The Situation Analysis of children and their families in Botswana

Summary Report:
Findings and Recommendations to Policy Makers 2010/11
Acknowledgements

This report was written by Constance Formson UNICEF Botswana Social Policy Specialist a.i., based on the Situational Analysis of Children and their Families, prepared by a team of consultants headed by Prof. Garton Kamchedzera for UNICEF Botswana. This publication has been produced under the guidance of Marcus Betts, Deputy Representative and various programme section staff of UNICEF Botswana.

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Acronyms

ACRWC  African Charter on the Rights and Welfare of Children
AIDS  Acquired Immune Deficiency Syndrome
ARI  Acute Respiratory Infection
ART  Anti-Retroviral Treatment
ARV  Anti-Retroviral
BAIS  Botswana AIDS Impact Survey
BFHS  Botswana Family Health Survey
BLFS  Botswana Labour Force Survey
CCF  Children's Consultative Forum
CRC  Convention on the Rights of the Child
CSO  Central Statistics Office
ECE  Early Childhood Education
GER  Gross Enrolment Ratio
GoB  Government of Botswana
GDP  Gross Domestic Product
HIES  Household Income and Expenditure Survey
HIV  Human Immunodeficiency Virus
IMR  Infant Mortality Rate
MICS  Multiple Indicator Cluster Survey
NCC  National Children's Council
NDP  National Development Plan
NER  Net Enrolment Ratio
NPA  National Plan of Action
OVC  Orphans and Vulnerable Children
PMTCT  Prevention of Mother to Child Transmission
SADC  Southern Africa Development Community
U5MR  Under-5 Mortality Rate
UB  University of Botswana
UN  United Nations
UNESCO  United Nations Education, Scientific and Cultural Organization
UNGASS  United Nations General Assembly Special Session
UNICEF  United Nations Children's Fund
Botswana recognises that its current and future prosperity, to a large extent, depends on the well-being of its children. Having acceded to the Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC), Botswana remains committed towards the realisation of the rights of its children. With a strong sense of botho as a guiding principle in attitudes and relationships, Botswana can take pride in the progress made to date to ensure that every child in Botswana enjoys a dignified life.

The realisation of Vision 2016 – and of the Millennium Development Goals – rests on a clear understanding of the situation of children in the country. This report on the Summary, Findings and Recommendations of the situation analysis of children in Botswana offers important insights. What the Report brings out clearly is that the realisation of the rights of children to survival, development, participation and protection will only be effected through addressing the areas where further progress is required to address the age-specific needs of children, and their families, and which, importantly, takes into account the voices of Botswana’s children.

This report finds solid evidence that there has been sound investment in ensuring the well-being of children through provision of basic social services. This foundation, if strategically capitalised on, will progressively improve the quality of life of Botswana’s children and the country’s socio-economic development as a whole. It is my hope that policy makers, development programmers, service providers, and all of us who are responsible for making ‘Botswana fit for children’, will build on this foundation as we adopt a much needed child-sensitive rights-based approach that will ensure that children lead dignified lives that realize their fullest potential.

Dr. Doreen Mulenga
UNICEF Representative
Executive summary

This report presents the findings and recommendations emerging from an in-depth assessment and analysis of the situation of children and their families in Botswana. The study analyses disparities in child well-being, the causes of such disparities and the capacities required to respond.

This analysis was undertaken from the perspective of both the children themselves and of those who have duties and obligations towards them. In addition, the study presents a number of policy recommendations emerging from the findings of the analysis.

In the context of high HIV prevalence (17.6% among the general population1), rapid economic growth and considerable human development gains since independence in 1966, the basic rights of a child to survival, development, participation, and protection are recognised in Botswana’s Children’s Act of 2009. The inauguration of the first National Children’s Council in 2010 is a step in the right direction, however, a number of laws and regulations remain in conflict with the Children’s Act, and call for the review, harmonisation and coordination of policies regarding children. This is coupled with a need to operationalise the Children’s Act in order to realise the rights of children, alongside public education and advocacy on the rights of children. This analysis of the well-being of children in Botswana revealed that on:

Young child survival: with the implementation of PMTCT and introduction of ARV, although HIV and AIDS is no longer an immediate and leading cause of child mortality it remains a significant threat to child survival.2 Child mortality and malnutrition status have both increased since the late 1990s. The under-five mortality rate in 2007 was 57 per 1000 live births as compared to 48 per 1000 live births in 1994.3 This increase is primarily attributable to increased neonatal mortality and Acute Respiratory Infections (ARIs).

Child development: Between 2000 and 2007, child malnutrition saw no improvement; in 2000 stunting and wasting among children under-5 was 23% and 5% respectively, and increased to 26% and 7% respectively in 2007 (ibid). Although school enrolment rates at primary and secondary school level are relatively high, 10%-15% of primary school aged children and 38% of secondary school aged children are out of school.

Child protection: children remain exposed to a number of violations such as violence, sexual abuse, neglect, poverty, and child labour; and are at risk and vulnerable to HIV and AIDS. The legislative environment on child protection has improved over the years but further improvements in system strengthening and implementation are required to secure the rights of children to protection.

Child participation: children remain ‘voiceless’ in society. The introduction of the Children’s Act of 2009 and the establishment of the Children’s Consultative Forum (CCF) provide opportunities to facilitate participation of children in decision making at all levels of society.

Poverty: poverty is most prevalent among households with children aged 3–4 at 44% and next among households with children 0–2 at 41% compared to a national average of 30.6%.

Recommendations put forth based on the findings of the study are:

1. A Botswana Fit For Children: towards MDGs and VISION 2016

Key indicators of progress for both the MDGs and VISION 2016 will be the well-being of children. This will require timely availability of information and data on children in Botswana.

• The need for evidence based research: on socio-economic matters that impact on the short term and long term well-being of children. This will support evidence-based child-sensitive policy and programming.

• Improved child data: there is need for systematic and up to date data on the well-being of children at all ages of childhood 0–18, not just early childhood, with a focus on disparities in gender, geographic location, household wealth and other vulnerabilities. Specifically, there is need:
  • To prepare for a multiple indicator household survey to provide timely data for MDG and VISION 2016 reporting.
  • To develop and apply indicators on child participation and topics specific to OVC, including child-headed households.
  • To track progress towards malaria elimination.
  • To focus on issues of newborn care as a key driver of infant mortality.
  • To assess HIV-free survival at 18 months for HIV exposed infants.

• Advocacy: For the National Children’s Council to mount an advocacy campaign that links the realization of VISION 2016 with the fulfilment of children’s rights in the CRC and the Children’s Act (2009).

2. **3D service delivery**: simultaneously address both access and quality of services, plus equity — with a special focus on vulnerable children and their families.

Botswana has significant achievements with regards to infrastructure and overall access to services. This needs to be consolidated with increased attention to quality of those services and to address any remaining disparities in access.

- **Improved harmonisation, coordination and implementation of child related policies and programmes:**
  
  Programmes in particular, should take into consideration the age-specific needs of children and specific vulnerabilities and disparities.
  - The National Children’s Council will need to be capacitated for the attainment of this.

- **Organisational capacity building for service providers who deliver services to children:**
  
  There is also a need for service providers to adopt child-sensitive principles focused on the best interests of the child and a focus on those facing multiple deprivations and vulnerabilities.
  - This should include scaling-up implementation at district level of low-cost high-impact interventions addressing the major causes of childhood illnesses and deaths.
  - The report notes specific areas where quality is the key constraint, e.g.:
    - Neonatal care
    - Pre-primary, primary and secondary education
    - Infant and young child feeding
    - Family outreach on health education

  Affected districts to be supported to address specific access constraints that still persist for, inter alia, out-of-school children, early childhood education, disabled children, birth registration and bednets for pregnant mothers and children under-five.

- **Increased child protection and care practices:**
  
  There is need for education and improved knowledge among caregivers and the community on child protection, care and nurturing practices. In particular there is need:
  - To adopt child – and HIV – sensitive social protection approaches in meeting the protection and care needs of children, and especially for children and adolescents living with HIV or AIDS.
  - To promote parenting skills and community support for vulnerable families.

3. **Public education and child participation**

Public attitudes to child rights are broadly supportive, especially in regard to survival, development and protection, but remains contested in regard to discipline and child participation.

