Reflections on Children in Botswana 2010

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Acknowledgements

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Thari ya bana

Reflections on Children in Botswana 2010

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Contents

Foreword

We are delighted to welcome you to the first edition of the joint UNICEF and University of Botswana publication ***'Thari Ya Bana: Reflections on Children in Botswana 2010'.***

The title, *'Thari Ya Bana',* refers to the blanket that holds the infant safe behind the mother – and was chosen to symbolise the support that all children need, from infancy through to adolescence and the transition to adulthood, where the roles reverse and the focus moves to parenthood. And so the cycle continues.

The papers presented here bring together research and reflections on children's issues in Botswana. The chapters have been structured to follow the life cycle of the child as she or he grows up and different issues need to be addressed:

- Young Child Survival
- Child Development
- Child Protection

A number of papers explore children in the context of HIV and AIDS. Papers on policy-making and how it can affect children are also included in the book.

To complement the analytical papers, the book also highlights a compendium of the most current data available on a wide range of indicators of child wellbeing, drawing mostly from recent household surveys conducted by the Central Statistics Office.

The range of topics for this inaugural edition is also matched by a range of authors – many of them from the University of Botswana (both lecturers and students), but also from practitioners in the field. In addition, UNICEF staff have also taken this opportunity to share their work with a wider audience.

Some of the authors draw upon their already published work, some share work in progress, while others simply reflect on issues and priorities. All of them aim not only to disseminate information to their peers, but also to present their work in an accessible format to all those working to improve the lives of children in Botswana.

In future editions, *'Thari Ya Bana'* will be developed around annual themes related to children, but with the same intention of sharing current work and information with a broader audience.

We encourage you to peruse *'Thari Ya Bana'* and to use the evidence provided in it to influence your own professional work, research or advocacy with and for the children of Botswana. And we look forward to your feedback and future contributions!

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Child nutrition and household economic situation in the context of rising food prices: A baseline study in Mabutsane and Bobirwa

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Introduction and background information

Several population-based surveys in Botswana show that child malnutrition is a persistent problem and there are significant disparities in its prevalence across and within districts (CSO, 2001, 2009). Despite concerted efforts to prevent malnutrition in children 0-5 years of age, the prevalence of malnutrition in some areas has remained at worryingly high levels for decades. Amongst the most affected are children in households with poor socio-economic indicators (Nnyepi, 2007) and those in health districts[1] in regions with poor poverty indicators such as Mabutsane, Kweneng West, Kgalagadi and some areas of Mahalapye (Ministry of Health, 2010).

The problem of malnutrition is not unique to Botswana. In fact child malnutrition is also a serious problem in many countries in Sub-Saharan Africa. Predictions consistently paint a grim picture for many Sub-Saharan countries (Rosegrant *et al.,* 2000). The immediate determinants of malnutrition in children are inadequate dietary intake and illnesses. These determinants are influenced by several other factors such as household food insecurity, lack of care, political problems and other factors that are clearly outlined in the conceptual framework of malnutrition (UNICEF, 1990). Sadly these predisposing problems are quite common in Sub Saharan Africa.

The determinants of malnutrition are influenced by both chronic and sporadic stressors. The recent (2006 – 7) dramatic increase in food prices is one stressor that is expected to

[1]Health Districts are different from Administrative Districts. These Health Districts are as defined in Botswana Nutrition Surveillance Data.

adversely affect the nutritional status of children. Amongst the most vulnerable in Botswana are children in poor households who, according to observations made prior to the rise in the global food prices, revealed that they spend a disproportionately high percentage of their income on basic food items compared to more affluent households (Central Statistics Office, 2003). For such poor households, even the slightest shocks can aggravate their situation and predispose them to food insecurity and undermine their children's nutritional status. This baseline study was carried out to document the nutrition economic situation of children in more vulnerable regions in Botswana during a period marked by dramatic increases in food prices. The specific objectives were to 1) describe the nutrition-economic situation of the under-fives in at-risk areas in Botswana and 2) to determine important determinants of child malnutrition during a period marked by significant rises in food prices.

Methodology

To fully appreciate the nutrition situation of children and the economic situation of households during a period marked by high food prices, two districts with variable levels of underweight (low weight-for-age) children were selected based on a review of the food and nutrition, and poverty literature in the country (Ministry of Health, 2009; CSO, 2008; UNICEF Botswana, 2010). Thus in this study, the nutrition-economic situation of children in Mabutsane, a district with the highest prevalence of malnutrition in the country, was compared to the nutrition-economic situation of children in Bobirwa, which has near average rates of malnutrition. The study protocol was approved by the Health Research Development Committee.

Data collection

Using a cross sectional survey design, baseline data were collected from consenting households in three villages from each district. The villages were selected such that each village represented small, middle or large villages in the district. Overall 742 households were selected proportionately (based on population size) from each village. The size of the sample was determined using a procedure recommended by Lwanga (1991). Pilot tested survey instruments were then administered to the head or spouse of the head of the household by trained assistants. The information collected included socio-demographic data and information on household food security, sources of household income, sources of household food, types of household assets, health and immunization information. Further, all children under five years were weighed and measured to establish their nutritional status. Children's immunization information was also collected from their clinic records.

Results

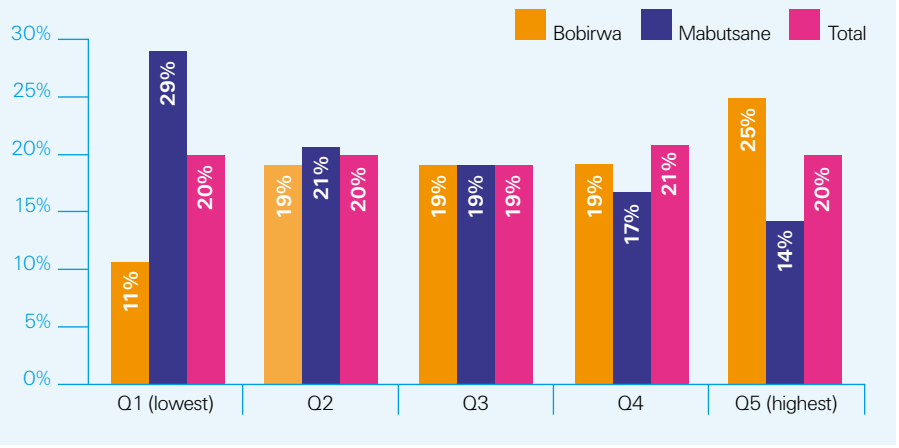
Demographic characteristics of households

Observations were drawn from 742 households and 1003 children. Most households were single parent-headed households. In Mabutsane, 55.4% were single parent families compared to 35.0% in Bobirwa. The household sizes were generally large. Most (61%) of them had 5 to 9 members compared to the average of 4 nationally. The level of unemployment was generally high in both districts, although Mabutsane had higher rates.

Regarding household sources of income more households in Mabutsane ranked government transfers (23.6%) and remittances (20.4) as their most important sources of income. In Bobirwa, however, salaries (37.5%) and remittances (19.9%) were said to be the most important sources of income for households. With respect to household access to facilities such as access to safe water, toilet facilities, cooking and lighting energy (data not shown), households in Mabutsane fared worse than those in Bobirwa. This was also true with respect to ownership of cattle and other assets.

The economic situation of households in Mabutsane was therefore generally worse than the situation in Bobirwa. There were also more households in Mabutsane who fell in the 1st and 2nd quintile of household per capita income. The opposite was true with respect to Bobirwa (Figure 1).

