Botswana

Country programme document 2010-2014

The draft country programme document for Botswana (E/ICEF/2009/P/L.2) was presented to the Executive Board for discussion and comments at its 2009 annual session (8-10 June 2009).

The document was subsequently revised, and this final version was approved at the 2009 second regular session of the Executive Board on 15 September 2009.

unite for children

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Basic data[†] *(2007, unless otherwise stated)*	
Child population (millions, under 18 years)	0.8
U5MR (per 1,000 live births)	40[a]
Underweight (%, moderate and severe, 2000)	13
Maternal mortality ratio (per 100,000 live births, 2005)[b]	380[c]
Primary school enrolment (% net, male/female, 2005)	83/85
Survival rate to last primary grade (%, 2004)	75
Use of improved drinking water sources (%, 2006)	96
Use of improved sanitation facilities (%, 2006)	47
Adult HIV prevalence rate (%)	23.9
Child labour (%, children 5-14 years old)	...
GNI per capita (US$)	5 840
One-year-olds immunized against DPT3 (%)	97
One-year-olds immunized with measles vaccine (%)	90

[†] More comprehensive country data on children and women are available at http://www.unicef.org.

[a] The Government of Botswana estimates 76 per 1,000 live births (Botswana Demographic Survey, 2006).

[b] The 2005 estimate developed by WHO/UNICEF/UNFPA and the World Bank, adjusted for underreporting and misclassification of maternal deaths. For more information, see http://www.childinfo.org/areas/maternalmortality/.

[c] The Central Statistics Brief 2008 estimates maternal mortality at 190 per 100,000 live births in 2004.

Summary of the situation of children and women

1. The situation of children and women in Botswana continues to improve, with the greatest challenge to progress being the negative impact of the AIDS epidemic. Botswana is a middle-income country where access to all basic social services is above or close to ninety per cent: primary school attendance, access to health facilities, immunization coverage and access to safe water. The Millennium Development Goal on gender parity in education has already been achieved. Justice, transport, telecommunications, insurance, banking, security and commercial systems are all fully functional. And yet infant and child mortality increased sharply between 1988 and 2006.[1]

2. The Government has a rigorous planning process, and routinely generates data through the national census, demographic surveys, the Multiple Indicator Cluster Survey, among others. The development of the 10th National Development Plan (NDP10) highlighted two main challenges: overdependence of the economy on diamonds, requiring economic diversification, and high HIV prevalence, requiring stronger prevention and impact mitigation. While there are relatively high levels of per capita financial resources and a positive enabling environment in place for economic and social development, other areas of concern include the potential

[1] The 2006 Botswana Demographic Survey estimates the infant mortality rate at 51 per 1,000 live births (2005), compared to 37 per 1,000 live births reported in 1988.

impact of climate change, high rate of youth unemployment, gender inequality, increasing crime levels, violence against women, alcohol abuse and, to a lesser extent, child labour.

3. In spite of high economic growth since independence, some 30 per cent of the population is poor by standard development benchmarks, and income inequality is high by international standards, both between urban and rural areas, as well as within these groups. Census and household survey data reveal that 58 per cent of households are headed by a single parent, absentee fathers are common, and some two per cent of households are headed by children.

4. As a result of sustained investment in the health sector, 95 per cent of the population lives within eight kilometres of the nearest health facility. While overall access rates to services are high, the more remote rural areas are relatively underserved and have poorer outcomes for children.

5. Good rates of access to services are not always matched by quality of service, with limited positive effect on family and community practices to support child survival, development, protection and participation. For example, while antenatal care attendance rates are very high, neonatal mortality is estimated to be comparatively high, at 34 per 1,000 live births (2004), highlighting concerns about newborn care, support and infant feeding practices. The potential of health education assistants in programme communication is not fully utilized.

6. The major underlying cause of child morbidity and mortality is HIV infection. It is estimated that 58 per cent of deaths among children under five are attributable to HIV or AIDS. Surveillance data show that HIV prevalence among women attending antenatal care is 32 per cent (2006). However, aggressive programming has reduced mother-to-child transmission (of HIV) from 40 per cent in 1998 to 3 per cent in 2007. The introduction of dried blood spot testing in 2006 has improved the testing of HIV exposed infants. Paediatric antiretroviral treatment is available nationwide, with high-level specialty care available in the two largest cities. Access to paediatric antiretroviral therapy and quality of service provision need to be further scaled up to reduce HIV-related under-five mortality. Data on tuberculosis among children are not available.