- **Increased public education and advocacy on the rights of children:** to survival, development, protection and participation.
  - The National Council for Children will need to develop and implement an advocacy and communication strategy.

- **Increased participation of children:** this should be done at all levels of society and should allow the voices of children, especially vulnerable children to be heard.
  - The Children’s Consultative Forum will need to be supported to fulfil this role to promote child participation as an effective strategy for protection of child rights.
  - Opportunities to be supported at national, district and local levels for children to a) engage in programme design and evaluation to improve their relevance and effectiveness and b) promote the civic engagement and development of the youth.

- **Adoption of positive discipline practices:** despite the fact that discipline is a part of a child’s development into a mature adult that is socially conscious, corporal punishment is not in the best interest of the child.
  - It is important that non-punitive methods for teaching valuable social and life skills in a manner that is respectful and encouraging for both children and adults (parents, teachers, childcare providers, youth workers, and others) are adopted. This will require advocacy and public education.

In conclusion the report finds that although child friendly policies have been put in place, contradictions exist due to lack of sufficient policy harmonisation. In addition, although resources have been invested in child survival and development, and overall access indicators are positive, indicators of child well-being such as mortality and poverty rates are too high to be in the best interest of the child. This suggests that there is a greater need to address the quality of services provided. Children remain vulnerable to neglect, sexual, physical and emotional abuse and, continue to be voiceless in decision making and budgeting at all levels of society. There is therefore need for greater child sensitivity in policy design, implementation, community mobilization and monitoring and evaluation. As such increased child focused research will facilitate enhanced evidence-based child-sensitive policy, implementation and monitoring and evaluation.
Background

This report presents the findings and recommendations emerging from an in-depth assessment and analysis of the situation of children and their families in Botswana that was undertaken between 2008 and 2010. The study analyses disparities in child well-being, the causes of such disparities and the capacities required to respond. This analysis was undertaken from the perspective of both the children themselves and of those who have duties and obligations towards them.

Across the board the situation analysis on the well-being of children in Botswana finds that although there has been progress towards realisation of the rights of the child and there are ample policies and programmes that advance the well-being of children, much more needs to be done. The general findings are that policy, and programming on children is not sufficiently child sensitive. In particular integrated child sensitive service delivery improvements in the local government system is required.

These findings are echoed in the perceptions of the children who participated in the analysis. Overall, the children who participated in the analysis expressed the desire to have parents, caregivers and community members appreciate their right to survival and development, protection and participation. In doing so the children acknowledged the importance of their parents and community members to facilitating and securing their well-being as well as being role models. These perceptions are articulated in the text boxes on ‘voices of Botswana’s children’. These ‘voices’ were facilitated through focus group discussions with children interviewed in the context of this analysis.

This Summary, Findings and Recommendations report is structured as follows: this section provides the context within which the analysis was conducted. The next two sections focus on the findings on young child survival and child development. This is followed by a section on the well-being of adolescents and young people. The two sections that follow are on child protection and child participation. The last two sections provide the main recommendations and the conclusions. The annex provides statistics on key indicators on child survival, development, protection and participation.

Objective of the report and methodology

The main objective of the report is to present findings and key recommendations of the situation analysis on children and their families in Botswana. The analysis takes a human rights-based analytical framework to establish factors that impact on the well-being of children. It focuses on child survival, development, participation, and protection.

The human rights-based approach to programming adopted by UNICEF in 1998, aims to incorporate the paradigms and provisions of the Convention on the Rights of the Child (CRC) into UNICEF supported development programmes. The ultimate goal of the approach is to strengthen national processes of social and cultural change towards respect for and fulfilment of the rights of children.

This analysis was facilitated through both secondary and primary data analysis, and was participatory in nature. In addition to focus group discussions with parents and children from various communities, the analysis consisted of a desk review involving analysis of existing literature and data. Outputs of the analysis were reviewed through a Multi-sectoral Technical Reference Group and validated in a children’s validation meeting.

Child population

Botswana’s population is estimated to be 1.8 million in 2011. The majority of the population resides in urban areas (52%) as compared to rural areas (48%). The female population has remained slightly higher than the male population; in 2001 52% of the population was female.
The human rights-based approach to programming

For UNICEF, a human rights based approach to programming means that:

• Child rights and human rights principles guide programming in all sectors at all phases of the programme process; and,
• Programmes of Cooperation focus on the development of the capacities of duty bearers, at all levels, to meet their obligations to respect, protect and fulfil rights; as well as the development of the capacities of rights holders to claim their rights.

Economic growth, poverty and inequality

From being one of the poorest countries in the world at independence, Botswana has attained middle income status based on prudent macro-economic management of mineral wealth, primarily diamonds and copper-nickel. In the 42 years up until 2007/08, the country experienced rapid growth, with real growth in GDP averaging 8.7% per year. In 2010, growth in real GDP was 10.8%; a large proportion of GDP growth remains attributable to the mining sector (30.8% in 2010). In contrast the agricultural sector, which was the backbone of the country at independence, accounted for only 2.7% of GDP in the same year.

The direct benefits from mining have been invested in education and other social services and infrastructure. To date education has continued to receive the greatest share of total Government expenditure. Recurrent expenditure on education constituted 26% of total expenditure for the three year period 2005 to 2008.

Despite these successes an area of concern is the high level of unemployment which reflects the capital intensive nature of Botswana’s mineral led growth. Of particular concern is the high unemployment among the youth aged 20–24 years and women, given that female headed families are in the majority (discussed in detail below). According to the 2005/2006 Labour Force Survey, unemployment is higher among the youth (26.5%) and females (20%) compared to males (15%).

In addition to unemployment, persistently high poverty and inequality have remained a challenge for Botswana. According to the 2002/03 Household Income and Expenditure Survey, at a national level, 30.6% of the population is poor; with poverty more prevalent in rural areas (45%) compared to cities/towns (11%). In addition poverty in Botswana has distinct gender and age disparities that impact adversely on children, women and the elderly.

Botswana is also one of the most unequal countries in the world. The Gini coefficient increased from 0.54 in 1993/94 to the 0.57 in 2002/03. The top twenty percent of the population earns 67% of income, while the middle forty percent earns 22% and the bottom twenty percent earns a mere 11%. There are geographical and gender dimensions to inequality in Botswana that affect rural populations and women more than other population groups. Over the years, to mitigate the impact of various risks on vulnerable groups, the government has put in place various social protection mechanisms such as the destitute programme and the recently approved orphans and vulnerable children’s plan (2010–2016).

The political context

Botswana is a multiparty democracy that has been politically stable and characterised by good governance since independence in 1966. Elections are held every five years; the last elections were held in October 2009 and 7 political parties contested in the elections. Compared to other African countries Botswana has maintained very good indicators on governance. According to the World Bank’s World-Wide Governance Indicators, Botswana’s indicators have remained relatively strong for the period 1998 to 2008. However, several dimensions of governance still need to be improved. These include voice and accountability, which declined from its high of 0.85 in 2003 to 0.55 in 2008. Similarly, regulatory quality which was 0.75 in 1998, declined from its high of 0.84 in 2002 to 0.64 in 2008. Government effectiveness appears to have improved marginally by 0.01 since 1998; the fact that it reached 0.75 in 2005 indicates that this is another area worth attention. These three dimensions of governance are strongly linked to human rights in that the decline of:

• the indicator on voice and accountability suggest that both the human rights principles of participation and accountability need to be strengthened; and,
• regulatory quality and the relative low position of government effectiveness indicates the need for strengthened public sector service delivery.
Disaster management

Botswana is vulnerable to a range of both natural and human induced disasters that occur with varying degrees of regularity and intensity. Major disasters include drought, floods, veldt fires, accidents and outbreaks of diseases. HIV/AIDS was also declared a national emergency. The country has put in place an institutional and policy framework to deal with the impact of disasters on vulnerable groups. The National Policy on Disaster Management was developed in 1999, and relates to the following elements of disaster management: prevention, mitigation, preparedness, response and recovery and development. During the current national planning period 2010–2016, key policy and regulatory interventions that will strengthen the disaster management system in Botswana will be the development of disaster management legislation, a disaster management plan and institutional capacity building to strengthen emergency preparedness.

