BOTSWANA: Millennium Development Goals
Status Report 2015
Sustaining progress to 2015 and beyond

Republic of Botswana

UNITED NATIONS
“Additional confidence can be drawn from the fact that our progress through people centred development continues to be people driven. This is reflected in Government’s continuous engagement with the public through various fora and media from dikgotla, questions from radio call - in programmes and contact centres as well as online engagement. The latter is indicative of the wider role now being played by new technologies in moving our country forward.”

H.E. Lt. Gen. Seretse Khama Ian Khama
President of the Republic of Botswana
The 2015 Millennium Development Goals Report is the third and final one since Botswana committed to the Millennium Declaration and its corresponding millennium development goals in 2000. Commendable progress Botswana made towards achieving the Millennium Development Goals over the past fifteen years was mainly due to the prudent macro-economic principles and good governance which spurred significant economic growth. Additionally the national frameworks of the Vision 2016 and the National Development Plans as well as the strong social development programmes put in place, provided the necessary guidance towards realizing the indicators we set ourselves to achieve. A combination of these made a positive contribution towards improvement of the quality of life and standard of living for our citizens in the past two decades.

I am pleased to report the significant improvements felt across the various sectors of the economy, thereby enabling us to achieve eight of the twelve MDG targets. Botswana more than halved the proportion of people living below the poverty datum line five years ahead of the target date from 47% in 1993 to 19.3% by 2010. Even more impressive is the fact that between 2003 and 2009/10, these reductions were more pronounced in rural areas than in urban areas.

Universal access to 10 years of basic education has consistently been high, around 90% throughout the period under review. The most significant achievement is that, the net enrolment rate for ages 6 to 12 years exceeded that of ages 7 to 13 years in the past five years. Progress in the elimination of gender disparity within the entire education system is reflected by the continuous increase in the number of girls per number of boys enrolled over the years. Good progress has been made in the number of women holding key decision making positions between 2002 and 2012 while on the contrary, a major reversal was observed in the proportion of seats held by women in Parliament. Gender based violence is also still prevalent, especially among women and girls.

A major breakthrough has been realised in reducing the levels of infant and child mortality by two-thirds after long periods of stagnation. Child mortality declined from 56 to 11 deaths per 1000 children in 2001 and 2011 respectively. Maternal mortality also declined from 193 in 2007 to 134 per 100 000 in 2013, thanks to the targeted interventions of the MDG Acceleration Framework employed in 2011 to 2014.

On the issue of HIV and AIDS, Botswana Government is steadfast in its commitment to achieving universal access to HIV prevention, treatment, care and support. The provision of universal access to treatment over the years, is cognisant of the human rights aspect for those infected with HIV and AIDS. However, the huge investment in this sector is unsustainable as the annual budget for HIV and AIDS related interventions continues to grow.

The country achieved the water and sanitation targets well ahead of time, which is very encouraging. However, we are yet to manage pressure exerted on our natural resources due to human activity and challenges in land use, human-wildlife conflict, wildlife poaching as well as wild fires.

| TWG | Thematic Working Groups |
| NSPR | National Strategy for Poverty Reduction |
| IMR | Infant Mortality Rate |
| ODA | Official Development Assistance |
| PMIS | Poverty Monitoring and Information System |
| PMTCT | Prevention of Mother-to-Child Transition |
| PSIA | Poverty and Social Impact Assessment |
| RADD | Remote Area Dweller Programme |
| RED | Reaching Every District |
| RNPE | Revised National Policy on Education |
| RIA | Regulatory Impact Assessment |
| SRH | Sexual Reproductive Health |
| TIMSS | International Mathematics and Science Study |
| USMR | Under-5 Mortality Rate |
| UNFCCC | United Nations Framework Convention on Climate Change |
| WASH | Water Sanitation and Hygiene |
| YDF | Youth Development Fund |
| YFF | Young Farmers Fund |
The 2008/09 financial and economic crunch saw the Government budget drift from a surplus to deficit position with the ratio of Government debt to GDP escalating from 10% in 2008 to slightly above 30% in 2012. This necessitated initiatives to strengthen domestic resource mobilisation efforts and cost-sharing measures, intensify private sector participation in the economy as well as foreign direct investment.

Going forward, the challenges that face Botswana revolve around ensuring the provision of quality education and skills to match the demands in the job market. Whilst Government produced graduates with various skills mix, the test lies in the creation of employment opportunities and ending the prevalent income inequality.

Lessons learnt from the millennium development goals provide an opportunity for Government to increase investments in the provision of high quality education and health services as well as the water and energy sectors. The long-term benefits of this investment are the production of a healthy and educated workforce, likely to spur future economic growth and development as well as eradicate poverty in all its forms.

The fact that this year’s report underscored the disaggregation of data at district level vis a vis the national aggregates and averages in measuring progress, accorded our Government an opportunity to take steps towards localizing the current MDGs and the envisaged sustainable development goals (SDGs) at district level. This approach will go a long way towards enhancing evidence-based planning for the communities.

Finally, I wish to sincerely thank all our stakeholders for their continued and invaluable support in the journey to realize the MDGs. My gratitude also goes to our Development Partners for their continued support to the development agenda of the Republic of Botswana as we look up to the new global framework. I am hopeful that we will continue to dialogue as we strive to overcome the MDG unfinished business as well as capitalize on the synergies that may exist between the three pillars of economy, social development and environment which are pivotal to achieving sustainable development for our present and generations to come.

O.K. Matambo
Minister of Finance & Development Planning
This Botswana Millennium Development Goals (MDG) report has a special significance. It is the last for Botswana before the curtain falls on the MDGs and the world welcomes the Post-2015 development agenda. The story of how far humanity has progressed between 1990 and 2014 has been told many times. It is a story of many successes but also some failures. But the narrative has two constant features: (i) the MDGs have taken humanity further than would otherwise have been the case; and (ii) collective action - local, national and global – has delivered tangible results for the world’s poor people and developing nations.

By 2010, global poverty had been halved, five years ahead of schedule. More than 90% of children in developing countries now have access to primary education and everywhere, the access gap between the girl child and the boy child is disappearing; health indicators – on malaria, tuberculosis, HIV/AIDS and other diseases are improving; an additional 2.3 billion people have access to safe drinking water; two billion more have access to sanitation.

As the 2013 Human Development Report notes, the developing world is experiencing progress that is unprecedented both in speed and scale, with dozens of countries and billions of people moving up the human development ladder.

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The development aspirations of Batswana go well beyond lifting everybody above the poverty line. In fact they go further than subsistence at just above the poverty line, or even further than subsistence at just above the poverty line, or even so. So, with just a little over a year left before the end of the MDGs, Botswana has a good MDG story to tell. But even so, the work is far from finished specifically on MDG 4 and 5.

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Second, development policies and strategies must seek true sustainable human development, which requires achieving economic, environmental and social sustainability. There is growing evidence, including violent conflict, that economic and social inequities imperil development, so sustainable development requires socially, economically and environmentally sustainable approaches to development.

Third, the economy must be transformed to achieve inclusive growth, create jobs, reduce poverty, diversify and build resilience to shocks. This shift envisages profound transformation to expand opportunities, improve livelihoods and end extreme poverty. It will not happen without bold and innovative policy and strategy responses that are followed through with implementation.

Fourth, there is need to build effective, open and accountable institutions. Human development thrives in an environment of peace, rule of law, transparency and accountability.

Finally, the future requires countries to forge viable partnerships for development. Global cooperation is still a priority but there is much that a country such as Botswana could do to create additional momentum for development. The High Level Panel on the Post 2015 development agenda, convincingly makes the case that empowered local government and local economic development are critical for the transformation of economies for jobs and stronger and more secure livelihoods. Civil society is another development partner that could contribute significantly to economic and social transformation. Botswana’s ongoing work on a decentralization and local economic development is thus encouraging. Empowered local government and strong civil society can help accelerate development.

As the United Nations we welcome Botswana’s 2014 MDG report and celebrate the good progress reported. At the same time, we look forward to the Post 2015 development agenda and urge Botswana to pursue it as strongly as it has pursued the MDGs. There is still work to be done and opportunities to be seized. Together I am confident we will be able to unleash Botswana’s full potential.

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Anders Pedersen
United Nations Resident Representative
EXECUTIVE SUMMARY

Botswana has made much progress towards achieving the MDGs. A combination of strong social programmes and supported production activities has had a direct positive bearing on the welfare of the citizens. Ongoing substantial investment in social and physical infrastructure has provided a strong basis for the improvement in both welfare and social development programmes. Below is a summary of achievements attained in each goal.

MDG 1: Eradicate Extreme Poverty and Hunger. Whereas 47% of the population lived below the Poverty Datum Line in 1993, this variable had declined to 30.6% in 2003. It had further decreased to 19.3% by 2010. Taking 1993 as a base for comparison, Botswana had surpassed the global target of halving the proportion living below the poverty datum line before 2010. With ongoing aggressive abject poverty eradication projects driven by His Excellency the President, the figure will most likely decrease further prior to and beyond 2015. More reassuring is the fact that available data from the Botswana Core Welfare Indicators Survey of 2009/10 shows that rural areas experienced more pronounced poverty alleviation than urban areas in the period between 2003 and 2009/10.

On hunger and malnutrition, national trends show that in 1998 20% of children under the age of 5 years were underweight. This figure fell to 7.1% in 2003 and to 4.6% in 2007. It further went down to 3.5% in 2012. These results show that Botswana has achieved MDG 1.

The above achievement notwithstanding, Botswana still faces the challenge of not having a Poverty Monitoring and Information System (PMIS) to make possible evidence-based policy development, implementation and monitoring. Furthermore, the absence of a Regulatory Impact Assessment (RIA) or Poverty and Social Impact Assessment (PSIA) has hampered policy development, implementation and monitoring. Furthermore, the absence of a Regulatory Impact Assessment (RIA) or Poverty and Social Impact Assessment (PSIA) has resulted in poverty programmes that are not well integrated into other macro-economic policies.

MDG 2: Achieve Universal Primary Education. After experiencing an initial decrease in enrolment figures both in absolute terms and in net enrolment rates, the Primary education sector has seen a positive reversal. A total of 330 000 primary school children were enrolled in 2003. This figure had decreased to 327 000 children by 2008. However, the number went up to 337 206 in 2012. The corresponding net enrolment figures were a decrease from 90% in 2003 to 85% in 2008 and an increase to 93.1% in 2012. The most significant achievement in respect of this MDG was that between 2010 and 2011, when the net enrolment rate for ages 6 to 12 years-exceeded the NER for ages 7 to 13. This was due to the fact more parents were now enrolling their children for grade 1 at age 6 and not 7 as was previously the case. This must be seen as a positive move towards the achievement of universal primary education. A decrease in primary school dropout rates from 1.5% in 2003 to 1% in 2012 also signifies the progress that Botswana has made towards the achievement of this MDG. Of policy interest is the fact dropout rates are highest for standard 1 and that generally more boys than girls drop out at primary school level. Furthermore, regional data analysis reveals that dropout rates for Gantsi District stand at 4% against a national average of 1%.

Education remains the recipient of the largest share of Government budget, and positive trends towards universal access are likely to continue, such that Botswana would have achieved this MDG by 2015. The trend shows the country will be able to sustain the achievement beyond 2015.

While the teacher-student ratio has continuously decreased - from 29:1 in 2003 to reach 24:1 in 2012, Botswana is still faced with the challenge of matching the volume of investment into the sector with the quality of education that results from it.

MDG 3: Promote Gender Equality and Empower Women. Available data indicates that during the period 2006 to 2009 primary school enrolment was more biased towards boys than girls. In 2006, for every 100 boys enrolled there were 96 girls. This trended downwards to 95 in 2009. Further positive reversal occurred during the period 2010 -2012 when the figure increased to 95.3 in the first year, then 95.6 and 95.7 in 2011 and 2012 respectively. The continuous increase in the number of girls enrolled indicates elimination of gender disparity in primary school enrolment. Time series data sets have also shown that for the whole population, females are more literate than males. This is more pronounced in rural than in urban areas. Botswana has thus succeeded in eliminating gender disparity in respect of education.

Women have however not fared well in key decision-making positions. Whereas 27% of cabinet positions were held by women in 2002, this figure plummeted to 17% in 2012. Similarly -women occupied 18.2% of parliamentary seats in 2002, but their representation had dwindled to only 7% in 2012. For the private sector the figure decreased from 27% to 21% during the same period. A similar trend was observed for Non-Governmental Organisations where women representation drifted from 48% to 46%. However the Civil Service sector registered positive trends as the number of women in key decision-making positions went up from 28% in 2002 to 42% in 2012. Women have also been disadvantaged in the ownership of assets, particularly agricultural properties. For example, in 2003, for every 100 men who owned land, there were 64 women. The figure stood at 100 men to 39 women for cattle ownership. Gender-based violence is yet another area where women have been disadvantaged. While cases are grossly under-reported, police records showed at one stage, gender-based violence increasing by 65% in three years.

A major breakthrough has, however, been achieved by way of changes in government policy and legislation. The most significant was the Abolition of Marital Power Act of 2004. The new Act brought parity between husbands and wives in the management of their joint estate. Government has also significantly reduced the period during which girls who leave school on account of pregnancy, can return to school, from two years to six months.

While mixed results emerge in respect of the promotion of gender equality and empowerment of women, a strong environment for change exists and thus more change is likely to occur by 2015 or shortly thereafter. The challenge that remains, however, is that gender issues are very strongly linked to economic factors. Women who experience gender-based violence are in most cases dependent on their abusers. There is as such a direct link between poverty and gender-based violence. This explains the few reports of gender-based violence incidents. Needless to say, this limits the assembling of robust data sets...
that can be used for policy programming. Another challenge is that even though effort has been made to improve the situation, counteractive cultural dimensions remain strong and militate against this change.

MDG 4: Reduce Child Mortality. Actual data on both infant mortality and Under Five Mortality Rates (U5MR) is difficult to find, as such the analysis in this report was based on estimates. The emerging picture is that the estimated IMR and U5MR remained above the targeted levels at one stage. Whereas the USMR target for 2001 was 45.5 per 1000 live births, the estimated rate for the same year was 74 deaths per 1000 live births. The 2011 Census data however, shows a drastic decrease for both IMR and U5MR at 17 and 28 deaths per live births respectively. The turnaround is attributable to the positive impact of the Government Anti-retroviral Therapy (ART) and Prevention of Mother-to-Child Transmission of HIV (PMTCT) programmes.

There are, however, a number of challenges that work against the achievement of this MDG target. HIV and AIDS continues to be a major health and social problem with significant financial and other resource implications. Furthermore, notwithstanding the success of the PMTCT programme, there are mortality related issues that arise from the quality of care given to newly born babies. The risks that arise from unhygienic handling and improper preparation of formula milk for babies may be high. This is particularly so because baby-minders are not always those trained on how to handle milk — which is normally done by clinics. Another challenge is timely provision of health services and care in remote areas, particularly those with difficult terrain. The poverty status of residents of such places also makes it difficult for them to access, and where necessary, wait for medical services in central locations.

MDG 5: Improve Maternal Health. The period 1990 to 2005 witnessed a sharp decrease in maternal mortality rate (MMR) of about 60% as the number of deaths dropped from 326 to 135 deaths per 100,000 live births. However, a reversal occurred beginning 2006 such when MMR - reached 163/100 000 live births in 2011. The current levels and trends of MMR suggest Botswana may not be able to meet the Global target of 82/100 000 by 2015. According to the Botswana MDG Acceleration Compact Report, a significant proportion of maternal deaths is due to delayed referral decisions that end up leading to loss of life. Secondly, some deaths arise from sub-standard care which manifests itself in the form of, “misdiagnosis, mismanagement and poor monitoring.” The solution to the maternal mortality problem thus lies more in the improvement of systems and human resource capacity building than in the provision of more infrastructure.

Other challenges to this problem are that while Government has developed a robust health infrastructure, remote area dwellers (RADs) remain hard to reach due to logistical constraints and harsh terrain. Furthermore, unsafe and/or unsupervised abortions are increasing in Botswana and this leads to greater maternal mortality. Another challenge is that the interplay between cultural practices and modern medicine has not been fully researched and remains unknown. As such its effect on this MDG is not well known.

Going forward, Botswana will have to pay particular attention to and review its maternal health system with a view to improving its efficacy towards, during and post 2015. The synergies between this MDG with other MDGs, particularly MDG 6, will have to be investigated and programmed for. The same should happen with regard to the interaction between the modern health system and cultural practices.

MDG 6: Combat HIV and AIDS, Malaria and other diseases: Botswana has made significant strides in reversing and reducing the spread of HIV and AIDs. HIV prevalence rate for the rate hovered between 30-40% in the 1990s. It had slowed down to 3.3% in 3011 years - from 37.4 % in 2003 to 30.4% in 2011. At the same time the prevalence rates for younger female cohorts decreased from 28.6% in 1999 to 10% for the 15-19 year olds, and from 42.9% to 19% for the 20 - 24 year olds. This implies a decrease in new infections in these age groups.

The PMTCT programme, launched in 2002, had a strong uptake which resulted in great success in the reduction of HIV positive children born to infected mothers. Whereas the rate hovered between 30-40% in the 1990s, it had slowed down to 3.3% in 2011 years - from 37.4 % in 2003 to 30.4% in 2011. At the same time the prevalence rates for younger female cohorts decreased from 28.6% in 1999 to 10% for the 15-19 year olds, and from 42.9% to 19% for the 20 - 24 year olds. This implies a decrease in new infections in these age groups.

On malaria, the annual unconfirmed cases declined from 71,555 in 2000 to 115 in 2012 representing a 99.8% decline. Confirmed malaria cases dropped from 8,056 to 193 cases, which is a 97.6% decline. Deaths attributed to malaria declined from 35 in 2000 to only 3 in 2012, a 91.4% decline over a ten year period. Botswana has clearly achieved its set target. As stated in the 2010 MDGs Status report. Botswana has suffered serious setbacks in its battle against TB on account of HIV and AIDS. The country recorded very high TB and HIV co-infection, reported at 63% in 2011. Treatment outcomes still lag behind global achievements. In 2011, treatment success was 81.5 % against a global achievement rate of 85%.

MDG 7: Ensure Environmental Sustainability. The 2004 MDGs Status Report adjudged Botswana as firmly on course to achieving universal access to safe drinking water. The 2010 Status Report reaffirmed this position but went on to acknowledge Botswana’s deliberate policy and strategy action that had enabled the country to meet its water and sanitation targets well ahead of schedule. About 83.3% of the population had access to piped water system (indoor, outdoor and communal) by 1993/94. By 2010 the majority (88.9%) of the population had access to any of the three supply systems.

Much human activity has led to a lot of pressure on natural resources. This has resulted in changes to the environment and loss of biodiversity. Areas of concern in Botswana include human-wildlife conflict, wildlife poaching incidents, widespread wildfires and changes in land use. Such human activity affects biodiversity – from large ungulates and globally threatened wildlife to birds and fish. It also reduces the quality of the land resource.
MDG 8. Development of Global Partnerships. In the period following 2008 Botswana’s exports have significantly been exceeded by imports. The Government budget drifted from a surplus position to a deficit. Similarly, the ratio of Government debt to GDP shot from 10% in 2008 to slightly above 30% in 2012. It has emerged that the mining sector does not only dominate exports but also draws the biggest share of FDI at 78.8%. The Government is therefore no longer a dominant player in the economic growth of the country, and there is an urgent need for private sector participation through both domestic and foreign direct investment. Given the fact that Botswana has so far successfully met most targets of the MDGs because of the strength of the government budget, sustainability of the achievement has become suspect as the government experiences more budget deficits, and its debt mounts.

