BOTSWANA MATERNAL MORTALITY RATIO 2022

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STATISTICS BOTSWANA

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PREFACE

This Stats Brief presents information on Maternal Mortality for the year 2022. The Ministry of Health provides data used from the brief, through reports gathered from health facilities.. The brief assesses the major causes of maternal mortality to monitoring the effectiveness of Government interventions to ensure that no mother dies as a result of childbirth. This commitment is underscored by Government subscription to the Sustainable Development Goal of 'ensuring healthy lives and promoting wellbeing for all ages. The SDGs commit countries to reducing global Maternal Mortality Ratio (MMR) to less than 70 deaths per 100,000 live births. The Goals also advocate for a large proportion of births being attended to by skilled health personnel.

The brief shows that 89 maternal deaths were reported in 2022 from 50,704 live births yielding a Maternal Mortality Ratio (MMR) of 175.5 maternal deaths per 100,000 live births. Over the years there has been a fluctuating trend in the Maternal Mortality Ratio (MMR) ranging from 127 deaths per 100,000 live births (lowest) in 2015 to 240 deaths per 100,000 live births (highest) in 2021. This shows that the country is yet to reach the 70 deaths per 100,000 live births target set by the World Health Organization (WHO).

We continue to note a high number of mothers delivering in health facilities. The brief shows an overwhelming 99.8 percent of all births are estimated to have occurred in health facilities supervised by a skilled health professional.

Statistics Botswana welcomes the contributions of all stakeholders and collaborating partners who ensure that this product is made possible. We welcome suggestions on how to improve this brief to effectively monitor the SDGs and ensure that no mother dies during childbirth due to preventable causes.

Thank you

Ketso Makhumalo
Acting Statistician General
July 2024

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Definition of Maternal Mortality Ratio (MMR)

Maternal Death Definitions for Classification and Calculation of MMR

MMR: key terminologies	
The following World Health Organization (WHO) maternal death definitions were used for classification and calculation of MMR. The classification of causes of maternal deaths is also according to WHO International Classification of Diseases Volume 10 (ICD 10).	
Maternal Death	A death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
Direct Maternal Death	A death resulting from complications of pregnancy, labor or delivery or their management.
Indirect Martenal Death	A death in which pregnancy exacerbated a pre-existing health problem.
Non-Maternal Death	A death that occurred during pregnancy or within 42 days of termination of pregnancy, but was considered unrelated to pregnancy (e.g. due to injury, homicide, or suicide).
Maternal Mortality Ratio (MMR)	Number of maternal deaths during a given period per 100,000 live- births during the same time-period. The ratio is expressed as follows: $\frac{\text{Maternal deaths}}{\text{Live births}} * K$ Where K = 100,000
Proportion Maternal (PM)	Proportion of all-cause deaths for women of reproductive age (15-49years) that are due to maternal causes.

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1. Introduction

This Stats Brief provides information on Botswana Maternal Mortality Ratio for the period 2014 – 2022, however comparative analysis is being done against previous years where data is available. Maternal Mortality Ratio is defined as the number of maternal deaths per 100,000 live births. The Sustainable Development Goal (S.D.G) 3.1 sets a target by 2030, to reduce the global Maternal Mortality Ratio (MMR) to less than 70 per 100,000 live births. As part of a collaborative effort between Statistics Botswana and the Ministry of Health {Department of Public Health - Sexual and Reproductive Health Division (SRHD)} to improve the availability and quality of maternal mortality information, the parties, ensure that data on live births and maternal deaths are provided. We hope readers and users of this information will find this brief informative and we welcome input on how to further improve the content of this publication.

2. Access to Health Services and Birth Attendants Assistance

The 2020 Vital Statistics report indicates that over 99 percent of deliveries have been born in health facilities. This shows that high number of births are attended to by skilled health personnel. The high number of birth attendances by skilled health personnel should lead to accurate identification and classification of maternal death cases, as well as certification of causes of maternal deaths. Hence, there is a high coverage and precision in the collection of birth and death data on mothers and their newborns.

3. Maternal Deaths

3.1 Maternal Deaths per Health District and Type of Health Facility

Table 1 presents the distribution of maternal deaths that occurred in the Health districts, disaggregated by the facility type where they occurred in 2022. Almost three fifths of maternal deaths (57.3%) occurred in Gaborone and Francistown DHMT's with Gaborone leading at 31.5 percent followed by 25.8 percent of births occurring in Francistown. The table further shows that 43 of the deaths occurred in Referral hospitals, 29 in District hospitals and 12 in Primary hospitals. Clinics recorded for 5 maternal deaths.

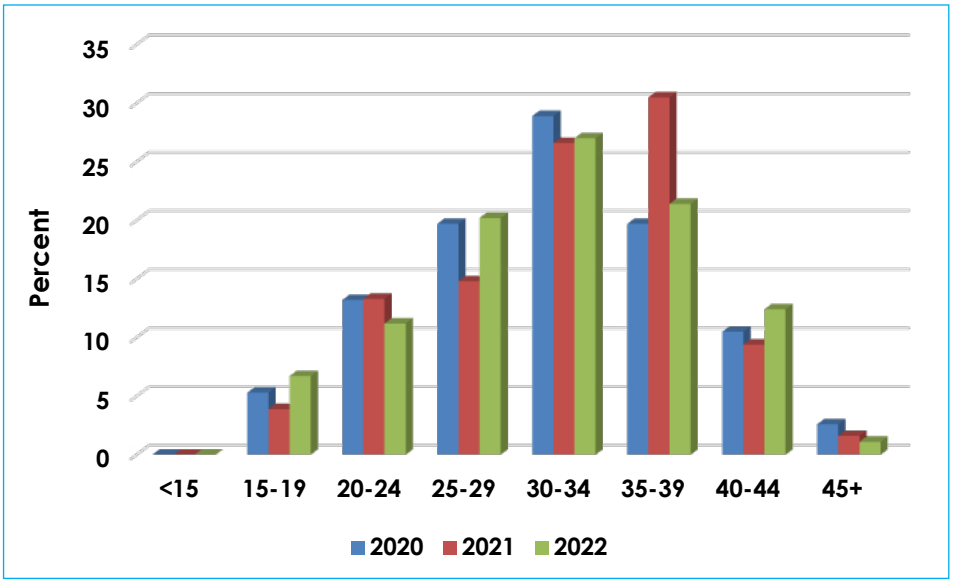
Table 1: **Distribution of Maternal Deaths per District and Type of Facility, 2022**