Children in the Botswana context

Botswana acceded to the Convention on the Rights of the Child (CRC) in 1995, with a reservation on Article 1, and acceded to the AU’s African Charter on the Rights and Welfare of the Child (ACRWC) in 2001. In addition, in 2003 Botswana acceded to the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography as well as ratifying in 2004 the Optional Protocol to the CRC on the involvement of Children in Armed Conflict. However, the country is behind on its reporting obligations to the United Nations Committee for the Convention on the Rights of the Child. Botswana’s initial and only report to the Committee was submitted in 2001, with Concluding Observations from the Committee received in 2004.

In traditional Botswana culture, children have not been viewed as right holders, and are expected to be subservient to their parents and other adults. Children’s rights are often misunderstood and perceived to be a threat to cultural and customary principles. The Children’s Act provides a valuable platform for further programming and advocacy on the rights and participation of children.

The Children’s Act came into effect in 2009, and various pieces of legislation relating to children have been modified over the years, however, further policy harmonisation is required and subsequent amendments to be made to ensure compliance with the Children’s Act. Particular attention needs to be provided to harmonisation of customary and common law. Other laws and policies that have a key impact on the well-being of children in Botswana include the Adoption Act (1952), the Maintenance and Enforcement Act (1970); the Revised Destitute Policy (2002); the National Plan of Action (NPA) on Orphans and Vulnerable Children 2010–2016 (which supersedes the Short Term Plan of Action for Orphans (1999)), and the Second Botswana National Strategic Framework for HIV and AIDS 2010–2016.

To support its implementation, the Children’s Act provides for the establishment of the National Children’s Council (NCC), which was inaugurated in 2010 to coordinate, guide and advocate for the implementation of the Act, and the Children’s Consultative Forum (CCF) which was also established in 2010 as a mechanism through which children can make their voice heard.

Children remain a vulnerable population open to abuse and exploitation, due to their physical limitations, their dependence on adults for care and support, and their lack of political voice.

Table 1: Child Population Data

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>PERCENTAGE / NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2011)</td>
<td>1.8m</td>
</tr>
<tr>
<td>Under-5 population (2011)</td>
<td>12% (215,000)</td>
</tr>
<tr>
<td>Child population (&lt;18 yrs)</td>
<td>41% (750,000)</td>
</tr>
<tr>
<td>Girl population (&lt;18 yrs)</td>
<td>49.6% (371,000)</td>
</tr>
<tr>
<td>Boy population (&lt;18 yrs)</td>
<td>50.4% (377,000)</td>
</tr>
<tr>
<td>Orphaned children (&lt;18 yrs)</td>
<td>16.2% (111,567)</td>
</tr>
</tbody>
</table>

Sources: CSO (2001), Population and Housing Census; CSO (2009), Botswana Family Health Survey 2007.

Figure 1: Percentage of children in poor households by age and sex

- FEMALES
- MALES
- NATIONAL POVERTY LINE

Source: CSO (2004), Household Income and Expenditure Survey 2002/03.
In particular, poverty in childhood is more pronounced and has lifelong implications for their well-being.18 Child poverty estimates16 in Botswana, as is the case in many other countries, are higher than national poverty estimates with 33.2% of all children in 2002/3 living in poor households, compared to 30.6% of the overall population. Poverty is most pronounced in households with children aged 3–4 years, followed by those with children aged 0–2 years (see Figure 1). Child poverty is also found to be more prevalent in rural areas compared to urban areas.

Children in the context of the family and community

Children thrive best in the context of families, and by extension communities. Articles 9 and 11 of the CRC recognise the importance of parents and community members in ensuring the well-being of children, while Article 5 recognises the rights and responsibilities of parents and the community in their child-rearing function. As signatory to the CRC, Botswana also recognises these rights, and this is reflected in the Children’s Act (2009).

Overall, illiteracy, unemployment, and household poverty are key factors that contribute to insufficient care and protection of children. However, the family structure in Botswana has changed considerably since independence; traditional nuclear and/or extended family structures have been gradually replaced, to a significant extent, by single parent families, in particular, female-headed households.17 In Botswana, over two-thirds of children aged 7–17 do not live with their fathers.18 In addition, poverty is more prevalent among female-headed households (46%), compared to 27% for male-headed households),19 which has implications for the well-being of children as signified by the relatively high child poverty rates discussed above.

Family and community structures have also been heavily affected by the HIV and AIDS epidemic which continues to be a psychological, emotional and economic drain on family and community networks. The changing family structure has both short and long-term implications for the well-being of children as time and resources are diverted to care for the ill household members, who may well have been income earners. Beyond exposing children to greater risk, this has resulted in the emergence of child headed households, and households headed by grandparents as opposed to parents. In 2002 it was estimated that 1.5% of households were child-headed.20

Gender equality and women’s empowerment

Botswana’s Constitution prohibits all forms of discrimination, and the country has made considerable progress towards gender equality with parity having been virtually achieved in primary and secondary education.21 In order to develop a gender sensitive legal framework various policies and laws affecting that women have been developed, revised and harmonised as applicable in an effort to facilitate equal access to opportunities for both women and men.22 In 1996 the government adopted the National Policy on Women in Development. In the same year Botswana ratified the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). However, women do not fully participate in all aspects of national, economic, social and cultural development.23

Botswana has one of the highest proportions of households that are female-headed in the world and access to and control of productive resources and access to gainful employment all remain a major challenge for women.24 Women and female-headed households suffer poverty and economic marginalization more acutely than men and male-headed households, as discussed earlier. This partly emanates from a national culture that continues to promote men as decision makers at all levels of public and private life.25 Although there is evidence that there is progress in women’s participation in managerial positions and positions of leadership, women’s representation in political office in Botswana is well below the SADC threshold of 30%.26

A study on violence against women conducted in 1999 found that violence against women is a substantial problem; three out of every five women in Botswana have been subjected to gender based violence.27 Battering, rape and murder continue to be serious problems that show few signs of abating.28 The rate of femicide in Botswana doubled over the period 2004–2007, and by 2007, four women reported rape cases each day and, every 3 or 4 days a woman was murdered.29 Beyond this, women continue to be burdened by reproductive roles with limited or no support from men. Consequently, promoting gender equality and the adoption of gender sensitive programming perspectives as a cross-cutting issue remains an important part of socio-economic development in Botswana.
Investments in child survival

The current causes of child morbidity and mortality in Botswana are both preventable and treatable. In Botswana, a number of child survival programmes have been developed and are being implemented to address these problems. These include in particular the Expanded Programme on Immunisation, Antenatal Care, Accelerated Child Survival and Development strategy, growth monitoring and promotion, the Integrated Management of Childhood Illnesses Programme, Infant and Young Child Feeding strategies, the Baby-Mother Friendly Programme, the Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) and the Anti-Retroviral Treatment (ART) Programme. Although some of these programmes have substantive coverage, not all programmes are meeting their objectives. The Botswana Family Health Survey (BFHS) IV indicates that by the end of 2007:

- 90% of children aged 12–23 months were fully vaccinated
- 94% of pregnant women attended ante-natal clinics
- 94% of pregnant women delivered in health facilities
- 95% of deliveries took place under skilled attendance
- 89% of HIV positive pregnant women received ART to prevent MTCT
- Only 40% of early initiation of breastfeeding (first hour of birth)
- Only 20% of infants were exclusively breastfed up to 6 months
- 13% of under-fives were underweight, 26% were stunted, 7% observed with wasting and 10% were overweight.

Voices of Botswana’s children on their survival

The children expressed pride and pleasure in the fact that most parents/caregivers provided basic needs such as food to their children. They further expressed appreciation of the fact that mothers/female caregivers take their health and well-being seriously.

However, they felt that there is a general lack of good parenting skills among parents/caregivers. This manifests in some parents neglecting children in pursuit of alcohol and other self-gratifying pursuits; or situations where children under-5 are left in the care of other children. They further expressed that some parents/caregivers do not take financial responsibility for the family. In addition they complained of insufficient stimulation and engagement from parents/caregivers; a situation they perceived to be due to lack knowledge and skills on the part of parents/caregivers.
Infant and under-5 mortality

The increase in child mortality since the late 1990s reflects the effects of HIV and AIDS on child survival and the fact that current child health and survival interventions have not fully mitigated the effects of the epidemic. Since independence, both infant and under-five mortality were on a decline until the early 1990s but have been on the increase since the mid-1990s (see Figure 2). By 1997 under-five mortality had fallen to 50 per 1000 live births and the infant mortality rate had fallen to 36 per 1000 live births. From this low point under-five and infant mortality rose to 76 and 57 per 1000 live births respectively. The increased infant mortality experienced is also driven by increased neonatal mortality. In 2007 neonatal mortality (34 per 1000 live births) accounted for 60% of the IMR.