Figure 1 Per Capita income (quintile) in Bobirwa and Mabutsane

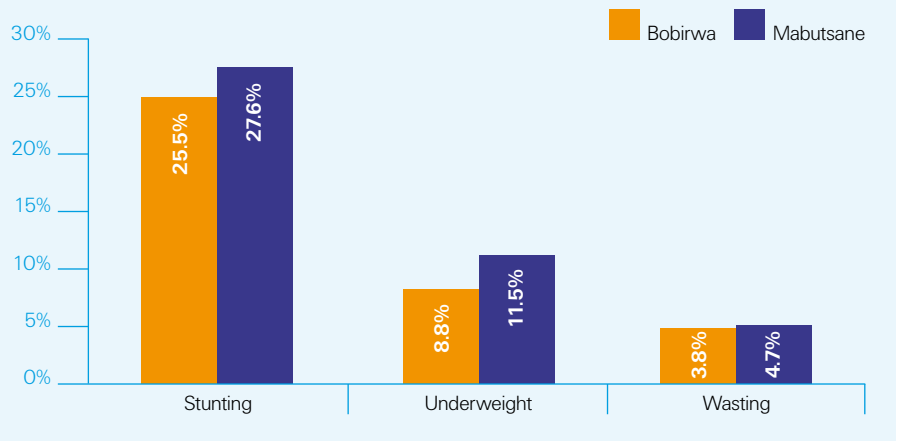


Food and Nutrition Situation of Children

Nutrition Situation

The prevalence of malnutrition (using the WHO standards) is summarized in Figure 2.

Figure 2 Nutritional status of children under five in Bobirwa and Mabutsane



The results show that low height-for-age (stunting) is the most common form of malnutrition in both districts followed by low body weight-for-age (underweight) and low body weight-for-height (wasting). In all the three indicators, children in Mabutsane were worse off. Furthermore, in both districts boys presented with higher prevalence of stunting and underweight than girls.

Quality of children's diet

The nutritional status of children is often related to caregivers' feeding practices and the quality of the children's diet. In this study 65.6% and 66.6% of children in Bobirwa and

Mabutsane were reported to have been breastfed. Most of these children were breastfed for about 12 months while a few were fed cow's milk. However, most children were introduced to water, sugared water and milk other than breast milk very early. By 2–3 months of age, 23.7% of children had been introduced to water, while 26.8% were introduced to water by 4–5 months of age. The proportion of children who were introduced to water before 6 months of age was 63.2%. This early introduction of fluids and foods before 6 months of age undermines the quality of breastfeeding.

With respect to the quality of the diet, the observations showed that most children (older than 6 months) had diets of low quality. The quality of the diet is shown by the number of different types of food the child was fed or served in a day. The higher the number of different types of food (food groups) the better the quality of the diet. In this study however, out of a possible 9 food groupings most children diets only had three different types of foods in a day. This therefore showed that children's diets in this study were limited. Also, the disparity between what children ate and what is recommended based on the food groupings was higher in Mabutsane compared to Bobirwa.

Household Food Security

A household is food secure when it has access to sufficient food to meet the nutritional needs of all members at all times. However, when households are periodically uncertain about the adequacy of their food supply, or have had to eat food of insufficient quality or quantity in the past 30 days then such households are food insecure. In this study 74.9% of households reported experiencing some anxiety about their food supply. Over 68% reported eating food of insufficient quality at least once in the past month while 67–86% reported that their food intake was insufficient at least once in the past 30 days. As shown in table 1, the situation is so serious that there are some households whose members had slept hungry at least once in the 30 days preceding the study, because there was no food in the home. Furthermore, considerably more households in Mabutsane experienced some form of food insecurity compared to those in Bobirwa: consistent with all other observations the mean household food insecurity access score was significantly higher for households in Mabutsane (11.8±7.1) compared to those in Bobirwa with 9.8± 7.7.

Measures of food insecurity were strongly associated with household asset profile, the marital status and employment status of the head of the household and total household income.

Determinants of child malnutrition in Bobirwa and Mabutsane

The determinants of child nutrition in this study fell into two broad categories: child factors and household factors. Amongst the child factors, the results showed that the risks of malnutrition in children were lower in children born in health facilities, children with birth weight greater than 2500 grams, children under 12 months and children cared for by grandmothers. Infant and young child feeding practices were poor in both districts. However, breastfeeding exposure and the number of times the children were fed in a day did not influence the risk of malnutrition, presumably because the early introduction of complementary foods promoted the replacement of highly nutritive breast milk with diets of low nutritive quality.

Amongst the household factors, household size, the age, educational level, and employment status of the head of the household, household ownership of productive assets, and household food security level were important determinants of child nutrition. In general children in larger households were less protected from malnutrition compared to those in smaller households. Similarly, children in households with no productive assets were more vulnerable.

Table 1 **Household experiences of food insecurity by district**

Domains of food insecurity	Households experiences of food insecurity	*Percentage of Households*		
		Mabutsane	Bobirwa	2–district average
Anxiety and uncertainty of food supply	Household who ever worried that food is not enough ($p < 0.001$)	74.9	59.6	67.3
Insufficient food quality	Household was not able to eat kinds of food they preferred	85.7	68.5	77.7
	Ate limited variety of Foods than desired ($p < 0.001$)	83.0	72.8	77.9
	Ate food they preferred *not to eat* (e.g. food of lesser quality) because there were no resources to obtain preferred food	76.3	67.4	71.8
Insufficient food intake	Household who ate smaller meals than desired ($p < 0.001$)	76.0	60.9	68.5
	Who had fewer meals per day than desired ($p < 0.001$)	77.6	62.5	70.1
	Who ever had no food of any kind	66.9	58.0	62.4
	Ever slept hungry in the past 30 days ($p < 0.05$)	39.5	32.1	35.8
	Ever went the whole day and night without food ($p < 0.05$)	29.3	22.1	25.7

However, the relationship between child malnutrition and household income, education and employment status of the head of the household was complex. This was particularly so in Mabutsane compared to Bobirwa. Higher educational achievement on its own was not necessarily protective. The protectiveness against child malnutrition of higher educational achievement of the head of the household seemed to be influenced by the employment status of the head and the significance of earned income compared to social benefit packages. In Mabutsane, for example, the odds of stunting in children whose household heads had primary level of education were reduced by about 46% compared to children whose heads of the household had no formal education or had Junior Certificate level of education. But most of the heads of households with Junior Certificate level of education were unemployed and younger. Employment alone also did not confer protection against malnutrition. In Mabutsane, children whose heads of households were employed were at least twice more likely to be stunted compared to children whose heads of the household were unemployed. Similarly the odds of wasting were 3.8 times higher for children from households with employed heads of households. When incomes are low, employment is a risk factor, in that it disqualifies heads of households from some social benefit packages. Contrary to the situation in Mabutsane, however, in Bobirwa the employment status of the heads of the household was not amongst the significant determinants of child nutrition — here the primary caregiver's employment improved the child's nutritional status.

Discussion and conclusions

This baseline study reveals a high prevalence of child malnutrition and households food insecurity in both districts. However the situation in Mabutsane is more serious than in Bobirwa. The prevalence of low weight-for-age and low height-for-age in these districts is much higher than the national average (BNNSS, 2010) and clearly indicates that more children in these districts are vulnerable. Further, the high level of stunting in children in both health districts suggests that children are chronically exposed to poor nutrition and other vulnerabilities which are probably independent from the recent changes in the food prices. These observations are consistent with the high proportions of food insecure households, single parent headed households and low ownership of productive assets observed in Mabutsane and to lesser extent in Bobirwa. That there is widespread food insecurity to the extent that households in Mabutsane find social benefits to be the most important sources of

income attests to the gravity of the situation in the area. This is a situation that should be addressed urgently because there is strong evidence that links stunting, which is a measure of both chronic malnutrition and child poverty, with cognitive development (Cravioto & Arietta, 1986), chronic morbidities later in adulthood (Black, et al, 2008), as well as an increased likelihood that the children will become poor adults (Yaqub, 2002).

