Republic of Botswana

MINISTRY OF HEALTH & WELLNESS

SITUATIONAL ANALYSIS OF AGEING AND HEALTH OF OLDER ADULTS IN BOTSWANA

JULY 2019

World Health Organization

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FOREWORD

The older adults' (60 and above) population is estimated by World Health Organization to double from about 11% to 22% globally thus between 2000 and 2050. According to the 2011 population census the proportion of older persons' in Botswana was 6% an increase from 5% in 2001. It is projected that it will be more than 8.5% and 20% in 2021 and 2050, respectively. Contributing factors here include but not limited to improved education and health systems as well as reduced mortality and fertility rates.

In 2019 with reference to the growing population and the associated challenges of the older adults, Botswana through the Ministry of Health and Wellness in collaboration with WHO conducted a Situational Analysis for Ageing and health of older adults. Hence, chapters covered as follows:

- Chapter 1; Introduction
- Chapter 2; Methodology
- Chapter 3; The demographic profile of Botswana older adults
- Chapter 4; The socio-environmental circumstances of older adults.
- Chapter 5; The health status of older adults in Botswana.
- Chapter 6;The major risks for non-communicable diseases among this cohort.
- Chapter 7; The organization and governance of the health care system.
- Chapter 8; The socio-political environment
- Chapter 9; Recommendations.

The justification of this study cannot be overemphasised. These results now turn to be the basic yard stick against which the future older adults' population situation can be rated for improvement or complication. However, there is a critical need for further research for this group population to inform, guide and address their needs

Hon. Dr Edwin G. Dikoloti

Minister of Health and Wellness

ACKNOWLEDGMENTS

This Study was conducted with technical and financial supports from the World Health Organization Regional Office for Africa. We wish to acknowledge all who made this situation analysis exercise a success. We acknowledge support of the WHO Representative in Botswana, and technical support provided by WHO country Office Botswana, WHO regional adviser on Healthy Ageing and National Programme Officer- Family Health Programme, WHO Botswana. Also, members of the Technical Working Group and members of the MoHW Health Promotion Division who refined the questionnaire for the survey, the data collectors, officers who entered and cleaned the data, and all staff of the MoHW Department of Health Service Management who made all preparation for the survey and Key Informants' interviews. We wish to acknowledge and thank all survey participants and all those who participated in the Key Informants' interviews, care beneficiaries and caregivers who committed time to providing data for the exercise. We are very much thankful to individuals who took time to review this document and provide constructive feedback that greatly improved its quality – the Technical Working Group, the Steering Committee, the MoHW Rehabilitation and Mental Health Division, and the WHO family – we are indebted to you!!

Ms Grace Muzila

Permanent Secretary

PREFACE

Botswana older adults' population currently projected at more than 6% poses a risk to the country's Health and Economic System; the mental and physical degeneration increases the burden of the already overstretched health care systems, calling for more human and material resources as well as increase in infrastructure. Factors such as declining fertility, increased access to higher education for women and their participation in formal employment, improvement to both the standard of living and access to health care and declining mortality rates bring an increase in the population of older persons in Botswana and world-wide. A situational analysis for ageing and health needs of this population was then carried out in 2019.

The findings showed that older persons are mostly living alone with limited access to social services. There is evidence that often older adults with disabilities do not use assistive. Older adults often have physiological and memory problems that limit their self-care and day-to-day activities as well. The older adults were also found to be more affected by Non-Communicable Diseases than the rest of the population. High poverty levels (91%) contributing to Malnutrition was also found to be a challenge to this population. Social insurance schemes for older persons were also found to be under-developed.

It is therefore expected that this study will inform all policy makers across organisations and ministries, working with the endeavour to meet the diverse needs of this unique and special population.

Mr Samuel S. Kolane

Community Health Services Advisor

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GLOSSARY OF ABBREVIATIONS

AFA	Associated Fund Administrators
AU	African Union
BAIS	Botswana Aids Impact Survey
BBCA	Botswana Business Coalition on AIDS
BCC	Botswana Council of Churches
BCSPA	Botswana Civil Service Pensioners Association
BIUST	Botswana International University of Science Technology
BHPCA	Botswana Hospice and Palliative Care Association
BOCAIP	Botswana Christian Aids Intervention Program
BOCONGO	Botswana Council of Non-Governmental Organisations
BONASO	Botswana Network of AIDS Service Organosations
BONEPWA	Botswana Network of People Living With HIV/AIDS
BORNUS	Botswana Retired Nurses Society
BQA	Botswana Qualification Authority
BUAN	Botswana University of Agriculture and Natural Resources
CHBC	Community Home Based Care
CMF	Change Management Framework
DDC	District Development Committee
DHC	District Health Committee
DHMTs	District Health Management Teams
EFB	Evangelical Fellowship of Botswana
GSAP	Global Strategy and Action Plan on ageing and health
HAA	Healthy and Active Ageing
HIMS	Health Information Management System
HSM	Health Services Managememt
ICOPE	Integrated Care for Older Persons
IHS	Institute of Health Sciences
IHSP	Integrated Health Service Management Plan
MDJS	Ministry of Defence , Justice and Security
MELSD	Ministry of Employment, Labour Productivity and Skills Development
MENT	Ministry of Environment, Natural Resources Conservation and Tourism
MFED	Ministry of Finance and Economic Development
MIAC	Ministry of International Affairs and Cooperation
MIH	Ministry of Infrastructure and Housing Development

MISA	Media Institute of Southern Africa
MITI	Ministry of Investment Trade and Industry
MLG&RD	Ministry of Local Government and Rural Development
MLWS	Ministry of Land Management, Water and Sanitation Services
MMGE	Ministry of Mineral Resources, Green Technology and Energy Security
MNIG	Ministry of Nationality, immigration and Gender
MoA	Ministry of Agriculture Development and Food Security
MoBE	Ministry of Basic Education
MoHW	Ministry of Health and Wellness
MOPAGPA	Ministry of Presidential Affairs, Governance and Public Administration
MoTE	Ministry of Tertiary Education, Research, Science and Technology
MTC	Ministry of Transport and Communications
MYSC	Ministry of Youth Empowerment, Sport and Culture Development
NCC	National Coordination Council
NDP 11	National Development Plan 11
NHIS	National Health Information Systems - DHIS2, IPMS, PIMS
NHP	National Health Policy
OAIC	Organization of African Instituted Churches
PHS	Primary Health Services
PIC	Performance Improvement Committee
Q	Quarter
RHMD	Rehabilitation and Mental Health Division
SC	Steering Committee
TOT	Trainer Of Trainee
TWG	Technical Working Group
UB	University of Botswana
UHC	Universal Health Coverage
UNDP	United Nations Development Program
VHC	Village Health Committee
WHO	World Health Organization

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EXECUTIVE SUMMARY

1. Introduction

Factors such as declining fertility, increased access to higher education for women and their participation in formal employment, improvement to both the standard of living and access to health care and declining mortality rates bring an increase in the population of older persons world-wide. The World Health Organization estimates that between 2000 and 2050, the older persons' population will double from about 11% to 22% the world over.

For Botswana, according to the 2011 population census the proportion of older persons' was 6% which was an increase from 5% in 2001. It is projected that it will be more than 8.5% in 2021.
Realizing the challenges posed by the growing population of older persons that in many countries has not been matched by development of infrastructure and services that are tailored to the needs of the older adult population, the World Health Organization (WHO) developed an Action Plan for Older Persons and urged member states to make Healthy Ageing a priority in their national health and development agenda, and to address the comprehensive health needs of older adults in a multisectoral approach.

In response, Botswana Ministry of Health and Wellness, with the support of WHO, embarked on a situational analysis of the health and general well-being of older adult population, the findings of which were meant to guide the next steps towards addressing the health needs of older persons. Major areas interrogated are the demographic profile of older adults in Botswana, their socio-environmental circumstances, their health status, and their major risks for non-communicable diseases. The health care system of the country and the general socio-political environment under which older adults live were also examined.

2. Methodology

The situation analysis employed a mixed-methodology with three components including desk reviews, key informant interviews, and field visits to collect information on "self-reported" current health status and living conditions of the older persons.

Desk review of documents provided information about ageing and older adults in Botswana. The desk review built on the first one conducted in 2013, with addition of new information including statistics from the 2011 population census.The cross-sectional assessment survey of the health status of older adults was done using a tool adapted from WHO SAGE, COURAGE and CFAS tools. A total of 770 older adults of mean age 73.3 years comprising 229 Male (30%) and 541 Females (70%) completed the questionnaire. The distribution of participants by locality was Francistown (15.1%), Molepolole (26.4%),

Tonota (23.4%) and Kanye (35.1%).

Focus group discussions and individual interviews were conducted with Key stakeholders in ageing, made up of representatives from different Ministry of Health and Wellness departments, education institutions from basic education to tertiary level, other government's ministries besides education and health, civil society, private sector, and community members. Analyses for the survey and the key informants' interviews were conducted separately, after which findings were integrated and collaborated with those from the desk review.

3.The demographic profile of Botswana older adults

Older adults, are generally dominated by females, with the ratio of females to males being about 6:4 or 3:2. Their educational attainment is generally low, being dominated by primary school leaving education or no education at all. The majority (51%) of older adults live in rural villages, leaving 40% and 9% for urban villages and cities and towns, respectively. Not many older adults have had formal occupations and those who have had employment were mainly in low paying and non-pension earning employment and the socio-economic status of older adults is generally low.

4. The socio-environmental circumstances of older adults

Generally many older adults population live with their children particularly when they reach advanced age. It also revealed that there are other older adults who do not have anyone to care for especially those having mobility challenges and other chronic health conditions such as blindness, diabetes, hypertension etc. Older adults usually have access to utilities such as water and electricity. However, not every village has electricity therefore the situation favors those in cities, towns and big villages over those in rural villages.

5. The health status of older adults in Botswana

About 33-39% of persons with disability in Botswana are older adults, with their common disabilities being visual impairment and mobility problems. There is evidence that often older adults with disabilities do not use assistive devices such as eye glasses and hearing aids for impaired vision and impaired hearing, respectively. Older adults often have physiological and memory problems that limit their self-care and day-to-day activities.

Hypertension has been found to be on the high among the non- communicable diseases affecting older adults followed by diabetes and musculoskeletal diseases. While among the communicable diseases HIV is on the high, not only because of their own positive HIV status but also because they are often

caregivers for HIV patients and children orphaned by AIDS. The burden of HIV is higher for females compared to males.

Generally the health care system does not have any intervention to enable regular health screening for specific or different health conditions among the population in the absence of symptoms.

6. The major risks for non-communicable diseases among this cohort

Limited consumption of fruits and vegetables and high BMI seem to be the most disturbing NCD risk factors among the older adults. Alcohol consumption and tobacco also is also another risk.

7. The organization and governance of the health care system

The health care system of Botswana presents ample opportunities for advancing the Healthy and Active Ageing mission. The system is aligned to vision 2036 that emphasizes opportunities for all people and the development of the family and the community. It is also aligned to National Development Plan 11 (NDP 11) that commits to enhancing policies and strategies for cushioning vulnerable and disadvantaged groups, access to water, shelter, sanitation, and social protection. The Integrated Health Service Management Plan maximizes the participation of both the health care professionals and the non-health sectors. A number of policies that benefit older adults, even though they are not specifically targeting them, are in place such as;

1. Ministry of Health and Wellness Strategic Plan
2. National Eye Health Programme
3. Strategy for the Prevention and Control of Non-communicable Diseases
4. The Pneumoconiosis Screening Programme for men who have worked in South African mines.
5. Botswana's Building Control Act was amended in 2009 in order to improve access to public facilities.
6 Accessibility of hospitals, clinics, and public transport was reported to be at least 70% in 2016.
7. Continued shortage of medicines especially for chronic conditions.

The major missing element in the health care system is a long-term care for older adults at primary health care level. Older adults are attended to through the integrated services that are often not paying attention to the health needs of older adults. Health care seeking behavior tends to be driven by ill health rather than health promotion and disease prevention.

8. The socio-political environment

Botswana is generally dominated by the patriarchal system which is assumed to be emanating from the customary law where males have generally a higher say in everything i.e. The male were capacitated by the patriarchal system which gave them opportunity to attend school while the woman were deprived

the same privileges hence their life in general including their health were negatively impacted.

9. Recommendations

Recommendations strategies to improve the health and quality of life of the older adults are as follows:

1. Development of an Older Persons' Act
2. Establishing a policy on ageing to guide healthy and active ageing agenda.
3. Developing a system of long-term care for older adults at primary health care level.
4. Developing capacity for and integrating old age in existing national policies and strategies.
5. Establishing older adults' homes both as day care and as residential for some areas.
6. Empowering communities for a better understanding of the needs of older adults and for taking a positive action toward healthy and active ageing.
7. Enhancing the economic capacity of older adults to live decent lives as well as to access health care services through, among other things, employment's support for workers' investment for post-retirement.
8. Consideration of the health and welfare needs of older women including their protection as key and put systems to address these.
9. Revival of the old systems for social integration and community support.
10. Establishment of monitoring and evaluation systems for older adults programmes.
11 . To standardize the definition of older adult to 60 and above as recommended by WHO.
12. Consider reviewing the universal old age pension.

1. INTRODUCTION

1.1 Global Ageing

The proportion of older people aged 60 years or over is increasing rapidly around the world. Between 2000 and 2050, the proportion will double from about 11% to 22%. The absolute number of people aged 60 years or over is projected to increase from 900 million in 2015 to 1400 million by 2030 and to 2100 million by 2050, and could rise to 3200 million in 2100 (World Health Organization (WHO), 2015). Although Africa has the youngest population structure, persons aged 60-plus years were estimated to be 45 million in 2015, with the population projected to reach 67 million by 2025 and 157 million by 2050 (WHO, 2015).

1.2 Emerging Health and Social Trends of Ageing

With the accelerated urbanization and international migration, fewer young people remain in rural areas to support the older adult population who face multiple social, economic and health problems. This is exacerbated by the additional responsibility on the older persons of having to care for sick children and orphaned grandchildren as a result of HIV/AIDS (Karlin, et al., 2017).

Fig 1 shows the life expectancy rate in Africa, Southern Africa and Botswana. As of early 2000, Botswana s life expectancy has been increasing above average of other African countries.

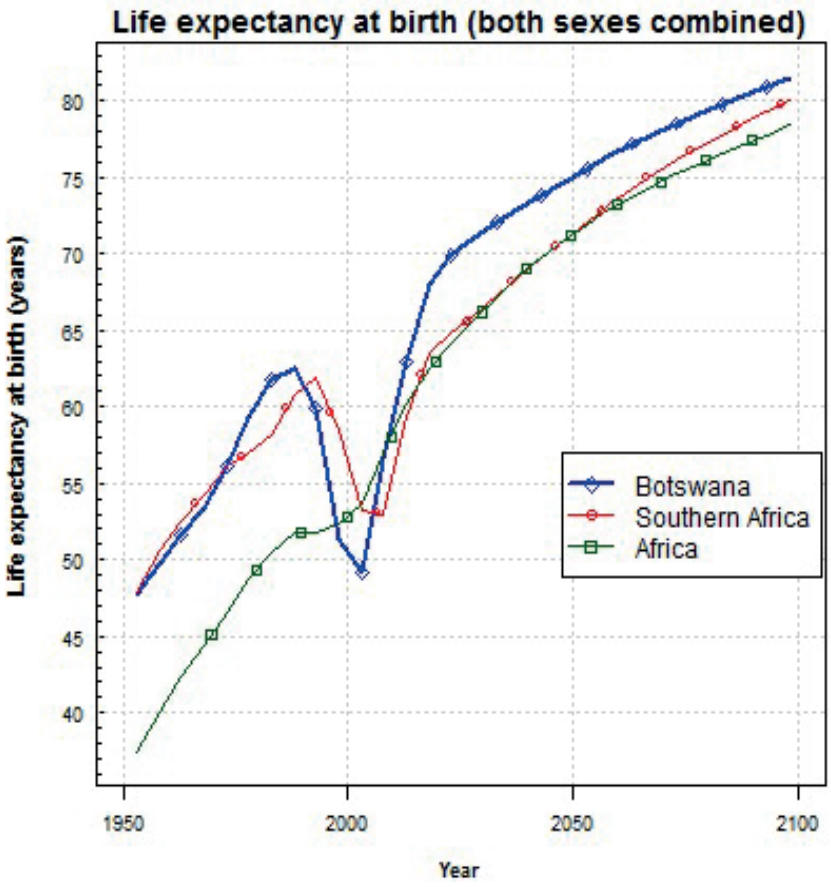


Figure 1: Increasing population of Older Adults in the African Region. Sourcehttps://population.un.org/wpp/Graphs/DemographicProfiles/

1.3 Ageing Situation in Botswana

Like many countries, Botswana is experiencing an increase in the population of the elderly. The population of persons aged 60 years and above increased from 5% to 6% between 2001 and 2011. It is projected that the population of persons aged 60 years and above will constitute 8.5% and 8.9% of the total population in 2022 and 2026, respectively (Statistics Botswana, 2015). Such growth has been attributed to factors such as declining fertility, increased access to higher education for women and their participation in formal employment, improved access to health care and declining mortality rates. (Nkwe, Mukamaambo, & Malema, 2017).

Owing to its rapid onset and other pressures including the country's unprecedented response to HIV, the increasing population of older adults has not been matched by development of infrastructure and services that are tailored to the needs of the older adult population. There are no laws and policies that specifically protect the rights and wellbeing of older adults. This has often left older adults marginalized, discriminated, neglected, and abused. Poverty is one of the major issues affecting older adults, only a small proportion (9%) of whom is reported to be living above the poverty datum line, and with the worst situation being in rural areas. Only a small proportion (8%) of older adults who retire from formal employment earn pension. The universal old age pension that was introduced in 1996 can barely meet the basic needs of older adults.

Older adults get largely health care from the integrated services. Generally, the health services are not responsive to the needs of the ageing population and this is partly exacerbated by the absence of disaggregated Health Information Management System (HIMS) statistics on this population group and related health needs.

2. STRUCTURE, PROCESS AND REPORTING OF THE SITUATIONAL ANALYSIS

The situational analysis employed mixed methodology with three components including: desk reviews, key informant interviews, and field visits to collect information on "self-reported" current health status and living conditions of the older persons.

Desk review of documents provided information about ageing and older adults in Botswana.

The cross-sectional assessment survey of the health status of older adults aged 60 years and above was done using a tool adapted from WHO SAGE, COURAGE and CFAS tools. Data were collected from persons (ages 60 years and above) in purposively selected sites at which many older adults could be accessed such as old people pension pay points, poverty relief public works (Ipelegeng) sites, health facilities, NGOs, and to a limited extent, households. The survey was conducted in one city and three urban villages. It covered Francistown, Tonota, Molepolole, and Kanye, . Francistown and Tonota

represented the northern region of the country while Molepolole and Kanye are in the southern region. A total of 770 older adults of mean age 73.3 years comprising 229 Male (30%) and 541 Females (70%) completed the questionnaire. The distribution of participants by locality was Francistown (15.1%), Molelopole (26.4%), Tonota (23.4%) and Kanye (35.1%).

Focus group discussions were conducted with Key informants in ageing, from Governmental, civil society, private sectors and community members. In addition, in-depth interviews were conducted with one older person and two caregivers. The interview guide covered a wide area as informants were representing multi-stakeholders in the "Healthy and Active Ageing" agenda.

Analysis for the survey and the key informants interviews were conducted separately, after which findings were integrated and collaborated with those from the desk review.

It must be noted that the government of Botswana uses age 64 years as the cut-off point for older adults, with those aged 65 years and above being classified as old adult population. This is evidenced from the census and other national surveys/reports as well as the eligible age for the universal old age pension. However, the government considers 59 years as the cut-off age for productive population as evidenced by the use of age 60 years as the retirement age for public servants. This leaves those aged 61 to 64 years suspended from receiving old age pension. On the other hand, WHO uses age 59 years as the cut-off point, with those aged 60 years and above being classified as older adults. The age of 60 is used for this situational analysis such that both the Botswana and the WHO definitions of old age are accommodated. In situations where the reports do not separate age group 60-64 from the rest of the adults, as has been the case in surveys prior to the 2011 housing and population census, the report will be based on available information.

3. DEMOGRAPHIC PROFILE OF BOTSWANA OLDER ADULTS

3.1 Proportion of Older Adults in the Population

According to fig. 2, the percentage of persons aged 60 years and older was reported as 5.5%, 6.2% and 6.8% in 2001, 2006, and 2011, respectively. However, in 2011, the age group 60-64 years was also reported separately and it constituted 1.9% of the total population. Persons aged 60 years and older therefore constituted 6.8% of the total population of 2024904 in the 2011 population and housing census. The percentage of older adults' population is projected to reach 8.5% and 8.9% of the total population in 2022 and 2026, respectively (United Nations, 2017).

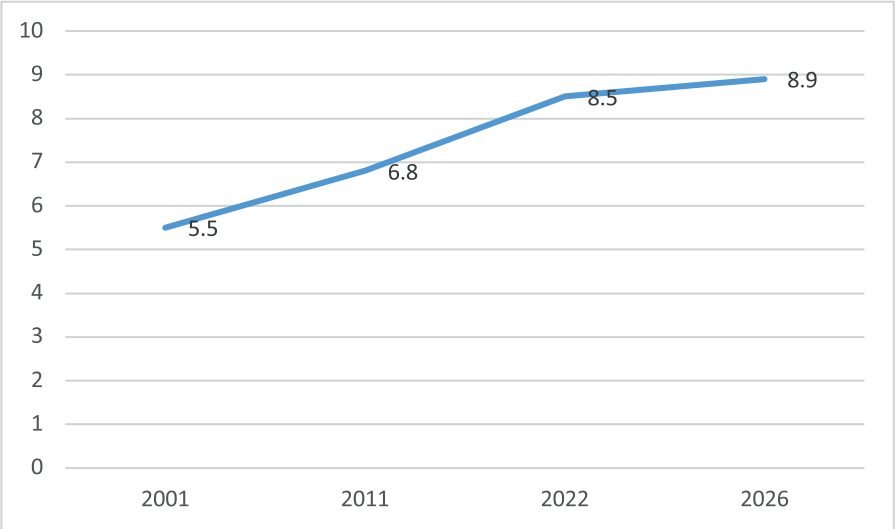


Fig. 2 shows the population trend of older persons from 2001 and as projected for 2026: United Nations, 2017. This typically an increasing population.