7. Other major causes of child morbidity and mortality include acute respiratory infections and diarrhoea. Despite this high morbidity rate (38 per cent of children had acute respiratory infections in the two weeks preceding the Multiple Indicator Cluster Survey 2000), only 14 per cent of these children received care from an appropriate provider. Malnutrition is the second major underlying factor contributing to child mortality. Among children under five, the stunting rate was about 26 per cent in 1993, and had not changed significantly in 2000 when it was 23 per cent. Overall, 82 per cent of the urban population and 26 per cent of the rural population have access to improved sanitation facilities. Limited access to sanitation and poor hygiene practices were identified as contributing factors in the 2006 diarrhoea outbreak.

8. Botswana is committed to malaria elimination by 2015. Malaria is endemic in only five northern districts, which account for over 80 per cent of reported malaria cases. The 2007 Malaria Indicator Survey revealed that only 12 per cent of children under five and 9 per cent of pregnant women in endemic districts used insecticide-treated bed nets to protect themselves.

9. Primary prevention is recognised as the greatest priority in the national response to HIV and AIDS. HIV incidence increases sharply within the 15-24-year-old age group. Prevalence among 15-19-year old females and males is nine per cent and three per cent, respectively, and for 20-24-year-olds it is 27 per cent and 10 per cent, respectively (Botswana AIDS Impact Survey, 2004). Despite various campaigns, adolescents and young people still lack correct and comprehensive information, relevant skills and adequate services. An investigation about the sources of information[2] on HIV and AIDS revealed that the teacher in the classroom, followed by the radio, television and the newspaper were the main information sources for adolescents 10-18 years old. There was minimal communication on HIV or AIDS in the family. Less than 1 per cent of the adolescents had obtained information from the church. Combined factors, including multiple concurrent partnerships, age-disparate sex, very limited practice of male circumcision, and inconsistent condom use among adolescents, constitute an extremely high risk context, where adolescent females are disproportionately at higher risk of HIV infection then adolescent males.

10. Some 15 per cent of all children are orphans. Children are disproportionately found among the poorest households, typically rural ones headed by women. Despite established safety nets, only 34 per cent of households with orphans and vulnerable children receive external support and only 19 per cent of households below the poverty line receive any government transfers.[3]

11. The interactions of gender violence, alcohol and the spread of HIV are assumed to be significant, but there is little research to confirm this to date. Gender-based violence takes many forms, including emotional and physical abuse, rape, and, more recently passion killings. Due to stigma and the inappropriate manner in which rape cases are handled by the police, many rapes go unreported or cases that have been reported are withdrawn. The new Domestic Violence Act (2008) complements criminal law by providing civil remedies to enable greater protection under the law for survivors of violence while they await the criminal justice system to take its course.

12. There is limited coordination of services among the security, justice, health and social welfare sectors to respond to child and women victims of abuse, violence and exploitation. The social welfare system is also relatively limited in its capacity to follow up with individuals beyond their initial contact and registration with social services.

13. There are relatively small numbers of refugees in Botswana. These increased sharply in 2007-2008 due to an influx from Zimbabwe. Most are accommodated in the Dukwe refugee camp, where shelter, food, water, health, sanitation and education services are provided. The capacity of government institutions to prepare for and respond to emergencies is well established for minor flood and drought response, but less so for other potential disasters.

14. To inform effective communication strategies, Botswana currently lacks audience studies. However, a limited (urban and peri-urban adults) study in 2006[4]

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[2] *Rapid Baseline Assessment Survey of HIV and AIDS Prevention: Knowledge and Beliefs among Adolescents in Botswana* (UNICEF, forthcoming in 2009).

[3] *Social safety nets in Botswana*, Botswana Institute for Development Policy Analysis (2007).