IN CONCLUSION

Innovative policies, strategies and political goodwill have ensured Botswana’s success so far in its achievement of MDGs targets. However, attention should be paid to the following areas in the country’s post 2015 development agenda.

1) Private sector participation and sustainability of MDGs achievements: With the Government experiencing more budget deficits and the national debt growing, a shift from government budget-driven economic growth to private sector driven growth becomes inevitable. If not properly managed, this switch might result in de-emphasis of the MDGs and reversal of achievements so far made. A paradigm shift that will ensure increased private sector participation is achieved concurrently with the MDGs, is therefore necessary. The Inclusive Economic Growth model has been suggested for inclusion in the post 2015 agenda. The model allows for private sector participation in growing the economy of the country while at the same time paying attention to socio-economic dimensions such as those included under the MDGs.

2) Appreciating the interconnectedness of MDGs: Even though Botswana has achieved most of these goals, little attention has been paid to the interconnectedness of the MDGs. For example, the interrelation between poverty alleviation and environmental sustainability has not been directly addressed in Botswana, and there is no policy programming for it. Similarly, the relationship between MDGs 4,5 and 6 is not clearly known although failures in MDGs 4 and 5 are suspected to arise from MDG 6. Appreciating and addressing these interrelations would allow for estimation of achievement of MDGs and its net effect on the society.

3) Understanding the effects of global warming: The NDP 10 Mid-term Review suggests “low level of awareness in respect of the causes and impacts of climate change on ecosystems, human health, welfare and economy”. Botswana will need to have certain components of its post-2015 agenda designed to mount an awareness campaign of the same magnitude as that for HIV and AIDS prevention, to ensure the general public and private sector understand the effects of their collective activity on the climate.

4) Addressing disparity Gaps: Achievements may seem to occur at a national level while results at regional and individual levels do not reflect that success. Failure to mainstream such disparities can conceal key policy needs that may require programming. For example, to say a country is achieving poverty alleviation when there is a huge rural-urban disparity can mislead policy formulation. Policy programming will thus address all possible disparities that may occur in the post-2015 agenda.
THE MILLENNIUM DEVELOPMENT GOALS AND TARGETS: AN OVERVIEW

INTRODUCTION

The 1990s witnessed an intense conference process that discussed Human Development. The conference process culminated in the United Nations’ 189 countries adopting the Millennium Declaration and its eight chapters and key objectives. The Declaration called for the observance of international human rights law, and international humanitarian law under the Principles of United Nations Charter, as well as the treaties on sustainable development. It espoused Freedom, Equality, Solidarity, Tolerance, and Respect for nature through management of all living species and natural resources, “in accordance with the precepts of sustainable development.” The countries would work together towards Peace, Security and Disarmament; Development and Poverty Eradication; Protecting our Common Environment; Human Rights; Democracy and Good Governance; Protecting the Vulnerable; Meeting the Special Needs of Africa and Strengthening the United Nations.

Following adoption of the Millennium Declaration the UN set up a roadmap that articulated eight time-bound development goals in 2000. The goals sought to address poverty, education, gender equality, health and the environment. Countries were expected to have met each target by 2015. This roadmap came to be known as the Millennium Development Goals (MDGs). All 189 UN members, which included Botswana, committed to achieving the goals by 2015. These interconnected, mutually reinforcing goals constituted a global agenda that consisted of the following:

Goal 1: Eradicate Poverty and hunger
Goal 2: Achieve Universal primary education
Goal 3: Promote gender equality and empower women
Goal 4: Reduce child mortality
Goal 5: Improve maternal health
Goal 6: Combat HIV and AIDS, malaria and other diseases
Goal 7: Ensure Environmental sustainability
Goal 8: Develop a global partnership for development

A robust monitoring and evaluation framework was put in place to determine progress made toward the achievement of these MDGs. The production of interim status reports, such as this one, became an integral aspect of the monitoring and evaluation process.

THE MDG PROCESS IN BOTSWANA

Reporting on progress made towards the achievement of MDGs is one of the major obligations of the signatories to the Millennium Declaration. In addition, the membership is expected to keep these targets and goals at the forefront of their development agenda. Expectation therefore is that a broad based ownership of these targets and goals is engendered through broad participation at decision-making level. That way, the process does not become government-dominated but involves other actors in the private sector, civil society and development partners. The declaration also gives member states the latitude to adapt the goals to their local situation by setting national targets, in addition to the MDGs. Botswana has not only embraced the MDGs but has successfully adapted them to its local situation as captured in the following sections.

The country’s commitment to the MDG process is demonstrated by the way it has factored goal principles in its policy formulation process. For example, in its 2012 Mid-term Review of the National Development Plan (NDP) 10, Botswana’s policy and strategy for development comprised four thematic working areas (TWAs) that were in tandem with the MDGs. These MDG-specific TWAs were Economy and Employment; Social Uplift and Sustainable Environment. Further testimony to Botswana’s commitment to the MDGs framework is the country’s current drive to eradicate abject poverty. The effort is championed by the President. Government has also introduced strong social support programmes and designed complimentary production support schemes to ensure gains in poverty eradication are sustained. Botswana has also demonstrated its commitment to the MDGs through its regular production of MDGs status reports as part of the monitoring and evaluation framework. The country was among the first to produce and submit an MDGs Status Report in 2004. It produced its second status report in 2010. This is its third report. Furthermore, to ensure compliance to the MDGs framework, Botswana has followed an inclusive and participatory approach, which embraces government organs, the private sector, civil society and Development partners when preparing all status reports. For example, the preparation of this report, as was the case with the previous ones, was driven by Thematic Working Groups (TWG) drawn from a category of participants in the areas of Education and Gender; Health; Sustainable Development; Poverty, Economy and Global Collaboration. These groups actively participated in the provision of data, guided the drafting process of the report and, more importantly, validated data used and issues raised from the data set.
Millennium Goals Status at a Glance

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<th>GOALS</th>
<th>TARGET</th>
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<td>1. Halve between 1990 and 2015 the proportion of people living on less than $1 a day</td>
<td>Proportion of people below $1 a day per day</td>
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<td>2. Halve between 1990 and 2015 the proportion of people who suffer from hunger</td>
<td>Proportion of people below national poverty line</td>
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<td>5. Reduce maternal mortality and child mortality</td>
<td>Prevalence of underweight children under 5-years of age</td>
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<td>4.6</td>
<td>4.6</td>
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<tr>
<td>2. Achieve Universal Primary Education</td>
<td>3. Ensure that by 2015 everywhere, boys and girls alike, will be able to compete for a full course of primary schooling</td>
<td>Net enrolment rate for primary school (6-12 years)</td>
<td>88.0</td>
<td>90.0</td>
<td>86.9</td>
<td>89.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of pupils starting std. 1 who reach last grade of primary school</td>
<td>76.0</td>
<td>86.9</td>
<td>86.9</td>
<td>88.4</td>
</tr>
<tr>
<td></td>
<td>4. Reduce by two-thirds between 1990 and 2015 the under-five mortality</td>
<td>Literacy rate of 15-24 year olds, women and men</td>
<td>89.0</td>
<td>93.7</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio of boys to girls in primary school</td>
<td>100</td>
<td>98.0</td>
<td>96.0</td>
<td>95.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio of boys to girls in secondary school</td>
<td>...</td>
<td>108</td>
<td>106</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio of boys to girls in tertiary education</td>
<td>...</td>
<td>84.0</td>
<td>100</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>3. Promote Gender equality and empower women</td>
<td>Share of women in wage employment in non-agricultural sector</td>
<td>34.0</td>
<td>40.0</td>
<td>43.4</td>
<td>43.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of seats held by women in national parliament</td>
<td>5.0</td>
<td>11.0</td>
<td>11.0</td>
<td>7.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ratio of literate females to males of 15-24 years old</td>
<td>...</td>
<td>...</td>
<td>1.2</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>4. Reduce Child Mortality</td>
<td>Under 5 mortality rate</td>
<td>57</td>
<td>76.0</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infant mortality rate per 1000 births</td>
<td>48</td>
<td>57.0</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Improve maternal health</td>
<td>Proportion of 1 year old children immunised against measles</td>
<td>45.0</td>
<td>...</td>
<td>90.0</td>
<td>94.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Proportion of births attended by skilled health personnel</td>
<td>77</td>
<td>96.1</td>
<td>94.6</td>
<td>99.1</td>
</tr>
<tr>
<td></td>
<td>6. Reduce by three quarters the maternal mortality ratio</td>
<td>Maternal mortality (100,000)</td>
<td>326</td>
<td>193</td>
<td>186.9</td>
<td></td>
</tr>
</tbody>
</table>

Synergy Between MDGs and Vision 2016

Botswana’s own Vision 2016 strategy, has facilitated the country’s easy fit into the MDGs framework. The country undertook an independent and widespread stakeholder consultation, at the time the global discourse on Human Development was gaining momentum. The outcome of this process was Vision 2016 whose overarching objective was to work “Towards Prosperity for all”. It was launched in 1997 - three years before the Millennium Declaration. The vision’s agenda turned out to be very much complementary and mutually reinforcing with the MDGs. Each Vision 2016 pillar comprises different Key Result Areas (KRAs) and Key Performance Indicators (KPI) for each KRA. The MDGs on the other hand initially started with 18 targets and 48 indicators and 8 goals.
These are all to be achieved by the year 2015. The overlap and areas of synergy between the seven Vision 2016 pillars and the eight MDGs can be illustrated by positioning specific Vision 2016 KPAs under specific MDGs as shown in the table below.

<table>
<thead>
<tr>
<th>MILLENNIUM DEVELOPMENT GOAL</th>
<th>RELATED VISION 2016 PILLARS</th>
<th>RELATED VISION 2016 KPAS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eradicate Extreme Poverty &amp; Hunger</td>
<td>Prosperous, Productive and Innovative Nation</td>
<td>Economic Growth and Diversification</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainable Development</td>
</tr>
<tr>
<td></td>
<td>Compassionate, Just &amp; Caring Nation</td>
<td>Poverty &amp; Income Distribution</td>
</tr>
<tr>
<td></td>
<td>Moral &amp; Tolerant Nation</td>
<td>Discrimination-free Society</td>
</tr>
<tr>
<td>Achieve Universal Primary Education</td>
<td>Educated, Informed Nation</td>
<td>Universal, Continuing and Quality Education</td>
</tr>
<tr>
<td></td>
<td>An Informed society</td>
<td></td>
</tr>
<tr>
<td>Promote Gender Equality &amp; Empower women</td>
<td>A Safe and Secure Nation</td>
<td>Crime, Safety and Security</td>
</tr>
<tr>
<td></td>
<td>A Moral and Tolerant Nation</td>
<td>Discrimination free society</td>
</tr>
<tr>
<td></td>
<td>United and Proud Nation</td>
<td>The Institution of the Family</td>
</tr>
<tr>
<td>Reduce Child Mortality</td>
<td>Compassionate, Just &amp; Caring Nation</td>
<td>Quantity &amp; Quality of Health Services</td>
</tr>
<tr>
<td>Improve Maternal Health</td>
<td>Compassionate, Just &amp; Caring Nation</td>
<td>Quantity &amp; Quality of Health Services</td>
</tr>
<tr>
<td>Combat HIV and AIDS, Malaria and other Diseases</td>
<td>Compassionate, Just &amp; Caring Nation</td>
<td>Quantity &amp; Quality of Health Services</td>
</tr>
<tr>
<td></td>
<td>Combating HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td>Ensure Environmental Sustainability</td>
<td>Prosperous, Productive and Innovative Nation</td>
<td>Economic Growth and Diversification</td>
</tr>
<tr>
<td></td>
<td>Sustainable Development</td>
<td></td>
</tr>
<tr>
<td>Develop Global Partnerships for Development</td>
<td>Prosperous, Productive and Innovative Nation</td>
<td>Economic Growth and Diversification</td>
</tr>
<tr>
<td></td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Educated, Informed Nation</td>
<td>An IT Literate Society</td>
</tr>
</tbody>
</table>

BOTSWANA’S MDGS PROGRESS VIS-À-VIS GLOBAL PERFORMANCE

As the year 2015 approaches, it is imperative to assess the extent to which the comprehensive agenda on human development that the United Nations family set for itself has been achieved. There is need to identify those areas where significant progress has been made or is being made so these successes can become lessons. Those areas in which progress has only been moderate also need to be identified so that strategies for their accelerated implementation can be drawn to ensure that success is achieved by 2015. Greater work will need to be done on areas that lag behind. Overall, all this assessment critically feeds into the design of the post 2015 agenda.

Therefore, before a detailed outline of Botswana’s performance is given, it is necessary to give a brief comparison of Botswana’s performance relative to the global performance on MDGs as reported in the United Nations’ Millennium Development Goals Report (2013).

According to the Report, poverty alleviation is one of the targets that have already been achieved as the proportion of people living in extreme poverty has been halved globally. The fraction of people living below $1.25/day fell from 47% in 1990 to 20% by 2010. Botswana compares well. Its Household Poverty incidence declined from 47 % in 1993/94 to 17.9 % in 2009/2010.

Improved access to better sources of drinking water is one of those targets that have been satisfactorily achieved at a global level. The proportion of people with access to improved sources of good drinking water increased from 76% in 1990 to 89% in 2010. Botswana’s access to piped water increased from 83.3% in 1993/94 to 89% in 2010, indicating the country’s ability to meet the globally set goals.

Global achievement has also been made in the fight against Malaria and Tuberculosis. Malaria related mortality decreased by 25% between 2000 and 2010. Botswana fared well in this area too. The country registered a 99.8% decline in annual unconfirmed malaria cases - from 71,555 in 2000 to 115 in 2012. Confirmed malaria cases dropped from 8,056 to 193, which is a 97.6% decline during the same period. Deaths attributed to malaria declined from 35 in 2000 to 3 in 2012, representing a 91.4% decline over the period. Malaria incidence in Botswana declined from 42.57 cases per 1000 population in 2000 to 0.15 cases per 1000 population in 2012.

The same MDGs Report for 2013 estimates that globally, deaths from tuberculosis would be halved by 2015. Sadly the record shows that due to increased prevalence of Multi Drug Resistance (MDR) TB, Botswana’s situation has actually worsened and accelerated interventions are necessary.

The world still lags behind in achieving the Environmental Sustainability goal. Carbon emissions are estimated to be 46% higher than 1990 levels and there has also been an increase in the over-exploitation of natural resources and wholesale destruction of wild animals and fauna. Of late Botswana has experienced increased poaching of wild animals, widespread wildfires and increased over-mining of river sand, which compromises the health of the rivers and the environment in general. In response to this, the country has had to come up with environmental plans that seek to address the situation. The plans include rehabilitation of wild animals, restocking programmes for species at risk of extinction and a solid anti-poaching programme. The country has also imposed a moratorium on sand mining in some heavily mined rivers and is encouraging the use of finely crushed stones as a sand substitute. The country has so far planted 400 000 trees out of a target of 650 000.

The UN 2013 MDG Report states that while big gains have been made globally in child survival, more work still needs to be done with regards to Infant Mortality. This is because the global community has only been able to bring down infant mortality from 87 deaths per 1 000 live births in 1990 to the current 51 deaths in 1 000 births, which is a 41% decrease. The reduction still falls short of the 57% target. Coming closer home, Botswana initially experienced a reversal where infant mortality decreased from 56 deaths per 1 000 live births...
to 50 per 1000 in 1997, before it rose to 76 per 1000 in 2007. It then drastically decreased to 17 deaths per 1000 live births in 2011. Similarly, the country’s under five mortality rate decreased from 40 per 1000 in 1992 to 36 per 1000 in 1997. It went up to 57 per 1000 in 2007, before lowering to 28 deaths per 1000 live births in 2011.

A similar pattern as in the infant mortality case can be observed with maternal mortality. Globally maternal mortality declined by 47% from 400 maternal deaths per 100 000 live births in 1990 to 210 per 100 000 in 2011. This fell short of the 75% decline global target or 100 per 100 000 per live births. For Botswana, not only has the target been missed but, a major reversal also occurred. Initially, maternal mortality decreased from 326 maternal deaths per 100 000 live births to 135 per 100 000 live births in 2006 only to rise sharply to 196 deaths per 100 000 in 2009. A slight decline - 189 per 100 000 - occurred in 2012.

While the UN 2013 MDG Report states that the target for universal access to antiretroviral therapy has been missed at the global level, Botswana achieved near universal access at 96% in 2011.

Despite the fact that at the global level, too many children have been denied access to primary education, Botswana has made great strides towards this target. The report states that while the number of out-of-school children declined by half from 110 million between 2000 and 2010 Botswana recorded an enrolment of 99.5 % in 2012. The country has experienced high positive increases in total enrolment and transition rates, and decreases in dropout rates.

Another area of achievement has been improved sanitation. Botswana achieved the global target as early as 2007, with 79% of the population having improved access to sanitation. The country is well poised to achieve its more ambitious goal of universal access to improved sanitation by 2016.

Globally there has been some success in the reduction of debt and improved climate for trade. The ratio of debt service to export revenue for most developing countries decreased from 12% in 2000 to 3.1% in 2011, and duty free market access increased to 80% in 2011. However, for Botswana, the debt burden has increased from around 5% of the GDP in 1990 to about 35% in 2012.

Regarding Official Development Assistance (ODA) there has been, at a global level, a 4% decrease in real terms, with this decrease affecting developing countries more. Botswana experienced phenomenal decrease in Official ODA between 2000 and 2012 following its reclassification as a Middle Income Country. In 2000 Botswana’s ODA stood at only 3% of the Government budget.

CROSS CUTTING MDGS ISSUES

At global level, experience has been that urban centres have fared better than rural areas in meeting MDGs. For example gender inequality has dominated the global experience. Even where MDGs have been met, gender inequality has remained an issue of concern. Another obvious inequality is that it is children from poor background who dominate the out-of-school group. This militates against strategies for empowering children of the poor through education.

Coming closer home, poverty surveys have shown that while poverty remains relatively high in rural areas, rates have declined faster in rural areas than in urban villages and cities. On gender based inequalities in decision making, the trend is that males are still dominant in decision-making than females. However there have been notable improvements in the civil society group with the public sector doing relatively better than the private sector. There is no clear evidence that children from rich backgrounds have better access to education than those of the poor. This is primarily due to the fact government has invested heavily in the education infrastructure to ensure children of the poor have access to education too. That notwithstanding, the absence of a well-established pre-school system has allowed pre-school attendance to only those children whose parents can afford to pay private school fees. However the government is currently working on a pilot pre-entry school project that seeks to address this inequity.