3.2. The Structure of the Older Adults Population in Botswana

The 2014 Statistics Botswana data show a decreasing population of men and women from ages 60 to 94 years (Fig. 3). After 94 years, the numbers increase again for both sexes. From the lowest age group, the number of women exceeds that of men at all age groups, with male-to-female percentage ratios of 45:55, 40:60 and 35:65. After age 94 years, the number of males slightly exceeds that of females, with the percentage ratio of males-to-females being 52:48. The age distribution may suggest that men who live beyond 94 years are more resilient than others. However, what the report does not show are the demographics of marital status, level of education and previous occupation, which may explain resilience.

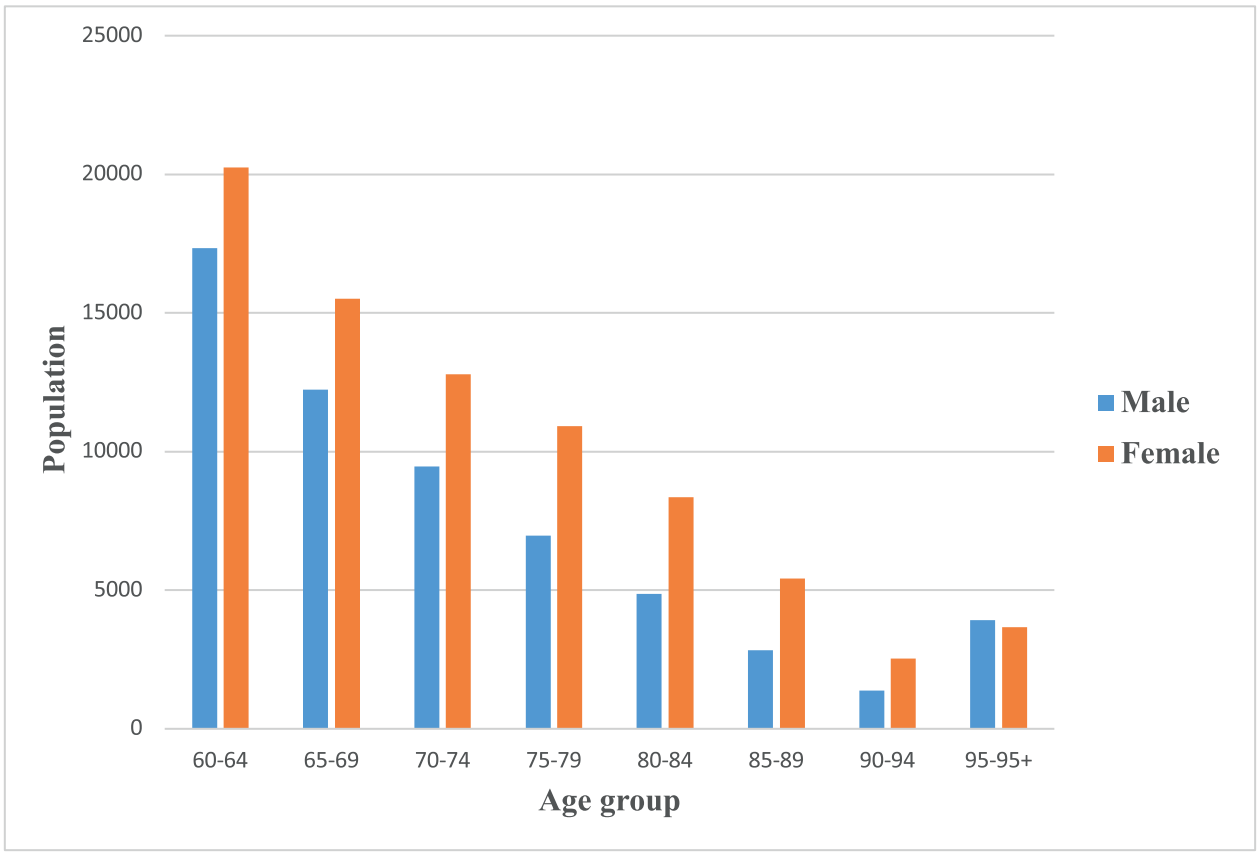


Figure 3: Number of Older Adults by Age Groups: Statistics Botswana 2014

In the current survey fig.4, shows a similar pattern of women exceeding in numbers more than men per age group while both sexes simultaneously decrease significantly up to the age of 80. However after the age of 80 there seems not to be a significant change in numbers of both sexes.

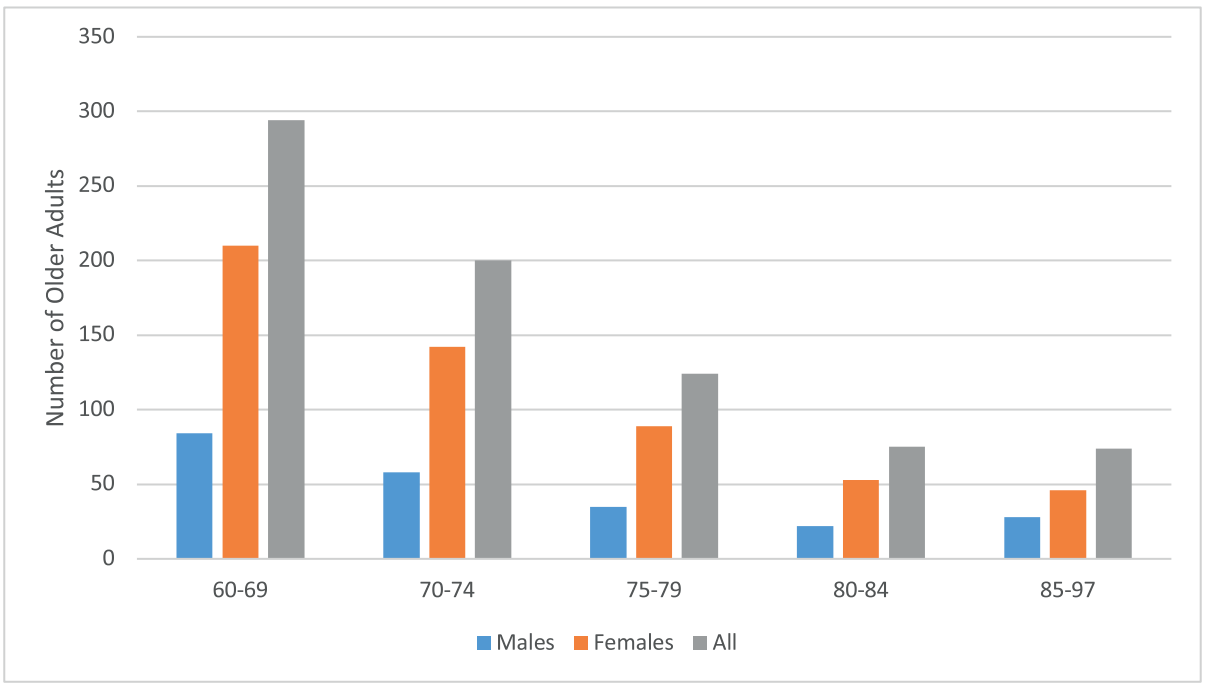


Fig. 4 shows the 2019 current survey of the 770 older persons by age and sex.

3.3 Distribution of the Older Adult Population by Type of Residence

Statistics Botswana (2014) report indicated that 51% of older adults reside in rural areas and settlements, 40% in urban villages and 9% in cities and towns (Fig 5).

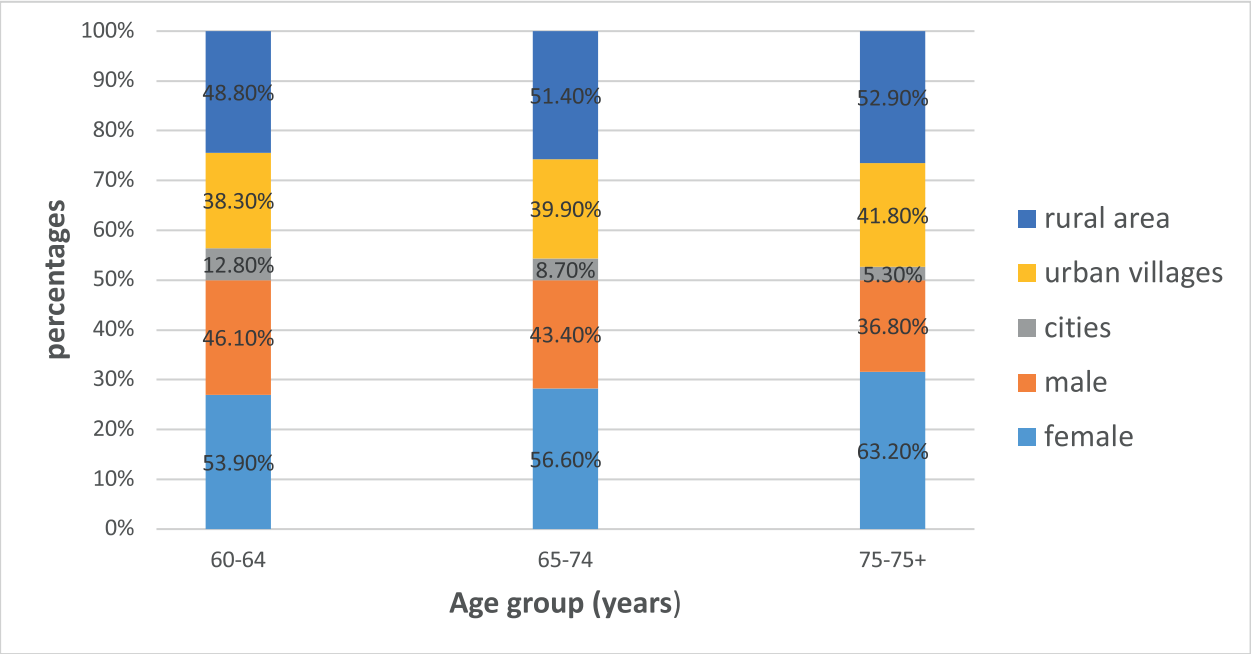


Figure 5: Percentage age distribution by gender and type of residence: Statistics Botswana (2014). Botswana in Figures 2012/13

3.4 Marital Status

The 2011 population and housing census report (Fig. 6 and Fig 7) shows that the "never married" category is common among females across all groups from 60 years to over 75 years. Majority of Females (80%) were widowed and less than 20% men were widowed.

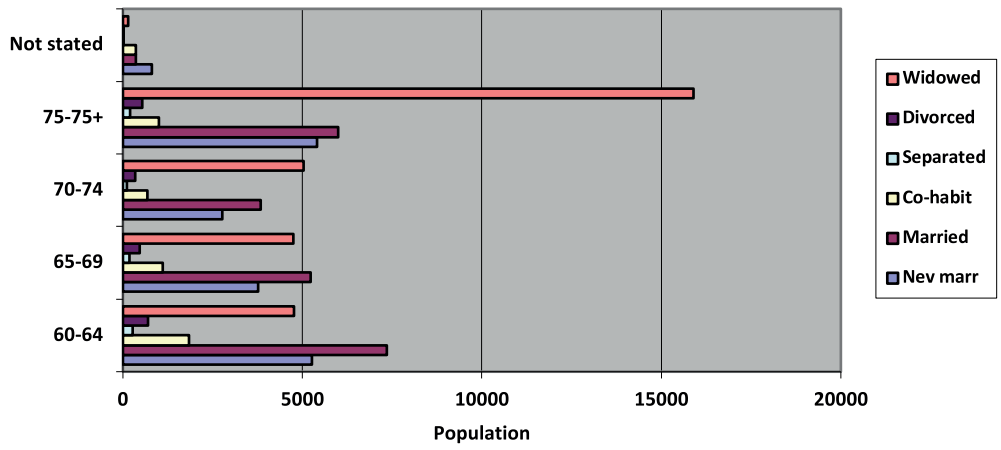


Figure 6: Females' Marital Status: Census 2011

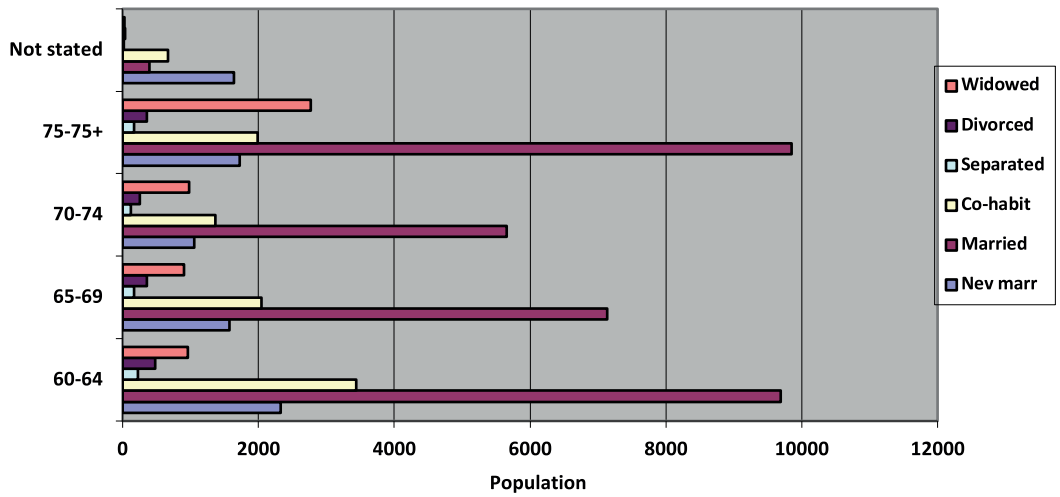


Figure 7: Males' Marital Status: Census 2011

The 2019 survey shows more females were single or widowed and more males reported being married. However, the survey has insignificant number of separated and divorced males and females (Fig. 8)

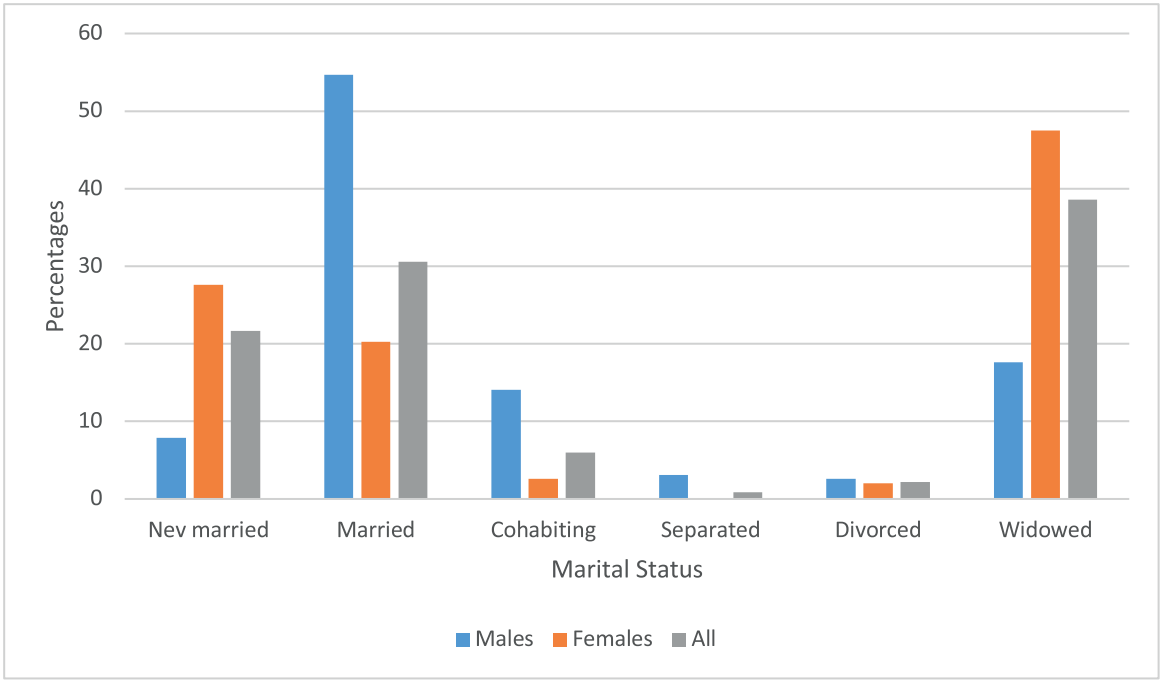


Figure 8: Marital Status: 2019 Survey on a sample size of 770

3.5 Educational Attainment

Figure 9 shows 47% of older adults had no formal education (Statistics Botswana, 2017). Findings of the current survey (Fig. 10) indicate that 93.7 % of the sample had either no education or attained primary education.

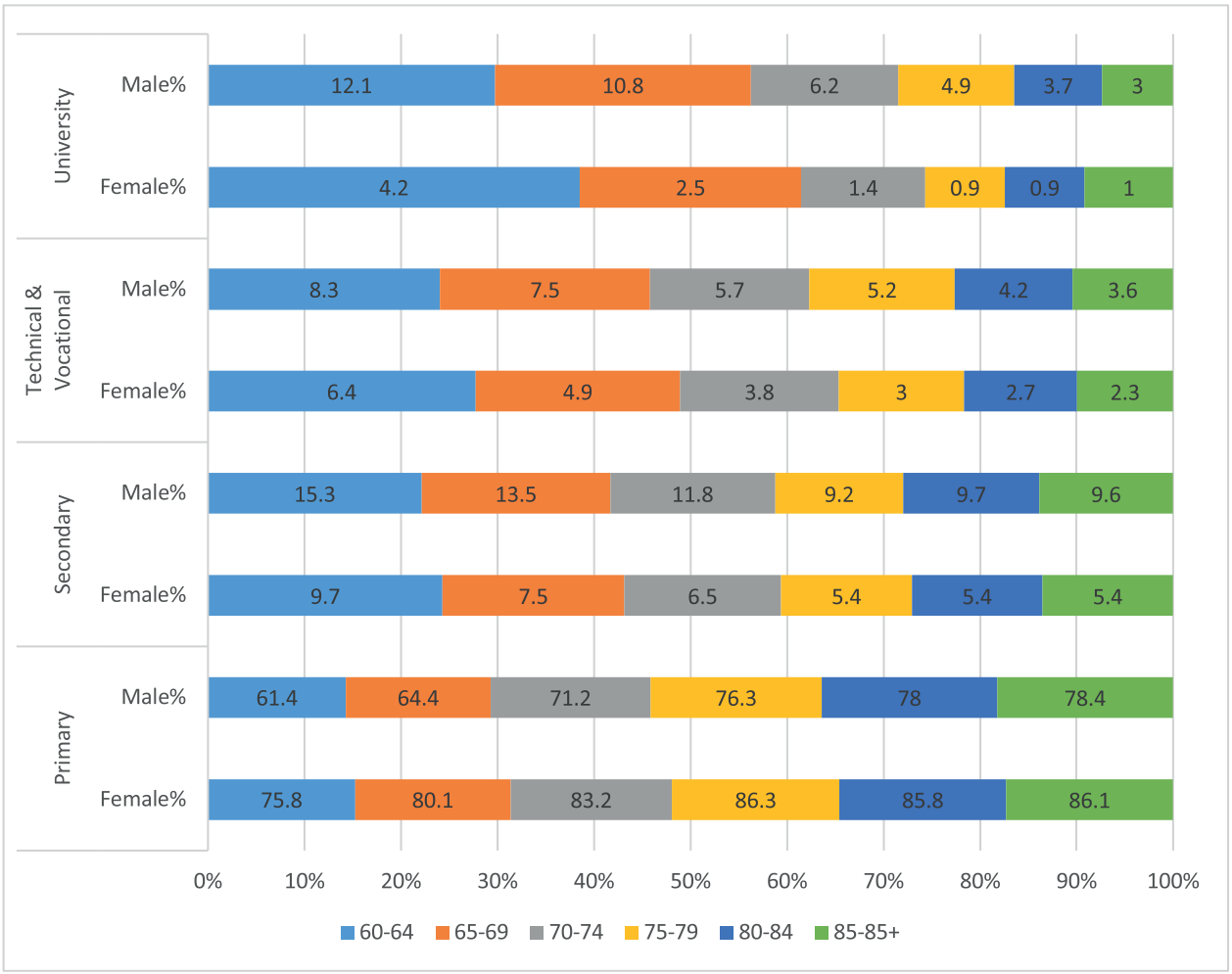


Figure 9: Educational attainments of older adults: Census 2011

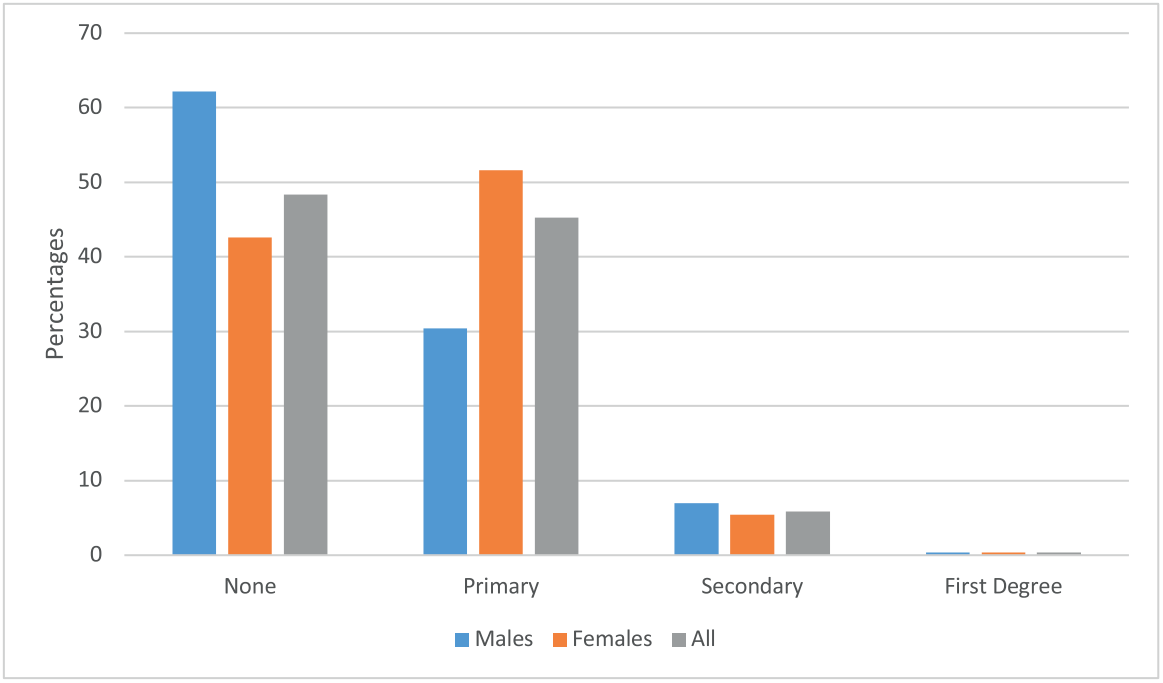


Figure 10: Educational attainments of older adults: 2019 current survey

3.6 Employment History and Income

In the 2019 current survey only 11.5% of the participants reported that they had enough income for their basic needs; while 37.1% were satisfied with their living conditions.

