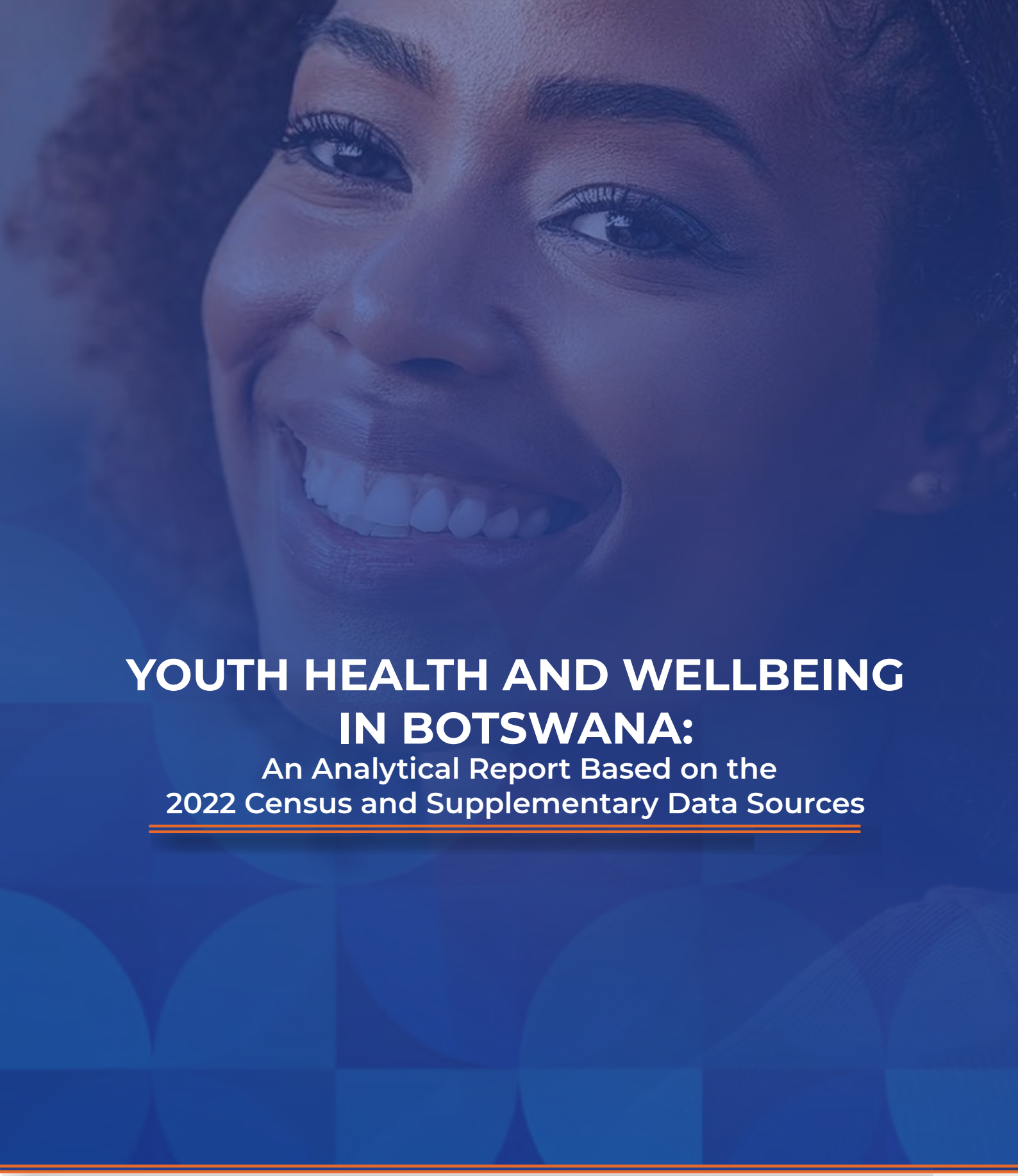


YOUTH HEALTH AND WELLBEING IN BOTSWANA:

An Analytical Report Based on the 2022 Census and Supplementary Data Sources

Private Bag 0024
Gaborone
Tel: 3671300
Toll Free: 0800 600 200

Private Bag F193,
Francistown
Tel: 241 5848

E-mail:
info@statsbots.org.bw
Website
www.statsbots.org.bw

Four Thirty Square,
Plot 54350
PG Matante Road, CBD
Gaborone

STATISTICS BOTSWANA

Republic of Botswana

UNFPA

YOUTH HEALTH AND WELLBEING IN BOTSWANA:

An Analytical Report Based on the 2022 Census and Supplementary Data Sources

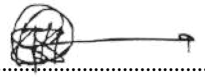
Preface

The 2022 Population and Housing Census **(PHC)** marked a transformative milestone in Botswana's statistical development, being the country's first fully digital census. This technological advancement significantly improved the quality, efficiency, and timeliness of data collection and dissemination—setting a new standard for national statistical operations. The PHC offers a rich and comprehensive dataset capturing critical demographic, social, and economic dimensions, and provides a strong foundation for evidence-based research, policy formulation, and monitoring of development frameworks, including Vision 2036, the National Development Plans **(NDPs)**, the Sustainable Development Goals (SDGs), and the African Union Agenda 2063.

This analytical report, titled **"Youth Health and Well-Being in Botswana,"** focuses on a key segment of the population that holds immense potential for the country's future. Youth health and well-being are central to national development, shaping not only current public health outcomes but also the long-term social and economic trajectory of the country. The report is a product of collaboration between Statistics Botswana and the United Nations Population Fund **(UNFPA)**. This partnership is part of a broader initiative aimed at strengthening the availability and use of disaggregated health data to support informed decision-making and programming for young people.

Drawing on the 2022 Botswana Population and Housing Census and integrating data from supplementary sources—including the Botswana AIDS Impact Survey V **(BAIS V)** and relevant administrative datasets—the report examines a range of youth health indicators. These include sexual and reproductive health, mental health, and access to health services, substance use, and health-related behaviors. The analysis identifies key trends, disparities across geographic and socio-demographic groups, and potential areas for policy and programmatic intervention.

We extend our sincere gratitude to the technical teams, analysts, and institutional partners who played a critical role in the compilation, validation, and interpretation of the data. We also acknowledge the continued support of UNFPA, whose commitment to youth empowerment and health equity has been instrumental in the production of this report.



Dr Khaufelo Raymond Lekobane
Statistician General
February, 2026

Tlangelani Shilubane-Pietersen

Ms Tlangelani Shilubane-Pietersen
Head Of Office, UNFPA
February, 2026

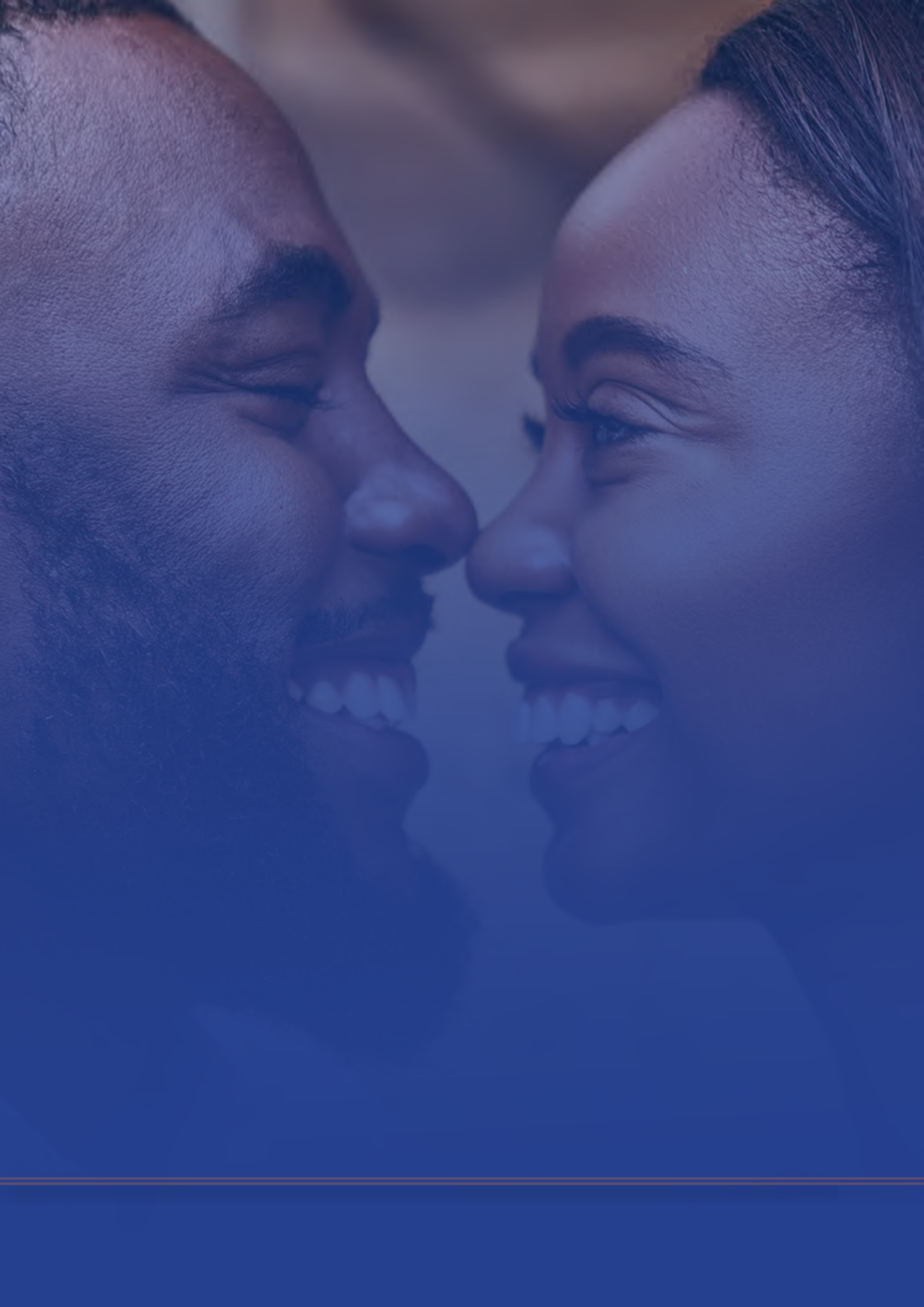
TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ASRHR	Adolescent Sexual and Reproductive Health and Rights
BDS	Botswana Demographic Survey
BAIS	Botswana AIDS Impact Survey
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
IEET	In Education, Employment, or Training
LFS	Labour Force Survey
LMIS	Labour Market Information System
MICS	Multiple Indicator Cluster Survey
MoESD	Ministry of Education and Skills Development
MoH	Ministry of Health
MoHW	Ministry of Health and Wellness
MYSC	Ministry of Youth, Gender, Sport and Culture
MMR	Maternal Mortality Ratio
MMRate	Maternal Mortality Rate
NEET	Not in Education, Employment, or Training
NGO	Non-Governmental Organisation
NDP	National Development Plan
NHP	National Health Policy
NIP	National Implementation Plan
NMM	Notifiable Maternal Mortality
OPD	Organisation of Persons with Disabilities
PHC	Population and Housing Census
PMDF	Proportion of Maternal Deaths among Female Deaths
QMTS	Quarterly Multi-Topic Survey
RH	Reproductive Health
SDG	Sustainable Development Goals
SE	Standard Error
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
TVET	Technical and Vocational Education and Training
UNFPA	United Nations Population Fund
WHO	World Health Organization

LIST OF TABLES

LIST OF FIGURES



EXECUTIVE SUMMARY

This report provides an in-depth analysis of youth health and wellbeing in Botswana, focusing on individuals aged 10 to 35 years. It is intended for policymakers, development partners, civil society organisations, and service providers involved in youth development. Using data from the 2022 Population and Housing Census (PHC), BAIS V, Quarterly Multi-Topic Surveys (QMTS), and Ministry of Health administrative records, the report evaluates youth outcomes in maternal health, sexual and reproductive health (SRH), HIV testing, disability, and economic participation. The findings are meant to inform policy formulation, guide programme design and resource allocation, and strengthen accountability systems aimed at improving health and development outcomes for young people in Botswana.

Highlights of Findings

1. Understanding Discrepancy between MoH and Census Maternal Mortality Data Sources

- Where discrepancies between sources arise, such as in estimates of maternal mortality, this is often due to methodological differences. PHC estimates reflect broader household reporting, which may include unverified or out-of-facility deaths and be affected by recall bias, whereas Ministry of Health data are limited to officially reported facility-based events. This distinction is important and is discussed in greater detail in later sections of the report.

2. Elevated Maternal Mortality Among Young Women

- Maternal mortality remains a critical concern among youth. It is concentrated among young women aged 20–24 years. Based on adjusted estimates from the 2022 PHC, the Maternal Mortality Ratio (MMR) peaks sharply in this group at 404.0 per 100,000 live births, compared to 33.0 for ages 15–19, 93.1 for ages 25–29, 101.2 for ages 30–34, and 92.2 for age 35. The MMR for the 20 to 24 year olds is significantly higher than the global Sustainable Development Goal (SDG) target of fewer than 70 per 100,000 live births by 2030 (WHO, 2023), and also exceeds the global average MMR of 223 (WHO, 2023). These findings underscore the vulnerability of younger mothers and the importance of targeted interventions.

Ministry of Health data from 2022 show a different pattern of maternal mortality risk, with the highest MMRs recorded among older youth. The MMR increases steadily with age: 100.6 per 100,000 live births for ages 15–19, 76.1 for 20–24, rising to 136.8 for 25–29, 222.0 for 30–34, and peaking at 228.8 for age 35. This highlights the importance of distinguishing between maternal death counts and actual risk when interpreting age-specific trends.

The PHC highlights an especially high burden among 20–24-year-olds, while MoH data show increasing risk with age. Together, the data confirm that maternal mortality affects both younger and older youth, with varying intensity depending on the data source.

3. Persistent Adolescent Fertility and Early Childbearing

- Adolescent fertility remains a pressing concern in Botswana, even as national trends show steady improvement. According to the 2022 PHC, the Adolescent Fertility Rate (AFR) stands at 35.2 births per 1,000 girls aged 15–19—declining from 37.5 in 2011 and 53.3 in 2001. This is slightly lower than the global average of 39 and the Southern African average of 46 (UNICEF, 2023). However, fertility is disproportionately higher in rural areas (64.3), among adolescents with no education (95.5), and those not in education, employment, or training (NEET), where the AFR is 64.4 compared to 18.9 among employed

peers. District-level hotspots include Kweneng West (71.9), Ngwaketse West (69.0), and Ghanzi (56.4). Although rare, early adolescent childbearing (ages 10–14) remains a red flag, with an ASFR of 1.66 per 1,000 in 2022. These trends are above the global average of approximately 1 per 1,000 live births (UNICEF, 2023) and reinforce the need for early intervention and strengthened protection systems.

4. Contraceptive Use Among Adolescents and Young Adults

- Contraceptive use among young people aged 15–24 remains moderate but unevenly distributed. Nationally, 40.9 percent of all youth use modern contraceptives, rising to 70.9 percent among those who are sexually active. However, coverage among adolescents aged 15–19 is only 20.4 percent, far below global targets. WHO has raised concerns about declining condom use and low contraceptive uptake globally, especially among adolescents (WHO, 2024). However, coverage varies widely by district — from highs of 86.4 percent in Central Mahalapye and 80.6 percent in Selibe Phikwe to lows of 52.3 percent in Gaborone and 57.1 percent in Kweneng East. Surprisingly, several rural districts report higher CPRs than urban ones, likely due to effective outreach and primary healthcare integration. Use also differs by subgroup: adolescents aged 15–19 (20.4%) use contraceptives far less than those aged 20–24 (61.6%), and females (44.6%) more than males (36.2%). A reverse wealth gradient was observed, with CPR highest among the poorest youth (49.7%) and lowest among the wealthiest (30.9%). Regression analysis confirmed that higher education and marital status are strong predictors of contraceptive use, while youth from wealthier hous**eholds were significantly less likely to use contraception than their poorer peers.**

5. HIV Testing Among Youth

- HIV testing coverage among youth aged 15–35 is relatively high, with 82.6 percent ever tested nationally. However, among young people aged 15–24, coverage drops to 67.5 percent, exposing a substantial adolescent testing gap. Within this younger cohort, only 46.4 percent of adolescents aged 15–19 had tested, compared to 88.6 percent of those aged 20–24. These patterns mirror regional disparities, where in Eastern and Southern Africa only 29 percent of adolescent girls and 19 percent of boys aged 15–19 had tested and received results in the past year (UNICEF, 2023). Botswana's adolescent testing rates remain higher than regional averages but indicate significant room for improvement.

- HIV testing rates in Botswana increase with age, education, and marital status, and are slightly higher among females (84.3%) than males (80.2%). District-level disparities are evident, with Kweneng West (87.9%) and Selibe Phikwe (78.4%) outperforming Jwaneng (58.8%) and Ghanzi (60.1%). Interestingly, NEET youth report the highest testing rates (88.3%), compared to their employed or in-school peers (73.2%), a trend likely driven by targeted outreach efforts. Regression analysis confirms that age, education, marital status, and NEET status are the strongest independent predictors of HIV testing. These findings support the expansion of adolescent-friendly and school-based HIV testing, alongside efforts to sustain high coverage among older youth.

6. NEET Rates (Ages 15 to 35 Years)

- Youth disconnection from education, employment, and training (NEET) remains alarmingly high in Botswana, with 47.1 percent of youth aged 15–35 classified as NEET in the 2022 PHC and 41.3 percent reported in Q1 2024 QMTS. The rate is much higher than the global average among high- and middle-income countries. By comparison, the Organisation for Economic Co-operation and Development (OECD) countries average NEET rate for youth aged 15–29 is around 13 percent (OECD, 2022). Botswana's NEET rates are especially high among females (50.0%), youth aged 20–24 (55.4%), and those

with no education (69.5%). District disparities are stark: rural and peripheral areas such as Ngwaketse West (58.6%) and Ngamiland West (58.3%) report much higher NEET rates than urban centres like Sowa (30.0%) and Gaborone (33.2%). Regression analysis confirms that rural residence, female sex, younger age, lower education, disability, and being never or previously married significantly increase the odds of being NEET. These findings highlight the need for spatially targeted, gender-responsive, and disability-inclusive youth empowerment strategies that combine education access, job creation, and skills training

7. Disability Status among Adolescents and Youth (Ages 10–35 Years)

- Disability prevalence among adolescents and youth aged 10–35 in Botswana is 1.1 percent, with higher rates observed in rural areas (up to 1.6%) and in districts such as Kweneng West (1.9%), Ngwaketse West (1.8%), and Ghanzi (1.7%). Urban centres such as Gaborone, Orapa, and Jwaneng report much lower rates, ranging between 0.4 percent and 0.8 percent. Educational attainment shows the strongest protective effect: youth with no formal education have a disability prevalence of 12.2 percent, while adolescents with no education report a prevalence of 26.1 percent, compared to less than 1 percent among those with secondary or tertiary education.

  Disability is also more prevalent among NEET youth and adolescents—1.6 percent and 1.7 percent respectively—than among those in education or employment, whose prevalence ranges from 0.8 percent to 1.0 percent. Male adolescents and youth show slightly higher disability prevalence than females (1.2% vs 1.0%), likely due to higher exposure to injuries and hazardous environments.

  Multivariate analysis confirms that rural residence, low education, NEET status, and male sex are significant predictors of disability across age groups. Among adolescents specifically, being aged 15–19 and having no education are especially strong risk factors. These findings highlight the urgent need for inclusive education policies, early detection and intervention programmes, and youth-friendly disability services, particularly in underserved rural communities.

Priority Areas for Intervention

Based on the findings presented, several districts consistently emerge as high-priority areas for targeted youth health and development interventions. These include Kweneng West, Ngwaketse West, Ngamiland West, Ghanzi, and Barolong, which report elevated levels of adolescent fertility, maternal mortality, NEET rates, disability prevalence, and gaps in HIV testing. Despite geographic and infrastructure constraints, these areas can benefit from integrated service delivery models, mobile outreach, inclusive education efforts, and youth-centred economic empowerment programmes. Urban districts such as Gaborone and Jwaneng also require attention for their unexpectedly lower contraceptive use and HIV testing coverage among youth.

Strategic Actions for Youth Health and Wellbeing

1. **Expand Life-Course Youth Development Programmes:** Design programmes tailored to distinct youth life stages—adolescents (10–19), young adults (20–24), and older youth (25–35)—in response to the varied vulnerabilities observed across age groups. For example, adolescents face low HIV testing (46.4%) and limited access to SRHR, while youth aged 20–24 face the highest maternal mortality risk. Programmes should integrate SRHR, digital and green skills, financial literacy, and mental health support, and be delivered through youth-friendly spaces and digital platforms.

2. **Scale Up Adolescent SRHR Access:** Adolescent girls aged 15–19 have high fertility rates in several districts (e.g., Kweneng West and Ngwaketse West) and low contraceptive use (20.4%). School- and community-based outreach must prioritise this group with contraceptive education, free commodities, menstrual health support, HIV testing, and mental health services. Peer educators and mobile health units can bridge access gaps, particularly in rural and underserved areas.

3. **Target Maternal Health Support to Youth Aged 20–24:** The adjusted MMR among women aged 20–24 is disproportionately high (404.0 per 100,000 live births, PHC 2022). This group needs targeted access to youth-friendly antenatal care, skilled delivery services, and postpartum care. Maternity visits should be used to provide SRH education, especially for first-time mothers navigating both reproductive and socio-economic transitions.

4. **Address NEET Through District-Level Employment and Training Programmes:** Nearly half (47.1%) of youth aged 15–35 are NEET, with highest rates in Ngwaketse West, Ngamiland West, and Barolong. Establish youth economic empowerment hubs in these districts, offering vocational training, startup support, and job readiness programmes. Embed these efforts in district development plans to promote sustainable engagement and reduce exclusion from economic and social life.

5. **Ensure Gender-Responsive Policy Implementation:** Women face higher NEET rates (50% vs. 44% for males), are more likely to be caregivers, and are at risk of early marriage and GBV. Gender-responsive strategies must tackle these root causes by promoting female entrepreneurship, education retention, and access to safe spaces. Addressing these barriers will help reverse gendered disadvantage in youth health, employment, and empowerment.

6. **Invest in Disability-Inclusive Services and Planning:** Youth with disabilities—especially those with no education—face significantly higher exclusion, with disability prevalence reaching 12.2 percent (15–35) and 26.1 percent (10–19) among those with no schooling. Train service providers in inclusive practices, improve physical accessibility of SRH facilities and schools, and involve OPDs in planning to ensure services reach this often-invisible population.

7. **Improve Data Disaggregation and Accountability:** Gaps in disaggregated data hinder the ability to respond to disparities in youth health and wellbeing. Disaggregate all indicators by age, sex, disability, locality, and education, and institutionalise youth dashboards under Statistics Botswana and NDP 12 monitoring. This will enable real-time accountability and support evidence-based policy and programming.

8. **Establish a Multi-Sectoral Youth Wellbeing Council with Accountability Mandate:** Fragmented governance and weak inter-sectoral coordination contribute to duplication and missed opportunities in youth development. Establish a formal Youth Wellbeing Council comprising key government ministries (Health, Youth, Education, Labour), civil society organisations (CSOs), youth networks, and Organisations of Persons with Disabilities (OPDs) to guide cross-sectoral implementation, align data systems, and monitor progress on youth outcomes across health, education, and employment. To elevate the Council from a coordination platform to an accountability mechanism, mandate it to track and publicly report youth-related budget allocations across sectors. Ensure that at least 40 percent of Council members are youth aged 15–35, representing diverse regions, genders, and abilities. This will institutionalise youth voice, promote transparency, and safeguard investment in youth-focused priorities.

9. **Empower Youth as Partners in Solutions:** The report highlights gaps in youth engagement in programme design and monitoring, despite their centrality to health and wellbeing outcomes. Involve youth in co-designing interventions, peer education, and evidence generation. Support youth-led initiatives and develop their capacities as researchers, digital communicators, and civic leaders to promote inclusive development and accountability.

1. INTRODUCTION

1.1. Rationale and Importance of Youth Health

Young people are at the heart of Botswana's demographic profile, representing a major opportunity for accelerated development if investments in their health, education, and skills are well-aligned. According to the 2022 Population and Housing Census, individuals aged 10 to 35 years constitute a significant proportion of the population, forming the backbone of the country's future workforce, innovation base, and civic leadership. The World Health Organization (WHO) underscores that adolescence and youth represent a formative period for lifelong health behaviours, identity, and social wellbeing (WHO, 2021).

Youth health is a cornerstone of sustainable development. Good health enables young people to stay in school, access decent work, avoid risky behaviours, and make informed life decisions. Poor health outcomes, on the other hand—such as early pregnancy, untreated mental health issues, or sexually transmitted infections—can undermine not only personal potential but also national development aspirations (UNFPA, 2023; United Nations, 2015).

In the Botswana context, while progress has been made in improving adolescent sexual and reproductive health, significant challenges persist. The Botswana Demographic and Health Survey (2018) showed persistent levels of adolescent childbearing. High youth unemployment and limited access to mental health services further compound vulnerabilities. The National Commitment for Adolescent Well-Being (2023) identifies six key domains for youth wellbeing—health, connectedness, safety, learning, resilience, and agency—and calls for integrated approaches to address the complex and intersecting factors that affect young people's lives (Government of Botswana, 2023).

The need for more regular, disaggregated, and policy-relevant data on youth health was highlighted in the Review of the Revised National Population Policy and the Addis Ababa Declaration on Population and Development (AADPD) implementation review. This analytical report responds to that need by leveraging data from the 2022 Population and Housing Census, complemented by surveys and administrative sources, to present a comprehensive picture of youth health and wellbeing in Botswana.

1.2. Definition of Youth and Age Range

Globally, the definition of "youth" varies depending on policy context and programming goals. The United Nations typically defines youth as those aged 15–24 years, while the African Union and several international frameworks extend this range to 15–35 years to reflect the prolonged transition to adulthood in many African contexts (African Union, 2006).

In Botswana, the Revised National Youth Policy (2010) defines youth as individuals aged 10 to 35 years, a range that aligns with regional trends and reflects the extended educational, economic, and psychosocial transitions young people experience (Ministry of Youth, Sport and Culture, 2010). This report therefore adopts the 10–35 age range as the basis for its primary analysis. However, where relevant, data are also presented for subgroups such as adolescents (10–19 years), young people (10–24 years), and young adults (25–35 years) to better capture differences in needs and outcomes across the youth spectrum).

This approach is supported by UNFPA and WHO, which recommend tailoring youth programming and health interventions to distinct stages of development, from early adolescence (10–14) through late adolescence (15–19) and into young adulthood (20–35), recognising that health risks, access needs, and behavioural patterns vary substantially across these life stages (UNFPA, 2023; WHO, 2021).

Accordingly, this report adopts a 10–35 age range for its primary analysis. This broader span reflects Botswana's national policy definition and acknowledges the prolonged and uneven transitions experienced by young people. Many adolescents face early challenges—including school dropout, early pregnancy, and gender-based violence—while young adults encounter delayed entry into the labour market, extended economic dependence, and low rates of formal employment, particularly among those aged 20–35. These realities are compounded by high NEET rates, urban–rural disparities, and persistent gender and disability-related exclusion. Capturing this full transition period allows for more accurate analysis and better-targeted policy recommendations. **Figure 1** provides a visual representation of the age ranges of adolescence, young people and youth.

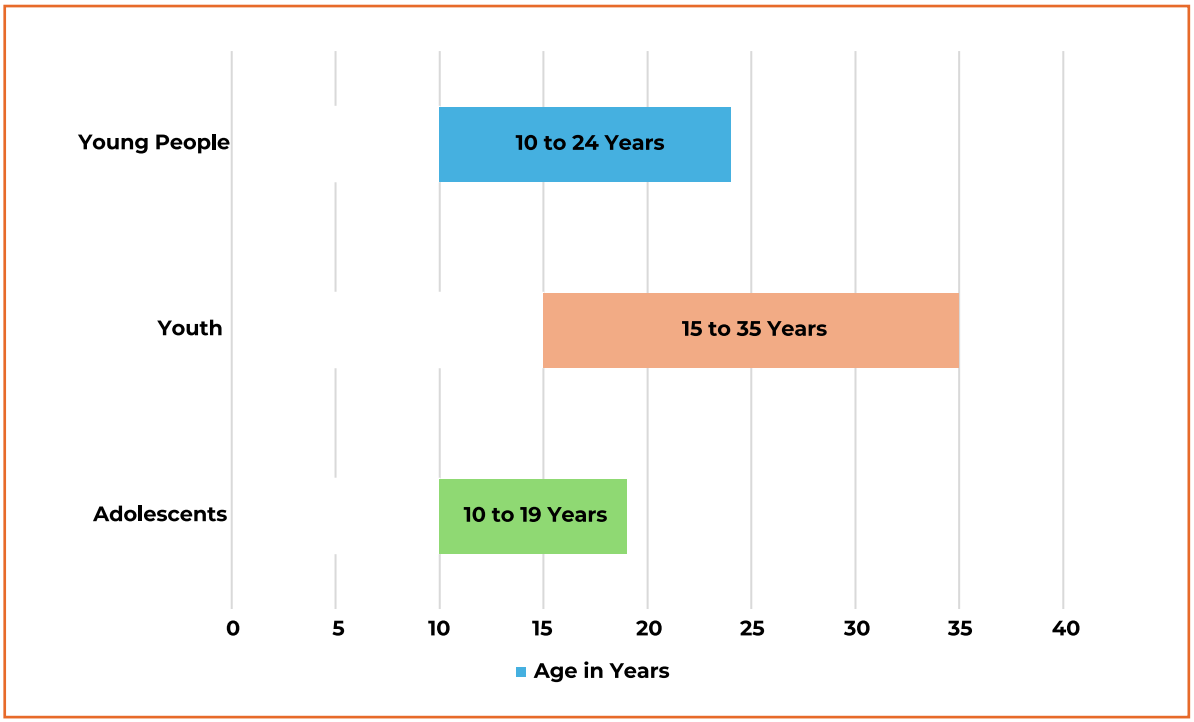
Where appropriate, findings for this analysis are further disaggregated into the following life-stage categories:

- **Adolescents: 10–19 years** (See Figure 1)
- **Young People: 10–24 years** (See Figure 1)
- **Young Adults: 25–35 years** (See Figure 1)

This approach aligns with guidance from UNFPA and WHO, which recommend tailoring youth programming and health interventions to distinct developmental stages—from early adolescence through to young adulthood—since health risks, service needs, and behavioural patterns vary substantially across this spectrum (UNFPA, 2023; WHO, n.d.).