In conclusion, Botswana’s performance record in the achievement of MDGs compares well with the global picture. This achievement is attributable to the mutually reinforcing nature of the national vision 2016 objectives with the MDGs framework. The commitment to poverty alleviation by the country’s political leadership has also significantly contributed to this success. This has taken the form of direct provision of resources as well as the mainstreaming of MDGs ideals in policy formulation and national programme implementation.

ORGANISATION OF THIS REPORT

The report highlights the major policy priorities for Botswana and the actual challenges the country faces in implementing the policies. Some data from the 2004 and 2010 MDGs Status reports are used to supplement the new data from surveys that were not available at the time the earlier reports were prepared. The report also aims to identify potential issues that can be considered for inclusion in the post-2015 agenda. In addition to monitoring progress, the report shall serve as a tool for advocacy, awareness raising, alliance building and renewal of political commitment at country level. It summarises the development context, the policy environment and national priorities as well as mechanism for monitoring progress.

ASSESSMENT OF MONITORING ENVIRONMENT

For each concluding section of the goals, an assessment of the monitoring environment is given and the following criteria applied:

- Data gathering capacity is rated ‘strong’ if there is capacity for periodic and regular collection of data with respect to a particular MDG.
- Statistical tracking capacity is rated ‘strong’ if a relatively strong mechanism is in place to capture and analyse information.
- Capacity to incorporate statistical analyses into policy formulation is rated ‘strong’ if new information and data analysis are systematically fed into policy making and planning.
- Monitoring and evaluation is rated ‘strong’ if a systematic information-based review and planning process is an integral part of programming.
GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

In efforts to eradicate extreme poverty the Government wholly subsidises subsistence farmers like this one with seeds, fertilisers and farming implements. Farmers are also paid for using their own animals or tractors to plough their land and that of other people.

1.0 INTRODUCTION

When the 2004 MDGs Status Report assessed the extent to which these targets had been met, it concluded that the population living below the poverty datum line had decreased from 47% in 1993 to 36% in 2002. The report stated that poverty rates were highest in rural areas. It was concluded that poverty in Botswana had a moderate gender bias. The decrease in under-five malnutrition from 14% in 1991 to 6.5% in 2002 was used as a proxy for measuring hunger and malnutrition, and it was concluded that Botswana had made good progress against this target. This progress was attributed to Government-sponsored welfare programmes, as well as the existence of an effective national food security policy that ensured the physical availability of food.

The next Botswana MDGs Status Report, which was in 2010 concluded that the country met the Global target of halving the proportion of the population living on less than US$1.25 a day in 2007. It however expressed doubt as to whether the country was on track to achieve the target of getting “zero Batswana living below the poverty datum line by 2016”. That notwithstanding, the report acknowledged “the hunger target was achievable given Botswana’s strong social protection initiatives”.

In line with its predecessor reports in what follows below, the Botswana 2013 Status Report seeks to establish how Botswana has performed in terms of its poverty and hunger eradication targets.

1.1 CURRENT SITUATION AND TRENDS

<table>
<thead>
<tr>
<th>GLOBAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halve, between 1990 and 2015, the proportion of people whose income is less than US$1.25 a day</td>
<td>Has been met</td>
<td>No persons living below the income poverty datum line</td>
<td>Unlikely</td>
<td>Strong</td>
</tr>
<tr>
<td>Halve, between 1990 and 2015, the proportion of people who suffer from hunger</td>
<td>has been met</td>
<td>Reduce by 50%, the proportion of people who suffer from hunger and malnutrition by 2016</td>
<td>Likely</td>
<td>Strong</td>
</tr>
</tbody>
</table>

Botswana’s poverty reduction progress is illustrated in Table 1.1 and Figure 1.1a. In 1993/94 47% of the population lived below the poverty datum line (PDL), but as can be seen from Table 1.1 by 2010 it had reduced by more than half as it now stood at 19.3%. Figure 1.1a shows that the global target of halving the proportion of the population living below the PDL was long achieved before 2010. During the period 2002/3 to 2009/10 poverty incidence dropped nationally by 11.3% from 30.6% in 2002/03 to 19.3% in 2009/10. This constitutes a 37% decrease in the proportion of the population living below the PDL and translates to an average annual decrease rate of 5.2%.

<table>
<thead>
<tr>
<th>Table 1.1: Head Count Poverty Incidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002/2003</td>
</tr>
<tr>
<td>Cities &amp; Towns</td>
</tr>
<tr>
<td>Rural Urban</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>National</td>
</tr>
</tbody>
</table>

Source: calculated from the BCIWS data
While poverty levels remain highest in rural areas, the actual improvement in levels, as measured by the annual rate of change, seems to have occurred in this group. Rural areas experienced a 45.7% decrease in poverty against 24.5% and 21.6% decrease achieved by cities and towns, and urban villages respectively. Also noteworthy is that cities and towns experienced a relatively faster decrease in poverty rates than rural urban centres.

Table 1.2: Household Poverty Incidence

<table>
<thead>
<tr>
<th></th>
<th>2002/2003</th>
<th>2009/2010</th>
<th>Change</th>
<th>Rate of change</th>
<th>Annual rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cities &amp; Towns</td>
<td>8.8</td>
<td>5.2</td>
<td>-3.6</td>
<td>-40.9</td>
<td>-5.8</td>
</tr>
<tr>
<td>Rural Urban</td>
<td>17.4</td>
<td>10.4</td>
<td>-7</td>
<td>-40.3</td>
<td>-5.7</td>
</tr>
<tr>
<td>Rural</td>
<td>33.4</td>
<td>14.5</td>
<td>-18.9</td>
<td>-56.6</td>
<td>-8.1</td>
</tr>
<tr>
<td>National</td>
<td>21.7</td>
<td>10.8</td>
<td>-10.9</td>
<td>-50.2</td>
<td>-7.2</td>
</tr>
</tbody>
</table>

Source: calculated from the BCWIS data

Table 1.2 and Figure 1 indicate that the household poverty incidence pattern mirrors that of the poverty head count, save for the fact that poverty rates are lower in the former. Similarly, policy impact, as measured by the rate of decrease, is stronger in the household poverty incidence case than in the poverty head count case.

A simple calculation is made to answer the question whether the foregoing analysis implies that Botswana is now better placed to achieve its zero persons below the PDL target by 2015. If the average annual rate of decrease in poverty of 5.2% is assumed and applied to reduce the 19.3% figure of 2010 on annual bases up to the end of the period, the result is that by 2015 the proportion of the population living below the PDL will stand at 14.8%. This means that even though Botswana achieved the global objective of halving the proportion of the population leaving below a US$1 a day, it is unlikely to achieve “zero proportion of the population below the PDL” by 2015.

By introducing the police special constable cadre, government not only brought down crime incidence but also provided employment to thousands of previously unemployed people.

Figure 1.1 Average Annual Rates of Improvement in Poverty Incidence

Source: Calculated from the BCWIS 2010 data

A calculation of the annual rates of improvement in poverty levels indicates that rural areas experienced significantly higher rates of improvement in poverty than other geographical locations in both head count and household instances.
Table 1.3: Head Count Poverty and rate of Improvement

<table>
<thead>
<tr>
<th></th>
<th>Head Count Poverty (HIES 2002)</th>
<th>Head Count Poverty (BCWIS 2009/10)</th>
<th>Annual Rate of Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ngami West</td>
<td>53.3</td>
<td>46.2</td>
<td>1.9</td>
</tr>
<tr>
<td>Kgalagadi South</td>
<td>50.6</td>
<td>16.9</td>
<td>9.5</td>
</tr>
<tr>
<td>Kweneng West</td>
<td>48.5</td>
<td>32.4</td>
<td>4.7</td>
</tr>
<tr>
<td>Ngwaketse West</td>
<td>48.1</td>
<td>41.7</td>
<td>9.5</td>
</tr>
<tr>
<td>Central Bobonong</td>
<td>41.4</td>
<td>32.8</td>
<td>3.2</td>
</tr>
<tr>
<td>National</td>
<td>3.6</td>
<td>19.3</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Source: Derived from BCWIS (2010)

Aggregate national figures can mask the reality on the ground and this can hamper policy targeting. Breaking poverty incidence data into districts can thus be beneficial and the results are as presented in Figures 1.2 and Figure 1.3. The picture that emerges reveals the national figure for head count poverty to be 19.3%. Corresponding figures for the five poorest regions are as in Figure 1.3.

Ngami West and Ngwaketse West have remained at over 40% while Kgalagadi South has fallen to 16.9% and Kweneng West and Central Bobonong have decreased to around 32%. It can also be read from Table 1.2 that Orapa, Jwaneng and Chobe, and to some extent Gaborone, have extremely low levels of poverty. Sowa Town and Francistown increased their levels of poverty during the period under consideration.

Figure 1.2: Poverty Head Count Ratios

Figure 1.3: Poverty Improvement Rates by District

The extent to which benefit or value is equitably distributed has a bearing on the rate of poverty reduction. The GINI Coefficient is normally used to measure the extent to which value or benefits are equitably distributed. This coefficient should lie between zero and one. The closer the coefficient is to zero the more equity in distribution there is, and the closer it is to one, the less equity there is. The BCWIS report has calculated three categories of GINI coefficients - one based on household alleviation. Orapa virtually eliminated poverty to zero. Sowa Town and Francistown surprisingly regressed as can be read from Figure 1.3. Interestingly, Kweneng West registered a very strong improvement rate but still remained in the category of high poverty incidence rates. This is because the district started at very high levels and the relatively decent improvement in poverty alleviation was not sufficient to bring its poverty levels down significantly.

Figure 1.4: Various National GINI Coef at 2002/3 & 2009/10

Source: Derived from BCWIS (2009/10)
total income, another on cash income and the third on consumption income. In the case of total income, the GINI coefficient increased from 0.573 in 2002/3 to 0.645 in 2009/10. This increase in the coefficient signifies a worsening income distribution. The same situation applies to cash income as the GINI coefficient increased from 0.626 to 0.715 during the period 2002/3 – 2009/10. The picture is however, different for consumption. In this case the GINI Coefficient instead decreased from 0.571 in 2002/3 to 0.495 in 2009/10. This indicates that consumption of goods and services was more equitably distributed in Botswana during this period, whereas total income and cash income actually experienced worsening equity in distribution. This comes as no surprise as it captures the effect of government social protection programmes that have placed emphasis on food welfare, as well as production related packages – such as the Integrated Support Programme for Arable Agricultural Development (ISPAAD). While Government has not given direct income and cash to social welfare beneficiaries it has made consumer goods available to them and this has led to improvement in equity in consumption.

Table 1.4 below shows that not only did income get regressively distributed but, that it occurred at a faster rate than consumption, which got more equitably distributed. This result answers the question of whether government should address poverty through cash-based or consumption-based programmes.

Table 1.4: Rates of Change for Different GINI Coefficients (2002/3 to 2009/10).

<table>
<thead>
<tr>
<th></th>
<th>Disposable Income GINI Coefficient</th>
<th>Disposable Cash Income GINI Coefficient</th>
<th>Consumption GINI Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>12.6</td>
<td>14.2</td>
<td>-13.3</td>
</tr>
<tr>
<td>Cities &amp; Towns</td>
<td>20.9</td>
<td>20.7</td>
<td>-7.3</td>
</tr>
<tr>
<td>Urban Villages</td>
<td>19.5</td>
<td>21.6</td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>-0.2</td>
<td>21.7</td>
<td>-13.3</td>
</tr>
</tbody>
</table>

Source: Derived from BCWIS (2009/10)

UNEMPLOYMENT AS A POVERTY DIMENSION

Government’s Public Works (Ipelegeng) programme provides employment to unskilled and poor members of the society.

The BCWIS report estimated the national unemployment rate to be about 17.8 % with female unemployment standing at 21.4 % and male at 14.5%. The age groups 15 - 19 and 20 - 24 had the highest unemployment rate at 41.4% and 34% respectively. The same report established that the majority of households living on less than US$1 a dollar a day were headed by unemployed persons. However, cities and towns households were mainly headed by employed persons. Census data reveals an unemployment rate of 19.6 percent for population aged 19 years and above. This is slightly higher, compared to 17.9 percent yielded by the 2009/10 Botswana Core Welfare Indicator Survey (BCWIS). It should be noted however, that the BCWIS information refers to economic activities covering the whole year and is therefore automatically adjusted for seasonal effects, while the census information depicts activities during one season. Unemployment is generally higher among females than males, resulting in overall levels of 22.6 percent and 17.7 percent respectively. This point is, to an extent, captured in Figure 1.5.
Figure 1.5: Employment & Unemployment Rates for some Districts

Source: Derived from BCWIS (2009/10)

Figure 1.6: Five most important Income Sources for the Poor

Source: Derived from BCWIS (2009/10)

Figure 1.7: Who Employs These Poor Heads of Households?

Source: Derived from BCWIS (2009/10)

Figure 1.7 further shows that a significant proportion of heads of poor households are employed by the Private Sector (33%) followed by Government (25%), Private Households (22%) and Own business with no employees (13%). These figures may give an indication the amount of wages received by household heads is not the only determinant of the poverty status of the household. Other factors such as household size can be a source of household vulnerability to poverty. It is therefore entirely possible that an individual may be employed and still be a member of a household that is below the PDL.

It can be concluded from the foregoing that Botswana has achieved the global target of halving the proportion of people who live on less than US$1 a day as this figure has decreased from 47% in 1993 to 19.3% in 2009/10. It is also significant to note that there has been more progress in rural than in other geographical areas. However, the national target of achieving zero population living below the PDL does not seem likely as projections indicate that by 2015, 14.8% of the population will still be below the PDL.

HUNGER AND MALNUTRITION

To meet the nutrition needs of school children government has in place a feeding regimen for schools across the country. The 2010 Status Report described the results on hunger and malnutrition as mixed. This was because while the Botswana National Nutrition Surveillance System (BNNSS) claimed that child total malnutrition had sharply decreased between 1998 and 2002, the Botswana Family Health Survey (BFHS2007) reported that child nutrition was still a major problem.
However, Figure 1.8 indicates that total child malnutrition has generally trended downwards. These figures have since decreased from 4.5% in 2008 to 3.5% in 2012. A closer examination of the rate at which malnutrition is changing could be more informative. There are two instances where it significantly shot upwards. The period 2008-2012 seems to suggest the improvement momentum is being lost. Overall, the level of under-five malnutrition seems to have significantly decreased, indicating reduced hunger and suffering.

In 1997 total malnutrition was about 18 percent for the under-five population. This figure had declined to 3.5 percent by 2011. This demonstrates that both the global and national targets of halving the proportion of people who suffer from hunger have been achieved.

A regional analysis of malnutrition in Figure 1.9 however, captures a worrying picture where all the nine districts whose total malnutrition was above the national average in 2010 have maintained the status quo for the consecutive two years. Kgalagadi North is the worst case where the district’s total malnutrition percentage is more than twice that of the national average, and the gap is widening. Kgalagadi South, Gantsi and Kweneng East levels have also remained relatively higher than the national average. Only the Good Hope District seems to have gravitated towards national average levels. This calls for acceleration of targeted poverty alleviation programmes.

While the indication is that Botswana must have done very well in respect of the achievement of MDG1 there are two major facts that militate against the robustness of this finding. First, the scantiness of up-to-date data makes it very difficult to accurately conclude what the 2015 status will be. For example 2009/10 data is being used to project on the 2015 situation and yet the situation could change drastically. An acute and drastic change in global financial markets could very easily alter the government budget rendering it unable to support its well-intended poverty eradication programmes.

The second problem is that Botswana is highly dependent on the importation of food and fuel. Pricing for the two products is mainly determined at world market level and as such the country cannot easily manage it through its macroeconomic policies, namely the exchange rate and monetary policies. There is no doubt that changes in global food and fuel prices have a bearing on the food security of the country. Moreover, the country has been going through a continuous spell of droughts. These two factors therefore, have a bearing on the robustness of these positive results on MDG 1.

Comfort can however, be taken from the fact that Botswana imports its food mainly from South Africa and for the past three years the Rula has remained strong against the Rand. For example, in 2010 when BCWIS was undertaken the Pula/Rand exchange rate was P1 = R1.01 As at April 2014 it stood at P1 = R1.16. A reversal in food security levels is unlikely. Similarly Botswana inflation rate has been continuously decreasing and is currently at its lowest level at 5%. If this situation holds perpetually Botswana’s food security is likely to remain in place and so no reversal may be expected. It can therefore be concluded that the findings on MDG 1 are robust as they are expected to remain unchanged by 2015 and beyond.

1.2 MAJOR CHALLENGES

While Botswana has had for many years, a focused poverty reduction strategy, which has now been elevated to abject poverty eradication, there is no Poverty Monitoring and Information System (PMIS) to make possible evidence-based policy development, implementation and monitoring. As was further emphasised in the 2010 Status Report, Poverty policy formulation neither a Regulatory Impact Assessment (RIA) nor a Poverty and Social Impact Assessment (PSIA). All these have prevented
the integration of the poverty programme -into other macro-economic policies, leading to some contradictions, which include:

- Emphasis on poverty related policies geared too much towards social welfare without drawing synergies with other programmes to ensure sustainable growth, thereby risking reversals in the future, particularly when government adopts austerity measures due to an ever tightening budget.
- Employment creation, which is the most meaningful way of fighting poverty, is limited due to the narrow base of the economy.
- High HIV prevalence does not only limit the government’s ability to fund poverty alleviation programmes but also adds to poverty directly through reduced earning capabilities of the infected.
- The undiversified nature of the economy makes poverty eradication programmes highly vulnerable to global economic shocks.

1.3 KEY POLICIES AND PROGRAMMES.

In its determination to fight poverty Botswana has come up with a number of programmes whose main aim is to achieve social justice. Some of these are:

- The National Strategy for Poverty Reduction (NSPR) of 2003, currently under review. Through its multi-sectoral approach the strategy guides the entire national effort against poverty.
- The Remote Area Dweller Programme (RADP) targets the disadvantaged minorities who live in the countries’ more remote areas.
- Destitute welfare programmes.
- A non-selective Old-Age Pension for anyone over age 65.
- An Orphanage programme mainly aimed at closing gaps caused by AIDS related deaths. It however covers all orphans regardless of causes of parent’s death.
- Integrated Support Programme for Arable Agriculture Development (ISPAAD) which infuses a production dimension into the fight against poverty to ensure sustainability of poverty eradication gains.
- Ipelegeng provides temporary employment opportunity for the poor.
- The Youth Development Fund (FDF) and the Young Farmers Fund (YFF) both of which aim to nurture youth entrepreneurship as well as providing employment

- The Backyard Garden programme, which addresses the needs of the very poor and aims to eradicate poverty
- The Livestock Management and Infrastructure Development (LIMID) which ensures that the poor are empowered with production facilities.

1.4 MONITORING PROGRESS TOWARDS MDG 1

Over the years Botswana has used the Central Statistics Office (CSO) now turned into a parastatal organisation, Statistics Botswana, to collect data through surveys that directly feed into poverty programming. Some of those surveys are Household Income and Expenditure Survey (HIES), the Botswana Demographic Survey (BDS) and the Botswana Family Health Survey (BFHS). The only census is the National Population and Housing Census. All these are intensive and high quality processes that are based on international standards and are undertaken at regular intervals during a 10 year period.

While effort is being made to maintain comparability of data between surveys, the data collected is never fully analysed and in some cases takes long to be released. Disaggregation of data is also a challenge.