Seventy four percent (74%) reported having had formal employment (Table 1), of which majority were engaged in non-skill based occupations such as mining and cleaning.

The 2011 population and housing census (Fig. 11) revealed that only 3.8% and 8.1% of older adults were engaged in seasonal and non-seasonal paid work, respectively. A higher percentage of males than females reported being in paid employment in the last 12 months. More females (45.8%) than males (20.8%) reported being home makers. Twenty percent (20.4%) of persons aged 65 years and older reported that they had spent the last 12 months prior to the census not participating in any economic activity because they were sick.

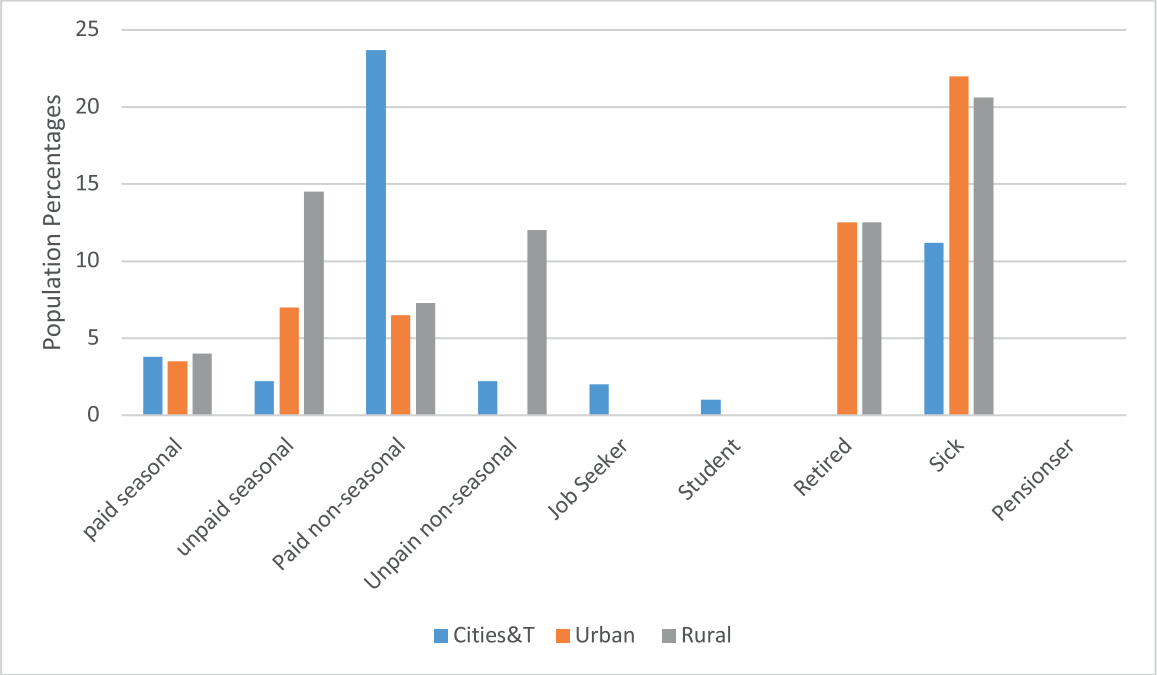


Figure 11: Percentage distribution of Economic Activities by Type of Residence: Census 2011

Table 1: Pre-retirement Longest Occupation: 2019 current survey on a sample size of 770

	Female		Male		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
White collar/Office or Profession	24	84.9	5	17.2	29	5.1
Blue collar/Manual or industrial	329	5.2	212	94.8	541	94.9
Total	353 of 441	100	217 of 229	100	570 of 770	100

Comments: A total of 200 or 26% (186 females and 14 males) never had a formal occupation)

Table 2: Post Retirement Work: 2019 Survey current survey on a sample size of 770

	Female		Male		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Paid	139	70.2	104	49.1	245	59.2
Unpaid	59	29.8	108	50.9	169	40.8
Total	198	100	212	100	414	100

Comments: To note that post-retirement paid work could be Ipelegeng (government's poverty reduction program).

4. SOCIO-ENVIRONMENTAL CIRCUMSTANCE OF OLDER ADULTS IN BOTSWANA

4.1 Living Arrangements, Social Contacts and Social Participation

Living arrangements affects the person's quality and satisfaction with life as it may influence access to support resources. According to Fig.12, the 2011 population and housing census revealed that 12.6% of older adults aged 65 years and older live alone, that 37.1% live with spouse, that 50.4% live with their children, that 53.8% live with close relatives, that 13.2% live with other relatives, and that 7.8% live with persons they are unrelated to; that more males (17.4%) than females (9.3%) live alone, and that the likelihood of living alone decreases with advancing age. By type of residence, the results show that 15.7%, 11.2% and 8.9% of older adults live alone in rural villages, cities and towns, and urban villages, respectively. The majority of older adults who live with their children are in urban villages, followed by those who are in cities and towns, and lastly by those who are in rural villages.

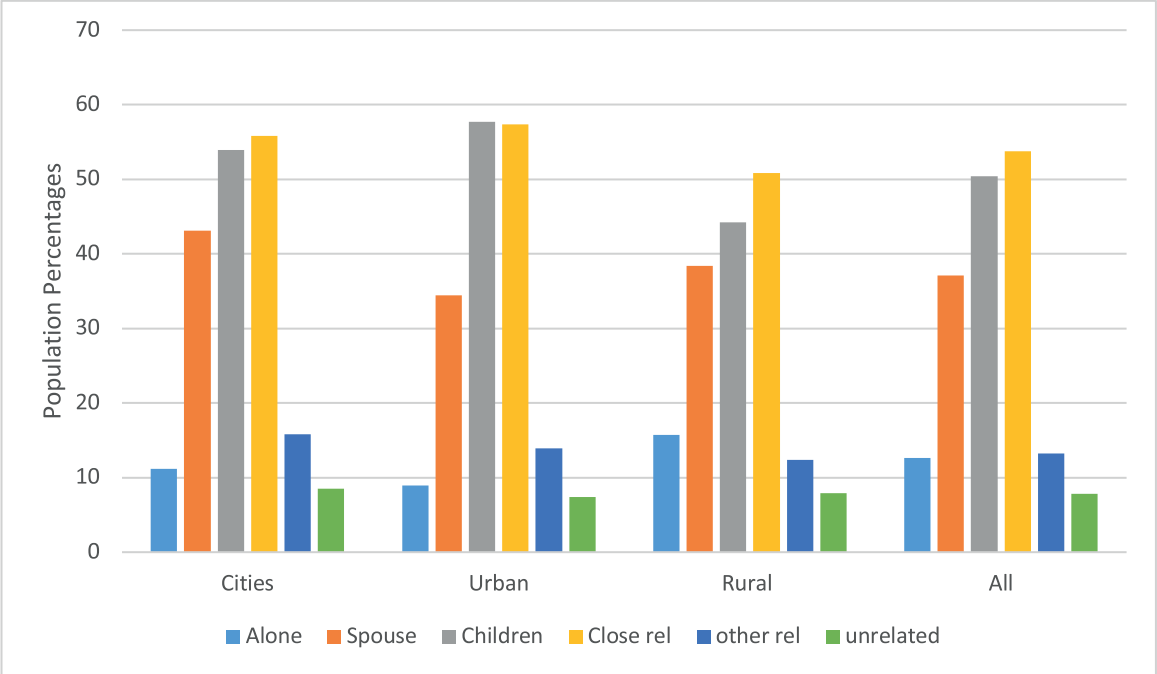


Figure 12: Living Arrangement by Residence: Census 2011

In the 2019 current survey (Fig 13 & 14), on a sample size of 770, the majority (88.8%) of the older adults were living with children or relatives (91.2% for females and 86.3% for males). Only two (one male and one female) reported living in institutions. Sixty four percent of the sample reported having someone helping with the day-to-day tasks; and the helpers were mainly daughters (56.8% of females), daughters-in-law (46% of males) and sons in-law (23.6% of males). More males than females listed spouses as their helpers (19.4% versus 5.9%). Thirty percent of the sample reported seeing or speaking to a relative on a daily basis. However, males were less likely to speak to a relative on daily basis than females. Less than 50% reported participating in community meetings/activities occasionally (47.4%) or regularly (43%). Males seemed to be more regular participants than females (49.6% versus 41.6%).
Seventy-seven (77.2%) percent of the sample reported no incidents of abuse or maltreatment in the past two years. Occasional and regular older adult abuse was reported by 16.2% and 6.6% of the sample, respectively. There was no difference in abuse by gender of the older adult.

About 47% reported feeling lonely, either persistently (31.5%) or infrequently (15.1%). There were no gender differences in feeling lonely. However, 56.4% of the sample reported having had feelings of being tense and worrying about 'this and that' more than usual. There were no gender differences. On the intensity of worrying, 40.7% reported not unduly worrying while 38% reported worrying a lot; there were no gender differences. When asked whether or not they had recently been sad, miserable or low spirited:41.4% report depressed mood, 38.4% for rare experience of depressed mood, and 19.6% for no experience of depressed mood, respectively. Seventy-four percent (74%) of the participants reported having mobile phones while 2.6% home Internet, respectively.

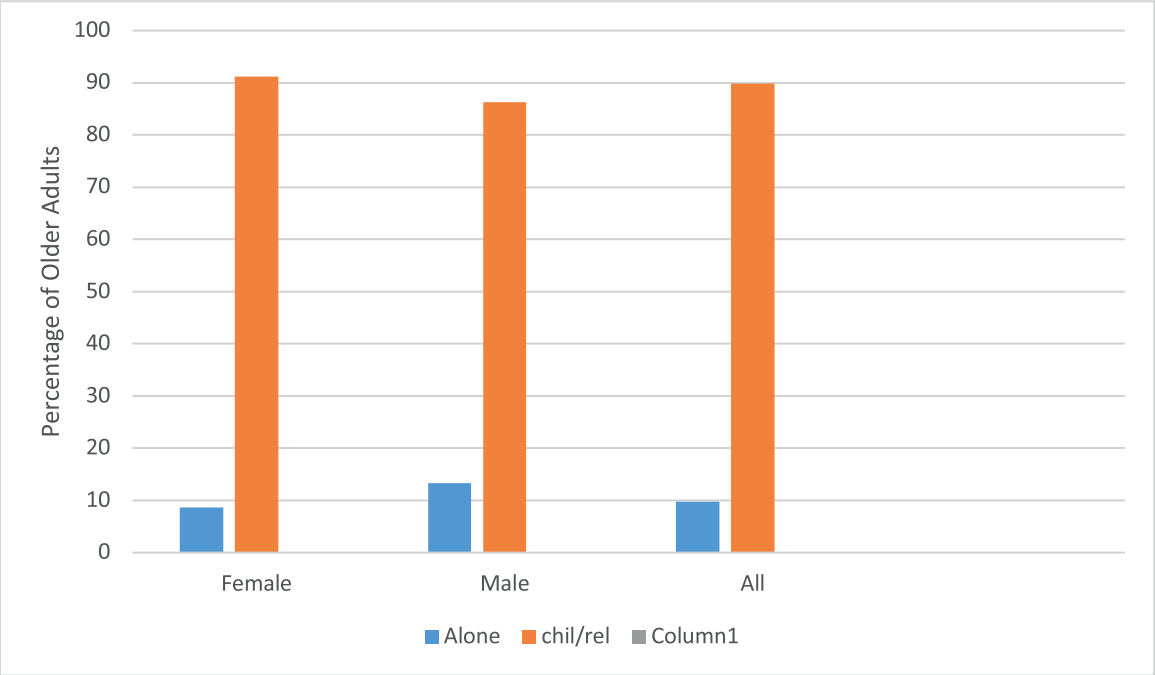


Figure 13: Living Arrangement: 2019 current survey on a sample size of 770

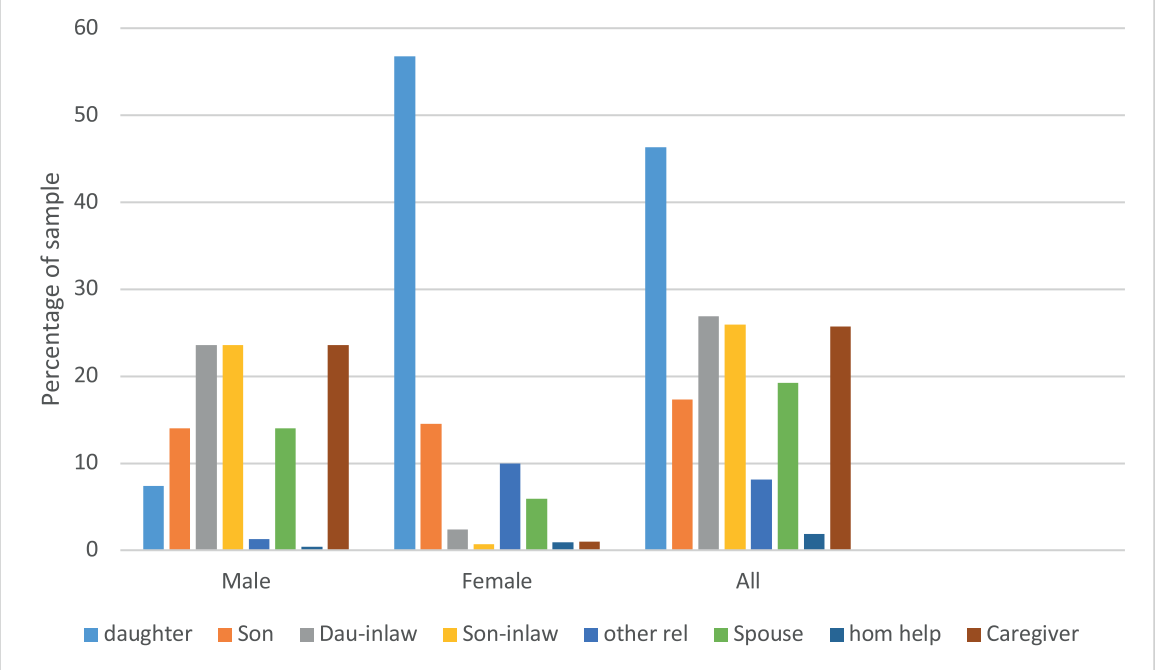


Figure 14: Relationship with helper: 2019 current survey on a sample size of 770

4.2 Housing

Through its National Policy on Housing of 1999, the government of Botswana is committed to ensuring the population's access to housing that is safe and that has acceptable sanitary conditions. The government takes housing as instrumental to economic empowerment and poverty alleviation (Singh & Dwivedi, 2015). According to Fig.15, between 1991 and 2011, the proportion of traditional housing

units to modern ones in the country reduced from 64% to 13%. However, rural villages still have higher number of housing with non-durable building materials compared to cities and urban villages (Singh & Dwivedi, 2015). Although the report on households and housing unit was not disaggregated by the age of occupants, the 2017 national demographic survey report indicates that the distribution of modern durable housing unit by residence (based on wall construction materials) is 99.1% for towns and cities, 97.8% for urban villages, and 67.1% for rural villages, with an average of 87.5% for the total households. Distribution of housing units with non-durable construction materials was 32.5% for rural villages, 2.1% for urban villages, and 0.7 for cities and towns, with a national average of 10.0%. Considering that about half of the older adult population resides in rural villages, the numbers suggest that many older adults could be living in non-durable and unsafe housing structures.

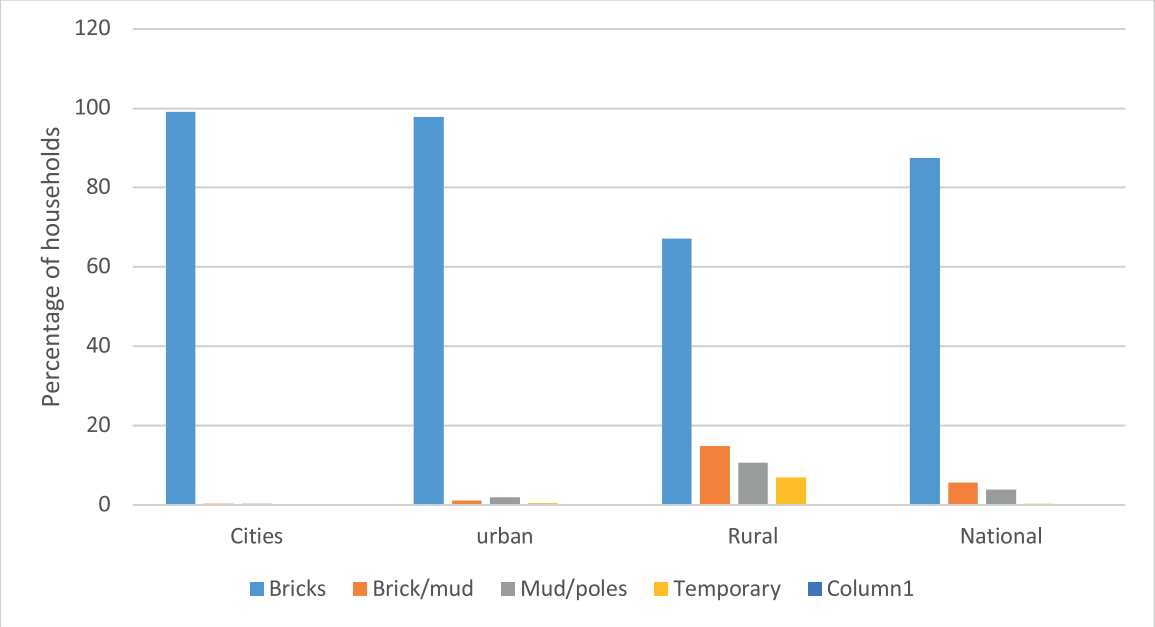


Figure 15: Housing Wall Structure by Residence: Census 2011

Population and housing census report on household headship indicates that 17% of the households were headed by older adults (60 years old and above) whereas 83% were headed by the working age population (15-59 years)(Fig 16). Disaggregated by gender, age group 60-64 years had 49.8% of households headed by females while the rest of the group had 55.9% households headed by males. For the entire households sampled, females headed 47.5% while male headed 52.5% of households. The average household sizes were 2.9, 3.5, and 2.4 members for cities and town, urban villages, and rural villages, respectively. It is evident that the burden of household headship for females increases with advancing age. This scenario may be related to widowhood that is more common among females.

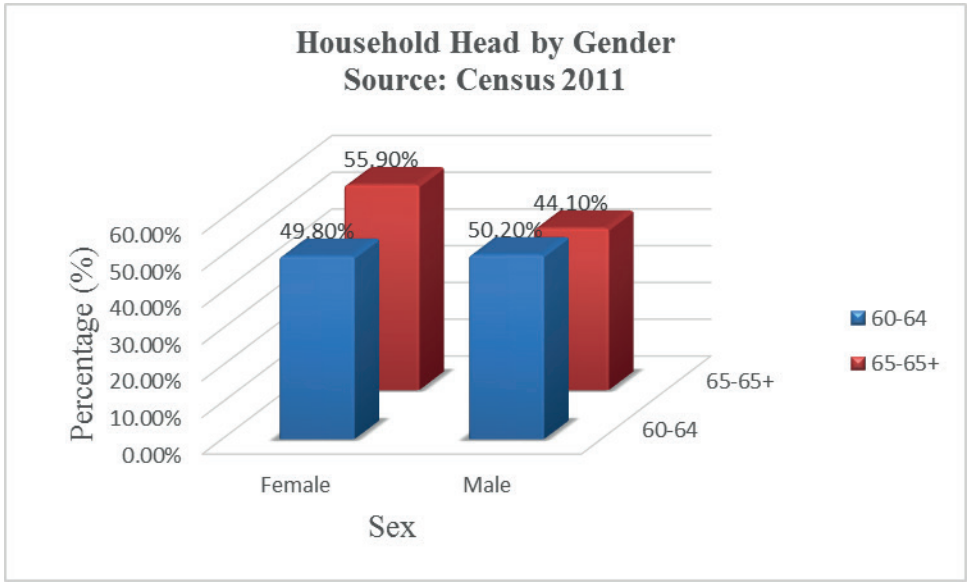


Figure16: Household Head by Gender

4.3 Access to Clean Water

Through its Public Health Act, Botswana recognizes human right to water and sanitation and authorizes health officers to take lawful action to ensure that water meant for human and domestic use is free from contamination. The country's national water master plan was reviewed (2008-2013) to improve access to clean water for the population. Water in Botswana is mainly from rivers, dams and pans (surface water) and boreholes (underground water). Access to clean water in Botswana reached 99.5% for urban areas and 84.1% for rural areas in 2008 (Government of Botswana, 2012). In the recent 2019 survey, 87.8% (90.3% of female and 83.8% of males) of the survey population reported having access to portable water supply.

According to Fig 17, cities and urban villages have more access to safe and clean water when compared to rural villages.