Regionally, youth definitions also vary: for example, South Africa and Zimbabwe define youth as 15–34, while Zambia and Namibia use 15–35. Botswana's extended definition stands out for including individuals aged 10–14, reflecting a progressive policy stance that accommodates both global guidance and national realities, including high NEET rates among 20–35-year-olds and limited SRHR access among early adolescents.

FIGURE 1: VISUAL SHOWING AGE RANGES OF ADOLESCENCE, YOUNG PEOPLE AND YOUNG PEOPLE



1.3. Link to Global and National Development Priorities

The health and wellbeing of young people are central to achieving both global and national development priorities. Globally, the 2030 Agenda for Sustainable Development—adopted by all United Nations Member States—recognises the importance of youth as agents of change and development. Key Sustainable Development Goals (SDGs) relevant to youth health include:

- **SDG 3:** Ensure healthy lives and promote wellbeing for all at all ages (with a focus on sexual and reproductive health, mental health, and substance use prevention),
- **SDG 4:** Ensure inclusive and equitable quality education and promote lifelong learning,
- **SDG 5:** Achieve gender equality and empower all women and girls,
- **SDG 8:** Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all, and
- **SDG 10:** Reduce inequality within and among countries.

At the continental level, the African Youth Charter (2006) and Agenda 2063: The Africa We Want underscores the role of youth in driving inclusive growth, innovation, and transformation. It envisions an Africa where young people are healthy, empowered, well-educated, and actively contributing to sustainable development. The framework calls for full implementation of rights-based, youth-centred health and development programmes, especially in the areas of sexual and reproductive health, gender equality, HIV prevention, and youth employment (African Union, 2015).

Additionally, the Addis Ababa Declaration on Population and Development (AADPD)—adopted in 2013 by African ministers and endorsed by the African Union—provides a bold continental agenda for integrating population issues, including youth health and wellbeing, into sustainable development strategies. The AADPD prioritises adolescent and youth health, comprehensive sexuality education, elimination of early and forced marriages, and reduction of youth unemployment as key levers for development.

At the national level, youth health is strongly aligned with the priorities outlined in Botswana's Vision 2036, which positions youth as a critical force in achieving a high-income, inclusive, and knowledge-based economy. Vision 2036 explicitly commits to empowering young people through health, education, innovation, and employment initiatives, and calls for building an equitable society where no one is left behind (Government of Botswana, 2016).

The Revised National Population Policy (RNPP, 2010) also recognises youth as a priority population group whose health, education, and economic empowerment are critical for harnessing the demographic dividend. The RNPP advocates for:

- **Reduction of adolescent fertility and youth unemployment,**
- **Increased access to sexual and reproductive health services,**
- **Elimination of harmful practices affecting young people,**
- **Comprehensive youth development planning.**

Further, the National Commitment on Adolescent Well-being (2023) reflects Botswana's pledge to address the six interconnected domains of adolescent wellbeing: health and nutrition, connectedness and contributions, safety and a supportive environment, learning and competence, agency and resilience, and economic empowerment. This commitment aligns closely with the Global Consensus on Meaningful Adolescent Engagement and demonstrates Botswana's intent to prioritise youth in its development planning.

1.4. National and Sectoral Youth Policy Frameworks

In addition to overarching development plans, Botswana's youth health agenda is underpinned by several national policy instruments. The Revised National Youth Policy (2010) serves as a foundational document, affirming the rights of youth to access health, education, employment, and protection from discrimination. It articulates key strategic areas such as youth and health, gender equality, and vulnerable youth, and calls for multisectoral coordination of youth programming (Ministry of Youth, Sport and Culture, 2010).

Complementing this, the Gender Affairs Strategy 2025 provides a forward-looking roadmap for addressing gender disparities in youth outcomes, including sexual and reproductive health, access to opportunities, and protection from violence (Ministry of Youth and Gender Affairs, 2025). It reports alarming trends such as the persistently high NEET rate (41.3% in Q1 2024), as well as ongoing gender-based vulnerabilities that affect both male and female youth.

The National Policy on Gender and Development (2015) further calls for gender mainstreaming across all sectors and recognises young people as a particularly vulnerable group in need of targeted interventions (Republic of Botswana, 2015).

At the strategic analysis level, the 2024 National Human Development Report by UNDP Botswana highlights persistent urban–rural disparities, structural barriers to youth employment, and intersectional inequalities that particularly affect young women and marginalised groups. It emphasises the need for evidence-based planning to ensure equitable access to services and empowerment for all youth (UNDP Botswana, 2024).

This analytical report aligns with international indicator frameworks, such as the WHO's Adolescent Health and Wellbeing Indicators Reference Guide, which provide global benchmarks for monitoring adolescent fertility, HIV testing, mental health, and protective factors. Grounded in these frameworks, the report offers an evidence base to track progress, identify gaps, and inform future investments in youth health and wellbeing. Its findings will support the implementation of national strategies, including the ASRHR Strategy, and guide the development of inclusive programmes under Botswana's National Development Plan 12.

2. METHODOLOGY

2.1. A Review of Data Sources for Youth Health

2.1.1. Introduction

This section reviews national data sources used to analyse the health and wellbeing of youth in Botswana. The analysis focuses on indicators relevant to adolescents and young people aged 10 to 35 years, in alignment with national youth policy frameworks. The review assesses each source based on its ability to generate youth health indicators and socio-demographic correlates. Specifically, the review supports the measurement of:

- Adolescent fertility rate (AFR)
- Contraceptive prevalence rate (CPR)
- Youth unemployment and NEET (Not in Education, Employment, or Training)
- Access to sexual and reproductive health (SRH) services
- Other relevant youth health and wellbeing dimensions (e.g., HIV prevalence, disability, mental health where data permit)

Each source is evaluated for its scope, strengths, and limitations, particularly in terms of variable coverage, data quality, and potential for disaggregation by age, sex, district, disability status, education, urban/rural location, and other equity dimensions.

2.1.2. 2022 Population and Housing Census (2022 PHC)

The 2022 PHC, conducted by Statistics Botswana, provides the most comprehensive and nationally representative dataset for analysing youth health and wellbeing. It includes detailed individual and household-level data on demographics, education, employment, fertility, disability, and selected indicators on access to services.

In the context of youth health, the 2022 PHC offers:

- Age- and sex-disaggregated population structure for 10–35 years
- Adolescent births by age of mother (starting from age 10)
- School attendance, education level, and literacy
- Employment status, occupation, and income-related characteristics
- Disability status using the Washington Group Short Set
- Urban/rural classification and household living conditions

The data source is instrumental for mapping social determinants of health and quantifying adolescent fertility. Its complete coverage allows for disaggregation by district and sub-population groups, enabling equity analysis.

Key limitations of the 2022 PHC:

- Does not collect clinical or behavioural health data (e.g., contraceptive use, HIV status, sexual behaviour).
- Lacks data on mental health and SRH (sexual and reproductive health) service utilisation.
- Does not capture youth-specific health needs.
- No information on the quality of services accessed by young people.

2.1.3. 2011 and 2001 Population and Housing Censuses

The 2011 and 2001 Censuses serve as critical reference points for examining long-term trends in youth demographic and socio-economic characteristics. Although they lack the current focus on youth health and wellbeing, they provide:

- **Historical data on adolescent fertility and education**
- **Labour force and unemployment trends**
- **Socioeconomic conditions of young people across time**

These earlier censuses are useful for evaluating progress in education, employment, and youth inclusion across decades, and for understanding the baseline against which post-2022 trends can be assessed.

Key Limitations to the 2011 and 2001 PHCs

- **No direct health or SRH indicators.**
- **Limited relevance to current youth health context.**
- **Outdated socioeconomic classifications and variables.**

2.1.4. Botswana Demographic Survey (BDS) 2017

The 2017 BDS is a nationally representative survey that includes a youth module with data on:

- **Contraceptive use among young women (15–24)**
- **Fertility and sexual debut**
- **Education, marital status, and employment**
- **Knowledge of HIV and access to SRH services**

The BDS is valuable for understanding youth sexual and reproductive health behaviour. It complements the 2022 Census by offering behavioural indicators not captured in the PHC.

Key Limitations of the 2017 BDS

- **Excludes adolescents aged 10–14 years.**
- **Small sample size limits sub-national or district-level analysis.**
- **No direct measures of adolescent mental health.**
- **No information on the quality of SRH or other health services utilization**

The Multi-Topic Household Surveys (MTHS) conducted by Statistics Botswana provide rich socio-economic data relevant for youth wellbeing analysis. These include:

- **Labour force participation and unemployment (including NEET rates)**
- **Income, housing, and access to health insurance**
- **Education attainment and school attendance**

While not youth-focused, these surveys are vital for monitoring economic and social conditions of young people, particularly in terms of poverty, inequality, and employment.

Key Limitations of the MTHS (2019 – 2024):

- **Absence of health and behavioural data (e.g., mental health, SRH)**
- **Aggregation of some youth groups within broader age categories**

2.1.6. Botswana AIDS Impact Surveys (BAIS) IV (2013) and BAIS V (2021)

The BAIS IV and V are essential for tracking HIV and SRH outcomes among youth. They provide:

- **HIV prevalence by age and sex (including 15–24 years)**
- **Sexual behaviour, knowledge of HIV prevention**
- **Condom use and testing behaviour**
- **Exposure to SRH communication**

These surveys enable analysis of HIV-related risks and service uptake among adolescents and young adults.

Key Limitations of the BAIS IV & V:

- **Coverage limited to 15–24 years; does not cover the full 10–35 youth age range.**
- **No data on mental health, disability, or barriers to accessing contraception and other SRH services.**

Cross-sectional design limits the ability to track changes in behaviour over time.

2.2. Alignment with SDG 17.18 on Disaggregation

A key strength of the reviewed data sources, particularly the 2022 Population and Housing Census and household surveys, is their ability to support disaggregation of youth health indicators by age, sex, disability status, location (urban/rural), education, and other equity dimensions. This directly contributes to Botswana's commitment to SDG Target 17.18, which emphasises the need for high-quality, timely, and disaggregated data to monitor development progress and ensure no one is left behind.

2.3. Key Indicators Analysed

2.3.1. Core Youth Health and Wellbeing Indicators

Table 1 shows the key indicators that are used in this report by data source and their relevance in youth health issues.

Table 1: Key indicators that are used in this report by data source and relevance

Indicator	Data Source(s)	Age Group	Relevance
	2022 PHC, Vital Statistics, MoH Maternal Mortality Notification records	**10-19** (Adolescents)	• **10–19 (Adolescents):** Highlights early maternal risks; vital for adolescent SRHR interventions.
		10-24 (Young People)	• **10–24 (Young People):** Captures transition-related risks; supports targeted health and education policies.
		15-35 (Youth)	• **15–35 (Youth):** Covers full youth reproductive span; informs broader youth health planning.
Adolescent fertility rate **(10–14, 15–19)**	2022 PHC, Vital Statistics	**10–19** (Adolescents)	• Measures early childbearing risks
Contraceptive prevalence (modern methods)	2017 BDS, BAIS V	**10–24**	• SRH service uptake among youth
HIV prevalence	BAIS V	**15–24**	• Risk assessment, program targeting
Youth unemployment and NEET	MTHS, 2022 PHC	**15–35**	• Economic participation and empowerment
Education status	2022 PHC, MTHS	**10–35**	• Foundation for health and wellbeing
Disability among youth	2022 PHC	**10–35**	• Measures vulnerability and inclusion

2.4. Explanatory Variables for Disaggregation

To ensure a comprehensive and equity-sensitive analysis, all key youth health and wellbeing indicators will be disaggregated by relevant demographic and socio-economic variables, wherever data permits. Disaggregated analysis allows for the identification of disparities in outcomes and service access across different segments of the youth population, supporting the development of targeted interventions.

The primary variables for disaggregation include:

- **Age group:** Data will be analysed in 5-year age bands from 10 to 35 years (e.g., 10–14, 15–19, 20–24, 25–29, 30–35). This enables identification of age-specific health risks and transitions during adolescence and early adulthood.
- **Sex:** Disaggregation by male and female youth allows for the examination of gender-based differences in health outcomes, service utilisation, and socio-economic opportunities.
- **District and health district:** Spatial disaggregation will be conducted using administrative districts and Ministry of Health–defined health districts. This enables the detection of geographic inequalities and supports sub-national planning and resource allocation.
- **Urban/rural residence (Locality Type[1]):** Classification of respondents by place of residence allows the analysis to explore disparities in access to services and opportunities between urban and rural youth, which is essential for addressing structural inequalities.
- **Education level:** The highest level of education attained will be used to assess the relationship between educational attainment and youth health indicators such as fertility, employment, and HIV knowledge.
- **Disability status:** The analysis will incorporate self-reported disability based on the Washington Group Short Set of questions included in the 2022 Census. This facilitates an inclusive analysis of youth health, recognising the added vulnerabilities faced by youth with disabilities.
- **Employment status and NEET:** Employment status (employed, unemployed) and NEET (Not in Education, Employment, or Training) classification will be used to understand how economic engagement—or lack thereof—affects youth health and wellbeing.
- **Household wealth:** A household wealth index, constructed from asset ownership and housing characteristics, will be used as a proxy for economic status. Disaggregating by wealth quintiles enables assessment of equity and socio-economic gradients in health outcomes.

This disaggregation approach aligns with Botswana's Vision 2036, the Sustainable Development Goals (SDGs), and the National Commitment on Adolescent Well-being (2023). It reflects the commitment to "leave no one behind" by identifying and addressing the health needs of youth across social, geographic, and economic divides.

2.5. Statistical and Analytical Methods

The analytical strategy for this report combines descriptive, bivariate, and multivariate statistical techniques to explore the levels, patterns, and determinants of youth health and wellbeing in Botswana. The analysis draws primarily from the 2022 Population and Housing Census, supplemented by other national surveys such as the Botswana Demographic Survey (2017), Multi-Topic Household Surveys, and the Botswana AIDS Impact Surveys (BAIS IV and V).

2.5.1. Descriptive Analysis

Descriptive statistics will be used to summarise the core indicators related to youth health and socio-demographic characteristics. This includes computation of frequencies, proportions, and age-specific rates for indicators such as adolescent fertility, contraceptive use, youth unemployment, NEET status, and educational attainment. Cross-tabulations will be conducted by key disaggregation variables, including age, sex, education level, disability status, urban-rural residence, and district. These will help to identify variations in youth health outcomes across population subgroups.

[1] In the BAIS V survey, locality type (residence) is classified into only two categories: urban and rural. In contrast, the 2011 PHC, 2022 PHC, and other national surveys use a three-tier classification system, categorising locality type as Towns/Cities, Urban Villages, and Rural Areas.

To aid interpretation and facilitate policy engagement, the findings will be presented visually using appropriate charts, bar graphs, and geographic maps, highlighting spatial and demographic patterns of youth health and vulnerability.

2.5.2. Bivariate and Multivariate Analysis

Bivariate analysis will be employed to examine the statistical associations between youth characteristics and health outcomes. Chi-square tests will be used to test relationships between categorical variables such as education level and contraceptive use, or employment status and HIV awareness.
To better understand the determinants of key youth health outcomes, multivariate logistic regression models will be applied. These models will estimate the likelihood of specific outcomes—such as adolescent fertility, contraceptive use, NEET status, and HIV testing or awareness—while controlling for relevant confounders such as age, education, economic status, and place of residence. The results will be presented as adjusted odds ratios (AORs) with 95 percent confidence intervals to indicate the strength and direction of associations.

This mixed analytical approach enables both broad profiling and deeper examination of underlying factors that shape youth health and wellbeing in Botswana, thereby informing evidence-based policy and programmatic responses.

2.6. Ethical Considerations and Confidentiality

All secondary data sources used in this analysis were collected by national institutions following ethical guidelines and data protection protocols. Individual-level data were anonymised prior to analysis, ensuring strict confidentiality. No personally identifiable information was accessed or reported. The analysis aligns with established research standards, including the responsible use of administrative and survey data for public health research.

3. DEMOGRAPHIC AND SOCIO-ECONOMIC PROFILE OF YOUTH

3.1. Introduction

This chapter presents the demographic and socio-economic profile of young people in Botswana using data from the 2022 Population and Housing Census (PHC). It provides an overview of the spatial distribution and key characteristics of youth aged 15 to 35 years, young people aged 10 to 24 years, and adolescents aged 10 to 19 years. The analysis focuses on variations by district, locality type, sex, age groups, marital status, education levels, employment status, NEET (Not in Employment, Education, or Training) status, and disability. Understanding these patterns is crucial for informing youth development policies, targeted interventions, and resource allocation across different regions and population subgroups.

3.2. Percentage Distribution of Youth[2] (15 to 35 Years) by District: 2022 PHC

Table 2 presents the distribution of youth aged 15 to 35 years across Botswana's districts based on the 2022 Population and Housing Census (PHC). The data shows that the highest proportion of youth resided in Kweneng East, accounting for 15.1 percent of the total youth population, followed by Gaborone with 12.9 percent and Central Serowe-Palapye at 7.9 percent. Other districts with notable shares include South East (5.6%), Ngamiland East (5.5%), Southern (5.3%), and Kgatleng (5.2%). In contrast, districts such as Sowa (0.1%), Orapa (0.3%), and Jwaneng (0.8%) recorded the lowest proportions of youth. This distribution highlights the concentration of youth in more urbanised and economically active areas of the country.

One in every four youth aged 15–35 in Botswana lives in just two districts: Kweneng East (15.1%) and Gaborone (12.9%).

Policy Implication: The spatial distribution of youth shows a strong concentration in Kweneng East (15.1%), Gaborone (12.9%), and Central Serowe–Palapye (7.9%), reflecting urban and peri-urban migration patterns for education, employment, and services. This underscores the need for urban-focused investments in youth housing, public transport, employment centres, and SRHR services. Meanwhile, smaller districts like Sowa, Orapa, and Ngwaketse West, despite hosting fewer youth, may require targeted outreach programmes to address access barriers due to remoteness or infrastructure limitations

[2]In the context of Botswana, youth are officially defined as individuals aged 15 to 35 years.

Table 2: Percentage Distribution of Youth (15 to 35 Years) by District: 2022 PHC

DISTRICT	Number	Percent (%)
Gaborone	106,254	12.9%
Francistown	41,317	5.0%
Lobatse	11,159	1.4%
Selibe Phikwe	14,789	1.8%
Orapa	2,461	0.3%
Jwaneng	6,788	0.8%
Sowa	1,234	0.1%
Southern	43,309	5.3%
Barolong	16,730	2.0%
Ngwaketse West	7,395	0.9%
South East	45,981	5.6%
Kweneng East	124,572	15.1%
Kweneng West	18,088	2.2%
Kgatleng (Wards)	42,624	5.2%
Central Serowe -Palapye	64,915	7.9%
Central Mahalapye	37,899	4.6%
Central Bobonong	22,078	2.7%
Central Boteti	25,703	3.1%
Central Tutume	49,380	6.0%
North East	20,489	2.5%
Ngamiland East	45,151	5.5%
Ngamiland West	23,889	2.9%
Chobe	11,167	1.4%
Ghanzi	21,277	2.6%
Kgalagadi South	11,554	1.4%
Kgalagadi North	8,264	1.0%
TOTAL	**824,467**	**100.0%**

3.3. Percentage Distribution of Youth (15 to 35 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

According to **Table 3**, the majority of youth aged 15 to 35 years lived in urban villages (49.2%), followed by cities and towns (22.3%) and rural areas (28.5%). The sex distribution was almost evenly split, with females constituting 50.8 percent and male's 49.2 percent. In terms of age groups, the 25–29 year-olds formed the largest group (24.3%), closely followed by 20–24 year-olds (23.5%) and 30–34 year-olds (23.4%). The majority of youth (84.4%) had never married, while 15.4 percent were married or cohabiting. Regarding education, most youth (69.4%) had attained secondary education, and a substantial proportion (22.6%) had reached tertiary level. Employment data showed that only 35.4 percent of youth were employed, while 64.6 percent were unemployed. Notably, 47.1 percent of youth were classified as NEET (Not in Employment, Education, or Training), while 52.9 percent were IEET (In Employment, Education, or Training). Disability prevalence among youth was low, with only 1.1 percent reporting a disability.

Nearly half of all youth (47.1%) are NEET (Not in Employment, Education, or Training), and only 35.4% are employed — pointing to a severe youth labour market challenge.

The analysis reveals that youth who are rural-based, have low levels of education, and live with disabilities face compounded vulnerabilities. For example, rural areas host 28.5 percent of youth, 8.0 percent of whom have only primary or no education, and disability prevalence, though low at 1.1 percent, is disproportionately higher in rural and low-education groups. These intersecting disadvantages reinforce barriers to employment, education, and SRH services, increasing the risk of long-term marginalisation and deepening spatial and social inequality.

Policy implication: With nearly half of youth (47.1%) classified as NEET and only 35.4 percent employed, Botswana faces a significant challenge in transitioning young people from education to productive employment. Urban villages host the largest proportion of youth, signalling where interventions should be concentrated. The combination of high unemployment, low engagement in education or training, and gender disparities in NEET status calls for targeted youth employment policies, re-skilling programmes, and localised job creation initiatives, especially in districts such as Kweneng East, Central Serowe–Palapye, and Gaborone.

3.4. Percentage Distribution of Young People[3] (10 to 24 Years) by District: 2022 PHC

The spatial distribution of young people aged 10 to 24 years is shown in **Table 4**. Kweneng East had the highest share, accommodating 14.0 percent of this group, followed by Gaborone (11.0%) and Central Serowe-Palapye (8.6%). Significant proportions were also observed in Central Tutume (7.2%) and Southern district (5.9%). As with youth aged 15 to 35, fewer young people were found in Sowa (0.1%), Orapa (0.3%), and Jwaneng (0.7%), illustrating similar patterns of concentration in urban and peri-urban areas.

One in four young people (10–24 years) live in just three districts: Kweneng East (14.0%), Gaborone (11.0%), and Central Serowe–Palapye (8.6%).

[3] Young people are defined as individuals aged 10 to 24 years, a category that includes adolescents aged 10 to 19 years.

Table 3: Percentage Distribution of Youth (15 to 35 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

SOCIO-DEMOGRAPHIC CHARACTERISTICS		Number[4]	Percent (%)
Locality	Cities/Towns	184,002	22.3%
	Urban Villages	405,591	49.2%
	Rural Areas	234,874	28.5%
Sex	Male	405,292	49.2%
	Female	419,175	50.8%
Age Group	15 to 17 Years	119,474	14.5%
	18 to 19 Years	79,407	9.6%
	20 to 24 Years	194,047	23.5%
	25 to 29 Years	200,333	24.3%
	30 to 34 Years	193,193	23.4%
	35 Years	38,013	4.6%
Marital Status	Never Married	660,008	84.4%
	Married/Cohabiting	120,560	15.4%
	Ever Married	1,811	0.2%
Highest Level of Education	None	12,625	1.6%
	Pre/Primary	49,864	6.4%
	Secondary	541,535	69.4%
	Tertiary	176,223	22.6%
Employment Status	Employed	276,350	35.4%
	Unemployed	503,735	64.6%
NEET Status	NEET	367,288	47.1%
	IEET	413,166	52.9%
Disability Status	No Disability	815,337	98.9%
	Has Disability	9,130	1.1%
TOTAL		**824,467**	**100.0%**

Policy Implication: The largest concentrations of young people aged 10–24 are found in Kweneng East (14%), Gaborone (11%), and Central Serowe–Palapye (8.6%), reflecting patterns of internal migration for education and employment. These spatial patterns highlight the importance of strengthening urban infrastructure, schooling capacity, and youth services in high-density districts. Moreover, youth development initiatives should account for the increasing demand for education, housing, and health services in rapidly growing urban areas.

[4] Some totals may not sum to 824,467 due to missing values

Table 4: Percentage Distribution of Youth (10 to 24 Years) by District: 2022 PHC

DISTRICT	Number	Percent (%)
Gaborone	68,843	11.0%
Francistown	28,931	4.6%
Lobatse	8,183	1.3%
Selibe Phikwe	12,055	1.9%
Orapa	2,122	0.3%
Jwaneng	4,287	0.7%
Sowa	756	0.1%
Southern	36,728	5.9%
Barolong	14,872	2.4%
Ngwaketse West	6,357	1.0%
South East	30,340	4.9%
Kweneng East	87,185	14.0%
Kweneng West	14,618	2.3%
Kgatleng (Wards)	30,969	5.0%
Central Serowe -Palapye	53,364	8.6%
Central Mahalapye	33,396	5.4%
Central Bobonong	19,622	3.1%
Central Boteti	19,268	3.1%
Central Tutume	44,633	7.2%
North East	17,797	2.9%
Ngamiland East	32,534	5.2%
Ngamiland West	20,121	3.2%
Chobe	6,738	1.1%
Ghanzi	14,943	2.4%
Kgalagadi South	9,331	1.5%
Kgalagadi North	5,889	0.9%
TOTAL	**623,882**	**100.0%**

3.5. Percentage Distribution of Young People (10 to 24 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

As shown in **Table 5**, nearly half (49.0%) of young people aged 10 to 24 years lived in urban villages, 20.1 percent resided in cities and towns, and 31.0 percent were in rural areas. The sex distribution was balanced, with females making up 50.1 percent and males 49.9 percent. In terms of age breakdown, 37.0 percent were 10–14 years old, 31.9 percent were 15–19 years, and 31.1 percent were 20–24 years. Almost all young people (96.8%) had never married. Educational attainment was predominantly at the secondary level (61.1%), while 29.4 percent had pre-primary or primary education. Only 8.5 percent had achieved tertiary education. Employment among young people was relatively low, with only 13.2 percent employed. A significant share (28.1%) was classified as NEET, reflecting challenges in economic and educational engagement for this age group. Disability prevalence stood at 1.1 percent.

Among young people (10–24), only 13.2% are employed, and 28.1% are NEET, despite 71.9% being engaged in education or training.**

Vulnerability among young people is shaped not by a single factor, but by the intersection of socio-economic and geographic disadvantages. Young people who are rural residents (31%), out of school or unemployed (NEET = 28.1%), and have disabilities (1.1%) face structural challenges that limit access to services and opportunities. Those with only primary education (29.4%) are particularly at risk of being excluded from the formal labour market. These overlapping factors demand a multi-sectoral, equity-driven approach to policy design and resource targeting.

Policy Implication: While a majority of young people are still in education or training (IEET: 71.9%), the 28.1% NEET rate—combined with only 13.2 percent employment—signals a need for stronger school-to-work linkages and second-chance education opportunities. Females and youth with only primary or no education are especially vulnerable. To bridge these gaps, Botswana should implement district-based skilling and entrepreneurship programmes, expand youth innovation hubs, and strengthen career counselling and mentorship in secondary schools.

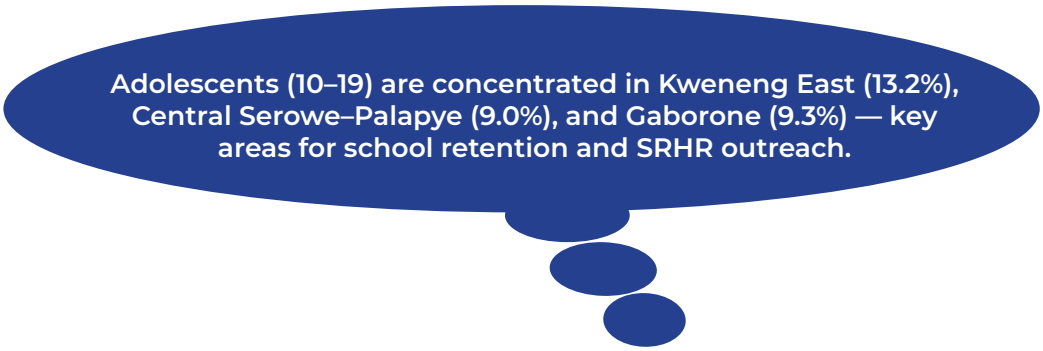
Table 5: Percentage Distribution of Youth (10 to 24 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

SOCIO-DEMOGRAPHIC CHARACTERISTICS		Number[5]	Percent (%)
Locality	Cities/Towns	125,177	20.1%
	Urban Villages	305,522	49.0%
	Rural Areas	193,183	31.0%
Sex	Male	311,554	49.9%
	Female	312,328	50.1%
Age Group	10 to 14 Years	230,954	37.0%
	15 to 19 Years	198,881	31.9%
	20 to 24 Years	194,047	31.1%
Marital Status	Never Married	582,862	96.8%
	Married/Cohabiting	19,042	3.2%
	Ever Married	120	0.0%
Highest Level of Education	None	5,738	1.0%
	Pre/Primary	176,073	29.4%
	Secondary	366,534	61.1%
	Tertiary	51,136	8.5%
Employment Status	Employed	66,035	13.2%
	Unemployed	434,975	86.8%
NEET Status	NEET	168,390	28.1%
	IEET	431,468	71.9%
Disability status	No Disability	617,229	98.9%
	Has Disability	6,653	1.1%
TOTAL		**623,882**	**100.0%**

[5]Some totals may not sum to 623,882 due to missing values.