[4] *Botswana All Media and Products Survey*, MTC Marketing and Research Solutions (2006).

showed that Setswana is the language spoken at home for 86 per cent of the population. According to the survey, only 18 per cent of the respondents had television sets and 3 per cent had computers, while 95 per cent had a radio. The study also showed that just over half of the respondents go to church regularly. Regarding community engagement, there is also a lack of studies.

15. Overall the legal and policy environment for children will be strengthened by the National Child Rights Bill, which is tabled for parliament in the first session of 2009. The discussion of the bill on radio and television and in the print media provided many opportunities to raise public awareness about children's rights. The bill will address one of the main recommendations of the Committee on the Rights of the Child: to domesticate the provisions of the Convention on the Rights of the Child. Other major recommendations of the committee include more systematic data collection, greater dissemination of the Convention, more active promotion of birth registration, greater attention to HIV prevention, improved access to the highest attainable standards of health care and protection for the most disadvantaged children.

16. Botswana's initial report on the implementation of the Convention, which was submitted in 2001, was discussed by the Committee on the Rights of the Child on 16 September 2004. Both the combined second and third Convention reports (overdue since April 2007) and the initial and second reports, due in 2003 and 2006, respectively, are to be submitted in 2009.

17. Further improvements in the situation of children and women are integral to NDP10, but in the medium term they may be overshadowed by the impact of the global financial crisis. While the impact on government resource allocations for key social services for children and families may be cushioned by drawing upon government reserves, there may be some contraction as government spending is restricted as a share of gross domestic product. More directly, however, families are likely to be affected by the sharp rise in unemployment and reduced incomes.

Key results and lessons learned from previous cooperation, 2008-2009

Key results achieved

18. The 2008-2009 programme of cooperation bridged the transition from the 2003-2007 programme to a joint United Nations programme for 2010-2014. To date, the main achievements of the 2008-2009 cooperation include the development and endorsement of the strategic plan on Accelerated Child Survival and Development (ACSD) to help structure health initiatives and resource allocations at national and district levels from 2009 onwards. The preparation of the Children's Bill, for enactment in 2009, will put in place significant measures to protect children's rights. The programme also advocated successfully for a higher and broader profile for social protection, and the recognition by the Government of the need for a comprehensive social development policy. All were achieved through the provision of specific technical assistance to the Ministries of Health and Local Government.

Lessons learned

19. The 2008-2009 programme identified the need for a strategic shift from service delivery, such as direct support to orphans, to more "upstream" work to

build the capacity of the Government to develop child rights-based policies, norms and standards. This is a more effective use of the limited resources available to the country programme, and the policy-level work has been explicitly requested and welcomed by the Government. The 2010-2104 programme of cooperation will consolidate this shift, and is consistent with the broad "upstream" approach adopted by the UNDAF 2010-2016. The preparation and discussion of the Children's Bill provided an opportunity for public education and debate on children's rights. Similar opportunities to raise awareness of children's rights should be seized in the future.

20. The development of the national strategic plan on ACSD in 2008 demonstrated the potential for data and advocacy to inform government priorities. The continuing work on costing to develop an investment case is expected to further inform resource allocations by the Government. Thus, the programme of cooperation will need to emphasize the role of evidence-based decision-making and the importance of integrating monitoring, evaluation and accountability throughout the programme cycle.

21. The high levels of coverage across a range of social services for children, combined with the high rates of morbidity and mortality, suggest that infrastructure and services are not the constraint; rather, attention should focus on behaviour and the unequal access (by area or socio-economic group) to quality services. Thus, communication for development, grounded in research and the specific situation in of Botswana, must play a prominent role in closing the gap between services and behaviour. Some groups still do not access social services, which points to the need to improve targeting and partnerships with civil society and religious groups in this regard.

22. Primary prevention of HIV is recognized as the single most important priority in order to make a difference in one of the eight "hyper-endemic" countries of the world. The country programme will need to reflect a deeper understanding (including research initiated in 2008-2009) of the decision-making processes that adolescents follow in a variety of contexts that put them at risk of infection, or risk transmission to others.