District	Clinics	District Hospital	Primary Hospital	Referral Hospital	Total	Percent
Gaborone	3	5	0	20	28	31.5
Francistown	0	0	0	23	23	25.8
Ngamiland	0	8	0	0	8	9.0
Kweneng East	0	4	0	0	4	4.5
Mahalapye	0	3	1	0	4	4.5
Gantsi	1	0	2	0	3	3.4
Jwaneng	0	3	0	0	3	3.4
Southern	0	3	0	0	3	3.4
Tutume	0	0	3	0	3	3.4
Boteti	0	0	2	0	2	2.2
Kgatleng	0	2	0	0	2	2.2
Goodhope	0	0	1	0	1	1.1
Lobatse	0	1	0	0	1	1.1
Moshupa	1	0	0	0	1	1.1
Okavango	0	0	1	0	1	1.1
Palapye	0	0	1	0	1	1.1
Tsabong	0	0	1	0	1	1.1
Total	5	29	12	43	89	100.0

3.2 Age Distribution of Maternal Deaths

Figure 1 shows the proportion of maternal deaths reported among age groups for the period 2020 - 2022. The highest maternal deaths in 2022 were reported among age groups 30-34 years (27.0%), followed by ages 35-39 years (21.4%) and 25-29 years (20.2%). There were two cases of maternal deaths recorded for ages 45 and above. However, no cases were reported in less than 15 years of age. This distribution seems to suggest that child bearing is less risk at lower ages and a high risk as age increases, however it should be noted that prevalence of child bearing at lower ages is lower.

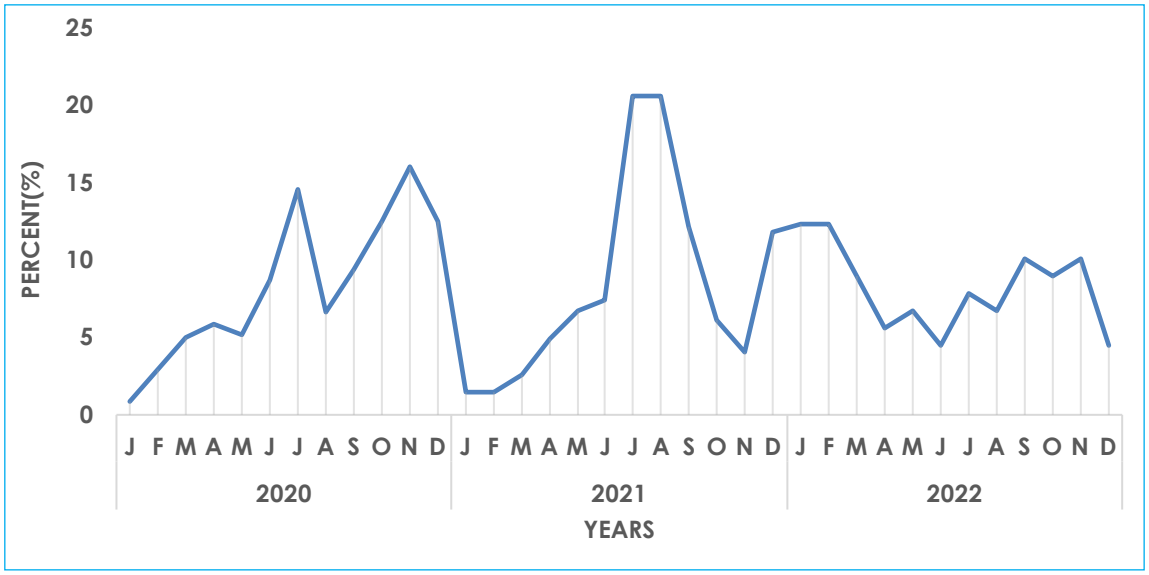
Figure 1: **Age Distribution of Maternal Deaths, 2020-2022**



3.3 Seasonal Variations in Maternal Deaths

Figure 2 presents the occurrence of maternal mortality by month for the years 2020 to 2022. The graph shows that 2020 and 2021 maternal deaths presented a bimodal distribution. Maternal deaths were highest in January – March and steadily decreased until July where the lowest was observed thereafter increasing. The second peak for maternal deaths was observed towards the end of the year from September to November 2022. In 2020 the major mode was observed in November while the minor in July whereas in 2021 the major mode was observed in July and August and the minor mode in December.

Figure 2: **Seasonal Variations in Maternal Deaths, 2020-2022**



3.4 Maternal Mortality Ratio

Botswana Maternal Mortality Ratio for the period 2014 to 2022 is shown in Table 2. The MMR sharply decreased by 27.1 percentage points from 240.0 to 175.5 maternal deaths per 100,000 live-births between 2021 and 2022. Over the years the MMR has been fluctuating with the highest recorded in the year 2021(240.0) and the lowest in 2015(127.0).