3.6. Percentage Distribution of Adolescents[6] (10 to 19 Years) by District: 2022 PHC

Table 6 outlines the distribution of adolescents aged 10 to 19 years across districts. The highest proportions were recorded in Kweneng East (13.2%), Central Serowe-Palapye (9.0%), and Gaborone (9.3%). Central Tutume also had a notable adolescent population at 7.8 percent. On the other hand, Sowa (0.1%), Orapa (0.4%), and Jwaneng (0.7%) continued to register the lowest shares, highlighting the urban and peri-urban preference for adolescents as well.



Policy Implication: Adolescents are highly concentrated in Kweneng East, Central Serowe–Palapye, and Gaborone, which also reflect national fertility and early pregnancy hotspots. Given the SRHR and educational vulnerability of this age group, it is critical to expand comprehensive sexuality education, mental health support, and school retention programmes, particularly in urban and peri-urban districts experiencing rapid youth population growth.

[6]Adolescents are defined as individuals aged 10 to 19 years

Table 6: Percentage Distribution of Youth (10 to 19 Years) by District: 2022 PHC

DISTRICT	Number	Percent (%)
Gaborone	39,884	9.3%
Francistown	19,110	4.4%
Lobatse	5,664	1.3%
Selibe Phikwe	9,110	2.1%
Orapa	1,650	0.4%
Jwaneng	2,934	0.7%
Sowa	513	0.1%
Southern	27,040	6.3%
Barolong	11,185	2.6%
Ngwaketse West	4,701	1.1%
South East	17,578	4.1%
Kweneng East	56,674	13.2%
Kweneng West	10,753	2.5%
Kgatleng (Wards)	20,759	4.8%
Central Serowe -Palapye	38,627	9.0%
Central Mahalapye	25,344	5.9%
Central Bobonong	14,878	3.5%
Central Boteti	13,858	3.2%
Central Tutume	33,566	7.8%
North East	13,407	3.1%
Ngamiland East	22,612	5.3%
Ngamiland West	14,776	3.4%
Chobe	4,234	1.0%
Ghanzi	10,030	2.3%
Kgalagadi South	6,810	1.6%
Kgalagadi North	4,138	1.0%
TOTAL	**429,835**	**100.0%**

3.7. Percentage Distribution of Adolescents (10 to 19 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

Table 7 shows that 49.1 percent of adolescents aged 10 to 19 years lived in urban villages, 18.3 percent in cities and towns, and 32.5 percent in rural areas. The sex distribution was almost equal, with males constituting 50.3 percent and female's 49.7 percent. In terms of age groups, 53.7 percent were aged 10–14 years and 46.3 percent were aged 15–19 years. The overwhelming majority (99.5%) were never married, reflecting expected patterns given their age. . In terms of educational attainment, 57.6% of adolescents had completed secondary education, while 39.7% had only pre-primary or primary education. A very small proportion (1.9%) had attained tertiary education. Employment levels were extremely low, with just 3.5% of adolescents employed and a corresponding unemployment rate of 96.5%. The proportion of adolescents classified as NEET stood at 18.0%, while the majority (82.0%) were either in education or employed.Disability prevalence was low at 1.1 percent.

Among adolescents, multiple disadvantages often reinforce one another. Rural adolescents (32.5%) with limited education (40.5% with primary or no education) and those with disabilities (1.1%) are more likely to be excluded from both education and early employment pathways. While NEET levels are relatively lower (18%), adolescents affected by poverty, disability, and gendered caregiving

expectations may face an increased risk of disengagement as they transition into adulthood. Tackling adolescent exclusion thus requires integrated interventions that address education, SRHR, disability inclusion, and household-level deprivation together.

Although 82% of adolescents are engaged in education or employment, 18% are NEET and only 3.5% are employed, raising concerns for early disengagement.

Policy Implication: Despite high education enrolment, employment among adolescents is extremely low (3.5%), with 18 percent classified as NEET. This early disengagement, especially among 15–19-year-olds in rural areas, raises concerns about long-term exclusion and underachievement. Targeted after-school programmes, early vocational exposure, and mobile outreach services are needed to sustain engagement and prevent social drift during critical formative years.

Table 7: Percentage Distribution of Youth (10 to 19 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

SOCIO-DEMOGRAPHIC CHARACTERISTICS		Number[7]	Percent (%)
Locality	Cities/Towns	78,865	18.3%
	Urban Villages	211,073	49.1%
	Rural Areas	139,897	32.5%
Sex	Male	216,330	50.3%
	Female	213,505	49.7%
Age Group	10 to 14 Years	230,954	53.7%
	15 to 19 Years	198,881	46.3%
Marital Status	Never Married	416,568	99.5%
	Married/Cohabiting	2,140	0.5%
	Ever Married	10	0.0%
Highest Level of Education	None	3,247	0.8%
	Pre/Primary	165,382	39.7%
	Secondary	240,219	57.6%
	Tertiary	7,948	1.9%
Employment Status	Employed	11,048	3.5%
	Unemployed	307,279	96.5%
NEET Status	NEET	75,106	18.0%
	IEET	342,033	82.0%
Disability status	No Disability	425,246	98.9%
	Has Disability	4,589	1.1%
TOTAL		**429,835**	**100.0%**

[7] Some totals may not sum to 429,835 due to missing values.

3.8. Summary

In summary, the demographic and socio-economic profile of youth, young people, and adolescents in Botswana reflects a population that is predominantly urban-based, highly concentrated in key districts such as Kweneng East, Gaborone, and Central Serowe–Palapye, and largely engaged in education. However, significant challenges persist—particularly among youth aged 15 to 35 years—marked by high unemployment, with only 35.4 percent employed, and a NEET rate of 47.1 percent, indicating widespread disengagement from both education and the labour market.

These patterns are further compounded by gender disparities, rural–urban divides, and the exclusion of youth with disabilities and limited education. These patterns are further compounded by gender disparities, rural–urban divides, and the exclusion of youth with disabilities and limited education. Adolescents aged 10–19 also face low employment rates (3.5%) and early NEET risks, highlighting vulnerability during critical developmental stages.

Policy Implication: These findings underscore the urgent need for targeted, cross-sectoral policies and programmes that support education-to-employment transitions, reduce regional and gender disparities, and promote the full inclusion of youth with disabilities. Investing in inclusive education systems, district-based employment centres, adolescent-friendly services, and youth-focused skilling programmes will be essential to harness the country's demographic dividend and reduce long-term exclusion. This demographic foundation provides a critical lens through which youth health outcomes are explored in the following chapters.

4. KEY YOUTH HEALTH INDICATORS

4.1. Youth, Young People and Adolescent Maternal Mortality Ratio

4.1.1. Introduction

The Youth Maternal Mortality Ratio (Youth MMR) refers to the maternal mortality ratio among women aged 15–35 years. For Young People, it would refer to the maternal mortality ratio among women aged 10–24 years. Lastly, Adolescent Maternal Mortality maternal mortality ratio among women aged 10–19 years. The formula for MMR = (Maternal deaths among women aged x years/Live births among Women aged x) multiplied by 100,000.

4.1.2. Youth, Young People and Adolescent MMR Using 2022 Population and Housing Census

Youth MMR: The total number of reported youth maternal deaths (15 to 35 years) among households during the 2022 PHC totalled 196 and the number of live births totalled 42,246.

- **Youth MMR$_{CENSUS}$ = (196 / 42,246) X 100,000 = 463.9.**

This gives us **463.9** youth maternal deaths per 100,000 live births.

Young People MMR: The total number of reported young people maternal deaths (10 to 24 years) among households during the 2022 PHC totalled 127 and the number of live births totalled 15,303.

- **Young People MMR$_{CENSUS}$ = (127 / 15,303) X 100,000 =829.9.**

This gives us **829.9** young people maternal deaths per 100,000 live births by young people.

Adolescent MMR: The total number of reported adolescent maternal deaths (10 to 19 years) among households during the 2022 PHC totalled 3 and the number of live births totalled 3,451.

- **Adolescent MMR$_{CENSUS}$ = (3 / 3,641) X 100,000 =82.4**

This gives us **82.4** adolescent maternal deaths per 100,000 live births by adolescents.

Census data shows an alarmingly high Young People MMR of 829.9 per 100,000 live births (ages 10–24), compared to 463.9 for Youth (15–35).

4.1.3. Youth, Young People and Adolescent MMR Using the 2022 Ministry of Health Maternal Mortality Administrative Data and Vital Statistics

The Ministry of Health and Wellness monitors maternal deaths in health facilities through a notifiable reporting system, with cases medically certified and classified according to international standards such as ICD-10. In 2022, the Ministry recorded 62 maternal deaths among youth aged 15–35 years, 16 deaths among young people aged 10–24 years, and 6 deaths among adolescents. Corresponding live births reported by Vital Statistics for the same year were 44,836, 19,227, and 6,078, respectively.

This results in the following maternal mortality ratios (MMRs):

- Youth MMR$_{MOH}$ = (62 / 44,836) X 100,000 = **138.3**
- Young People MMR$_{MOH}$ = (16 / 19,227) X 100,000 = **83.2**
- Adolescent MMR$_{MOH}$ = (6 / 6,078) X 100,000 = **98.7**

Administrative data from the Ministry of Health showed lower MMRs, with Youth MMR at 138.3, Young People MMR at **83.2**, and Adolescent MMR at **98.7** per 100,000 live births, respectively. The observed differences between the two sources may reflect variations in reporting coverage, case verification, and data collection methodology.

MoH administrative data shows the highest maternal risk is among women aged 30–34 (MMR = 222.0), despite 20–24-year-olds having the most births

4.1.4. Rationale for Preferring Ministry of Health Data for Youth, Young People, and Adolescent MMR Estimates

The Ministry of Health's maternal mortality data provides a more reliable and medically verified measure of maternal deaths among adolescents and young people in Botswana.These records use certified causes of death, standardised classification, and benefit from near-complete coverage of health facility-based events. When paired with Vital Statistics live birth data, they provide a robust basis for calculating MMR.

In contrast, census-based estimates rely on household-reported deaths, which are not clinically verified and lack ICD coding. While they are useful for highlighting disparities across subgroups and capturing maternal deaths that occur outside the formal health system, these data are subject to limitations such as recall bias, misclassification, and incomplete reporting of pregnancy status.

Scenario: For example, a maternal death that occurs at home in a remote village—without access to a health facility and without formal registration—may never enter Ministry of Health records. However, during the census, the deceased's relatives may report that the woman died "while pregnant" or "during childbirth," allowing the event to be captured through household enumeration.

This example illustrates how the census can supplement official data by uncovering hidden maternal deaths, especially in rural or underserved areas. However, for precise national MMR estimates, the combined use of Ministry of Health mortality data and Vital Statistics birth records remains the most credible and actionable approach for these age groups.

4.1.5. Adjusting Census-Based Youth, Young People and Adolescent MMR Estimates Using Benchmark Data

To address the gap between census- and MoH-based maternal mortality estimates, a correction factor from verified administrative data can be applied to adjust census-derived MMRs for youth, young people, and adolescents. This enhances accuracy while retaining the demographic strengths of census data.

Using total maternal deaths (MoH = 89; Census = 234), the correction factor is:

- **Correction Factor = 89 / 234 = 0.38**

Applied to the census-based Youth MMR of 463.9 per 100,000 live births:

- **Adjusted Youth MMR_{CENSUS} = 463.9 × 0.38 = 176.3**

Applied to the census-based Young People MMR of 829.9 per 100,000 live births:

- **Adjusted Young People MMR_{CENSUS} = 829.9×0.38 = 315.4**

Applied to the census-based Young People MMR of 82.4.1 per 100,000 live births:

- **Adjusted Adolescent MMRCENSUS = 82.4 x 0.38 = 31.3**

Despite applying a national correction factor to adjust census-based maternal mortality ratios (MMRs), significant discrepancies persist when compared to Ministry of Health (MoH) administrative estimates. For example, the adjusted Youth MMR from census data is 176.3, whereas the MoH estimate is lower at 138.3. Similarly, the adjusted Young People MMR (315.4) remains almost four times higher than the MoH figure of 83.2, while the adjusted Adolescent MMR (31.3) is considerably lower than the corresponding MoH estimate of 98.7.

These inconsistencies likely stem from several factors, including:

- The uniform application of a national correction factor across age groups, which may not adequately capture age-specific reporting errors or data inconsistencies.
- Small numbers of maternal deaths within specific age brackets in Botswana, which introduce statistical instability when estimating age-specific MMRs using census data; and
- Differing case definitions and completeness between census and administrative systems, particularly regarding non-facility deaths and delayed reporting.

After adjustment, the Youth MMR drops from 463.9 to 176.3, but remains higher than the MoH estimate (138.3), exposing data quality gaps.

Given these limitations, it is more plausible and advisable to rely on the MoH administrative data as the primary source for estimating maternal mortality ratios in Botswana. The use of national-level correction factors for census adjustments remains methodologically sound, particularly in low mortality settings, because disaggregated age-specific maternal death counts are often too small to yield reliable estimates. Therefore, while census data remains valuable for demographic analysis and disaggregation, MoH-certified and ICD-10-classified data should be prioritised for monitoring and benchmarking Botswana's maternal mortality burden across age cohorts.

4.1.6. Age Group Disparities in Maternal Mortality using 2022 PHC data.

An analysis of maternal deaths among young women aged 10–35 years, using data from the 2022 Population and Housing Census, reveals significant age-related disparities in maternal mortality risk. As shown in **Table 8,** youth aged 20–24 years accounted for the overwhelming majority of reported maternal deaths—63.3 percent (124 out of 196 deaths)—highlighting this age group as the most vulnerable during pregnancy and childbirth among the youth population. Women aged 25–29 years and 30–34 years each contributed 16.3 percent of maternal deaths, while adolescent girls aged 15–19 years represented a smaller proportion (1.5%). Only five maternal deaths (2.6%) were recorded among women aged exactly 35 years.

Adjusted MMR for youth aged 20–24 is 404.0 per 100,000 live births—more than double the average—highlighting a critical vulnerability in first-time pregnancies.

Table 8: Percentage Distribution of Reported Maternal Deaths by Age group of Women: 2022 PHC.

Age Group	Number of Deaths Reported	Percent
15 to 19 Years	3	1.5%
20 to 24 Years	124	63.3%
25 to 29 Years	32	16.3%
30 to 34 Years	32	16.3%
35 Years Only	5	2.6%
Total	**196**	**100.0**

Age-specific maternal mortality ratios (MMRs), adjusted using the national correction factor of 0.38 to account for overreporting in census data, are presented in **Table 9.** The adjusted MMR was highest among young women aged 20–24 years, at 404.0 deaths per 100,000 live births—more than double the overall youth adjusted MMR of 176.3. This is a significant public health concern, especially given that this age group also had the highest fertility.

Women aged 25–29 and 30–34 years recorded similar adjusted MMRs of 93.1 and 101.2, respectively, reflecting relatively safer childbearing ages. The adjusted MMR among adolescents aged 15–19 years was lower, at 33.0 deaths per 100,000 live births, corresponding to their lower fertility rates. Among youth aged exactly 35 years, the adjusted MMR was 92.2.

Table 9: Adjusted Maternal Mortality Ratio by Age Group of Women: 2022 PHC

Age Group	Number of Maternal Deaths Reported	Live Births	MMR	Adjusted MMR
15 to 19 Years	3	3451	86.9	33.0
20 to 24 Years	124	11,662	1,063.3	404.0
25 to 29 Years	32	13,057	245.1	93.1
30 to 34 Years	32	12,016	266.3	101.2
35 Years Only	5	2,060	242.7	92.2
Total	**196**	**42,246**	**463.9**	**176.3**

These findings emphasise the urgent need to intensify maternal health interventions for young women aged 20–24 years, who accounted for the highest number of maternal deaths reported in the 2022 Population and Housing Census. However, it is important to note that women aged 30–34 years faced the highest maternal mortality risk per live birth, according to Ministry of Health data. This distinction underscores the need to target both age groups: interventions for 20–24-year-olds should focus on first-time pregnancy risks, access to antenatal care, and youth-friendly services, while for 30–34-year-olds, efforts must address biological risk factors and cumulative reproductive exposure. Although adolescents and women aged 35 years and above contributed fewer maternal deaths, they should not be overlooked, as they may encounter unique biological, social, or service access-related vulnerabilities.

4.1.7. Age Group Disparities in Maternal Mortality Using the 2022 Ministry of Health Maternal Mortality Administrative Data and Vital Statistics.

Administrative data from the Ministry of Health and Vital Statistics for 2022 provide a complementary perspective on maternal mortality among young women aged 10 to 35 years. A total of 62 maternal deaths were recorded within this age range. As shown in **Figure 2**, women aged 30–34 years accounted for the highest proportion of deaths (38.7%), followed by those aged 25–29 years (29.0%). Adolescent girls aged 15–19 years contributed 9.7 percent of the deaths, and young women aged 20–24 years contributed 16.1 percent. Only 4 deaths (6.5%) were recorded among youth aged exactly 35 years, while no maternal deaths occurred among adolescents aged 10–14 years.

Despite contributing fewer deaths, 35-year-olds had the highest MMR (228.8) in MoH data—attributable to lower birth counts and increased biological risks.

Age-specific maternal mortality ratios calculated from administrative data are summarised in Table 10 and visualised in **Figure 3.** The highest MMRs were recorded among young women aged 30–34 years (222.0) and 35 years (228.8). Despite having fewer deaths, the MMRs in these age groups were elevated due to lower live birth counts. Young women aged 25–29 years also recorded a relatively high MMR (136.8), while those aged 20–24 years and 15–19 years had lower MMRs of 76.1 and 100.6, respectively. No maternal deaths were reported for the 10–14 age group, though 111 live births were recorded.

FIGURE 2: PERCENTAGE DISTRIBUTION OF RECORDED MATERNAL DEATHS BY AGE GROUP OF WOMEN (10-35 YEARS): MINISTRY OF HEALTH MATERNAL MORTALITY 2022 ADMINISTRATIVE DATA AND 2022 VITAL STATISTICS.

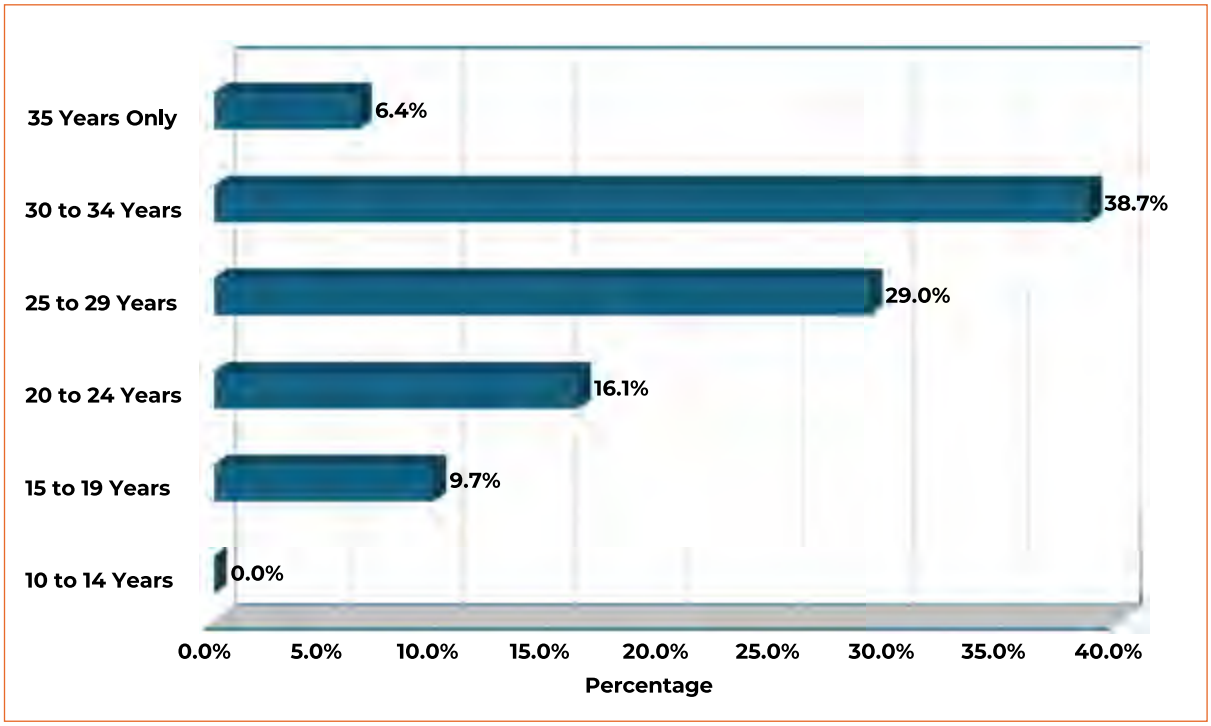
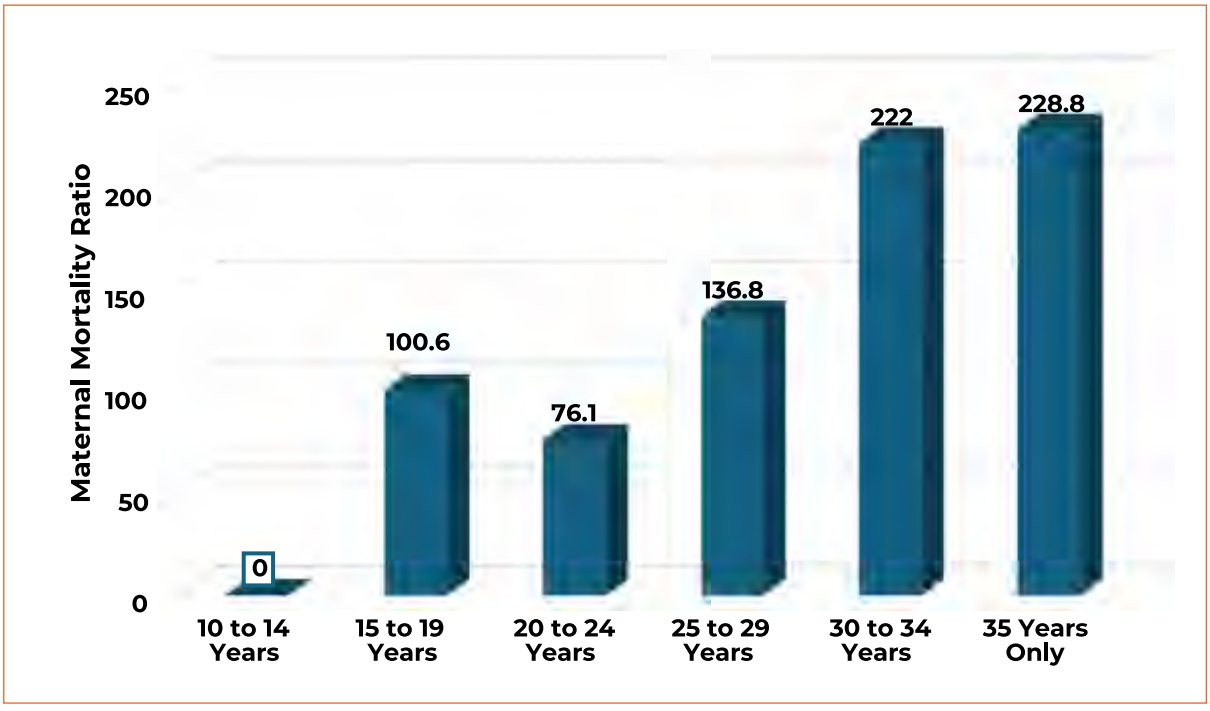


Table 10: Maternal Mortality Ratio by Age Group of Women: Ministry of Health Maternal Mortality Administrative Data and Vital Statistics.

Age Group	Number of Maternal Deaths Recorded	Live Births Recorded	MMR
10 to 14 Years	0	111	0.0
15 to 19 Years	6	5,967	100.6
20 to 24 Years	10	13,149	76.1
25 to 29 Years	18	13,160	136.8
30 to 34 Years	24	10,812	222.0
35 Years Only	4	1,748	228.8
Total	**62**	**44,947[8] (44,836[9])**	**137.9[10] (138.3[11])**

FIGURE 3: MATERNAL MORTALITY RATIO BY AGE GROUP OF WOMEN: MINISTRY OF HEALTH MATERNAL MORTALITY ADMINISTRATIVE DATA AND VITAL STATISTICS



These findings reinforce the pattern observed in census data: while women aged 20–24 years have the highest number of births; the risk of maternal death increases notably among women aged 30 and above. Preventive interventions must therefore adopt a dual focus: reducing mortality among high-fertility younger women (especially 20–24 years), while strengthening clinical surveillance and response systems for complications common among older youth (30–35 years). Addressing these risks will be essential to improving maternal outcomes among Botswana's youth.

[8] This represents the total number of live births among all young people, including adolescents aged 10 years up to youth aged 35 years.
[9] This excludes the total number of live births among adolescents aged 10 years up to 14 years.
[10] This MMR represents the total number of live births among all young people, including adolescents aged 10 years up to youth aged 35 years.
[11] This MMR excludes the total number of live births among adolescents aged 10 years up to 14 years.

4.2. Adolescent Fertility Rate

4.2.1. Introduction

Adolescent fertility is a critical indicator of sexual and reproductive health and overall youth wellbeing. It reflects the extent of early childbearing and is associated with health risks, school dropout, limited economic prospects, and increased vulnerability to poverty and social exclusion. High adolescent fertility also contributes to maternal morbidity and mortality, particularly in low-resource settings.

In Botswana, adolescent fertility is monitored using the Adolescent Fertility Rate (AFR), defined as the number of live births per 1,000 girls aged 15–19 years in a given year. When data permits, analysis is extended to include the 10–14 age group, where pregnancies—though rare—raise significant concern due to their severe social and health implications.

This subchapter examines adolescent fertility using data from the 2022 Population and Housing Census (PHC), focusing on the 10–14 and 15–19 age groups. It explores differences in AFR by district, locality type, education level, marital status, employment (NEET) status, and disability status. The section also compares current levels with past censuses to highlight national trends and progress. Overall, the analysis aims to inform policy and programme responses aimed at preventing early pregnancy and promoting adolescent sexual and reproductive health in Botswana.

4.2.2. Adolescent Fertility Rate (AFR) (15-19 Years)

The Adolescent Fertility Rate (AFR), also known as the Adolescent Birth Rate (ABR), is defined as the number of live births per 1,000 girls aged 15–19 years in a given year. It is a global indicator tracked under SDG 3.7.2 and widely used by UNFPA, WHO, and other agencies.

Botswana's national Adolescent Fertility Rate (AFR) is 35.2 births per 1,000 girls aged 15–19 years (2022 PHC), showing a continued decline from previous census years.

For Botswana, the 2022 PHC data reveals an AFR of 35.2 per 1,000 adolescent girls aged 15–19 years **(See Figure 4).** This rate, while lower than historical figures, indicates that adolescent childbearing remains a concern, especially among socioeconomically vulnerable groups.

4.2.3. Early Adolescent Birth Rate

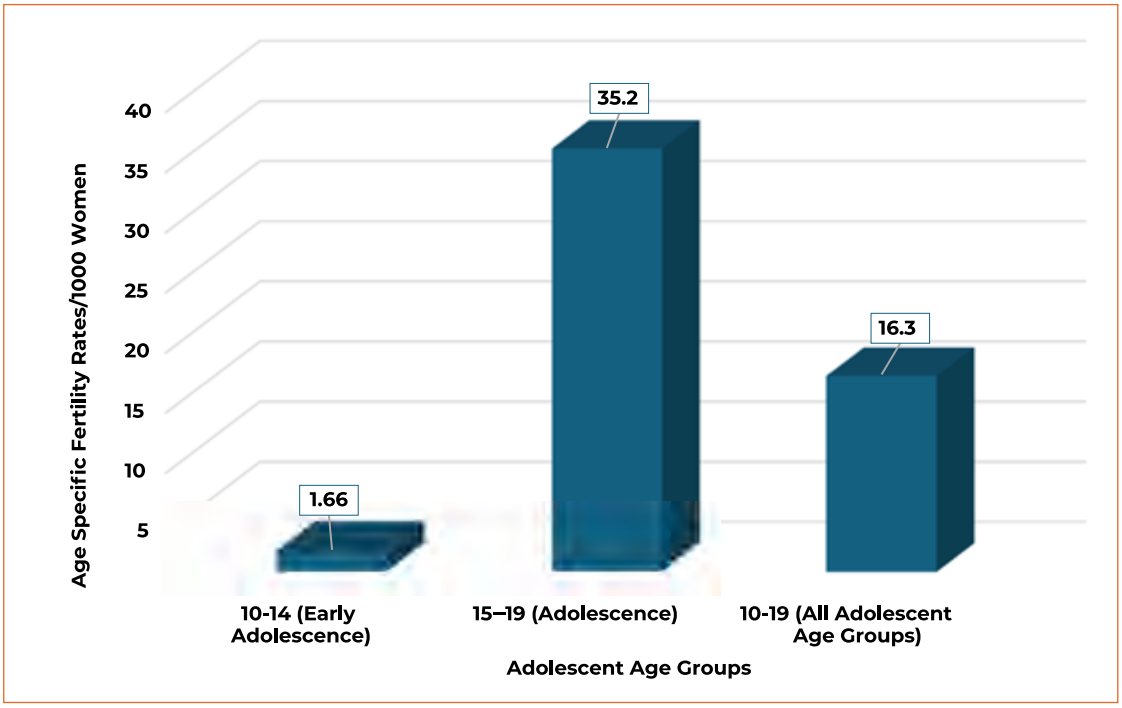
The Early Adolescent Birth Rate refers to the number of live births per 1,000 girls aged 10–14 years. It is rarely used as a standard indicator because births in this age group are exceptionally rare, and the data are often incomplete or underreported. However, where reliable data exist—as in the case of the 2022 PHC—it serves as a critical red flag for very early childbearing.

