.

5. Improve capacity building to strengthen the skills base of VHC members. Some of the skills required are resource mobilization, proposal development, identification of potential funders, etc. Complementary to this effort should be capacity building in financial management, which is a requirement for donors across the globe.

6. CSOs need minimize reliance on donor and/or government funding, as this tends to compromise their independence and ability to hold donors accountable. This can be achieved by strengthening resource mobilization efforts and expanding their revenue streams.

7. There is need for a Freedom of Information law in Botswana, so that members of the public would be entitled to request information from public authorities any time there is need to hold them to account. As things stand information is not shared on a need basis but more at the discretion of those under whose control it falls.

CONCLUSION

Generally, the assessment shows that accountability is fairly high in Botswana, mainly due to political stability, robust high-level financial oversight and strong government-community engagement. Traditional social regulation mechanisms like Bogosi and Kgotla sytems were found to be effective to ensure that public officials account for the provision of public goods that are consistent with societal standards and norms. However, the study unveiled individual and institutional shortcomings whose remedies require deliberate efforts that reinforce skills and competences of key accountability stakeholders like VHC, CSO, budget holders.

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ANNEXES:
DATA COLLECTION TOOLS

KII FOR ACCOUNTABILITY MAPPING EXERCISE
GOVERNMENT AND DEVELOPMENT PARTNERS

This study is conducted by the Department of Policy Planning & Research of the Ministry of Health and Wellness with support from Amref Health Africa on behalf of the African Collaborative for Health Financing Solutions' (ACS) project. ACS is a five- year (2017-2022), USAID-supported project with the overarching goal of advancing implementation of health financing policies that support movement towards Universal Health Coverage (UHC) in Sub-Saharan Africa. ACS offers the technical support, facilitation, and coaching to countries that need to make progress toward universal health coverage. It is led by Results for Development in partnership with the Duke Global Health Innovation Center, Feed the Children, Amref Health Africa, and Synergos.

One of ACS' pillars is to strengthen accountability so that UHC health financing solutions are designed, implemented, and tracked through a process that is evidence-based, transparent, and accessible. ACS formed the regional Accountability Learning Collaborative (ALC) with the goal of generating evidence and promoting learning about accountability for informed action towards UHC. The mapping exercise is a first step towards gathering evidence on the status of accountability for UHC in the region. The exercise will involve mapping the key stakeholders involved in accountability for UHC, mapping the approaches being employed to promote accountability in Africa, and gaps in actors' capacity to promote accountability around UHC. The findings of this mapping exercise will inform the capacity building initiatives to be carried out with a goal of strengthening capacity of stakeholders, particularly youth and CSO movements, to promote accountability for UHC. The study will also generate and disseminate knowledge to promote peer learning and the uptake of learning on accountability.

Data Collection

Thank you for agreeing to participate in the study. The interview contains a series of questions on participation in processes aimed at boosting cooperation between national and decentralised government units, health service providers and citizens/users in such a way as to improve health sector performance. We would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
    a. Name and occupation
    b. Institution and role in the health sector
2. UHC efforts in your country
    a. Is UHC a priority in Botswana?
    b. Are there attempts to develop policy documents and sensitization to provide direction in achievement of UHC?
    c. Provide examples if possible
    d. Are there any achievements so far?
    e. Do you see any role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC – Health planning and forecasting
    a. How would you describe accountability in the work that you are doing?
    b. Botswaana is currently implementing the National Development Plan 11; How participatory was the NDP 11 development plan process?
    c. How were the stakeholders sensitised
    d. What accountability mechanisms have been put in place to ensure that the implementation of the plan is successful? Who or what is the focus by these activities?
    e. Are there any tools or specific approaches that are being used to promote accountability in the health sector? Examples of potential answers performance contracts, performance audits, review sessions, Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
    f. What stakeholder engagement platforms/networks exist to strengthen accountability efforts? and how inclusive and representative are they?
    g. What platforms are available to monitor planning and implementation of NDP 11?
    h. How involved is the civil society in ensuring accountability in health service delivery?
    i. Are there any actors (donors, partners, academic institutions etc.) working with your office to promote accountability in health service provision? If yes, name some of them
    j. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?

4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
    a. How and where do you acquire the evidence you need for health planning?
    b. How does information flow on the HMIS. How reliable is the data on the system?
    c. Is there a feedback mechanism to the peripheral and intermediate levels on the quality of evidence/data being shared?
5. Additional efforts for health/UHC accountability in the policy spaces where you are active
    a. What needs to be done differently to fast track greater accountability towards UHC?
    b. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
    c. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

KII FOR ACCOUNTABILITY MAPPING EXERCISE
MEDIA

Thank you for agreeing to participate in the study. The interview contains a series of questions on processes that boost local cooperation between national and local governments, health service providers and citizens/users in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the interview. I hope I have your permission to continue with the interview?