Table 2: Botswana Maternal Mortality Ratio 2014–2022

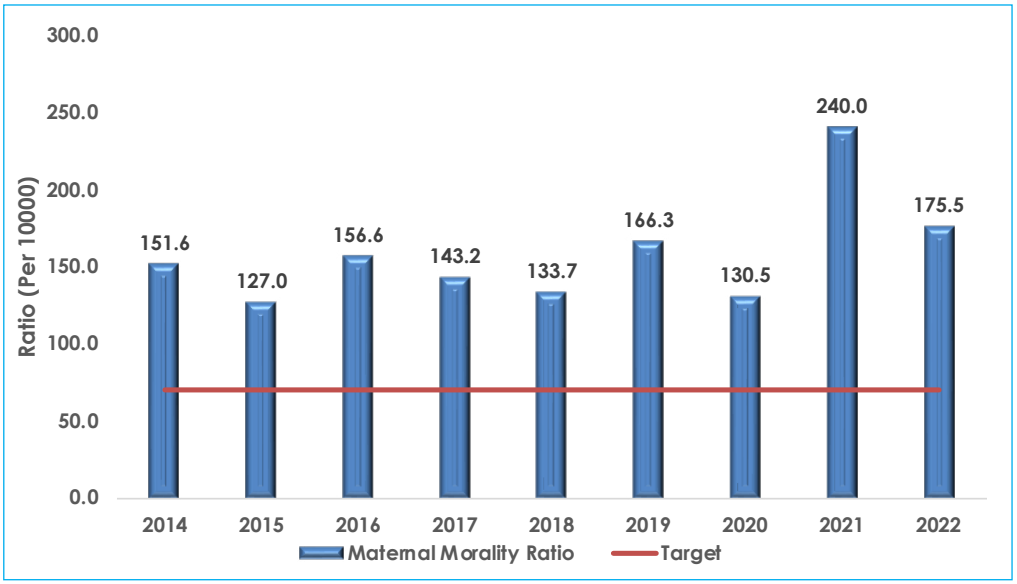
Variable	2014	2015	2016	2017	2018	2019	2020	2021	2022
Institutional live births	47,273	57,290	54,159	52,242	52,999	52,206	58,146	53,227	50,605
Non-Institutional live-births	205	190	108	116	117	98	*98	99	*99
Total live-births	47,478	57,480	54,267	52,358	53,115	52,304	58,244	53,326	50,704
Maternal Deaths	72	73	85	75	71	87	76	128	89
Maternal Morality Ratio (per 100,000 live-births)	151.6	127	156.6	143.2	133.7	166.3	130.5	240	175.5

*Brought Forward

3.5 Progress towards Achieving Sustainable Development Goal (SDG) 3.1

Figure 3 shows a trend in Maternal Mortality Ratio from 2014 – 2022 in relation to the set target of 70 deaths per 100,000 live births. The figure shows that Botswana has not reached the 70 per 100,000 live births since 2014. However in 2021 there was a major setback in Botswana trying to attain SDG 3.1c with the most maternal deaths recorded attributed mainly to COVID-19. In 2022 a slight reduction was observed.

Figure 3: **Botswana Maternal Mortality Ratio 2014-2022**



3.6 Underlying Causes of Maternal Deaths

3.6.1 Top ten Causes of Maternal Deaths

Table 3 shows the top ten underlying causes of maternal deaths in 2021and 2022. A total of 89 deaths were recorded in 2022 a decrease of 30.5 percent in 2021. The highest reported leading cause was Genital tract and pelvic infection following abortion and ectopic and molar pregnancies (14.6%). The second leading causes were the Rapture of the uterus during labor and Diseases of the circulatory system complicating pregnancy childbirth and the puerperium (7.9% each). Six of the top ten conditions in 2022 were similar to 2021.

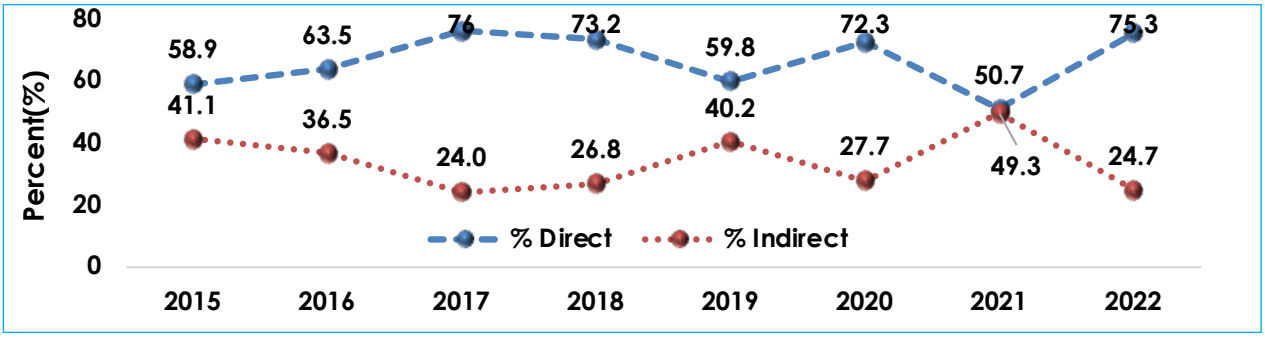
Table 3: **The Top Ten Leading Causes of Maternal Death, 2021-2022**