According to the 2022 PHC, the Age-Specific Fertility Rate (ASFR) for girls aged 10–14 was 1.66 births per 1,000. Although relatively low, this figure remains important for guiding early pregnancy prevention efforts.Pregnancies in this age group often signal serious gaps in child protection, comprehensive sexuality education, and access to adolescent-friendly sexual and reproductive health services.

Although rare, early adolescent births (10–14 years) still occurred, with an ASFR of 1.66 per 1,000 girls, raising serious child protection concerns.

Notably, **Figure 4** shows a combined ASFR of 16.3 for the entire 10–19 age group, highlighting that adolescent fertility, though declining, still warrants focused intervention.

FIGURE 4: ADOLESCENT AGE SPECIFIC FERTILITY RATES: 2022 PHC



4.2.4. Trends in Adolescent Age Specific Fertility Rates

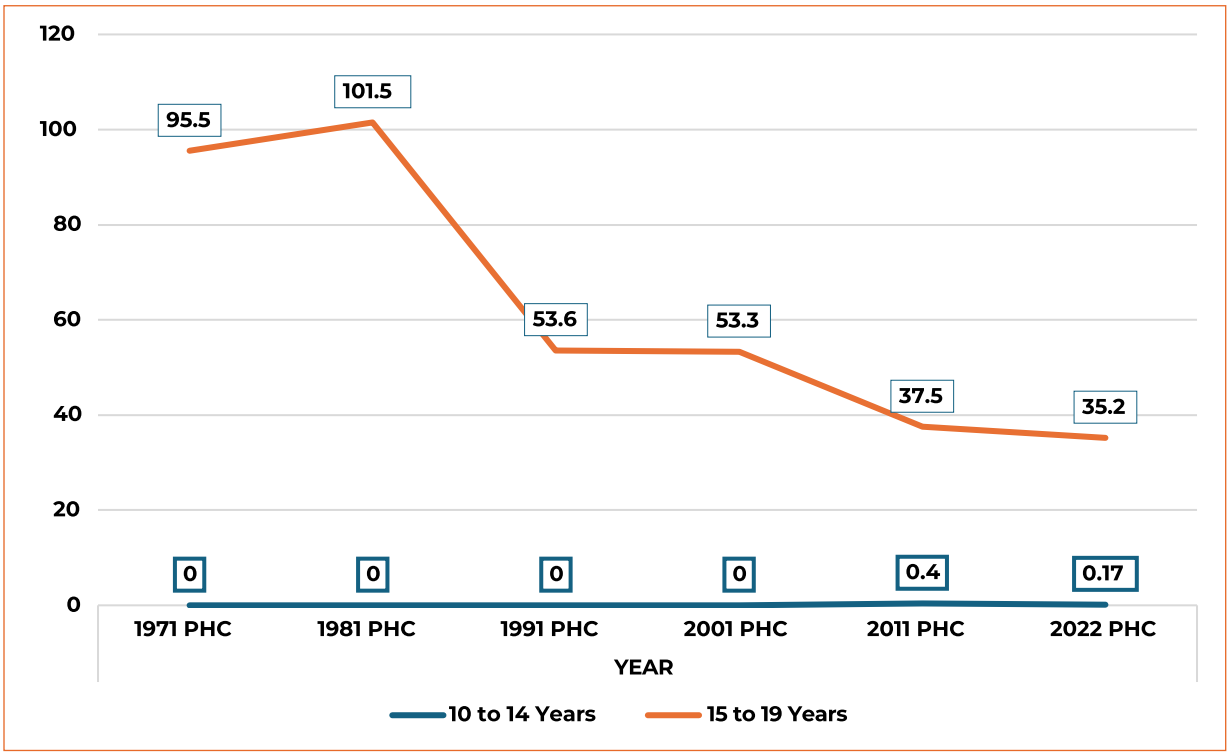
A comparison with previous censuses reveals a steady decline in adolescent fertility. In 1971, the AFR for girls aged 15–19 was 95.5 births per 1,000, rising slightly to 101.5 in 1981, before declining steadily to 53.3 in 2001, 37.5 in 2011, and now 35.2 in 2022. For the 10–14 age group, the ASFR declined from 0.4 births per 1,000 girls in 2011 to 0.17 in 2022. **(See Table 11 and Figure 5)**. This decline mirrors regional patterns in Southern Africa and reflects progress in delaying childbearing. However, even low levels of adolescent fertility must be tracked closely, given the social and health risks associated with early pregnancy.

AFR for 15–19 year-olds declined from **95.5 in 1971** to **35.2 in 2022**, reflecting **steady progress** in delaying childbearing over 50 years.

Table 11: Trends in Adolescent Age Specific Fertility Rates (Per Woman)

Age Group	1971	1981	1991	2001	2011	2022
10-14	-	-	-	-	0.0004	0.00017
15–19	0.0955	0.1015	0.0536	0.0533	0.0375	0.0352

FIGURE 5: CHART SHOWING TRENDS IN ADOLESCENT AGE SPECIFIC FERTILITY RATES (PER WOMAN)



4.2.5. Adolescent Fertility Rates by Districts

District-level analysis shows significant variation in adolescent fertility. The highest ASFRs (15–19 years) were recorded in Kweneng West (71.9), Ngwaketse West (69.0), and Ghanzi (56.4), suggesting clear geographic hotspots for adolescent pregnancies. In contrast, the lowest rates were observed in urban areas such as Gaborone (8.0) and Jwaneng (8.6). Early adolescent births (10–14) were rare but not absent, with isolated cases reported in Ghanzi, Chobe, Kgatleng, and Southern districts **(see Table 12).**

Kweneng West and Ngwaketse West reported the highest adolescent fertility—71.9 and 69.0 per 1,000, respectively—highlighting key intervention hotspots.

Several factors may explain these district-level disparities. Traditional norms favouring early unions, limited access to adolescent-friendly SRH services, low educational attainment, and weak outreach infrastructure are likely contributing to higher adolescent fertility in rural districts like Kweneng West and Ngwaketse West. In these areas, long distances to health facilities, confidentiality concerns, and limited school retention among girls may heighten the risk of early childbearing. In contrast, urban districts benefit from better service coverage, higher education levels, and more accessible health information.

These findings point to the need for district-level, culturally sensitive interventions that address the social determinants of early pregnancy and expand SRHR access for rural adolescents, especially in high-fertility areas.

Table 12: Adolescent Age Specific Fertility Rates by Districts

DISTRICT	10-14 Years			15-19 Years		
	Births	Women	ASF per Woman	Births	Women	ASF per Woman
Gaborone	0	9282	0.0000	91	11361	0.0080
Francistown	1	4845	0.0002	113	4879	0.0232
Lobatse	0	1483	0.0000	26	1333	0.0195
Selibe Phikwe	0	2353	0.0000	27	2242	0.0120
Orapa	0	524	0.0000	2	352	0.0057
Jwaneng	0	832	0.0000	6	701	0.0086
Sowa	0	131	0.0000	0	112	0.0000
Southern	1	7283	0.0001	199	6083	0.0327
Borolong	0	3250	0.0000	131	2246	0.0583
Ngwaketse West	1	1296	0.0008	65	942	0.0690
South East	0	4319	0.0000	82	4689	0.0175
Kweneng East	4	14585	0.0003	393	13949	0.0282
Kweneng West	1	2946	0.0003	158	2196	0.0719
Kgatleng (Wards)	2	5439	0.0004	141	5001	0.0282
Central Serowe -Palapye	0	10327	0.0000	310	8506	0.0364
Central Mahalapye	2	7207	0.0003	229	5159	0.0444
Central Bobonong	1	4199	0.0002	157	3055	0.0514
Central Boteti	0	3728	0.0000	181	3014	0.0601
Central Tutume	1	9546	0.0001	335	6755	0.0496
North East	0	3850	0.0000	96	2740	0.0350
Ngamiland East	2	6079	0.0003	239	5190	0.0461
Ngamiland West	0	4205	0.0000	200	3051	0.0656
Chobe	1	1178	0.0008	34	883	0.0385
Ghanzi	2	2702	0.0007	125	2218	0.0564
Kgalagadi South	0	1751	0.0000	83	1529	0.0543
Kgalagadi North	0	1095	0.0000	43	884	0.0486
Total	**19**	**114435**	**0.0002**	**3466**	**99070**	**0.0350**

4.2.6. By Demographic and Socioeconomic Characteristics

The 2022 Population and Housing Census reveals clear and significant disparities in adolescent fertility across key demographic and socioeconomic groups. These variations provide essential insights for targeted policy interventions aimed at reducing early childbearing and improving adolescent sexual and reproductive health outcomes in Botswana **(See Table 13).**

Adolescent girls with no education have an ASFR of 95.5, compared to only 10.4 for those with tertiary education—demonstrating education's strong protective effect.

o **Locality Type:** Adolescents in rural areas experience substantially higher fertility rates compared to their counterparts in urban villages and cities/towns. The ASFR among girls aged 15–19 in rural areas stands at 64.3 births per 1,000, more than five times higher than the rate in urban centres (12.6 per 1,000), and more than twice that of urban villages (28.3 per 1,000). This rural–urban divide reflects differing levels of access to SRHR services, comprehensive sexuality education, and economic opportunities. In rural areas, barriers such as long distances to health facilities, cultural norms around early marriage, and lower school completion rates may contribute to the elevated fertility rates.

o **Educational Attainment**: Education remains one of the most powerful protective factors against adolescent pregnancy. Adolescents with no formal education recorded an ASFR of 95.5, significantly higher than those with primary (9.25), secondary (34.8), or tertiary education (10.4). The steep gradient in fertility by education level underscores the importance of improving school enrolment and retention, particularly for girls in vulnerable or marginalised communities. Early pregnancies are often both a cause and consequence of school dropout, leading to a cycle of limited life opportunities.

o **Marital Status:** Adolescent fertility is heavily influenced by marital status. Those who were ever married or cohabiting had an ASFR of 294.6 per 1,000, while those who were divorced, separated, or widowed had an even higher ASFR of 375.0, albeit from a small population base. In contrast, never-married adolescents had a significantly lower ASFR of 31.2. These figures reflect the persistent link between child marriage or early union formation and early childbearing, which calls for stronger enforcement of laws prohibiting child marriage and more robust community-level awareness campaigns.

o **NEET Status:** Adolescents classified as NEET (Not in Education, Employment, or Training) showed an ASFR of 64.4 births per 1,000, compared to 18.9 among those who were employed or in school/training (IEET). This means that NEET girls are more than three times as likely to become adolescent mothers. This disparity reflects not only greater vulnerability and economic dependence but also a lack of access to structured support systems, including sexual and reproductive health education. The elevated fertility rate among NEET girls points to both a lack of opportunity and a lack of structured SRHR education, often compounded by low self-efficacy, peer pressure, or limited parental engagement. These findings reinforce the urgent need for multi-sectoral youth development strategies that go beyond health—integrating skills training, mentorship, psychosocial support, and education retention programmes—especially for vulnerable adolescent girls who are disconnected from formal systems.

NEET Girls Are 3.4 Times More Likely to Become Adolescent Mothers

o **Disability Status:** The data reveal a slightly lower ASFR among adolescents with disabilities (21.6) compared to those without disabilities (35.1). While this may seem positive at face value, it warrants a nuanced interpretation. The lower fertility rate could reflect barriers to sexual relationships, health services, or childbearing itself—not necessarily improved SRHR outcomes. Adolescents with disabilities often face multiple layers of exclusion, including limited access to accessible health information and services, discrimination, and lack of autonomy in decision-making. Thus, efforts to prevent early pregnancy must be inclusive of adolescents with disabilities, ensuring their SRHR needs are recognised and met.

Table 13: Adolescent Age Specific Fertility Rates by Demographic and Socioeconomic Characteristics

Characteristics		Age Specific Fertility Rates (ASFRs)		Overall Adolescent Fertility Rate
		10-14	15-19	10-19
Locality Type	Cities/Towns	0.0001	0.0126	0.0066
	Urban Villages	0.0002	0.0283	0.0135
	Rural Areas	0.0002	0.0643	0.0267
Level of Education	None	0.0015	0.0955	0.0486
	Primary	0.0002	0.0925	0.0047
	Secondary	0.0001	0.0348	0.0245
	Tertiary	0.0000	0.0104	0.0104
Marital Status	Never Married	0.0002	0.0312	0.0143
	Ever Married/Cohabiting	0.0000	0.2946	0.2933
	Divorced/ Separated/ Widowed	0.0000	0.3750	0.3750
NEET Status	NEET	0.0018	0.0644	0.0617
	IEET	0.0001	0.0189	0.0067
Disability Status	Not Disabled	0.0002	0.0351	0.0164
	Disabled	0.0000	0.0216	0.0111
Total		**0.0002**	**0.0350**	**0.0163**

4.3. Young People (15 to 24) Contraceptive Use

4.3.1. Introduction

This section presents an analysis of modern contraceptive use among young people in Botswana, using data from the Botswana AIDS Impact Survey V (BAIS V)—the most recent nationally representative survey that includes indicators on sexual and reproductive health and contraceptive use. It is important to highlight that BAIS V collects data only from individuals aged 15 years and above, and as such, this analysis focuses on the age group 15 to 24 years to represent contraceptive use among young people in Botswana. Although adolescents aged 10–14 fall within the broader youth category, they are not captured in the BAIS V contraceptive use module, and their patterns cannot be assessed through this dataset.

The importance of understanding contraceptive use among young people cannot be overstated. Low contraceptive use among adolescents, early and unintended pregnancies, and limited access to youth-friendly services contribute significantly to adverse reproductive health outcomes in this age group. Early pregnancy is associated with increased health risks, school dropouts, and diminished economic opportunities, particularly for adolescent girls. Ensuring that young people have access to modern contraceptive methods is therefore critical for achieving national and global health and development goals, including those outlined in Botswana's National Commitment on Adolescent Wellbeing (2023) and the Sustainable Development Goals (SDGs).

This section presents data on contraceptive prevalence rates (CPR) among all young people aged 15–24, as well as among those who are sexually active, disaggregated by district, demographic, and socioeconomic characteristics. It also includes a statistical model identifying the determinants of contraceptive use within this group, to support evidence-informed policy and programme planning.

4.3.2. Contraceptive Prevalence Rate by Districts

This section examines the geographic distribution of modern contraceptive use among young people aged 15 to 24 years across Botswana's districts, based on data from the Botswana AIDS Impact Survey V (BAIS V). Table 14 presents contraceptive prevalence rates (CPRs) for all young people and for those who are sexually active within this age group.

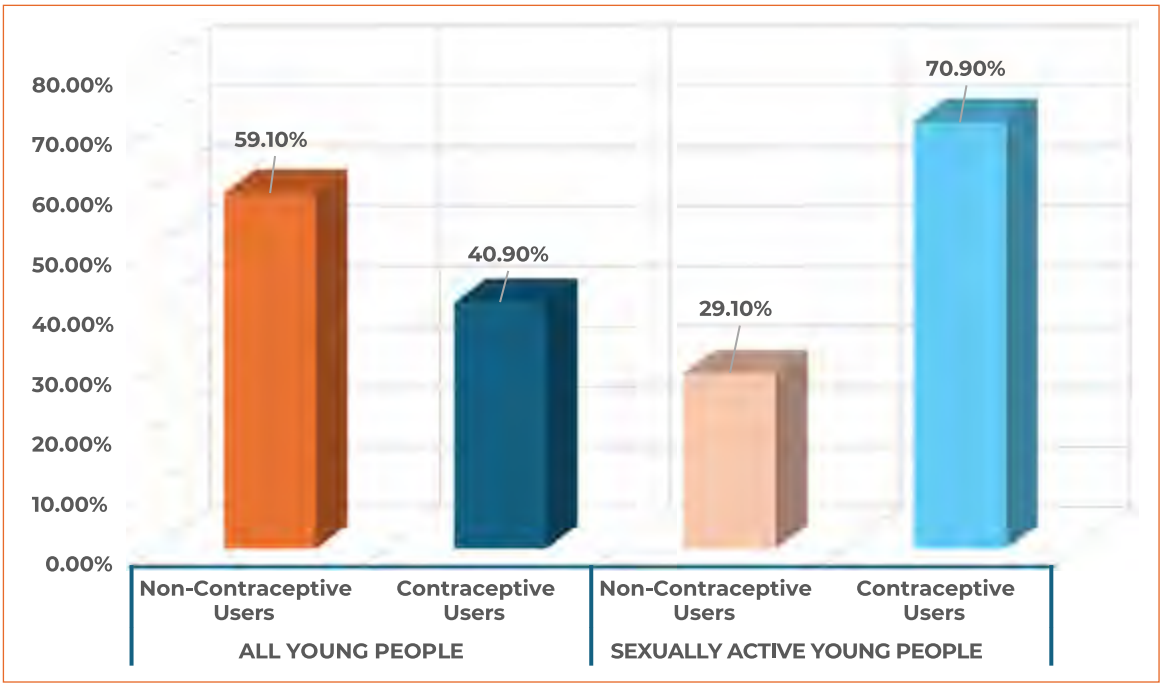
At the national level, the overall CPR among all youth aged 15–24 was 40.9 percent, while among sexually active youth, the CPR was significantly higher at 70.9 percent **(See Figure 6).** This disparity underscores the importance of distinguishing between overall coverage and coverage among those most in need of

Youth in Central Mahalapye, Selibe Phikwe, and Tutume reported the highest contraceptive use among sexually active youth—86.4%, 80.6%, and 79.8% respectively. In contrast, the lowest CPRs were observed in Gaborone (52.3%), Kweneng East (57.1%), and Lobatse (59.5%).

The data reveal considerable variation across districts, highlighting both expected and surprising patterns. Among sexually active young people, the highest contraceptive prevalence was observed in:

- Central Mahalapye (86.4%)
- Selibe Phikwe (80.6%)
- Tutume (79.8%)
- Kgalagadi North (77.2%)
- Ngwaketse West (72.4%)
- Ngamiland West (69.5%)

FIGURE 6: CONTRACEPTIVE USE AMONG ALL YOUNG PEOPLE AND SEXUALLY ACTIVE YOUNG PEOPLE AGED 15–24 YEARS



Many of the top-performing districts in terms of CPR are rural or remote, such as Ngwaketse West, Ngamiland West, and Kgalagadi North, which are traditionally characterised by dispersed populations and limited infrastructure. Their unexpectedly high performance may reflect:

- **The presence of community-based or mobile SRH outreach services,**
- **The integration of family planning into primary health care platforms,**
- **Strong community health worker networks,**
- **Or possibly positive social norms around contraceptive use, bolstered by effective local advocacy or trust in primary care services.**

In contrast, several urban and mining districts, where higher CPRs might typically be expected due to proximity to health facilities and better infrastructure, recorded lower levels of contraceptive use. These include:

- **South East (65.5%)**
- **Jwaneng (66.2%)**
- **Orapa (66.2%)**
- **Gaborone (52.3%)**

These findings suggest that urbanisation and access to infrastructure do not always guarantee higher contraceptive use. Several possible explanations may account for this counterintuitive pattern:

- **Perceived or real stigma around youth accessing contraceptives in densely populated areas where anonymity is limited,**
- **Overburdened health facilities in urban settings with limited time for counselling or youth-friendly service delivery,**
- **Poor provider attitudes or lack of training in adolescent-friendly care,**
- **Or the absence of targeted outreach to young people in urban environments where services may focus primarily on adults or married couples.**

Notably, in urban districts such as Gaborone and South East, CPR among sexually active young people remains significantly below the national average, despite proximity to health infrastructure. This trend may seem counterintuitive but is increasingly observed across urban contexts in Southern Africa. In these high-density settings, youth often face heightened fear of stigma, limited privacy, and perceived judgment from providers, particularly when seeking contraceptives at facilities also used by parents or elders. Furthermore, service delivery in urban areas may prioritise adults or married couples, lacking tailored approaches for unmarried youth. These findings signal an urgent need for urban-specific outreach strategies such as digital demand generation, peer-led counselling, and confidential youth-friendly services that better respond to the realities of urban youth.

These results underscore the importance of contextual factors—including community engagement, health system responsiveness, cultural norms, and youth empowerment—in shaping contraceptive behaviours beyond simple rural–urban divides.

The Pearson Chi-square test ($p<0.001$) confirms that these district-level differences in contraceptive prevalence are statistically significant, highlighting real and meaningful inequalities in contraceptive use among youth across Botswana.

This geographic diversity in CPR emphasises the need for district-level planning and tailored programme design. High-performing rural districts can provide lessons for replication, particularly in how to reach young people through flexible, community-based approaches. Meanwhile, low-performing urban districts may require youth-specific service improvements, enhanced confidentiality, and greater targeted demand generation efforts to overcome barriers to access and utilisation.

Table 14: Contraceptive Prevalence Rate (CPR) among all Young People and Among the Sexually Active Young People (15–24 Years) by District (BAIS V)

DISTRICT	ALL YOUNG PEOPLE (N=4398)		SEXUALLY ACTIVE YOUNG PEOPLE (N=2278)	
	Non-Contraceptive Users	Contraceptive Users	Non-Contraceptive Users	Contraceptive Users
Gaborone	69.2%	30.8%	47.7%	52.3%
Francistown	62.4%	37.6%	36.8%	63.2%
Lobatse	63.0%	37.0%	40.5%	59.5%
Selibe Phikwe	57.3%	42.7%	21.1%	80.6%
Orapa	63.7%	36.3%	19.4%	66.2%
Jwaneng	67.1%	32.9%	33.8%	66.2%
Sowa	61.9%	38.1%	29.3%	70.7%
Southern	63.5%	36.5%	33.7%	66.3%
Borolong	66.5%	33.5%	30.1%	69.9%
Ngwaketse West	63.2%	36.8%	27.6%	72.4%
South East	59.6%	40.4%	34.5%	65.5%
Kweneng East	69.1%	30.9%	42.9%	57.1%
Kweneng West	57.8%	42.2%	30.1%	69.9%
Kgatleng (Wards)	60.7%	39.3%	28.4%	71.6%
Central Serowe -Palapye	58.5%	41.5%	26.2%	73.8%
Central Mahalapye	50.0%	50.0%	13.6%	86.4%
Central Bobonong	65.9%	34.1%	35.8%	64.2%
Central Boteti	52.5%	47.5%	28.9%	71.1%
Central Tutume	52.2%	47.8%	20.2%	79.8%
North East	60.4%	39.6%	29.7%	70.3%
Ngamiland East	49.9%	50.1%	23.0%	77.0%
Ngamiland West	47.5%	52.5%	30.5%	69.5%
Chobe	55.7%	44.3%	30.6%	69.4%
Ghanzi	56.4%	43.6%	27.2%	72.8%
Kgalagadi South	64.7%	35.3%	30.3%	69.7%
Kgalagadi North	56.1%	43.9%	22.8%	77.2%
Total	**59.1%**	**40.9%**	**29.1%**	**70.9%**

Pearson Chi-Square P-Value <0.001 (Statistically Significant)

4.3.3. Contraceptive Prevalence Rate by Demographic and Socioeconomic Characteristics among Young People

The use of modern contraceptives among young people aged 15 to 24 years in Botswana is influenced by a range of demographic and socioeconomic characteristics. Analysis of data from the Botswana AIDS Impact Survey V (BAIS V) reveals significant disparities in contraceptive use when disaggregated by sex, age group, education, marital status, employment status, and household wealth.

- **Among All Youth Aged 15–24**

As shown in **Table 15**, contraceptive prevalence among all youth aged 15–24 was 40.9% nationally, but this figure conceals meaningful differences across population subgroups **(See Figure 7 and Table 15).**

40.9% of all young people aged 15–24 reported using modern contraceptives nationally.

- **Sex:** Female youth had a substantially higher CPR (44.6%) than their male counterparts (36.2%), with this difference being statistically significant ($p < 0.001$). This may reflect targeted family planning efforts that traditionally focus on females, or greater contraceptive motivation among females due to direct pregnancy risk.

- **Age Group:** There is a stark contrast in contraceptive use between adolescents aged 15–19 years (20.4%) and young adults aged 20–24 years (61.6%). This significant age-related gap ($p < 0.001$) may be due to lower levels of sexual activity among younger adolescents, social stigma, legal access barriers, or limited SRH knowledge. These findings highlight the need for early intervention in contraceptive education and service provision, particularly among adolescents.

- **Education:** Youth with tertiary education reported the highest CPR (49.2%), while those with primary education had the lowest (38.3%). Those with no formal education surprisingly had a relatively high CPR (45.3%), possibly reflecting targeted outreach in vulnerable or underserved populations. The positive association between higher education and contraceptive use ($p < 0.001$) aligns with global evidence that educational attainment enhances reproductive autonomy and access to information.

- **Marital Status:** Contraceptive use was markedly higher among youth who were ever married or cohabiting (77.6%) and those who were divorced, separated, or widowed (76.3%), compared to never-married youth (37.1%).These differences were statistically significant ($p < 0.001$), suggesting that youth in formal or informal unions are more likely to perceive a need for contraception due to increased sexual activity or family planning intentions.

- **Household Wealth:** A reverse gradient was observed in contraceptive use across wealth quintiles. Youth in the lowest wealth quintile had the highest CPR (49.7%), while those in the highest quintile had the lowest (30.9%). This pattern ($p < 0.001$) may reflect greater programmatic outreach or NGO targeting of economically vulnerable populations, or greater reproductive health needs among poorer youth. It may also indicate cost-related barriers or complacency among wealthier youth.

FIGURE 7: CONTRACEPTIVE PREVALENCE RATE BY DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS AMONG ALL YOUNG PEOPLE 15 TO 24 YEARS.

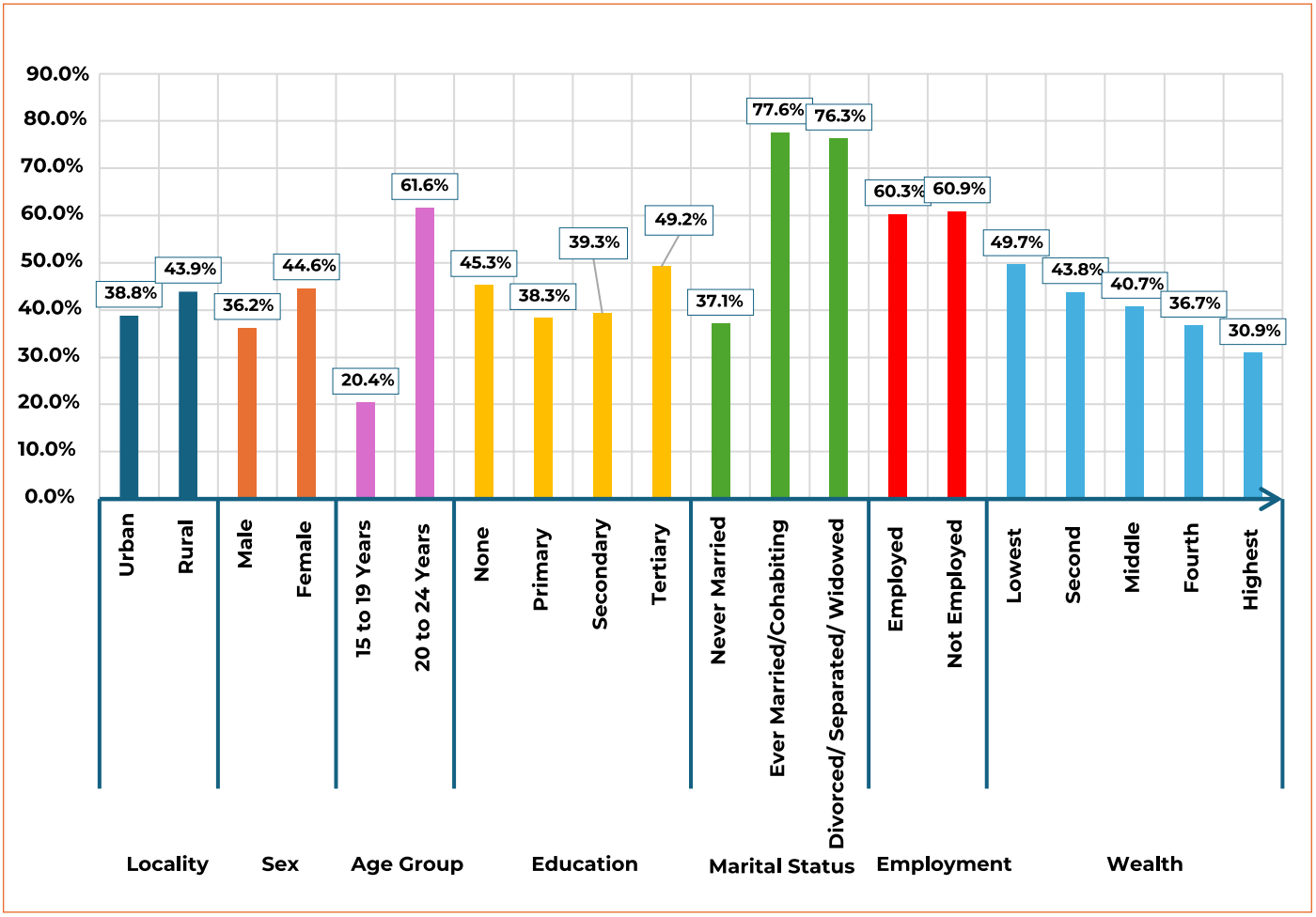


Table 15: Contraceptive Prevalence Rate by Demographic and Socioeconomic Characteristics among All Young People 15 to 24 Years.