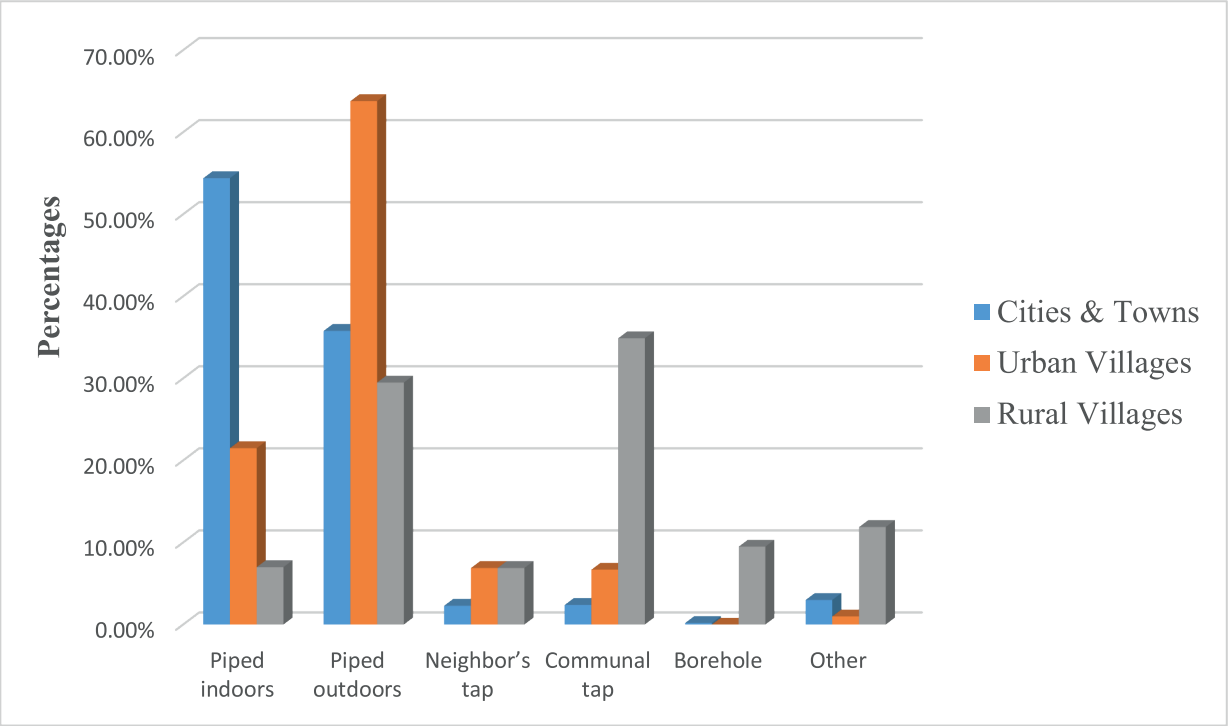


Figure 17: Water Supply for Population aged 65 years and older: Census 2011

4.4 Sources of Energy

It is evident that accessibility of electricity for lighting is increasing, having sharply increased from 38.3% in 2006 to 67.4% in 2017. Fig.18 shows access to electricity and type of residence, even though it is still low in rural villages, the use of electricity for lighting is 85.6%, 84.0% and 35.4% for cities and towns, urban villages and rural villages, respectively. Rural villages still have substantial percentage of households using paraffin (22.9%) and candle (18.1%) for lighting (Statistics Botswana, 2018). With regard to cooking, most households in cities and towns and urban villages use liquid petroleum gas (62.9%) followed by electricity (49%). However, rural households commonly use wood for cooking (72.6%) followed by liquid petroleum gas (15.2%) (Statistics Botswana, 2018). The use of energy for heating spaces is low at all types of residence. However a high proportion of rural residents (51%) still use wood for heating spaces.

In the current 2019 survey, 75.5% (78.8% for females and 69.3% for males) of the sample reported having access to electricity in the home.

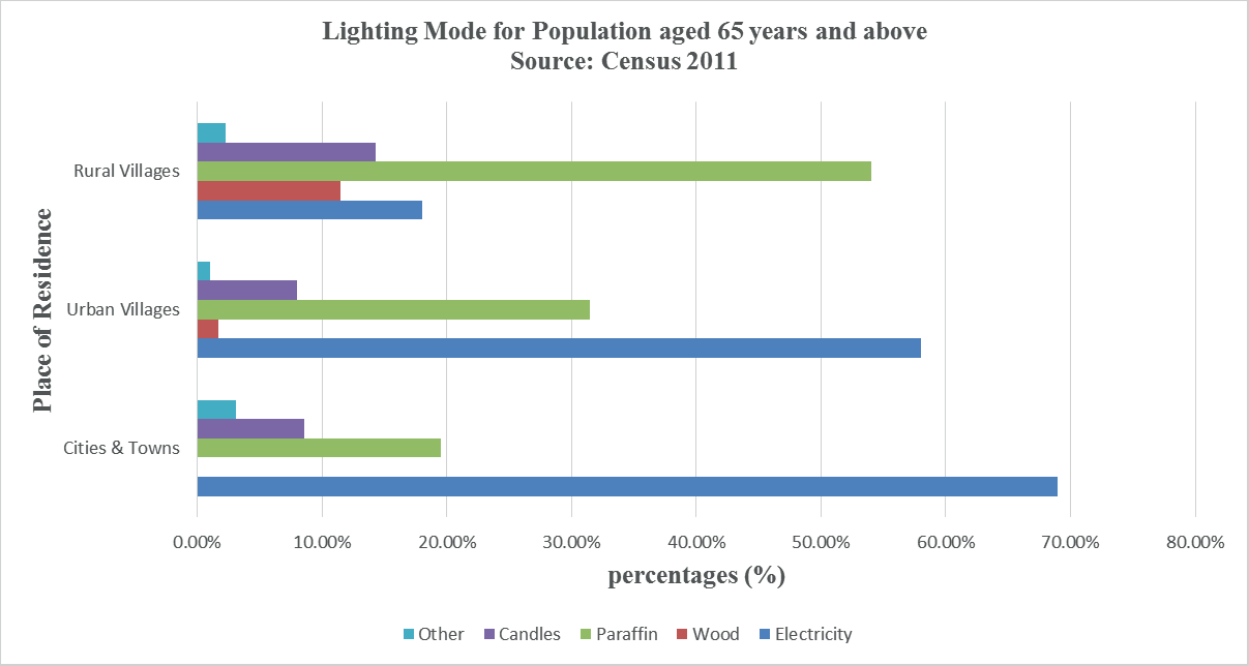


Figure 18: Lighting Mode for 65-Year-Old

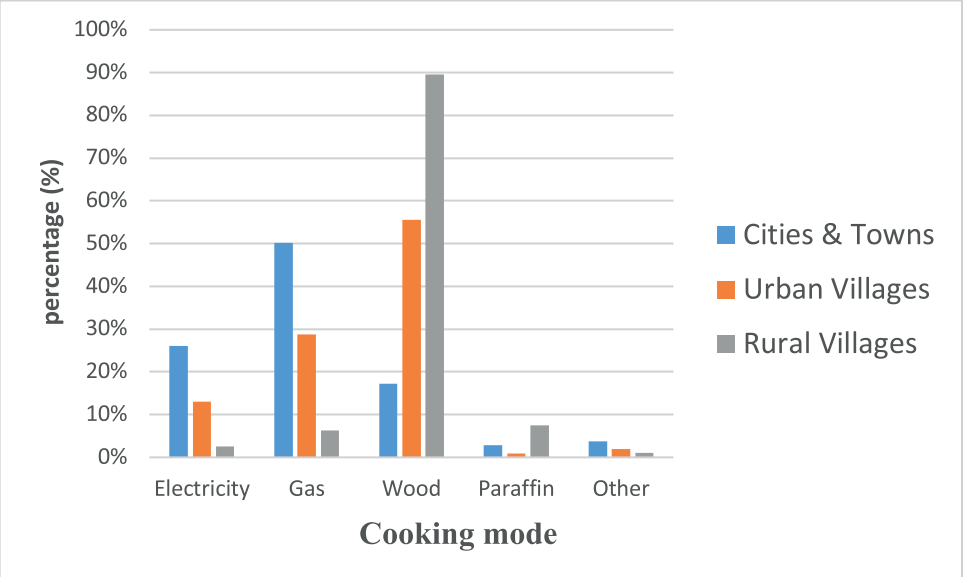


Figure 19: Cooking mode for population aged 65 years and above: Census 2011

4.5 Sanitation and Refuse Disposal

Although the National Wastewater and Sanitation Policy and the National Master Plan for Wastewater and Sanitation are supposed to guide waste management, the policy lacks a finance plan, which makes implementation difficult.

Examining households with older adults aged 65 and older, the 2011 population and housing census revealed that in cities and towns, 54.7% of the population owned water borne system toilet while for urban villages and rural villages, ownership of flush toilets was 52% and 39%, respectively. Complete absence of toilet amenities was 0.5%, 3.7% and 37.8% for cities and towns, urban villages, and rural villages, respectively. In the 2019 survey, 84.8% (87.3% for females and 85.1% for males) (Fig 20& 21) reported having access to sanitation and refuse disposal. The complete absence of toilets across types of residence is disturbing and even more so in rural villages where it approaches 50% of the households with very old people. When that happens in cities and towns, it is most likely in poor overcrowded neighborhoods and this puts the health of populations at risk.

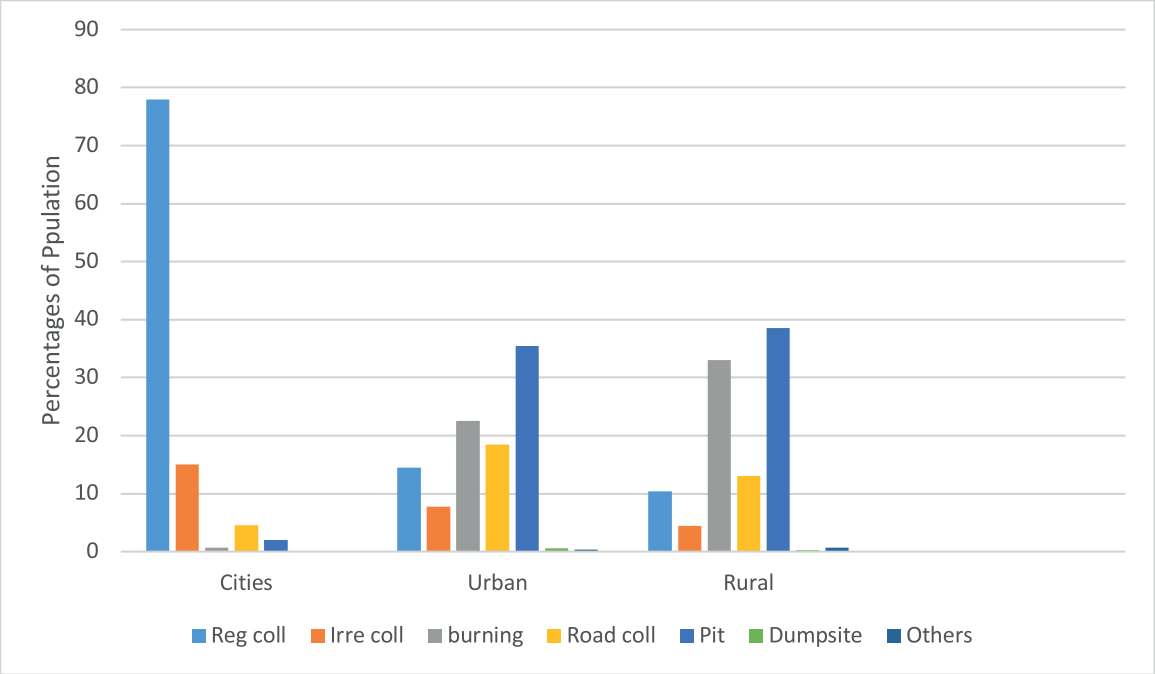
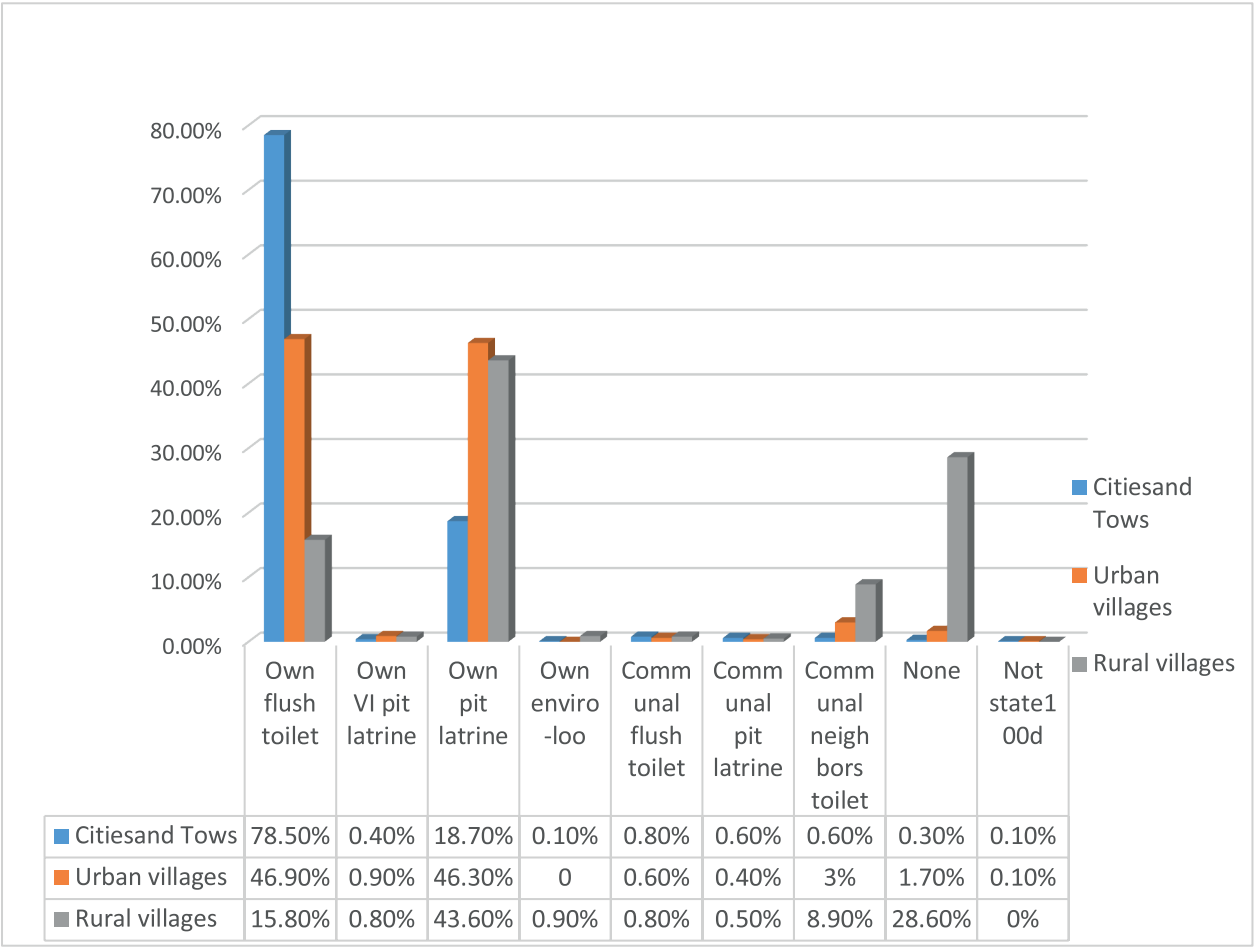


Figure 20: Refuse Disposal: Census 2011



	Own flush toilet	Own VI pit latrine	Own pit latrine	Own enviro -loo	Comm unal flush toilet	Comm unal pit latrine	Comm unal neigh bors toilet	None	Not state1 00d
Citiesand Tows	78.50%	0.40%	18.70%	0.10%	0.80%	0.60%	0.60%	0.30%	0.10%
Urban villages	46.90%	0.90%	46.30%	0	0.60%	0.40%	3%	1.70%	0.10%
Rural villages	15.80%	0.80%	43.60%	0.90%	0.80%	0.50%	8.90%	28.60%	0%

Figure 21: Household facilities by type of locality for all population (not by age of population): Census 2011.

4.6 Access to Utilities and Satisfaction with Living Conditions

The 2019 survey, on a sample size of 770 participants were asked if they had access to a list of utilities including portable water supply, sanitation and sewage services, electricity, mobile telephone, internet, and enough income for basic needs. They were also asked to indicate whether or not they were satisfied with their general conditions of living. They generally reported to have access to most utilities. According to Fig. 22, highest percentage reporting to have access was for portable water supply at 87.8% and the lowest was for internet in the home at 2.6%. Income for the basic needs was reported by only 11.5% of the participants (12.8% of females and 8.3% of males). Thirty-seven percent (37.1%) of the participants (37.75% of females and 36.7% of males) reported to be satisfied with the general living conditions. Except for income, there were no major differences between males and females.

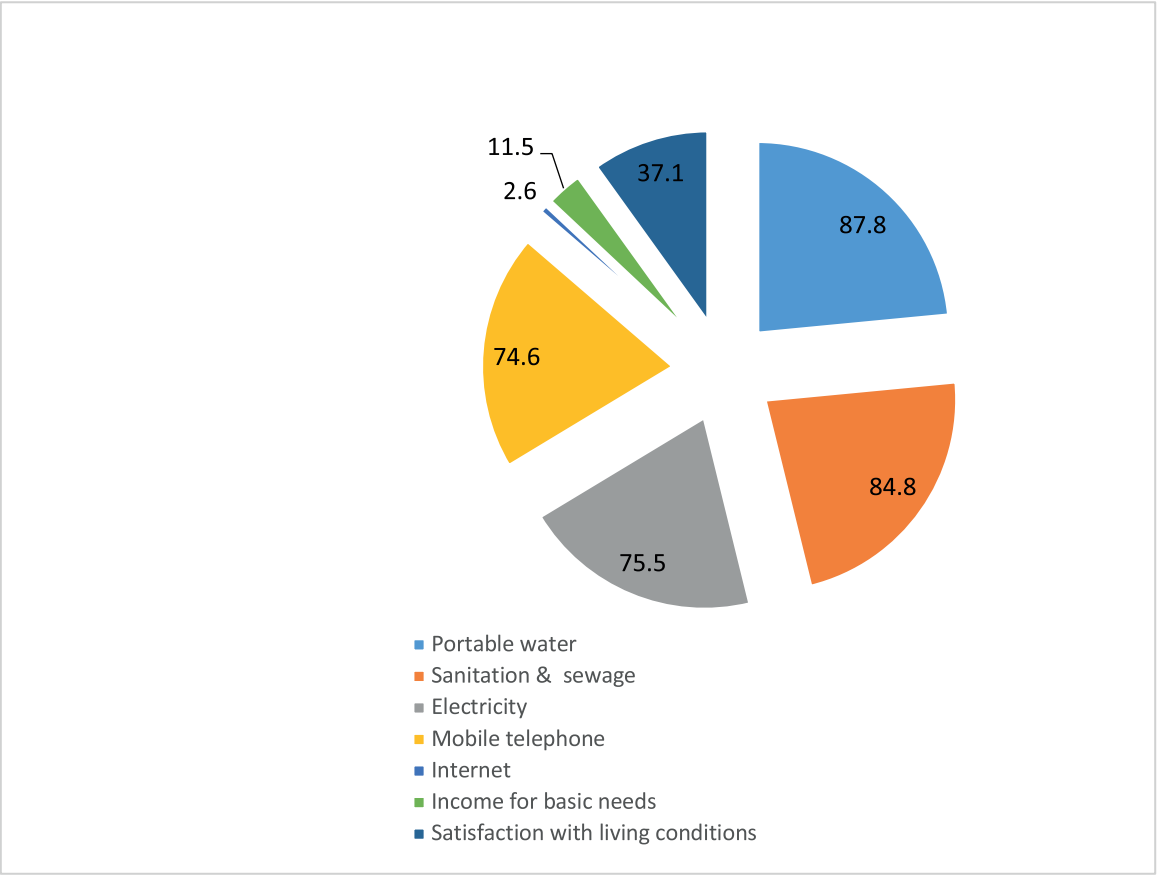


Figure 22: Participants 'Access to Utilities

5. HEALTH STATUS OF OLDER ADULTS IN BOTSWANA

5.1 Functional Capacity

Healthy ageing centers on functional capacity, which is the combination of the intrinsic capacities of the individual, the characteristics of his/her living environment, and their interaction (Beard et al., 2016). Four priorities for enhancing functional capacity in old age include:

- alignment of the health system to older populations, provision of systems that maintain functional ability of older persons
- provision of age-friendly environment characterized by interconnected domains of meeting older persons' basic needs
- providing opportunities for older people to learn, grow, and make decisions
- putting in place improved measurements for Monitoring and Evaluation

From its definition and description, functional capacity covers quite a wide variety of areas and factors, among others, level of income and education. However, one area that is obviously linked to functional capacity is disability, which is defined in the Botswana National Policy on Disability of 2011 in terms of person's inability to function on an equal basis with others who have no impairment, including the ability to carry out activities of daily living.

A large proportion of older adults in Botswana have disability. Out of the 59,103 population of persons with disability counted in the 2011 population and housing census, 19,699 or 33.2% were aged 60 years and above. In the Botswana Demographic Survey of 2017, older adults (60 years and above) constituted 39.2% or 35,629 of the 90,945(Fig.23 & 24) persons with disability. The most common disability for older adults was visual impairment (37.1%) followed by impairment of legs (27.9%) and hearing impairment (14.2%). Self-care disability (inability to carry our activities such as bathing and dressing up without assistance) was at 4.9%; and it was reported to be higher for males than females.