ICD10 Code	Diagnosis	2022			2021		
		Rank	Number	Percent	Rank	Number	Percent
O08.0	Genital track and pelvic infection following abortion and ectopic and molar pregnancies	1	13	14.61	8	4	3.1
O71.1	Rapture of uterus during labour	2	7	7.87	4	5	3.9
O99.4	Diseases of the circulatory system complicating pregnancy, childbirth and puerperium	3	7	7.87	3	7	5.5
O14.1	Severe pre-eclampsia	4	6	6.74	2	9	7
O98.7	Human Immunodeficiency (HIV) disease complicating pregnancy, childbirth and the puerperium	5	5	5.62	-	-	-
O14.9	Pre-Eclampsia, Unspecified	6	4	4.49	-	-	-
O15.0	Eclampsia in Pregnancy	7	3	3.37	-	-	-
O15.1	Eclampsia in Labour	8	3	3.37	-	-	-
O88.2	Obstetric blood-clot embolism	9	3	3.37	5	5	3.9
O90.3	Cardiomyopathy in the puerperium	10	3	3.37	6	5	3.9
O98.5	Other viral diseases complicating pregnancy, childbirth and the puerperium (COVID-19)	-	-	-	1	37	28.9
O00.1	Tubal Pregnancy	-	-	-	7	4	3.1
O14.2	HELLP syndrome	-	-	-	9	4	3.1
O62.2	Other uterine inertia	-	-	-	10	4	3.1
Total Above			54	60.7		84	65.6
Other			35	39.3		44	34.4
Grand Total			89	100		128	100

3.6.2 Direct and Indirect Causes of Maternal Deaths

Figure 4, shows the percentage distribution of direct and indirect maternal deaths from 2015 to 2022. Overall, over the years direct causes have been higher than indirect causes. In 2021, direct causes contributed 5 0.7percent of total maternal deaths which is relatively closer to indirect causes (49.3%). This increase in indirect maternal deaths was predominantly due to maternal deaths from COVID-19. However, in 2022 there were more direct causes (75.3%) than indirect causes (24.7%).

Figure 4: **Direct and Indirect Causes of Maternal Mortality, 2015-2022**

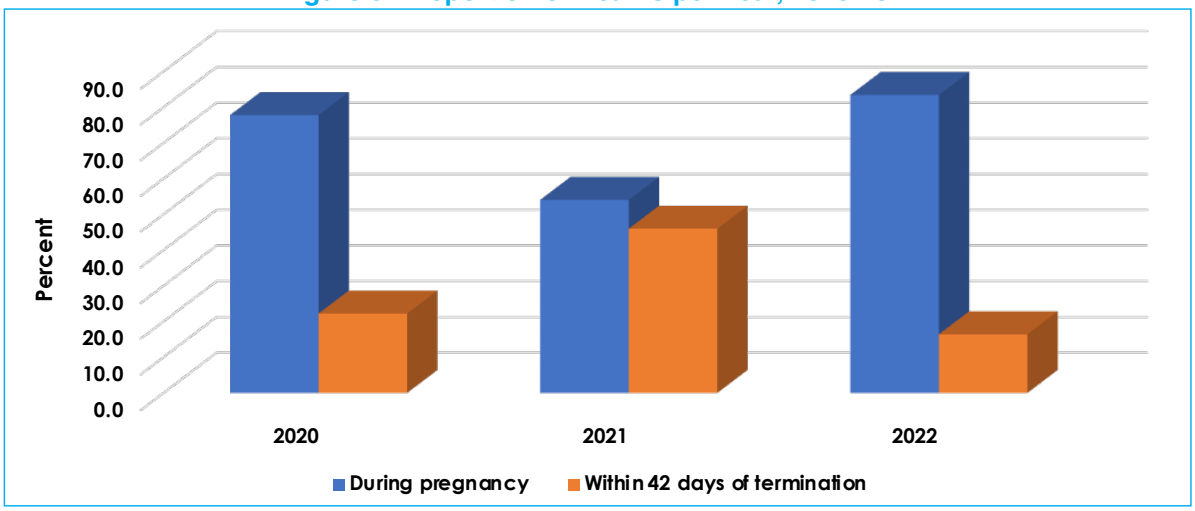


The most common causes of death among direct and indirect causes are indicated in **Annex 1**. The leading cause of maternal deaths among the direct causes was Genital tract and pelvic infection following abortion and ectopic and molar pregnancy (13 Cases) followed by Rupture of the uterus during labor (7 Cases). Among the indirect causes the most common causes were, Human Immunodeficiency (HIV) diseases complicating pregnancy, childbirth and the puerperium and diseases of the circulatory system complicating pregnancy, and childbirth with 5 cases each.

3.7 Gestation at Time of Maternal Deaths

A maternal death is a death of a woman while pregnant or within 42 days of termination of pregnancy. Figure 5 shows proportion of maternal deaths for 2020 - 2022 as per gestation at time of death. Generally, there were more Maternal deaths that occurred during pregnancy compared to those that occurred post-delivery for all the years. The figure further shows that in 2022 more than four fifth of death occurred during pregnancy.