Characteristics		CPR (N=4398)	Pearsons Chi-Square P-Value
Locality	Urban	38.8%	P<0.001
	Rural	43.9%	
Sex	Male	36.2%	P<0.001
	Female	44.6%	
Age Group	15 to 19 Years	20.4%	P<0.001
	20 to 24 Years	61.6%	
Level of Education	None	45.3%	P<0.001
	Primary	38.3%	
	Secondary	39.3%	
	Tertiary	49.2%	
Marital Status	Never Married	37.1%	P<0.001
	Ever Married/Cohabiting	77.6%	
	Divorced/ Separated/ Widowed	76.3%	
Household Wealth Quintile	Lowest	49.7%	P<0.001
	Second	43.8%	
	Middle	40.7%	
	Fourth	36.7%	
	Highest	30.9%	
Total		**40.9%**	

- **Among Sexually Active Youth Aged 15–24**

Among the sexually active subset of youth (N=2,278), the national contraceptive prevalence rate was 70.9 percent, reflecting a relatively high uptake of modern methods among those at risk of pregnancy. However, even within this subgroup, disparities remain, as shown in **Table 16**.

70.9% of sexually active youth aged 15–24 used modern contraceptives—nearly double the rate among all youth.

- **Locality:** CPR was higher in rural areas (73.1%) compared to urban areas (69.2%), with the difference reaching statistical significance (p = 0.041). This pattern may appear counterintuitive, but it could be explained by the effectiveness of rural outreach initiatives, including community health workers and mobile clinics, as well as possibly stronger engagement with primary healthcare providers in rural communities.

- **Sex:** Among sexually active youth, there was no significant difference in contraceptive use by sex (71.9% for males vs. 70.3% for females, p = 0.422), indicating that once sexually active, both genders are relatively equally likely to use contraception—possibly through shared decision-making or mutual intention to prevent pregnancy.

Female youth (44.6%) had significantly higher contraceptive use than males (36.2%).

- **Age Group:** There was no statistically significant difference in CPR between adolescents aged 15–19 (71.2%) and young adults aged 20–24 (70.7%, p = 0.835), a finding that contrasts with patterns observed among all youth. This suggests that once adolescents become sexually active, their likelihood of using contraception is comparable to that of their older peers.

Youth aged 20–24 had 3x higher contraceptive use (61.6%) than adolescents aged 15–19 (20.4%).

- **Education:** While not statistically significant (p = 0.069), CPR was highest among those with primary education (80.3%), followed by those with secondary (71.5%) and tertiary education (68.3%). This may suggest that lower education levels are not necessarily a barrier to contraceptive use in sexually active youth, potentially due to outreach interventions targeting vulnerable groups.

Contraceptive use was highest among youth with tertiary education (49.2%), and lowest among those with only primary education (38.3%).

- **Marital Status:** Similar to the broader youth population, sexually active youth who were ever married or cohabiting (78.2%) and divorced/separated/widowed (81.7%) had significantly higher CPR than never-married youth (69.3%), with the differences being highly statistically significant (p < 0.001). This pattern reflects the heightened perceived or actual need for family planning within union settings.

- **Wealth Quintile:** Consistent with patterns among all youth, contraceptive use among sexually active youth declined with increasing household wealth. The lowest wealth quintile had the highest CPR (77.2%), while the highest quintile recorded the lowest (67.1%), a statistically significant difference (p < 0.001). This reinforces the finding that economic vulnerability may heighten motivation or need for contraceptive use, possibly due to the greater consequences of unintended pregnancies among poorer youth.

Sexually active youth from the lowest wealth quintile had the highest CPR at 77.2%, while youth from the highest quintile had the lowest at 67.1%.

These patterns suggest that contraceptive use among youth is shaped less by affluence or urban access and more by a combination of perceived reproductive need, marital status, and educational empowerment. The finding that CPR is higher among economically and geographically disadvantaged youth challenges conventional assumptions and highlights the success of targeted public health efforts, while also signalling the need to ensure that wealthier and urban youth are not neglected in reproductive health outreach and service delivery.

Table 16: Contraceptive Prevalence Rate by Demographic and Socioeconomic Characteristics among Sexually Active Young People 15 to 24 Years.

Characteristics		CPR (N=2278)	Pearsons Chi-Square P-Value
Locality	Urban	69.2%	P=0.041
	Rural	73.1%	
Sex	Male	71.9%	P=0.422
	Female	70.3%	
Age Group	15 to 19 Years	71.2%	P<0.835
	20 to 24 Years	70.7%	
Level of Education	None	59.0%	P<0.069
	Primary	80.3%	
	Secondary	71.5%	
	Tertiary	68.3%	
Marital Status	Never Married	69.3%	P<0.001
	Ever Married/Cohabiting	78.2%	
	Divorced/ Separated/ Widowed	81.7%	
Employment Status	Employed	69.7%	P<0.485
	Not Employed	71.1%	
Household Wealth Quintile	Lowest	77.2%	P<0.001
	Second	69.7%	
	Middle	71.1%	
	Fourth	66.4%	
	Highest	67.1%	
Total		**70.9%**	

4.3.4. Determinants of Adolescent Contraceptive Use (Contraceptive Prevalence Rate (CPR) among Sexually Active young people aged 15 to 24

Table 17 presents the results of a binary logistic regression model that examined the factors associated with modern contraceptive use among sexually active youth aged 15–24 years.

The analysis revealed several important findings:

- **Education was one of the strongest predictors.** Compared to those with no education, youth with primary (AOR = 2.43), secondary (AOR = 1.87), and tertiary education (AOR = 1.84) were significantly more likely to use contraceptives.
- **Marital status was also significant.** Those ever married or cohabiting (AOR = 1.55) were more likely to use contraceptives than those never married.
- **Household wealth showed a reverse relationship**: youth in the second (AOR = 0.72), fourth (AOR = 0.64), and highest (AOR = 0.69) wealth quintiles were less likely to use contraceptives compared to those in the lowest quintile. This may reflect greater demand or targeted outreach among more vulnerable groups.
- No statistically significant differences were observed by sex, age group, urban/rural residence, or employment status, after controlling for other variables.

Education and marital status drive contraceptive use among youth aged 15–24.

Despite the relatively low explanatory power of the model (pseudo-R^2 = 0.022), the findings underscore the importance of educational attainment, marital status, and wealth-related need in influencing contraceptive use among youth.

These results suggest that policy and programme interventions should:

- Prioritise access to contraceptives for in-school and out-of-school youth,
- Promote comprehensive sexuality education to raise awareness and confidence in contraceptive decision-making,
- Tailor outreach strategies to meet the needs of youth in low-income and underserved settings, including those who may be less empowered to access services on their own.

Table 17: Determinants of Modern Contraceptive use among Young People Aged 15-24 Years: Results from Multivariate Logistic Regression

Characteristics		Odds Ratios	95% Confidence Interval
Locality	Urban (REF)	1	-
	Rural	1.1	0.900-1.345
Sex	Male (REF)	1	-
	Female	0.883	0.728-1.071
Age Group	15 to 19 Years	1	-
	20 to 24 Years	0.956	0.768-1.190
Level of Education*	None (REF)	1	-
	Primary	2.432*	1.080-6.035
	Secondary	1.868*	1.070-3.595
	Tertiary	1.839*	1.028-3.645
Marital Status*	Never Married (REF)	1	-
	Ever Married/Cohabiting	1.552	1.157-2.083
	Divorced/ Separated/ Widowed	1.841	0.946-3.581
Household Wealth Quintile*	Lowest (REF)	1	-
	Second	0.717	0.544-0.946
	Middle	0.779	0.575-1.057
	Fourth	0.64	0.476-0.862
	Highest	0.69	0.491-0.970
Model Statistics			

* Statistically Significant:

4.4. HIV Testing

4.4.1. Introduction

HIV testing remains a cornerstone of HIV prevention, treatment, and care efforts, particularly among young people whose health behaviours and access to services critically shape the future trajectory of the epidemic. Testing allows for early diagnosis, linkage to care, and reduction of further transmission. For young people and youth, understanding testing coverage provides insight into both the reach of prevention initiatives and the gaps that need to be addressed.

This section draws on data from the Botswana AIDS Impact Survey V (BAIS V, 2021/22) to analyse HIV testing coverage among:

- Youth aged 15–35 years, and
- Young people aged 15–24 years.

Out of those surveyed and eligible for analysis:

- A total of 9,071 youth aged 15–35 years were included in the HIV testing analysis.
- For young people aged 15–24 years, 4,375 individuals were analysed for HIV testing status.

The findings presented here examine whether individuals had ever been tested for HIV and highlight disparities across districts, demographic groups, socio-economic factors, and urban–rural divides. Moreover, multivariate models explore the determinants associated with HIV testing uptake, offering guidance for targeted interventions.

4.4.2. HIV Ever Testing among the Youth (15 to 35 Years) by District

At the national level, 82.6 percent of youth aged 15–35 years reported ever being tested for HIV, reflecting Botswana's strong commitment to expanding HIV services to younger populations **(See Figure 8)**. However, substantial geographic variation was observed across districts **(see Table 18).**

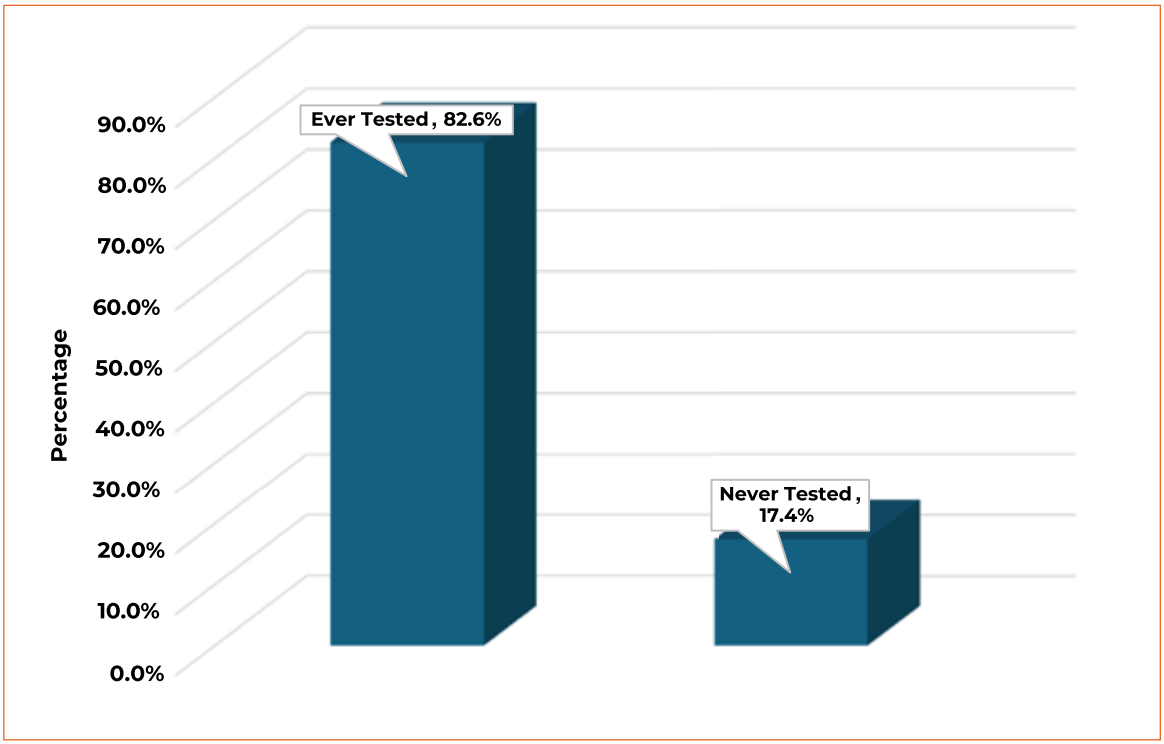
- **82.6% of youth aged 15–35 years in Botswana have ever tested for HIV.**
- **Highest testing coverage: Kweneng West (87.9%), Selibe Phikwe (87.2%), Gaborone (86.8%).**
- **Lowest testing coverage: Kgalagadi South (76.5%), Ghanzi (78.0%), Ngwaketse South (77.6%).**

Urban districts such as Gaborone (86.8%), Francistown (83.8%), and Selibe Phikwe (87.2%) recorded relatively high HIV testing coverage among youth. This can be attributed to greater access to health facilities, widespread public health campaigns, and more anonymous testing opportunities in urban environments.

On the other hand, while districts such as Kgalagadi South (76.5%) and Ghanzi (78.0%) still achieved relatively high coverage, their slightly lower testing rates suggest that remoteness, limited outreach, or persistent stigma could hinder testing uptake in rural settings.

Interestingly, some rural and remote districts—such as Kweneng West (87.9%) and Chobe (86.1%)—demonstrated impressive HIV testing rates, which may reflect strong mobile health campaigns, community mobilisation, or effective peer-led interventions.

FIGURE 8: PERCENTAGE DISTRIBUTION OF YOUTH (15 TO 35 YEARS) BY WHETHER EVER TESTED FOR HIV



The variations highlight the importance of maintaining both facility-based and community-level HIV testing services, particularly in rural and underserved regions where structural barriers may persist. Targeted intensification of HIV testing outreach in districts like Ngwaketse South (77.6%) and North East (79.7%) could further close these gaps.

Table 18: Percentage Distribution of youth (15 to 35 Years) by whether ever tested for HIV by District

DISTRICT	Ever Tested		Never Tested		Total
	Number	Percent	Number	Percent	
Gaborone	223	86.8%	34	13.2%	**257**
Francistown	176	83.8%	34	16.2%	**210**
Lobatse	296	85.3%	51	14.7%	**347**
Selibe Phikwe	109	87.2%	16	12.8%	**125**
Orapa	370	79.4%	96	20.6%	**466**
Jwaneng	269	80.3%	66	19.7%	**335**
Sowa	172	85.1%	30	14.9%	**202**
Ngwaketse South	304	77.6%	88	22.4%	**392**
Borolong	248	84.4%	46	15.6%	**294**
Ngwaketse West	223	83.5%	44	16.5%	**267**
South East	382	84.1%	72	15.9%	**454**
Kweneng East	266	82.9%	55	17.1%	**321**
Kweneng West	343	87.9%	47	12.1%	**390**
Kgatleng	287	81.5%	65	18.5%	**352**
Central Serowe Palapye	297	84.6%	54	15.4%	**351**
Central Mahalapye	197	86.8%	30	13.2%	**227**
Central Bobonong	226	83.1%	46	16.9%	**272**
Central Boteti	257	81.1%	60	18.9%	**317**
Central Tutume	293	83.0%	60	17.0%	**353**
North East	224	79.7%	57	20.3%	**281**
Ngamilang East	654	81.4%	149	18.6%	**803**
Ngamilang West	433	83.4%	86	16.6%	**519**
Chobe	260	86.1%	42	13.9%	**302**
Ghanzi	288	78.0%	81	22.0%	**369**
Kgalagadi South	391	76.5%	120	23.5%	**511**
Kgalagadi North	302	85.3%	52	14.7%	**354**
Total	**7,490**	**82.6%**	**1,581**	**17.4%**	**9,071**

4.4.3. HIV Ever Testing among the HIV among youth (15 to 35 Years) by Demographic and Socioeconomic Characteristics

Significant differences in HIV testing uptake were observed across key demographic and socio-economic subgroups, as presented in **Table 19.**

- **Locality Type:** Youth residing in urban areas (83.1%) were slightly more likely to have ever tested for HIV compared to rural youth (81.8%), but the margin was relatively narrow. This suggests that Botswana's rural HIV testing strategies—including mobile clinics and community-based testing—have been relatively effective at bridging urban–rural disparities.
- **Sex:** Female youth (84.3%) were significantly more likely to have ever tested for HIV compared to male youth (80.2%). This reflects patterns observed elsewhere, where women's greater contact with health services (especially during antenatal care) increases their opportunities for testing. It may also indicate higher perceived risk or social expectations for women to test.

- **Adolescents lag behind in HIV testing. Only 36.1% of 15–17-year-olds have ever tested, compared to 88.6% among 20–24 and 95.8% among 25–29-year-olds.**
    - **Women: 84.3% tested | Men: 80.2% tested**
    - **Youth with tertiary education (92.3%) far outpace those with no education (77.0%).**

- **Age Group:** HIV testing uptake increased sharply with age. Only 36.1 percent of 15–17-year-olds had ever tested, compared to 60.1 percent among 18–19-year-olds. Testing rates exceeded 88 percent among those aged 20–24 years and rose above 95 percent among youth aged 25–34 years. The findings highlight a critical gap among adolescents, suggesting the need to expand adolescent-friendly testing services to reach younger teenagers earlier and improve early HIV diagnosis and prevention efforts.

- **Marital Status:** Married youth exhibited the highest testing coverage (97.2%), compared to never married youth (78.3%) and previously married individuals (94.4%). This trend reflects both greater perceived HIV risk within marital or cohabiting relationships and the integration of HIV testing within marital counselling and reproductive health services.

- **Level of Education:** Testing rates improved with educational attainment: 77.0 percent among those with no education, 80.8 percent among those with primary education, 79.5 percent for those with secondary education, and a notable 92.3 percent for youth with tertiary education. Education is a key enabler of health-seeking behaviours, enhancing awareness of HIV risks and the benefits of testing.

- **NEET Status:** Youth who were NEET (Not in Education, Employment, or Training) had significantly higher testing rates (88.3%) compared to their employed or in-education peers (73.2%). This may reflect more intensive outreach to out-of-school youth by HIV programmes targeting vulnerable populations.

- **Household Wealth:** Testing coverage was high across all wealth quintiles, although slight declines were noted among the wealthiest youth (80.0%) compared to those in the lowest quintile (81.6%). These patterns may suggest that testing campaigns have successfully prioritised inclusion of economically disadvantaged groups, although targeted messaging towards wealthier segments could improve their engagement.

These findings underscore the importance of targeted, age-specific, gender-sensitive, and equity-focused HIV testing strategies to ensure that all youth, regardless of background, can access lifesaving knowledge of their HIV status.

Table 19: Percentage Distribution of youth (15 to 35 Years) by whether ever tested for HIV by Selected Demographic and Socioeconomic Characteristics

CHARACTERISTICS		Ever Tested	Never Tested	TOTAL
Locality	Urban	83.1%	16.9%	**5,412**
	Rural	81.8%	18.2%	**3,659**
Sex	Male	80.2%	19.8%	**3,879**
	Female	84.3%	15.7%	**5,192**
Age group	15 to 17 Years	36.1%	63.9%	**1,249**
	18 to 19 Years	60.1%	39.9%	**943**
	20 to 24 Years	88.6%	11.4%	**2,183**
	25 to 29 Years	95.8%	4.2%	**2,178**
	30 to 34 Years	97.4%	2.6%	**2,081**
	35 Years Only	97.0%	3.0%	**437**
Marital Status	Never Married	78.3%	21.7%	**6,938**
	Married	97.2%	2.8%	**1,794**
	Previously Married	94.4%	5.6%	**319**
Level of Education	No Education	77.0%	23.0%	**183**
	Primary	80.8%	19.2%	**443**
	Secondary	79.5%	20.5%	**6,297**
	Tertiary	92.3%	7.7%	**2,145**
NEET Status	NEET[12]	88.3%	11.7%	**5,625**
	IEET[13]	73.2%	26.8%	**3,441**
Household Wealth Quintile	Lowest	81.6%	18.4%	**2,028**
	Second	83.9%	16.1%	**1,938**
	Middle	83.3%	16.7%	**1,693**
	Fourth	83.8%	16.2%	**1,787**
	Highest	80.0%	20.0%	**1,625**
TOTAL		**82.6%**	**17.4%**	**9,071**

4.4.4. Determinants of HIV Ever Testing among Youth (15 to 35 Years)

Multivariate logistic regression analysis confirmed and expanded the understanding of factors associated with HIV testing uptake among youth **(see Table 20).**

- **Education and marital status drive HIV testing:**
  Youth with **tertiary education** had **nearly five times** the odds of testing compared to those with no education.Married youth were significantly more likely to test **(AOR = 0.375).**NEET youth had **1.6 times** higher odds of testing than non-NEET youth.

[12] NEET stands for Not in Education, Not in Employment or Training
[13] IEET stands for In Education, or Employment or Training

- **Sex:** After adjusting for confounding factors, females remained more likely to have tested for HIV (AOR = 0.871; 95% CI: 0.763–0.994), highlighting persistent gender differences in testing patterns.
- **Age:** Strong age effects were observed. Compared to youth aged 30–34, adolescents and young adults (especially those 15–17 and 18–19) had significantly lower odds of testing, underscoring an urgent need to improve adolescent-focused HIV services.
- **Education:** Higher educational attainment remained strongly protective. Youth with secondary and tertiary education were much more likely to have tested compared to those with no education ($p<0.001$).
- **Marital Status:** Marriage and cohabitation significantly increased the likelihood of testing, with married youth being much more likely to have undergone HIV testing ($p<0.001$).
- **NEET Status:** Youth who were NEET had 1.6 times higher odds of ever testing for HIV compared to non-NEET youth, again suggesting successful targeting of out-of-school and unemployed youth.
- **Wealth:** Lower wealth was associated with slightly higher odds of HIV testing, particularly among those in the lower wealth quintiles, although the effect was smaller than that of age, education, or marital status.

Model diagnostics indicated a good fit, with Nagelkerke $R^2 = 0.414$ and a significant Hosmer–Lemeshow test ($p=0.011$).

Table 20: Determinants of Modern Contraceptive Use among Sexually Active Young People Aged 15-35 Years: Results from Multivariate Logistic Regression.

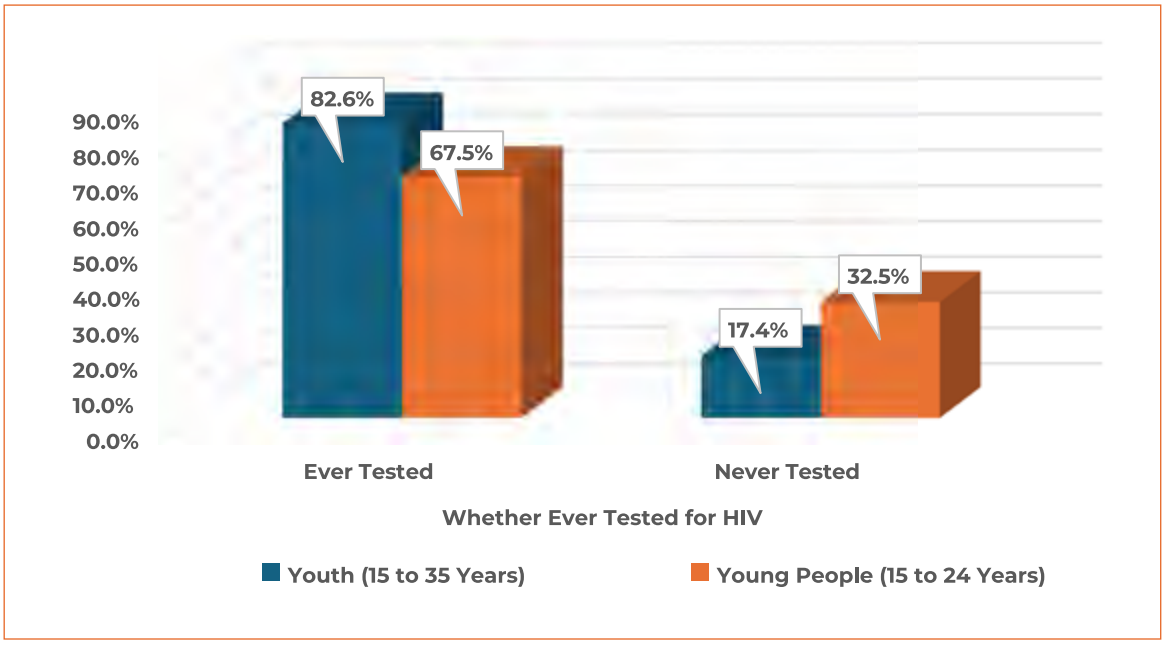
CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality	Urban	1	
	Rural	1.119	0.969-1.292
Sex	Male	1	
	Female	0.871	0.763-0.994
Age group*	15 to 17 Years	1	
	18 to 19 Years	0.440	0.363-0.534
	20 to 24 Years	0.090	0.074-0.110
	25 to 29 Years	0.033	0.025-0.043
	30 to 34 Years	0.022	0.016-0.030
	35 Years Only	0.025	0.014-0.044
Level of Education*	No Education	1	
	Primary	0.505	0.302 -0.844
	Secondary	0.289	0.188 0.445
	Tertiary	0.206	0.129 -0.327
Marital Status	Never Married	1	
	Married	0.375	0.275 -0.512
	Previously Married	0.585	0.346 0.992
NEET Status	NEET[14]	1	
	IEET[15]	1.613	1.405 -1.853
Household Wealth Quintile	Lowest	1	
	Second	0.769	0.628- 0.942
	Middle	0.929	0.749 -1.153
	Fourth	0.812	0.655 -1.006
	Highest	1.144	0.910- 1.438

[14]NEET stands for Not in Education, Employment and Training
[15]IEET stands for In Education, or Employment or Training

4.4.5. HIV Ever Testing among the Young People (15 to 24 Years) by District

Focusing specifically on young people aged 15–24 years, the overall HIV testing coverage was 67.5 percent, lower than that observed among the broader 15–35 age group. This lower coverage emphasises the continuing vulnerability of young people, particularly adolescents, in accessing testing services **(see Figure 9).**

FIGURE 9: BAR CHART SHOWING THE PROPORTION OF YOUTH AND YOUNG PEOPLE WHO HAVE EVER TESTED FOR HIV (2021 BAIS V



However, the analysis reveals notable variations across districts (see Table 21):

- Higher testing coverage was observed in districts such as Central Mahalapye (78.5%), Selibe Phikwe (78.4%), and Kweneng West (74.7%) **(see Table 21)**. In these districts, strong integration of youth services into primary healthcare, targeted youth outreach, and school-based HIV education programmes could be contributing factors.
- Conversely, lower testing coverage was recorded in districts like Ngwaketse South (60.5%), Ghanzi (60.1%), Jwaneng (58.8%), and Kgalagadi South (60.2%). These areas may face unique barriers including limited-service availability, stigma surrounding youth sexual health, lack of adolescent-friendly services, or lower perceived HIV risk among young people **(see Table 21).**

- **Only 67.5% of young people aged 15–24 had ever tested for HIV.**
- **Highest testing: Central Mahalapye (78.5%), Selibe Phikwe (78.4%), Kweneng West (74.7%)**
- **Lowest testing: Jwaneng (58.8%), Ghanzi (60.1%), Kgalagadi South (60.2%)**

It is particularly concerning that even in urban districts such as Gaborone (75.0%) and Francistown (69.0%), testing rates, although higher than rural averages, remain below optimal levels. Given the easier physical access to health services in urban areas, these findings may point to non-structural barriers, such as fear of confidentiality breaches, judgmental attitudes of health workers, or lack of targeted youth demand generation.

Moreover, smaller urban mining towns like Orapa and Jwaneng, despite higher employment and better health infrastructure, reported lower testing coverage (61.6% and 58.8% respectively) compared to rural

districts like Kweneng West (74.7%). This highlights that service proximity alone is not sufficient—service accessibility must be youth-friendly, confidential, and culturally sensitive.

Testing coverage among young people is highly uneven across districts. There is an urgent need for district-specific strategies, with particular emphasis on urban mining towns, rural underserved districts, and districts with rapidly growing youth populations, to ensure no young person is left behind in HIV prevention efforts.

Table 21: Percentage Distribution of youth (15 to 24 Years) by whether ever tested for HIV and District

	Ever Tested		Never Tested		
DISTRICT	Number	Percent	Number	Percent	Total
Gaborone	90	75.0%	30	25.0%	120
Subtotal	**90**	**75.0%**	**30**	**25.0%**	**120**
Francistown	69	69.0%	31	31.0%	100
Lobatse	109	71.7%	43	28.3%	152
Selibe Phikwe	58	78.4%	16	21.6%	74
Orapa	149	61.6%	93	38.4%	242
Jwaneng	87	58.8%	61	41.2%	148
Sowa	54	64.3%	30	35.7%	84
Ngwaketse South	127	60.5%	83	39.5%	210
Borolong	109	70.3%	46	29.7%	155
Ngwaketse West	95	71.4%	38	28.6%	133
South East	142	70.0%	61	30.0%	203
Kweneng East	98	65.3%	52	34.7%	150
Kweneng West	124	74.7%	42	25.3%	166
Kgatleng	113	67.7%	54	32.3%	167
Central Serowe Palapye	109	68.6%	50	31.4%	159
Central Mahalapye	95	78.5%	26	21.5%	121
Central Bobonong	91	67.4%	44	32.6%	135
Central Boteti	93	66.9%	46	33.1%	139
Central Tutume	130	71.8%	51	28.2%	181
North East	89	62.7%	53	37.3%	142
Ngamilang East	279	67.1%	137	32.9%	416
Ngamilang West	163	69.1%	73	30.9%	236
Chobe	83	68.0%	39	32.0%	122
Ghanzi	107	60.1%	71	39.9%	178
Kgalagadi South	162	60.2%	107	39.8%	269
Kgalagadi North	127	73.4%	46	26.6%	173
Total	**2,952**	**67.5%**	**1,423**	**32.5%**	**4,375**

4.4.6. HIV Ever Testing among Young People (15 to 24 Years) by Demographic and Socioeconomic Characteristics

A disaggregated analysis by key demographic and socio-economic variables reveals pronounced disparities in HIV testing uptake among young people, offering important clues for targeted programming. **(See Table 22)**

- **Testing gap by age is alarming between adolescents (15-19) with 46.4% and young adults (20-24) with 88.6%.**
- **Young women lead slightly in HIV testing.**
- **HIV testing increases with education.**
- **Married young people are far more likely to test.**
- **NEET youth test more than IEET youth.**
- **Wealth doesn't always predict testing.**

- **Locality (Urban/Rural):** Surprisingly, no difference was observed between urban and rural young people — both reported identical testing rates (67.5%). This suggests Botswana's rural HIV outreach strategies have succeeded in narrowing the urban–rural gap. However, deeper qualitative exploration is warranted, as similar testing rates may mask differences in service quality, consent procedures, or repeat testing uptake.