Under-five, infant and neonatal mortality are higher in rural areas as compared to urban areas (see Table 2).

Immediate causes of child mortality

In 2008, the leading immediate causes of child morbidity in Botswana were Acute Respiratory Infection (ARI) (in particular pneumonia), diarrhoea, newborn conditions and malaria. According to the Botswana Causes of Mortality study in 2008 (2010), between 2007 and 2008, pneumonia remained the main cause of child mortality. In 2008 eleven percent (11%) of children under-5 had ARIs other than pneumonia of which 37% were treated accordingly. In 2007, pneumonia accounted for 21% of infant deaths and 19% of deaths of children before their fifth birthday. By 2008 this had declined to 10% of deaths among infants and 7% among children under-5.

Although also on a decline, dehydration caused by severe diarrhoea also continues to be a major cause of death among young children. Approximately 18% of both infants and children under-5 died from diarrhoea in 2007. In 2008 both infants and child mortality due to diarrhoea had declined to 7% each.

As discussed above, newborn mortality contributes to about 60% of infant mortality and the major causes are prematurity, low birth weight, birth asphyxia and sepsis.

Malaria is prevalent in five northern districts. Implementation of the National Malaria Control Programme has resulted in a significant decline in the number of malaria cases. However, according to the 2007 Malaria Indicator Survey in Okavango, Chobe and Tutume, 88% of children under five and 91% of pregnant women did not use insecticide treated nets (ITNs).

Table 2 Child mortality

<table>
<thead>
<tr>
<th>PLACE OF RESIDENCE</th>
<th>NEONATAL IMR</th>
<th>U5MR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cities/Towns</td>
<td>24</td>
<td>54</td>
</tr>
<tr>
<td>Urban villages</td>
<td>31</td>
<td>44</td>
</tr>
<tr>
<td>Rural</td>
<td>42</td>
<td>70</td>
</tr>
<tr>
<td>National</td>
<td>57</td>
<td>57</td>
</tr>
</tbody>
</table>

Figure 2 Infant mortality rate and under 5 mortality rate trends in Botswana


Underlying causes of child mortality
In addition to HIV (discussed below), maternal health and mortality is a significant underlying cause of child morbidity in Botswana. In the context of a supportive policy and programme environment, maternal mortality declined significantly in the 1990s. As indicated earlier, 97% of all pregnant women used antenatal services and 95% of all deliveries were attended to by qualified healthcare personnel in 2007. Despite this, between 2006 and 2009, maternal mortality, as measured by the maternal mortality ratio, increased from 140 deaths per 100,000 live births to 190 deaths per 100,000 live births in the respective years.

HIV and AIDS and children
In 2008, against a national HIV prevalence of 17.6%, the lowest infection rates were among children aged 1.5 to 4 years of age at 2%, with the highest infection rate being among those aged 30–45 at 41%. AIDS is still the key underlying cause of child mortality in Botswana despite the fact that child mortality due to AIDS has declined significantly since 2007 from 12% to 0.8% in 2008 for children under-5. It should be noted however, that HIV or AIDS may not always be recorded as an underlying cause. Reducing the incidence of HIV and that of unintended pregnancy amongst HIV positive women remains critical to child survival in Botswana. PVMTCT coverage in Botswana is high. Women attending ante-natal care are tested and by 2009, 94% were initiated on ARV for prevention of mother to child transmission of HIV. The remaining challenge is to reach those women who do not access PMTCT services and contribute to the majority of children born HIV positive. Continued efforts are required to reach the goal of elimination of new paediatric HIV infections. Paediatric ART is provided in all the 32 ART clinics but infant follow up, testing and initiation of treatment still remains a challenge. Other challenges are sub-optimal infant feeding counselling and support for young child feeding, supply chain management, and repeat unintended pregnancies among HIV infected women.

Water and sanitation
The provision of reliable water supply is costly in Botswana because there are few surface water sources. Dams have been constructed to improve water supply mainly for urban areas adversely affecting water supply in other areas. The major water users are human settlements, livestock, mining and energy and irrigation. The high reliance on ground water (estimated to be 80% in 2005) poses several challenges, including protection from pollution and the high cost of provision.

Nevertheless, the country has achieved high levels of potable water provision. The 2007 BFHS estimated that 96% of the population has access to safe drinking water (100% in cities/towns/urban villages and 91% in rural areas) through improved water sources. Ministry of Local Government reports occasional problems of lack of reliability of supply in some villages, and also has concerns about the accuracy and timeliness of quality monitoring data.

Access to improved sanitation facilities, however, lags behind. Improved sanitation facilities are available to 80% of the population (99% cities/towns, 96% urban villages, 58% rural). Due to water scarcity, the preferred technology for rural areas is non-flushing latrines such as VIP. However, this data does not reflect disaggregation between ‘homes’ and ‘lands areas’/’cattle posts’, where families spend part of their time, and many children under-5 years are sent to be cared for by grand-parents.

Key points on child survival

* Prevention of HIV infection among women and ensuring universal access to PMTCT services among HIV infected women remains critical to child survival.
* Improved implementation and communication on low cost high impact interventions that target the major causes of mortality in children including the newborn.
* Improved service quality and delivery are instrumental in addressing the increase in child mortality in particular neonatal and infant mortality.
* Improved service delivery and quality will need to be addressed through increased skilled personnel, and improvements in supply chain management of commodities and provision of psycho-social support to HIV positive children and women.
* Scaling-up community-based health and nutrition preventive high impact interventions is required to complement the gains made through the Botswana health care system.
Child development and education

Early childhood, the age between 0 and 5 is a crucial stage in a child’s life that has implications for the entire lifespan. A child’s holistic development during this stage is therefore of great importance. This section of the report presents the findings on child development, including nutrition, family care and support and education.

Voices of Botswana’s children on their development

The children acknowledged and appreciated the roles of parents, extended families, and community members in providing them with moral guidance and advice. In addition, they expressed that parents and caregivers should spend more quality time with their children. Further, some parents lack adequate parenting skills, and resort to violent modes of discipline. The children also articulated their need for play and recreation as part of their development. The role of communities and linkage between communities and health facilities needs strengthening for improved child care practices.

However, the intimacy enjoyed by a child when such guidance and advice is provided by a biological or close care giver is often absent. They felt that parents “should do good things and set good examples for their children” and that there “should be mutual respect between adults and children.” In addition, they appreciated the fact that many parents provided young children with their basic needs such as food, health care, and taught them good moral behaviour, “according to culture and acceptable behaviour.” And that at the household level, parents provide emotional and material support for child well-being. However, they expressed the desire to have the emotional and material support of both parents not just their mothers whom on average are the principle care givers and breadwinners, with limited or no support from their fathers.

Child nutrition

Child nutrition reflects current and chronic nutrition deficits which can affect both physical and mental development in later life. Between 1996 and 2000, national rates of stunting (low height for age), underweight (low weight for age) and wasting (too thin for their height) among children under-5 years were decreasing. However, since 2000, child malnutrition trends indicate a worrying stagnation or even worsening in stunting and wasting at 26% and 7% respectively in 2007, while underweight is at 13%. In 2007, 10% of children under five years old were overweight. In addition the increase in low birth weight from 8% in 2000 to 13% in 2007 calls for special attention to prenatal health and nutrition care.