Table 1.4 gives an overview of the capacity to monitor progress towards MDG 1.

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data gathering capacities</td>
<td>Strong</td>
</tr>
<tr>
<td>Quality of Survey Information</td>
<td>Strong</td>
</tr>
<tr>
<td>Statistical Tracking Capabilities</td>
<td>Fair</td>
</tr>
<tr>
<td>Statistical Analysis Capacities</td>
<td>Fair</td>
</tr>
<tr>
<td>Capacity to use statistical analyses in policy</td>
<td>Good</td>
</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>Fair</td>
</tr>
</tbody>
</table>

CONCLUSION

This section has used poverty data to establish how poverty levels in 1993 compared with those in 2009/10. It has emerged that overall, the percentage of the population living below the poverty datum line decreased from 47% in 1993 to 19.3% in 2009/10. This is an encouraging achievement considering half of 47% is 23.6%. 
GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

INTRODUCTION

When discussing the achievements of MDG 2, the Botswana 2004 Status Report concluded that Botswana had achieved universal primary education, that the estimated Net Enrolment Ratio (NER) for children aged 7-13 was above 95% as it had reached 100% in 1999 and 2000 respectively. It however, cautioned that the Gross Enrolment Ratio (GER) was 11 points above the NER due to some dropouts and the fact some parents started their children late for school. The report assessed Botswana's institutional capacity to be sufficient enough to guarantee 10 years of basic education for all school-age children. It further concluded that gender parity had been achieved in the formal educational system. On the quality of education, the report concluded that the results suggested that learning was not very effective at the early primary school level. This was attributed to possible lack of pre-school training which would have prepared pupils for the classroom learning environment.

The 2010 Status Report affirmed the position of the 2004 Report that “Botswana has made good progress towards achieving universal access to ten years of basic education for its children”. This conclusion was derived from trends in enrolment, transition and dropout rates. On the quality of basic education, the status report observed that Botswana needed to ensure that “the quality of education matches the volume of investment”. It noted the country had not performed well in such standard tests as the Trends in International Mathematics and Science Study (TIMSS).

Applying the same measurements used by the two early status reports, an assessment of Botswana’s performance in respect of the two stated targets can be made.

Table 2.1 Overview of performance towards global and national education targets

<table>
<thead>
<tr>
<th>GLOBAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</td>
<td>Likely</td>
<td>Achieve universal access to 10 years of basic education by 2016</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td>Improve the relevance and quality of basic education</td>
<td>likely</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.1 CURRENT STATUS AND TRENDS

UNIVERSAL ACCESS TO PRIMARY EDUCATION

There has been a considerable increase in the number of children who enrol for primary school since 2010, as captured in Figure 2.1. The rise is attributable to increases in total enrolment, both NER and GER, and transition rates as well as decreased drop-out rates as captured in Figures 2.1 to 2.5.

Figure 2.1 Total Enrolment

Figure 2.1 above shows that despite a prominent decrease in total enrolment during the years 2003 – 2008, total enrolments increased substantially during the years 2009-2012. The increase was with enhanced momentum between the period 2010 and 2012.

The 2004 Status Report raised some objections to the 11 point gap between the NER (6 - 12) and NER (7-13) that occurred during the period of its assessment. The objectionable factor was that NER (7-13) was greater than NER (6-12) because children 6 years of age were prevented from starting school until they turned 7. As the report stated, the loss was a cost both to the children and the country.
Figure 2.2: NER (6-12) & NER (7-13)

Source: Stats Brief 2013

Figure 2.2 above shows that these two NERs started converging beginning 2008, while the period after 2010 witnessed a situation where NER (6-12) started exceeding NER (7-13). Indications are that so far the gap between the two is broadening but this time with NER (6-12) above NER (7-13). The Figure shows that since 2009 NER (6-12) has been consistently increasing. A major explanation would be that more and more children are now starting school age of 6. Further research is however, needed to confirm this. Figure 2.3 below shows the improvement in access to primary education.

Figure 2.3: GER (6-12) & NER (6-12)

Source: Stats Brief 2013

Both GER (6-12) and NER (6-12) in Figure 2.3 are increasing when it should be expected that the two would actually converge as age cohorts enrol in their rightful class categories. The increase in GER could be attributed to Botswana’s flexible admission to primary school.

Figure 2.4: Drop Out Rate

Source: Stats Brief 2013

Improvement in educational access also manifests itself through the decrease in dropout rates. Since 2009, the dropout rate has been decreasing, save for the year 2012 when it rose to 2010 levels (see Figure 2.4). An analysis of the class at which most pupils drop out might assist policy makers. Figure 2.6 shows most dropouts at primary school level happen in standard 1. The dropout rate for this group is above 20% while the next high dropout cohort is below 15%. The fact that the youngest children are the ones who drop out most could be attributed to, among other factors, the distance they walk to school. This could also give credence to the argument that parents are reluctant to take their children to school at age 6. The fact that Standard 7 has the lowest dropout rate also gives credibility to this argument. Surprisingly, with standard 1 registering the highest dropout rates, Standards 2 and 3 record the lowest dropout rates.

To answer the question whether it is boys or girls who drop out most from school, a Gender Parity Index was generated from the dropout rates data. This index answers the question –"for each boy who drops out how many girls drop out?"
Figure 2.6: Boys & Girls- Who really is Dropping Out?

Source: Stats Brief 2013.

Figure 2.6 reveals that at primary school, significantly more boys drop out than girls. This could suggest that dropout rates are more, due to economic than cultural factors. In the past, girls were discouraged from going to school as they were expected to get married at an early age. Economic factors for dropout rates would possibly include young boys being taken out of school to look after livestock in return for a wages. This could also indicate that at their tender age, boys play more truant than girls. The fact that more girls dropout in standard 7 relative to other standards seems to support the argument that as they reach puberty, girls become more delinquent with the result some even get pregnant and drop out of school.

Figure 2.6a: Percentage Dropout Rate by District & Gender 2011

Source: Stats Brief 2013.

A breakdown of dropout rates by district level may provide further insight. Gantsi District, which has more remote area dwellers, most of whom are semi-nomadic Basarwa, shows outlier dropout levels of over 5%. The next highest dropout level is found in the North West District at a distant 2.9%. Another noteworthy point is that the four districts that are well known for high levels of poverty, namely North West, Kgalagadi, and to some extent Kweneng and the Southern District, have dropout rates that are above the national average. It is important to note that it is only Kweneng West and Ngwaketse West and not the whole Kweneng and Southern districts that have high poverty levels. Figure 2.6 (a) further confirms the fact that boys have higher dropout rates than girls across districts.

Figure 2.7: Transition Rates to STD 5 & 7

Source: Stats Brief 2013

Related to the dropout theory is the transition rate which measures the proportion of a cohort that reaches a given level of schooling. Primary school pupils sit transition examinations at Standard 4 and Standard 7. Figure 2.7 shows that 86.4% of those who entered standard 1 in 2005 reached Standard 5 in 2009. In the same vein 88.4% of those who started standard 1 in 2009 reached std. 5 in 2012. This shows that Standard 5 transition rates have continuously increased - signifying increased access to primary education.

From the foregoing discussion on enrolment, dropout rates and transition rates it can be concluded that Botswana continues to make good progress towards achieving universal access to primary education, and will likely meet the Global MDG targets on education.
UNIVERSAL ACCESS TO 10 YEARS OF BASIC EDUCATION BY 2016

Students at secondary school are given opportunity to do optional subjects to enrich learning

Having demonstrated that Botswana has achieved universal access to Primary Education it is necessary to demonstrate that the country can achieve its more ambitious objective of 10 years of access to basic education. There is, therefore, a need to show that Botswana has achieved high levels of transition from Primary School to Junior Secondary School level. Figure 2.7a captures the transition rate from primary school to lower secondary school level. While there has been a general upward trend in these transition rates during the period 2000 to 2012, there is also evidence that transition rates increased to substantially high levels (96.5%) before stabilising to 96.6%. The upward trend in transition from primary school to lower secondary school combined with high transition rates at primary school level signify increased access to 10 years of basic education. Percentages are also close to 100% which suggests the achievement of universal access to basic education. Owing to increased commitment by the Botswana Government to human resource development through investment in education, sustainable attainment of 10 year universal education can be expected beyond 2015.

RELEVANCE AND QUALITY OF BASIC EDUCATION

The fact that Botswana has invested heavily in its education system can be easily read from Figures 2.8 and 2.9. The students/teacher ratio in the Botswana educational system has steadily progressed from 1:29 in 1993 to 1:26 in 2010 and 1:24 in 2012. Figure 2.8: Pupil to Teacher Ratio

Not only has the number of students per teacher decreased, the quality of teachers has also improved. Figure 2.9 shows 72% of primary school teaching staff hold either a diploma or a university degree. Only less than one percent of the teaching staff is unqualified. However, the absence of a solid pre-school programme may have limited the derivation of maximal benefits from this deliberate investment in the sector. However, plans are at an advanced stage to roll out the preschool programme. This will enhance the country’s ability to achieve this target.
In conclusion, Botswana has invested adequate effort towards achieving the objective of improved relevance and quality of basic education. Government’s efforts at providing adequate physical infrastructure, for both pre-service and in-service teacher training will go a long way in ensuring availability of qualified teachers and reduction of teacher/student ratios. However more work needs to be done to ensure the curriculum is more relevant to the needs of the economy.

**QUALITY AND RELEVANCE OF BASIC EDUCATION**

Government has now introduced pre-school classes across the country.

It is important to assess whether the achievement in universal access to primary education has been accompanied by increased quality in education. The Southern and Eastern African Consortium for Monitoring Education Quality (SACMEQ) has undertaken two assessments on Botswana. These are SAMSEQ II (2000) and SAMSEQ III (2007). The two exercises looked at conditions of schooling, quality of education, home background, learning environment, resource availability at school level and teachers’ and school heads’ characteristics. Pupils as well as teachers were assessed.

**Table 2.2: Botswana & SAMSEQ Pupil and Teachers’ Average Scores in Mathematics & Reading**

<table>
<thead>
<tr>
<th></th>
<th>SAMSEQ II</th>
<th>SAMSEQ III</th>
<th>SAMSEQ II</th>
<th>SAMSEQ III</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PUPILS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOTSWANA</td>
<td>512.2</td>
<td>520.5</td>
<td>521.1</td>
<td>534.6</td>
</tr>
<tr>
<td>SAMSEQ</td>
<td>500</td>
<td>509.7</td>
<td>500</td>
<td>509</td>
</tr>
<tr>
<td><strong>TEACHERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOTSWANA</td>
<td>753.3</td>
<td>780.0</td>
<td>757.7</td>
<td>769.0</td>
</tr>
<tr>
<td>SAMSEQ</td>
<td>791.6</td>
<td>789.0</td>
<td>733.9</td>
<td>749.7</td>
</tr>
</tbody>
</table>

*Source: SAMSEQ II (2000) and SAMSEQ III (2007)*

Botswana pupils outperformed the regional average for both Mathematics and Reading in SAMSEQ II and SAMSEQ III. Teachers performed below the regional average for mathematics in both SACMEQ II and SACMEQ III. However they surpassed the regional average for reading in both assessments.

**Table 2.3: % Pupil Reaching Acceptable Levels in Mathematics and Reading by Region**

<table>
<thead>
<tr>
<th>District</th>
<th>SACMEQ II</th>
<th>SACMEQ III</th>
<th>Change Rate</th>
<th>SACMEQ II</th>
<th>SACMEQ III</th>
<th>Change Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central North</td>
<td>32.0</td>
<td>54.3</td>
<td>22.3</td>
<td>69.3</td>
<td>82.8</td>
<td>13.5</td>
</tr>
<tr>
<td>Central South</td>
<td>28.5</td>
<td>41.5</td>
<td>13.0</td>
<td>63.1</td>
<td>74.2</td>
<td>11.1</td>
</tr>
<tr>
<td>Gaborone</td>
<td>48.1</td>
<td>65.1</td>
<td>16.7</td>
<td>88.2</td>
<td>89.4</td>
<td>1.2</td>
</tr>
<tr>
<td>North</td>
<td>42.0</td>
<td>37.6</td>
<td>10.2</td>
<td>78.5</td>
<td>82.0</td>
<td>3.5</td>
</tr>
<tr>
<td>South Central</td>
<td>42.0</td>
<td>30.9</td>
<td>-4.4</td>
<td>79.7</td>
<td>72.8</td>
<td>-7.0</td>
</tr>
<tr>
<td>South</td>
<td>31.4</td>
<td>30.9</td>
<td>-0.5</td>
<td>76.5</td>
<td>63.7</td>
<td>-12.9</td>
</tr>
<tr>
<td>West</td>
<td>32.0</td>
<td>37.5</td>
<td>5.1</td>
<td>69.4</td>
<td>73.4</td>
<td>4.0</td>
</tr>
<tr>
<td>Botswana</td>
<td>35.1</td>
<td>43.5</td>
<td>5.5</td>
<td>73.8</td>
<td>75.8</td>
<td>2.0</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>29.8</td>
<td>36.9</td>
<td>8.4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Source: SAMSEQ II and SAMSEQ III (2007)*
The good pupil performance notwithstanding, a close look at educational district performance shows a worrisome picture. For Mathematics, four of the eight education districts performed below the regional average in SAMSEQ III. This result unmasks the fact that Botswana’s performance is boosted by the good performance of such urban regions as Gaborone, which performed at about 76% above the sub-continental average. The Central North District also performed at 47% above the regional average. These two exceptional performances placed the country’s average well above that of the region. This is corroborated by Table 2.4 results that show urban performance was significantly higher than that of rural areas. On equitable access to quality education, Table 2.4 reveals that the bottom 25% scored below the regional average in terms of income status and substantially below the top 25% in both SAMCEQ II and III. The bottom 25% actually worsened by 11.8% between the two assessments while the top quartile improved its score by 3.5%.

The Table also shows that girls scored significantly higher than boys in both SAMSEQ II and III.

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SAMSEQ II</th>
<th>SAMSEQ III</th>
<th>RATE OF CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pupil Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys</td>
<td>508.2</td>
<td>517.5</td>
<td>9.3</td>
</tr>
<tr>
<td>Girls</td>
<td>517.4</td>
<td>523.6</td>
<td>6.2</td>
</tr>
<tr>
<td>School Location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural</td>
<td>500.5</td>
<td>501.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Urban</td>
<td>524.8</td>
<td>538.8</td>
<td>14.0</td>
</tr>
<tr>
<td>Socio-Economic Status(SES)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low SES (25% bottom)</td>
<td>490.8</td>
<td>479.0</td>
<td>-1.8</td>
</tr>
<tr>
<td>High SES (25% Top)</td>
<td>549.6</td>
<td>553.1</td>
<td>3.5</td>
</tr>
<tr>
<td>Botswana</td>
<td>512.9</td>
<td>520.5</td>
<td>7.6</td>
</tr>
<tr>
<td>SACMEQ</td>
<td>500</td>
<td>509.7</td>
<td></td>
</tr>
</tbody>
</table>


2.2 MAJOR CHALLENGES

While it is true that education is an empowerment tool, it is also true that on its own it does not do much to empower anyone. An unemployed educated person is just as disempowered as anyone else. As such, complementary factors that are needed to make education an empowerment tool should always be readily available. Employment creation is one of these factors, and poverty alleviation is another. It is difficult to convince a starving parent to remove his/her child from paid employment and send him/her send back to school when the child’s employment is the only source of livelihood for the household.

2.3 SUPPORT POLICIES AND PROGRAMMES

Parliament’s passing of the Children’s Act has provided legislative protection for children’s rights to education.

- The Revised National Policy on Education (RNPE) has on the other hand provided guidance and the regulatory framework that enable easy management of the Education system. To guide the relevant utilisation of educational products, the Botswana Government has created policy infrastructure such as the Education Hub whose mandate is to provide a link between the sector and the economy.

- The Human Resource Development Council (HRDC) has also been created to provide an environment that will feed on products of this sector, and convert
them into inputs for the development of the economy.

The Botswana Examination Council (BEC) is charged with overseeing and ensuring best practice in examinations’ conduct and quality, assessment policy and programme development, regulation of national schools examinations programmes and the award of certificates for programmes in the general education sector. The SAMCEQ 2007 report cites specific initiatives undertaken by the Ministry of Education with a view to improving the quality of primary education. These are:

- Reviewing and adapting the primary education curriculum to incorporate emerging issues, as well as improving accessibility for children with special education needs.
- Increasing the provision of teaching and learning materials for children with special needs.
- A flexible admission policy for standard 1, to ensure children from remote areas and vulnerable groups are not excluded from the education system.
- Introduction of gender-sensitive policies and mainstreaming of gender issues in the curriculum, providing equal opportunities to all learners as well as maintaining flexible re-admission policies to encourage learners to re-enter the education system at various levels.
- Introduction of life skills programmes to assist learners to function effectively, and be able to make informed decisions.

2.4 MONITORING PROGRESS TOWARDS MDG 2

Statistics Botswana has a dedicated unit responsible for collecting, assembling and publishing educational data. Over the years the unit has developed the capacity to gather and track data used for education policy formulation. Most education data comes from administrative sources such as schools, which makes the data collection system robust and dependable. As is the case with most aspects of statistics in Botswana, there exists room for further improvement in data analysis and information dissemination. Table 2.2 summarises the progress monitoring capacity of the sector.

<table>
<thead>
<tr>
<th>Dimension of Capacity</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data gathering capacities</td>
<td>Strong</td>
</tr>
<tr>
<td>Quality of survey information</td>
<td>Strong</td>
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<tr>
<td>Statistical tracking capabilities</td>
<td>Strong</td>
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<tr>
<td>Statistical analysis capabilities</td>
<td>Strong</td>
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<tr>
<td>Capabilities to use statistical analysis in policy</td>
<td>Strong</td>
</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>Good</td>
</tr>
</tbody>
</table>
GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

According to the 2004 Status Report, violence and rape were attributes of deep-seated socio-cultural practices and institutions, to the extent that "there was no indication that efforts to contain and eliminate violence against women were paying off." As explained by the 2010 Status Report, this was mainly because Botswana's violence occurred between consensual partners and was strongly linked to men's economic and social control of women. While acknowledging the enactment of the Domestic Violence Act, the report indicated that leaving out marital rape from the Act was a major omission.

Regarding participation of women in leadership, the 2004 Status Report stated "Political and economic power was still controlled by men". While acknowledging that some steady progress was being made in the civil service and the public sector, it noted the private sector was still lagging behind in this area. The 2010 Status Report also noted a decrease in women representation in Parliament - from 11% in 2004 to 7% in 2009. The report further pointed out that women representation in councils in Botswana stood at 20% which was far lower than the SADC 30% threshold. An update on the current status of these four areas is given in Table 3.1 below. It gives an overview of the performance on this MDG at both global and national levels.