The higher rate of child malnutrition in Mabutsane is consistent with the environment in Mabutsane which is less ideal for the care of children. Undoubtedly, the larger size of households in Mabutsane overstretches resources. Already the predominant type of household structure (single headed households) in Mabutsane (55.4%), which is associated with limited household resources, coupled with the fact that households are larger, worsens the situation. This is also consistent with the observations that compared to Bobirwa, Mabutsane households had poorer access to potable water, toilet facilities and cooking energy. Overall, observations from this baseline study show that children are living in environments that are not conducive to their optimum development and they are therefore vulnerable. In the midst of these pre-existing vulnerabilities, any more stressors such as the marked increase of food prices can only serve to exacerbate child malnutrition and household food security. However this study, being a baseline, cannot alone give a final answer on the impact of rising food prices on child malnutrition and household food security in Mabutsane and Bobirwa.

Recommendations

Assessing the effects and impact of rising food prices in Mabutsane and Bobirwa would require a monitoring of household and children's situation in these districts over a period of time. This can ideally be done either through a follow-up cross sectional survey after some time, or through the integration of some of the survey key indicators i.e. socio-economic status, food security indicators, etc within the existing nutrition surveillance system in these districts, though this would have shortcomings.

Malnutrition in children is influenced by many factors. Many of these factors lie outside the health discipline and straddle several sectors. Evident in this study are the poor socio-economic indicators at household level which are unlikely to be addressed by any one sector because central to the poor nutrition situation of children are households that are food insecure, household members who are unemployed, underemployed, undereducated and without adequate access to safer waste disposal facilities and reliable means of livelihoods.

There is a need for a multi-sectoral approach that will empower households and bring about more sustainable poverty alleviation solutions. Given the long-term nature of such an approach, it is further recommended that needy households should be cushioned with safety nets that target children under five until their households can sufficiently take care of them.

Lastly, there is a need for a follow up qualitative case study of Mabutsane that will help to tease out factors that make Mabutsane a perennial poor performer in both nutrition indicators and socio-economic indicators. Such a study should focus on a broad range of factors that include but are not limited to means of livelihoods, child rearing behaviours, household structures and support systems, household perceptions about self development and others. The thrust of the study should lead to better understanding of causal pathways of household and child vulnerabilities to socio-economic stressors.

References

Black, R. E; Allen L.H; Bhutta Z.A; Caulfeild L.E; de Onis M; Ezzati *et al.* (2008), Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet,* 371:243-260.

Cravioto J, and Arrieta, R. (1986), Nutrition, mental development and learning. In: Falkner F, Tanner J, editor. *Human growth: A comprehensive treatise.* Vol. 3. New York: Plenum Press; 1986. p. 2/e.

Central Statistics Office. (1996). *Botswana Family Health Survey III,* 1997. Government Printers, Gaborone, Botswana.

Central Statistics Office. (2001). *Botswana Multiple Indicator Survey, 2000.* Government Printers, Gaborone Botswana.

Central Statistics Office. (2003). *Botswana's Household Income and Expenditure Survey, 2002-3.* Government Printers, Gaborone Botswana.

Central Statistics Office. (2008). *Poverty Datum Line for Botswana,* Department of Printing and Publishing Services, Gaborone, Botswana.

Central Statistics Office. (2009). *Botswana Family Health Survey IV, 2007.* Government Printers, Gaborone, Botswana.

Ministry of Finance and Development Planning (1996). *Determinants of Child Nutritional Status in Botswana: A national study.*

Ministry of Health. (2009), *Botswana National Nutrition Surveillance System Quarterly Report,* Department of Public Health, Ministry of Health. Gaborone.

Ministry of Health. (2010), *Botswana National Nutrition Surveillance System Trend Report,* Department of Public Health, Ministry of Health. Gaborone.

Nnyepi, M. S. (2007). *Household factors are strong indicators of children's nutritional status in children with access to primary health care in the greater Gaborone area,* Scientific Research and Essay, 2(2): 055–061.

Rosegrant, M. W; Paisner, M. S; Meijer, S; & Witcover, J. (2000), *Global Food Projections to 2020: Emerging Trends and Alternative Futures.* International Food Policy and Research Institute, Washington, DC.

UNICEF. (1990), *A UNICEF Policy Review – Strategy for improved nutrition of children and women in developing countries.* UNICEF, New York, N.Y. USA.

UNICEF Botswana (2010). *Nutrition Economic Study in the context of the rising food prices*. Unpublished consultancy Report (UNICEF).

Yaqub, S. (2002), Poor children grow into poor adults: harmful mechanisms or over-deterministic theory? *Journal of International Development* 14: 1081 – 1093.

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Complementary feeding: A sore spot in the nutritional status and survival of children in Botswana

Introduction

Good nutrition is central to the development, growth and survival of children. While it is important that children are fed nutrient-rich meals at all times, there are critical periods in childhood during which inadequacies of certain nutrients can lead to irreversible skeletal and cognitive impairments. In significant proportions of children globally, these nutrition-related impairments have far-reaching effects into adulthood. The transition from exclusive breast-feeding or formula feeding to family foods, commonly referred to as complementary feeding, is recommended to commence from six months and be completed by 18–24 months of age.

In Botswana, complementary feeding starts earlier and foods given to children during this phase are generally of low nutritive value. Consequently, the complementary feeding phase in Botswana is one phase during which children face nutritional insults that greatly undermine their wellbeing. Children of complementary feeding age present with a higher prevalence of malnutrition and increased incidence of gastro-intestinal infections compared to younger and older children in the under-five age group. While the reasons are numerous, they can be linked to poverty, caregiver feeding characteristics, health seeking behaviour of caregivers, maternal health during pregnancy and gaps in the health and social benefits packages. In this paper the authors use local and international research observations to discuss the nutrition challenges of children of complementary feeding age in Botswana and suggest evidence-based interventions with potential to address complementary feeding problems.

Background

Nutrition influences the development, growth and survival of children. Not only is nutrition crucially important during pregnancy, but also during the first two years of life. Indeed there are many developmental and health problems in children between 0–24 months that can be attributed to inadequate nutrition. Some of these are delayed physical growth, anaemia, and reduced cognitive development. There is a strong link between good nutrition and children's ability to achieve developmental milestones.

To sustain continued growth and development after birth, there is a need to provide infants with adequate nutrients through the provision of exclusive breast feeding, or in a few cases, a recommended alternate such as infant formula, for the first six months of life. At 6 months of life, adequate, safe and nutritious complementary foods are introduced to complement breast milk (or infant formula) in order to provide the necessary energy and nutrient intake for optimal growth and development. Fed as recommended, infants everywhere are expected to grow and develop well physically and cognitively. Adequately nourished infants are more resilient, and, in the event of infections, recover comparatively faster than poorly nourished children (Schroeder & Brown, 1994; Rowland, Rowland & Cole, 1988).

In significant proportions of children globally, however, there are inadequacies in the nutrition content of diets of children of complementary feeding age and in the feeding behaviours of caregivers. Poor complementary feeding practices are one of the principal causes of malnutrition and rates of malnutrition usually peak during this period (6–24 months) for several reasons. First, children have such high nutrient needs that breast milk or infant formula alone is not adequate. Secondly, younger infants (the 6–11 months old) are just learning to eat and must be fed suitable foods more frequently than it is often the case. Lastly, children are wholly dependent on the caregiver to provide safe and adequate nourishment. Any

challenges with respect to any of these can lead to significant nutrition-related inadequacies that may have far-reaching effects into adulthood (Black *et al*, 2008; Cravioto and Arrieta, 1986; Victora *et al,* 2008)

Unfortunately, children in Botswana are no exception, and studies in children of complementary feeding age in Botswana outline some of these nutrition and feeding challenges. In this paper, the authors describe diets of children of complementary feeding age in Botswana, their nutritional status and suggest interventions with potential to address complementary feeding problems.

What is complementary feeding?