- **Sex:** Female young people (67.9%) had marginally higher rates of HIV testing compared to their male counterparts (67.0%). Although the difference is small, it reflects a consistent trend seen across most countries: young women are more likely to interact with health services due to reproductive health needs, pregnancy care, and greater targeted health messaging.

- **Age Group:** The contrast between adolescents aged 15–19 years (46.4%) and young adults aged 20–24 years (88.6%) is striking. While nearly 9 in 10 young adults have ever tested for HIV, more than half of adolescents have never been tested. This enormous testing gap (over 40 percentage points) is a red flag indicating major barriers to early adolescent testing. These may include:

    - Fear of disclosure,
    - Insufficient adolescent-specific HIV services,
    - Lower self-perceived risk,
    - Consent or parental permission requirements for testing,
    - Lack of proactive youth engagement outside of sexual or reproductive health settings.

- **Education:** Testing rates increased progressively with educational attainment:

    - No education: 57.8%
    - Primary education: 56.2%
    - Secondary education: 65.8%
    - Tertiary education: 79.5%

Youth with tertiary education were over 20 percentage points more likely to have tested compared to those with no or only primary schooling.

Education enhances health literacy, self-efficacy, and access to preventive services, underlining the importance of integrating HIV education earlier within school curricula.

- **Marital Status:** Young people who were married or cohabiting exhibited exceptionally high testing rates (95.8%), compared to 64.7 percent among single youth. Married youth likely encounter routine HIV testing through antenatal care, marriage counselling, or family planning services. Nevertheless, single young people, representing the vast majority of youth (90%+), remain an important group needing intensified outreach.

- **NEET Status:** Young people classified as NEET (not in education, employment, or training) reported higher testing rates (76.9%) compared to their employed or in-school peers (56.3%). This trend may reflect the impact of targeted community or peer-driven initiatives aimed at out-of-school populations. However, the relatively low testing among employed or in-education youth raises concerns that school-based testing campaigns and workplace HIV outreach may not be sufficiently prioritised for young people.

- **Wealth Quintile:** Minor differences were observed across wealth quintiles, but young people in the second lowest quintile (70.5%) showed slightly better coverage than those in the highest quintile (60.8%). This pattern suggests that targeted health campaigns in lower-income communities have been effective, but that youth from wealthier households may feel less at risk or be under-represented in testing outreach.

Young people's HIV testing behaviours are shaped most strongly by age, education level, and marital status—even more than locality or wealth. Closing the adolescent testing gap and strengthening services for single, in-school, and wealthier youth should be urgent priorities.

Table 22: Percentage Distribution of youth (15 to 24 Years) by whether ever tested for HIV and Selected Demographic and Socioeconomic Characteristics

CHARACTERISTICS		Ever Tested	Never Tested	TOTAL
Locality	Urban	67.5%	32.5%	**2,581**
	Rural	67.5%	32.5%	**1,794**
Sex	Male	67.0%	33.0%	**1,936**
	Female	67.9%	32.1%	**2,439**
Age group	15 to 19 Years	46.4%	53.6%	**2,192**
	20 to 24 Years	88.6%	11.4%	**2,183**
Marital Status	Never Married	64.7%	35.3%	**3,953**
	Married	95.8%	4.2%	**330**
	Previously Married	86.3%	13.8%	**80**
Level of Education	No Education	57.8%	42.2%	**64**
	Primary	56.2%	43.8%	**153**
	Secondary	65.8%	34.2%	**3,480**
	Tertiary	79.5%	20.5%	**678**
NEET Status	NEET[16]	76.9%	23.1%	**2,378**
	IEET[17]	56.3%	43.7%	**1,995**
Household Wealth Quintile	Lowest	68.3%	31.7%	**998**
	Second	70.5%	29.5%	**966**
	Middle	68.6%	31.4%	**777**
	Fourth	68.2%	31.8%	**848**
	Highest	60.8%	39.2%	**786**
TOTAL		**67.5%**	**32.5%**	**4,375**

4.4.7. Determinants of HIV Ever Testing among Young People (15 to 24 Years)

Multivariate regression analysis provided robust confirmation of the factors independently associated with HIV testing uptake among young people **(See Table 23).**

[16]NEET stands for Not in Education, Not in Employment or Training
[17]IEET stands for In Education, or Employment or Training

- **Strongest predictors of testing are age, education, marital status and NEET Status.**
- **Age: 20–24-year-olds were 7x more likely to test than 15–19-year-olds.**
- **Education: Youth with tertiary education had 4x higher odds of testing than those with no education.**
- **Marital status: Married/cohabiting youth had 5.6x greater odds of HIV testing than never-married peers.**
- **NEET status: NEET youth had 1.7x higher odds of testing than their employed/studying peers.**
- **No urban–rural gap detected after adjusting for other factors**

- **Sex:** Being female increased the odds of having tested for HIV by 17% compared to males (AOR = 1.17, p=0.035). This finding reflects both greater exposure to sexual and reproductive health services and socialisation patterns that encourage women to seek care more readily.

- **Age:** Adolescents aged 15–19 years had dramatically lower odds of HIV testing compared to young adults aged 20–24 (AOR ≈ 0.144; p<0.001). Age remains the most powerful predictor of testing, reinforcing the need for adolescent-centred HIV services that are accessible, confidential, and non-judgmental.

- **Education:** Youth with secondary and tertiary education were significantly more likely to have tested for HIV compared to those with no education. The likelihood of testing was almost four times higher among youth with tertiary education compared to those with no education. Education builds empowerment, health agency, and navigation of the healthcare system.

- **Marital Status:** Being married or cohabiting increased the odds of HIV testing almost fivefold compared to never-married youth (AOR = 0.178; p<0.001). Marriage exposes youth to multiple formal and informal testing opportunities, whereas unmarried youth may need deliberate targeting through school-based, youth club, or social media campaigns.

- **NEET Status:** NEET youth had 1.7 times higher odds of HIV testing compared to those employed or in education (AOR = 1.688; p<0.001). This suggests outreach campaigns targeting vulnerable and disengaged youth have been successful—but further programming for employed youth is still needed.

- **Urban–Rural Locality:** No statistically significant association between urban or rural residence and HIV testing uptake was found after adjusting for other factors, suggesting Botswana's national HIV outreach has successfully achieved geographic equity.

- **Wealth:** Wealth effects were less consistent, but youth in the middle to higher wealth quintiles appeared slightly less likely to test for HIV compared to poorer youth, although these associations were not always statistically significant.

The model had an acceptable fit (Hosmer–Lemeshow p<0.001), a Nagelkerke R^2 of 0.307, indicating that about 31 percent of the variation in HIV testing status among young people could be explained by the included variables.

In summary, age, education, marital status, and NEET status are the strongest independent predictors of HIV testing among young people. Adolescent-specific strategies, school-based and workplace testing innovations, and the scaling-up of youth-friendly services are necessary to achieve universal HIV testing coverage among Botswana's young population.

Table 23: Determinants of HIV Ever Testing Young People Aged 15-24 Years: Results from Multivariate Logistic Regression.

CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality	Urban	1	
	Rural	1.094	0.934-1.281
Sex*	Male	1	
	Female	1.17	1.011-1.354
Age group*	15 to 19 Years	1	
	20 to 24 Years	0.144	0.122-0.171
Level of Education*	No Education	1	
	Primary	0,576	0.287-1.155
	Secondary	0.336	0.186-0.605
	Tertiary	0.255	0.137-0.476
Marital Status*	Never Married	1	
	Married	0.178	0.101-0.312
	Previously Married	0.517	0.256-1.045
NEET Status*	NEET[18]	1	
	IEET[19]	1.688	1.448-1.967
Household Wealth Quintile*	Lowest	1	
	Second	0.802	0.642-1.003
	Middle	0.896	0.705-1.139
	Fourth	0.851	0.674-1.075

* Statistically Significant:

4.5. Not in Education, not in Employment or Training (NEET) Status among the Youth (15 to 35 Years)

4.5.1. Introduction

The analysis of youth Not in Education, Employment, or Training (NEET) status in Botswana draws from two complementary data sources: the Quarterly Multi-Topic Surveys (QMTS) and the 2022 Population and Housing Census (PHC). While QMTS data—available from 2019 through the first quarter of 2024—enable the tracking of trends over time, the 2022 PHC provides a nationally representative snapshot of geographic and socioeconomic disparities in NEET status. Together, these sources offer a robust understanding of youth disconnection from productive engagement.

The latest data from Q1 2024 reveal that 41.3 percent of youth aged 15 to 35 years were NEET, up from 38.5 percent in Q3 2023, a 2.8 percentage point increase. Disaggregated analysis by age and sex (Table 24) reveals stark disparities among subgroups. NEET rates are lowest among adolescents aged 15–17 years (20.8%), likely due to their continued engagement in schooling. The rate then rises dramatically among youth aged 18–24, peaking at 49.0 percent for those aged 20–24 years, indicating a vulnerable transition period from school to work or further training.

[18]NEET stands for Not in Education, Employment and Training
[19] IEET stands for In Education, or Employment or Training

- 41.3% of youth (15–35 years) in Botswana were NEET in Q1 2024, up from 38.5% in Q3 2023.
- Females aged 25–29: 46.7% NEET, vs 30.4% for males — a 16.3 percentage point gap.
- Youth aged 20–24 recorded the highest NEET rate at 49.0%.

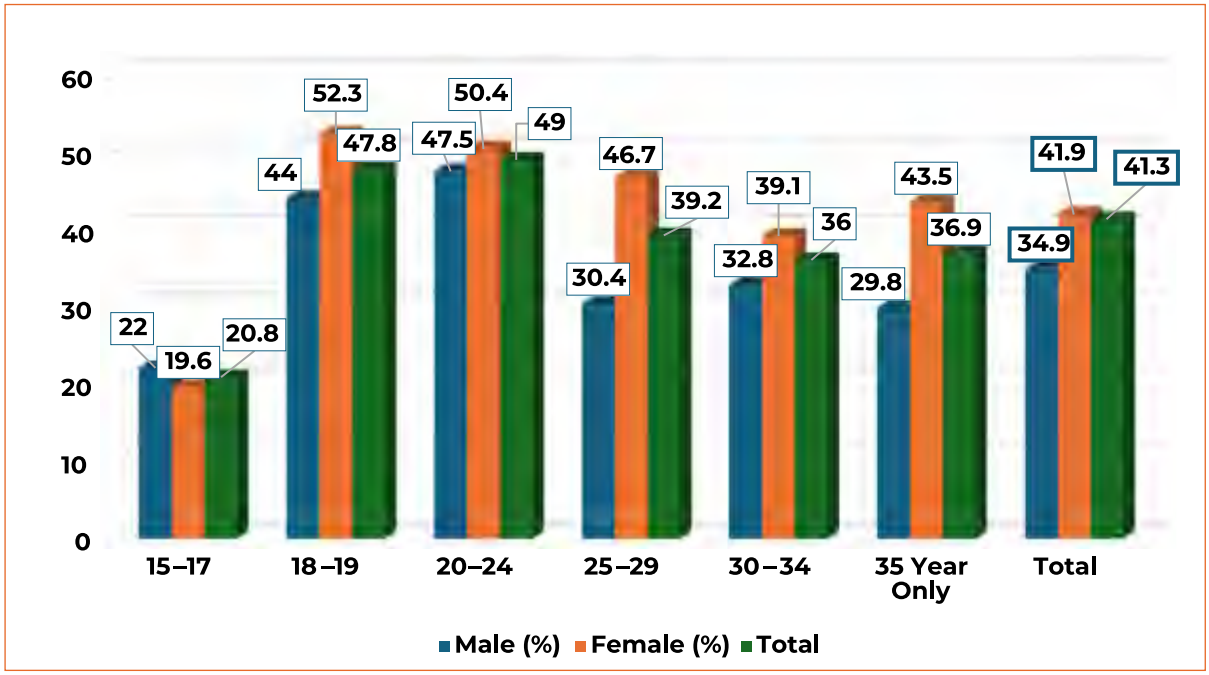
Among youth aged 25–35 years, NEET rates begin to decline but remain elevated, particularly among females, who consistently record higher rates than males across all age groups. . The gender gap is particularly pronounced among the 25–29 and 35-year-old cohorts, where female NEET rates exceed male rates by 16.3 and 13.7 percentage points, respectively **(see Figure 10)**. These disparities highlight the dual challenges of early adulthood vulnerability and structural gender inequalities in access to employment and education.

Table 24: NEET Rate by Age Group and Sex – Q1 2024

Age Group	Male (%)	Female (%)	Total
15–17	22.0	19.6	20.8
18–19	44.0	52.3	47.8
20–24	47.5	50.4	49.0
25–29	30.4	46.7	39.2
30–34	32.8	39.1	36.0
35 Year Only	29.8	43.5	36.9
Total	**34.9**	**41.9**	**41.3**

Source: Statistics Botswana, 2024a.

FIGURE 10: NEET RATE BY AGE GROUP AND SEX – Q1 2024



4.5.2. Trends in the Overall NEET Rate for Youth Aged 15–35 Years (2019–2024): QMTS 2019-2024

Analysis of NEET rates over time, as presented in **Table 25** and visualised in **Figure 11**, shows a persistently high burden of youth disengagement from education, employment, and training. Between Q4 2019 and Q1 2024, the NEET rate among youth aged 15–35 years fluctuated between 36.1 percent and 41.3 percent, with a recent surge observed in the latest quarter. This upward trend signals worsening integration of youth into the labour market and post-school systems.

- **NEET rate has hovered between 36.1% and 41.3% since 2019.**
- **Female NEET rate peaked at 44.4% in Q4 2021; male NEET rose to 40.6% in Q1 2024.**
- **Census 2022 shows higher NEET (47.1%) than QMTS—suggesting possible underestimation in quarterly surveys.**

Gender disparities are evident throughout the trend period. Female NEET rates have consistently outpaced those of males, peaking at 44.4 percent in Q4 2021 and remaining elevated at 42.0 percent in Q1 2024. Meanwhile, male NEET rates have increased more sharply in recent quarters, reaching 40.6 percent in Q1 2024, thus narrowing the gender gap. This shift suggests emerging vulnerabilities among young men, potentially due to structural shifts in male-dominated sectors or educational disengagement.

In parallel, the 2022 Population and Housing Census (PHC) estimated an overall NEET rate of 47.1 percent for youth aged 15–35 years, substantially higher than QMTS estimates for the same period. The census findings further reveal a 44.0 percent NEET rate among males and a significantly higher 50.0 percent among females, reinforcing the persistent gender gap and highlighting the broader national scope of disengagement. The census-based rate, which reflects self-reported economic and educational status across all households, suggests that quarterly surveys may underestimate the extent of youth marginalisation—particularly in rural or informal settings.

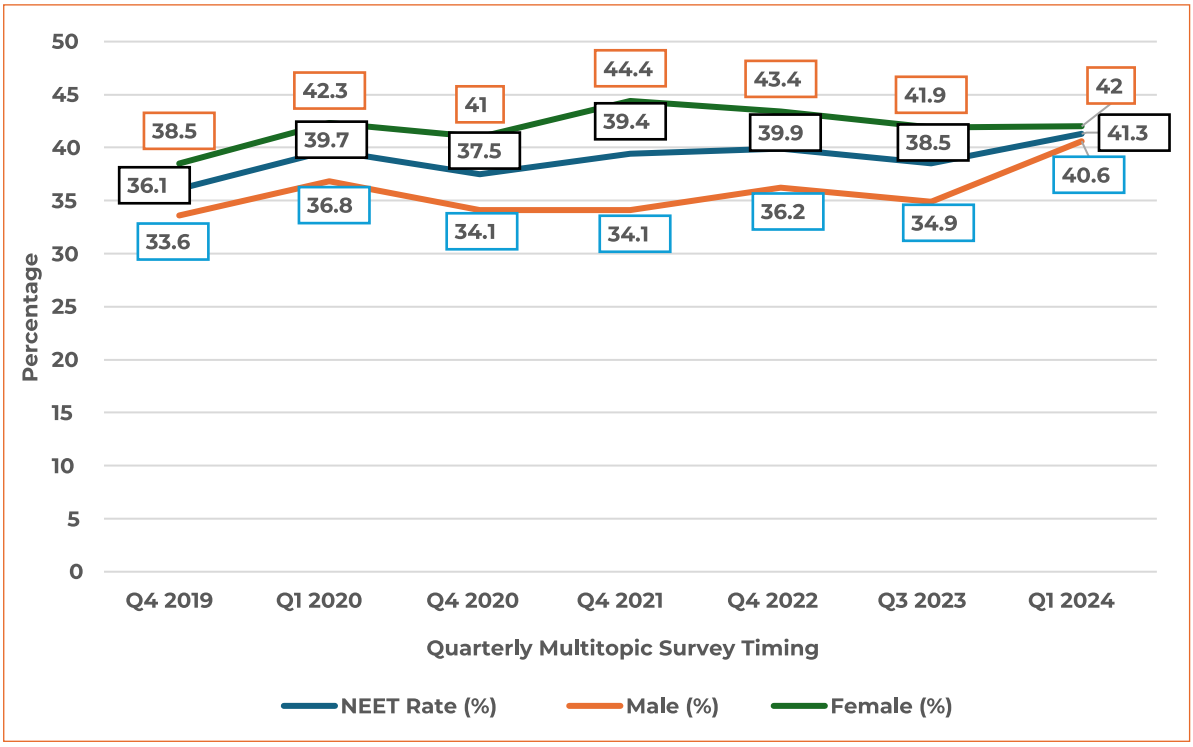
Taken together, these trends and benchmarks point to a chronic and widening challenge in Botswana's youth development landscape, requiring targeted policy action across education, skills development, and job creation sectors.

Table 25: Overall NEET Rate for Youth Aged 15–35 Years (2019–2024):

Year/Quarter	NEET Rate (%)	Male (%)	Female (%)
Q4 2019	36.1	33.6	38.5
Q1 2020	39.7	36.8	42.3
Q4 2020	37.5	34.1	41.0
Q4 2021	39.4	34.1	44.4
Q4 2022	39.9	36.2	43.4
Q3 2023	38.5	34.9	41.9
Q1 2024	41.3	40.6	42.0

Sources: Statistics Botswana, 2020; Statistics Botswana, 2020a; Statistics Botswana, 2021; Statistics Botswana, 2022; Statistics Botswana, 2023; Statistics Botswana, 2023; Statistics Botswana, 2024; Statistics Botswana, 2024a.

FIGURE 11: TRENDS IN THE OVERALL RATE FOR YOUTH AGED 15–35 YEARS (2019–2024) BY SEX: QMTS 2019-2024



4.5.3. NEET Status by District: 2022 PHC

An analysis of NEET status by district using the 2022 Population and Housing Census reveals wide spatial disparities in youth disconnection from education, employment, or training. As shown in **Table 26**, the national NEET rate stood at 47.1%, but district-level figures ranged from as low as 30.0% in Sowa to as high as 58.6 percent in Ngwaketse West.

Highest NEET districts:
- **Ngwaketse West: 58.6%**
- **Ngamiland West: 58.3%**
- **Barolong: 57.3%**

Lowest NEET districts:
- **Sowa: 30.0%**
- **Orapa: 33.5%**
- **Gaborone: 33.2%**

Generally, rural and remote districts recorded higher NEET rates. Ngwaketse West (58.6%), Ngamiland West (58.3%), and Barolong (57.3%) had the highest proportions of disengaged youth, suggesting limited access to secondary and tertiary education institutions, low levels of formal sector employment, and transportation barriers. In contrast, urban centres like Gaborone (33.2%), Orapa (33.5%), and Sowa (30.0%) had lower NEET rates, likely due to better education and labour market infrastructure.

Some districts traditionally regarded as urban—such as Francistown (39.9%), Lobatse (39.4%), and Selibe Phikwe (40.6%)—still recorded high NEET rates, reflecting deeper structural issues such as economic stagnation, industrial decline, or poor alignment between education outcomes and local employment opportunities.

The overall picture illustrates a core–periphery divide, where youth in more urbanised areas tend to be better integrated into productive activities, while those in rural and peripheral districts face entrenched disadvantages. These findings call for spatially targeted interventions, including rural youth empowerment programmes, decentralised skills development centres, and investment in local employment generation.

Table 26: Percentage Distribution of Youth aged 15 to 35 Years by NEET Status and District: 2022 PHC

DISTRICT	NEET	IEET
Gaborone	33.2%	66.8%
Francistown	39.9%	60.1%
Lobatse	39.4%	60.6%
Selibe Phikwe	40.6%	59.4%
Orapa	33.5%	66.5%
Jwaneng	35.4%	64.6%
Sowa	30.0%	70.0%
Southern	53.0%	47.0%
Barolong	57.3%	42.7%
Ngwaketse West	58.6%	41.4%
South East	37.0%	63.0%
Kweneng East	49.8%	50.2%
Kweneng West	54.6%	45.4%
Kgatleng (Wards)	48.7%	51.3%
Central Serowe -Palapye	51.3%	48.7%
Central Mahalapye	54.8%	45.2%
Central Bobonong	48.2%	51.8%
Central Boteti	53.2%	46.8%
Central Tutume	52.3%	47.7%
North East	44.8%	55.2%
Ngamiland East	51.9%	48.1%
Ngamiland West	58.3%	41.7%
Chobe	38.4%	61.6%
Ghanzi	50.7%	49.3%
Kgalagadi South	53.2%	46.8%
Kgalagadi North	45.2%	54.8%
Total	**47.1%**	**52.9%**

4.5.4. NEET Status of Youth (15 to 35 Years) by Demographic and Socioeconomic Characteristics: 2022 PHC

Table 27 provides a detailed breakdown of NEET status among youth aged 15–35 years by demographic and socioeconomic factors. The findings point to significant inequalities based on locality, sex, age, education level, marital status, and disability status **(See Figure 12).**

- **Rural youth NEET: 54.6% vs urban youth: 35.7%.**
- **Youth with no education: 69.5% NEET vs Tertiary-educated youth: 28.2%.**
- **Youth with disabilities: 64.2% NEET, compared to 46.9% for non-disabled youth.**

- **Locality:** NEET rates were highest among youth living in rural areas (54.6%), followed by those in urban villages (47.9%), with the lowest rates observed in cities and towns (35.7%). This pattern confirms the impact of limited access to jobs, training institutions, and support services in less urbanised areas.

- **Sex**: Females (50.0%) were more likely to be NEET compared to males (44.0%), reinforcing persistent gender barriers including care responsibilities, early motherhood, and discrimination in the labour market.

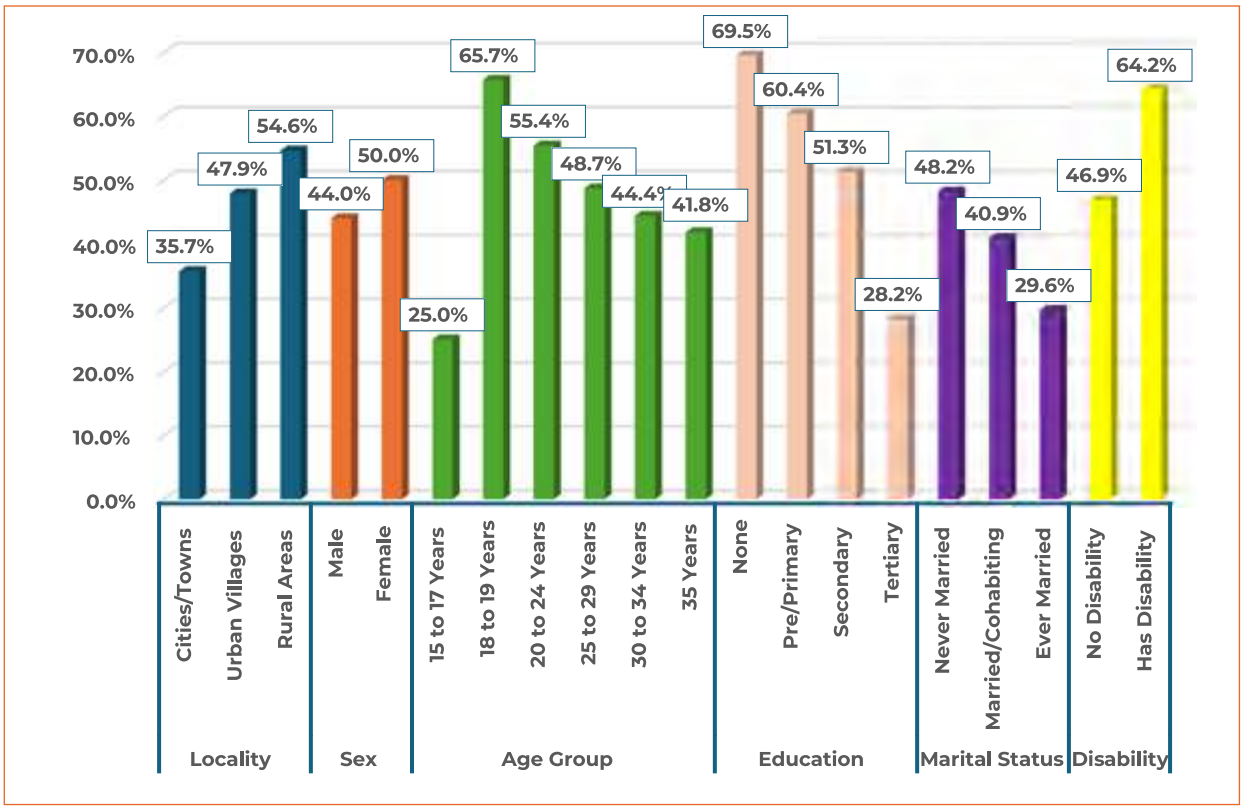
- **Age:** NEET rates were highest among 18–19 year-olds (65.7%) and 20–24 year-olds (55.4%), reflecting the vulnerable transition period from education to employment or further training. Rates declined with age, but even among those aged 30–35 years, over 40 percent remained NEET.

- **Education:** There is a clear inverse relationship between educational attainment and NEET status. Youth with no education (69.5%) or only primary education (60.4%) had the highest NEET rates. The rate drops significantly for those with tertiary education (28.2%), confirming the protective effect of advanced education against economic inactivity.

- **Marital Status:** Never married (48.2%) and married/cohabiting youth (40.9%) recorded higher NEET rates than previously married youth (29.6%), suggesting complex interplays between family responsibilities, labour market participation, and educational status.

- **Disability:** Youth with disabilities experienced much higher exclusion, with 64.2 percent classified as NEET compared to 46.9 percent of those without disabilities. This disparity underscores the need for inclusive education and employment policies that actively dismantle physical, attitudinal, and institutional barriers.

FIGURE 12: PERCENTAGE DISTRIBUTION OF YOUTH AGED 15 TO 35 YEARS BY NEET STATUS AND BY DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS: 2022 PHC



Together, these factors suggest that youth who are rural-based, female, younger, less educated, never married, or disabled are disproportionately vulnerable to being NEET. This intersectional disadvantage must be acknowledged and addressed in the design of youth development strategies and policy reforms.

Table 27: Percentage Distribution of Youth aged 15 to 35 Years by NEET Status and by Demographic and Socioeconomic Characteristics: 2022 PHC

Background Characteristics		NEET[20](%)	IEET[21] (%)
Locality	Cities/Towns	35.7%	64.3%
	Urban Villages	47.9%	52.1%
	Rural Areas	54.6%	45.4%
Sex	Male	44.0%	56.0%
	Female	50.0%	50.0%
Age Group	15 to 17 Years	25.0%	75.0%
	18 to 19 Years	65.7%	34.3%
	20 to 24 Years	55.4%	44.6%
	25 to 29 Years	48.7%	51.3%
	30 to 34 Years	44.4%	55.6%
	35 Years	41.8%	58.2%
Highest Level of Education	None	69.5%	30.5%
	Pre/Primary	60.4%	39.6%
	Secondary	51.3%	48.7%
	Tertiary	28.2%	71.8%
Marital Status	Never Married	48.2%	51.8%
	Married/Cohabiting	40.9%	59.1%
	Ever Married	29.6%	70.4%
Disability status	No Disability	46.9%	53.1%
	Has Disability	64.2%	35.8%
Total		**47.1%**	**52.9%**

4.5.5. Determinants of NEET Status: 2022 PHC

To understand the underlying factors associated with youth NEET status, a binary logistic regression model was applied using 2022 PHC microdata. The model showed a statistically significant fit (Nagelkerke R^2 = 0.167), and the Hosmer and Lemeshow test confirmed model validity (X^2 = 3380.992, d.f. = 8, $p < 0.001$).

- **Youth with no education were 5.8× more likely to be NEET than those with tertiary education.**
- **Never-married youth had 1.4× greater odds of being NEET than married youth.**
- **Youth with disabilities had 1.7× higher odds of being NEET than those without disabilities.**
- **Rural youth had 45% higher odds of being NEET than youth in cities/towns.**

[20]NEET refer to Not in Education, Employment, or Training.
[21]IEET refers to In Education, Employment or Training.