Table 3.1: Overview of Performance towards the Global and National Gender Targets

<table>
<thead>
<tr>
<th>GLOBAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</td>
<td>Achieved</td>
<td>To reduce gender disparity in all education by 2015</td>
<td>Achieved</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce gender disparity in access to and control of productive resources by 2015</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce discrimination and violence against women, and the incidence of rape by 50% by 2011</td>
<td>Potentially</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To increase participation of women in leadership, governance and decision-making positions by at least 60% by 2016</td>
<td>Likely</td>
<td>Strong</td>
</tr>
</tbody>
</table>

3.1 CURRENT STATUS AND TRENDS

GENDER DISPARITY IN EDUCATION

Botswana's national target of reducing gender disparity throughout the education sector by 2015 has been fully achieved. Figure 3.1 shows that between 2006 and 2009 the number of girls enrolled for primary school against every 100 boys enrolled was decreasing. While in 2006 for every 100 boys enrolled there were only 96.5 girls,
this figure decreased to 95 in 2009. The period following 2009 has seen a turnaround where the number of girls enrolled per 100 boys has continuously increased to finally reach 95.5 by 2012.

The decrease during the period 2006 and 2009 has not been fully researched and explained. However it can be assumed that the decrease happened at the height of HIV and AIDS where enrolment figures in absolute terms decreased. As the disease took its toll, girls were removed from school to take care of family members. The government is currently investigating this development and its impact.

**Figure 3.1 Primary School Enrolment Gender Parity Index**

![Graph of Primary School Enrolment Gender Parity Index](source: Education Statistics 2009)

Figure 3.1a below closely examines the enrolment gender parity index by region. It emerges from this figure that only the Gantsi District has a GPI of 100% implying that for every boy enrolled at primary school level there is a girl enrolled. Given that there are more boys at birth than girls, the GPI of 100% implies that Gantsi parents are keener to send girls to school than boys. The opposite can be observed for Kgalagadi, which has a GPI slightly below 90%. The Chobe, as well as Kgatleng Districts have a GPI less than the national average of 95%. As in the Gantsi case, the South East District, at about 98% has an enrolment GPI above the National average. Further research is needed to unravel the cultural and socio-economic factors that may explain these regional variations.

**Figure 3.1a Enrolment Gender Parity Index by District 2011**

![Graph of Enrolment Gender Parity Index by District](source: Education Statistics 2009)

Figure 3.1b captures the dominance of females in tertiary education where for every 100 males enrolled there are more than 100 females. In 2012/13 there were over 120 females enrolled at tertiary school for every 100 males. The trend illustrates the fact that the dominance of females is increasing over time.

**Figure 3.1b Gender Parity Index For Tertiary Education**

![Graph of Gender Parity Index for Tertiary Education](source: Derived from educational statistics (2013))
The progress in gender parity in education is also confirmed by trends in literacy rates as reported by the BCWIS 2009 report. As captured in figure 3.2 above, the period 1999 to 2003 witnessed female rates that were slightly above those for males. They have since started converging. That female literacy rates are above those for male was also confirmed by the BCWIS data.

Literacy rates were used to generate Gender Parity Index and the results are as shown in Figure 3.3. Interestingly, rural areas have more literate women than men compared to cities and towns. The GPI calculation shows that it is only in urban villages that men surpass women in literacy rates. Even then, only marginally so.

Access to employment and productive assets also can define the extent of gender balance and ability to make key decisions in a country. Fig. 3.4 below shows that women have equal access as men to paid employment in the non-agricultural sector. Women only have an upper hand in the informal sector, where for every 100 men employed sector there are 122 women. The only problem is that earnings in this sector are relatively lower than those of other sectors. Also emerging from the data is that women’s access to waged employment in the civil service and the rest of the formal sector is not substantially lower than that of men. For example, for every 100 men employed in the civil service there are 96 women. It is the same with other formal sectors.
The picture changes significantly when it comes to asset ownership - particularly agricultural related property. For every 100 men who own farmland there are only 64 women. The situation gets worse for cattle ownership where the figure decreases to 39 women for every 100 men. These figures show that significant gender disparity in terms of access and control of productive assets still exist.

The origins of this disparity become clear when unemployment data (figure 3.5) is scrutinised. The data set reveals that for every 100 unemployed men with no training there are 150 unemployed women of the same category. The information in Figure 3.5 suggests that relative to men, women will find it difficult to find a job except when they hold an Institute of Health Services (HIS) Diploma, Education College Certificate or Other Diploma. This resonates well with the 2010 Status Report that revealed women dominated the education and health sectors.

A GPI of less than 100 implies that women are disadvantaged relative to men. The information coming from Figure 3.6 shows that men are favoured in all areas of key decision-making positions. That notwithstanding, women closely compete with men for key positions in the civil society sector as well as the public service sector. In the former, for every 100 men in key decision-making positions there are 84 women. The figure stands at 100:72 for the public service. Surprisingly the private sector is way down at 27 women for every 100 men. The country’s Parliament, which has 61 members has only seven women while Ntlo ya Dikgosi (formerly House of Chiefs), with 34 members has only nine women. This set of figures shows that women are seriously disadvantaged when it comes to taking up key decision-making positions.

It is however worth noting that even though a GPI of 27 for the private sector implies that a man is almost four times likely to hold a key decision-making position than a woman, the few women who have had the chance to occupy these positions have been in fairly senior positions.
DISCRIMINATION AND VIOLENCE AGAINST WOMEN

According to the Gender Based Violence Indicators Study undertaken by Gender Links Botswana and the Women Affairs Department (WAD) in 2012, in Botswana, gender based violence (GBV) includes physical and severe beating, sexual assault, incest, sexual harassment, rape, verbal and emotional abuse and murder. Victims of GBV are normally women who are in most cases violated by their partners. The GBV Indicator Study’s main findings on GBV in Botswana are as follows:

- Of all women interviewed in the study 67% had experienced some form of GBV in their lifetime, while 44% of all men said they perpetrated some form of violence.
- The most common form of GBV experienced by women is Intimate Partner Violence (IPV) with 62% women reporting lifetime experience and 47% of men disclosing perpetration.
- The most common form of IPV is emotional, followed by physical, economic, and sexual
- 58% of victims of rape or defilement were found to be between 16 to 35 years of age with 27% of them being below the age of 16.
- The majority of male suspects are aged between 18 and 32 years.
- At one stage the police reported defilement cases increased by 65% in three years.

The picture portrayed here could be worse as many cases go unreported due to the fact many victims depend on their violators for a living. Stigma and family pressure also contribute to this under-reporting. The phenomenal increase in GBV has been attributed to increased alcohol abuse, changes in the socio-economic environment where women have remained economically dependent on men as well as increased multiple partnerships resulting in male jealousy. It has also been argued that culturally based perceptions, which subordinate women to men perpetuate and increase tolerance of violence against women. Figure 3.2 captures some of these statistics.

### Table 3.2: Violence against Women

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</thead>
<tbody>
<tr>
<td>Defilement of girls under 16</td>
<td>303</td>
<td>320</td>
<td>219</td>
<td>324</td>
<td>391</td>
<td>428</td>
<td>487</td>
<td>518</td>
<td>529</td>
<td>534</td>
</tr>
<tr>
<td>Rape Cases</td>
<td>1506</td>
<td>1517</td>
<td>1540</td>
<td>1534</td>
<td>1596</td>
<td>1875</td>
<td>1754</td>
<td>1865</td>
<td>1800</td>
<td>2073</td>
</tr>
<tr>
<td>Partner Killings</td>
<td>54</td>
<td>56</td>
<td>85</td>
<td>62</td>
<td>101</td>
<td>81</td>
<td>93</td>
<td>105</td>
<td>81</td>
<td>89</td>
</tr>
</tbody>
</table>

Source: Botswana Police Service as quoted in the GBV Indicator Study (2012)

### 3.2 MAJOR CHALLENGES

- Over 66% of all rape is perpetrated by a man known to the victim
- Rape cases constitute 70% of GBV.
- Female killings (femicide) doubled over the period 2004 – 2007
- Between the years 2003 and 2007, 91% of femicide cases were perpetrated by partners. These also constituted the bulk of murder cases handled by the police.

The picture portrayed here could be worse as many cases go unreported due to the fact many victims depend on their violators for a living. Stigma and family pressure also contribute to this under-reporting. The phenomenal increase in GBV has been attributed to increased alcohol abuse, changes in the socio-economic environment where women have remained economically dependent on men as well as increased multiple partnerships resulting in male jealousy. It has also been argued that culturally based perceptions, which subordinate women to men perpetuate and increase tolerance of violence against women. Figure 3.2 captures some of these statistics.

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Source: Botswana Police Service as quoted in the GBV Indicator Study (2012)

### 3.2 MAJOR CHALLENGES

- That education is a critical empowerment tool is indisputable. While data shows that females are leading in terms of literacy and enrolment, their access to productive resources still remains limited compared to that of males. There exists a system bottleneck that frustrates their empowerment that should arise from their literacy vantage position. There is therefore need to investigate and address these bottlenecks at cultural, legal and institutional levels with a view to bringing about a solution that allows for the empowerment of women through education.
- There exists a strong link between the economic status of an individual and his/her dependency on the next person. This dependency has, in the Botswana situation, manifested itself in domestic violence and abuse. Solutions that address the abuse directly and those that address the dependency dimension are needed. A strong advocacy campaign is therefore needed to address this problem. There is need to reconcile culture with legal dimensions of the society to address in particular spousal rape and inheritance of property by females.
Collaboration between different sectors and actors is needed to deal with the issue of gender violence. Until this is done, the extent of the violence will never be fully known and understood. Through stakeholder collaboration, a robust and long-lasting solution to GBV can be found. This will also facilitate the establishment of an improved gender violence monitoring system.

3.3 SUPPORT POLICIES AND PROGRAMMES.

These were exhaustively summarised by the 2010 Status Report as follows:

- The Domestic Violence Act seeks to provide the legislative protection to victims of home violence. The Abolition of the Marital Power Act is a great boost to gender equality in Botswana. In a major way it has made it possible for women to acquire assets including those for productive purposes.
- The National Gender Programme Framework, together with its action programme, provides an overarching framework for gender issues.
- The Policy on Women in Development recognises women’s disadvantaged position in development and attempts to address the shortcomings.

3.4 MONITORING PROGRESS TOWARDS MDG 3

As a cross cutting factor, Gender has numerous stakeholders with varied interests. This has made the coordination, particularly standardisation of concepts and types of data collected a challenge. However, the Education and Employment Sectors have made good effort to compile such data. The challenge has however been more in respect of empowerment data, violence, and asset ownership. Lack of proper coordination has resulted in under-reporting and where reporting has been done, there emerged limited comparability of variables. Table 3.2 below captures Botswana’s capacity to monitor gender equality related data.

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data gathering capacity</td>
<td>Good</td>
</tr>
<tr>
<td>Quality of survey information</td>
<td>Good</td>
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<tr>
<td>Statistical tracking capacities</td>
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<td>Good</td>
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</tbody>
</table>

GOAL4: REDUCE CHILD MORTALITY

Botswana is fully committed to reducing child mortality through provision of quality health care

INTRODUCTION

The survival of children up to age five depends on a number of factors including their health condition at birth, the quality and accessibility to good health care and the poverty status of the household into which they are born. The child’s health condition at birth is very closely related to the HIV status of its mother. The Prevention of Mother to Child Transition (PMTCT) programme has gone a long way in improving the health of children at birth, as close to 97% of children born to HIV positive mothers were born being negative. To address the poverty dimension the Botswana Government introduced the National Plan of Action in 2005 with the objective of preventing child malnutrition and vulnerability to disease. Reducing child mortality is one of the millennium developmental goals which Botswana has committed to ensuring its accelerated achievement.
4.1 CURRENT SITUATION AND TRENDS

Table 4.1: Overview of performance towards global and national child mortality targets

<table>
<thead>
<tr>
<th>GLOBAL TARGETS</th>
<th>WILL THE TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL THE TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce by two thirds, between 1990 and 2015, the under-five mortality rate</td>
<td>Unlikely</td>
<td>To reduce the Infant Mortality Rate (IMR) from 48/1000 live births in 1991 to 16/1000 live births in 2015</td>
<td>likely</td>
<td>Strong</td>
</tr>
<tr>
<td>Reduce by 2/3, the under-five mortality rate (U5MR) from 63/1000 live births in 2015</td>
<td>likely</td>
<td>To increase the proportion of one year old children who are fully immunized</td>
<td>Achieved</td>
<td></td>
</tr>
</tbody>
</table>

Botswana initially experienced a decrease in both Infant Mortality and Under-five Mortality Rates (USMR) before experiencing a reversal. Infant mortality fell from 48/1000 in 1991 to 37/1000 in 1996. The U5MR, on the other hand, decreased from 63/1000 in 1991 to 50/1000 in 1997. The country however then experienced a reversal in both rates with IMR reaching 57/1000 in 2007 and U5MR rising to 76/1000 in the same year. This reversal has preoccupied policy formulation and programming in Botswana for a while, as it became apparent that both the global and national mortality objectives on Infant mortality and under 5 mortality rates would not be achieved by 2015.

Estimations of IMR and U5MR have heavily depended on the use of different estimation techniques due to the unavailability of vital statistics in Botswana. Hence, different estimation techniques have been applied to survey census data to produce these mortality rates. Indirect Estimation Techniques were previously used in the 1991 and 2001 census data as well as the Botswana Demographic Survey 2006 (BDS) data to produce mortality rates that are being referred to in this write up as actual mortality data. The outcome captures an initial negative reversal in these mortality rates and then a positive reversal with mortality rates drastically decreasing. The initial reversal has been attributed to the increased prevalence of HIV during that period, while the second has been attributed to the success of the ART and PMTCT programmes.

Note was taken during the processing of the 2011 census data that assumptions under which the use of Indirect Estimation techniques are made would not hold for the 2010-2011 period.

Statistics Botswana, this technique works better in circumstances where the national mortality and fertility rates remain constant. Clearly, the ART and PMTCT programmes and other material support given to the public by the Botswana Government, resulted in notable change in the mortality rates at the national level, therefore the use of Indirect Estimation Techniques to estimate both IMR and U5MR could no longer suffice. For that reason, Statistics Botswana applied Direct Estimation Techniques to the 2011 census data to estimate mortality rates as captured in Figure 4.1. This result reflects a substantial decrease in both IMR and U5MR in 2011. Botswana Statistics places the IMR for 2011 at 17 deaths per 1000 live births, while USMR is placed at 28 deaths per 1000 live births. In both cases the decreases are quite drastic and imply a near achievement of both the global and national Infant Mortality Rates targets.

Figure 4.1: IMR & U5MR using National Census and BDS Data

At IMR of 17/1000 in 2011 Botswana should by now have achieved the global objective of reducing its Infant Mortality Rate (IMR) from 48 deaths per 1000 live births in 1991 to 16 deaths per 1000 live births in 2015. The intensification of the national ART and PMTCT programmes would most likely have pushed this rate even lower. Similarly, at 28 deaths per 1000 live births USMR the country must by now be well positioned to achieve its national objective of reducing by 2/3, the under-five mortality rate (U5MR) from 63/1000 live births in 1991 to the 2015 level of 21 deaths per 1000 live births. The result indicates that Botswana’s commitment to improving the health status of its population and its heavy investment into the health sector has paid dividends.

Statistics Botswana’s analysis of the 2011 Census data further reflects the following:

- Rural areas have the highest IMR at 21/1000 followed by urban villages at 17/1000 with cities and towns having the lowest rate at 10/1000. Similarly, for USMR, Rural Areas are highest at 32/1000, followed by urban villages at 27/1000 and cities and towns coming last at 20/1000.
- Males have a higher IMR (18/1000) compared to females (17/1000)
- The most poverty stricken regions of Kweneng West and both Ngamiland East and West have the highest IMR of 28/1000, 25/1000 and 23/1000 respectively. Ngamiland West and Ngamiland East have the highest USMR at 48/1000 and 42/1000, respectively.
It should be noted however, that trends in the infant mortality rates for the period beyond 2015 will greatly depend on the country’s ability to sustain its HIV and AIDS programmes, particularly the ART and PMTCT interventions.

The national target of increasing the proportion of one-year old children who are fully immunised to 90% in 2016 was achieved as long back as 2007. Botswana’s strong coverage programme in the health sector can also be read from the high rate of pregnant women attending ante-natal clinics, which stood at 94.1% in 2007 with 94.6% of deliveries taking place under skilled personnel attendance.

CAUSES OF UNDER-FIVE MORTALITY

The two leading causes of institutional death in children 1 - 59 months are pneumonia, and diarrhoea. As shown in Figure 3 below, pneumonia accounts for 19.3% and diarrhoea for 18.3% as cause of death in infants 1-11 months of age; together they account for over one-third of institutional under one year mortality (excluding neonates).

Similarly, the leading causes of institutional death in children 12-59 months were pneumonia (16.6%) and diarrhoea (16.2%). The proportion of all other causes of death was less than 3% except septicaemia (see Fig.4).

Most of the causes of diarrhoeal disease are preventable with available cost effective interventions. As has been observed in the 2006 outbreak, diarrhoeal morbidity was associated with contaminated water, unhygienic practices at household level, poor sanitation, infant feeding practices and malnutrition.

As shown in Figure 5 below, the trend of reported number of diarrhoeal cases and deaths has significantly reduced, as diarrhoeal cases declined from 54,448 in 2006 to 20,659 in 2012. Similarly diarrhoeal related deaths dropped from 649 in 2006 to 206 in 2012. However diarrhoea case fatality rate has progressively increased from 0.5% in 2007 to 1.0% in 2012. The high case fatality (1.2%) observed in 2006 might be explained by the diarrhoea outbreak, but the increase in subsequent years might be due to poor diarrhoeal case management or delays in seeking medical assistance. Figure 4.4 below provides the trend of diarrhoea morbidity and mortality.
4.2 CHALLENGES

Lack of reliable and timely estimation of national and district based under-five mortality annual data for rational planning and assessment of health service delivery.

Lack of functional systems to determine the causes of under-five mortality including socio-economic determinants for proper planning and best use of resources to prevent and treat diseases. There is therefore need to establish an under-five mortality review to estimate and publish the total burden of childhood mortality, and determine the causes of under-five death annually.

Weak integration of maternal, neonatal and child health services at community and household levels. There is need to establish and implement an integrated community, maternal, neonatal and child health care at community and household levels through existing structures.

HIV/AIDS continues to be a major health and social problem with significant financial and other resource implications.

Low implementation of civil birth and death registration.

Notwithstanding the success of the PMTCT programme, there are mortality related issues that arise from the quality of care given to newly born babies. The risks that arise from hygienic handling and improper preparation of formula milk for babies may be high. This is particularly so because children are not always attended to by those trained on how to handle milk.

Provision of health services in remote areas, particularly those with difficult terrain, is a challenge that may lead to late access to medical care. The poverty status of residents of such places also makes it difficult for them to access, and where necessary, await advanced medical attention in central locations.

4.3 KEY INTERVENTIONS TO REDUCE CHILD MORTALITY

To ensure the highest standards of physical and mental well-being for children, the government has developed and implemented a number of effective and efficient universal interventions. These are:

EXPANDED PROGRAM ON IMMUNISATION (EPI)

The Compressive Multi-Year Plan 2012-2016, to guide the implementation of Child Health intervention. Several strategies like the African Vaccination Week (AVW), Child Health Days, Reaching Every District (RED) and Accelerated Child Survival and Development (ACSD) support and strengthen routine immunisation coverage. Supportive supervision is in place particularly in low performing districts and those with hard to reach communities.