Regarding infant and young child feeding practices, despite having most pregnant women delivering in health facilities, only 40% of the newborns are breastfed within the first hour of life. The six months exclusive breastfeeding rate stands at


46. CSO (2009), 2007 Botswana Family Health Survey IV Report.
20% and by 20–23 months only 6% of children continued to be breastfed. The current nutritional status of children under five is an indication of suboptimal infant feeding practices and psychosocial support. There has however been notable national progress in the area of micronutrient with vitamin A supplementation coverage for children 6–59 months reaching 89% in 2009.47

Early childhood development and education

Early childhood development relates to the physical, cognitive, language, social and emotional development of a child between birth and the age of 5. Every child has the right to be cared for by both parents and grow up in a family environment.48 In Botswana, there is a high incidence of early pregnancy, and single female parent households49 all of which impact on the well-being of children, particularly in the formative years of childhood. This is coupled with inadequate parental skills and a traditional approach to child upbringing. In addition, there is a lack of appreciation and understanding of the rights of children to leisure, play and recreation. The Baseline Study on Early Childhood Development (2006) found that 44% of parents and caregivers did not recognise the importance of play for a child’s cognitive development. This societal trend of thought is reflected in the lack of recreational facilities for children, and is an issue flagged for action in the Children’s Act (2009).

Cognitive development of children under-5 years is compromised by low and uneven delivery of early childhood education (ECE). In 2007 only 18% of pre-school aged children (those 36–59 months), were enrolled in pre-school education primarily in urban areas. The Education Act does not recognise a child’s right to early education. This right is however recognised in the Children’s Act which calls for district wide provision of ECE.50 However, the existing policy inconsistency, lack of coordination and standardisation has implications for the delivery of ECE, and will need to be addressed if ECE is to provide a firm foundation for later schooling.

Basic education

Botswana has done remarkably well in providing universal access to 10 years basic education with a strong supportive policy environment. The education sector is well resourced and on average accounts for 25% of the national budget; in 2010/11 education accounted for 31.5% of the national budget.51 Government investments in education has resulted in ‘good education infrastructure, adequately staffed schools, rising teacher qualifications, and adequate supplies of equipment and materials in schools’.52 The result of this is that unlike many other African countries, gender disparities in education are negligible; girls tend to access and progress in education more than boys.

Despite these investments and high enrolment rates Botswana’s education system is characterised by geographical location, quality, and drop out discrepancies. The estimated primary Net Enrolment Ratio (NER) in 2010 for 6–12 year olds at primary school was 89.4% an increase of 4.4% from 2009.53 While the NER for those 7–13 years was 90.8% in the same year (ibid). This indicates that some 10% to 15% (depending on the age group of measurement) of primary school age children were out of school in 2010.

Although Botswana’s education system strives for equity in education, this goal is yet to be realised as a result of existing barriers to education. Barriers of note include access to education for disadvantaged populations such as special needs students (i.e., children with physical, mental and learning

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48. CRC, Article 5, 18, ACRWC, Article 18, 19.
49. GoB (2006), Baseline Study on Early Childhood Development found that 68.5% of the households surveyed had an absentee father.
of pre-school education in preparing children for primary education. Research indicates that children who attend pre-school are more prepared for and more likely to remain in school.\textsuperscript{53} Achieving higher primary education rates is also fundamental to strengthening the number of young adolescents ready to progress and remain in secondary school at the appropriate age.\textsuperscript{60}

Current Government policy allows pupils to transit from primary to secondary school irrespective of examination results. This coupled with the pupil-teacher ratio\textsuperscript{57} and quality of teaching has had an impact on the quality of education. This has been reflected in declining learner achievement.\textsuperscript{52} There is therefore need to ensure that the quality of education matches the level of government investment (bxd). The Government Primary School Feeding Program, which is available to all primary school children, is an effort to increase learner retention.

In Botswana the official school entry age is 6 years however many children do not start school at 6. The spread between the NERs for the 6–12 and 7–13 cohorts suggest that many children go to school at the age of seven, instead of age six.\textsuperscript{56} This last year is a cost to both the children and the country, and requires government attention (ibid).

The main reasons for children dropping out of school include desertion,\textsuperscript{57} income poverty, child labour practices, teenage pregnancy, cultural life styles especially those associated with religious and nomadic groups of people, and unfriendly school environments (see Figure 3).\textsuperscript{58} Addressing the issue of quality education needs to be a priority for Botswana given the number of out of school children and the rights of a child to an education. In particular the fact that most dropouts occur in Standard 1 highlights the importance of pre-school education in preparing children for primary

![Figure 3 Reasons for primary school dropouts in 2006](source)

**Key points on child development**

- Greater effort is required to improve the nutritional status of children under-5, and in particular those 0–2 years. These efforts need to be boosted during the 1000 days window of opportunity starting from pregnancy to the first two years of life of every child.
- Male involvement in the care, education, and development of children is critical for a child’s social, cognitive, and academic achievement and their behaviour. There is therefore need for advocacy on the importance of male involvement in child rearing in an effort to facilitate greater male involvement.
- Play is instrumental of every aspect of a child’s physical and cognitive development. Parent and caregiver education on this is important for realisation of a child’s right to play and leisure, as well as development.
- Caregivers are essential to the well-being of children; children thrive best in the context of families. There is therefore need to scale up interventions for caregivers that address their immediate needs and enable them to provide better care and support to children alongside positive discipline practices.
- Early childhood education is a fundamental part of human capital development that should be nationally institutionalised in the education system.
- Building an educated and informed nation will, to a great extent, depend on the ability to deliver quality education and the removal of barriers to education.

\textsuperscript{53} CSO (2010) Education Statistics Brief indicates a pupil-teacher ratio decreased from 29 in 2003 to 26 in 2010.


\textsuperscript{56} GoB/UN (2010), Botswana Millennium Development Goals Status Report 2010.

\textsuperscript{57} Desertion refers to instances where children disappear from school for unknown reasons. CSO (2007) Education Statistics indicates that in that year 82% of children who dropped out of school for this reason.

\textsuperscript{58} CSO (2010), Education Statistics Brief.


\textsuperscript{61} CSO (2010), Education Statistics Brief indicates that the pupil-teacher ratio decreased from 29 in 2003 to 26 in 2010.

Adolescents and young people

Adolescence, which spans between 10 to 19 years, consists of two parts, early adolescence (10–14 years) and late adolescence (15–19 years). Adolescence is ‘a dynamic transition period to adulthood marked by opportunities’. The age between 20–24 years, the stage where adolescents enter ‘adulthood’, is also a critical stage that calls for proper care and nurturing. This realisation is reflected in Botswana’s Youth policy that aims ‘to ensure that young women and men are given every opportunity to reach their full potential, both as individuals and as active citizens in Botswana society’.

This section presents the finding on the situation of adolescents and young people in Botswana.

HIV and AIDS and the challenges for adolescents and young people

‘Preventing the transmission of HIV is one of the most important challenges for adolescent survival and health’. Although relatively good statistics exist on the survival of infants and children under-5, statistics, other than on HIV, on the survival of older age groups is very limited. However statistics on the causes of child mortality indicate that in Botswana HIV/AIDS was the cause of 7.8% of death of all children excluding neonates in 2008.

Research shows that the risk of HIV infection is higher among adolescent girls than adolescent boys; indicating that there are significant gender-related distinctions in the prevalence of HIV that commence during adolescence. In Botswana, although HIV prevalence rates for children are lower than those for most adult age groups, the disproportionate spread of infection and prevalence amongst girls clearly indicates gender-based inequalities (see Figure 4). In 2008, only 43% of adolescents and young people (15–24 years age group) in Botswana were fully knowledgeable about HIV and AIDS. The key drivers of the epidemic are gender based violence, intergenerational sex, multiple concurrent partners and substance abuse. Life skills development therefore remains a critical intervention in preventing the spread of HIV among adolescents and young people in Botswana.

The Botswana AIDS Impact Survey III found that in 2008 the HIV prevalence for adolescents 10–14 years and 15–19 was 3.5% and 3.7% respectively. While the prevalence was the same for both sexes in early adolescence (10–14 years) at 3.5%, the prevalence amongst females in late adolescence and young adulthood was higher than that of males of the same age group. In late adolescence the prevalence in 2008 was 2.4% and 5% for males and females respectively (see Figure 4). As adolescents transit into adulthood HIV
prevalence rates, in particular that of young women, change dramatically. In the 20–24 age group, the prevalence rate was 12.3% for both sexes and 7.4% and 16.2% for males and females respectively (see Figure 4). These statistics correspond to the indications that adolescent girls are more likely to engage in unprotected sex as is evidenced by the relatively high rate of school drop outs due to pregnancy (see the section on education in adolescence below). The key causes of HIV and AIDS in Botswana to which adolescent girls remain vulnerable are: inter-generational sex, unplanned first sexual encounters without condoms, and contestations against sticking to a faithful uninfected partner and abstinence from sex.  