Complementary feeding refers to the feeding of safe, nutritious, adequate and appropriate food to children between the ages of 6 and 24 months, whose nutrient needs can no longer be met by breast milk or infant formula (World Health Organization, 2004). The total energy[1] requirement for infants and young children ranges from 600 Kcal/day for children aged 6–8 months, to 700 Kcal/day and 900 Kcal/day for infants and young children aged 9–11 months and 12–24 months respectively (World Health Organisation, 2004). The amount of complementary food provided is progressively increased in response to the child's cues until the food provided adequately meets these nutritional requirements. At the onset of complementary feeding, therefore, the energy contributed by complementary food is low relative to that contributed by breast milk or infant formula but increases such that by 24 months, the child's dependence on breast milk is greatly reduced. Given the high nutrient needs for growth and development and the limited capacity of the children's stomach, the nutrient density of complementary feeding diets should be much higher than nutrient densities of adults' diet. Consistent with this observation, it is recommended that the diet of children of complementary feeding age should include meat, fish, poultry or eggs (animal products or milk)[2] and fruits and vegetables rich in Vitamins A and C every day. Because of their relatively low nutrient densities, cereal-only meals are not recommended as the primary constituents of the diets of children 6–24 months. Unless fortified, therefore, vegetarian complementary diets are often inadequate in both energy and nutrient density and are unable to support the growth and development of children of complementary feeding age (World Health Organization, 2004).

Complementary diets and complementary feeding in Botswana

Contrary to the World Health Organizations' recommendations on complementary feeding, observations in Botswana reveal serious limitations both in the diets of children of complementary feeding age and in the feeding practices of caregivers. These problems fall in several categories: 1) over-dependence on unfortified sorghum porridges in the feeding of children 6–24 months, 2) early introduction of complementary foods and a lower feeding frequency than recommended; 3) inadequate provision of nutrient-dense foods such as meat, fish or poultry, and fruits and vegetables.

There are no recent and comprehensive national data on the quality of children's diets and child feeding practices in Botswana. However, some studies have reported a list of foods that are commonly fed to children. One such study is the 1996 study by the Ministry of Finance and Development Planning (1996). Though dated, this study found that 47% and 53% of children were predominately fed sorghum porridge as a weaning food nationally and in rural areas respectively (Ministry of Finance and Development Planning, 1996). The authors also reported that out of 689 children who were on complementary foods, children who were ever fed eggs, fruits and vegetables and other foods were very few (in the lower single digits).

[1] I Kilocalorie (Kcal) = 4.1868 Kilo Joule (KJ).

[2] Foods which might trigger allergic reactions such as eggs and cow's milk should be introduced later than other foods and with caution.

In another study by the Ministry Of Health (1996), caregivers of breastfeeding children were reported to have fed their younger children and children of complementary feeding sugared water (13/61), juice (22/61), tea (10/61), infant formula (16/61), fresh milk (19/61) and *tsabana*[3] (40/61). Additionally, more caregivers in this study were reported to have chosen to feed their ill children soft porridge (43.5%) compared to cow's milk (23.8%) and fruits (9.9%). These observations were echoed by a study reported in 2000, which examined the relationship between the mothers' choice of complementary foods and nutritional status of children in Gabane (Nnyepi, 2000). In this study, 71.6% of children were predominately fed fermented sorghum porridge, while 9.4% were fed unfermented sorghum porridge (Nnyepi, 2000). Only about 8.6% were primarily fed a variety of commercially prepared complementary foods. Amongst children fed porridge, 41.5% and 10.6% of the children either had a small amount of milk, or milk and sugar added to the porridge respectively. All other children had meals with no animal products of any kind.

Observations from a more recent study show slight improvements in the characteristics of complementary diets (UNICEF Botswana, unpublished report). Though the data gathered are not nationally representative, observations show that cereals still form the basis of complementary foods for most children, as shown in Table 1. These data suggest an increase in the proportion of children of 6–24 months who are also fed animal products and fruits and vegetables. Certainly, there is a need to improve this even more, and also to address the use of teas or other sweetened beverages in complementary feeding.

Table 1 Food represented in the 24 hour dietary intake of children in Mabutsane and Bobirwa

Food groups represented in the 24 hour dietary intake	% of all children	% of all children 0–5 months	% of all children 6–24 months	% of all children >25 months
Milk and milk products	46.4	80.0	60.1	38.5
Plain water	93.4	66.7	90.8	96.1
Sweetened beverages	13.0	0	12.4	13.6
Cereals	87.0	93.3	92.2	84.3
Fruits	23.5	0	20.9	26.1
Vegetables	32.2	0	22.9	38.2
Meat, offal, poultry, or fish	39.6	6.7	34.0	43.9
Pulses, legumes/nuts	29.1	6.7	25.5	31.7
Tea	73.1	6.7	59.8	83.0
Other liquids	1.9	0	1.6	2.0

UNICEF Botswana (unpublished report)

In most of these studies, children of complementary feeding age were predominately fed sorghum based complementary foods (*motogo*/soft porridge) and had very little if any of foods rich in animal protein, minerals and vitamins. It is worth noting that these characteristics are largely influenced by adults' diets (Nnyepi, Ngwenya & Majelantle, 2008; Clausen *et al*, 2005). Clausen *et al*. (2005) observed that 35.2%, 59.3% and 22.4% of older persons in Botswana did not consume dairy products, fruits, and vegetables respectively regularly. Given that most children are served foods from the household pot, these findings further suggest that unless there are significant improvements in adults' diets, improvements in children's diets will be slow.

[3]Blended sorghum-soya bean weaning food product with added vitamin and mineral premix.

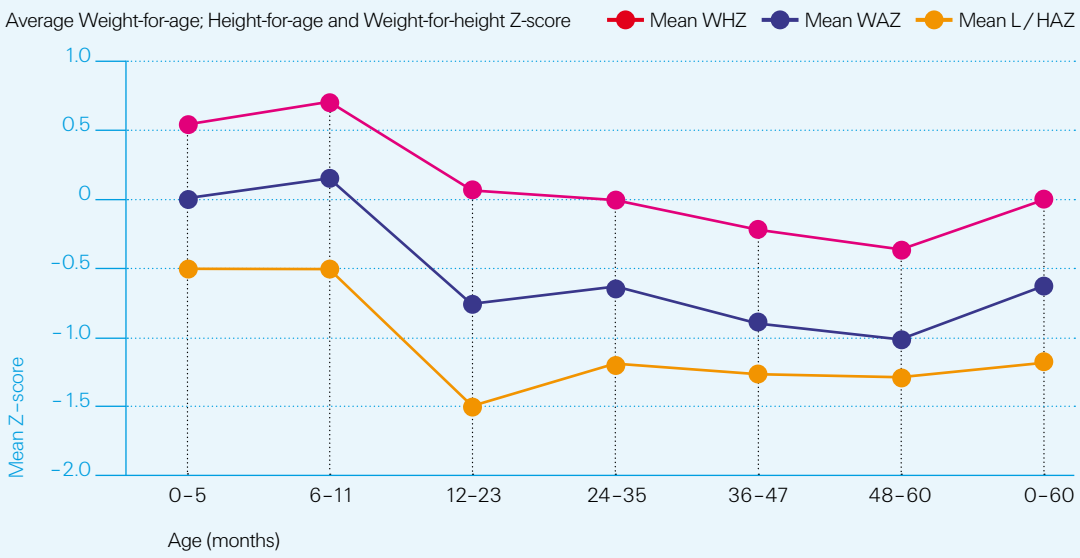
Early introduction of complementary feeding is another serious concern in the feeding of children in Botswana. Water, sweetened beverages including tea, ultra high temperature pasteurized cow milk and porridges are still introduced to children younger than 6 months of age (Ministry Of Health, 1996; Ministry of Finance and Development Planning, 1996, and Nnyepi, 2000; UNICEF Botswana, unpublished report). It is not uncommon for children under a month of age to have been introduced to water or sugared water. In the Mabutsane and Bobirwa survey for example, 7.2% and 23% of infants were introduced to water before one month and by 2-3 months of age respectively. These are serious concerns in that early introduction of complementary feeding increases the child's exposure to risks of food-borne infections. Complementary feeding this early in their lives also promotes the replacement of nutrient-dense breast milk or infant formula with fluids of low nutritive value. For children, therefore, early introduction of complementary fluids/foods is not only unnecessary but it is harmful.