Routine measles immunisation coverage hovered over 80% between 1996 and 2006. Following a lapse in 2007, it was further increased to over 90% until 2010. Botswana had a follow up measles vaccination, vitamin A and deworming campaign in November 2013. As part of measles elimination strategy a second round of measles vaccination, taken at 18 months was added to the national immunisation program in 2011. The country has maintained measles elimination through implementation of elimination strategies, which include achieving a high routine immunisation coverage (>90%) through strong partnership with WHO and UNICEF (See Fig. 6).

Fig. 6. Trend of measles cases and immunisation coverage

In response to the high burden of the two leading causes of under-five mortality i.e. pneumonia and diarrhoea, the Botswana developed effective intervention against these two diseases which entailed introduction of new vaccines, namely, Haemophiles Influenza type b (Hib) vaccine in 2010, pneumococcal (PCV13) and rotavirus (Rotarix) vaccines in 2012.
The success of PMTCT programme was partly attributed to the introduction of formula milk as an alternative to breast feeding to address nutritional needs of babies.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

The government adopted IMCI Strategy in 1997. It now forms part of the Ministry of Health (MoH) Strategic Plan to reduce USMR and Infant mortality rate through quality case management of common childhood illness in primary health care settings. With funding from the Government, IMCI is being implemented in all districts and all institutes of health sciences. Although progress has been made with regard to training of health workers in IMCI in all 24 districts, uptake of IMCI services is still low. There is also inadequate follow-up by trained health workers and lack of support from district health management teams.

ACCELERATED CHILD SURVIVAL AND DEVELOPMENT (ACSD)

Basic package of child survival and development, Nutrition and Water Sanitation and Hygiene (WASH) services was developed and endorsed at the highest level under the Accelerated Child Survival and Development (ACSD) strategy in 2009 to deliver the package to all, in three phases (2009/10-2015/16). The strategy was developed, and is being implemented towards prevention and treatment of diarrhoea, pneumonia, malaria, malnutrition, measles, and to concurrently accelerate service delivery and achievement of the Millennium Development Goal targets.

The high impact interventions (HII) that Government has prioritised for implementation at a national scale are: Use of Insecticide Treated Nets; Exclusive Breastfeeding; Complementary feeding; Oral Rehydration Therapy; Neonatal care; Early care seeking behaviour for illness; Use of Zinc Sulphate tablets for diarrhoea management, Hand-washing with Soap and Deworming.

Botswana embarked on a nationwide strategy to incorporate these HIIs into child services with a view to attaining MDG4. The months of May and November were earmarked for the acceleration of implementation of the HII during Child Health Days.

PMTCT PROGRAM

The PMTCT programme commenced in 2002 with full integration to the existing MCH service and has greatly contributed to the reduction of infant and under-five mortality since its introduction in 2002.

EARLY CHILD DEVELOPMENT

In 2012 Botswana initiated its Early Childhood Development programme to respond to physical and emotional care needs of young children in the family through involvement of parents, who are provided with the necessary skills to feed their children adequately, stimulate their development and be responsive to their psychosocial needs.

This programme promotes exclusive breastfeeding (EBF) as the optimal way of feeding for children in the first 6 months of life. Currently the country’s EBF rate stands at 28%. The programme also mitigates against poor infant feeding practices that contribute to the high incidence of diarrhoea and malnutrition.

PUBLIC, PRIVATE AND CIVIL SOCIETY PARTNERSHIP

The existence of a strong public-private partnership has resulted in improved health services delivery. In addition development partners and donors have contributed both financially and technically towards improved care and financing. All of these have enabled the country to effectively bring needed child health interventions to infants and children.
4.4 MONITORING PROGRESS TOWARDS MDG 4

As stated in the 2010 Status Report, Botswana’s capacity to measure and monitor child mortality remains strong. This is because a significant proportion (80%) of children in Botswana attends Child Welfare Clinics (CWCs) where their anthropometry data are collected during visits. A population based child mortality measure is collected through the Botswana Welfare Survey, which is undertaken every ten years. In between successive surveys this variable is tracked through the Botswana Demographic Survey. The assessment on the monitoring capacity is strong in almost all areas save for Statistical Analysis Capacities, which is judged as fair.

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
<th>ASSESSMENT</th>
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</thead>
<tbody>
<tr>
<td>Data gathering capacities</td>
<td>Strong</td>
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<tr>
<td>Statistical tracking capacities</td>
<td>Strong</td>
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<tr>
<td>Statistical analysis capacities</td>
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</tr>
<tr>
<td>Capacity to use statistical analysis in policy</td>
<td>Strong</td>
</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>Strong</td>
</tr>
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</table>

**GOAL 5: IMPROVE MATERNAL HEALTH**

**GLOBAL TARGET**

<table>
<thead>
<tr>
<th>WILL TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce by three quarters, between 1990 and 2015, Maternal Mortality Rate (MMR)</td>
<td>Unlikely</td>
<td>To reduce Maternal Mortality Ratio (MMR) of 326 deaths per 100,000 live births in 1991 to 150 by 2011</td>
<td>Unlikely</td>
</tr>
<tr>
<td>Achieve by 2015, universal access to reproductive health</td>
<td>Likely</td>
<td>100,000 live births in 1991 to 150 by 2011</td>
<td>Likely</td>
</tr>
</tbody>
</table>

Due to good infrastructure and high antenatal care coverage, 99% of births occur in health facilities.
INTRODUCTION

The 2004 Status Report failed to assess progress on the achievement of this target on account of incomplete data. It however described the maternal death rate as being too high despite the fact that there was good infrastructure, good antenatal coverage, and a high proportion of deliveries was being handled by trained professionals. Similarly the 2010 Status Report pronounced that the emerging trends emanating from the HIV and AIDS suggested Botswana would not be able to meet its MDG 5 maternal health targets. The material deprivation that might arise from an HIV and AIDS situation directly affects the quality of health of the concerned household. Moreover, compromised immunity that arises from an HIV condition makes pregnant mothers susceptible to other diseases such as malaria, cancer TB etc.

5.1 CURRENT STATUS AND TRENDS

The period 1990 to 2005 witnessed a very sharp decrease in maternal mortality rate (MMR) of about 60%, from 326 to 135 deaths per 100 000 live births. However, there was a reversal in 2006 when the MMR started to steadily increase (figure 5.1). With the MMR having been 163/100 000 live births in 2011, the 150/100 000 national target on this Millennium goal has clearly been missed. The current levels and trends of the MMR suggest Botswana will not be able to meet the Global target of 82/100 000 by 2015. Not only is the target too high, but the time left is also too little.

The Botswana Maternal Mortality Framework(2013) states that almost all maternal deaths in Botswana are institutional deaths in that they occur in health facilities. It can be read from Figure 5.2 that about 99 % of births in Botswana occur in health institutions. What is however worrisome, is that no data is available on deaths of non-institutional deliveries. Figure 5.3 suggests that these deliveries are concentrated in a few places with Gantsi and Mabutsane areas accounting for 75% of such deliveries. This concentration is a result of the dominance of remote area dwellers who are more dependent on traditional birth attendants for deliveries in this region.
Figure 5.4: Causes of Death

Figure 5.4 shows a breakdown of maternal death causes as according to Botswana 5-Year Maternal Mortality Report (2007-2011). The report attributes maternal deaths to haemorrhage at 96(28%), followed by hypertensive disorders at 60 (17%) and HIV related infections also at 60 (17%). Abortion causes follow at 53 (15%) as reflected on Figure 5.4. The remaining 23% is attributed to other causes. As a significant proportion of maternal deaths occurs in health care facilities, most of the deaths could be attributed to failure to provide quality care. Such sub-standard care is evident in inappropriate management and delayed interventions as reflected in Figures 5.5 and 5.6.

Figure: 5.6 Sub-standard care sub-groups

As can be seen from the above pie chart “sub-standard care” in Figure 5.5 is responsible for a total of 79 % of maternal deaths. The creation of two categories, one for “deaths under sub-standard care” and the other for “deaths under standard care” shows the solution to Botswana’s maternal mortality problem lies more with the improvement of the systems and human resource capacity than with provision of more infrastructure.

UNIVERSAL ACCESS TO REPRODUCTIVE HEALTH

Botswana has adopted the International Conference on Population and Development (ICPD) as well as the Sexual and Reproductive Health (SRH) programme which includes the following plans:

- Safe motherhood programme which Botswana adopted in 1992. Government’s main objective through the programme is to reduce maternal morbidity and mortality, to monitor pregnancies as well as provide supplementary food and vitamins to the pregnant where necessary. The programme also provides for Family Planning.
- SRH postpartum check-ups and visits by health staff to the mothers’ place of residence soon after delivery are made to ensure the mothers are safe and that there are no post-delivery complications.
Adoption of these programmes by Botswana has helped the country to achieve these encouraging Reproductive Health related scores:

- Antenatal care attendance reached 94% by 2007;
- Post natal care stood at 85.2% in 2007;
- 98.3% of births were attended to by skilled birth attendants

It can be concluded from this that Botswana is indeed on track to achieving Universal Access to Reproductive Health.

5.2 MAJOR CHALLENGES

Botswana finds itself in a very awkward situation as it has to report that it has made huge strides in respect of halting the spread of HIV and AIDS but, at the same time having to use its HIV situation to explain its failure to achieve other MDG targets. As already stated these include the country’s failure to meet MDG 5 target to reduce maternal mortality. There are, however, other factors that have militated against the achievement of these particular goals. Reducing maternal mortality demands funding along similar lines as the fight against HIV and AIDS has been funded. The sustainability of such programmes is threatened by the pulling out of donors and drying of external funding.

- Unsafe or unsupervised abortions are increasing in Botswana and thus increase the maternal mortality burden.
- While Government has done much to put in place a robust health infrastructure, poor segments of the population, most of whom live in remote areas, remain hard to reach due to logistical constraints and harsh terrain. Their poverty status also makes it impossible for them to access such health facilities.
- While it is clear that most Batswana now fully believe in modern medicine, and present themselves to clinics and hospitals when in need of medical attention, cultural beliefs, particularly in the areas of child delivery and maternal health, still abound. These interfere with efforts to contain maternal mortalities. There exists no clear knowledge of how these beliefs complement or compete with modern medicine.

5.3 KEY POLICIES AND PROGRAMMES

The following Programmes and policies, most of which were stated in the 2010 Status report are specific to maternal health.

- The National Sexual and Reproductive (SRH) Programme Framework developed in 2002 to guide the implementation of the safe Motherhood Programme. The Safe Motherhood Programme whose main purpose was to significantly reduce maternal mortality and morbidity through targeting maternal health risks was launched in 1992.

An Adolescent Sexual and Reproductive Health Implementation Strategy, targeting youth in general but with emphasis on early pregnancy.

The National Road Map for Accelerating the Reduction of Maternal and New-born babies.

The Botswana MDG Acceleration Compact which is the country’s final effort to reduce maternal mortality before the 2015 deadline.

The maternal mortality monitoring system, which guides auditing of maternal deaths.

5.4 MONITORING PROGRESS TOWARDS MDG 5

As stated in the 2010 status Report, most of the maternal mortality data is generated from antenatal clinics. To the extent that attendance of such clinics is high, such data is well representative of the population. Suffice it to say, such facility data sets capture people with specific attributes and leave out segments that might have different attributes. For example, people who do not attend these clinics may be strong believers in traditional medicine. Failing to have instruments that capture them in the data collection process could be a major loss to the policy process. Table 5.2 below summarises the country’s capacity to monitor maternal health issues.

Table 5.2 Overview of Capacity to Monitor Progress towards MDG 5

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
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</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>strong</td>
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</tbody>
</table>
INTRODUCTION
Botswana is one of the countries hardest hit by HIV and AIDS. The negative impact that HIV and AIDS had on the national welfare of the country can be observed from the trends in the Human Development Index (HDI), which declined from just below 0.7 in 1990 to just above 0.6 in 2000. The period after 2000, nonetheless witnessed a positive reversal as the country’s HDI trended up and restored the index to its 1990 levels by 2007. This was a result of the Botswana Government determination and courage to institute strong and focused prevention and mitigation programmes for HIV and AIDS. Assisted by its Development Partners, Botswana came up with a strong HIV and AIDS programme that became an international benchmark particularly for Sub-Saharan Africa. Table 6.1 below gives an overview of Botswana’s performance towards its global and national targets for HIV and AIDS, malaria and tuberculosis.

Table 6.1 Botswana’s National Versus Global Performance on HIV and AIDS, malaria and tuberculosis

<table>
<thead>
<tr>
<th>GLOBAL TARGET</th>
<th>WILL TARGET BE MET?</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET?</th>
<th>SUPPOITIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have halted HIV by 2015 and begun to reverse the spread of HIV and AIDS</td>
<td>Likely</td>
<td>To halt and reverse the incidence of HIV particularly among the youth</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td>Achieve, by 2010, universal access to the treatment for HIV and AIDS for all those who need it</td>
<td>Likely</td>
<td>To reduce the number of infants (born to HIV infected mothers) who are HIV positive by their 18th month by half by 2006 and to less than 1% by 2016</td>
<td>Achieved (2006)</td>
<td>Strong</td>
</tr>
<tr>
<td>Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</td>
<td>Likely</td>
<td>To reduce morbidity and mortality caused by Tuberculosis</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To reduce the incidence of confirmed malaria cases to below 20 cases per 1000 people</td>
<td>Achieved strong</td>
<td></td>
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</tbody>
</table>

6.1 CURRENT TRENDS AND STATUS

HALTING AND REVERSING HIV AND AIDS
Both the global and national targets aim for a reversal and halt of HIV and AIDS. Figure 6.1 sheds some light on whether the spread of HIV and AIDS has been halted and reserved in Botswana. As can be seen from the figure during the years 2004 through 2012 there was a decline in HIV prevalence for the age cohort 34 years and below while the reverse was the case for older age cohort. That the age group below 34 years of age is the most sexually active section of the population and is the child bearing group is worth noting as this should be the most vulnerable group. Furthermore, the increase in HIV prevalence for the older age group should be seen in positive light as it captures the success of both the ART and the PMTCT programmes. As the HIV positive segment of the population lives longer due to available HIV treatment, the number of older HIV positive people goes up, and thus translates to an increase in prevalence rates.

A joint analysis of figures 6.2, 6.3 and 6.4 further reveals that significant success in halting and reversing the spread of HIV and AIDS as stated in both the global and national goals has been achieved. Figure 6.2 below captures the fact that the HIV prevalence rate for the reproductive female segment has declined at an annual average rate of 3.8% from 37.4 % in 2003 to 30.4% in 2011.

GOAL 6: COMBAT HIV AND AIDS, MALARIA AND OTHER DISEASES
Even more encouraging is the fact that prevalence rates for younger child bearing age cohorts, 15-19 and 20-24 has actually started decreasing (see figure 6.3).

A hidden and greatly encouraging message in these graphs is that, as the prevalence rates for younger cohorts decrease, there is greater likelihood for HIV incidence to also decrease as there are fewer infections in these age groups. The decrease from the prevalence rate of 28.6% in 1999 to 10% in 2011 for the cohort 15-19 years and from 42.9% to 19% for the 20 - 24 years cohort during the same period signifies a decrease in new infections in these age groups, an achievement that satisfies the national objective of halting HIV incidence, particularly among the youth.

While suggesting HIV prevalence rates for age cohorts above 30 are increasing, as also stated in the 2011 Botswana Second Generation HIV/AIDS Antenatal Sentinel Technical Report, Figure 6.4 is actually captures the increased survival rate of HIV positive women through the use of ART, thus underscores the strength of Botswana’s interventions for HIV and AIDS.

REDUCING THE NUMBER OF INFANTS BORN HIV POSITIVE

Botswana’s PMTCT programme was launched in 2002. In 2004 Government implemented the Routine HIV Testing Policy which greatly increased PMTCT programme uptake as can be seen from Figure 6.5. This increased uptake resulted in fewer children being born positive. The rate has reduced from between 30-40% in the 1990s to only 3.3% in 2012 (see figure 6.5). This puts Botswana in a good position to achieve its target of 1% transmission by 2016.
A geographical analysis of HIV prevalence reveals that towns have had the highest prevalence rates followed by cities. Save for BAIS III which shows rural areas had slightly higher prevalence rates than urban villages, the other two studies show rural areas had the lowest prevalence.

**UNIVERSAL ACCESS TO TREATMENT AND CARE**

The success of the Botswana’s ARV programme can be seen in the fact that it increased life expectancy from 45 years to 65 years and reduced morbidity and mortality related to HIV and AIDS. The number of patients requiring home-based care has significantly been reduced. Absenteeism at work has been greatly reduced and there is a lower demand for hospital beds. That Botswana has achieved this target can be read from figures 6.6a and 6.6b. Between 2009 and 2010 the cumulative number that was on ART increased by 15.4% from 139,643 to 161,219 and by another 10.8% in the next year to 178,684. This places the ART coverage of those who needed the service at 96.1% in 2011, from 90% in 2009. Such high level of achievement signifies universal access to treatment. The challenge that remains however, is that of the sustainability of this success, as government budget becomes tighter and donor fatigue sets in.

**HALT MALARIA AND REDUCE THE NUMBER OF Confirmed CASES TO 20 PER 1000 PEOPLE**

Botswana’s malaria cases have been declining since 2000. Annual unconfirmed malaria cases declined from 71,555 in 2000 to 115 in 2012 representing a 99.8% decline. Confirmed malaria cases dropped from 8,056 to 193 cases representing a 97.6% decline. Deaths attributed to malaria declined from 35 in 2000 to only 3 in 2012 which signifies a 91.4% decline over a ten year period. Malaria incidence declined from 42.57 cases per 1000 population in 2000 to 0.15 cases per 1000 population in 2012. Botswana has clearly achieved its set target.

An integrated approach to prevention through house spraying, and distribution of treated mosquito nets in combination with the Anti-malaria Combination treatment (ACT), which was introduced in 2007 has brought about this substantial decrease in malaria. Given its low incidence rate, effective health systems, and strong political commitment, Botswana is likely to achieve goal of eliminating malaria by 2015.
REDUCING TUBERCULOSIS RELATED MORBIDITY

According to the 2010 Status Report “Botswana has suffered serious setbacks in its battle with TB on account of HIV and AIDS”. This has been confirmed by very high TB and HIV co-infection, reported at 63% in 2011. These high rates of co-infection justify the urgent call for a comprehensive TB/HIV collaborative response. Treatment outcomes still lag behind global achievements. In 2011, treatment success was 81.5% against a global achievement of 85%.

At the peak of the HIV scourge TB notification rates climbed from 476 in 1997 to 623 in 2002 before trending downwards. The Botswana National Tuberculosis Programme (BNTP) in the 2012 report, attributes this to successful programme intervention but it also does not rule out the possible effect of test procedure limitations. However, Figure 6.9 seems to support the argument that there has been improvement in intervention. Overall, Figure 6.9 shows that the notification rates have been below target.