The number of adolescents on Anti-Retroviral Therapy in Botswana is increasing rapidly primarily a result of children who were born with HIV surviving into their teenage years. ’Current records indicate that over 1,400 adolescents are enrolled in the government’s ARV programme’.  

A conservative estimate of Botswana’s teen ARV needs indicates that nearly 4,000 adolescents need ARV. In addition to medical treatment, adolescents and young people living with HIV need specialized care and support to help them overcome the hurdles of puberty and adolescence. Addressing the complex needs of this age group requires child focused HIV sensitive social protection interventions that address age specific needs of adolescents and young people. In 2009, all districts had trained staff (medical officers and nurses) to provide care for HIV infected children and their families.  

Two junior secondary school children work at a computer terminal

Education in adolescence

According to the CRC and the ACRWC, every child must enjoy the right to education. Although the CRC provides standards for primary, secondary, vocational, and tertiary education, Botswana’s Children’s Act of 2009 only recognises the right to ‘basic education’. Nevertheless, as discussed the country’s education system is well-resourced, and education is recognised as a priority for development and well-being by government.

Secondary education is critical to adolescent empowerment, development and protection. Enrolment rates at secondary school level have increased over the years, but have remained lower than primary school enrolment rates. Unlike most countries, in Botswana enrolment rates for adolescent girls have been higher than for boys. According to the 2006 Education Statistics, in 2006 the NER for both females and males of ages 13–17 years and 14–18 years was 62.2% and 70.5% respectively. The data also indicates that overall more boys than girls start secondary school late. In addition, more girls than boys progress in secondary school.

Although there have been successes, as signified by the enrolment rates, there are discrepancies and disparities regarding access to and provision of secondary education.

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75. CSO (2009), Education Statistics 2008.
Key points on adolescence and young people

- Adolescence is a pivotal decade in an individual’s life that requires special attention and protection.
- Investment in sexual reproductive health knowledge and services for adolescents should be a key priority towards an HIV and AIDS free generation.
- In line with this is improved capacity for adolescent-friendly services and HIV sensitive social protection.
- Investment in child sensitive social protection is vital to breaking the intergenerational cycle of poverty, and creates opportunities for young people.
- Life skills training and vocational opportunities are important aspects of human capital development as regards adolescents and young people.
- The role of education in addressing unemployment and poverty among adolescents and young people is critical for the country’s socioeconomic development.
Child protection
The CRC and the ACRWC outline the rights to be protected from economic exploitation and harmful work, from all forms of sexual exploitation and abuse, and from physical or mental violence, as well as ensuring that children will not be separated from their family against their will.

Voices of Botswana’s children on their protection

The children expressed that it is common to witness domestic violence, be subjected to violence, and have angry adults shouting at children. In general they appreciated that parents and guardians provide counselling and guidance on acceptable behaviour; in their words, “parents and guardians provide life skills education to help children meet the challenges of life.” These examples of care and nurturing provided by parents and guardians are understood by the children as necessary for children’s protection.

However, the children noted that some parents, guardians and care givers at the household level are negligent, sexually, emotionally and or physical abusive to children. At the community level, the children underlined that they further needed to be protected from negative peer pressure to which they are subjected. They added that they also need to be protected from discrimination, especially for children with disabilities.

Children’s legal and social protection
While various child friendly policies have been developed in the recent past, much still remains to be done. A baseline study on child protection found that children face numerous challenges in Botswana. These include issues of abuse (physical, emotional, psychological economic and social deprivations), child labour, inadequate access to psychosocial support services, property grabbing, and intergenerational sexual relations. In addition, corporal punishment is permissible in Botswana law and is used as a way of disciplining children at home, schools (as stipulated in the Education Act) and as a sanction in the juvenile justice system. This is an issue of deep concern that requires urgent legislative reform to prohibit the use of corporal punishment in the family, schools and other institutions and to promote awareness of alternative approaches to discipline.


The Children’s Act of 2009 criminalises child abuse; it is an offense for parents or guardians to neglect, abuse, or exploit their children or allow others to do so.79 Neglect is the failure to provide for a child’s basic needs; that is adequate food, shelter, medical care, as well as exposing children to circumstances that are likely to cause mental, psychological or physical distress. However, although widespread with reported incidences increasing in recent years; child abuse in Botswana is often not dealt with as a legal matter. Convictions for criminal abuse and neglect of children are very rare in Botswana and are usually not pursued in court.80 The Children’s Act of 2009 criminalises child abuse; it is an offense for parents or guardians to neglect, abuse, or exploit their children or allow others to do so.79 Neglect is the failure to provide for a child’s basic needs; that is adequate food, shelter, medical care, as well as exposing children to circumstances that are likely to cause mental, psychological or physical distress. However, although widespread with reported incidences increasing in recent years; child abuse in Botswana is often not dealt with as a legal matter. Convictions for criminal abuse and neglect of children are very rare in Botswana; in 2000, only 16 such cases were convicted.80 Preventive and curative policies and strategies in place have proven to be inadequate. Consequently adoption of the Children’s Act of 2009 presents Botswana with a potentially strong child protection framework; this framework, as is the case with other existing child related legislation, will need to be strengthened to adequately respond to the protection needs of children.

Child labour exists in Botswana despite the fact the country has ratified a number of Conventions of the International Labour Organisation, including the Minimum Age Convention (C138) which sets the minimum employment age at 15 and the Worst Forms of Child Labour Convention (C182) in 1997 and 2000 respectively. In 2008 the country also adopted the National Action Programme towards the Elimination of Child Labour in Botswana. Despite these interventions, there is a general lack of awareness and understanding of child labour and trafficking among children and people working with children.81 In addition, there is no specific law on child trafficking in Botswana; however some aspects of child trafficking is found in different pieces of legislation such as the Children’s Act, the Penal Code and Employment Act. This situation contributes to exploited and trafficked children not being given the appropriate protection and support. The section on orphans and vulnerable children (OVC) includes a more detailed discussion on child labour.

Access to social protection and other social services is only possible if a child is a citizen; birth registration is therefore an important factor for realisation of the rights of children in Botswana. The Birth and Death Registration Act (section 6) requires registration of every child born in Botswana.

According to the BFHS IV in 2007, 27.8% of children under—5 were not registered. In the same year an estimated 24.4% of children did not have birth certificates. The main reasons cited for non-registration were: lack of knowledge that a child should be registered and of where and how to register a child (11.5%); high cost (25.9%), and travel distance (23.1%).82

Building a protective environment for children

Building a protective environment for children that will help prevent and respond to violence, abuse and exploitation involves eight essential components: Strengthening government commitment and capacity to fulfill children’s right to protection; promoting the establishment and enforcement of adequate legislation; addressing harmful attitudes, customs and practices; encouraging open discussion of child protection issues that includes media and civil society partners; developing children’s life skills, knowledge and participation; building capacity of families and communities; providing essential services for prevention, recovery and reintegration, including basic health, education and protection; and establishing and implementing ongoing and effective monitoring, reporting and oversight.


Key points on child protection

• Greater advocacy and public awareness on child protection is instrumental to the realisation of children’s rights; and the realisation that children’s rights are not a threat to traditional cultural values.
• Life skills development, knowledge of their rights and participation of children in socioeconomic development will help prevent child abuse.
• An effective system for reporting cases of abuse, including sexual abuse, of children is of paramount importance.
• Cases of violence and abuse against children should be investigated through child-sensitive judicial procedures and sanctions imposed on perpetrators, with due regard to the right to privacy of the child.
• Advocacy and awareness creation of positive, participatory, non-violent forms of discipline should be undertaken to ensure that disciplining of children is administered in a manner consistent with the child’s human dignity and in conformity with the CRC, especially article 28, paragraph 2.
• There should be greater prioritisation of child protection in budgetary allocations, to ensure implementation of the economic, social and cultural rights of children.
Child participation

Article 12 of the CRC provides that every child has a right to have views and express these views freely in all matters affecting them. The Committee on the Rights of the Child has underlined that this right ‘reinforces the status of the young child as an active participant in the promotion, protection and monitoring of their rights. Respect for the young child’s agency — as a participant in family, community and society — is frequently overlooked, or rejected as inappropriate on the grounds of age and immaturity’.