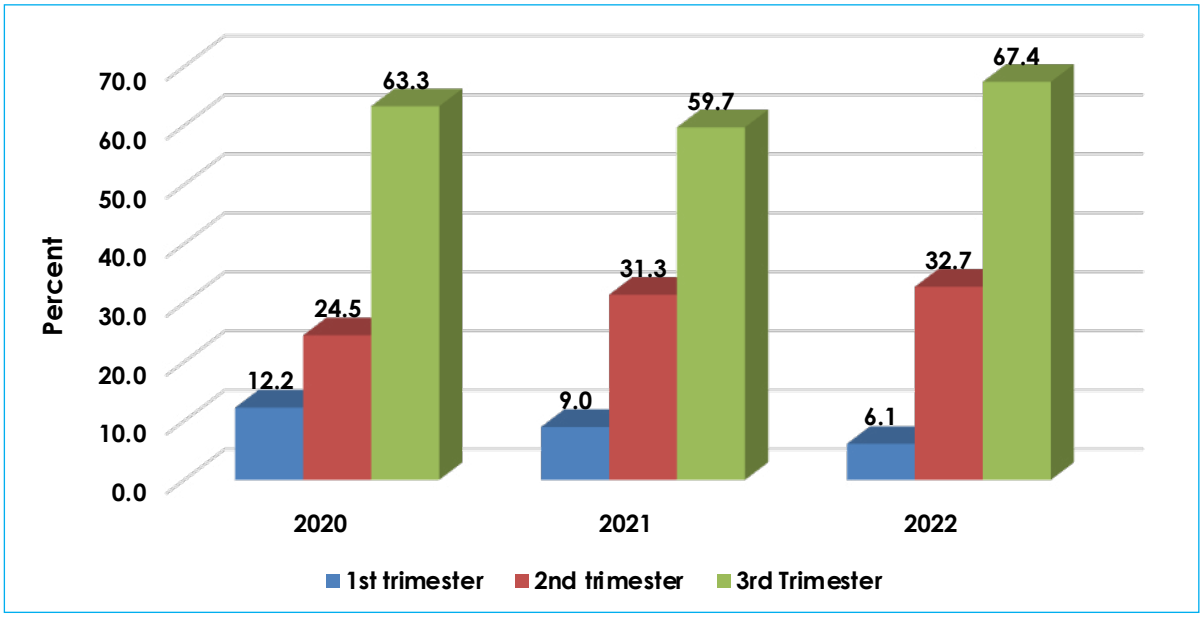
Figure 5: Proportion of Deaths per Year, 2020-2022



3.7.1 Maternal Deaths during Pregnancy

Figure 6 shows the proportion of maternal deaths that occurred during pregnancy in 2020 - 2022. A pregnancy is divided into trimesters: the first trimester is from week 1 to the end of week 12, the second trimester is from week 13 to the end of week 26 and the third trimester is from week 27 to the end of the pregnancy. The figure shows that the risk of maternal death increases with the onset of pregnancy in all the years. Maternal mortality is low in the first trimester, increases in the second trimester and is highest in the third trimester. In 2022, maternal deaths in the first trimester contributed 6.1 percent, in the second trimester (32.7%) and the third trimester (67.4%).

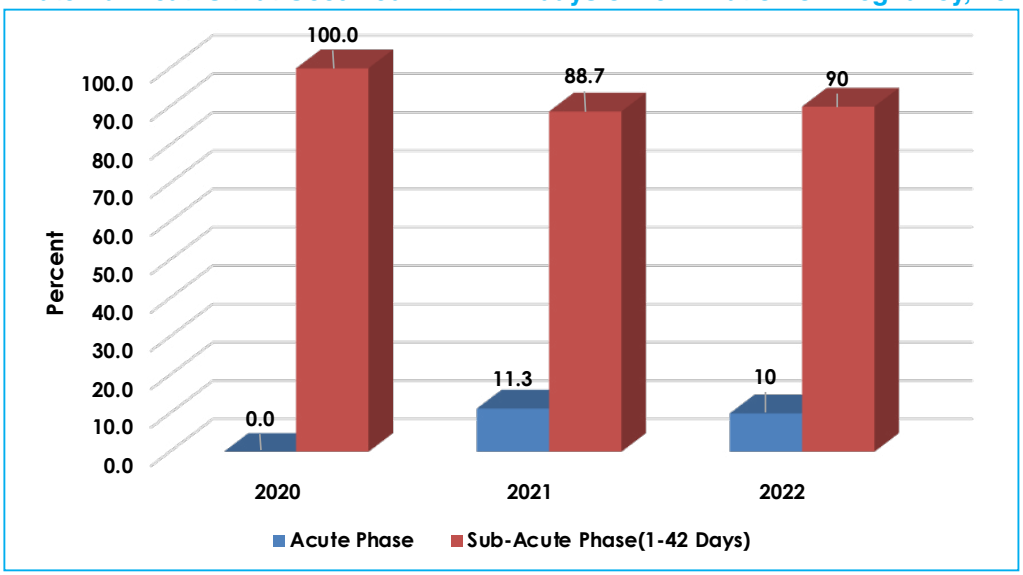
Figure 6: Proportion Maternal Deaths that Occurred During Pregnancy, 2020-2022



3.7.2 Post Natal Maternal Deaths

Figure 7 shows the proportion of maternal deaths that occurred within 42 days of termination of pregnancy in 2020 - 2022. The postnatal period is generally distributed into three distinct, but continuous phases: Acute Phase: 24 hours immediately following delivery, Sub-Acute Phase: which can last 2-6 weeks following delivery and Late Phase: which can last from 6 weeks - 6 months following delivery. From 2020 – 2022 the majority of deaths occurred in the Sub-Acute phase (1-42 days). In 2020 100 percent of deaths occurred in the Sub-Acute phase while in 2021 and 2022 deaths reported were 88.7 percent and 90 percent, respectively.