Nutrition status of complementary feeding age in Botswana

Consistent with the reported poor complementary diets and feeding practices for children 6–24 months, malnutrition in children in Botswana in this age group is also a concern. Many of these children are born adequately nourished but begin to deteriorate after six months of age. In support of this observation is the relatively low rate of low birth weight in Botswana compared to other countries in the region. Low birth weight is an indicator that is used to assess child malnutrition at birth. It is an indicator that reflects poor growth during pregnancy but it is also correlated with stunting in children. Observations from several studies in Botswana estimate that the prevalence of low birth weight ranges from 8% (Central Statistics Office 2000) to about 13% (Central Statistics Office, 2009). Despite the fact that there has been an increase in the prevalence of low birth weight, the prevalence of low birth weight in Botswana has remained lower than that reported for Africa (14%), Sub-Saharan Africa (15%), developing countries (16%) and the least developed countries (17%) (UNICEF, 2009). Thus it can be argued that while there is evidence of some nutrition inadequacies during gestation as reflected by the prevalence of low birth weight, nutrition inadequacies during the complementary feeding period seem to contribute more to child malnutrition in this country. In fact the deviation of the children's growth from the mean of the reference population (shown in Figure 1) is more pronounced during the complementary feeding period (from 6–11 months to 11–23 months) than is the case shortly after birth (0–5 months).

Figure 1 shows the nutritional status of children under-five years of age for Mabutsane and Bobirwa health districts as reported by UNICEF (unpublished report). In this figure, a mean z-score of 0 means that the nutritional status of study children does not differ from that of normally growing children in the WHO reference population. In this study, however, the nutritional status of children in Mabutsane and Bobirwa deteriorates progressively from 6 months to the lowest levels at 12–23 months. While there is some recovery after 23 months, children do not recover completely. Interestingly, however, the pattern of child growth observed in Mabutsane and Bobirwa is the same as that reported by others locally (Ministry of Finance and Development Planning, 1996; Ministry of Health 1996; Central Statistics Office, 2000; and Central Statistic Office, 2009). These patterns clearly indicate that children of complementary feeding age in Botswana are exceptionally vulnerable. And while there is indeed a need to address malnutrition in children overall, children 6–24 months of age require more attention.

Figure 1 Growth parameters of children in Mabutsane and Bobirwa (UNICEF Botswana — unpublished report)



Conclusion and Recommendations

Inadequate complementary feeding contributes significantly to poor nutritional status of children 0–5 years of age in Botswana. Concerted efforts are necessary to improve the diets of children 0–5 years overall and more specifically for children 6–24 months of age. While the government is currently providing *tsabana* to enhance the quality of the diets of children of complementary feeding age and *tsabana* is of high nutritive value, many children seem not to benefit from this food supplement. In many cases, as shown in some of the data summarized in this paper, caregivers consider *motogo* (soft sorghum porridge) as the primary complementary food compared to *tsabana.* This and other current complementary feeding practices present a challenge for many children.

These feeding practices are largely influenced by adults' conceptions of what constitutes a suitable diet for children and perceptions of how children should be fed. Unfortunately, these concepts are not consistent with the nutrient requirements of children and recommended feeding behaviours and therefore need to be addressed.

Empirical evidence elsewhere show that models that promote adequate nutritional status in children of complementary feeding age are those that promote consistent and effective nutrition education for caregivers, the use of animal protein in children's diet and the economic empowerment of caregivers. Where such an approach was used children of complementary feeding age had better diets and nutritional status compared to their controls (Neumann *et al*, 2007). It is therefore recommended that Botswana should consider adopting some of these principles.

Further, while fortified and centrally processed complementary mixes such as *tsabana* have a role in improving the diet quality, and thus the nutritional status of children of complementary feeding age, caregivers lack information on the nutrition principles that have been used in the formulation of such products, so they do not appreciate the nutritive value of such products. This lack of information may promote the inappropriate use of such products. In addition

when caregivers have locally available food resources that, if mixed well, can achieve similar objectives as the centrally processed mixes like *tsabana*, they often fail to take advantage of this opportunity. Therefore, it is important that caregivers are empowered to fully appreciate principles that underpin blended complementary foods and how they can employ similar principles locally in the preparation of complementary foods for their children.

Finally, it is recommended that Botswana undertake a comprehensive and nationally representative assessment of complementary feeding to help address complementary feeding behaviours across geographic, social and economic groupings in Botswana. Such an assessment and gap analysis should include the World Health Organization-endorsed indicators that describe complementary feeding behaviours for children 6–23 months old (World Health Organization, 2008). One such indicator is a summary indicator that identifies the proportion of children who receive a sufficiently diverse diet often enough to meet the nutrient needs of children in this period of rapid growth.

References:

Black, R. E, Allen L.H., Bhutta Z.A, Caulfeild L.E., de Onis M., Ezzati et al. (2008). Maternal and child undernutrition: global and regional exposures and health consequences, *Lancet,* 371: 243–260.

Clausen T., Charlton, K.M., Gobotswang, K.S.M, Holombe-Ottesen, G. (2005). Predictors of Food Variety and dietary diversity among older persons in Botswana, *Nutrition* 21: 86–95.

Cravioto J, Arrieta, R. (1986).) Nutrition, mental development and learning. In: Falkner F, Tanner J, Editors. *Human growth: A comprehensive treatise,* Vol. 3. New York: Plenum Press; 1986. p. 2/e.

Central Statistics Office. (2000). *Botswana Multiple Indicator Survey,* Government Printers, Gaborone.

Central Statistics Office.(2009). *Botswana Demographic Health Survey IV Report*, Gaborone.

Ministry of Finance and Development Planning and Ministry of Health, MOH and UNICEF. (1996). *Determinants of child nutritional status in Botswana: A national study*, Unpublished report.

Ministry Of Health (1996). *Micronutrient malnutrition in Botswana: A national survey to assess the status of iodine, iron and Vitamin A,* Unpublished report.

Neumann, C. G., Murphy, S.P., Gewa, C., Grillinberger, M., Bwibo, N.O. (2007). Meat supplementation improves growth cognitive and behavioural outcome in Kenyan children, *Journal of Nutrition* 137: 1119–1123.

Nnyepi, M.S. (2000). *The effect of the mother's choice and timing complementary foods on the growth of children in Gabane, Botswana,* Thesis Submitted to Michigan State University. East Lansing, MI.

Nnyepi, M. S. (2007). *Household factors are strong indicators of children's nutritional status in children with access to primary health care in the greater Gaborone area,* Scientific Research and Essay, 2(2): 055–061.

Nnyepi, M.S., Ngwenya, B.N. and Majelantle, R.(2008). Assessment of food insecurity and dietary diversity in the Okavango Delta and the potential contribution of indigenous foods, in Ahmed, A. (2008). *Managing Science and Technology for Sustainable Future;* WASD 2008 conference proceedings, Brighton, UK.

Rowland, M.G., Rowland, S.G. and Cole, T.J. (1988). Impact of infection on the growth of children from 0–2 years in an urban West African community, *American Journal of Clinical Nutrition,* 47: 134-48.

Schroeder, D.G. and Brown, K.H. (1994). Nutritional status as predictors of child survival, summarizing the association and quantifying its global impact, *Bulletin of the World Health Organization,* 72: 569-79.

UNICEF Botswana. (2010). *Nutrition Economic Study in the context of the rising food prices,* Unpublished report.

UNICEF. (2009). *Tracking progress on child and maternal nutrition. A survival and development priority,* New York, USA.

Victora CG, Adair L, Fall C *et al.* (2008) Maternal and child undernutrition: consequences for adult health and human capital, *Lancet,* 2008, 371(9609):340-357.

World Health Organization. (2005). *Guiding principles for feeding non breastfed children 6–24 months of age,* Geneva, Switzerland.

World Health organization. (2004). *Feeding the non breastfed child 6–24 months of age,* meeting report. Geneva, Switzerland.