The analysis identified several significant predictors of NEET status among youth aged 15–35 **(See Table 28):**

- **Locality:** Compared to youth living in cities/towns, those in urban villages (OR = 0.636) and rural areas (OR = 0.555) were significantly more likely to be NEET, confirming that geographic location independently affects opportunity access.
- **Sex:** Male youth were less likely to be NEET than females (OR = 0.680), after controlling for all other variables, suggesting systemic gender inequalities in engagement.
- **Age Group:** The odds of being NEET decrease with increasing age, particularly for adolescents and young adults. For instance, those aged 15–17 had an 86 percent lower likelihood of being NEET compared to the reference age group.
- **Education Level:** NEET status was strongly linked to education. Youth with no education were nearly 5.8 times more likely to be NEET compared to those with tertiary education (OR = 5.788). Even those with secondary or primary education faced elevated risks.
- **Marital Status:** Being never married (OR = 1.446) or previously married (OR = 2.278) increased the odds of being NEET compared to those who were currently married or cohabiting, suggesting that social support structures may play a role in economic engagement.
- **Disability Status:** Youth with disabilities were significantly more likely to be NEET (OR = 0.580), even when accounting for other variables, reinforcing the need for disability-responsive programming.

These findings highlight the complex and multidimensional nature of youth NEET status in Botswana. Addressing it requires integrated policy responses that combine targeted education, training, and employment interventions with social protection, gender equity, and inclusive development planning.

Table 28: Logistic Regression Results for Determinants of NEET Status among Youth Aged 15–35 Years – 2022 PHC.

CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality*	Cities/Towns	1	
	Urban Villages	0.636	0.628-0.643
	Rural Areas	0.555	0.548-0.563
Sex*	Male	1	
	Female	0.680	0.673-0.686
Age group*	15 to 17 Years	1	
	18 to 19 Years	0.143	0.140-0.146
	20 to 24 Years	0.188	0.184-0.191
	25 to 29 Years	0.229	0.225-0.233
	30 to 34 Years	0.261	0.257-0.266
	35 Years Only	0.296	0.289-0.304
Level of Education*	No Education	1	
	Primary	1.405	1.346-1.468
	Secondary	1.844	1.772-1.919
	Tertiary	5.788	5.554-6.031
Marital Status*	Never Married	1	
	Married	1.446	1.426-1.466
	Previously Married	2.278	2.048-2.534
Disability Status*	Has Disability	1	
	No Disability	0.580	0.554-0.608

* Statistically Significant:

These findings confirm that NEET risk is not evenly distributed across the youth population, but instead disproportionately affects young people who are female, rural based, less educated, and living with disabilities. The intersection of these vulnerabilities multiplies the likelihood of economic and educational exclusion. For example, young women in rural areas with low educational attainment face compounded barriers—ranging from mobility constraints and childcare responsibilities to social stigma and limited-service availability. Similarly, youth with disabilities are twice as likely to be NEET as their peers without disabilities, reflecting both structural and attitudinal exclusion. These patterns call for precision-targeted youth development policies that are not only district-specific but also explicitly gender-responsive and disability-inclusive. Empowerment initiatives must be prioritised in high-risk districts—such as Ngwaketse West, Ngamiland West, and Kweneng West—and designed with layered interventions that address these overlapping forms of disadvantage.

4.6. Disability Status among the Youth (15 to 35 Years)

4.6.1. Introduction

Disability status among youth is a key measure of social inclusion, health disparities, and access to opportunities. Youth living with disabilities face unique challenges that can affect their education, employment, health outcomes, and civic participation. Analysing disability prevalence among youth offers insight into the magnitude of vulnerabilities and guides the design of responsive policies and programmes.

This section draws on data from the 2022 Population and Housing Census to examine disability status among youth aged 15–35 years.

Out of the youth population analysed, a total of 824,467 youth aged 15–35 years were enumerated, and 9,130 youth were recorded as having a disability, yielding a prevalence rate of 1.1%.

The analysis presented covers differences across districts, key demographic and socio-economic characteristics, and identifies predictors of disability among youth through multivariate regression.

4.6.2. Disability Status by District among the Youth (15 to 35 Years)

While the national prevalence was 1.1 percent, considerable inter-district variation was observed **(See Table 29):**

- **Urban Advantage:** Urban districts like Gaborone (0.7%), Francistown (1.0%), and Selibe Phikwe (0.8%) had lower disability prevalence rates. This likely reflects better access to preventive healthcare, earlier disability detection, higher literacy levels, and stronger social support systems in urban settings.

- **Rural Disparities:** Rural districts such as Kwening West (1.9%), Ngwaketse West (1.8%), and Ghanzi (1.7%) showed almost double the national average. Factors contributing could include greater distances to healthcare facilities, higher occupational risks (e.g., agricultural work), poorer early childhood health interventions, and systemic barriers to accessing assistive devices and rehabilitation services.

- **Mining Town Exception:** Mining towns such as Orapa (0.4%) and Jwaneng (0.6%) had remarkably low disability rates. These towns often have superior employer-provided healthcare services and stricter occupational health and safety regulations.

Geographical disparities suggest that health system strengthening, targeted disability prevention, and outreach services must be intensified in rural and semi-urban areas, especially where resources are thinly stretched.

Table 29: Percentage Distribution of youth (15 to 24 Years) by Disability Status and District

DISTRICT	No Disability		Has Disability		Total
	Number	Percent	Number	Percent	
Gaborone	105,466	99.3%	788	0.7%	**106,254**
Francistown	40,905	99.0%	412	1.0%	**41,317**
Lobatse	11,024	98.8%	135	1.2%	**11,159**
Selibe Phikwe	14,672	99.2%	117	0.8%	**14,789**
Orapa	2,452	99.6%	9	0.4%	**2,461**
Jwaneng	6,748	99.4%	40	0.6%	**6,788**
Sowa	1,221	98.9%	13	1.1%	**1,234**
Ngwaketse South	42,869	99.0%	440	1.0%	**43,309**
Borolong	16,470	98.4%	260	1.6%	**16,730**
Ngwaketse West	7,262	98.2%	133	1.8%	**7,395**
South East	45,554	99.1%	427	0.9%	**45,981**
Kweneng East	123,396	99.1%	1,176	0.9%	**124,572**
Kweneng West	17,751	98.1%	337	1.9%	**18,088**
Kgatleng	42,232	99.1%	392	0.9%	**42,624**
Central Serowe Palapye	64,250	99.0%	665	1.0%	**64,915**
Central Mahalapye	37,311	98.4%	588	1.6%	**37,899**
Central Bobonong	21,784	98.7%	294	1.3%	**22,078**
Central Boteti	25,441	99.0%	262	1.0%	**25,703**
Central Tutume	48,682	98.6%	698	1.4%	**49,380**
North East	20,234	98.8%	255	1.2%	**20,489**
Ngamilang East	44,658	98.9%	493	1.1%	**45,151**
Ngamilang West	23,466	98.2%	423	1.8%	**23,889**
Chobe	11,056	99.0%	111	1.0%	**11,167**
Ghanzi	20,912	98.3%	365	1.7%	**21,277**
Kgalagadi South	11,370	98.4%	184	1.6%	**11,554**
Kgalagadi North	8,151	98.6%	113	1.4%	**8,264**
Total	**815,337**	**98.9%**	**9,130**	**1.1%**	**824,467**

4.6.3. Disability Status by Demographic and Socioeconomic Characteristics among the Youth (15 to 35 Years)

Significant socio-demographic patterns emerged **(See Table 30):**

By Education Level
- No education: **12.2%**
- Primary: **3.3%**
- Secondary/Tertiary: **0.8%**

By Locality
- Rural youth: **1.5%**
- Urban villages: **1.0%**
- Cities/towns: **0.8%**

By NEET Status
- NEET youth: **1.6%**
- IEET youth: **0.8%**

By Marital Status
- Never married: **1.2%**
- Married/cohabiting: **0.7%**
- Previously married: **1.5%**

- **Locality:** Disability prevalence was 1.5 percent among rural youth, compared to 1.0 percent in urban villages and only 0.8 percent in cities/towns. Despite urbanization advances, rural-urban divides in healthcare, education, and living conditions remain a key challenge.

- **Sex:** Disability prevalence was identical among males and females nationally (1.1%), but deeper multivariate analysis later revealed that males had slightly elevated odds of disability when controlling for other factors. This could relate to higher exposure to physical risks among young men (e.g., occupational hazards, traffic injuries).

- **Age:** The prevalence slightly increased across the youth age spectrum with the 15–34 years with approximately 1.1 percent, increasing to 1.3 percent among the 35-year-olds. This suggests that disability accumulation, through injuries, diseases like diabetes, or chronic conditions rises with age even within youth years.

- **Education:** Education had a strong protective effect with youth with No education having a 12.2 percent disability prevalence. The disability prevalence among the youth with a primary education stands at 3.3 percent whereas it is 0.8 percent among the youth with Secondary/Tertiary. This highlights how education fosters health literacy, prevention behaviours, early healthcare-seeking, and economic independence.

- **Marital Status:** The never married youth reported a disability rate of 1.2 percent, higher than the 0.7 percent among married/cohabiting youth. Divorce, separation, and widowhood were associated with even higher disability risks (1.5%), reflecting possible social exclusion or economic decline post-partnership.

- **NEET Status:** Youth Not in Education, Employment, or Training (NEET) had a disability prevalence of 1.6 percent compared to 0.8 percent among IEET youth. This twofold risk suggests that disengagement from education and employment both results from and reinforces disability-related exclusion.

Tailored interventions must prioritize inclusive education and employment pathways for youth with disabilities, particularly in rural settings. While disability prevalence among youth aged 15–35 years is reported at 1.1 percent, this figure likely understates the true burden due to underreporting, stigma, and limitations in self-identification, particularly in household census settings. Many young people with mild or episodic disabilities may not be captured, and cultural perceptions often lead families to under-declare disability status. Crucially, youth with disabilities—especially

those who are NEET—face compounded vulnerabilities. NEET youth have double the disability prevalence (1.6%) compared to their engaged peers (0.8%) yet often remain invisible in sexual and reproductive health (SRH) programming. Their access to SRH services is frequently constrained by physical inaccessibility, negative provider attitudes, communication barriers, and limited SRHR education. These intersecting forms of exclusion demand a more deliberate policy response to ensure that youth with disabilities are not left behind in Botswana's adolescent and youth wellbeing agenda.

Table 30: Percentage Distribution of youth (15 to 35 Years) by Disability Status and Selected Demographic and Socioeconomic Characteristics

CHARACTERISTICS		No Disability	Has Disability	TOTAL
Locality	Cities/Towns	99.2%	0.8%	**184,002**
	Urban Villages	99.0%	1.0%	**405,591**
	Rural	98.5%	1.5%	**234,874**
Sex	Male	98.9%	1.1%	**405,292**
	Female	98.9%	1.1%	**419,175**
Age group	15 to 17 Years	98.9%	1.1%	**119,474**
	18 to 19 Years	98.9%	1.1%	**79,407**
	20 to 24 Years	98.9%	1.1%	**194,047**
	25 to 29 Years	98.9%	1.1%	**200,333**
	30 to 34 Years	98.9%	1.1%	**193,193**
	35 Years	98.7%	1.3%	**38,013**
Level of Education	No Education	87.8%	12.2%	**12,625**
	Primary	96.7%	3.3%	**49,864**
	Secondary	99.2%	0.8%	**541,535**
	Tertiary	99.2%	0.8%	**176,223**
Marital Status	Never Married	98.8%	1.2%	**660,008**
	Married	99.3%	0.7%	**120,560**
	Previously Married	98.5%	1.5%	**1,811**
NEET Status	NEET[22]	98.4%	1.6%	**367,288**
	IEET[23]	99.2%	0.8%	**413,166**
TOTAL		**98.8%**	**1.2%**	**780,454**

4.6.4. Determinants of Disability among the Youth (15 to 35 Years)

Multivariate logistic regression results revealed several significant associations between background characteristics and disability status among youth aged 15 to 35 years **(see Table 31).**

- **Geography:** Rural youth have **15% higher odds** of reporting disability than city youth (OR = 1.150)
- **Sex:** Males have **10% higher odds** of reporting disability than females (OR = 1.104)
- **Education Matters:** Youth with **no education** are nearly **4x more likely** to report disability than those with tertiary education
- **NEET Effect**: NEET youth are **1.68x more likely** to report disability (OR = 0.594)
- **Marriage as a Buffer:** Being married **reduces disability risk by 47%** (OR = 0.535)

[22]NEET stands for Not in Education, Not in Employment or Training
[23]IEET stands for In Education, or Employment or Training

- **Locality:** Youth residing in rural areas had a 15 percent higher likelihood of reporting a disability compared to their counterparts in cities and towns (Odds Ratio [OR] = 1.150, $p<0.001$). No statistically significant difference was found between youth living in urban villages and those residing in cities, suggesting that rural disadvantage remains the primary geographic disparity affecting disability among youth.

- **Sex:** Male youth were found to have 10 percent higher odds of reporting disability compared to female youth (OR = 1.104, $p<0.001$). This may reflect gendered patterns of occupational risks, health-seeking behaviours, and exposure to injuries or hazardous environments.

- **Age Group:** An increasing age gradient was observed, with the likelihood of disability rising steadily across the youth age spectrum. The sharpest increases in disability prevalence were noted after age 30, indicating that health deterioration and cumulative exposure to disability risk factors intensify as youth transition into later stages of young adulthood.

- **Education:** Educational attainment emerged as a powerful protective factor. Youth with no formal education were approximately four times more likely to report a disability compared to those with tertiary education ($p<0.001$). Each successive level of education was associated with a substantial decrease in the odds of reporting disability, underscoring the critical role of education in enhancing health literacy, preventive behaviours, and access to health services.

- **Marital Status:** Marital status showed a strong association with disability risk. Youth who were married or cohabiting had significantly lower odds of disability (OR = 0.535, $p<0.001$) compared to those who were never married. This may reflect mutual caregiving within partnerships or selection effects whereby individuals without severe disabilities are more likely to marry.

- **NEET Status:** Youth who were Not in Education, Employment, or Training (NEET) had substantially higher odds of reporting disability compared to their engaged peers ($p<0.001$). Being NEET could both contribute to, and result from, underlying disability, creating a reinforcing cycle of vulnerability and socio-economic exclusion.

- **Model Diagnostics:** The logistic regression model demonstrated acceptable explanatory power, with a Nagelkerke R^2 of 0.083, indicating that about 8.3 percent of the variance in disability status was explained by the variables included in the model. The overall classification accuracy was high at 98.8 percent, suggesting that the model effectively distinguished between youth with and without disabilities.

Table 31: Determinants of Disability among Sexually Active Young People Aged 15–35 Years: Results from Multivariate Logistic Regression

CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality	Cities/Towns	1	-
	Urban Villages	1.017	0.957-1.081
	Rural Areas	1.150	1.078-1.226
Sex*	Male	1	-
	Female	1.104	1.058-1.152
Age group*	15 to 17 Years	1	-
	18 to 19 Years	0.776	0.709-0.848
	20 to 24 Years	0.807	0.751-0.868
	25 to 29 Years	0.834	0.776-0.897
	30 to 34 Years	0.871	0.810-0.937
	35 Years	0.990	0.888-1.103
Level of Education*	No Education	1	-
	Primary	0.256	0.238-0.275
	Secondary	0.065	0.061-0.069
	Tertiary	0.076	0.070-0.082
Marital Status*	Never Married	1	-
	Married	0.535	0.497-0.576
	Previously Married	1.117	0.758-1.646
NEET Status*	NEET[24]	1	-
	IEET[25]	0.594	0.567-0.622

* Statistically Significant:

4.7. Disability Status among the Young People (10 to 24 Years)

4.7.1. Introduction

Disability during adolescence and early adulthood can have profound effects on a person's life trajectory. It affects not only physical health but also educational achievement, labour force participation, social inclusion, and long-term well-being. For national development strategies aiming to harness the demographic dividend, understanding the scale and patterns of disability among young people is essential.

This section draws on the 2022 Population and Housing Census to analyse disability among young people aged 10–24 years. Among the young people surveyed, a total of 623,882 individuals aged 10–24 years were recorded. Of these, 6,653 were identified as living with a disability, representing an overall prevalence rate of 1.1%, similar to that observed among the broader youth cohort.

The analysis explores spatial patterns, demographic and socio-economic inequalities, and determinants of disability.

[24]NEET stands for Not in Education, Employment and Training
[25]IEET stands for In Education, or Employment or Training

4.7.2. Disability Status by District among Young People (10 to 24 Years)

The distribution of disability prevalence by district revealed important geographic pattern and Selibe Phikwe (0.7%) reported lower disability rates among young people**(see Table 32)**. This urban advantage likely reflects better early healthcare interventions, inclusive education opportunities, and access to assistive technologies.

Kweneng West, Ghanzi, and Ngwaketse West recorded the highest disability prevalence among young people—each above 1.5%. In contrast, mining towns like Orapa (0.4%) and Jwaneng (0.7%) had the lowest rates

- **Mining Towns:** Mining towns such as Orapa (0.4%) and Jwaneng (0.7%) exhibited the lowest disability prevalence among all districts, suggesting superior employer-provided healthcare and early child health surveillance.
- **Rural and Remote Areas:** Disability prevalence was notably higher in districts like Kweneng West (1.7%), Ghanzi (1.7%), and Ngwaketse West (1.5%). These areas are typically characterized by limited healthcare infrastructure, economic hardship, and lower educational attainment, all of which contribute to disability risk.
- **Unexpected High Performers:** Some rural districts, such as Chobe (0.9%), showed lower-than-expected disability prevalence, which may reflect 1successful mobile health outreach efforts or community-based rehabilitation models.

The clear rural-urban gap in disability prevalence underscores the need to intensify inclusi1ve education, preventive health services, and early detection programmes, especially in under-served and geographically isolated areas.

Table 32: Percentage Distribution of youth (10 to 24 Years) by Disability Status and District

DISTRICT	No Disability		Has Disability		Total
	Number	Percent	Number	Percent	
Gaborone	68,339	99.3%	504	0.7%	**68,843**
Francistown	28,601	98.9%	330	1.1%	**28,931**
Lobatse	8,090	98.9%	93	1.1%	**8,183**
Selibe Phikwe	11,966	99.3%	89	0.7%	**12,055**
Orapa	2,114	99.6%	8	0.4%	**2,122**
Jwaneng	4,257	99.3%	30	0.7%	**4,287**
Sowa	751	99.3%	5	0.7%	**756**
Ngwaketse South	36,399	99.1%	329	0.9%	**36,728**
Borolong	14,670	98.6%	202	1.4%	**14,872**
Ngwaketse West	6,259	98.5%	98	1.5%	**6,357**
South East	30,084	99.2%	256	0.8%	**30,340**
Kweneng East	86,366	99.1%	819	0.9%	**87,185**
Kweneng West	14,365	98.3%	253	1.7%	**14,618**
Kgatleng	30,709	99.2%	260	0.8%	**30,969**
Central Serowe Palapye	52,850	99.0%	514	1.0%	**53,364**
Central Mahalapye	32,924	98.6%	472	1.4%	**33,396**
Central Bobonong	19,381	98.8%	241	1.2%	**19,622**
Central Boteti	19,091	99.1%	177	0.9%	**19,268**
Central Tutume	44,053	98.7%	580	1.3%	**44,633**
North East	17,592	98.8%	205	1.2%	**17,797**
Ngamilang East	32,179	98.9%	355	1.1%	**32,534**
Ngamilang West	19,814	98.5%	307	1.5%	**20,121**
Chobe	6,678	99.1%	60	0.9%	**6,738**
Ghanzi	14,688	98.3%	255	1.7%	**14,943**
Kgalagadi South	9,195	98.5%	136	1.5%	**9,331**
Kgalagadi North	5,814	98.7%	75	1.3%	**5,889**
Total	**617,229**	**98.9%**	**6,653**	**1.1%**	**623,882**

4.7.3. Disability Status by Demographic and Socioeconomic Characteristics (10 to 24 Years)

- **Locality:** Disability prevalence was 1.4 percent in rural areas, compared to 1.0 percent in urban villages and 0.8 percent in cities and towns. Despite Botswana's impressive rural health campaigns, young people in remote areas remain more vulnerable **(see Table 33).**

Young people with no formal education had a disability prevalence of 21.3%—nearly 20 times higher than those with secondary education (0.7%). NEET youth showed a disability prevalence of 1.5%, almost double that of IEET youth (1.0%).

- **Sex:** Male young people had a disability prevalence of 1.2 percent, slightly higher than 1.0 percent for females. Although the difference is small, it suggests potential gender-specific vulnerabilities, such as higher injury risks among young males.
- **Age Group:** Disability prevalence showed a modest upward trend across the 10–24-year age spectrum, increasing from 1.0 percent among 10–14-year-olds to 1.1 percent among both 15–19-year-olds and 20–24-year-olds. This slight increase may reflect the cumulative effects of health risks, injuries, and delayed diagnosis as individuals progress through adolescence and early adulthood.
- **Education:** A dramatic disparity in disability prevalence emerged based on educational attainment. Among young people aged 10 to 24 years, those with no formal education had a disability prevalence of 21.3 percent, which was markedly higher compared to 1.3 percent among those with primary education, 0.7 percent among those with secondary education, and 0.9 percent among those with tertiary education. Notably, young people without any education were nearly 20 times more likely to report a disability compared to their peers who had completed secondary schooling. This striking gradient highlights the powerful protective role that education plays in mitigating the risk and consequences of disability.
- **Marital Status:** The few young people who were married/cohabiting showed lower disability prevalence (0.7%) compared to the never married (1.1%). However, previously married youth (widowed, divorced) showed a sharp spike in disability prevalence (5.0%).
- **NEET Status:** Those Not in Education, Employment, or Training (NEET) had a disability prevalence of 1.5 percent compared to 1.0 percent among IEET youth.
- **Policy Implication:** The findings stress the importance of integrating disability-sensitive approaches into school enrolment drives, adolescent health services, and youth employment programmes.

Table 33: Percentage Distribution of youth (10 to 24 Years) by Disability Status and Selected Demographic and Socioeconomic Characteristics

CHARACTERISTICS		No Disability	Has Disability	TOTAL
Locality	Cities/Towns	99.2%	0.8%	**125,177**
	Urban Villages	99.0%	1.0%	**305,522**
	Rural	98.6%	1.4%	**193,183**
Sex	Male	98.8%	1.2%	**311,554**
	Female	99.0%	1.0%	**312,328**
Age group	10 to 14 Years	99.0%	1.0%	**230,954**
	15 to 19 Years	98.9%	1.1%	**198,881**
	20 to 24 Years	98.9%	1.1%	**194,047**
Level of Education	No Education	78.7%	21.3%	**5,738**
	Primary	98.7%	1.3%	**176,073**
	Secondary	99.3%	0.7%	**366,534**
	Tertiary	99.1%	0.9%	**51,136**
Marital Status	Never Married	98.9%	1.1%	**582,862**
	Married	99.3%	0.7%	**19,042**
	Previously Married	95.0%	5.0%	**120**
NEET Status	NEET[26]	98.5%	1.5%	**168,390**
	IEET[27]	99.0%	1.0%	**431,468**
TOTAL		**98.9%**	**1.1%**	**599,858**

[26]NEET stands for Not in Education, Employment and Training
[27]IEET stands for In Education, or Employment or Training

4.7.4. Determinants of Disability among Young People (10 to 24 Years)

Multivariate logistic regression results highlighted critical factors associated with disability status among young people aged 10 to 24 years **(see Table 34).**

- **Locality:** Young people residing in rural areas were found to have approximately 26 percent higher odds of reporting a disability compared to those living in cities and towns (OR = 1.259, p<0.001). The difference between urban villages and cities, although present, was less pronounced and not consistently statistically significant.

- **Sex:** After adjusting for confounding factors, male young people were found to have a 7 percent lower likelihood of reporting disability compared to females (OR = 0.927, p=0.003). This somewhat unexpected finding may reflect underreporting among young males or different disability types predominating by gender.

- **Youth in rural areas were 26% more likely to report disability than those in cities (OR = 1.259, p<0.001).**
- **Youth aged 10–14 had nearly double the odds of reporting disability compared to those aged 20–24 (OR = 1.857, p<0.001).**
- **Young people with tertiary education were over 25 times less likely to report disability compared to those with no education (OR = 0.036, p<0.001).**
- **Previously married youth had nearly 3 times higher odds of reporting disability than their never-married peers (OR = 2.747, p=0.034).**

- **Age Group:** Age emerged as a powerful predictor of disability. Compared to young adults aged 20–24 years, adolescents aged 10–14 years had 1.86 times higher odds (OR = 1.857, p<0.001), and those aged 15–19 years had 1.62 times higher odds (OR = 1.622, p<0.001) of reporting disability. The findings suggest that early adolescence remains a highly vulnerable period.

- **Education:** Young people with no formal education had an extraordinarily high risk of reporting disability compared to those with tertiary education (OR = 0.073, p<0.001). Educational attainment sharply reduced disability odds at every level.

- **Marital Status:** Previously married young people were almost three times more likely to report disability compared to those never married (OR = 2.747, p=0.034), likely reflecting vulnerabilities associated with early marriage, spousal loss, or social isolation.

- **NEET Status:** Being NEET was associated with an increased likelihood of disability (p<0.001), although the magnitude of effect was moderate compared to other predictors.

- **Model Diagnostics:** The logistic regression model demonstrated good explanatory fit, with a Nagelkerke R^2 of 9.3 percent and an overall classification accuracy of 98.9 percent.

Table 34: Determinants of Disability among Sexually Active Young People Aged 10–24 Years: Results from Multivariate Logistic Regression

CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality	Cities/Towns	1	-
	Urban Villages	1.045	0.971-1.124
	Rural Areas	1.259	1.167-1.358
Sex*	Male	1	-
	Female	0.927	0.881-0.975
Age group*	10 to 14 Years	1	-
	15 to 19 Years	1.857	1.713-2.014
	20 to 24 Years	1.622	1.488-1.768
Level of Education*	No Education	1	-
	Primary	0.073	0.067-0.080
	Secondary	0.027	0.025-0.029
	Tertiary	0.036	0.032-0.041
Marital Status*	Never Married	1	-
	Married	0.487	0.407-0.581
	Previously Married	2.747	1.082-6.976
NEET Status*	NEET[28]	1	-
	IEET[29]	0.818	0.768-0.873

4.8. Disability Status among Adolescents (10 to 19 Years)

4.8.1. Introduction

Adolescence is a critical period for physical, cognitive, and emotional development. The emergence or persistence of disability during this stage can significantly influence educational attainment, employment opportunities, social participation, and future health outcomes. Interventions targeting adolescents with disabilities are essential to mitigate long-term disadvantages and promote social inclusion.

- **National adolescent disability prevalence: 1.1% (n=4,589 out of 429,835 adolescents).**
- **Highest adolescent disability prevalence: Kgalagadi South and Ghanzi (1.6%), Ngamiland West and Kweneng West (1.5%).**
- **Lowest adolescent disability prevalence: Orapa (0.3%), Sowa (0.4%), Selibe Phikwe (0.5%).**

This analysis draws from the 2022 Population and Housing Census data and focuses on adolescents aged 10–19 years. Of the adolescent population analysed, a total of 429,835 adolescents were enumerated, and 4,589 adolescents were reported to be living with a disability, resulting in a national disability prevalence of 1.1 percent.

This section examines geographic patterns, demographic and socio-economic differentials, and multivariate determinants of disability among adolescents.

[28] NEET stands for Not in Education, Employment and Training
[29] IEET stands for In Education, or Employment or Training

4.8.2. Disability Status by District Status among Adolescents (10 to 19 Years)

Substantial district-level variations in disability prevalence were observed (see Table 35):

- **Urban Districts:** Cities like Gaborone (0.8%), Francistown (1.2%), and Selibe Phikwe (0.5%) reported relatively lower disability prevalence among adolescents. These findings reinforce the consistent urban advantage observed across youth and young people, likely linked to better maternal and child health services, stronger education systems, and greater access to rehabilitation services.

- **Mining Towns Districts:** Mining hubs such as Orapa (0.3%), Jwaneng (0.7%), and Sowa (0.4%) had the lowest disability prevalence across all districts, suggesting that better healthcare, occupational safety, and early health interventions in these locations benefit even the adolescent population.

- **Rural and Remote Districts:** Adolescents living in rural districts such as Ngwaketse West (1.5%), Ngamiland West (1.5%), Ghanzi (1.6%), and Kgalagadi South (1.6%) exhibited notably higher disability rates. The higher disability burden in rural settings may reflect a combination of factors, including poorer antenatal and child health services, nutritional deficiencies, delayed diagnosis, and limited access to inclusive education and rehabilitation.

- **Border Districts:** . Areas such as Chobe (1.0%) and North East (1.1%) exhibited intermediate prevalence levels, potentially reflecting cross-border health dynamics and variations in access to services.

The persistent rural disadvantage highlights the need for greater investments in rural health systems, inclusive education strategies, and adolescent health promotion programs that address both prevention and early intervention for disabilities.