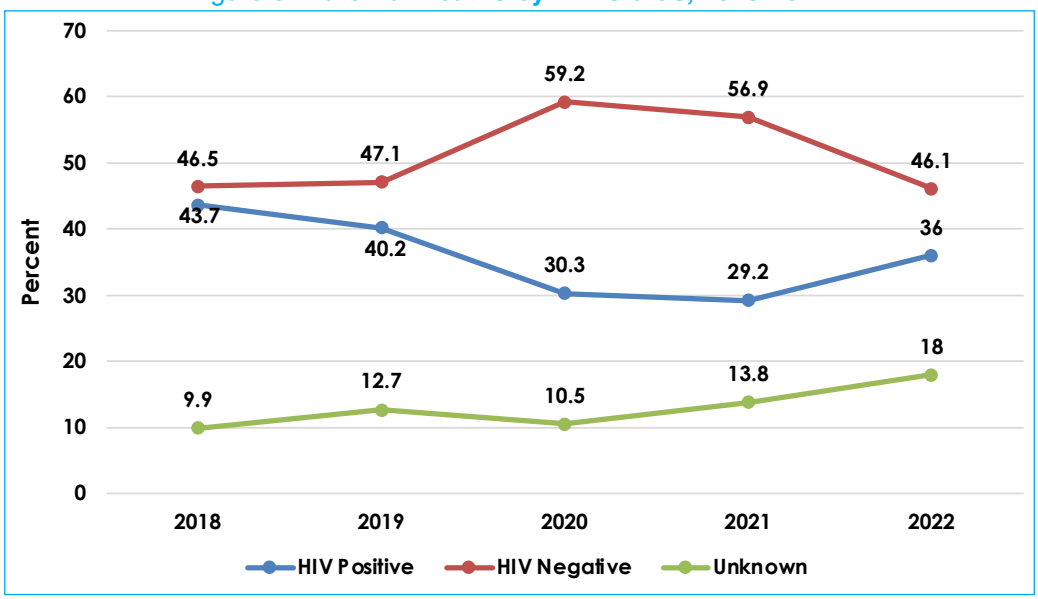
Figure 7: **Maternal Deaths that Occurred Within 42 days of Termination of Pregnancy, 2020-2022**



3.8 Prevalence of HIV positivity among maternal deaths over the years

It has been realized that among the mothers dying due to specified maternal causes, were found to have been living positively with HIV/AIDS. From the 89 maternal deaths reported 36.0 percent were HIV infected women, 46.1 percent HIV negative and 18.0 percent-unknown status (Figure 8 refers). The figure also shows that from 2020 – 2022 there has been an increase in the proportion of HIV+ deaths. Annex 2, further shows that most of the HIV+ deaths were in the age group 30-34 years (13.2%) followed by 25-30 years (7.9%) and 35-39(5.3%). .

Figure 8: **Maternal Deaths by HIV Status, 2018-2022**



4. Institutional Births VS Non-Institutional Births

There were 50,704 live births registered in 2022. **Table 4** shows that most births (59.2%) occurred in General Hospitals, as compared to 22.2 percent in primary hospitals and 18.4 percent in clinics respectively. This pattern has been consistent from 2017 to 2022. The table further shows that most mothers (99.8%) delivered in health facilities.

Table 4: **Live Births by Place of Delivery 2017 – 2022**

	2017		2018		2019		2020		2021		2022	
Place of Birth	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
General Hospital	33,442	63,9	34,071	64,1	33,013	63,1	35,656	61,2	32,649	61.0	30,019	59.2
Primary Hospital	11,285	21,5	11,689	22	11,321	21,6	11,720	20,1	10,873	20.4	11,248	22.2
Clinics	7,515	14,4	7,239	13,6	7,872	15,1	10,770	18,5	9,705	18.3	9,338	18.4
Non - Institutional	116	0,2	116*	0,2	98	0,2	98	0,2	99	0.2	99	0.2
Total Live Births	52 358	100	53,115	100	52,304	100,0	58,244	100,0	53,326	100.0	50,704	100.0

4.1 Born Before Arrival (BBA)

The born before arrival (BBA) refers to babies brought to the health facility within 24 hrs after delivery. The BBA accounted for 4.4 percent (2,243) of 50,704 live births in 2022 as compared to 4.3 percent(2,274) of 53,227 live births in 2021 (**Annex 2**).

4.2 Non-Institutional Births

The 2022 non-institutional Live births constitute 0.2 percent of the total births (**Table 4**). It has been realized that non-institutional births reported by Health Facilities to Ministry of Health have been insignificant ever since Ministry of Labour and Home Affairs inaugurated the collection of births and death certificates. Furthermore, it is worth noting that South East district reported the highest non-Institutional births accounting for 18.2 percent, followed by Greater Gaborone and Central Bobonong with a tie of 10.1 percent, Selibe Phikwe and Kweneng East recording 8 births each (8.1%)then Barolong and Central Mahalapye with a tie of 7 births (7.1%). However, the distribution of these non- institutional births is shown in **Annex 4**.

5. Technical Note

The availability of data on number of live births and maternal mortality are a collaborative effort between Ministry of Health-Sexual Reproductive Health Division and Statistics Botswana through its Health Statistics Unit to ensure production of quality national maternal mortality information.