World Health Organization. (2008). *Indicators for assessing infant and young child feeding practices*, Report of a consensus meeting held 6–8 November 2007 in Washington DC, USA.

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Distribution of long lasting insecticide treated bed nets

This article describes an initiative taken by the Government of Botswana, supported by UNICEF, to encourage increased use of Long Lasting Insecticide Treated Nets (LLIN) to protect people living in malarial areas against infection. It describes the approach taken to increase the use of such nets, the outcomes of the pilot exercise and the cost of the activity. The article is based on the Ministry of Health's paper (2009) on the pilot project on distributing LLIN in the Okovango sub-district.

Malaria is one of the major public health problems in Botswana and is endemic mainly in five districts in the northwest part of the country: Okavango, Chobe, Ngamiland, Boteti and Tutume. 28% percent of the country population live in these districts where over 80% of malaria transmission of the country occur. In 2009 the malaria incident rate in the endemic areas was 27 cases per 1,000 population. (National Malaria Control Programme, Ministry of Health). According to the 2007 Malaria Indicator Survey (MIS) in three of the malaria endemic districts, 9.4% of households have at least one Insecticide Treated Net (ITN). This is significantly below the level of 80% coverage by ITNs recommended by the World Health Organization (WHO). Only 6.5% of children under five years of age and 3.8% of pregnant women used an ITN to protect themselves from malaria. In response to this, Botswana has made the elimination of malaria a public health priority.

An innovative campaign supported by UNICEF linked the free distribution of LLINs to mothers and children to a Communication for Development (C4D) strategy. The strategy also benefited from the inputs provided by community stakeholders who participated in the Triple A exercise, an iterative participatory problem-solving cycle consisting of three consecutive steps: **A**ssessing the problem, **A**nalyzing its causes and initiating **A**ctions to improve the situation. The Triple A process helped to better tailor the intervention not only to the public health approach for malaria prevention, but also to identifying communities' needs as of when and how to use the ITNs.

C4D Strategy

The strategy included the following steps:

Training of distributors and their supervisors

The 10-day training for distributors and supervisors focused on knowledge on malaria and LLINs, functionality of bednets, proper usage and care of bednets, distribution process and logistics, specific roles and responsibilities of team members, data recording, interpersonal communication skills and use of Geographic Positioning System (GPS) to map out households and areas where LLINs have been distributed.

Training of community mobilization agents (demonstrators)

10 community-based drama performers received 2 days of training on basic knowledge on malaria including the definition, causes, prevention, symptoms and detection of malaria, focusing on the most vulnerable groups, children under 5 and pregnant women. The performers developed an interactive play giving messages on basic knowledge about malaria as well as demonstrating the proper use and benefits of using LLINs. Each village was covered by two performers.

Training of follow-up team

Health Education Assistants and members of the village health committees were trained

on interpersonal communication skills and assessment of proper use of bednets using the house-to-house strategy. Their role was to check and assess knowledge and skills among the population and collect data on proper hanging, frequency of use and care of bednets.

Community-based demonstrations

The demonstrations which preceded the bed net distribution took place in a total of 33 communities, to prepare communities for, and sensitize them about the up-coming mass distribution. In each village, LLIN demonstrators performed at local primary school and during *kgotla* (public meeting), presided over by the *kgosi* (traditional leader).

The presentations were interactive with performers engaging community members in a dialogue on issues related to malaria and benefits of using bednets. Community members actively participated in the demonstration; they came forth to feel and touch the net, hang it up and lie under it to have a feeling of the protective nature of the net. As a result, the communities easily related to the performers, understood the messages and demonstrated eagerness to practice the new behaviour once bed nets were distributed.

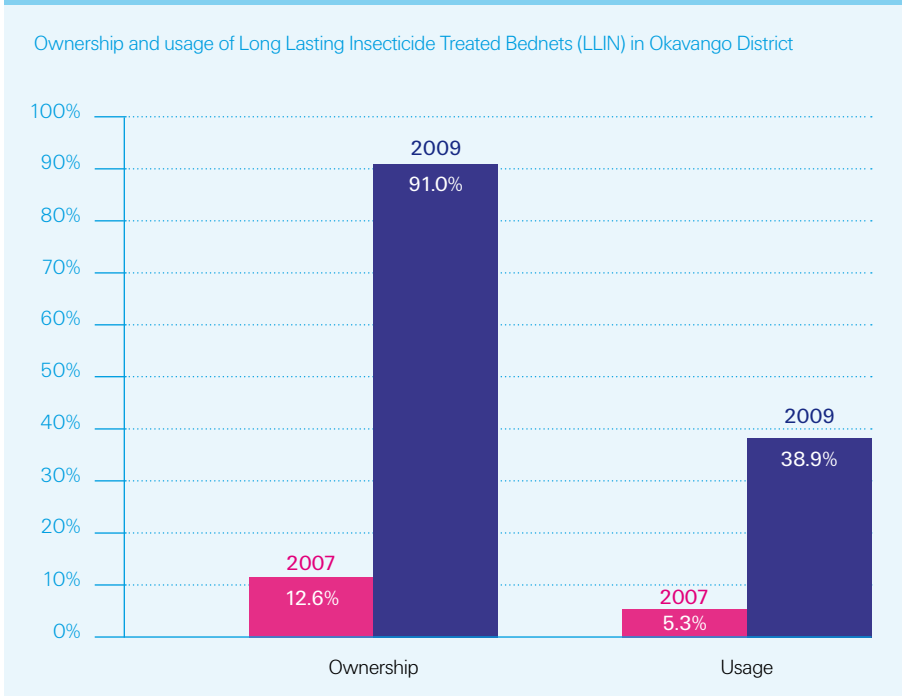
Mass distribution of LLINs

The mass distribution of LLINs followed soon after community demonstrations in each location. During the distribution, each household was provided with a calendar with peak malaria months shaded in.

Partnerships, local structures, services and resources

This was a tripartite project funded by Ministry of Health, the Okavango sub-district, the Clinton Foundation who had acquired the LLINs through Malaria No More and UNICEF. Local structures involved in the project included traditional leaders, clinics and community health workers, as well as the Village Health Committees in each village.

Figure 1 Increase in LLIN ownership 2007–2009



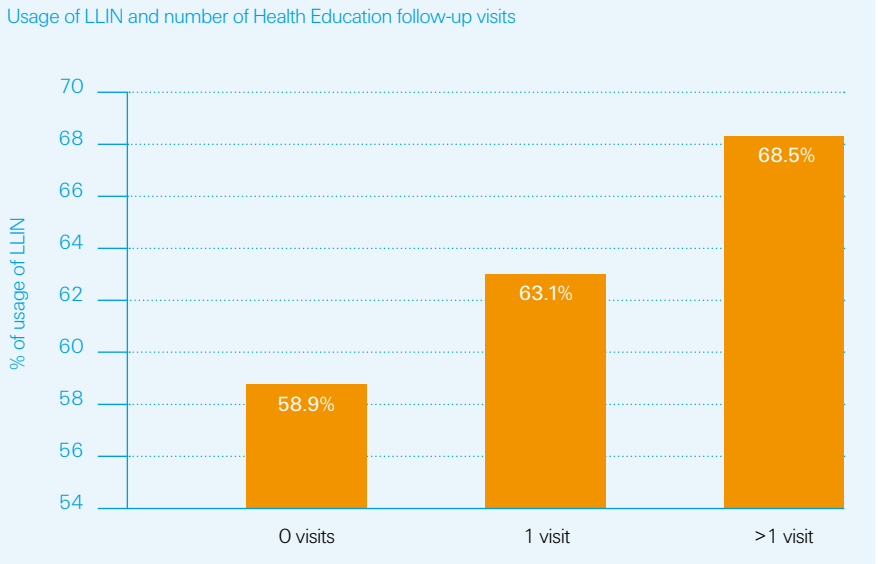
Progress and results

The mass distribution of nets was completed at the end of March 2009 and a total of 33,000 nets were distributed in Okavango sub district. Each household was given bednets according to the number of sleeping spaces or the number of people living in the household, based on the assumption of one net for every two people.