Table 35: Percentage Distribution of youth (10 to 19 Years) by Disability Status and District

DISTRICT	No Disability		Has Disability		Total
	Number	Percent	Number	Percent	
Gaborone	39,576	99.2%	308	0.8%	**39,884**
Francistown	18,883	98.8%	227	1.2%	**19,110**
Lobatse	5,599	98.9%	65	1.1%	**5,664**
Selibe Phikwe	9,063	99.5%	47	0.5%	**9,110**
Orapa	1,645	99.7%	5	0.3%	**1,650**
Jwaneng	2,914	99.3%	20	0.7%	**2,934**
Sowa	511	99.6%	2	0.4%	**513**
Ngwaketse South	26,800	99.1%	240	0.9%	**27,040**
Borolong	11,046	98.8%	139	1.2%	**11,185**
Ngwaketse West	4,631	98.5%	70	1.5%	**4,701**
South East	17,421	99.1%	157	0.9%	**17,578**
Kweneng East	56,127	99.0%	547	1.0%	**56,674**
Kweneng West	10,577	98.4%	176	1.6%	**10,753**
Kgatleng	20,582	99.1%	177	0.9%	**20,759**
Central Serowe Palapye	38,263	99.1%	364	0.9%	**38,627**
Central Mahalapye	25,007	98.7%	337	1.3%	**25,344**
Central Bobonong	14,712	98.9%	166	1.1%	**14,878**
Central Boteti	13,737	99.1%	121	0.9%	**13,858**
Central Tutume	33,134	98.7%	432	1.3%	**33,566**
North East	13,259	98.9%	148	1.1%	**13,407**
Ngamilang East	22,354	98.9%	258	1.1%	**22,612**
Ngamilang West	14,552	98.5%	224	1.5%	**14,776**
Chobe	4,193	99.0%	41	1.0%	**4,234**
Ghanzi	9,867	98.4%	163	1.6%	**10,030**
Kgalagadi South	6,704	98.4%	106	1.6%	**6,810**
Kgalagadi North	4,089	98.8%	49	1.2%	**4,138**
Total	**425,246**	**98.9%**	**4,589**	**1.1%**	**429,835**

4.8.3. Disability Status by Demographic and Socioeconomic Characteristics Status among Adolescents (10 to 19 Years)

Significant differences in disability prevalence were observed across various demographic and socioeconomic characteristics **(see Table 36).**

- **Locality:** Disability prevalence among adolescents showed notable variation across locality types. Adolescents living in rural areas recorded a disability prevalence of 1.3 percent, compared to 1.0 percent among those residing in urban villages and 0.9 percent among those living in cities and towns. Although these differences may appear numerically small, they are meaningful given the larger adolescent population base involved and the lifelong implications that early-onset disabilities can have on education, employment, and health outcomes. The findings underscore the persistent rural disadvantage in health and social determinants that needs to be addressed through targeted interventions.

- **Locality:** 1.3% in rural areas vs 1.0% in urban villages and 0.9% in cities/towns.
- **Sex:** 1.2% of males vs 0.9% of females reported disability.
- **Age:** Disability prevalence rose from 1.0% (10–14 years) to 1.1% (15–19 years).
- **Education:** No education: 26.1% vs Primary: 1.1% vs Secondary: 0.7% vs Tertiary: 1.3%
- **NEET Status:** 1.7% among NEET adolescents vs 1.0% among IEET.
- **Marital Status:** 1.1% for never married vs 0.7% for married adolescents.

- **Sex:** Male adolescents exhibited a higher disability prevalence (1.2%) compared to their female counterparts (0.9%). This pattern aligns with international literature suggesting that boys may be biologically more susceptible to certain early childhood illnesses or may be more exposed to injuries and environmental risks during their formative years. Gendered risk exposures, including higher engagement in risk-prone physical activities among boys, could partially explain this discrepancy.

- **Age:** Disability prevalence also increased slightly with age across adolescence. Among those aged 10–14 years, the prevalence stood at 1.0 percent, rising to 1.1 percent among adolescents aged 15–19 years. While the increase is modest, it likely reflects the cumulative impact of health risks acquired during early adolescence, as well as the delayed diagnosis of disabilities that may become more apparent as adolescents face greater demands for functional independence, mobility, and participation in educational and social activities.

- **Level of Education:** Stark differences in disability prevalence emerged by educational attainment. Adolescents with no formal education had an exceptionally high disability prevalence of 26.1 percent, highlighting a major area of concern. In contrast, those with primary education recorded a prevalence of 1.1 percent, while adolescents with secondary education had the lowest prevalence at 0.7 percent. A slightly higher prevalence of 1.3 percent was observed among those with tertiary education, though the numbers in this group were relatively small. These findings reveal a double disadvantage faced by adolescents with disabilities: not only are they at greater risk of exclusion from education, but the lack of education further compounds their vulnerability to health problems, social exclusion, and poor economic outcomes.

- **Marital Status:** Marital status analysis showed that almost all adolescents were never married, with a disability prevalence of 1.1 percent. Among the very small proportion of adolescents who were married (mainly older adolescents aged 17–19), the disability prevalence was slightly lower, at 0.7 percent. Although the numbers were small, this slight difference may reflect selection effects where adolescents with severe disabilities are less likely to marry early.

- **NEET Status:** When considering engagement in education, employment, or training, adolescents who were Not in Education, Employment, or Training (NEET) exhibited a disability prevalence of 1.7 percent, notably higher than the 1.0 percent observed among their counterparts who were engaged in education, employment, or training (IEET). This pattern underscores how disability can limit adolescents' access to education and early work opportunities, setting the stage for long-term social and economic exclusion if unaddressed.

Overall, the findings point to clear vulnerabilities among adolescents with disabilities. Targeted early childhood development interventions, inclusive education policies, and comprehensive adolescent health services must remain a cornerstone of Botswana's efforts to eliminate inequities faced by adolescents with disabilities. Proactively addressing these disparities will be crucial for ensuring that all adolescents, regardless of disability status, are empowered to achieve their full potential.

Table 36: Percentage Distribution of youth (10 to 19 Years) by Disability Status and Selected Demographic and Socioeconomic Characteristics

CHARACTERISTICS		No Disability	Has Disability	TOTAL
Locality	Cities/Towns	99.1%	0.9%	**78,865**
	Urban Villages	99.0%	1.0%	**211,073**
	Rural	98.7%	1.3%	**139,897**
Sex	Male	98.8%	1.2%	**216,330**
	Female	99.1%	0.9%	**213,505**
Age group	10 to 14 Years	99.0%	1.0%	**230,954**
	15 to 19 Years	98.9%	1.1%	**198,881**
Level of Education	No Education	73.9%	26.1%	**3,247**
	Primary	98.9%	1.1%	**165,382**
	Secondary	99.3%	0.7%	**240,219**
	Tertiary	98.7%	1.3%	**7,948**
Marital Status	Never Married	98.9%	1.1%	**416,568**
	Married	99.3%	0.7%	**2,140**
	Previously Married	100.0%	0.0%	**10**
NEET Status	NEET[30]	98.3%	1.7%	**75,106**
	IEET[31]	99.0%	1.0%	**342,033**
TOTAL		**98.9%**	**1.1%**	**417,139**

4.8.4. Determinants of Disability Status among Adolescents (10 to 19 Years)

Multivariate logistic regression analysis revealed key determinants of disability among adolescents aged 10 to 19 years **(see Table 37).**

- **Rural adolescents: 27% higher odds of disability than urban peers (OR = 1.273).**
- **Female adolescents: 15% lower odds than males (OR = 0.850).**
- **Older adolescents (15–19 years): 74% higher odds vs 10–14 age group (OR = 1.744).**
- **Education as a protective factor: Primary (OR = 0.043) vs Secondary (OR = 0.018) vs Tertiary (OR = 0.034)**

- **Locality:** Adolescents residing in rural areas were found to have approximately 27 percent higher odds of reporting a disability compared to their peers living in cities and towns (OR = 1.273, $p<0.001$). This finding emphasizes the enduring impact of geographic disparities on adolescent health outcomes.

- **Sex:** Male adolescents exhibited 15 percent higher odds of reporting a disability than female adolescents (OR = 0.850, $p<0.001$). The gender gap suggests a need to tailor adolescent health programs to recognize differential risks and care needs by sex.

- **Age Group:** Older adolescents (aged 15–19 years) had significantly greater odds of reporting disability compared to those aged 10–14 years (OR = 1.744, $p<0.001$). This may reflect both a natural increase in disability onset with age and improved recognition or reporting of disability as young people mature.

- **Education:** Education emerged as the most potent protective factor against disability. Adolescents with no education were dramatically more likely to report disability compared to those with tertiary education (OR = 0.043, p<0.001). Adolescents who completed secondary or primary schooling also had significantly lower disability risks, reinforcing education's critical role in promoting health and resilience.

- **Marital Status:** Although marriage was rare among adolescents, married adolescents had lower odds of reporting disability (OR = 0.316, p<0.001) compared to never-married adolescents. However, caution is warranted in interpreting this result due to small sample sizes among married adolescents.

- **NEET Status:** Unlike among older youth and young people, NEET status was not a statistically significant predictor of disability among adolescents (p=0.288). This finding likely reflects the dominance of school attendance in defining adolescent life status, rather than employment or training participation.

- **Model Diagnostics:** The logistic regression model showed acceptable fit, with Nagelkerke R^2 = 10.0 percent, indicating that 10 percent of the variance in adolescent disability status was explained by the included predictors.

Table 37: Determinants of Disability among Sexually Active Young People Aged 10–19 Years: Results from Multivariate Logistic Regression

CHARACTERISTICS		ODDS RATIOS	95% CONFIDENCE INTERVAL
Locality*	Cities/Towns	1	-
	Urban Villages	1.080	0.986-1.183
	Rural Areas	1.273	1.159-1.398
Sex*	Male	1	-
	Female	0.850	0.799-0.904
Age group*	10 to 14 Years	1	-
	15 to 19 Years	1.744	1.596-1.906
Level of Education*	No Education	1	-
	Primary	0.043	0.039-0.048
	Secondary	0.018	0.017-0.021
	Tertiary	0.034	0.027-0.043
Marital Status*	Never Married	1	-
	Married	0.316	0.186-0.536
	Previously Married	0	0.000-0.001
NEET Status	NEET[32]	1	-
	IEET[33]	0.953	0.872-1.041

[32]NEET stands for Not in Education, Employment and Training
[33]IEET stands for In Education, or Employment or Training

5. Policy and Programme Implications

5.1. Introduction

This section outlines the key implications of the findings for youth health and wellbeing policy and programming in Botswana. Drawing from the evidence across maternal mortality, adolescent fertility, contraceptive use, HIV testing, disability, and NEET status, three core domains of action emerge: (1) youth-focused programmes, (2) gaps in service provision, and (3) integration of sexual and reproductive health (SRH) in broader youth development frameworks.

5.2. Youth-focused programmes

The findings clearly demonstrate that Botswana's youth—especially those aged 20 to 24 and 25 to 29 years—face heightened health, economic, and social risks. NEET status affects 47.1 percent of youth nationally, adolescent fertility persists despite improvements, and disparities in contraceptive use, HIV testing, and disability are widespread.

This underscores the need for strengthened multi-sectoral youth-focused programmes that:

- Prioritise transitions from school to work through skills development, apprenticeships, and inclusive employment schemes, especially for rural youth and young women.
- Expand access to youth-friendly sexual and reproductive health services, ensuring confidentiality, affordability, and quality counselling.
- Target young women aged 20–24 years for maternal health and family planning interventions, given their disproportionate share of maternal deaths.
- Integrate mental health and psychosocial support into youth health strategies, especially for NEET youth and adolescents with disabilities.

There is also a strong case for district-level programming, tailored to areas with the highest NEET rates (e.g., Ngwaketse West, Ngamiland West), adolescent fertility (e.g., Kweneng West), or low contraceptive uptake (e.g., Gaborone, Jwaneng).

5.3. Gaps in service provision

Despite the overall policy commitment to youth wellbeing, the report identifies several systemic and programmatic gaps:

- **Disability inclusion remains weak.** Youth with disabilities face NEET rates of 64.2 percent, far above the national average. Mainstreaming disability-sensitive planning, service accessibility, and inclusive education/employment is urgent.
- **Disaggregated service delivery is limited.** Services are often not designed to cater to the different needs of adolescents (10–14), older adolescents (15–19), young adults (20–24), and older youth (25–35). A life-course approach is lacking.
- **Urban youth paradox.** Urban districts like Gaborone, despite better infrastructure, showed low contraceptive use and moderate HIV testing rates, suggesting that stigma, provider attitudes, or service fatigue may be deterring uptake.
- **Gendered vulnerabilities persist.** Female youth continue to experience higher rates of NEET, early pregnancy, and maternal death, requiring gender-transformative policies that address root causes such as early marriage, low labour force participation, and social expectations.
- **Limited adolescent SRHR access.** Adolescents aged 15–19 have low contraceptive prevalence (20.4%) and HIV testing rates (46.4%), calling for early interventions in schools, community centres, and through digital platforms.

5.4. Integration of SRH in Youth Development Frameworks

Sexual and reproductive health (SRH) must be positioned as a central pillar in youth empowerment and development strategies. The evidence confirms strong links between NEET status, education, and poor SRH outcomes. Therefore:

- The National Youth Policy, ASRHR Strategy, and NDP 12 must include explicit SRH indicators and accountability frameworks.
- SRH services must be integrated with TVET, youth skills centres, and employment programmes, especially in high-NEET districts.
- The education sector should strengthen comprehensive sexuality education (CSE), including life skills, HIV prevention, and disability inclusion.
- Data systems need to improve disaggregation of SRHR indicators by age (10–14, 15–19, 20–24, etc.), sex, disability, and locality to guide tailored interventions.
- Stronger linkages between MoH, MYSC, MoESD, and Statistics Botswana are essential to monitor progress and enable coordinated, cross-sectoral action.

6. Conclusions

This report has presented a comprehensive analysis of the health and wellbeing of youth aged 10 to 35 years in Botswana, drawing on the 2022 Population and Housing Census and supplementary sources such as the Botswana AIDS Impact Survey (BAIS V) and Quarterly Multi-Topic Surveys (QMTS). The evidence confirms that while Botswana has made significant strides in expanding access to health services and education, substantial challenges remain in ensuring equitable outcomes for all youth.

The data reveal clear age-, sex-, and locality-based disparities in key health indicators. Young women aged 20–24 years are disproportionately affected by maternal mortality and adolescent fertility, and adolescents continue to have low levels of contraceptive use. Adolescent girls and young women continue to initiate childbearing early, often without adequate access to sexual and reproductive health services. Meanwhile, the 15–24 age group faces the dual burden of poor contraceptive uptake and low HIV testing coverage, highlighting critical service delivery gaps during a formative life stage.

The high NEET rate of 47.1 percent, particularly among females, rural youth, and persons with disabilities, underscores systemic exclusion from economic and educational opportunities. The intersection between NEET status, poor SRH outcomes, and geographic disadvantage calls for holistic, life-course-oriented youth development strategies.

Geographically, rural and peripheral districts such as Ngwaketse West, Ngamiland West, and Central Mahalapye exhibit some of the highest NEET and adolescent fertility rates. Conversely, even urban districts like Gaborone face concerning service uptake gaps, such as low contraceptive use, suggesting non-geographic barriers such as stigma, provider bias, or socio-cultural norms.

The logistic regression model confirmed that locality, sex, age, education level, marital status, and disability status are all significant predictors of youth NEET status. These variables also mirror trends in SRH outcomes and highlight overlapping vulnerabilities that require integrated policy responses.

In conclusion, Botswana's youth health and wellbeing agenda must move beyond generalised interventions toward targeted, data-driven, and equity-oriented programming. This means strengthening youth-friendly services, addressing the needs of specific subgroups such as adolescent girls, young people with disabilities, and rural youth, and ensuring the integration of sexual and reproductive health into broader youth development and empowerment frameworks.

Without deliberate, coordinated action across government, civil society, and communities, Botswana risks falling short of its commitments to the SDGs, Vision 2036, and the National Youth Policy. The findings in this report provide a critical roadmap for action.

7. Recommendations

Drawing from the evidence presented in this report, the following recommendations are aimed at guiding national stakeholders—policy makers, development partners, civil society, and youth organisations, in strengthening the health and wellbeing of youth aged 10 to 35 years. The recommendations are framed around three strategic domains: targeted empowerment strategies, enhanced youth-friendly services, and data systems and monitoring improvements.

7.1. Targeted Youth Empowerment Strategies

- Prioritise marginalised youth in rural and underserved districts such as Ngwaketse West, Ngamiland West, and Barolong by designing district-specific employment and livelihoods programmes that link young people with skills development, job placements, and enterprise support. These initiatives should be informed by local labour market demand and aligned with district development plans to ensure sustainability.

- Develop gender-responsive youth empowerment strategies that explicitly address the structural challenges faced by young women, including gender norms, caregiving burdens, and early childbearing. Programmes should provide both economic empowerment (e.g., access to finance, vocational training) and social protection (e.g., childcare support, GBV prevention), especially for females aged 15–24 who are most at risk of being NEET or adolescent mothers.

- Scale up vocational education, apprenticeships, and youth enterprise initiatives targeting out-of-school and unemployed youth. These interventions should bridge the transition from education to the labour market and include wrap-around services such as career guidance, digital skills training, entrepreneurship coaching, and startup grants for youth-led businesses, especially in peri-urban and rural areas.

- Mainstream disability inclusion into all youth programmes and services. This includes adapting physical infrastructure, communication materials, and training approaches to accommodate youth with visual, hearing, intellectual, and mobility impairments. Dedicated funding streams and partnerships with Organisations of Persons with Disabilities (OPDs) should be established to reduce the 64.2 percent NEET rate among youth with disabilities.

- Develop targeted support mechanisms for youth during life-stage transitions, such as peer mentoring programmes for school leavers, structured gap-year programmes, and social protection interventions for newly unemployed graduates. These should be complemented by youth “safe spaces” and empowerment hubs at community level where young people can access career information, psychosocial support, and network-building opportunities.

7.2. Enhancing Youth-Friendly Services

- Invest in the expansion and institutionalisation of youth-friendly sexual and reproductive health (SRH) services across health facilities, community clinics, schools, and youth centres. These services must guarantee privacy, non-judgmental attitudes, and age-appropriate counselling. Standardised national guidelines and provider certification should be enforced to improve quality and consistency

- Deliver targeted SRH outreach to adolescents aged 15–19, especially in schools and community-based platforms. This group has among the lowest levels of contraceptive use (20.4%) and HIV testing (46.4%) yet faces increasing exposure to sexual activity and risk. Interventions should include integrated school health programmes, mobile health clinics, peer educator models, and digital health platforms tailored to adolescents.

- Enhance service access in rural and remote areas through mobile and digital innovations, such as mobile health units, SMS appointment reminders, confidential SRHR chatbots, and virtual counselling. These tools can mitigate stigma, transport barriers, and service bottlenecks, especially for young people in rural villages or those afraid of judgement from providers.

- Close service delivery gaps in urban districts with paradoxically low uptake, such as Gaborone and Jwaneng, by investigating barriers such as stigma, misinformation, cost, or provider fatigue. Outreach campaigns, youth-led dialogues, and collaboration with local influencers should be deployed to re-engage urban youth in SRHR services.

- Strengthen health provider capacity through mandatory pre-service and in-service training on youth-centred service delivery, gender sensitivity, disability inclusion, and mental health first aid. Providers should also be monitored and supported through supervision and mentorship frameworks to maintain service quality and youth responsiveness.

7.3. Data Improvements and Monitoring Mechanisms

- Mandate the disaggregation of all youth health and wellbeing indicators by detailed age bands (10–14, 15–19, 20–24, 25–29, 30–35), sex, locality, disability status, education level, NEET and marital status across all national statistical and administrative systems. This will enable more precise targeting and progress monitoring.

- Institutionalise routine reporting on youth NEET status, SRHR indicators, and adolescent wellbeing through integration into national monitoring tools such as the Health Information Management System (HIMS), Education Management Information System (EMIS), and Labour Market Information Systems (LMIS). Quarterly reporting by Statistics Botswana should be expanded to include youth development dashboards.

- Embed youth-specific indicators in national frameworks such as the National Development Plan 12 (NDP12), Vision 2036, and the implementation plans for the National Youth Policy and Adolescent Sexual and Reproductive Health and Rights (ASRHR) Strategy. This would promote cross-sectoral alignment and accountability.

- Establish a cross-sectoral Youth Health and Wellbeing Observatory, hosted within Statistics Botswana or a national planning body, to synthesise data, track priority indicators, and provide early warnings for emerging youth health risks. The observatory should publish annual Youth Wellbeing Reports and convene policy dialogues.

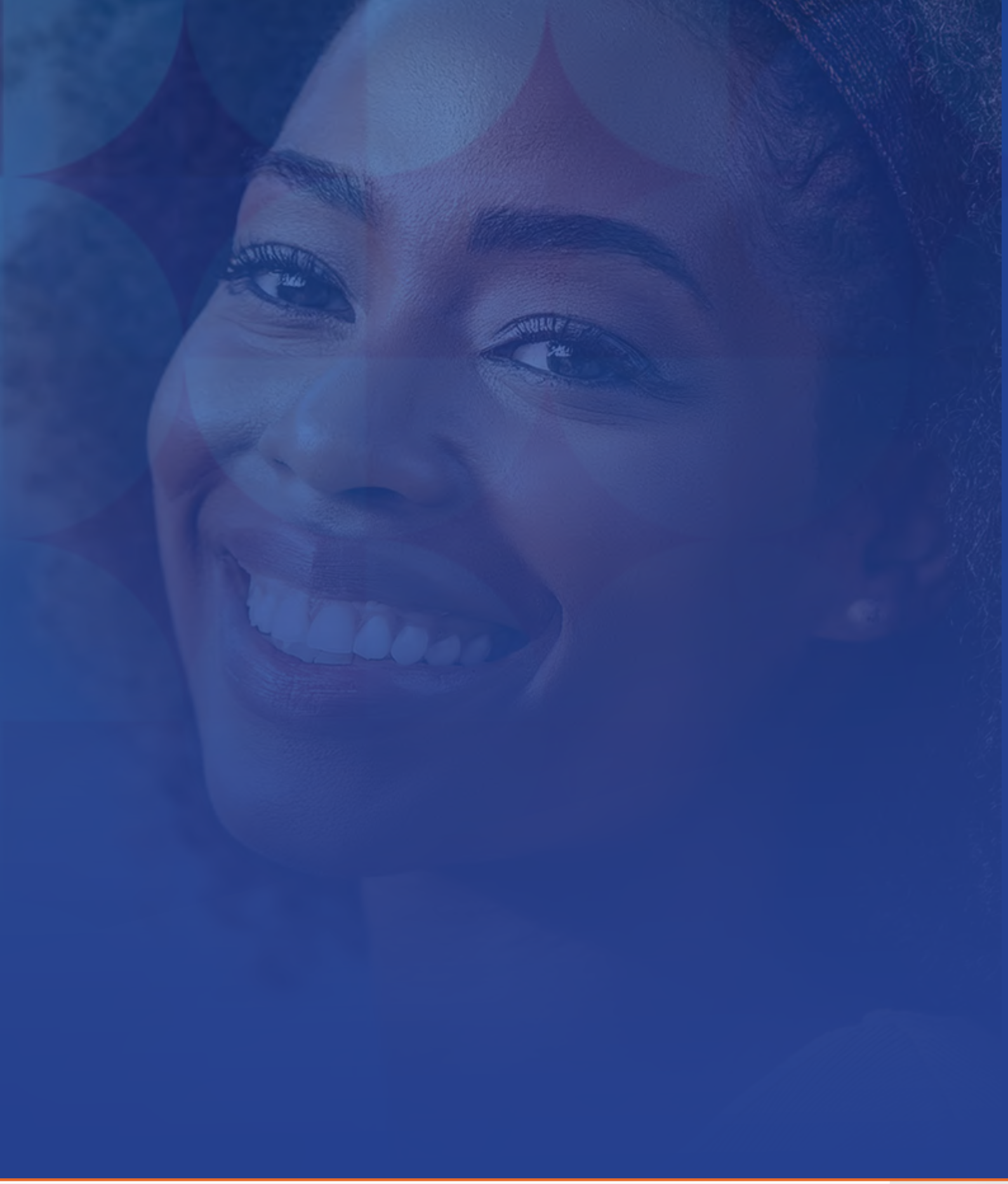
- Promote meaningful youth participation in data systems, including co-designing survey tools, participating in monitoring and evaluation exercises, and conducting peer-led research. Capacity building for youth in data literacy and evidence use should be integrated into national youth development programming to foster ownership and accountability.

- Establish a Multi-Sectoral Youth Wellbeing Council with Budget Tracking and Representation Mandates. Operationalise a high-level Youth Wellbeing Council that goes beyond coordination to include mandated tracking of youth-related budget allocations and expenditures across ministries. The Council should publish annual accountability reports on resource flows for youth health, education, employment, and SRHR. To ensure genuine youth leadership, mandate that at least 40 percent of the Council's members be youth aged 15–35, drawn from diverse geographic, gender, and ability backgrounds. This will elevate the Council into an accountability body that supports transparency, inter-ministerial coordination, and the institutionalisation of youth voice in national governance frameworks.

8. References

- African Union. (2006). African Youth Charter. Addis Ababa: African Union Commission.
- African Union. (2015). Agenda 2063: *The Africa We Want*. African Union Commission.
- Botswana Ministry of Health. (2012). *National Health Policy Towards a Healthier Botswana*. Government of Botswana.
- Botswana Ministry of Health. (n.d.). *National Adolescent Sexual and Reproductive Health and Rights (ASRHR) Strategy*. Government of Botswana.
- Government of Botswana. (2010). *Revised National Youth Policy 2010*. Ministry of Youth, Sport and Culture. Republic of Botswana.
- Government of Botswana. (2010). *Revised National Population Policy (RNPP)*. Ministry of Finance and Development Planning. Republic of Botswana.
- Government of Botswana. (2015). *National Policy on Gender and Development*. Gender Affairs Department, Ministry of Nationality, Immigration and Gender Affairs. Republic of Botswana.
- Government of Botswana. (2016). *Vision 2036: Achieving Prosperity for All*. Republic of Botswana.
- Government of Botswana. (2023). *National Commitment for Adolescent Well-being in Botswana*. Ministry of Health & Ministry of Youth, Gender, Sport and Culture. Republic of Botswana.
- Government of Botswana. (n.d.). *National Development Plan 11 & Draft NDP 12*. Government Printer.
- International Conference on Population and Development (ICPD). (1994). *Programme of Action*. United Nations.
- Letamo, G. (2014). Trends and determinants of maternal mortality in Botswana: Evidence from national health surveys. *BMC Pregnancy and Childbirth,* 14(1), 1–12.
- Ministry of Youth and Gender Affairs. (2025). *Gender Affairs Strategy 2025:* Draft Strategic Plan for 2025/26. Gaborone: Government of Botswana.
- Mokomane, Z., & Roberts, B. (2018). Socioeconomic determinants of adolescent fertility in Botswana: A multivariate analysis. *Journal of Population Research*, 35(2), 187–206.
- OECD. (2022). *Education at a Glance 2022: OECD Indicators*. Paris: OECD Publishing. https://doi.org/10.1787/3197152b-en
- Office of the President. (2024). *Review of the 10-Year Implementation of the Addis Ababa Declaration on Population & Development (AADPD)*. National Planning Commission, in collaboration with UNFPA. Gaborone: Botswana.
- Office of the President. (2024). *Review of the Botswana Revised National Population Policy (RNPP) of 2010*. National Planning Commission, in collaboration with UNFPA. Gaborone: Botswana.
- Statistics Botswana. (2015–2016). *Botswana Multi-Topic Household Survey Report*. Government of Botswana.

- Statistics Botswana. (2017). *Botswana Demographic Survey (BDS)*. Government of Botswana.
- Statistics Botswana. (2018). *Botswana Demographic and Health Survey (BDHS)*. Government of Botswana.
- Statistics Botswana. (2022). *2022 Population and Housing Census: Preliminary and Analytical Reports*. Government of Botswana.
- Statistics Botswana. (2023). *Quarterly Multi-Topic Survey: Labour Force Module Reports (2019–2024)*. Government of Botswana.
- Statistics Botswana. (2021). *Vital Statistics Report*. Government of Botswana.
- UNDP Botswana. (2024). Botswana *National Human Development Report 2024: Summary Report*. Gaborone: UNDP Botswana.
- UNICEF. (2023). *Early Childbearing – Adolescent Birth Rates*. https://data.unicef.org/topic/child-health/early-childbearing/
- UNICEF. (2023). *Adolescents and Young People – HIV/AIDS Data*. https://data.unicef.org/topic/hivaids/adolescents-young-people/
- United Nations. (2015). *Transforming our World: The 2030 Agenda for Sustainable Development*. United Nations.
- United Nations Population Fund (UNFPA). (2023). *State of the World Population Report 2023: 8 Billion Lives, Infinite Possibilities*. UNFPA.
- UNFPA. (2023). *Global Consensus on Meaningful Adolescent Engagement*. New York: United Nations Population Fund.
- WHO. (2023). *Maternal Mortality: Levels and Trends 2000 to 2020*. https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
- WHO. (2024). *WHO warns of declining condom use among adolescents*. https://nypost.com/2024/08/30/lifestyle/gen-z-ditches-condoms-alarming-decline-in-contraceptive-use-prompts-who-warning/
- World Health Organization (WHO). (n.d.). *Global Health Observatory Data Repository: Adolescent Health and Maternal Mortality*. Retrieved from https://www.who.int/data/gho
- World Health Organization (WHO). (2021). *Adolescent Health and Wellbeing Indicators: A Technical Reference Guide*. Geneva: WHO



Private Bag 0024
Gaborone
Tel: 3671300
Toll Free: 0800 600 200

Private Bag F193,
Francistown
Tel: 241 5848

E-mail:
info@statsbots.org.bw
Website
www.statsbots.org.bw

Four Thirty Square,
Plot 54350
PG Matante Road, CBD
Gaborone

STATISTICS BOTSWANA

Republic of Botswana

UNFPA

Audit trail

Details

FILE NAME	YOUTH HEALTH AND WELLBEING IN BOTSWANA final report UNFPA signed_compressed - 2/5/26, 2:03 PM.pdf
STATUS	Signed
STATUS TIMESTAMP	2026/02/05 12:12:31 UTC

Activity

SENT	keetile@unfpa.org **sent** a signature request to: • Tlangelani Shilubane-Pietersen (shilubane@unfpa.org)	2026/02/05 12:03:55 UTC
SIGNED	**Signed** by Tlangelani Shilubane-Pietersen (shilubane@unfpa.org)	2026/02/05 12:12:31 UTC
COMPLETED	This document has been signed by all signers and is **complete**	2026/02/05 12:12:31 UTC

The email address indicated above for each signer may be associated with a Google account, and may either be the primary email address or secondary email address associated with that account.