APPENDICES

Appendix 1: Causes of Maternal Mortality by Age Group of Mother – 2022

ICD10 Code	Diagnosis	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Grand Total
				Direct					
O08.0	Genital tract and pelvic infection following abortion and ectopic and molar pregnancy	-	2	3	4	3	1	-	13
O71.1	Rupture of uterus during labour	-	-	3	1	3	-	-	7
O14.1	Severe pre-eclampsia	1	1	1	1	2	-	-	6
O14.9	Pre-Eclampsia, unspecified	1	1	1	1	-	-	-	4
O15.1	Eclampsia in Labour	-	1	-	1	-	1	1	4
O15.0	Eclampsia in pregnancy.	-	1	-	1	-	1	-	3
O88.2	Obstetric blood clot embl	-	-	1	-	2	-	-	3
O90.3	Cardiomyopathy in the purperium	-	-	-	2	-	1	-	3
O00.1	Tubal Pregnancy	1	-	-	-	1	-	-	2
O06.1	Unspecified Abortion	-	-	-	2	-	-	-	2
O13	Gestational (Prenancy-Induced) hypertension with significant proteinura	1	1	-	-	-	-	-	2
O14.2	HELLP syndromme	-	-	-	1	-	1	-	2
O15.9	Eclampsia, unspecified as to time period	1	-	-	1	-	-	-	2
O44.1	Placenta praevia with haemorrhage	-	-	1	1	-	-	-	2
O62.2	Other uterine inertia	-	-	-	1	1	-	-	2
O85	Puerperal sepsis	1	1	-	-	-	-	-	2
O99.4		-	-	1	1	-	-	-	2
O03.1	Spontaneous Abortion	-	-	-	1	-	-	-	1
O21.0	Mild hyperemesis gravidarum	-	-	1	-	-	-	-	1
O23.5	Infections of the genital tract in pregnancy	-	-	-	1	-	-	-	1
O45.0	Premature separation of placenta with coagulation defect	-	1	-	-	-	-	-	1
O46.0	Antipartum haemorrhage with coagulation defect	-	-	-	-	1	-	-	1
O70.2	Other uterine inertia	-	-	1	-	-	-	-	1
Total		6	9	13	20	13	5	1	67
				Indirect					
O98.7	Human Immodeficiency(HIV) disease complicating pregnancy, childbirth and the puerperium	-	-	2	1	1	1	-	5
O99.4	Diseases of circulating system complicating pregnancy , childbirth and the pueperium	-	-	1	1	1	2	-	5
O99.8	Other specified diseases and conditions complicating pregnancy, childbirth and the pueperium	-	1	-	1	-	1	-	3
O99.6	Diseases of digestive system complicating pregnancy ,childbirth and the pueperium	-	-	-	-	1	1	-	2
099.4	Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium	-	-	-	1	-	-	-	1
O98.0	Tuberculosis complicating pregnancy,childbirth and the puerperium	-	-	-	-	1	-	-	1
O99.3	Mental disorders and diseases of the nervous system complicating pregnancy ,childbirth and the pueperium	-	-	1	-	-	-	-	1
O99.5	Diseases of respiratory system complicating pregnancy , childbirth and the pueperium	-	-	-	-	-	1	-	1
Y29.9	Contact with blunt object,undetermined intent	-	-	-	-	1	-	-	1
Y54.4	Loop(high-ceiling) diuretics	-	-	1	-	-	-	-	1
Total			1	5	4	5	6		21
O95	Obstetric death of unspecified cause	-	-	-	-	1	-	-	1
Grand Total		6	10	18	24	19	11	1	89

Appendix 2: Live births by Health Facilities – 2022

Health Facility	Discharged								New Borns Discharged				
	Number of Beds	Admissions	Alive	Dead	Patient Days	Occupancy Rate(%)	Length of-Stay(Days)	Turnover Rate	New Born	New BBA	Alive	Dead	Total Live Births
General Hospitals													
Letsholathebe II Memorial Hospital	340	5,526	5,543	155	82,597	67	14	17	2,638	72	2,662	48	2,710
Scotish Livingstone Hospital	350	10,021	10,051	263	68,632	54	7	29	2,892	189	3,052	29	3,081
Bokamoso Private Hospital	122	5,622	5,344	178	26,415	59	5	45	343	1	312	4	344
SDA Kanye Hospital	182	5,724	5,718	231	28,637	43	5	33	1,556	23	1,556	31	1,579
Mahalapye Hospital	320	5,764	5,772	253	58,569	50	10	19	2,079	75	2,132	21	2,154
Deborah Relief Memorial Hospital	167	4,433	4,429	169	39,224	64	9	28	1,721	71	1,779	13	1,792
Orapa Hospital	94	2,094	2,058	17	4,634	14	2	22	655	22	631	2	677
Princess Marina Referral Hospital	557	16,991	24,581	721	339,134	167	13	45	5,449	19	5,332	151	5,468
Gaborone Private Hospital	90	3,776	3,880	60	12,455	38	3	44	897	6	845	1	903
Nyangabwe Referral Hospital	497	20,957	20,915	1,070	201,785	111	9	44	4,230	66	4,173	123	4,296
Riverside Private Hospital	29	2,743	2,683	27	8,030	76	3	93	572	0	528	10	572
Bamalete Lutheren Hospital	138	9,160	5,365	133	18,965	38	3	40	1,645	16	1,646	15	1,661
Athlone Hospital	139	4,175	4,168	115	24,241	48	6	31	1,002	26	1,021	6	1,028
State Mental Referral Hospital	300	2,374	2,327	2	103,765	95	45	8	0	0	0	0	0
BCL Mine Hospital	15	12	11	1	24	0	2	1	0	0	0	0	0
Selibe Phikwe Government Hospital	65	5,427	5,466	124	25,384	107	5	86	1,249	21	1,264	6	1,270
Jwaneng Mine Hospital	60	0	0	0	0	0		0	0	0	0	0	0
Sekgoma Memorial Hospital	386	10,908	10,958	326	67,628	48	6	29	2,390	94	2,464	21	2,484
Total	3,851	115,707	119,269	3,845	1,110,119	79	9	614	29,318	701	29,397	481	30,019
Primary Hospitals													
Masunga Primary Hospital	48	1,512	1,513	9	1,609	9	1	32	263	10	271	2	273
Palapye Primary Hospital	50	3,632	3,598	105	18,370	101	5	74	1,411	35	1,425	21	1,446
Bobonong Primary Hospital	33	3,096	3,107	74	14,409	120	5	96	729	24	750	3	753
Mmadinare Primary Hospital	31	1,290	1,289	31	6,283	56	5	43	279	11	290	0	290
Thamaga Primary Hospital	61	2,481	2,487	61	10,146	46	4	42	922	26	940	3	948
Gantsi Primary Hospital	104	3,276	3,251	95	23,026	61	7	32	1,153	98	1,230	21	1,251
Sefhare Primary Hospital	38	1,923	1,917	52	7,188	52	4	52	434	12	445	1	446
Kasane Primary Hospital	30	1,701	1,724	24	9,977	91	6	58	434	17	443	8	451
Tsabong Primary Hospital	33	1,489	1,485	42	6,628	55	4	46	497	14	505	6	511
Tutume Primary Hospital	42	3,221	3,236	89	13,176	86	4	79	1,001	67	1,064	4	1,068
Gweta Primary Hospital	50	1,202	1,202	34	5,035	28	4	25	318	20	334	6	338
Rakops Primary Hospital	36	1,329	1,309	32	5,796	44	4	37	277	20	295	2	297
Letlhakane Primary Hospital	25	2,585	2,584	86	14,057	154	5	107	971	122	1,080	13	1,093
Gumare Primary Hospital	34	2,298	2,333	89	13,113	106	5	71	1,001	50	1,030	15	1,051
Thebephatshwa Primary Hospital	35	74	58	1	457	4	8	2	4	1	5	0	5
Goodhope Primary Hospital	40	2,064	2,065	75	23,751	163	11	54	606	27	632	1	633
Hukuntsi Primary Hospital	63	1,284	1,291	25	7,701	33	6	21	378	16	389	5	394
Total	753	34,457	34,449	924	180,722	66	5	47	10,678	570	11,128	111	11,248
Clinics	1,442	13,282	13,158	1	11,957	2	1	9	8,366	972	9,257	52	9,338
Grand Total	6,046	163,446	166,876	4,770	1,302,798	59	8	28	48,362	2,243	49,782	644	50,605