Voices of Botswana’s children on their participation

The children appreciated the increasing opportunities accorded to them by child-focused organisations such as UNICEF. However, they expressed that there are no avenues available for the views of children to be heard and appreciated by decision makers at community, district, and national level.

Children’s participation in society

In Botswana as in many other countries, children are primarily voiceless and are not free to express themselves. The Children’s Act of 2009 emphasizes and calls for children to be given information, opportunity and necessary assistance to enable them to participate in matters affecting them at all levels of society. Although this right is yet to be realised, the establishment of the Children’s Consultative Forum is expected to facilitate children’s participation in decision making at national, district and community level. Facilitating children’s participation in decision making requires public education and advocacy on the rights of children against a traditional perspective that do not consider children as rights holders with the right to participate in decisions that affect them.

Boys lean on a gate near their home

83. GoB (2009), Children’s Act, Sections 8 and 27 (4e)
Recommendations of the National Children’s Consultative Forum

The inaugural forum meeting of the NCCF identified the following key steps in facilitating children’s participation in socio-economic development:

- District level meetings to discuss various challenges experienced at village/district level;
- Wide dissemination of the Children’s Act to parents and all relevant stakeholders, at all levels of society;
- Up scaling of peer education on issues such as teen pregnancy/drug and alcohol abuse;
- Facilitate empowerment of parents with proper parenting skills in order to address the existing communication gaps between children and parents;
- Empowerment of children to acknowledge their responsibilities/duties/obligations that accompany their rights;
- Establishment of child based early warning interventions regarding issues of drug and alcohol abuse; and
- Institutionalisation of social workers and psychologists in the school system.


At the family level, many parents and guardians do not know how to stimulate, ensure children’s participation in decision making and at the same time uphold traditional norms and values. The children interviewed for this report expressed the desire to have their views heard at all levels of society particularly in matters that concern their well-being.

Key points on child participation

- The perception that children’s rights are a threat to cultural and customary principles results in lack of participation by children in decisions affecting them.
- Promoting children’s ‘voices’ facilitates child protection as children become more knowledgeable and responsibly vocal about their rights and responsibilities.
- Children’s participation should be mainstreamed into all programming process in order to facilitate child sensitive programmes and interventions that address the age specific needs of children.
- Active participation of adolescents in family and civic life fosters positive citizenship as they mature into adults.

Peer educators preparing for a sexual education workshop for adolescents
The situation of orphans and other vulnerable children

There are various categories of vulnerable children in Botswana made vulnerable by various factors. These include children living in remote areas, child labourers, children on the street, children in child headed households, children in conflict with the law, those with disabilities and orphans. The vulnerability of Orphans and Vulnerable Children (OVC), exacerbates their lack of opportunity, space and voice of participation in society, and leaves OVC open to greater instances of neglect, violence, exploitation, sexual and other forms of abuse.

Children in remote area: have limited access to services such as health and education. High school dropout rates are prevalent due to the cultural insensitivity of the education system. Also prevalent is relatively higher levels of gender inequality and neglect due, in part, to alcohol abuse.

Orphans: despite well-financed programmes on orphan care, orphaned children still remain susceptible to other forms of vulnerabilities. One key reason orphaned children remain susceptible to other forms of vulnerabilities is because initiatives meant to improve their well-being lack sufficient programmatic facilitation of child participation according to evolving capacities.

Child-headed households: The child-headed household is a mechanism for survival and necessity that illustrates the inadequacies of alternative care systems including the extended family. As a protection mechanism, child-headed households are too weak to protect its members from sexual abuse and other forms of abuse, exploitation, and neglect.

Children on the street: amidst rapid urbanisation and widening income inequality children on the street are becoming increasingly common. They face multiple risks that impact on their right to basic services. Inadequate availability of vocational training opportunities restricts the recovery and rehabilitation for children on the street who may not wish to return to primary or secondary schooling.

Child labour: children living in rural (12%) areas tend to work more than those in urban (5%) areas; rural boys represent 2/3 of those working.

The proportion of child-headed households is still high and stood at 1.5% in 2002/3.84 BAIS III estimates that 16.2% (111,567) of all children aged 0–17 years are orphans; with an estimated 12,303 children rendered vulnerable due to continued illness of parents/guardians. Based on the Central Statistics Office (CSO) demographic survey questionnaire of November 2006, the prevalence of vulnerable children who ‘lived in a household where there is no one gainfully employed’ was 30.6% and; 4.4% of children ‘lived in a household where there was a person who had been critically ill for at least 3 months’.

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84. CSO (2002). 2002/3 Household Income and Expenditure Survey
On the issue of child labour, the 2008 Labour Force Survey established that 9% of children aged 7–17 were engaged in economic activities (see Figure 7). The proportion of child labourers is higher in rural areas at 12.6%. The reasons for child labour vary, and relate to: children involved in economic activities because they feel duty bound to their families (63.8%); those that worked to assist their families (11.6%) and those that worked for monetary gain (11.8%).

In June 2010, the Department of Social Services was reported to have a total of 44,327 registered orphans and 36,183 registered vulnerable children.85 However, these registered numbers underestimate the larger population of the current OVC situation given the HIV prevalence, the extent of child labour and child poverty (33.2%). According to the 2008 Situation Analysis on OVC, approximately 49% of all households with OVC receive some form of assistance from Government. However, despite efforts to date, the characteristics of OVC households continue to be of concern. Data from the Situation Analysis shows an increasing number of female-headed households with OVC.86 In addition, most OVC were found to live with relatives. Most of these relatives were poor, unemployed, widowed, and had low education levels. The 2002/03 HIES found that 46% of female headed households, 41.4% of widows and 39.9% of households headed by children aged 12–15 years were poor. These estimates speak to the severity, complexity and multidimensional nature of vulnerabilities faced by OVC in Botswana.

Although their family situations and causes of vulnerability differ, OVC in Botswana face similar survival, development, participation and protection challenges. These challenges relate to limited access to health and education facilities and even greater lack of voice. Prior to the adoption of the NPA on OVC, policy and programming matters regarding orphans were guided by the Short Term Plan of Action on the Care of Orphans developed in 1999 and that of vulnerable children by the Destitute Policy of 2002. However, the destitute programme provided support primarily to children whose parents were destitute. Other categories of vulnerable children received little or no social support. The introduction of the NPA on OVC is a critical step towards realisation of the rights of OVC. To follow through with this, it is important that the operationalisation of the NPA on OVC be child sensitive, and focus on the best interest of the child.

85. The definition of a vulnerable child refers to a child below the age of 18 that falls into any of the following 6 categories: 1) lives in an abusive environment; 2) lives in a poverty-stricken family and cannot access basic services; 3) heads a household; 4) lives with a sick parent(s)/guardian; 5) is infected with HIV and; 6) lives outside family care.

86. GoB (2008), National Situation Analysis on Orphans and Vulnerable Children in Botswana.

Key points on orphans and vulnerable children

- Social protection for OVC is not a luxury but an essential part of any community development or poverty reduction approach.
- Failure to address the multidimensional needs of OVC has adverse repercussions for socioeconomic development.
- Investment in OVC is investment in future productive human capital and makes both human rights and economic sense.
- The lack of voice and dependence of OVC on adults is exacerbated by their particular circumstances, and requires comprehensive child sensitive social protection to address the psychosocial and socioeconomic needs of OVC.
**Key points on child sensitive budgeting**

- The budget process could be strengthening by (a) entrenching children’s budgeting in the budget process (both showing the impact of the budget on children, and engaging children in the budget process) and (b) promulgation of a Budget Act to provide for the publication of a pre-budget statement and monthly budget reports (also giving progress on the children’s budget)

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**Child sensitive budgeting**

‘Children are voiceless and vulnerable in public resource allocation’.87

Children’s budgeting is therefore an important aspect of improving the socio-economic well-being of children.

In Botswana, although resource allocation to basic social services has been in line with international standards, the budget preparation process has been Government-centred rather than child sensitive. The Children’s Act of 2009 alludes to the need for child sensitive budgeting, however child sensitive budgeting is not provided for in the law. Consequently, despite the adoption of child friendly laws and considerable budgetary allocations for children’s programmes, budgetary effectiveness is largely wanting as evidenced by adverse macroeconomic indicators such as poverty, child mortality, child labour etc., as discussed earlier.88 These indicators point to the budget related discrepancies that exist at both national and local government levels. In addition, because current budgeting does not adopt a life cycle approach, very young children, out of school children and those in non-formal education in particular are virtually invisible in budget allocation and expenditure.