A post- distribution survey gathered data to inform policy makers and future distribution methodologies for an LLIN distribution scale-up. A questionnaire based on the 2007 Malaria Indicator Survey was used to interview 557 randomly selected households throughout Okavango to assess coverage indicators (i.e. ownership and usage) and information, education, communication (IEC) message retention. Key results from the evaluation report are as follows:

53,578 people (or approximately 91% of the total sub-district population) were covered by this distribution, including 8,937 children under five (16% of total population) and 845 pregnant women (1.5% of total population). The pilot project was successful in quickly scaling up LLIN ownership in Okavango from 12.6% of households owning at least one ITN in 2007 to 91% owning at least one ITN in 2009, over 90% of which were LLINs distributed in the pilot of surveyed households. ITN usage also increased from 5.3% of Okavango women sleeping under a treated net in 2007 to 38.9% sleeping under a treated net in 2009.

Figure 2 Rate of usage of LLIN according to health education visits made to household



A number of challenges prevented many health education assistants (HEA) and village health committee (VHC) teams from starting their door-to-door follow-up campaigns. As a result, by the survey in May 2009, only 32.6% of households reported being visited by HEAs or VHC members to discuss LLIN usage. Only 4.7% reported being visited more than once. However, while 58.9% of households with 0 visits used an LLIN, 63.1% of households that received 1 visit used an LLIN and 68.5% of households that received more than one visit used an LLIN. These differences are significant (chi square 6.9857, df=2, p=0.0304) and indicate that health education visits are associated with higher usage.

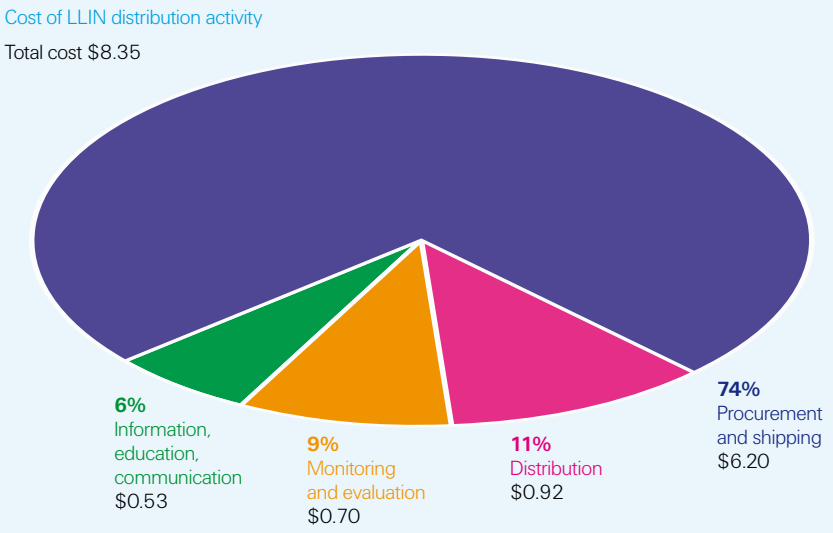
Posters explaining the use of LLINs were also issued to households. It was found that households with a visible poster were 26% more likely to use a LLIN than those either not displaying a poster or never having received a poster among those who received LLINs (RR 1.26, 95% CI 1.17=1.35, P<0.0001). Households with a visible poster were also more likely to use an untreated net, an interesting association that implies further community education on the importance of a treated net, although the poster explicitly stated to use a net with insecticide. The difference between the use of non-pilot distributed nets and ITNs and whether the household had a visible poster is small and not statistically significant.

The total expenditure for the Okavango LLIN pilot was $272,590, or $8.35 per LLIN distributed in the pilot. The cost of consumables contributed to the majority of costs (Figure 3), with personnel costs contributing 12% to overall expenditure. The nets themselves cost $5.65 (extra-large) and $4.89 (single). Training, transport and activities, such as poster design and printing, contributed the remaining 12% to the total cost.

Since 2009, this strategy has been expanded beyond the Okavango sub district to the four other malaria endemic districts. About 20,000 ITNs were also distributed in Ngamiland, another malaria endemic district. In 2010, the project has been scaled up to the five malaria endemic districts (Okavango, Ngamiland, Chobe, Boteti and Tutume) where 96,000 bednets have been distributed as of July 2010. Over the last two years, the project managed to distribute almost 150,000 LLINs.

To sustain the positive changes, it is planned to scale up the pilot model including community involvement, sensitization and LLINs free distribution by health workers targeting children and pregnant women, in addition to further stand-alone campaigns in five remaining malaria endemic districts. This scale-up of distribution will be evaluated in 2011 and nets will be then made available to district health offices and health facilities.

Figure 3 Costs composition per LLIN



References

Ministry of Health, Republic of Botswana (2009), *Door-to-Door Distribution of Long Lasting Insecticide Treated Nets: Okovango Sub-District Pilot Project Report,* (Working Draft, December 2009).

Child-rearing practices in Botswana: a challenge for developmentally appropriate education and career choices

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Introduction

Children all over the world are born into a specific culture. According to the socio–constructivist approach to cognitive development, culture shapes their thinking and personality. Children cannot make sense of the massive multifaceted stimulation without the help of child-rearing practices (Feldman 2007, Vygotsky 1978, 1986). Therefore, culture plays a pivotal role in child development. Cultural values and attitudes regulate the childrearing values, developmental expectations and emotional orientations of caretakers, and their child-rearing scripts for achieving valued developmental outcomes, in addition to the physical and social settings of everyday life (Rosenthal 1999).

Parents' beliefs and practices about children and their development are defined by what is considered adaptive in their cultural setting. For instance, in African settings, cultural groups are often characterized by more 'collectivist' or 'inter-dependent' cultural scripts. African cultures value collective goals more highly, such as learning to live in harmony with one another, competent participation in social events, obedience to authority, and a cooperative and altruistic orientation (Rosenthal 2000). The western culture is often characterized by an 'individualistic' cultural script, which is usually related to the acquisition by an individual of competence and independence, and which often values competition.

The African cultural goals and expectations mediate the daily experiences of children, their interactions with the persons, objects and symbols in their immediate environment (Rosenthal 2000). Cultural values and traditions are mediated by more proximal processes of child-rearing, such as specific child-rearing practices (Hwang, Lamb and Sigel 1996), which 'drive' their development. Research studies have provided several examples of cultural

variation in child-rearing behavior, which indicate potential sources of incongruence in child-rearing practices between home and child-care settings. For example, the extent to which parents take into account the wishes and feelings of the child and encourage expression of feelings differs according to the extent to which the culture values individuality or ability to function as a group member (Kagan 1984; Lee 1959). Parental discipline styles (for example, use of reasoning, showing disapproval, redirecting behaviors, using 'time out' or physical punishment) vary according to whether or not a culture believes external controls lead to self-discipline (Gonzalez-Mena 1997).

In traditional Setswana culture children have ample opportunity to interact with the parent and adult work, which generally occurs in the home settings. Parenting practices, in the universal sense, shape the lives of children. At the minimal level, Setswana families do share a common language (Setswana), religion, ideas concerning family, and Batswana ancestry that can lead to a common view of Batswana families if examined at the surface level. In a general sense, families of Batswana subscribe to the integral nature of family in their daily lives; functional dominance of males, complemented by a positive traditional role for women, reinforcement of sex-role distinctions through child-rearing practices, strong kinship bonds, centrality of children, and a precedent for the male as head of the household. According to Piaget (1930, 1963), a child is an active agent who constructs his or her own knowledge. Just after birth a child becomes a busy, self-motivated explorer of the environment, who forms ideas and tests them against mother first, secondly against the family and lastly the community at large.