The country programme, 2010-2014

Summary budget table

	(In thousands of United States dollars)		
Programme	*Regular resources*	*Other resources*	*Total*
Young child survival and development	1 175	3 075	4 250
Child and adolescent protection and participation	2 127	6 675	8 802
Advocacy and planning	248	4 500	4 748
Cross-sectoral costs	200	750	950
Total	**3 750**	**15 000**	**18 750**

Preparation process

23. In 2007, the joint Common Country Assessment (CCA) by the Government and the United Nations highlighted the main development challenges and established consensus on which areas the Government would draw upon United Nations support. The CCA focused on economic growth, access to social services, governance and the environment.

24. The UNDAF 2010-2016 is based on further analysis of the CCA findings, the emerging priorities of the NDP10 (2010/2011-2015/2016), Vision 2016 and the progress required to achieve the Millennium Development Goals. The NDP10 will be finalized and formally endorsed by the Government in early 2010.

25. The CCA and UNDAF processes were both consultative and inclusive. Participants in the process included resident and non-resident United Nations agencies; government ministries and departments; representatives of civil society organizations and the private sector; and other development partners. The process was overseen by a Reference Group co-chaired by the Ministry of Finance and Development Planning and the United Nations Resident Coordinator. The analysis and drafting was undertaken by five working groups, each co-chaired by the Government and United Nations technical managers.

26. UNICEF support in 2010-2014 will be an integral part of the Programme Operational Plan of the Government and United Nations, which will be completed in 2009, complementing the programmes and activities of other United Nations partners within the UNDAF.

27. Given the substantive consultation on the UNDAF and the Key Results for 2010-2016, it was agreed between the Ministry of Finance and Development Planning and UNICEF that smaller bilateral discussions, followed by a formal meeting of the Joint Planning and Coordinating Committee of the Government and UNICEF, would suffice.

28. Initial screening identified no proposed programming areas requiring environmental impact assessments.

Goals, key results and strategies

29. The overall goal of the country programme is to contribute to the achievement of NDP10 in areas directly and indirectly affecting the survival, development, protection and participation of children and families.

30. The programme design is sensitive to the high HIV-endemic status of Botswana, and includes strengthening the quality of prevention of mother-to-child transmission (of HIV) (PMTCT) and paediatric care and support, much greater emphasis on primary prevention and the development of greater quality and coverage of support and care for children affected by HIV. It also recognizes that there are other drivers of neonatal, infant and under-five mortality and therefore supports the quality and access to high-impact interventions to reverse these. In addition, the situation reveals a range of child protection issues, which need to be inclusive of (but not limited to) support to orphans and integrated within a broader social protection and social development agenda.

31. The key results for the UNICEF programme of cooperation are to contribute to (a) reduction of under-five mortality; (b) reduction of incidence of HIV among

young children; (c) reduction of adolescent girls' risk and vulnerability to HIV; and (d) reduction and mitigation of violence, abuse, neglect, discrimination and exploitation of children.

32. The overall strategy of the country programme will focus on policies, norms and standards and on strengthening national-level systems and capacities to ensure continued coverage, strengthened quality and equity of access to social services for children and families. Direct support for service delivery will continue to be very limited. Advocacy will focus attention on children's issues, building on the platform of the National Child Rights Bill (expected to be enacted in 2009).

33. Within a rights-based approach to programming, there will be increased strategic emphasis on evidence-based decision-making, the normative role of UNICEF and the United Nations, human-resource capacity-building, monitoring and evaluation, and more meaningful participation of children, youth, women, men, families and communities in reaching these results. Opportunities to use information and communication technologies in programme delivery will be exploited. Capacities for emergency preparedness and response will be developed in coordination with United Nations partners, including the United Nations Office for the Coordination of Humanitarian Affairs.

Relationship to national priorities and the UNDAF

34. The above key results define the areas where UNICEF support will contribute to the achievements of the Programme Operational Plan of the Government and United Nations. The Government-United Nations Programme Operational Plan will articulate the agency-specific or joint results contributing to the five UNDAF outcomes, in the areas of (a) governance and human rights promotion; (b) poverty reduction and economic diversification; (c) health and HIV and AIDS; (d) environment and climate change; and (e) child, youth and women empowerment. UNICEF support will reflect areas of clear mandate, such as child protection, as well as special contributions to cross-cutting areas, including communication for development, communications, human rights promotion, justice, and emergency preparedness and response.