In 2005/2006, the amount spent per student in non-formal education was P2,600, compared to primary school (P3,048 per student), secondary school (P8,007), brigades (P13,734), technical colleges (P29,350), the University of Botswana (P37,860) and teacher training and development (P52,541 per student).89
Key recommendations

The analysis on the well-being of children in Botswana in terms of survival, participation and protection, indicates that although there have been several positive developments, much remains to be done and there is a need for greater focus on child sensitive perspectives in both policy and programming.

Recommendations put forth based on the findings of the study are in three categories:

1. **A Botswana fit For children: towards MDGs and VISION 2016.**
   Key indicators of progress for both the MDGs and VISION 2016 will be the well-being of children. This will require timely availability of information and data on children in Botswana.
   - The need for evidence based research: on socio-economic matters that impact on the short term and long term well-being of children. This will support evidence-based child-sensitive policy and programming.
   - Improved child data: there is need for systematic and up to date data on the well-being of children at all ages of childhood 0–18, not just early childhood, with a focus on disparities in gender, geographic location, household wealth and other vulnerabilities. Specifically, there is need:
     - To prepare for a multiple indicator household survey to provide timely data for MDG and VISION 2016 reporting.
     - To develop and apply indicators on child participation and topics specific to OVC, including child-headed households.
     - To track progress towards malaria elimination.
     - To focus on issues of newborn care as a key driver of infant mortality.
     - To assess HIV-free survival at 18 months for HIV exposed infants.
   - Advocacy: For the National Children’s Council to mount an advocacy campaign that links the realization of VISION 2016 with the fulfilment of children’s rights in the CRC and the Children’s Act (2009).

2. **3D Service Delivery: Simultaneously address both access and quality of services, plus equity – with a special focus on vulnerable children and their families.**
   Botswana has significant achievements with regards to infrastructure and overall access to services. This needs to be consolidated with increased attention to quality of those services and to address any remaining disparities in access.
   - Improved harmonisation, coordination and implementation of child related policies and programmes: programmes in particular, should take into consideration the age-specific needs of children and specific vulnerabilities and disparities.
     - The National Children’s Council will need to be capacitated for the attainment of this.
   - Organisational capacity building for service providers who deliver services to children: there is also a need for service providers to adopt child-sensitive principles focused on the best interests of the child and a focus on those facing multiple deprivations and vulnerabilities.
     - This should include scaling-up implementation at district level of low-cost high-impact interventions addressing the major causes of childhood illnesses and deaths.
     - The report notes specific areas where quality is the key constraint, e.g.:
       - Neonatal care
       - Pre-primary, primary and secondary education
       - Infant and young child feeding
       - Family outreach on health education
     - Affected districts to be supported to address specific access constraints that still persist for, *inter alia*, out-of-school children, early childhood education, disabled children, birth registration and bednets for pregnant mothers and children under-five.
   - Increased child protection and care practices: there is need for education and improved knowledge among caregivers and the community on child protection, care and nurturing practices. In particular there is need:
     - To adopt child – and HIV– sensitive social protection approaches in meeting the protection and care needs of children, and especially for children and adolescents living with HIV or AIDS.
     - To promote parenting skills and community support for vulnerable families.
3. Public education and child participation

Public attitudes to child rights are broadly supportive, especially in regard to survival, development and protection, but remains contested in regard to discipline and child participation.

- Increased public education and advocacy on the rights of children: to survival, development, protection and participation.
  - The National Council for Children will need to develop and implement an advocacy and communication strategy.
- Increased participation of children: this should be done at all levels of society and should allow the voices of children, especially vulnerable children to be heard.
  - The Children’s Consultative Forum will need to be supported to fulfill this role to promote child participation as an effective strategy for protection of child rights.
- Opportunities to be supported at national, district and local levels for children to:
  a) engage in programme design and evaluation to improve their relevance and effectiveness and
  b) promote the civic engagement and development of the youth.
- Adoption of positive discipline practices: despite the fact that discipline is a part of a child’s development into a mature adult that is socially conscious, corporal punishment is not in the best interest of the child.
  - It is important that non-punitive methods for teaching valuable social and life skills in a manner that is respectful and encouraging for both children and adults (parents, teachers, childcare providers, youth workers, and others) are adopted. This will require advocacy and public education.

The overall finding on the situation of children in Botswana is that there have been positive developments that have improved the well-being of children. Central to this has been the adoption of the Children’s Act of 2009 which domesticates the CRC and the ACRWC. However, child survival, development, protection and participation are not at levels sufficiently in the best interest of the child. More effort should be dedicated to harmonisation and coordination of policies and programmes such that at the implementation level, services provided to meet the basic needs of children are child sensitive and are in the best interest of the child. In conclusion, increased child focused evidence based research and programme monitoring and evaluation will go a long way towards realisation of the rights of children in Botswana.
### Annex

**statistical tables**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline year</th>
<th>Total (baseline year)</th>
<th>Latest year</th>
<th>Latest national average</th>
<th>Male</th>
<th>Female</th>
<th>Urban</th>
<th>Rural</th>
<th>Age group</th>
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<td>2007</td>
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<td>Timely complementary feeding rate –%</td>
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<td>Diarrhoea treatment: ORT (ORS or RHF or increased fluids) with continued feeding –%</td>
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<td>Antibiotic treatment of suspected pneumonia –%</td>
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<td>Under-fives with fever receiving any antimalarial treatment –%</td>
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<td>Contraceptive prevalence –%</td>
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<td>Antenatal care (at least one visit) –%</td>
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<td>Skilled attendant at birth –%</td>
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<td>Institutional deliveries –%</td>
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<td>Use of improved sanitation facilities –%</td>
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<td>Correct knowledge and no misconceptions about HIV and AIDS (all five correct) –%</td>
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<td>Condom use at last sex among those with more than one sexual partner in the past year –%</td>
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<td>Sex before age 15 –%</td>
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<td>Higher-risk sex in past year –%</td>
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<td>Indicator</td>
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<td>Total (baseline year)</td>
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<td>Latest national average</td>
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<td>Female</td>
<td>Urban</td>
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<td>Secondary school net enrolment ratio – %</td>
<td>2006</td>
<td>62.2</td>
<td>56.6</td>
<td>67.8</td>
<td>Education Statistics 2006</td>
<td></td>
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</tr>
<tr>
<td>Secondary school net attendance rate – %</td>
<td>2000</td>
<td>39.5</td>
<td>35.7</td>
<td>43.6</td>
<td>MICS 2000</td>
<td></td>
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</tr>
<tr>
<td>Youth literacy rate – %</td>
<td>2003</td>
<td>94.1</td>
<td>2009</td>
<td>95.3</td>
<td>93.7</td>
<td>97.0</td>
<td>15–24 years</td>
<td><a href="http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx">http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child protection</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Birth registration – %</td>
<td>2000</td>
<td>69.2</td>
<td>2007</td>
<td>72.2</td>
<td>71.8</td>
<td>72.7</td>
<td>85.2</td>
<td>66.9</td>
<td>&lt;5 years</td>
<td>BFHS IV</td>
</tr>
<tr>
<td>Child labour – %</td>
<td>2005</td>
<td>9.0</td>
<td>10.9</td>
<td>7.0</td>
<td>5–14 years</td>
<td>BLFS 2005/2006</td>
<td></td>
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<tr>
<td>Child disability (at least one reported disability) – %</td>
<td>2001</td>
<td>1.7</td>
<td>2.0</td>
<td>3.4</td>
<td>5–9 yr</td>
<td>Census 2001, Dissemination Seminar</td>
<td></td>
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</tbody>
</table>

**Indicator trend**

- **Green**: Better
- **Pink**: Worse
- **Blue**: Static

**Key**

- **BAIS**: Botswana AIDS Impact Survey
- **BFHS**: Botswana Family Health Survey
- **BLFS**: Botswana Labour Force Survey
- **MICS**: Multiple Indicator Cluster Survey
- **NCHS**: National Centre for Health Statistics
- **UNGASS**: United Nations General Assembly Special Session
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