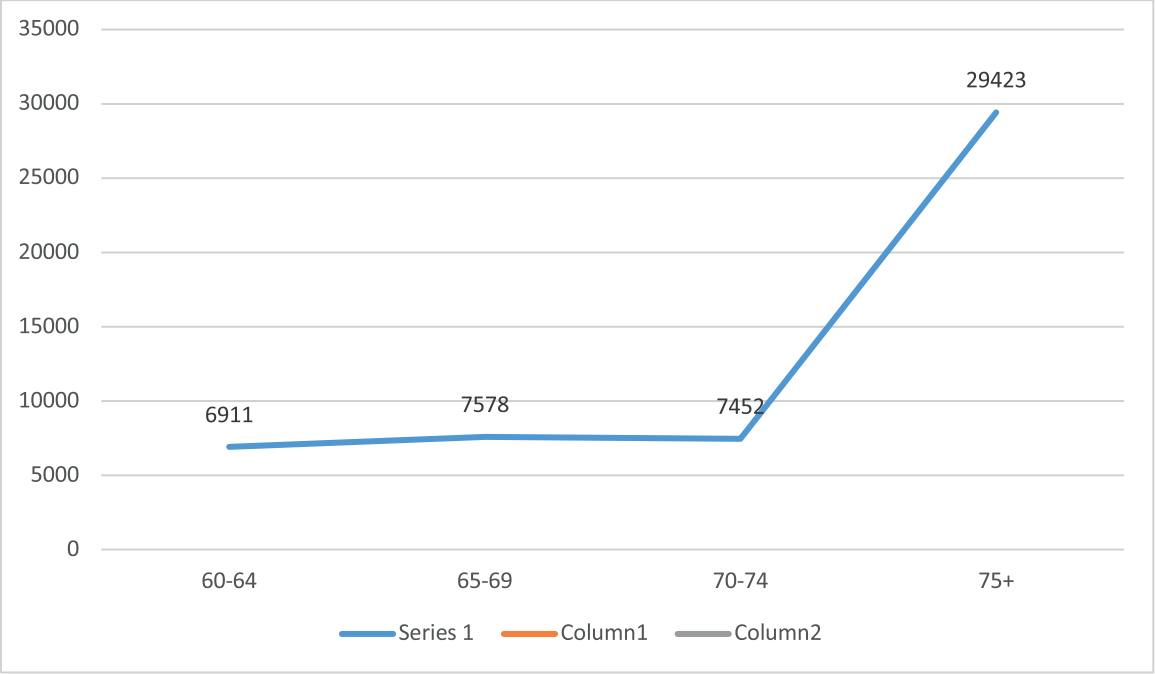


Figure 23: Older Adults with Disability: Statistics Botswana 2018

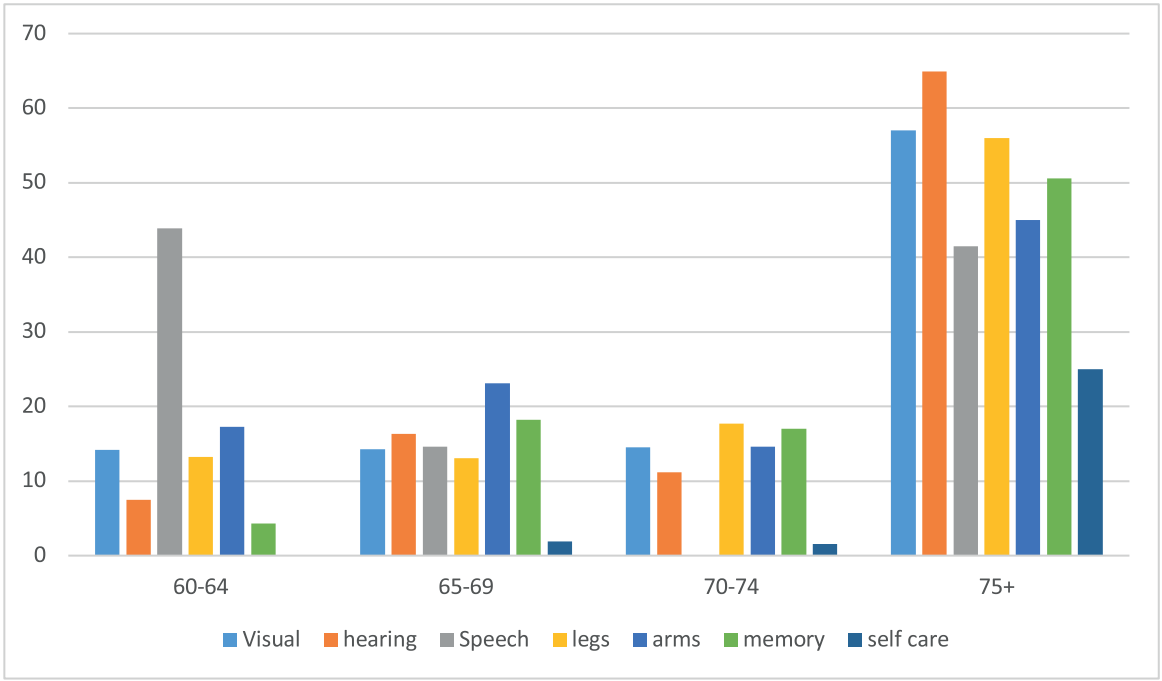


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Figure 24: Disability by Age: Statistics 2018

The 2019 older adult survey, on a sample size of 770, assessed participants' freedom of mobility. Even though the majority of the participants reported that they could access public transport, go up and down the stairs, get to and use the toilet, and access community public spaces even if they were visually or hearing impaired, they did so with some difficulty, and the frequency percentages were 16.9%, 57.2%, 87%, and 56.5%, respectively(Fig.25). Females tended to have slightly higher frequencies, indicating that they had slightly more serious mobility challenge. Seventy one percent (70.7%) reported that the neighborhood was suitable for walking and use of wheelchairs. Thirty six percent (35.9%), 20.6% and 38.4% reported that their ability to do practical things had not changed, changed for better, and changed for the worse, respectively during the past two years. There were no differences by gender. Almost all of the participants could cope with bathing (96%), dressing up (96.2), getting around indoors (95.9%), getting around outdoors including shopping (94.9%), and toileting alone (95.8%), No gender differences were noted. Regarding difficulty in walking long distances (e.g.1 kilometer),their experiences were as follows: 37.5%, reported no difficulty, 22.6%, mild difficulty, 18.3%, moderate difficulty, 18.4%, severe difficulty, and 3.3% , extreme difficulty, respectively. Eighty six percent (85.5%) of the sample reported that falls were either rare or absent for them; and there were no differences by gender.

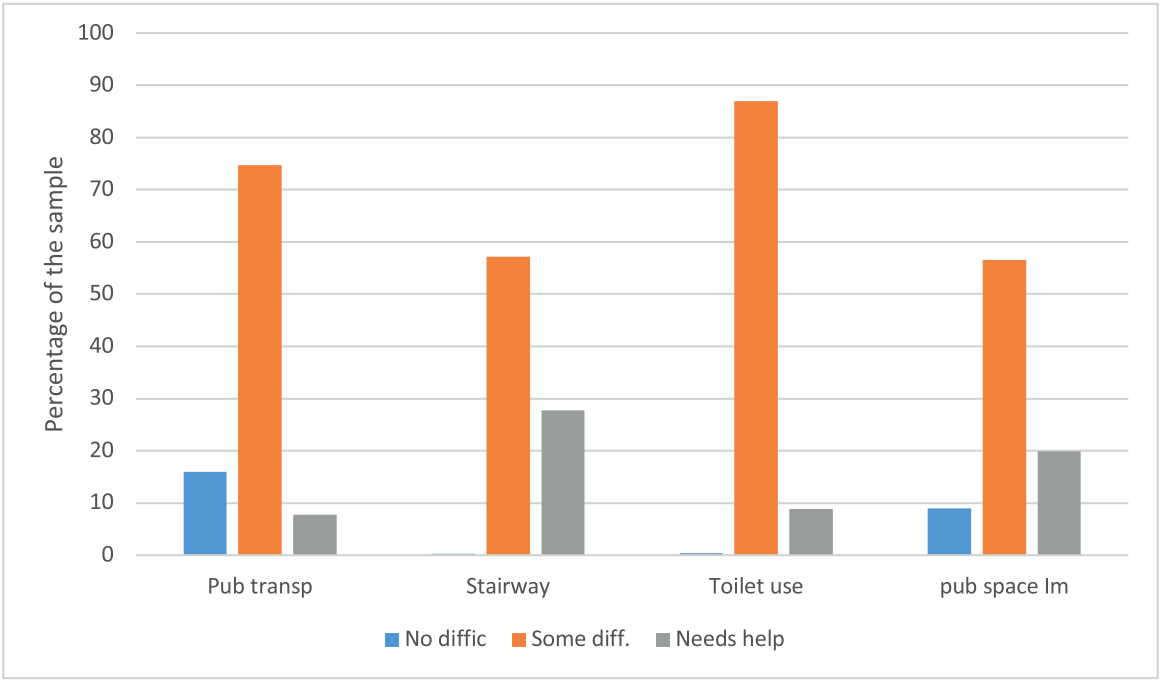

Figure 25: Freedom of Mobility: 2019 Survey on a sample size of 770 older persons

5.1.1 Physiological and sensory disturbance by gender; 2019 Survey, on a sample size of 770

The 2019 survey (Table 3 and Fig. 26), indicated that older adults were experiencing some disturbances in physiological and sensory functioning that to some extent limited their self-care and day-to-day activities. Twelve percent (12%) had experienced tremors of the hands with 6.2% of those being resting tremor and 5.8% experiencing action tremors.. Sixty percent reported difficulty starting and slowing walking, with 60.2% indicating that the impaired gait limited their day-to-day activities. Furthermore, 36.3% and 67.7% of older adults respectively had experienced hearing and eye sight problems, which interfered with their day-to-day activities. However, only 2.8% and 18.2% were using hearing aids and prescription glasses, respectively. Females seemed to be more inclined than males to seeking health services for their deteriorating sensory function, as, for instance, 87.5% and 19.6% females were using hearing aids, and prescription eye glasses, respectively, versus 2.8% and 0.2% of males using hearing aids and eye glasses, respectively.

The low use of assistive devises happens in a situation where persons over 65 years of age get such devises at a subsidized cost (MoHW & WHO, 2017). Seventy percent of the sample, with equal proportions of males and females, reported no bladder control problems, with 25.1% and 4.5% of those experiencing bladder control problems reporting occasional wetting and frequent wetting, respectively. A higher proportion of females than males with bladder control problem experienced frequent wetting (18% versus 4.4%). Regarding memory, 81% of the participants reported a tendency to forget things with more females (87.3%) than males (66.1%) reporting the problem; while 34.8% and 24.1% reported difficulty in learning a new task and having forgotten their way and gotten lost in the neighborhood, respectively. Ninety percent (90.4%) of those reporting forgetting indicated that it was a problem; with 52% viewing it as a moderate problem while 38.4% saw it as a severe problem.

Table 3: Memory Problems on a sample size of 770 older persons

	Female		Male		Total	
	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
Difficulty learning a new task	189 of 536	35.3	76 of 227	33.5	265 of 762	34.8
Tendency to forget things	468 of 536	87.3	150 of 227	66.1	618 of 763	81.0
Ever been lost in the neighborhood and forgotten your way	131 of 534	24.5	52 of 226	23.0	183 of 760	24.1

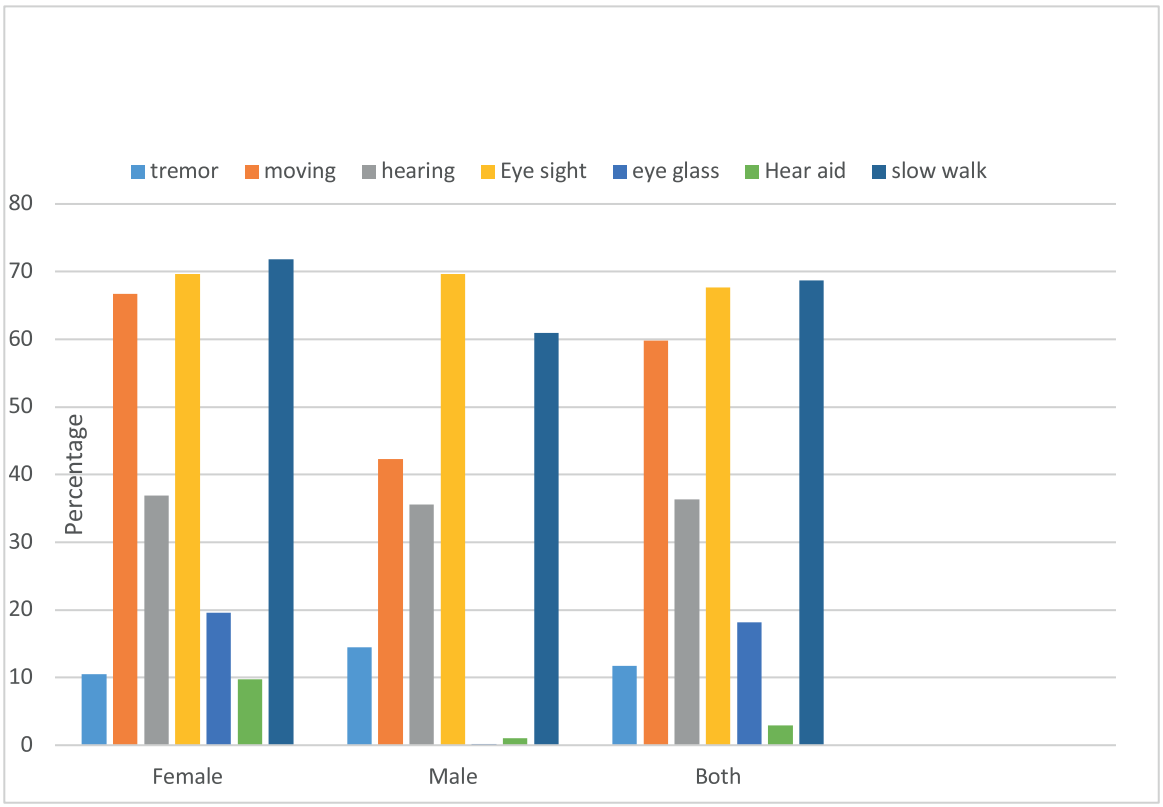

Figure 26: Impairment and Use of Assistive Devises by Gender: 2019 Survey on a sample size of 770 older persons

5.2 Diagnosis with Communicable and Non-Communicable Diseases

The latest available data from the Botswana Demographic Survey (BDS) of 2017(fig.27) are not disaggregated by age but all people aged 12 years and older are lumped together. It was reported that of the 523,949 12 years and older with non-communicable diseases and HIV and AIDS, 86% were receiving treatment while 14% were not. The report shows that HIV and hypertension were the leading causes of morbidity in both men and women, with rural residents being worst affected compared to those in cities and urban villages. The STEPs Survey of 2014 revealed that 23% of those with hypertension were undiagnosed and unaware of the disease. It was also found that 70% of the cancers were diagnosed when they were at advanced stages. Below is a Table showing diseases that were reported by at least 5% of the surveyed population.

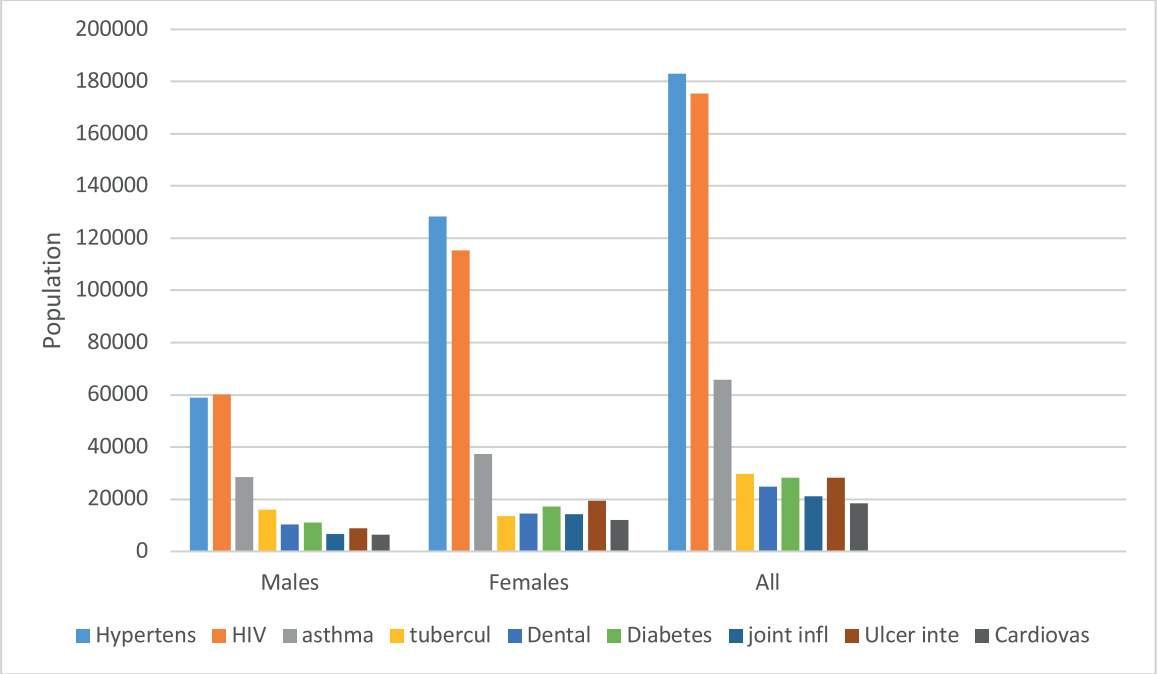

Figure 27: Common diseases for population aged 12 years and above. Demographic Survey 2017

In the 2019 survey (Fig 28), the most common current diagnosis was high blood pressure reported by 73% of the sample, followed by diabetes (13.3%), tuberculosis (7.1%), and Parkinsonism (1.2%). Again, there were more females than males in all the diagnoses. Nineteen percent (19%) of the sample did not report any medical diagnosis. Eighty percent of the participants reported having tested for HIV and of those, 21.5% were HIV positive (25.8% females and 19.8% males). Diseases that the participants had ever suffered from were arthritis (27.9%), asthma (6.9%) and ulcers (6.7%). History of heart attack, epilepsy, stroke and chronic bronchitis were reported by 4% of the participants in each area. History of cancer was reported by seven females and one male. The rest of the conditions were each reported by one percent or less of the survey participants. Except for chronic bronchitis that was reported by more males than females, the latter tended to have higher numbers reporting history of diseases. Thirty percent (30%) and 21.3% of females and males, respectively, reported to be taking care of persons with HIV infection. Those taking care of HIV orphaned children were 20.3% females and 12.4% males. Erectile dysfunction was reported by 55.9% males while 44.7% of females and 50.2% of males reported loss of libido.

The findings indicate the hypertension is leading in the diseases affecting older adults. The finding show that HIV is still a burden for older adult, not only because of their own positive HIV status but also because they are often caregivers for HIV patients and children orphaned by AIDS. The burden of HIV is higher for females compared to males. The findings also point to the significance of sexuality issues among older adults, with about 50 %(Table 4) of the participants reporting sexuality problems. Owing to its sensitivity, sexuality is an area that may be ignored when assessing the health status of older

adults. However, as the findings indicate, it needs to be assessed so that appropriate interventions can be employed. The higher report of Tuberculosis by males than females may be associated with history of mine work and needs to be investigated further whenever it is reported.

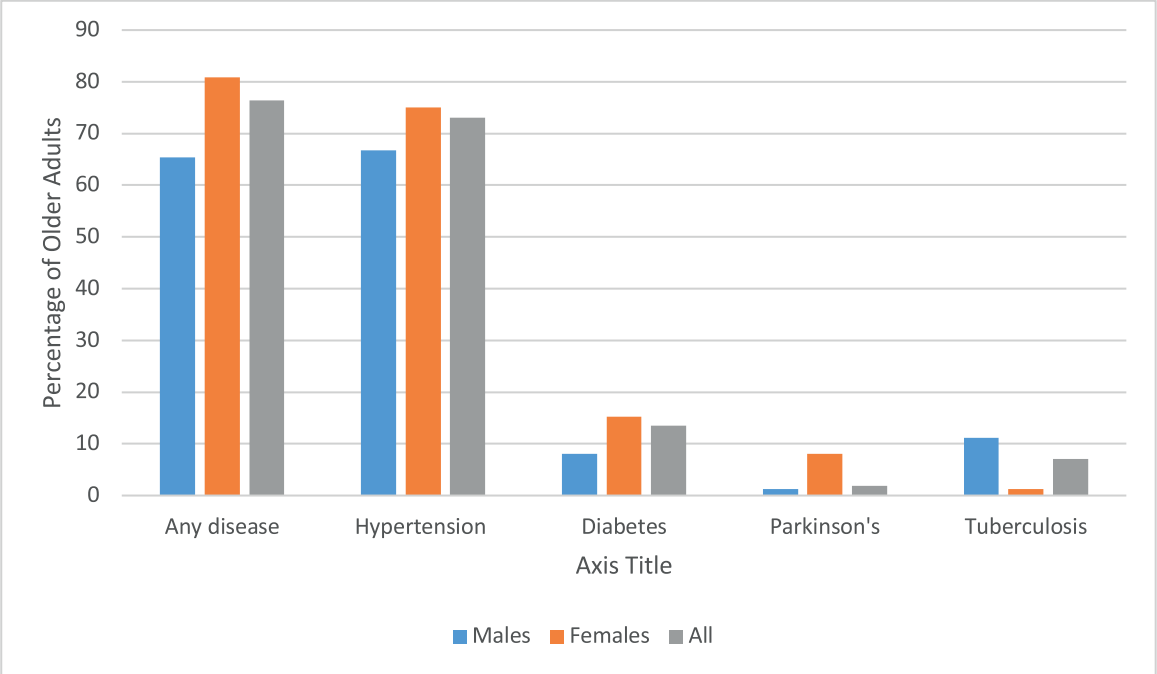

Figure 28: Current Disease Diagnosis: 2019 Survey on a sample size of 770 older persons

Table 4: Sexuality and HIV: 2019 Survey on a sample size of 770 older persons

	% Female	% Male	All
Suffer from low libido	44.7	50.2	50.2
Suffer from erectile dysfunctions	-	55.9	55.9
Affected by HIV and AIDS	39.5	34.8	37.9
Knows own HIV status	80.9	80.8	80.4
HIV Positive	19.8	25.8	21.5
Taking care of HIV⁺ person	30.0	21.3	27.4
Taking care of HIV orphans	20.5	12.4	18.1

Responding to a question that asked about their self-perceived general health status (Table 5 & 6 & Fig 29), 46% of the participants reported fair health status while 40% reported poor health status. Excellent and good health status registered .03% and 11.7%, respectively. There were no gender differences. Most frequent health services recently received were care from a nurse that was reported by 46.4% of the participants, care from a doctor (39.3%), outpatient visit in the last three months (16.6%) and visit to the dentist in the past year (16.1%). Asked to reflect on their experience with the health care facility

during their recent visit, the responses were pleasant (61.6%), very pleasant (18%), somehow pleasant (13.5%), and unpleasant (6.8%). When asked to report any other diseases they had not been asked about, two males who were ex-miners reported chronic and severe cough and chest pains. The two gentlemen may be just some of several others who have not been reached by the ex-miner screening that is being performed between Botswana and South Africa. Out-reach to older adults at their homes/communities may help in the identification of those who may have missed the call to assessment of ex-miners.