35. The UNDAF 2010-2016 harnesses the resources of all United Nations agencies, organizations and programmes (resident and non-resident) as the basis for a single programme of support for the realization of the goals of NDP10, Vision 2016 and the Millennium Development Goals and the Millennium Declaration. Other specific national frameworks are implicitly included, such as the National Strategic Plan on Accelerated Child Survival and Development, the National Strategic Framework on HIV and AIDS, and the National HIV Prevention Operational Plan.

Relationship to international priorities

36. The country programme will be aligned, through the UNDAF, to support the achievement of the Millennium Development Goals, particularly with regard to child survival and poverty and combating HIV, malaria and other diseases, and with the Millennium Declaration, particularly Section VI. The programme also directly aligns with the UNICEF medium-term strategic plan, addressing HIV and AIDS and Children (focus area 3) as the overarching concern, supported by young child

survival and development (focus area 1), child protection (focus area 4) and policy, advocacy and partnerships for children's rights (focus area 5).

Programme components

37. **Young child survival and development.** Support to PMTCT and paediatric care will strengthen the existing PMTCT and paediatric treatment interventions, aiming to achieve universal access to and participation in PMTCT and universal treatment and care for HIV-positive children. This will include infant feeding practices for HIV exposed children and improved treatment for HIV-exposed children through increased adherence to cotrimoxazole prophylaxis.

38. Support to high-impact interventions within the National Strategic Plan on ACSD will increase access, quality and coverage of services that address the other major causes of child morbidity and mortality, and provide the child with the best start in life. These will include assistance to the national authorities in the ACSD roll-out, especially in the technical areas of management of acute malnutrition, micronutrients, malaria elimination, information on safe water, sanitation and hygiene and the introduction of new vaccines as well as integrated early childhood development. Support will also be provided to strengthen the supply chain management by the Ministry of Health.

39. To strengthen the link between services and positive behaviour, the capacity of the Government to promote positive family and community practices will be strengthened in areas such as care-seeking behaviour, antenatal, neonatal and postnatal care follow-through, and infant and young child feeding practices.

Child and adolescent protection and participation

40. Support to efforts in reducing the incidence of HIV among children and adolescents will focus on the groups most at risk, in particular girls and young mothers (with a link to PMTCT). Reducing adolescent girls' risk and vulnerability to HIV will be achieved by prioritizing support around the achievement of the following outputs: (a) ensuring adolescents have comprehensive knowledge and skills for HIV prevention (especially among young women and girls); and (b) strengthening evidence-informed behavioural and social change interventions aimed at to reducing multiple concurrent partners and age-disparate sex among adolescent girls (and their partners). Communication for development approaches will be critical to better understand the drivers of adolescent behaviour and thereby increase individual knowledge and skills and promote positive social norms.

41. Protection, care and support for vulnerable children will focus on systems development and strengthening, and will prioritize the following outputs: (a) strengthened justice and social systems, including the follow-up on implementation of the Child Rights Act, the subsequent realignment of legislation, as well as promotion of the ratification of the optional protocols to the Convention on the Rights of the Child and strengthening reporting, monitoring and implementation of the Convention and the African Charter on Human and Peoples' Rights; (b) effective social protection mechanisms established, based on vulnerability assessments, research and analysis; (d) strengthened service providers' capacity to implement child protection measures (preventative, responsive and monitoring); and (d) universal birth registration for children under five. The

programme will promote respect for the views of children and their participation in all matters affecting them in accordance with their age and maturity.

42. In collaboration with key United Nations partners, UNICEF assistance will apply a mix of upstream and midstream operational and system development support to national partners — on evidence-informed HIV prevention programming with and for adolescent girls and on strengthening child protection systems. Since attendance rates at the primary school level are over 80 per cent, the potential of the education sector will be harnessed for HIV prevention, therefore UNICEF will work with the Ministry of Education and other partners to ensure that policies and programmes (such as lifeskills and school health) effectively address HIV prevention. Recognizing that there are geographic areas within Botswana with substantially higher HIV prevalence and disparities in access to social protection, the country programme will strategically utilize human and financial resources to focus on a select number of learning districts to generate evidence-based guidelines and standards around effective programming for children and adolescents, linking interventions targeting schools, health facilities and communities. The programme will also strengthen social protection systems and specifically promote models for integrated response services for children and women who have survived abuse and violence and to increase access to child-friendly justice procedures.