Despite Botswana’s failure to reduce notification rates, the country has had notable increase in treatment success as can be seen from figures 6.10 and 6.11. Save for 2008 treatment success rate has continuously increased over the years. It increased from 73% in 2006 to reach 81.5% in 2011. Trends in tuberculosis mortality have averaged around 40%.
6.2 MAJOR CHALLENGES

While Botswana has made much progress in terms of halting HIV and AIDS and malaria, the same cannot be said about its fight against tuberculosis. Its success notwithstanding, the country still has to grapple with a number of major challenges in its overall fight against the diseases. The challenges are outlined below.

HIV and AIDS

- ART funding: as the Government budget gets tighter and donor fatigue sets in, the sustainability of progress so far made in reducing HIV and AIDS will become a major challenge. Reversals are a possibility if a strong funding strategy is not adopted.

- Success of both ART and PMTCT programmes might engender practices that encourage less caution on sexual relations and practices. This has the potential to reverse the gains so far made.

TUBERCULOSIS

- The close association of TB and HIV increases the burden of addressing HIV through a highly integrated programme.

- Multi Drug Resistant Tuberculosis (MDR-TB) prevalence also compounds the TB problem in Botswana.

PMTCT Programme

- Repeated pregnancies by HIV positive women

- Low uptake of HIV testing by couples

- Inadequate male involvement and participation in HIV prevention programmes

- Unsafe infant feeding practices that compromise the health of the child

- Lack of access to TAP/HAART by all eligible pregnant women

- Lack of follow up and testing of babies born to HIV positive mothers and initiation on HAART when necessary

MALARIA

- Lack of personnel to provide coverage and care

- Insecticide Treated Nets (ITN) coverage rates remain low, and considerably below the Rollback Malaria target of 80% for pregnant women and children. Community acceptance of spraying programmes also needs increased attention

- Inadequate resources to support the Malaria Elimination Strategy. Malaria elimination is a resource intensive endeavour and more resources are required to maintain the gains and prevent re-introduction of malaria into free zones and resurgence in cleared up areas

- Low partner base for the National Malaria Programme

6.3 KEY POLICIES AND PROGRAMMES

In addition to robust infrastructure and good human resource pool, Botswana has in place a number of programmes and policies that address the needs of the health sector. These are:
SUPPORT PROGRAMMES FOR HIV AND AIDS

- The National Health Policy which is implemented alongside an integrated Health Service plan and Essential Health Service package. Specific to HIV and AIDS, the Accelerated Child Survival and Development Strategy and a Maternal Health Roadmap have all been established. In addition, the following have also been put in place:
  - Sexually Transmitted Infections Programme of 1990;
  - Prevention of Mother to Child Transmission (PMTCT) programme of 1999;
  - Establishment of the National AIDS Coordinating Agency in 2000;
  - Introduction of Anti-Retroviral Therapy programme in 2001;
  - The National Strategic Framework (NSFII) for HIV and AIDS 2010-2016 has as one of its strategic objectives strengthening of the ethical and legal environment to support the national response
  - The National HIV and AIDS Policy provides a guide and framework for the national multi-sectoral response to HIV. The overall strategies of the National Policy on HIV/AIDS focus on Prevention, Treatment, Care and Support.
  - The Revised National Population Policy (2010) with its goal “improved quality of life and standard of living of all people in Botswana”. HIV and AIDS as a key national challenge receives due attention in this Policy which has as one of its objectives to “control the spread of HIV, reduce AIDS deaths and manage the impacts of HIV and AIDS on the economy and its repercussions on the society
  - A functioning Voluntary Counselling and Testing Programme is in place across the network of health facilities in the country
  - The National Operational Plan on HIV and AIDS: an engendered National Operational Plan for HIV and AIDS which is aligned to the strategic priorities of the NSFII.
  - The National Development Plan 10 integrates Adolescent Reproductive Health under the three goals of: Improving Maternal Health; reducing the incidence of HIV and enhancing the Socio-Economic Empowerment of Women and Youth.
  - Adolescent Sexual Reproductive Health Strategy and Implementation Plan: An ASRH strategy was developed in 2011; it has gender as an important thread that runs through it. A major objective of this plan is to scale up Youth Friendly Services and increase awareness and commitment to gender, diversity issues in HIV and AIDS ASRH services.

Policy initiatives that have been put in place to assist the Government of Botswana to fight malaria and TB are as follows:

- Malaria Policy of 2011
- Guidelines for the Diagnosis and Treatment of Malaria in Botswana 2007;
- Guidelines for Malaria Vector Control in Botswana 2007;
- Malaria Advocacy and Community Mobilization Strategy 2009;
- Malaria Case Based Surveillance Guidelines 2011
- The National Tuberculosis Strategy (2006-2015) that aims at reducing TB related mortality and morbidity is in place.

6.4 TRACKING PROGRESS TOWARDS TARGETS

Botswana has a very strong and well established system for monitoring progress in the achievement of MDGs for HIV and AIDS, Malaria, and Tuberculosis. In the case of HIV, data is collected on regular basis at clinic level. A major sources of HIV and AIDS data is the Botswana AIDS Impact Survey (BAIS) which is undertaken every four years. BAIS compiles more robust, detailed and disaggregated data that produces reliable information on HIV prevalence and incidence.

Data on Malaria and Tuberculosis are collected through the health system by capturing it at point of contact.

The challenge with health data is the comparability of institutional statistics with those from survey. Data collected at contact points is strongly influenced by the behavioural characteristics of the respondents. For example, data on child nutrition will be dominated and influenced by the characteristic of those who present themselves to clinics, and is thus less random. As such, the comparability between the more random surveys data with data collected at point of contact is a problem. This renders the use of institutional data to bridge survey gaps impossible. The consequence of this is an absence of reliable longitudinal data which in turn impairs the possibility of detailed analysis.

Another weakness with the data collection system is the dearth of capacity for robust analysis. Good data is useful to policy formulation only when it is rigorously and fully analysed. The capacity gap that exists in data analysis has therefore impaired the full utilisation of data sets that are being assembled by the health system.
GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

INTRODUCTION

The targets for this goal are stated in the table below.

<table>
<thead>
<tr>
<th>GLOBAL TARGETS</th>
<th>WILL TARGETS BE MET</th>
<th>NATIONAL TARGETS</th>
<th>WILL TARGETS BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halve by 2015 the proportion of the population without sustainable access to safe drinking water and basic sanitation</td>
<td>Achieved</td>
<td>Reduce by 50% the proportion of people without sustainable access to safe drinking water by 2016</td>
<td>Achieved</td>
<td>Strong</td>
</tr>
<tr>
<td>Reduce Biodiversity loss achieving by 2010 a significant reduction in the rate of loss</td>
<td>Likely</td>
<td>Reduce conflict between population growth, land usage and natural resource degradation</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td>Integrate the principles of sustainable development into the countries and programmes to reverse the loss of environmental resources</td>
<td>Likely</td>
<td>Promote environmental education and awareness necessary to reduce contamination and achieve sustainable development</td>
<td>Likely</td>
<td>Strong</td>
</tr>
</tbody>
</table>
ACCESS TO SAFE DRINKING WATER AND SANITATION

Botswana is on course to having universal access to safe drinking water by 2015.

Botswana was adjudged as being firmly on course to ensuring universal access to safe drinking water by the 2004 Status Report. The 2010 Status Report later affirmed this when it stated that deliberate policy and strategy action had placed Botswana in an enviable position of having met its water and sanitation targets well ahead of schedule. Below is a discussion of how this has been achieved.

In Botswana a significant proportion (83.3%) of the population had access to piped (indoor, outdoor and communal) water during 1993/94. The same proportion of the population was supplied with piped water during 2002/03, the only difference being that during this period supply for indoor piped water grew from 14.3% to 20.4% and that for outdoor piped water increased to 32.4%. Supply for the communal component decreased from 53% to 18.5%. By 2010 almost everyone (88.9%) had access to at least one of the three systems of piped water supply.
It emerges from Figures 7.2, 7.3, 7.4 that the Botswana Government had a deliberate policy that favoured urban areas in the supply of piped water. Figure 7.2 shows that for the period 2000-03, urban areas got the lion’s share of indoor piped water as 44% of urban centres had indoor piped water supply compared to 19.5% of urban villages and 5.1% of rural villages. The scenario significantly improved in 2009/10 when the percentage of rural area households with indoor piped water more than doubled to 12.4%. Figure 7.3 shows the skewed supply of outdoor piped water towards urban villages while Figure 7.4 shows communal piped water was mainly supplied to rural areas.

On sanitation the 2010 Status Report indicated that 79% of the population already had access to improved sanitation in 2007, therefore Botswana had already achieved the stated target and was on track to achieving the goal of universal access to improved sanitation by 2016.

**REDDUCING LOSS OF BIODIVERSITY**

Much human activity has led to a lot of pressure on natural resources. This has resulted in changes to the environment and loss of biodiversity. Areas of concern in Botswana include human-wildlife conflict, wildlife poaching incidents, widespread wild fires and changes in land use. Such human activity affects biodiversity – from large ungulates and globally threatened wildlife to birds and fish. It also reduces the quality of land.

**HUMAN WILDLIFE CONFLICT**

Population increase in Botswana, coupled with increased need for pastures has led to increased human-wildlife conflict as shown in Figure 7.5. The graph shows increasing numbers of conflict cases.

Leopards, lions and elephants account for a total of 83% of the human-wildlife conflict cases that occurred during the 2009-2011 period. The cause and nature of conflict can be deciphered from figure 7.6. The predominance of lion and leopard conflicts with humans suggests that 54% of the conflicts were over livestock. The elephant-human conflict is mainly over arable agriculture. The implication of this result for biodiversity is that as the conflict continues these animals will be killed leading to a reduction in their populations.
The Botswana Government has however put in place measures to protect the animals from being killed by farmers. For example, to encourage farmers not to kill lions and elephants, the government recently announced farmers would receive full compensation for loss arising from damage caused by the animals. This was a shift from the government’s previous partial compensation which was not enough motivation for farmers not to kill destructive animals.

WILDLIFE POACHING

The human wildlife conflict, combined with increased poaching, has also adversely affected wildlife numbers. In its recent aerial census of animals in Botswana the Department of Wildlife found that Springbok numbers had dropped by 71% between 1992 and 2012. Sitatunga numbers had decreased by 59% during the same period and Tsessebe by 79%. These huge drops in numbers are a cause for concern and herald the usual dangers arising from decreased biodiversity.

The same Aerial Census also established that elephant numbers increased by 297% during the same period. As the report aptly puts it, although this animal plays a pivotal role in the development and maintenance of the ecosystem, huge populations negatively impact on the conservation of biodiversity. For this reason, the Botswana Government finds itself having to protect the elephant from poachers and at the same time having to come up with strategies for optimally managing its rapidly increasing numbers.

WILD FIRES AND RANGELAND LOSS

A cross-section of the Gaborone Forestry Reserve. Government has put in place robust programmes to fight loss of biodiversity through deforestation and wildfires.

Human activity does also put pressure on biodiversity through wild fires. Large tracks of rangeland are destroyed by fire resulting in loss of land cover and precious biodiversity. Figure 7.7 shows the amount of land – in millions of hectares – that is damaged by wild fires every year. In 2011 alone, 16 million hectares of land were damaged by wild fires.
The consequence of such fires on forest cover can be read from Figure 7.8. The figure shows this cover has progressively decreased from 77.6% in 2010 to 75% in 2012. This, in a way, explains the trend emerging in Figure 7.9 where the carbon mass has declined from 680 million tons in 1990 to 646 million tons in 2010.

It was in recognition of the above that the Mid-term Review (MTR) of NDP 10 acknowledged that Botswana’s biological resources were under increased threat of habitat destruction and over-exploitation. Re-stocking of species at risk of extinction, anti-poaching, implementation of natural resources management plans for specific key areas, and manufacturing of sand from crushed rock to alleviate impacts of sand over-mining were all implemented. Specific to forest reserves, trees were planted as indicated in the table below.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>NUMBER PLANTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/2010</td>
<td>141 256</td>
</tr>
<tr>
<td>2010/2011</td>
<td>136 509</td>
</tr>
<tr>
<td>2011/2012</td>
<td>129 833</td>
</tr>
<tr>
<td>2012/2013</td>
<td>122 931</td>
</tr>
<tr>
<td>2013/2014</td>
<td>19 002</td>
</tr>
<tr>
<td>Totals</td>
<td>40 8275</td>
</tr>
</tbody>
</table>

Source: Department Of Forestry Report

LAND USE CHANGES

Unplanned land use change can compromise biodiversity. Lack of gazetted district land plans, mismanagement of grazing land leading to land degradation, encroachment of human settlement into agricultural and wildlife areas, as well as conversion of arable land to other uses can all lead to destruction of biodiversity. Land pollution can have similar effects.

Recognising the consequences of improper land use, the government decided during its Mid-term Review (MTR) of NDP 10, to focus on “the development and implementation of land management policies to facilitate access, distribution and demarcation, development and utilisation of land to achieve the sustainable development goal”. Specific initiatives listed were:

- Land Policy and database development, gazetting of potential agricultural land and Wildlife Management Areas (WMAs).
- Gazetting of WMA: legislative review of the Wildlife Policy had made significant progress and review of the Act was about to commence.
The draft Land Policy was developed with a total of 29 settlements to be demarcated.

Establishment of land information database aiming at capturing data on land ownership and use.

A total of 2.1 million hectares of agricultural land was gazetted against a target of 3 million.

**REDDING LOSS OF BIODIVERSITY: PROGRESS SO FAR**

Escalating levels of human wildlife conflict, increasing levels of poaching and prevalence of wildfires together with the pressure for change in land use as signified by illegal settlements and squatting, suggest Botswana is still challenged in its endeavour to manage biodiversity. The loss of forests due to fires and the declining numbers of some species also support the argument Botswana is yet to win the battle against loss of biodiversity. The government of Botswana has however put in place systems to address these challenges. Sustained, these efforts will likely enable the country to achieve this objective, going forward. Government’s commitment to the integration of principles of sustainable development into the country’s policies also shows determination at the highest levels of national leadership to reverse the loss of environmental resources through loss of biodiversity.

**PROMOTING ENVIRONMENTAL EDUCATION AND AWARENESS**

In its MTR for NDP 10, Government stated that the public, business communities, sector ministries and non-governmental organisations were sensitised to actively participate in environmentally friendly practices. However the desired impact was not realised. The MTR states that specific initiatives were undertaken to support arable agriculture, renewable energy, reduction of water and land pollution, and the associated negative health impacts such as water borne disease outbreaks were started but they are not yet yielding the desired results.

**7.2 MAJOR CHALLENGES**

Botswana faces major challenges in sustainable environmental resource use in the following areas:

- Shortage of serviced land for different uses. This causes land use conflicts arising from encroachment

- Limited awareness and understanding of global warming effects by both the general public and the private sector. This has limited the effectiveness of policies so far designed to address sustainable development issues

- High levels of poverty that limit the appreciation for and desire to maintain biodiversity

- Poor participation by stakeholders in fire suppression activities

- Shortage of resources (e.g. transport) for fire fighting purposes

**7.3 KEY POLICIES AND PROGRAMMES**

Most existing policies and strategies target the sectors of Agriculture, Energy, Tourism, Wildlife, Waste Management, Human Settlement and Water. Land management policies that facilitate access, distribution and demarcation of land are in place and remain central to sustainable development. Major in this group of initiatives is the Land Policy and data base development; as well as the gazetting of
potential agricultural and wildlife Management areas.

Policy initiatives that address the need to reverse the loss of biodiversity entail initiatives on land rehabilitation, restocking of species that are at risk of extinction and anti-poaching. Natural Resource Management Plans for such key areas as Makgadikgadi and Okavango have been put in place.

The Forestry Policy was approved by Parliament in 2011 and the Environmental Impact Assessment Act was repealed and replaced by the Environmental Assessment Act in 2011.

Botswana recognised the importance of the discourse on Climate Change by forming a Parliamentary Portfolio Committee on Wildlife, Tourism, Natural Resources and Climate Change in 2011. The country also compiled the second report to the Secretariat of the United Nations Framework Convention on Climate Change (UNFCCC) which identifies sectors of the economy that emit greenhouse gases and identifies mitigating strategies to reduce these emissions.

Going forward, Botswana is in the process of establishing the following:

- National Environmental Fund aimed at providing sufficient resources for the environmental activity agenda
- National Strategy for Sustainable Development (NSSD)
- National Energy Policy
- Land Infrastructure Servicing Policy
- And implementing both the Land Policy and the Wildlife Policy

7.4 MONITORING PROGRESS TOWARDS MDG 7

Over the years, Botswana has strengthened its capacity to assemble robust and useful databases on the environment. The sector’s current focus is on building an even stronger database particularly on land management. Skill shortage has however, continued to weaken both data analysis and use of such data for monitoring and evaluation. That notwithstanding, noble efforts are being made to use the data for policy making purposes. Table 7.2 summarises the sector’s ability to monitor progress in this MDG.

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
<th>ASSESSMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data gathering capacities</td>
<td>Good</td>
</tr>
<tr>
<td>Quality of survey information</td>
<td>Good</td>
</tr>
<tr>
<td>Statistical tracking capabilities</td>
<td>Good</td>
</tr>
<tr>
<td>Statistical analysis capacities</td>
<td>Good</td>
</tr>
<tr>
<td>Capacity to use statistical analysis in policy</td>
<td>Fair</td>
</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>Fair</td>
</tr>
</tbody>
</table>
INTRODUCTION

The first MDGs Status Report of 2004 revealed that Botswana was already well positioned to benefit from the global trading and economic system because of the investments that the country had already made - good foreign policy, strong governance systems and robust trade relations. The second Status Report of 2010 pointed to the fact that Botswana had initially benefitted from Official Development Assistance (ODA) which had now dried up. It was, therefore, prudent for the country to aim at positioning itself to benefit from the world trading system as an alternative source of economic growth. Table 8.1 gives an overview of performance towards the MDG 8 targets.

8.1 CURRENT STATUS AND TRENDS

The 2010 MDGs Status Report illustrated the negative trade balance in the Botswana economy where import levels exceeded exports beginning 2006. Figures 8.1a and 8.1b confirm this situation and further demonstrate that imports have exceeded exports for both goods and services.

Table 8.1: Overview of performance towards the global and national global partnership targets

<table>
<thead>
<tr>
<th>GLOBL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>NATIONAL TARGET</th>
<th>WILL TARGET BE MET</th>
<th>SUPPORTIVE ENVIRONMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop further an open, rule-based, predictable and non-discriminatory trading and financial system</td>
<td>Likely</td>
<td>Develop further an environment conducive for beneficial trade and foreign direct investment</td>
<td>Likely</td>
<td>Strong</td>
</tr>
<tr>
<td>In cooperation with the private sector, make available the benefits of new technologies</td>
<td>Likely</td>
<td>In cooperation with the private sector, make available the benefits of new technologies</td>
<td>Likely</td>
<td>Strong</td>
</tr>
</tbody>
</table>

To the extent that exports are more associated with employment generation than imports, the negative balance in both cases signifies the challenge that Botswana faces in trying to create employment and eradicate poverty.
That these exports are dominated by the capital intensive Diamond Sector, as illustrated in Figure 8.2, makes the situation even more challenging as the sector has low employment generating capacity. The above figure shows that close to 80% of the country’s total export goods were derived from the Diamond sector during both 2011 and 2012.