Appendix 3: Maternal Mortality in HIV Infected Women by Age Group of Mother – 2022

ICD10 Code	Diagnosis	15-19	20-24	25-29	30-34	35-39	40-44	45-49	Grand Total
015.1	Eclampsia in Labour	-	-	-	-	-	1	-	1
099.4	Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium	-	-	-	1	-	-	-	1
O08.0	Genital tract and pelvic infection following abortion and ectopic and molar pregnancy	-	1	2	-	-	1	-	4
O13	Gestational (Prenancy-Induced) hypertension with significant proteinura	1	-	-	-	-	-	-	1
O14.1	Severe pre-eclampsia	1	1	1	-	1	-	-	4
O14.2	HELLP syndromme	-	-	-	1	-	1	-	2
O14.9	Pre-Eclampsia, unspecified	1	1	1	-	-	-	-	3
O15.0	Eclampsia in pregnancy.	-	-	-	1	-	1	-	2
O15.1	Eclampsia in Labour	-	1	-	1	-	-	1	3
O15.9	Eclampsia, unspecified as to time period	1	-	-	-	-	-	-	1
O23.5	Infections of the genital tract in pregnancy	-	-	-	1	-	-	-	1
O44.1	Placenta praevia with haemorrhage	-	-	1	-	-	-	-	1
O45.0	Premature separation of placenta with coagulation defect	-	1	-	-	-	-	-	1
O62.2	Other uterine inertia	-	-	-	1	-	-	-	1
O70.2	Other uterine inertia	-	-	1	-	-	-	-	1
O71.1	Rupture of uterus during labour	-	-	3	1	1	-	-	5
O85	Puerperal sepsis	-	1	-	-	-	-	-	1
O88.2	Obstetric blood clot emblolism	-	-	1	-	1	-	-	2
O99.4	Diseases of the circulatory system complicating pregnancy, childbirth and the puerperium	-	-	1	1	1	1	-	4
O99.8	Other specified diseases and conditions complicating pregnancy ,childbirth and the pueperium	-	1	-	-	-	-	-	1
Y29.9	Contact with blunt object,undetermined intent	-	-	-	-	1	-	-	1
Total		4	7	11	8	5	5	1	41

Appendix 4 : **Non-Institutional Live births by District – 2022**

District of Birth	Number	Percent
Gaborone	10	10.1
Francistown	5	5.1
Lobatse	2	2.0
Selebi Phikwe	8	8.1
Orapa	-	-
Jwaneng	-	-
Sowa Town	-	-
Southern	3	3.0
Barolong	7	7.1
Ngwaketse West	-	-
South East	18	18.2
Kweneng East	8	8.1
Kweneng West	-	-
Kgatleng	-	-
Central Serowe/Palapye	6	6.1
Central Mahalapye	7	7.1
Central Bobonong	10	10.1
Central Boteti	1	1.0
Central Tutume	4	4.0
North East	1	1.0
Ngamiland East	5	5.1
Ngamiland West	1	1.0
Chobe	1	1.0
Ghanzi	2	2.0
Kgalagadi South	-	-
Kgalagadi North	-	-
Not Stated	-	-
Total	99	100.0

Appendix 5 : **Maternal Mortality Rate Statistical Metadata**

Maternal Mortality Rate	
This is the proportion of deaths of women from pregnancy - related causes, when pregnant or within 42 days of termination of the pregnancy for a specified period per 100,000 live births.	
Scope and coverage	National level
Sources of data	• Census • BMTHS (Botswana Multitopic Household Surveys) • Maternal Mortality Surveillance Administrative data
Compilation practices	• Administrative data is collected through the health facilities of Botswana. Data is audited to verify if it is a maternal death through the Department of Public Health {Sexual and Reproductive Health (SRH) of MOH}. Health Statistics Unit Codes, analyses and produce the report. • For data collected through the BMTHS. The population is stratified into regions after which information from sampled households is collected, centrally captured and analyzed. • For a census a complete enumeration is done on all households.
Computation method	Number of maternal deaths divided by the total number of recorded live births in the same period multiplied by 100,000.00
Accessibility and availability of data	This information can be accessed by users from the; Statistics Botswana website: www.statsbots.org.bw, Health Section, Maternal Mortality Ratio (MMR) Report.
Accounting conventions	The indicator is produced and released annually using administrative data and after every 10 years following the census.
Comments and limitations	High proportion of births attended by Skilled Health Workers increasing higher detection.

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