Table 5: Recent Utilization of Health Services by Sex: 2019 Survey on a sample size of 770 older persons

	Female	Male	Total
Frequency of use	**Percentage**	**Percentage**	**Percentage**
Any health service	43.1	50.2	54.5
Home health care	2.0	4.1	2.7
Chiropodist care	0.4	0.5	0.4
Physiotherapy	0.8	0.5	0.7
Speech Therapy	0	0	0
Day Care center services	1.5	0.5	1.2
Care from a doctor	41.6	34.1	39.3
Care from a nurse	49.7	38.6	46.4
Visit to the Dentist in the last year	15.2	15.5	16.1
Attendance for hospital out-patient care in the last three months	17.4	15.0	16.6

Table 6: Reflections on the Experiences of Recent Health Services: 2019 Surveyon a sample size of 770 older persons

	Percentages		
	Female	**Male**	**All**
Very pleasant	18.4	17.1	18.0
Pleasant	60.2	65.7	61.7
Somewhat pleasant	16.3	5.7	13.5
Unpleasant	5.1	11.5	6.8
Total	100	100	100

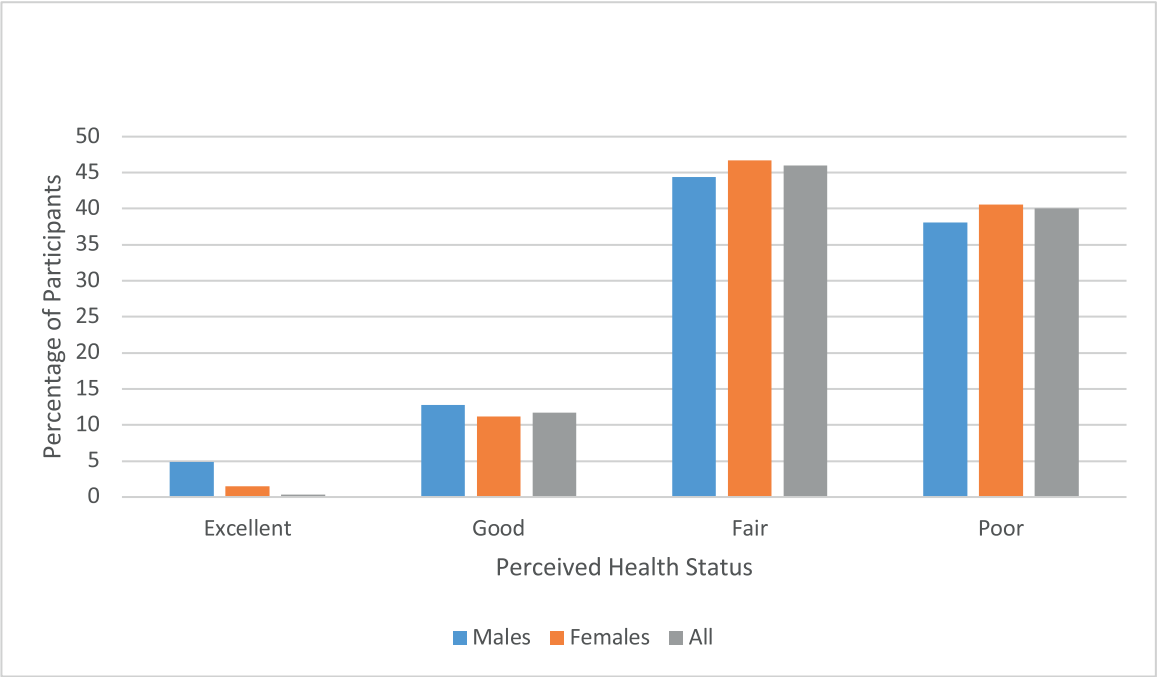

Figure 29 : Older Adult's Perceived Health Status: 2019 Survey on a sample size of 770 older persons

5.3 Experience of Negative Emotions

Responding to questions about their experience of negative emotions in the 2019 survey, on a sample size of 770 older persons(Fig. 30),only 6.6% of older adults reported being regularly abused or maltreated (6.2% of males and 9.9% of females). About 17% (16.8%) reported to be persistently feeling lonely (15.1% of males and 16.9% of females). Unusual tenseness or worry was reported by 54.4% of the participants (52.4% of males and 55.2% of females). About 20 percent (19.6%) reported to have recently felt sad and miserable (18.7% of males and 20% of females). Further surveys need to have some in-depth interview that can help causes of tenseness that was reported by nearly 50% of the participants. Feelings of loneliness may occur even when older adults live with their grown up children because, especially in cities and urban villages, many times they spend the day alone or with home helpers while their grown up children are at work. The ranges of emotions reported by older adults indicate that their emotional health needs to be given attention in both health assessment and intervention.

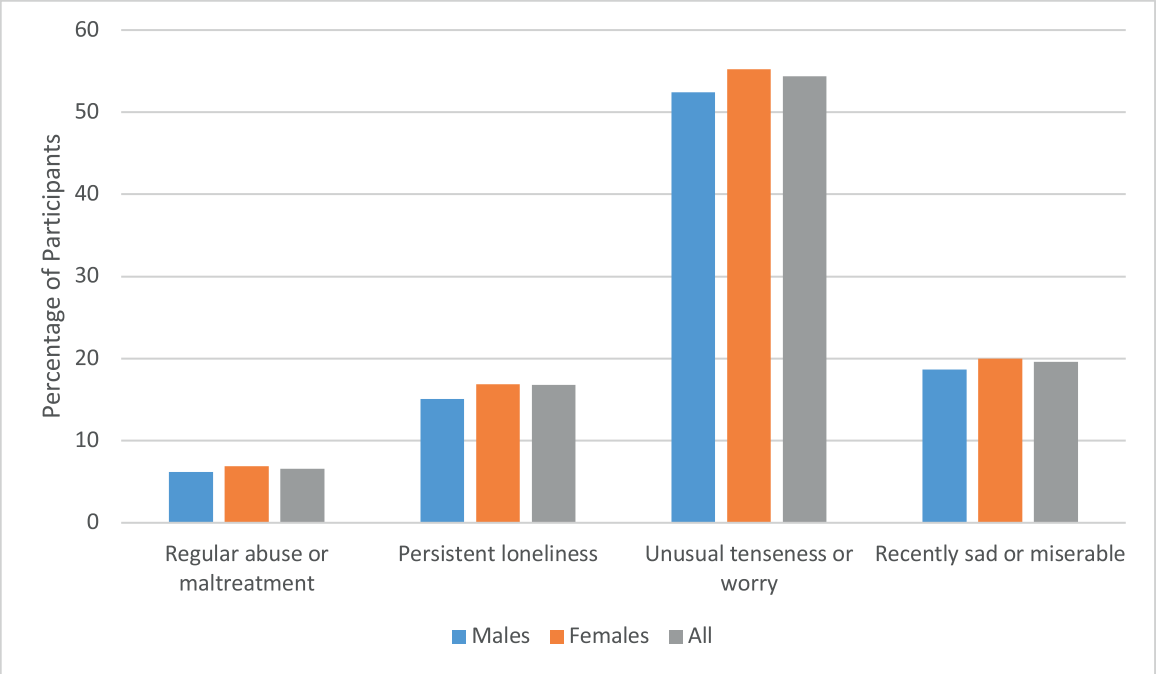

Figure 30: Older adults' experience of negative emotions: 2019 Survey on a sample size of 770 older persons

6. MAJOR RISK FACTORS FOR NON-COMMUNICABLE DISEASES

Botswana has been cited as one of the rapidly developing countries in the world now classified as a middle-income country. Urbanization and affordability of commodities and rapid adoption of unhealthy lifestyles have led to increased prevalence of diseases such as hypertension and diabetes. In a survey conducted in 2014 (Table 7), 94.8% of the participants ate less than the WHO recommended five servings of combined fruits and vegetables, 30.6% were overweight if not obese, 18.3% of the surveyed population were using tobacco, 18.3% were engaged in binge drinking (6 or more drinks on any one occasion in the past 30 days), and many did not engage in adequate physical activity nor take enough proportions of healthy foods. MoHW (2017)

In 2017, reported causes of death in Botswana were cardiovascular diseases (18%), other NCDs (8%), injuries (9%), cancers (5%), diabetes (4%), and respiratory diseases (4%). NCDs are among the leading causes of morbidity and mortality in the country. However, many of these diseases remain undiagnosed, and some remain so until they are at an advanced stage (Ministry of Health and Wellness, Botswana 2017); and this may be partly because of the culture of episodic health-seeking behavior and intervention versus routine health screening. NCDs are impoverishing to both the government and families; as they affect the most economically productive members of the society and are expensive to treat.

Although the statistics targeting older adult population and lifestyle for prevention of non-communicable diseases are not available, MoHW (2017) provides risk factors for the population age group 60-69 years. Eighteen percent (18%) of the population was currently using tobacco (12.3% females and 30.9%

males), and 18.6% was currently drinking alcohol (27.1% females and 11. 7% males). The Mean number of serving of fruits and vegetables was 1.5/day (0.8 for fruits and 1 for vegetables) with 95.5% of the participants taking less than one serving in a typical day (WHO recommends five servings of combined fruits and vegetables per day). The mean Body Mass Index (BMI) was 27.5 (27.3 for females and 23.9 for males). (BMI of 25 and above is considered obesity). Twenty five percent (25%) of the participants (28.2% females and 21.5% males) was not meeting WHO recommended physical activity level. WHO defines physical activity as any bodily movement that engages skeletal muscles in energy expenditure. Energy expenditure occurs when we walk, work, play or carry out household activities or when we engage in recreation activities or planned exercises. Physical activity varies in intensity; and the more intense it is the more the energy is expended. (WHO, 2011).

Table 7: Cardiovascular Risk for population aged 60 – 69 years: MoHW (2017). Botswana Multisectoral Strategy for the Prevention and Control of Non-Communicable Diseases 2018-2023

	Performance		
Risk factor	**Females**	**Males**	**Both**
Currently using tobacco	12.3%	30.9%	18%
Currently drinking alcohol	27.1%	11.7%	18.6
Binge drinking (≤ 6 drinks on any occasion in the 30 days)	-	-	18.3
Mean number of servings of fruits per day	1.0	0.5	0.8
Mean number of servings of vegetables per day	1.0	1.1	1.0
Taking less than 5 servings of fruits and/or vegetables in a typical day	93.2%	99.6%	95.6%
Not meeting WHO recommended physical activity level	28.2%	21.5%	25.2%

The 2019 survey, on a sample size of 770 older persons indicated that most of those who reported drinking alcohol did that either once or twice a month (19%) or once or twice a week (17.5%). More males (21.1% versus 16.4%) were drinking both once and twice a month and once or twice a week (22.5% versus 10.9%). Only 14.3% reported not drinking at all (27.3% females and 4.2% males). The majority (79.5%) of those who were currently drinking reported that alcohol was not a problem for them (87.1% females and 81.7% males) while 13.7% said it was a mild problem (23.9% females and 7% males).

males (11.3%) reported that alcohol was a serious problem for them. A small proportion (15.9%) was using tobacco (15.6% females and 16.8% males). Fifty-two percent (52.2 %) reported no fruits and vegetables in a typical day while 47.3% reported having one serving per day. Forty-seven percent (47%) reported that they were exercising regularly or taking part in sporting activities. (Table 8)

Table 8: Risk Factors for NCDs: 2019 current Survey, on a sample size of 770 older persons

Risk Behavior	Males	Females	All
Use of alcohol almost every day	14.1%	9.1%	14.3%
Severe alcohol problem	11.3%	-	6.8%
Use of tobacco	16.8%	15.6%	15.9%
No serving of fruits and vegetables at all	55.3%	50.8%	52.2%
One serving of fruits and vegetables per day	44.3%	48.6%	47.3%
2 or 3 servings of vegetables and fruits per day	0.4%	0.6%	0.5%
Engagement in regular exercise/sporting activity	45.4%	39.5%	41.2%

7. ORGANIZATION AND GOVERNANCE OF THE HEALTH CARE DELIVERY SYSTEM

All health facilities fall directly under the Ministry of Health and under the Department of Clinical Services. There are plans to have the management of health facilities decentralized to District Health Management Teams (DHMT) but this is yet to be fully operational. Hospitals are headed by medical officers while clinics and health posts are headed by nurses/midwives. Referral hospitals also have hospital managers to take care of the general administration (Seitio-Kgokgwe, Gauld, Hill, & Barnett, 2014).

7.1 Access to Primary Health Care Services

According to WHO (2014), Botswana health care service delivery is through a decentralized network of cascading levels of health facilities spread out in 27 health districts comprising of referral hospitals at the highest level, then district hospitals, primary hospitals, clinics, health posts and mobile clinics. As of 2014, there were 2 general referral hospitals, 1 psychiatric referral hospital, 15 district hospitals (includes private hospitals), 17 primary hospitals, 289 clinics, 347 health posts, and 894 mobile clinics, making a total of 1,565. Primary hospitals have 20-70 beds and serve a population of 10,000 or less while district hospitals have 71-250 beds serving a population of more than 10,000. Urban areas have 96% of the population within 5 km radius of a health facility and 4% between 5 & 8km radius. Rural areas have 72% of the population within 5 km radius of a health facility, 17% between 5and 8 km radius, and 11% between 8and 15 km radius. Older adults access integrated primary health care services from the network of health facilities distributed throughout the country.

7.2 Utilization of Health Services

Figure 31, reports on health services recently received 414 out of 770 participants (54.5%) in the 2019 survey reported to have received any health services, 46.4% had received care from a nurse, 39.3% have received care from a doctor, 16% had visited a dentist in the past year, and 16.6% had received out-patient care in the past three months. The majority (61.7%) of the 133 older adults who visited a health facility recently reported that their experience with the health facility had been pleasant.

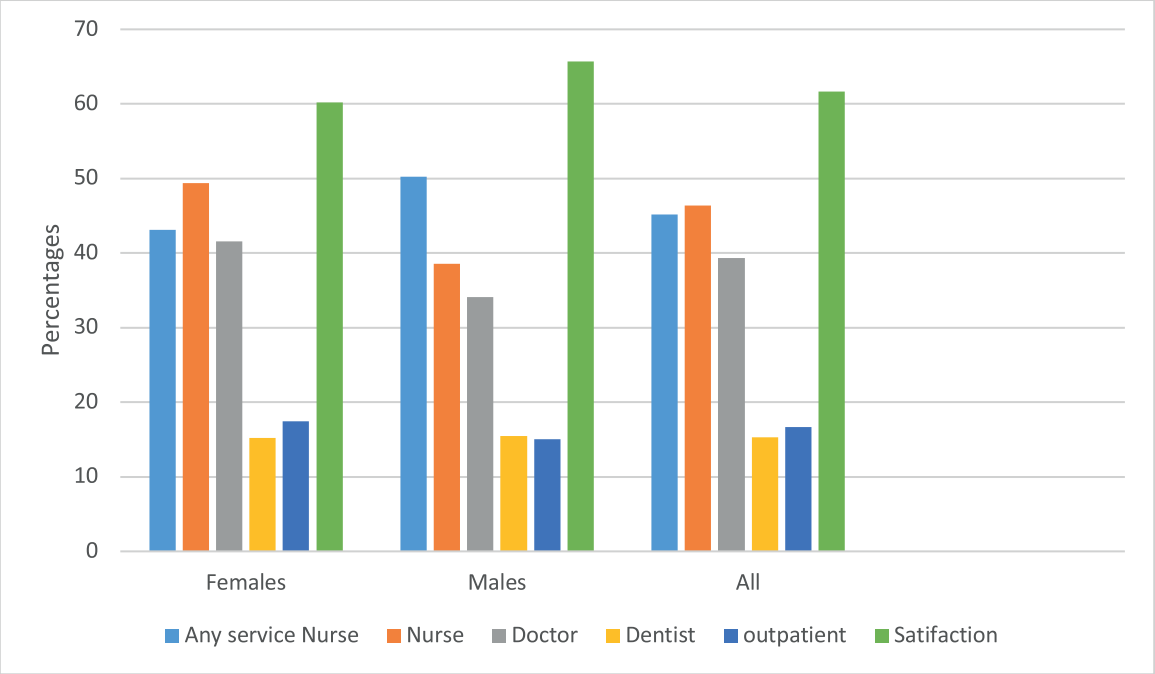

Figure 31: Utilization of and Satisfaction with Health Services, 2019 Survey, on a sample size of 770 older persons

Table 9: Types and numbers of Public Health facilities: Source: WHO (2014) WHO Country Cooperation Strategy, 2014-2020.

Facility Type	Number
Referral	3
District	15
Primary	17
Clinics	289
Health Post	347
Mobile services	894
Total	1,565

7.3 Service Capacity

Service capacity as used here concerns infrastructure and human resources. The infrastructure is made up the two general referral hospital, one psychiatric referral hospital, seven district hospital, six private hospitals and two faith based hospitals, 289 clinics and 347 health posts, and a number of general and specialized private clinics that are concentrated in cities, towns, and major urban villages. It is difficult to determine the adequacy of the infrastructure because, as has been noted, there is inequity in the distribution of hospital beds, with some hospitals having bed occupancy rates as high as 150% while some have rates as low as 40% (Seito-Kgokgwe et al., 2014). However, in the past few years, the government of Botswana has embarked on expanding and improving the health care infrastructure, including the psychiatric referral hospital and the new 450 bed teaching hospital that is yet to start functioning in the capital city.

As of 2014, estimated number of nurses (7427), doctors (830), and dentists (91) (WHO, 2014); and according to estimations by Nkomazana, Peersman, Wilcox, Mash, and Phaladze (2014), together, these three types of health personnel constitute about 48% of the total health workforce, excluding health professionals' educators. The total size of health workforce (excluding health professionals' educators) can therefore be estimated at 17,392-18,082.

Nursing personnel were mainly locals at 84%. Optimum utilization of available health personnel including the use of task shifting is important especially in rural areas where other cadres of health care providers may not be available to serve clients such as older adults.

Table 10: Numbers of Selected Health care Providers: Statistics Botswana 2016

Personnel Type	Number
Doctors	830
Dentists	91
Nurses	7,427
Total	8,348

7.4 Health Professional's Education

Through the Ministry of Health and Wellness and the Ministry of Tertiary Education and Skills Development, Botswana develops over 70% of health personnel at various educational levels. The cadres of health personnel trained locally include nurses, pharmacists, medical laboratory scientists, environmental scientists, and medical doctors. Some programs are yet to register a substantial mass of graduates because they are relatively new. The government absorbs the major share of funding for

health professionals' education, with private funding taking only a small share. Those who train outsidethe country get their education from countries such as South Africa, Australia, Europe, North America, South America, and South East Asia (Nkomazana et al., 2014). The major breakthrough has been the opening of a medical school in the country, which is expected to improve the supply of doctors who are at present in short supply, partly because they often choose not to return home upon graduation from better resourced countries.

7.5 Health System Financing

Currently, there is no budget item for the health care of older adults. Older adults are covered under the integrated health services distributed across primary, secondary, and tertiary care.

One way of reducing NCDs is to target older adults, who make a significant proportion of those affected by NCDs. As many older adults are in homes, they can best be reached through community out-reach approaches where education and counseling on diet and nutrition, physical activity, use of tobacco and alcohol, as well as screening for psychosocial issues and diseases such as high blood pressure, diabetes and cancer can be provided.

7.6 Health System's Response and Policies – Healthy and Active Ageing

The health system or stewardship role that the Ministry of Health and Wellness plays in the multisectoral approach to health care is housed in the second of the four pillars of the vision being "Human and Social Development." The pillar emphasizes opportunities for all people and development of the family, community, and the nation. Vision 2036 then informs Botswana's current short-term development road map, National Development Plan 11 (NDP 11) that runs from 2017 to 2023.

Among NDP 11's areas of emphasis with direct relevance to the situation of many older adults in Botswana is enhancement of policies and strategies for cushioning vulnerable and disadvantaged groups, enhancing access to water, shelter, sanitation, and health, and creating a single social register that consolidates all social protection interventions.

Ministry of Health and Wellness came up with the strategy "Integrated Health Service Management Plan 2010-2020" (IHSMP) that presents a vision for the improvement of the health status and health care for all people in Botswana. The strategy identifies priorities in the health care system and aims at ensuring that those health services that are delivered will provide the greatest benefits for all citizens and that they will be channeled to where they are most needed, using the most efficient approaches. The plan maximizes the participation of both the health care professionals and the general public, and ensures that the services reflect best international practices. The goals of the IHSMP cover six main areas that include:

- Service delivery
- Human resources
- Financing
- Procurement and logistics
- Health information and research
- Leadership and management

A number of policies and strategies, some of which with direct relevance to older adults, are in place. Examples of such policies/strategies are listed below:

1. Nutrition Strategy 2015 to 2020
2. Strategic Plan for the Prevention and Control of Non-communicable Diseases 2011-2020
3. National Eye Health Programme (NEHP)
4. Pneumoconiosis Screening Programme
5. Health and Active Ageing (HAA) Programme Although Botswana has not developed ageing policy, the Ministry of Health and Wellness has since 2018, established a Healthy and Active Ageing (HAA) desk office and appointed Program officer to coordinate healthy and active ageing activities.

7.6.1 Actors/stakeholders in healthy and active ageing

As indicated in the objectives of the IHSMP, the Ministry of Health and Wellness works in partnership with other government ministries, private sector, NGOs, civil society and development partners to deliver health services to the nation. Therefore many stakeholders take part in planning and delivery of the health services. The list

below shows some key stakeholders in Healthy and Active Ageing;

- Government ministries
- Development partners
- Civil Societies
- Non-governmental Organizations
- Fund Partners

8.0 GENERAL SOCIO-POLITICAL ENVIRONMENT AS ENABLING/DISABLING FOR HEALTHY AND ACTIVE AGEING

The Healthy and Active Ageing agenda requires an enabling overall socio-political environment. It is therefore important that as Botswana sets off to improve the life conditions of older adults, it examines the structures that are likely to retard progress, so that appropriate strategies may be devised to ease the path to healthy and active ageing.

8.1. Policy and Legal Structures

Botswana does not have a policy on ageing yet; but provides services to older citizens through the integrated primary health care services and through the safety nets that include old age pension, World War Veteran grants, destitute program, and supplementary feeding programs for needy families. Botswana is a signatory to a number of international conventions that protect the rights and welfare of all people.

Regulation of the customary law could remove any impediments to Botswana's ratification of some international protocols. The healthy and active ageing agenda must therefore seriously consider the gender dynamics of Botswana's legal system.

8.2 Older persons Political Advocacy

Consideration of Older persons' political advocacy is important in that conditions affecting older persons will be brought to the fore front.

8.3 Social Protection

Social protection is the process of preventing, addressing, or reducing the risk of poverty and vulnerability of individuals, families, and communities throughout their lives, through programmes initiated by government, private sector, or communities, and guided or supported by state policy (UNICEF, 2017).

Botswana's social protection is guided by four core national principles of (1) social justice, (2) self-reliance, (3) unity, (4) and Botho (humanness). Botswana provides social protection through three main mechanisms namely, employment pension, social assistance, and active labour market. Active labour market targets the youth while employees' pension and social assistance cover older adults.

9. RECOMMENDATIONS

In light of the findings of this situational analysis, the following recommendations are proposed;-

9.1 There is need to develop a comprehensive Ageing Policy

The policy would come with requisite resources to operationalize its mandate and could even provide for a structure that oversees its implementation.

9.2 There is need to enact a law for the protection of the rights of the older adults.

The proposed law should legislate for the protection of the interests of the older population and curb stereotypes.

9.3 Develop a System of Long-term Care and Support for Older Adults.

The proposed long-term care programme for older adults should go beyond health and social protection. This should also include establishing older adult centres or homes.

9.4 Healthy Ageing Agenda should be integrated into existing national Policies and Strategies

Integration of the needs of the ageing population ensures that all existing relevant policies and strategies are reviewed so they are aligned to the needs of older adults.

Integration is not limited to health services but extends to other ministries and departments.

9.5 Establishing Rehabilitation/Engagement Institutions/Centers for Older Adults

In addition to establishing rehabilitation and older adult centres, there is need for open spaces/parks where people could socialize, recreate, and dine together and must promote activity that can be in various ways such as walks around the park, aerobics, handcrafts, etc.

9. 6 Community Education on ageing

There is need to educate communities on older adults agenda, this will improve the community's recognition and appreciation of the older adults' various skills.

9.7 Post-retirement Support

Workplaces can make it mandatory for all employees to contribute toward a fund that can support them later in their lives.