Advocacy and planning

43. Support to research, planning and evaluation will develop and implement a strategic monitoring, evaluation and research plan to generate data and information in support of effective advocacy and inform programme design and accountability, as well as to strengthen national monitoring and evaluation systems and to generate lessons learned. In order to influence key decisions, the programme will promote the use of the most up-to-date data, analysis and information on the situation of children and women. Advocacy on social policy issues — budget allocations, budget utilization, progress on implementation of NDP10, progress towards the Millennium Development Goals, social safety nets, follow-up on the Convention on the Rights of the Child and other international human rights instruments — will be undertaken accordingly. Support to social policy development has been requested from UNICEF and will contribute to an overall enabling framework of social services and child rights realization. The component will provide technical support for policy dialogue and resource leveraging to sustain and improve coverage, quality and equity of access to social services for children and their families.

44. In partnership with the young child survival and development programme, the programme will also support costing of interventions, making the case for investments in health (public and private), strengthening household level safety nets, to ensure access to good quality health services.

Cross-sectoral costs

45. Cross-sectoral costs will support the operating costs for the provision of UNICEF assistance.

Major partnerships

46. The principal counterparts will be the Ministry of Finance and Development Planning, the Office of the President, line ministries and other legal authorities in

Botswana. Within the context of joint annual work plans, specific activities for technical assistance and capacity development will be defined.

47. Explicit efforts will be made to involve men and women, girls and boys, and to work more closely with and in support of civil society organizations, professional associations, the media, parliamentarians, traditional chiefs, political parties, religious organizations, academia and the private sector. Existing partnerships will be adjusted to reflect this shift in approach and emphasis on behaviour change and effective utilization of the widely available social services. Given the lack of donor agencies present in the country, UNICEF will also engage large-scale funding mechanisms, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United States President's Emergency Plan for AIDS Relief and the Clinton Foundation, to leverage resources for women and children and also influence policy through sub-regional bodies such as the Southern Africa Development Community.

48. Drawing upon the coordination mechanisms of the One United Nations Programme, partnerships with other United Nations agencies will be clearly defined within each of the UNDAF thematic areas. UNICEF is designated to chair the Theme Group on Governance and Human Rights Promotion and will co-chair the theme groups on health and HIV and AIDS; children, youth and women empowerment; and poverty reduction and economic diversification. UNICEF will be a member of the fifth theme group, on environment and climate change. UNICEF will also be a member of the United Nations Advocacy Committee and the Joint United Nations Team on AIDS.

49. In young child survival and development, UNICEF will continue to work closely with the World Health Organization and the United Nations Population Fund. The United Nations Population Fund will lead on sexual and reproductive health interventions which will address maternal mortality.

Monitoring, evaluation and programme management

50. The Government-UNICEF Programme Operational Plan will be complemented by a common budgetary framework, and will guide the joint preparation of annual work plans for each of the five UNDAF outcome areas.

51. For planning, implementation, review and monitoring purposes, a single programme coordination structure will be agreed under the overall leadership of the United Nations Resident Coordinator and the Ministry of Finance and Development Planning, with membership from key implementing agencies and stakeholders from the Government, umbrella organizations for civil society organizations and development partners. Within this framework, specific working groups will manage each of the UNDAF themes.

52. Based on the UNDAF, a common monitoring and evaluation framework will be developed as part of the Programme Operational Plan. Measuring results will be done jointly through existing government mechanisms and institutions. A midterm review of the United Nations Programme Operational Plan will be conducted in 2012, which will inform the priorities and strategies for the remainder of the UNDAF period.

53. Specific support towards enhanced monitoring, evaluation and statistical capacity will not only be geared towards monitoring progress towards NDP10 and

the Millennium Development Goals, but will also contribute to the UNDAF monitoring and evaluation requirements.