1. Introduction
    a. Name and occupation and role in the health sector
    b. Focus areas, membership etc.
    c. Institution – area of operation (Regional, National, Subnational etc.)
2. UHC efforts in your country
    a. Have you heard of Universal Health Coverage? Is UHC a priority in your country? Have you been sensitized on UHC?
    b. Are there any achievements? In your opinion, what's the role of accountability in achieving UHC?
    c. Health insurance has been identified as one of the key interventions to improve social protection of the poor and vulnerable citizens. In your opinion, is there any role of the media in the programme?
    d. Have you been sensitised on the programme?
    e. Do you contribute to development of policy documents to ensure that the role of the media is included in health policy? If yes, how?
3. Accountability efforts you are involved in for health/UHC
    a. Health has been declared a human right by WHO, what does this mean to you?
    b. In your opinion, is there citizen awareness in on their right to health? Do you see any role for the media in improving citizen awareness on their right to health?
    c. How does the media gain knowledge on health matters and priorities in the country?
    d. Are there deliberate efforts to sensitize media practitioners on health strategies and priorities?
    e. Are there platforms provided where the media contributes to the health agenda in the country?
    f. In your opinion, is there a role for the media in influencing health priorities in the country?
    g. In your opinion, how informed is the general population on health matters?
    h. Is the general population aware of their roles and responsibilities to accessing quality health care?
    i. In your opinion, what does accountability in health service provision mean?
    j. Are there any efforts by the media to promote accountability in health? Could you briefly describe the accountability activities you are involved in? (examples of potential answers –radio and TV programs highlighting health issues, Citizen/CSO/Youth-led anti-corruption campaigns, contribution to policy documents, etc.).
    k. What do these activities aim to achieve?
    l. How long have these activities been going on?
    m. Is there any documented evidence on these activities' existence? Could you refer us to these?
    n. If relevant, what engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they?
    o. Are there any tools or specific approaches that are being used by the media to promote accountability?
    p. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
    q. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
    r. At what levels of the health system or policy arena are these collaborative engagements most predominant? What explains this?
    s. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Let us talk about the evidence you use in your engagements on accountability towards improving health?
    a. How and where do you acquire the evidence you need for health advocacy?
    b. How credible is the evidence? Please briefly explain the reasons for saying so.
    c. How easy is it for you to acquire the evidence you use?
    d. How do you process and utilize the evidence?
    e. Do you think that gathering and presenting evidence is necessary for the accountability agenda?
5. Additional efforts for health/UHC accountability in the spaces where you are active
    a. Could you describe the common processes, approaches, strategies and/or platforms being used?
    b. In your own assessment, how effective are the current processes, approaches and strategies?
    c. What needs to be done differently to fast track greater accountability towards UHC?
    d. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
    e. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.

FGD FOR ACCOUNTABILITY MAPPING EXERCISE
CSOS, YOUTH & WOMEN GROUPS AND NETWORKS ETC.

Thank you for agreeing to participate in the study. The guide contains a series of questions on processes that boost local cooperation between this committee and other stakeholders involved in health service delivery such as health service providers in such a way as to support and improve health service delivery and policy formulation. I would like to assure you that any information you provide in the course of this interview will be treated with strict confidentiality. I estimate that we shall take roughly one hour for the focus group discussion. I hope I have your permission to continue with the interview?

1. Introduction
   a. Name of NGO, location, focus areas, no of members etc.
   b. What is the role of NGO in the health sector? Probe on their role on accountability
   c. How are all the members of the NGO 1) identified 2) sensitised on their role as NGO members?
2. UHC efforts in your country
   a. Have you heard of Universal Health Coverage? Yes Is UHC a priority in your country?
   b. Have you been sensitized on UHC? Yes
   c. Are there any achievements? In your opinion, what's the role of accountability in achieving UHC?
3. Accountability efforts you are involved in for health/UHC
   a. Are there accountability elements to the work that you are doing?
   b. Could you briefly describe the accountability activities you are involved in? (examples of potential answers - Citizen/CSO/Youth-led anti-corruption campaigns, policy documents, self-policing, codes of conduct, performance contracts, performance audits, parliamentary oversight etc.).
   c. Is there any documented evidence on these activities' existence? Could you refer us to these?
   d. Where do you get the information or evidence to engage in accountability efforts? Is it reliable?
   e. What engagement platforms/networks exist to strengthen your accountability efforts? and how inclusive and representative are they?
   f. Are there any tools or specific approaches that are being used to promote accountability? Examples of potential answers - Satisfaction surveys/report, cards, Service charters, CSO watchdogs etc.)
   g. In your view, how successful have these efforts been? What lessons do you have around how accountability efforts work in practice?
   h. Do you have any collaborative engagements with other actors around pushing for improved accountability for health / Universal Health Coverage?
   i. How can you be supported to engage in accountability for health to improve overall quality of health services?
4. Additional efforts for health/UHC accountability in the spaces where you are active
   a. What needs to be done differently to fast track greater accountability towards UHC?
   b. How involved are: (1) youth (2) women (3) people with disabilities in accountability processes?
   c. Should more be done for these demographics to be more included in these processes? Please explain the reasons for feeling so and what can be done.