9.8 Recognizing Gender Issues in Ageing

It is important that a gender lens is used in assessing older adults so that each gender's unique needs can be appropriately addressed.

9.9 Revival of the Old Systems for Social Integration and Community Out-reach

Communities must be re-oriented to revive the extended family system where siblings, children, and close relatives are connected and responsive to one another's needs. Families need to be sensitized on their responsibility for their ageing siblings, parents, spouses, and relatives. Home visits by multidisciplinary professionals would help provide a comprehensive approach to addressing older adults' multiple needs.

9.10 Improving Older Adult Data Capturing and Research on Ageing

There must be a well-developed and resourced national information management system that links systems of care including non-health sectors. There is need to build capacity on and increase funding for Research on ageing.

9.11 To standardize the definition of older adult to 60 and above as recommended by WHO.

Several Sectors in Botswana currently define older adults differently; Statistics Botswana defines older adults as 65+. Some program and initiates that target the older adult population in Botswana reference 65+

9.12 Scaling up the Universal Old Age Pension

The introduction of the pension scheme is a move that needs to be commended. However, the amount provided falls far short of meeting the basic needs of food, shelter, and clothing. There is a need to scale up the old age pension using objective information such as the Monthly Income Expenditure and Income Needs of 3 Common Family Sizes in Botswana Pula WageIndicator.org (2018) shown in table3 (Table 11).

Table 11; Monthly Income Expenditure and Income Needs

	Typical family	**Standard family**	**Single adult**
Food	3,880 - 5,250 (U$485-656)	3,170 - 4,290 (U$396 – 536)	790 -1,070 U$(99 – 134)
Housing	2,100 - 1,980 (U$263 -248)	2,100 - 1,980 (U$262 – 248)	1,200 -1,170 (U$150 – 146)
Transport	60 - 115 (U$8 -14)	60 - 115 (U$8 -14)	30 - 58 (U$4 – 7)
Health care	66 - 235 (U$8 – 29)	66 - 235 (U$8 – 29)	16 - 59 (U$2 -7)
Education	80 - 235 (U$10 – 29)	80 - 235 (U$10 – 29)	0

Other costs	310 - 390 (U$39 – 49)	275 - 345 (U$34 – 43)	100 - 120 (U$13 - 15)
Total Expenditure (BWP)	**6,496 - 8,205**	**5,751 - 7,200**	**2,136 - 2,477**
Total Expenditure (U$)	**812 - 1,026**	**319 - 900**	**267 - 310**

10. LIMITATIONS OF THE SITUATIONAL ANALYSIS

This report does not answer all questions that one would have about the situation of older adults in Botswana. Although desk review has been able to provide invaluable data about older adults, their health status, and their living conditions, it leaves a lot of gaps, mainly because many of the reviewed reports were not set out to specifically answer questions about older adults. Where national surveys have been comprehensive in the sense that they covered all localities, some of them did not address the whole age spectrum of 60 years and older as some looked at ages 12 years and above, some considered only ages 65 years and older, while others limited themselves to ages 60 to 69 years. While some studies conducted at academic institutions were good in that they targeted some specific questions about older adults, they were limited in geographical coverage and had small sample sizes.

The 2019 survey was good in that it provided recent data and asked specific questions about older adults. However, it was limited in that it covered limited geographical area, and most importantly, it excluded rural villages (defined as villages with a population not exceeding 5,000 people and that have less than 75% of the population engaged in non-subsistence farming in Botswana population and housing census). This limitation has important implication as most of the older adults are reported to be in rural villages which are also reported to be poorly reached by resources such as health care and good sanitation services. Many of the survey participants were recruited at the sites where they receive universal old age pension. Therefore the survey may have excluded those who were home-bound because of poor health status. Recruiting participants at their homes and having some in-depth questions could have provided more insight into the living conditions of older adults in surveyed localities.

Notwithstanding the limitations pointed out, the situation analysis provides some insight into the way forward, including improving the methodological approaches in future surveys/research. Future work could therefore provide better results.

11. CONCLUSION

This multi-methods situational analysis was a response to the realization that although the population of older adults is growing, Botswana has not taken a deliberate response to the situation. The findings of the situation analysis were expected to provide a direction that could guide the development of National Strategic Framework outlining comprehensive public-health and multi-sectoral response to meet the needs of older population in the country. The analysis involved establishing the size of the older adult population, where they are, their demographic profile, their health status, and their living conditions. The analysis also involved examination of the overall socio-political environment of Botswana that has a bearing on older adults' health status and life experiences. The socio-political environment examined covered the strategic frameworks such as long term visions and National Development Plans as well as specific policies in the health and non-health sectors. The legal framework, particularly affecting women who make up a larger proportion of older adults was also examined.

Where positive efforts were identified, they were acknowledged, as indeed, there is a lot that the government of Botswana and its partners are doing, to ensure that the country moves toward a better health status and the general standard of living. The main missing element seems to be policy and programmes targeted to older adults. The main challenges facing older adults appear to be poverty and compromised health status with limited ability of older adults to carry out activities of daily living. Mainly because of low income level, low literacy, and poor access to resources, older adults generally do not enjoy the quality of life enjoyed by other population groups. In addition, considering that women dominate the older adult population, examination of the legal framework of the country shows that there are a number of areas that put women at a disadvantaged position, including vulnerability to poverty and maltreatment.

Recommendations therefore centre around strategies that increase the visibility of older adults as a population deserving focused attention from government, other stakeholders, and the general community, that streamline national programmes in particular so they accommodate the needs of older adults. In order that the Healthy and Active Ageing agenda takes off smoothly and accomplishes its mandate, and that all stakeholders can be appropriately and adequately involved, a guiding and coordinating policy is recommended. The limitations of the situational analysis are provided which need to be considered in interpreting the report of the situational analysis and which should help in improving future interrogation of the situation of older adults in Botswana.

ANNEXES

KEY INFORMANTS' OBSERVATIONS DESERVING NOTING BYOLDER ADULT/CAREGIVER STORIES

Key Informants Observations Deserving Noting

Some key informants' verbatim excerpts are captured here for noting:

As far as the life of older adults in general is concerned, not much has been done; especially by government, when one considers that the old age pension is too low considering the cost of living and the contribution that older adults have made in building the nation.(currently P510/month). This is especially because though the pension is meant for the older adult, often it is the income that supports families. When older adults are taking care of grandchildren, including orphans, they do not only have to use the pension to support the children but may also need to hire child care so they can run some personal errands. Older adults pay the same public transport fee paid by the rest of the adults. Older adults share the same ward with children as young as 12 years in public hospitals when they could be made to enjoy privacy with their own age mates. There are no dedicated centers catering for older adults who have no family to live with, where they can enjoy the company of one another.

Like the rest of the community, older adults do have some degree of access to health care at all levels - primary, secondary, and tertiary, even though there is no label of "older adult." The problem is that the care is fragmented and uncoordinated. It is not based on any planning that is informed by the needs of the clientele, its numbers, and its diversities. If care was coordinated, it would be easy to refer or link clients with specialized services such as eye care. Even outside the Ministry of Health and Wellness, various government departments may not have visible work targeting older adults, but they do carry out services that contribute to the needs of the nation including older adults. Such departments do have the vision and potential to do more than what they are currently doing to contribute toward healthy and active ageing.

It would be difficult to see the direction for moving forward unless the nation takes a few steps back to appreciate where it is coming from. As a nation, Batswana (Botswana nationals) used to have a sense of community that gave them a sense of responsibility for one another, including older adult population. They used to have traditional institutions such as "Letsema" whereby people worked collectively to assist a needy person, Mephato (age regiments) and Dikgafela (thanksgiving community activities) which provided an opportunity for older adults to participate and find purpose in life. Such traditional structures connected people to one another. However, the nation has lost almost all those; and it has not been able to transmit those traditionally cherished values to children. Unless the nation takes pride in its culture and transmits that legacy to its children, not only through stories told but more importantly, through enacting it in the way people

instance, the saying "it takes a community to raise a child" must be seen in action. At one point there were "4B" clubs that instilled personal and social responsibility to children. There have been family welfare educators and nurses vising communities in their homes. Those systems are no longer there. Now health care workers are largely institution-based. The nation needs to pause and check if there is nothing that it can take from the past to illuminate its way as it looks forward to healthy and active ageing!

Looking at the workforce, one may say, the employers value people when they are still young and completely forget about them when they reach old age. The employer parts with people when they are 60 years old and completely forgets about them as no policy or legislation addresses them; and younger ones are taken in and the cycle continues. ……

…….In the sexual and reproductive health program, for instance, the system takes interest in the environment under which the child is conceived, see the woman and her unborn baby through pregnancy, manage labor and delivery, see that woman at postnatal care and at family planning and perhaps back to conception again, takes the child through child welfare clinic, passes him/her over to the schools, meets her/him at family planning and continues with the cycle until the woman is 49 years old. Thereafter, nobody knows what happens to the woman. …….

…….Even churches neglect their own members who are aged including Pastors. Some older adults are even neglected by their own children, who often only remember them when they are requested to list some beneficiaries in insurance policies. One major challenge that one can foresee in the endeavor to promote active and healthy ageing is that even those who do plan for old age do it late. This suggests that the process must be started earlier by empowering young people to plan for when they will be old.

Key Informants Interviews

This chapter presents key informants interviews summary as follows;

i) Old age pension- Key informants generally argued that the old age pension is too low considering the cost of living and the contribution that older adults have made in building the nation.(currently P510/month). This is especially because though the pension is meant for the older adult, often it is the income that supports families. When older adults are taking care of grandchildren, including orphans, they do not only have to use the pension to support the children but may also need to hire child care so they can run some personal errands. Older adults pay the same public transport fee paid by the rest of the adults.

ii) Centers catering for the older adults: Key informants observed that even though services are universally accessible in Botswana, there are no designated and coordinated centers for older adults. To this end, it is suggested there be designated areas "with sign boards" for the older persons across service points. For example, the elderly share the ward with children as young as 13 years in hospitals..

iii) Care for the older adults. Like the rest of the community, older adults do have some degree of access to health care at all levels - primary, secondary, and tertiary, even though there is no label of "older adult." The problem is that the care is fragmented and uncoordinated. It is not based on any planning that is informed by the needs of the clientele, its numbers, and its diversities. If care was coordinated, it would be easy to refer or link clients with specialized services such as eye care. Even outside the Ministry of Health and Wellness, various government departments may not have visible work targeting older adults, but they do carry out services that contribute to the needs of the nation including older adults. Such departments do have the vision and potential to do more than what they are currently doing to contribute toward healthy and active ageing.

iv. Social cohesion: As a nation, Batswana (Botswana nationals) used to have a sense of community that gave them a sense of responsibility for one another, including older adult population. There were traditional institutions such as "Letsema" whereby people worked collectively to assist a needy person, Mephato (age regiments) and Dikgafela (thanksgiving community activities) which provided an opportunity for older adults to participate and find purpose in life. Such traditional structures connected people to one another. However, the nation has lost almost all those; and it has not been able to transmit those traditionally cherished values to children. Unless the nation takes pride in its culture and transmits that legacy to its children, not only through stories told but more importantly, through enacting it in the way people relate to one another in families and in the community, an important legacy is dying out. For instance, the saying "it takes a community to raise a child" must be seen in action. At one point there were "4B" clubs that instilled personal and social responsibility to children. Some Churches neglect their own members who are aged including Pastors. Some older adults are neglected by their own children, who often only remember them when they are requested to list some beneficiaries in insurance policies. One major challenge that one can foresee in the endeavor to promote active and healthy ageing is that those who do plan for old age do it late. This suggests that the process must be started earlier by empowering young people to plan for when they will be old.

Caregiver and Care Beneficiary Stories

in addition to the various stakeholders who contributed their thoughts and experiences for the

advancement of health and active ageing, we present the voices of an older adult and two caregivers. Some of the contributions have been incorporated into the report. However, the voices are presented below to highlight what older adult care-giving could entail from the perspective of the caregiver and care beneficiary:

Older adult, Lorato (not a real name), 66 year old female with hemiplegia of about four years following stroke.

> ***What I value most is a consistent health provider when I visit the health facility because that facilitates familiarity with a given patient and therefore good chances of appropriate and effective intervention. I wish there were ambulance services that I could call if I wanted to go to the hospital because the family car that transports me to the hospital is small and therefore a bit uncomfortable for someone of my condition. I get irregular visits from home based care nurse. I get diapers (disposable protective under-wears) and clinical waste collection regularly from the City Council. I believe I have had some economic assessment as I have been asked if I am able to eat well.***
>
> ***At home, I value companionship. I love to be visited and always pray that God sends visitors. I need to be talking to somebody because loneliness begets a wandering mind, self-pity, and misery. I need to chat with people and to laugh. I have come to appreciate why hospitals have visiting hours because I can now understand that companionship is medicine in its own right. I fear being left alone because I imagine something happening to me with nobody to assist me. (e.g. falling and getting injured). I need to be bathed and to be wearing clean clothes. I hate interrupted care. For instance, if I am being bathed, I do not want to be uncovered and left alone because the caregiver is doing something else before they complete what they are supposed to be doing.***
>
> ***I have been referred to psychosocial services for depression and I believe that has helped me. (However, at intervals, she would get emotional).***

Lorato's Caregiver Gomolemo (not a real name), 73 year old male who is a primary caregiver for his 66 year old wife with hemiplegia from stroke. He is being assisted by their daughters, some of whom stay in while one stays out; and the Son who stays out and regularly visiting and helping with material things like food and cash.

> ***For me, caregiving has been a learning curve that has made me to appreciate the saying "thuto ga e golelwe" and to understand that "thuto ga e golelwe" is not always "good news" or something to***

look forward to. Caregiving is even challenging when one is caring for a person as close as a spouse because you will not always agree on how things should go. The patient may select from among the caregivers somebody that she trusts more than others. When that happens, I believe it is best to allow the patient to make her own judgment and let life continue, doing what you can do. One way of coping has been imagining myself in the shoes of my wife now, I being a patient and my wife providing care to me. I am motivated by the love that I have for my wife. I am thankful that some time back, my wife brought the idea of securing a plot for rental, which is now our economic resource. The fact that I have my own means of transport has made my care-giving a bit easier even though I fear that I will not be able to have my driving license renewed because of my diminishing eye sight. I prefer transporting the patient myself because I do not want to be rushed; I need time to prepare my patient and only leave when everything is ready. I am also taking into consideration the fact that the ambulance serves a wide community such that we may need to wait for it. Therefore I have not made any effort to use ambulance services.

My support has been my sisters-in-law, who visit time and again to provide support. The setback has been that I am not able to attend social events. I am therefore worried that should I need assistance of my social connections, they may not avail themselves. (Asked if it was not difficult for him as a man to provide care which is usually the purview of women) he said: I have had a close relative whose wife fell sick and who became the caregiver. When this happened to me, I thought about him and I was convinced I can also do it. I appreciate home care services that provide home based care supplies. The diapers are supplied on a monthly basis but they do not usually last a month. As such, I have to purchase additional ones from the shops. However the clinical waste plastics are not available in the stores. I wish they were available so that I could buy if I run out of supply. We usually use ordinary waste plastic in such situations. My wife was referred for treatment of depression at one point but I do not think that provided much help for her depression. I have received no education/counseling from the health system regarding such things as nutrition, physiotherapy, and others. My wife has blood pressure monitoring at the clinic or on irregular home visits. The blood pressure has remained stable as it had always been prior to the stroke.

Caregiver Maipelo (not real name), a nurse by profession, married with children and employed, has 80-year old mother who is widowed and staying alone.

I *am taking care of my mother who is 80 years and I am worried because she is staying alone more than a 100 km away because she prefers to stay in her own home. I am always worried because it is not safe for someone of her age to be staying alone because I imagine something happening and she is just by herself. Financially, caregiving is not that a burden to me because "o ne a itiretse,*

economically" (she made advanced plans for her financial sustenance). In our family, we value self-reliance because even before my father died, he said to us: "If following my death my relatives decide to grab what I have left for the family, do not hold on to anything. Use your personal resources such as the education you have to sustain yourself." My mother is a retired teacher and economically self-sustaining. She has a shop that she is renting and that helps her. I have a sister with whom I alternate in visiting our mother over the weekends. When visited, my mother prefers that we spend quality time with her before we leave. She resents it if we keep ourselves busy by preparing her meals or making tea for her. She wants us to sit down with her so she enjoys time with us. She used to enjoy gardening but now she is not able to do that because of functional limitations. She seems to be concerned about her own safety because she keeps herself locked up and thoroughly checks who is at the door when we knock. Sometimes she appears obsessed with locking as she can even lock the house when she is seated outside with visitors. Besides my younger sister and I, we have brothers who are also grown up and staying in their own homes. They also visit our mother and assist her where they can. One of them drives by my mothers' house when he goes to work and frequently stops by to check on her.

My mother values companionship and interacting with people. She wants to be comfortable with regard to basic needs such as food and shelter. She wants to be loved and respected and to interact with people that she can trust. She also wants to be safe. She prefers to be in her own home rather than move in with us because in her home, she is not just an ordinary person but a woman of respected and recognized social status within her late husbands' family and within the community. She has social connections and friends within her community that define who she sees herself to be. For her, re-locating to a social setup where she is a nonentity would be a loss of dignity and loss of part of herself.

My siblings and I enjoy healthy relationships with one another; we can meet and plan on how we will share taking care of our mother. My additional support comes from my church members who often visit and pray with my mother and help with caregiving. My mother herself is not affiliated to a church. The caregiving strain that I experience is that of balancing being a mother of young children, being a fulltime employee and being a caregiver for my mother who is about 100km away. I worry a lot about my mother's safety, especially nowadays when crime rates are high.

I have also previously taken care of my late brother-in-law who had married and divorced and who had no close family who could take care of him. He had spent his good part of his life drinking and had therefore not made any plans for hard times. Again my sisters-in-law were not prepared to take care of their brother and I had to shoulder the responsibility.

I see a need for institutional care for older adults who have no family or who otherwise cannot move in with their grown up children. However, rather than common hostel-like residential halls, I prefer that the institutional residence be the type that provides privacy and some personal space for the older adult, and where she can enjoy the company of visiting family members. Such residential places could provide the older person with companionship, food and housekeeping services. I also recommend flexi time for caregivers who are employed such that the employment schedule can accommodate their care-giving demands. It would be good if people could prepare for old age when they are young, and if children could be taught to value their grandparents from a tender age so that they can later take responsibility for older adult care-giving when they are adults. Being from a Christian background, I believe that Christianity can mold children so they grow up to be balanced individuals who are able to cope with demands of life such as the challenges of ageing and care-giving.

Gaps noted per sector in relation to older adults' needs.

NO	MINISTRY	GAPS	RECOMMENDATIONS
1	Ministry of Health and Wellness	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Developing a Policy on Ageing. • Develop a Legislation on Ageing • Governing Council
		• Non Communicable Diseases (NCDs) are responsible for most of the morbidity and the majority of the deaths among people aged 60 years and over. •A consequence of high prevalence of chronic diseases, co-morbidity and natural ageing process is impairment and disability. • Older people in the African region are affected by food insecurity problems with the proportion of underweight older people being between 5 to 15% • Older people, especially women, are victims of allegations of witchcraft, leading to stigmatization and collective acts of violence. • The health care system has not developed infrastructure and services that are inclusive of older adults. Older adults get largely episodic health care from the integrated services that are often short of the staff-mix demanded by the integrated approach. • 20.4% of persons aged 65 years and older reported that they had spent the last 12 months prior to the census not participating in any economic activity because they were sick. • About 47% reported feeling lonely, either persistently (31.5) or infrequently (15.1). • On the intensity of worrying, 38% reported worrying a lot • The 2019 survey indicated that older adults were experiencing some disturbances in physiological and sensory functioning that to some extent limited their self-care and day-to-day activities. • Low consumption of fruits and vegetables may be related to their unaffordability for older adults, many of whom are poor. • Use of tobacco and alcohol is also a significant risk factor.	• Integrating the Healthy and Active Ageing Agenda into Existing Policies and Strategies; Nutrition, NCDs, Rehabilitation and Mental Health, SRH, Eye Health, Environmental health, CHBC and Palliative Care, ARV, SMC, Health Promotion, Alcohol & Substance Abuse (Primary, Secondary, Tertiary) • Develop a System of Long-term Care for Older Adults - establishing Rehabilitation/Engagement Institutions/Centres for Older Adults • Community Education • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing • Revival of the Old Systems for Social Integration and Community Out-reach

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• There are no primary health care services specially targeted to older adults. • Community home based care strengthening	
		• Generally, the health services are not responsive to the needs of the ageing population and this is evidenced by the absence of disaggregated health Information management system (HIMS) statistics on this population group and their health needs.	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
2	Ministry of Presidential Affairs Governance and Public Administration	• Need for Healthy and Active Ageing National Coordination • A consequence of high prevalence of chronic diseases, co-morbidity and natural ageing process is impairment and disability. • No interlinked social register	• Establish Older Persons Agenda National Coordination • Integrating the Healthy and Active Ageing Agenda into Existing Policies and Strategies; Disability Policy • Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
3	Ministry of Local Government And Rural Development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• The universal old age pension that was introduced in 1996 can barely meet the basic needs of older adults. • With the accelerated urbanization and international migration, fewer young people as productive members of the population remain in rural areas to support the elderly who face multiple social, economic and health problems. • Lack of social support, poverty and interpersonal violence- • Poverty is one of the major issues affecting older adults, only a small proportion (9%) of whom is reported to be living above the poverty datum line, and with the worst situation being in rural areas. • There is also evidence that older people are victims of abuse in the form of violence, neglect, abandonment or disrespect. • Older people, especially women, are victims of allegations of witchcraft, leading to stigmatization and collective acts of violence. • Whereas Batswana have in the past taken care of their older adults within the extended family and kinship systems, in recent years, those systems have disintegrated, mainly as a result of the increased movement of productive members of the population to cities and towns, • Only a small proportion (8%) of older adults who retire from formal employment earn pension. • The 2011 population and housing census report shows that the "never married" category is common among females across all groups from 60 years to over 75 years. The patterns for "divorced" and "separated" are similar, with females being more frequently divorced or separated than males. Females dominated the "widowed" category with less than 20% men reporting to be widowed compared to females at more than 80% of 700 participants.(SURVEY , 2019) • The 2011 population and housing census revealed that only 3.8% and 8.1% of older adults were engaged in seasonal and non-seasonal, paid work, respectively. A higher percentage of males than females reported being in paid employment in the last 12 months.	• Scaling up the Universal Old Age Pension • Optimize the mechanisms (pension & social assistance) of social protection (Increase pension, allocate more resources) • Develop a System of Long-term Care for Older Adults; Old-age homes, Recreation Centres, socioeconomic support. • Community Education • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing • Revival of the Old Systems for Social Integration and Community Out-reach • Community home based care strengthening

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• 20.4% of persons aged 65 years and older reported that they had spent the last 12 months prior to the census not participating in any economic activity because they were sick. • About 47% reported feeling lonely, either persistently (31.5) or infrequently (15.1). • On the intensity of worrying, 38% reported worrying a lot • Distribution of housing units with non-durable construction materials was 32.5% for rural villages, 2.1% for urban villages, and 0.7 for cities and towns, with a national average of 10.0%. Considering that about half of the older adult population resides in rural villages, the numbers suggest that many older adults could be living in non-durable and unsafe housing structures. • Population and housing census report on household headship indicates that 17% of the households were headed by older adults (60 years old and above • Low consumption of fruits and vegetables may be related to their unaffordability for older adults, many of whom are poor.	
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
4	Ministry of Infrastructure and Housing development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons • A consequence of high prevalence of chronic diseases, co-morbidity and natural ageing process is impairment and disability.	• Integrating the Older Persons Agenda into Existing Policies and Strategies

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• From the health care system has not developed infrastructure and services that are inclusive of older adults. • About 47% reported feeling lonely, either persistently (31.5) or infrequently (15.1).	• Develop a System of Long-term Care for Older Adults; Age friendly infrastructure; institutions, old age homes, recreation centres • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• Distribution of housing units with non-durable construction materials was 32.5% for rural villages, 2.1% for urban villages, and 0.7 for cities and towns, with a national average of 10.0%. Considering that about half of the older	• Advocate for older persons subsides on building materials
		Adult population resides in rural villages, the numbers suggest that many older adults could be living in non-durable and unsafe housing structures.	
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
5	Ministry of Land Management Water and Sanitation Services	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies.

