Botswana

Adrian Wills* and Howard Moffat†

*Consultant Neurologist, Queens Medical Centre, Nottingham; †Consultant Physician, Princess Marina Hospital, Gaborone, Botswana; E-mail: adewills61@hotmail.com
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The state of Africa is a scar on the conscience of the world.

(A. Blair)

Men make their own history, but under conditions directly encountered, given and transmitted from the past. The traditions of dead generations weigh like a nightmare on the brains of the living.

(K. Marx)

Literature has the power to change lives, and having read about the adventures of Mma Ramotswe, Botswana's only fictional female detective, one of us (AW) was inspired to visit the country of Mma Ramotswe's birth – almost unique amongst African nations by virtue of prolonged post-independence political stability and lack of civil strife. Imagine his surprise to discover that the fictional Dr Moffat, who was instrumental in hastening Mma Ramotswe's recovery from severe depression, was based on a real character (HM)!

Botswana gained independence from Britain in 1966. The imperial legacy consisted of a couple of schools and a few miles of tarred roads, but the discovery of diamonds shortly thereafter provided the basis for future prosperity. Diamonds continue to account for 80% of GDP and sustain continued economic growth rates of 4–7% per annum.

Botswana lies north of South Africa, covers an area of 582 000 km² (about the size of Texas) and has a population of 1.7 million people (compared with 60 million in the UK). Most of the land is semi-arid or desert, but there are spectacular waterways in the north of the country, fed by the Okavango Delta, home to large numbers of birds and mammals (see Fig. 1).

The infant mortality is about 10 times greater than in the UK at 59/1000, and life expectancy is only 39 years. The reason for the appalling (and declining) life expectancy figures is, of course, AIDS. The overall prevalence of HIV-infected individuals in the general population is estimated at 18%, as high as 38% in the so-called 'sexually active' age group of 18–49. The impact that this has had on Botswana's people is almost unimaginable.

The healthcare system in Botswana is based on socialist principles and virtually free at the point of delivery. Patients pay 1 Pula (about £0.12) for an initial consultation; subsequent consultations and treatment (related to the index complaint) are free. There are over 20 general and primary hospitals throughout the country, with referral hospitals at Gaborone (the capital), Francistown and Lobatse. There are no neurologists at all in Botswana, although there are limited neurological investigational facilities in Gaborone including a CT scanner, angiography and myelography.

There is currently no medical school in Botswana, although the government has made a decision to establish one and the process is already well underway. In the interim, students are funded by the government to study elsewhere (notably in Ireland and South Africa) and then they return as newly qualified doctors to complete general training. Specialist training and the attainment of postgraduate qualifications are also unavailable in Botswana – the doctors have to study abroad. The attendant risk is, of course, that in spite of the provision of governmental funding, some doctors choose to stay abroad, lured by the possibility of better salaries and working conditions.

Figure 1 Swallow-tailed bee eaters, Okavango Delta, Botswana

AIDS has transformed the medical landscape in Botswana in a relatively short time. Bed occupancy on the medical wards runs at a staggering 200%. The majority (80–90%) of hospital medical in-patients have HIV-related conditions. This is in spite of the fact that, almost uniquely in Africa, the Botswana government does offer anti-retroviral therapy (HAART) to all HIV-positive patients where the CD4 count is less than 200, or in the presence of an AIDS defining illness. Unfortunately, treatment uptake amongst eligible patients is still only about 40%, mainly on account of insufficient capacity within the healthcare system although this is being continually increased.

The neurological complications of HIV are pervasive. Around 30% of HIV-positive hospital in-patients have neurological complications. These range from acute seroconversion syndromes (cerebellar ataxia, inflammatory neuropathies), through subacute (tuberculous/cryptococcal) and acute (pyogenic) meningitides to dementia, myelopathy and painful neuropathy associated with

low CD4 counts. General physicians manage all these problems admirably with virtually no neurological input.

So, reader, what has all this got to do with you? We would agree with Marx and Blair that a moral bond should exist between the nations of the world and an African continent which seems so vulnerable. This vulnerability is the direct consequence of imperialism and post-imperialist policies, whether designed to defeat the 'Evil Empire' at whatever cost, or to establish economic hegemony. The establishment of basic neurological services in Botswana is a feasible aim and could establish a model for other African nations to follow. How can this be achieved? Firstly, by providing subsidized neurological postgraduate training for Botswana graduates. Secondly, by encouraging senior neurological trainees and consultants to visit Botswana and impart their skills and expertise, backed up by communication networks based on the internet. There is funding available for projects of this nature; all that is required is organization and a willingness to help.

In spite of the provision of governmental funding, some doctors choose to stay abroad, lured by the possibility of better salaries and working conditions