Welfare implications of this situation are further captured in Figure 8.3 which shows that second to diamonds, fuel and food are the next major imports. The welfare implications of this is that Botswana has very little control over global fuel and food prices both of which have recently been subjected to substantial increases. This has no doubt adversely affected the welfare of Botswana consumers - particularly the poor and the unemployed.

In terms of what the situation looks like regarding Botswana’s trading system the answer is that Botswana needs to gear up its production system and boost its trade position.

The Botswana Government has however, taken a number of initiatives directed towards improving cross border trade. The Trade Act Amendment Bill was passed in 2010 with the aim of enabling a simplified and efficient licensing system in the economy to promote trade. The Companies Act was amended to enable the reduction of business start-up costs and in the same vein an indefinite licensing system was introduced. An Agricultural Hub was established to facilitate the establishment of mega agricultural projects that would entice the Private Sector to actively participate in the economy.

The Need for Foreign Direct Investment (FDI) and Official Development Assistance (ODA)

Government budget trends and debt position suggest that it cannot continue to directly participate in economic activities as it did in the past. Figure 8.4 shows that while the period before 2006 was characterised by increasing budget surpluses, the period after 2006 experienced decreases in surpluses which culminated in a deficit position in 2008. This means that Government no longer has savings to spend.
As a consequence, Government debt has significantly increased. This is captured by Figure 8.5. Figure 8.6 further shows that while before the Global Financial Crises (2008/9) the debt/GDP ratio never exceeded 10% and was as low as 5% in some years, there was a substantial increase in this ratio in the period following the crises -- reaching 30% in 2012. It should be noted however, that by law the maximum permissible Debt/GDP ratio in Botswana is 40% where the ceiling for internal debt is 20%; and that for external debt the ceiling is also 20%, yielding a total of 40% between the two of them.

In conclusion, this result confirms Botswana’s urgent need to open a rule-based predictable trading financial system and the need for an environment conducive for beneficial trade and foreign direct investment.

FOREIGN DIRECT INVESTMENT

Access to world markets in order to increase exports can be achieved through increased productivity. Figure 8.7 shows that FDI in Botswana is dominated by Mining at almost 75% share with the Finance sector coming a distant second at 17.5% share.

Retail is third at 2.26% and Manufacturing, Transport and Communication, Construction and Hospitality contribute less than 1% of FDI and are, thus, not visible in this figure. What is significant is that these sectors with insignificant shares are, in some quarters, believed to be Botswana’s potential future growth poles.
Figure 8.8 shows that about three quarters (74.2%) of FDI to Botswana comes from Europe, while 15.7% comes from Africa and only 1.1% from the Americas. Asia Pacific and Middle East almost bring no FDI into the economy. Luxembourg accounts for 90% of the European component with the United Kingdom coming a distant second at 8.9% of this share. South Africa dominates the African component of FDI to Botswana by accounting for 80.1% of the total FDI from this group. From the foregoing it can be concluded that FDI into Botswana is highly concentrated in the mining sector and comes from a very narrow and concentrated source. Trends in the government budget and debt position clearly suggest there is need to diversify both the sources of FDI and the sectors into which FDI should be channelled.

THE PRIVATE SECTOR’S ROLE IN ECONOMIC GROWTH?

Botswana has experienced phenomenal growth in the use of ICT particularly cellular phones and internet. When the global financial crisis struck in 2008/09 the Botswana mining sector shrunk by one third during the first three years of NDP 10 while the Non-mining sector, excluding government, grew by an average of 7.1%. The Mid-term Review for NDP 10 projected that this sector would continue growing until it reached 8.1% in 2015. This sector’s share of GDP was projected to grow from 71.1% in 2009/10 to 77.8% in 2015/16. That of the mining sector would decrease from 15.1% in 2009/10 to 11.6% in 2015/16. Botswana is therefore targeting, at policy level, private sector led economic growth.

According to the NDP 10 Mid-term Review, Botswana is aware of the fact that if it is to make any headway in attracting FDI, it has to improve its global rankings in Doing Business. In response to this need a Cabinet Committee on Doing Business and Global Competitiveness consisting of ministers of Trade and Industry (as the chair), Finance and Development Planning, Labour and Home Affairs, Lands and Housing, Local Government and that of Minerals, Energy and Water Resources has been set up to oversee the work of the National Doing Business and Global Competitiveness Committee. The committee’s mandate is to coordinate reforms necessary for improving the ease of doing business and to improve Botswana’s global competitiveness.

In addition to the provision of a conducive macroeconomic environment for the private sector, the country is also positioning itself to use the National Information and Communications Technology Policy (MaTiamo) for transformation through the effective use of Information and Communications Technology (ICT) through the areas of: e-Government, Connecting Botswana, Connecting Communities, e-Legislation, e-Education, e-Health and e-Commerce.

![Figure 8.9 ICT Use in Botswana](image)

The ICT picture seems very promising as captured by the telecommunication sector. Phenomenal growth in the use of ICT has been experienced in the use of cellular phones. This sector’s growth was probably highest during the 2005 and 2010 period. As at 2012, for every 100 people there were 160 phones being used, implying that people were now having more than one phone. This does not only reflect increased use of phones but also reflects the existence of competition in the sector as consumers diversify their service providers. While the use of internet started picking in 2011, fixed line use has remained virtually stagnant. The rise in the use of internet seems to have been riding more on the back of mobile internet than on fixed-line based internet.

Three clear conclusions can be drawn from the above in respect of Botswana’s need to develop a global partnership for development. First, Botswana trade patterns suggest an urgent need to boost exports of both goods and services. The focus
position and debt level call for increased FDI and ODA. The concentration of FDI in one sector and from limited sources also suggests an urgent need for diversification of sectors into which FDI is going and sources from which it is coming. All these points suggest that Botswana should invest more effort on global partnership for development.

Second, Mineral Sector Vulnerability to global instabilities requires a strong non-mining sector to be created by way of creating a conducive environment through policy and incentives.

Third, experience with the communication industry suggests that there is scope to use ICT as a vehicle for economic growth and poverty alleviation.

8.2 MAJOR CHALLENGES

Efforts to achieve the above discussed will be confronted by both external and internal challenges. Some of them are:

- Global economic instability encouraging rent seeking related investments as well as predatory investments instead of the standard long-term investment. As stated above, FDI is focused more on mining than other sectors mainly due to the rental that can be derived from this sector.
- Lack of Macroeconomic–Microeconomic congruence. The fact that macroeconomic policy only provides a conducive environment for investment while microeconomic policy ensures that investment actually occurs is normally overlooked. Lack of congruence between these environments can lead to counterproductive results. For example, the elimination of exchange controls in an economy that has high utility charges and stringent labour regulations will not necessarily attract FDI. The FIAS Report has listed a number of sectoral issues that Botswana needs to address to ensure that mileage is made from our strong macroeconomic environment.
- Botswana needs to identify where its comparative advantage lies and historically, this has not been easy.
- While FDI is good for growth of any economy as it brings into the economy technology, managerial skills, systems and employment generation, not all foreign investment can deliver that. FDI that does not have these components and does not have strong linkages with other sectors of the economy should be avoided.
- Botswana has, over the years, developed a very strong base for social infrastructure at the expense of productive infrastructure. Targeting infrastructure to production areas will not only boost economic growth but also attract FDI onto the not-so-easy-to-invest in sectors and areas.

8.3 KEY POLICIES AND PROGRAMMES.

Through the Economic Diversification drive a number of policies and programmes have been put in place. Some of them are the following:

- The National Export Strategy aimed at creating an environment where the private sector can invest in the economy through a conducive regulatory environment created by government
- The Export Development Programme is the vehicle for preparing Botswana to be export ready
- National Trade Policy promotes cross border trade with the private sector taking the lead
- Botswana Investment Strategy promotes both FDI and local private investment
- The Industrial Development Policy aims at capacity building for competitiveness
- Competition Policy and Law, aims at providing a stable and predictable environment to investors; and
- The Innovation Hub which was created to attract investors as well as mentor small and medium entrepreneurs

8.4 MONITORING PROGRESS TOWARDS MDG 8

The Bank of Botswana, the Ministry of Finance and Development Planning; the Ministry of Trade and Industry; Ministry of Foreign Affairs, and Statistics Botswana all have a wealth of experience in collecting, compiling and analysing data on trade and FDI. The rating for this area is given in Table 8.2

<table>
<thead>
<tr>
<th>DIMENSION OF CAPACITY</th>
<th>ASSESSMENT</th>
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<tbody>
<tr>
<td>Data gathering capacities</td>
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<tr>
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<tr>
<td>Statistical Tracking capabilities</td>
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<tr>
<td>Statistical Analysis capacities</td>
<td>Fair</td>
</tr>
<tr>
<td>Capacity to use statistical analysis in policy</td>
<td>Strong</td>
</tr>
<tr>
<td>Monitoring and evaluation mechanisms</td>
<td>Good</td>
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</table>
BEYOND THE MDGS - SOME THOUGHTS ON THE POST 2015 AGENDA

Botswana's performance has been impressive in all MDS except MDG 4 (Child Mortality) and MDG 5 (Maternal Mortality). The performance on MDG 3 (Gender equality) has been mixed as there has been some progress and some reversals. The critical question is whether the country’s current development context provides a conducive environment for the sustainability of these achievements up to 2015 and beyond? Below is a description of the development context and its implication for the post 2015 agenda.

TOWARDS SUSTAINABILITY

The office of the Ombudsman and Land Tribunal in Gaborone was built through a public-private partnership. Botswana is increasingly allowing the private sector greater participation in economic development.

The country's current development context is one in which robust strategies are needed to ensure that reversals in what was previously achieved do not occur. This is because the Mid-term Review (MTR) for National Development Plan (NDP) 10 projected that Botswana would experience a general and gradual decline in GDP growth from 8.1% in 2010/11 to 7.5% in 2011/12 finally reaching 5.7% in 2014/15 before marginally recovering to 6.0% in 2015/16. The situation is made worse by forecasts that during NDP 11, diamond mining might start moving away from the current open pit system to underground mining, a move that will reduce the profitability of this resource. In fact, NDP 10 projects that diamonds might actually start running out during NDP 12. It was further projected that the Government Sector's contribution to GDP would decrease from 13.8% in 2009/10 to 10.6% in 2015/16, while the mineral sector’s share would decrease from 15.1% in 2010/11 to 11.6% in 2015/16. These trends would cause the Non-mining sector - excluding Government Sector- to increase its share in GDP from 71.1% in 2010/11 to 77.8% in 2015/16.

The significance of this declining importance of the Government sector in economic growth to the MDG discussion in Botswana is that the country's sterling performance in the past was mainly dependent on Government expenditure as well as Government-spending driven economic growth. It has already been shown, in earlier sections of this report, that Government debt, both in absolute terms and as a percentage of GDP, has significantly increased and that the Government budget has moved from surplus to a deficit position. Should this trend continue, as it most likely will, the question of how the MDG achievements so far attained will be affected becomes critically important. To the extent that the achieved universal access to primary education has almost been exclusively funded through the government budget, this MDG's achievement is most likely to suffer, should the government budget significantly reduce. Poverty reduction programmes have also been almost exclusively funded by the government. The fact that these have been more income redistributive programmes than productive ones places poverty alleviation in more serious jeopardy of reversal, should the government budget position worsen. That the Botswana Government has funded the ARVs budget to the tune of 70% over the years suggests that the already attained universal access to HIV related medication might suffer a reversal should the government budget become seriously constrained. Botswana thus needs a well thought-out strategy ensure no reversals occur in the areas that progress has been made, as the economy becomes less government expenditure driven. How the previous MDG achievements can be sustained in the context of declining government spending and reduced economic growth momentum, should occupy the greater part of Botswana’s post 2015 agenda.

THE INCLUSIVE GROWTH APPROACH

One possible strategy to consider in the post 2015 agenda would be to determine how the Botswana Government could create an environment that encourages increased Private Sector participation in growing the economy, while at the same time contributing to the MDG agenda. The Inclusive Growth Approach to economic growth and development in the post 2015 era is one way through which economic
progress can be achieved without MDGs achievements reversal. Rapid and sustained economic growth requires inclusive growth that allows people to contribute to and benefit from the same growth. Such growth should be broad-based across sectors and inclusive of a large part of the country’s labour force. By its nature, inclusive growth takes a longer term perspective by focusing on productive employment of excluded groups rather than placing emphasis on direct income distribution. Income redistributive schemes impose a heavy burden on government budgets without producing any long-lasting solutions to poverty. Post 2015 Botswana will thus be challenged to take to a paradigm shift from government expenditure-dependent economic growth to a private sector dependent economic environment that places emphasis on inclusive economic growth.

The implication of such a strategy is that instead of just emphasising on economic diversification and the attraction of DFI, the country would place emphasis on economic diversification and FDI that create maximum employment. FDI should not just bring in investment funds but should also generate employment, and also bring into the country technological and managerial skills as well as access to global markets. Economic diversification should focus on those sectors that generate forward and backward linkages with other sectors in a manner that creates significant multiplier effects for the rest of the economy. As argued in earlier sections of this report, foreign direct investment should not concentrate on the mining sector alone but, should be diversified to other sectors of the economy, particularly those that have greater backwards and forward linkages with other sectors. Furthermore, the geographic origins of such FDI should be diversified to ensure improved market access to different global markets. The use of inclusive economic growth models will, through employment creation, directly address issues of unemployment and ensure sustained poverty eradication and thus avoid reversals.

The creation of a conducive environment for increased private sector participation will also open up the sector’s involvement in those areas that have previously been the preserve of Government. For example, with correct incentives the private sector might start appreciating the need to invest in enhanced labour productivity through education, training and health care programmes. The search for the correct education funding models that make employers active participants in the funding of education as well as the determination of relevant curricular can become a shared responsibility between the government and the private sector. Similarly, how government can provide proper incentives that encourage employers to contribute more towards HIV and health-related expenses should be sought as part of the post 2015 agenda. This will ensure Botswana sustains MDG achievements so far made.

SYNERGIES BETWEEN THE MDGS

The discourse on MDGs seems to have omitted issues around the synergies that exist among the MDGs themselves, be they negative or positive. The role of health as a means and an end to development has not been fully discussed and articulated in Botswana. It is for that reason that the private sector has not been very active in addressing HIV issues. Consequently HIV related funding remains almost exclusively government responsibility. The discussion of how good health as an end in its own right and as a means through which economic growth can be achieved is central to the MDG agenda in terms of sustainability of such achievements.

Another illustration of the need to pay attention to the synergies that exist between MDGs is the fact that Botswana has achieved MDG 6 but failed with respect to MDG 4 and MDG 5. How HIV dimensions may be responsible for the failure in these other two health MDGs has not been fully discussed and researched in Botswana. In its post 2015 agenda Botswana will need to research and articulate the nature of these synergies to better strategise for achievement of MDG 4 and MDG 5.

Yet another synergy related point is that the effect of human rights and discrimination effects on MDGs have not been fully considered. The discussion of the link between gender equality and the spread of HIV and AIDS has not been adequately researched and discussed. Similarly the link between gender equality and poverty alleviation has not been adequately discussed. The post 2015 agenda will need to discuss these under the MDG synergies agenda.

In Botswana, the illegal status of men who have sex with other men makes it difficult to determine this group’s role in the spread of HIV. Similarly, the illegal nature of supervised abortions has a bearing on maternal mortality rates. The illegal status of commercial sex work makes it difficult to assemble data that will enable proper programming of HIV prevention at a national level. The reconciliation of these legal dimensions with the need for HIV prevention strategies will need to be discussed as part of the post 2015 agenda.

A non-health related example of MDG synergy would be the link between poverty alleviation and environmental sustainability. Saying the poor not to over harvest firewood or mopani worms without giving them options for their livelihood could be self-defeating. The link between these two MDGs needs to be understood in order that proper programming can be undertaken.

In conclusion, it should be noted that as the post 2015 agenda takes on board MDGs synergy issues, it will now be possible to pronounce on whether the success in any particular MDG has net positive or negative effects on society’s overall welfare.
UNDERSTANDING EFFECTS AND IMPLICATIONS OF GLOBAL WARMING AND CLIMATE CHANGE

The effects of climate change: Gaborone Dam which supplies nearly 600,000 people was expected to dry up by October 2014 unless it received inflows. Southern Botswana has in recent years experienced below average to no rainfall.

The link between climate change and MDG 1, poverty alleviation and the Health MDGs and economic growth in general, is enormous. According to the Mid-term Review (MTR) of NDP 10, climate change manifests itself through extreme weather events such as floods, drought and high temperatures. Climate change can lead to disease outbreaks, decreased food production and can even accentuate rural-urban migration.

In spite of these listed above effects of climate change, the MTR states that Botswana’s ability to commit resources and capacity to respond to the impact of climate change is presently inadequate. The review cites one of the challenges faced in respect of climate change as “low level of awareness in respect of the causes and impacts of climate change on ecosystems, human health, welfare and economy”.

The fact that unlike HIV whose immediate effects are felt at individual level, those of climate change are global. While one can avoid HIV through individual behaviour change, healing the climate and avoiding causing damage to it can only be effected through coordinated collective action. This suggests that the need for awareness of climate change effects is just as important as that of HIV if not more important. In that respect, the post 2015 agenda will have to elevate climate change awareness campaign to the HIV campaign awareness levels. Such a campaign should involve the public and the private sectors.

ADDRESSING DISPARITY GAPS

The Millennium Development Goals Report of 2013 argues that disparities between locations and groups often stand in the way of further improvement called for by the MDGs. One such disparity is the persistent existence of rural-urban gaps in levels of income. Access to reproductive health services and to clean water is another example. Yet one other gap is that poorest children are most likely to out of school than those of the rich. Gender-based inequality in decision making between men and women is another gap that has persistently blocked the achievement of MDGs.

All these gaps have also been observed in Botswana. Notwithstanding the good progress that has been reported in most goals in Botswana, it is still not clear who has benefited most from these positive developments. For example, while it is clear that there has been a significant decrease in the primary school dropout rates, it has also emerged that boys, are the ones who drop out the most. One possible explanation for this has been that these dropouts may be economically motivated where young boys are forced to leave schools to seek employment to support their families. No data actually exist to the nature, causes and motivation of these primary school dropouts which makes policy targeting difficult. The post 2015 agenda will have to close such gaps.

A similar problem exists regarding the increase in both infant mortality and maternal mortality. It has been argued that economic factors may be at play where most of these deaths may be coming from poor households who are unable to sustain the welfare of the children and mothers once the government institutional support ceases to be available. It also could be the case that the poor households fail to maintain the required health standards due to lack of resources and cultural beliefs arising from lack of education. No concrete information and research knowledge exists about the situation on the ground is. The post 2015 agenda will have to take up these issues and address them.

As for the existence of gaps regarding information on these disparities it is recommended that the post 2015 MDG agenda should mainstream disparities in its analysis. National, regional and group specific analysis should be factored into the monitoring and evaluation framework of the MDG processes. In order for that to be possible, efforts to assemble detailed data that enables comprehensive analysis that can tease out these disparities should be put in place. These gaps will therefore have to remain central to the MDG programming process.
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