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• A consequence of high prevalence of chronic diseases, co-morbidity and natural ageing process is impairment and disability. • A consequence of high prevalence of chronic diseases, co-morbidity and natural ageing process is impairment and disability. • From the health care system has not developed infrastructure and services that are inclusive of older adults. • About 47% reported feeling lonely, either persistently (31.5) or infrequently (15.1).	• Develop a System of Long-term Care for Older Adults. Age friendly infrastructure; institutions, old age homes, recreation centres • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• Distribution of housing units with non-durable construction materials was 32.5% for rural villages, 2.1% for urban villages, and 0.7 for cities and towns, with a national average of 10.0%. Considering that about half of the older adult population resides in rural villages, the numbers suggest that many older adults could be living in non-durable and unsafe housing structures.	• Advocate for older persons priority on land allocation and subsides on building materials
		• Access to clean water in Botswana reached 99.5% for urban areas and 84.1% for rural areas in 2008 (Government of Botswana, 2012). • Access to water within households, either from indoors or outdoors within the compound has been reported at 90.2%, 84.3%, and 36.5% for cities and towns, urban villages, and rural villages, respectively, with the remaining being clean water from sources outside the compound such as communal tap, neighbour's tap and boreholes (Statistics Botswana, 2015).	• Advocate for older persons water bill subsides.
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
6	Ministry of Agriculture Development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies

NO	MINISTRY	GAPS	RECOMMENDATIONS
	and Food Security	• Older people in the African region are affected by food insecurity problems with the proportion of underweight older people being between 5 to 15% • Only a small proportion (8%) of older adults who retire from formal employment earn pension. Low consumption of fruits and vegetables may be related to their unaffordability for older adults, many of whom are poor.	• Employment's Support for Workers' Post-retirement Lives • Consider age-friendly Agricultural projects • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
7	Defence , Justice and Security	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Lack of social support, poverty and interpersonal violence • There is also evidence that older people are victims of abuses in the form of violence, neglect, abandonment or disrespect.	• Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
8	Ministry of Finance and Economic Development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Poverty is one of the major issues affecting older adults, only a small proportion (9%) of whom is reported to be living above the poverty datum line, and with the worst situation being in rural areas. • There are no laws and policies that specifically protect the rights and wellbeing of older adults. • Only a small proportion (8%) of older adults who retire from formal employment earn pension.	• Develop a System of Long-term Care for Older Adults. • Economic empowerment • Employment's Support for Workers' Post-retirement Lives

NO	MINISTRY	GAPS	RECOMMENDATIONS
		• The universal old age pension that was introduced in 1996 can barely meet the basic needs of older adults. • Surprisingly, households headed by persons with non-formal education had the second least representation in the poorest category of wealth, after those headed by tertiary education holders; and were next best represented in the richest category after those headed by tertiary education holders. One may postulate that those who enrol in non-formal education do that after a thorough introspection and are determined to do all they can, not only to attain functional literacy, but also to lift themselves out of poverty. • The 2011 population and housing census revealed that only 3.8% and 8.1% of older adults were engaged in seasonal and non-seasonal, paid work, respectively. A higher percentage of males than females reported being in paid employment in the last 12 months. • About 47% reported feeling lonely, either persistently (31.5) or infrequently (15.1). • Distribution of housing units with non-durable construction materials was 32.5% for rural villages, 2.1% for urban villages, and 0.7 for cities and towns, with a national average of 10.0%. Considering that about half of the older adult population resides in rural villages, the numbers suggest that many older adults could be living in non-durable and unsafe housing structures. • Population and housing census report on household headship indicates that 17% of the households were headed by older adults (60 years old and above • Low consumption of fruits and vegetables may be related to their unaffordability for older adults, many of whom are poor.	• Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing

NO	MINISTRY	GAPS	RECOMMENDATIONS
9	Ministry of Tertiary Education, Research, Science and Technology	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Older adults in Botswana do not have the level of education that could provide them with financial and knowledge resources for meeting the challenge of old age. • Surprisingly, households headed by persons with non-formal education had the second least representation in the poorest category of wealth, after those headed by tertiary education holders; and were next best represented in the richest category after those headed by tertiary education holders. One may postulate that those who enroll in non-formal education do that after a thorough introspection and are determined to do all they can, not only to attain functional literacy, but also to lift themselves out of poverty. • Undergraduate curricula in fields such as medicine, nursing, and social work need to be strengthened so they can equip programme graduates with basic skills for assessing older adults and attending to their needs at primary health care settings.	• Inclusion of vernacular local language in the curricular. (optional subjects) • Inclusion of Older persons modules in the tertiary education curriculum • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
10	Ministry of Basic Education	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Older adults in Botswana do not have the level of education that could provide them with financial and knowledge resources for meeting the challenge of old age. • Surprisingly, households headed by persons with non-formal education had the second least representation in the poorest category of wealth, after those headed by tertiary education holders; and were next best represented in the richest category after those headed by tertiary education	• Inclusion of vernacular local language in the basic education. • Inclusion of Older persons modules in the basic education curriculum

NO	MINISTRY	GAPS	RECOMMENDATIONS
		holders. One may postulate that those who enrol in non-formal education do that after a thorough introspection and are determined to do all they can, not only to attain functional literacy, but also to lift themselves out of poverty.	• Revision of Adult Education approach • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
11	Ministry of Employment, Labour Productivity and Skills Development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into existing Policies and Strategies- Flexi hours to care givers employees
		• With the accelerated urbanization and international migration, fewer young people as productive members of the population remain in rural areas to support the elderly who face multiple social, economic and health problems. • There are no laws and policies that specifically protect the rights and wellbeing of older adults. • Only a small proportion (8%) of older adults who retire from formal employment earn pension. The 2019 survey asked participants to indicate the longest occupation they had had. Seventy four percent (74%) had had formal employment with the majority of those who had history of employment (94.9%) having had non-skill based occupations such as mining and domestic work services, leaving only 5.1% for professional/office work. • Surprisingly, households headed by persons with non-formal education had the second least representation in the poorest category of wealth, after those headed by tertiary education holders; and were next best represented in the richest category after those headed by tertiary education holders. One may postulate that those who enroll in	• Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing

NO	MINISTRY	GAPS	RECOMMENDATIONS
		non-formal education do that after a thorough introspection and are determined to do all they can, not only to attain functional literacy, but also to lift themselves out of poverty. • The 2011 population and housing census revealed that only 3.8% and 8.1% of older adults • were engaged in seasonal and non-seasonal, paid work, respectively. A higher percentage of males than females reported being in paid employment in the last 12 months.	
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
12	Ministry of Transport and Communicatio ns	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Centralised specialised services leads to older persons transport burden	- Subsidise transportation fares for older persons - Community education
13	Ministry of Nationality Imigration and Gender Affairs	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Healthy and Active Ageing Agenda into Existing Policies and
		• There is also evidence that older people are victims of abuses in the form of violence, neglect, abandonment or disrespect. • There are no laws and policies that specifically protect the rights and wellbeing of older adults. • The 2011 population and housing census report shows that the "never married" category is common among females across all groups from 60 years to over 75 years. The patterns for "divorced" and "separated" are similar, with females being more frequently divorced or separated than males. Females dominated the "widowed" category with	• Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing

NO	MINISTRY	GAPS	RECOMMENDATIONS
		less than 20% men reporting to be widowed compared to females at more than 80%.(SURVEY , 2019) • Population and housing census report on household headship indicates that 17% of the households were headed by older adults (60 years old and above	
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
14	Ministry of Youth Empowerment, Sport and Culture Development	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Whereas Batswana have in the past taken care of their older adults within the extended family and kinship systems, in recent years, those systems have disintegrated, mainly as a result of the increased movement of productive members of the population to cities and towns,	• Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing • Revival of the Old Systems for Social Integration and Community Out-reach
		• No interlinked social register .	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
15	Ministry of Environment, Natural Resources Conservation and Tourism	• Botswana does not have a policy on ageing yet. • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
16	Ministry of International	• Botswana does not have a policy on ageing yet. • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda

NO	MINISTRY	GAPS	RECOMMENDATIONS
	Affairs and Cooperation		into Existing Policies and Strategies
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
17	Ministry of Investment Trade and Industry	• Botswana does not have a policy on ageing yet. • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Use of tobacco and alcohol is also a significant risk factor.	• Appreciate the impact and implication of tobacco and alcohol on the older persons health • Employment's Support for Workers' Post-retirement Lives • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register .	• Improving Older Adult Data Capturing and Establishing a Programme of Research on Ageing
18	Ministry of Mineral Resources, Green Technology and Energy Security	• Botswana does not have a policy on ageing yet • No Act to protect the rights of older persons	• Integrating the Older Persons Agenda into Existing Policies and Strategies
		• Energy bills increasing the older persons economic burden	• Advocate for subside for older person's energy bills. • Employment's Support for Workers' Post-retirement Lives. • Recognizing the Special Situation of Women and Ageing
		• No interlinked social register	• Improving Older Adult Data Capturing and Establishing a

NO	MINISTRY	GAPS	RECOMMENDATIONS
			Programme of Research on Ageing

ORGANISATIONS THAT PARTICIPATED DURING THE OLDER ADULTS SITUATIONAL ANALSIS AND STRATEGY DEVELOPMENT PROCESSES

HEALTHY AND ACTIVE AGEING PROGRAM STEERING COMMITTEE

NO	ORGANISATION	REPRESENTATIVE
1	Ministry of Health and Wellness DPS Health Service Management	Dr Tshepho Machacha
2	Ministry of Health and Wellness DPS Health Service Management	Dr Mareko Ramotsababa
3	Ministry of Health and Wellness DPS Health Service Management	Dr Morrison Sinvula
4	Ministry of Health and Wellness Health Service Management Rehabilitation & Mental Health (RHMD) Division Head	Mr Patrick Zibochwa
5	Ministry of Health and Wellness Health Service Management Rehabilitation & Mental Health Division Head	Ms Gaboelwe Rammekwa
6	Ministry of Health and Wellness Health Service Management RMHD-Healthy and Active Ageing Program.	Ms Ogopoleng Batisi
7	Ministry of Health and Wellness Health Service Management Nursing Office	Ms Onthatile Medupe
8	Ministry of Health and Wellness Health Service Management Community Home Based Care	Ms Penny Makuruetsa
9	Ministry of Health and Wellness Legal Advisor	Mr Rakubu Kagisano
10	Ministry of Tertiary Education, Research, Science and Technology	Ms Bosa R. Lebotse
11	Ministry of Transport and Communications	Mr Olefile Moakofi
12	Presidential Affairs, Governance and Public Administration	Ms Thapelo Moshia Moalusi
13	Presidential Affairs, Governance and Public Administration	Ms Katlego Sekabodiile
14	Ministry of Mineral Resources, Green Technology and Energy Security	Mr Midas Sekgabo
15	Ministry of Agriculture Development and Food Security	Ms Chada Koketso
16	Ministry of Infrastructure and Housing Development Building and Engineering Services Department	Mr Oteng Mashumba
17	Ministry of Infrastructure and Housing Development Building and Engineering Services Department	Mr Kelebogile Shomanah

18	Ministry of Land Management, Water and Sanitation Services Town and Country Planning Department	Ms Eunice Naledi Mmono
19	Ministry of Land Management, Water and Sanitation Services Town and Country Planning Department	Mr Leungo Mogotetsi
20	Ministry of Local Government and Rural Development Social Protection	Ms Mosidi C. Batsalelwang
21	Ministry of Local Government and Rural Development Social Protection	Ms Margret Mokgachane
22	Ministry of Local Government and Rural Development Tribal Administration	Ms Malebogo Mokotedi
23	Ministry of Local Government and Rural Development Tribal Administration	Mr Baboloki Phalaagae
24	Ministry of Finance and Economic Development	Ms Molly G. Makondo
25	Ministry of Employment, Labour Productivity and Skills Development	Ms Kgomotso B. Watemo
26	Ministry of Employment, Labour Productivity and Skills Development	Mr Nathaniel Tlhalerwa
27	Ministry of Youth Empowerment, Sport and Culture Development	Mr Moreetsi Bogosi
28	Ministry of Nationality, immigration and Gender	Mr Nonofo E. Leteane
29	Ministry of International Affairs and Cooperation	Ms Violet Losike
30	Ministry of International Affairs and Cooperation	Ms Omolemo Selato
31	Ministry of Basic Education	Ms Neo Habangana
32	University of Botswana Faculty of Medicine	Dr BillyTsima
33	University of Botswana Faculty of Health Sciences School Of Nursing	Dr Kefalotse Sylvia Dithole
34	University of Botswana Faculty of Social Sciences Department of Law	Professor Bonolo Dinokopila
35	University of Botswana Faculty of Social Sciences Department Social Work	Dr Tumani Malinga
36	University of Botswana Faculty of Social Sciences Department Of Demography	Dr Enock Ngome
37	Statistics Botswana	Mr Keamogetse Moreo
38	Media Institute of Southern Africa (MISA)	Mr Tefo Phatshwane
39	Ditshwanelo - The Botswana Centre For Human Rights	Ms Florah Kedibonye
40	Botswana Council of Non-Governmental Organisations (BOCONGO)	Mr Allen Tshekedi
41	Botswana Civil Service Pensioners Association (BCSPA)	Ms Nkae V. D. Molefe
42	Associated Fund Administrators (AFA)	Ms Thato Lesetedi

43	Associated Fund Administrators (AFA)	Ms Matshediso Matome
44	Botswana Council of Churches (BCC)	Mr Onkemetse S. Mathabathe
45	Organisation of African Instituted Churches (OAIC)	Mr Olebile Christopher Modikwa
46	Evangelical Fellowship of Botswana (EFB)	Pastor Balatedi Peggy Ratsebe
47	Interim Committee Traditional Doctors	Mr Kitso Peter Mbenge
48	World Health Organisation (WHO)	Ms Lucy S. Maribe
49	World Health Organisation (WHO)	Ms Mpona Manthe

HEALTHY AND ACTIVE AGEING PROGRAM TECHINCAL WORKING TEAM

NO	ORGANISATION	REPRESENTATIVE
1	Ministry of Health and Wellness Health Services Management Community Health Service Advisor	Mr Samuel Kolane
2	Ministry of Health and Wellness Health Service Management Rehabilitation & Mental Health Division (RMHD) Head	Mr Patrick Zibochwa
3	Ministry of Health and Wellness Health Service Management Rehabilitation & Mental Health Division Head	Ms Gaboelwe Rammekwa
4	Ministry of Health and Wellness Health Services Management RMHD-Healthy and Active Ageing Program.	Ms Ogopoleng Batisi
5	Ministry of Health and Wellness Health Services Management RMHD-Mental Health Unit	Ms Nellie Mafa
6	Ministry of Health and Wellness Health Services Management RMHD-Mental Health Unit	Mr Ookame Charles
7	Ministry of Health and Wellness Health Services Management RMHD-Audiology Unit	Ms Rina Katholo
8	Ministry of Health and Wellness Health Services Management RMHD-Physical Unit	Ms Onalenna Lekoba
9	Ministry of Health and Wellness Health Services Management RMHD-Health Promotion	Ms Irene Leteane
10	Ministry of Health and Wellness Health Services Management RMHD-Monitoring & Evaluation	Mr Moses Modise
11	Ministry of Health and Wellness Health Services Management RMHD-Strategy Consultant	Ms Itumeleng Tsaone Monageng
12	Ministry of Health and Wellness Princess Marina Hospital Spinals Unit	Dr Kobamelo Sekakela
13	Ministry of Health and Wellness Department of Health Services Monitoring and Evaluation Quality Assurance	Mr Patrick Tema
14	Ministry of Health and Wellness Department of Health Services Monitoring and Evaluation Quality Assurance	Ms Shifawu Odunsi
15	Ministry of Health and Wellness Department of Corporate Services Information Technology	Mr Quett Tsimane

16	Ministry of Health and Wellness Department of Health Policy Research and Development Informatics Unit	Ms Kelebogile Sebakeng
17	Ministry of Health and Wellness Health Services Management Eye Health Program	Ms Malebogo Mmereki
18	Ministry of Health and Wellness Health Services Management Environmental Health Division	Mr Farnwell Bojase
19	Ministry of Health and Wellness Health Services Management Environmental Health Division	Mr Kabelo Gobe Zwinila
20	Ministry of Health and Wellness Health Services Management Sexual and Reproductive Health Division	Ms Lesego Mokganya
21	Ministry of Health and Wellness Health Services Management Sexual and Reproductive Health Division	Mrs Gosatla Gaealafswe
22	Ministry of Health and Wellness Nutrition and Food Control Division	Ms Tumelo Joseph
23	Ministry of Health and Wellness Nutrition and Food Control Division	Ms Kehumile Modise
24	Ministry of Health and Wellness Health Services Management Community Home Based Care (CHBC)	Mr Stalin Makathayi
25	Ministry of Health and Wellness Health Services Management Disease Control Division	Dr Gontse Tshisimogo
26	Ministry of Health and Wellness Health Services Management Disease Control Division	Dr Virginia Letsatsi
27	Ministry of Health and Wellness Department of Corporate Services Safety & Health Environment Unit	Ms Milly Raphuti
28	Ministry of Health and Wellness Health Service Management Nursing Office	Ms Onthatile Medupe
29	Ministry of Health and Wellness Department of Health Policy Research and Development Institute of Health Science (IHS) Coordination	Ms Senewa D. Mooko
30	Ministry of Health and Wellness Department of Corporate Services Office of Strategy Management (Change Management Plan Unit)	Ms Heather Mothibedi
31	Ministry of Health and Wellness Department of Health Policy Research and Development Policy and Planning and Financing Unit	Mr Bennedict Moeng

32	Ministry of Health and Wellness Department of Health Policy Research and Development Policy and Planning and Financing Unit	Ms Onalenna Mokena
33	Ministry of Health and Wellness Department of Health Policy Research and Development Policy and Planning and Financing Unit	Ms Thamiso Sebolao
34	Ministry of Health and Wellness Department of Health Policy Research and Development Partnerships Unit	Ms Ludo Chube
35	Ministry of Health and Wellness Department of Corporate Services Public Relations office	Mr Khayalethu M. M. Mpofu
36	Ministry of Health and Wellness District Health Management Team	Ms Elinah Mbangwa
37	Ministry of Health and Wellness District Health Management Team	Ms Direpang Segosebe
38	Council Physical planners	Mr Asalepele Kgetho
39	Council Physical planners	Ms Letsema Masake
40	Council Architecture & Building	Mr Kealeboga Ramoupo
41	Ministry of Finance and Economic Development	Mr Shepherd Monyeki
42	Ministry of Basic Education	Ms Kelly Kopi
	Ministry of Basic Education	Ms Doreen Molosiwa
43	Ministry of Tertiary Education, Research, Science and Technology	Ms Bosa R. Lebotse
44	Ministry of Tertiary Education, Research, Science and Technology IHS Coordination	Ms Senewa D. Mooko
45	Ministry of Employment, Labour Productivity and Skills Development Monitoring and Evaluation office	Ms Bantle P. Zacharia
46	Ministry of Employment, Labour Productivity and Skills Development Monitoring and Evaluation office	Ms Tshoganetso Timela
47	Ministry of Employment, Labour Productivity and Skills Development Safety & Health Environment Office	Ms Kgomotso B. Watemo
48	Ministry of Local Government and Rural Development Social Protection	Ms Gomotsanang N. Manne
49	Ministry of Local Government and Rural Development Social Protection	Ms Sarah Keoagile
50	University of Botswana Faculty of Health Sciences School Of Nursing	Dr Miriam Sebego
51	University of Botswana Faculty of Social Sciences Department of Law	Mr Patrick B. Gunda
52	University of Botswana Faculty of Medicine	Dr. Maikutlo Kebaetse

53	University of Botswana Faculty of Social Sciences Department Of Population Studies	Dr. Enock Ngome
54	University of Botswana Faculty of Social Sciences Department Social Work	Dr Poloko Nuggert Ntshwarang
55	Botswana Hospice and Palliative Care Association	Mr Tswelelopele Brooklyn Masutha
56	Botswana Hospice and Palliative Care Association (BHPCA)	Mr Alfred Ntshonono
57	Botswana Retired Nurses Society (BORNUS)	Ms Esther Tladi
58	Botswana Retired Nurses Society	Ms Idah Nseula
59	Botswana Retired Nurses Society	Ms Goitsemang Boiteto
60	There 4 U Adult Care	Ms Chawa Enyatseng
61	Botswana Civil Service Pensioners Association (BCSPA)	Ms Itumeleng B. Manthe
62	Botswana Civil Service Pensioners Association (BCSPA)	Ms Bontle Patle

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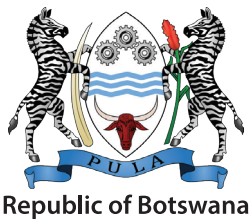

Republic of Botswana

MINISTRY OF HEALTH & WELLNESS

Private Bag 0038, Gaborone

Physical address: Plot 54609 Amos Street

Government Enclave, Gaborone