Lev Vygotsky emphasized that the rich social and cultural context passes or fails the child's ideas. According to him human cognition is culture based (Vygotsky, 1986). Setswana culture of child-minding provides ample opportunity for the child's exploration. There are intense social interactions at every stage of development from Botsetsi (a stage in which the delivery mother would be secluded post-natally, in a room to stay with the new baby for a period of 3–6 months traditionally, while nursing the newborn with a view to protect the baby from exposure to infections, communicable diseases as well as to provide optimal care, under the guidance of significant others, who have themselves experienced motherhood, in addition to other cultural rituals or beliefs that are observed in tandem with child monitoring) to young adulthood cultural training and mentoring. The parenting responsibilities and skills go a long way in socializing the child and ensuring that their intellectual development is appropriate for their cultural roles in the home, community and society at large (John, Dambe, Polhemus & John, 1983; Kann, Mapolelo & Nleya 1989; Mwamwenda 1989; Losike-Sedimo 1996). Culture moulds the child and influences who they will become in the future. A problem arises when the cultural influence is not used to advance the child's development be it socially, psychologically, emotionally or academically. There is also considerable variation in the ways that adults organise children's learning, ranging from deliberately arranging learning opportunities to relying on child-managed imitation and modelling (Sigel and Kim 1996; Gonzalez-Mena 1997).

Child-rearing practices in Botswana and cognitive development

Methodology

Research on the cognitive development of Batswana children has been extremely limited and narrowly focused. A major focus has been placed on language and its relationship to intelligence-test performance, academic achievement (Ramahobo, 1992; Losike–Sedimo, 1996). There are practices of Setswana culture which have been observed to have a direct bearing on cognitive development and career choices. Based on a cognitive development theory by Jean Piaget (1926/30) a qualitative survey was designed to investigate the

relationship between culture and cognitive development in Botswana. After receiving a research grant from the UB Office of Research and Development office, permission was obtained from two relevant ministries to conduct the study. We also obtained access and consent from participating villages, parents and children. The current study examines the relationship between Batswana parenting techniques and child cognitive performance on education and career choices. A number of questions were raised by the researchers: What more do we need to know about parenting beliefs, goals, and practices in the early socialisation of children to guide decisions about intervention strategies? How do different child-rearing practices influence social and cognitive outcomes in relation to their education attainment and ultimate career choices? Videotaped interviews and focus group interviews nationwide were conducted. Data were collected, transcribed, content analyzed and interpreted.

Findings and discussion

The results revealed that culture affects cognitive development in Botswana. Parents' beliefs, mostly mothers', influence development of early cognition; child-rearing practices in general influence both cognitive development and what the child chooses to be when they grow up. And that cultural cognitive ability is one of the facilitators of academic achievement. Similar findings were reported by (Ramahobo, 1992; Losike–Sedimo, 1996; Mwamowenda 1989; Eisenberg, Zhou, Spinrad, Valiente, Fabes, & Liew 2005 Losike–Sedimo, 2009). The role of the family is a very important dimension that influences the later social and cognitive performance of Batswana children (Losike–Sedimo, 2009; Reglin *et al,* 2003; Ramahobo, 1992). Children residing in nurturing and responsive environments benefit in social and cognitive growth (Garmezy, 1993; Taylor & Machida, 1994). The warmth and positive parental interactions with children and the responsiveness of the caregiver have been shown to be positively related to children's social, linguistic, and cognitive outcomes, which, in turn, influence future academic achievement and readiness (Brody, Stoneman, & McCoy, 1994; Estrada, Arsenio, Hess, & Holloway, 1987; Scott-Jones, 1987).

Children in villages and tribal cultures observe, learn and participate in cultural chores. In towns or cities in Botswana, children are mostly excluded from participating in parents' work or chores. Parents work in settings outside the home and parents hire house workers and child-minders. In towns and cities the work of equipping children with skills they would need to become competent workers and fitting members of the society is largely assigned to schools. Six-months-old to five-year-old children are sent to pre-primary schools which are privately owned and may be expensive. The child-parent interaction focuses on school home work from early childhood to secondary school education. In contrast the study showed that children in rural villages learn tribal culture by being participant observers. They spend many hours in contact with family members, doing their cultural duties or learning by observation as adults do their chores. Consequently they assume mature responsibilities at the childhood stage. This was also found to be true for the Republic of Congo and Guatemala (Rogoff & Chavajay 2003).

In an ethnographic study conducted in the southern part of Botswana (Jankie, 2001), it was observed that when young children are allowed to participate in daily cultural life structured around adult work, their competencies differ considerably from those of typical western preschoolers. This was also observed by Gaskins, Haight, and Lancy, 2007. A typical day in tribal cultures of most villagers is spent in farm work or household work. Men look after cattle, goats, sheep, donkeys and other big domestic animals. They also work in farms. Boys assist them until they are ready to take over. Women work in the farm, prepare meals, wash clothes, keep children, watch small stock, and work in home gardens assisted by daughters until they are ready to take over.

The progression of Batswana children through Piagetian stages

Every cultural task done contributes toward the achievement of a specific developmental task that will indicate to the family the intellectual maturity of the child. When the child reaches that milestone he or she is ready to go to school or to assume mature responsibilities. According to the results the sharper and competent the child is in carrying out cultural developmental tasks, the more intelligent he or she becomes. These abilities include, for example, having a longer attention span, attention seeking behaviours, speaking, counting and accounting skill, responding eagerly to adult instruction, just being quiet and having observation skills. By age 13/14 rural children have usually gone through the four stages of Piagetian cognitive development (Mwamwenda, 1989; Polhemus & Moorad, 1982). Other studies that linked cultural influence with intellectual development investigated the link between cultural maturity as indicated by readiness to carry out traditional chores and other non-formal education experiences, and academic achievement. The studies found that cultural maturity (developmental tasks) influenced academic achievement. Such abilities include number conservation, classification e.g. how many cows of what gender and colour, mass conservation, transitive inference, understanding other people's perspectives, and reading comprehension (Bigala, 1993; Losike-Sedimo, 1988; John *et al,* 1983)

Child-rearing practices and career choices

The study found that early stimulation by parents whether of tribal culture or western culture provides a good education to children. The concept of assisting or scaffolding the child was observed to be an influential factor in achievement. This has been observed in other parts of Africa such as Uganda where the parenting style equips children with skills, knowledge and attitudes that prepare them to be high achievers, confident and competent members of the society (Otaala, 1995). Culture also is believed to play a role in determining the level of confidence with which childrearing ideas are held by parents, and it seems to influence the extent to which parents may be prepared to be flexible in the light of new information (such as that provided during parent education). Thus, parents are likely to change or to resist change depending on whether the new information they receive is in accordance with the views held by people who are similar to them in terms of ethnicity, culture, or socioeconomic status. Whether or how new knowledge helps the parent to achieve culturally or locally valued goals may determine the success of the child's socialization and parent-to-child education.

Conclusions and recommendations

The conclusions reached by this study were: child rearing practices can prepare children for formal education, and that culture influences cognitive development and academic achievement.

1) *Recommendations for applications and educational implications*

Parents and teachers should a) consider appropriate social skills, stimulation, beliefs, activities and practices that enhance high levels of thinking, and b) aim high for profitable careers by exposing children to adult work of both traditional chore and modern jobs. c) The governments' effort to improve on the quality of education should consider embarking on strategies that will incorporate the cultural influence in school learning and teaching. d) Situating educational tasks accordingly (in terms of learners' cultural knowledge and skill) to reduce cultural bias in psychological testing, an approach called 'dynamic assessment' can be used (Berk, 2009, pp 340).

2) *Recommendations for community development*

a) Positive parenting for maximum stimulation and social interaction. Parents can be educated through health clinics, PTAs, other community organisation, and local media on the

advantages of raising children in a way that moves them forward by using appropriate parenting styles. b) It is also recommended to set up universal kindergartens for communities in both urban and rural areas. Vision 2016 and Millennium Goal 2, require achievement of universal primary education and an informed nation by 2016. The setting up of community pre-schools will ensure that children everywhere, boys and girls alike, will be able to complete a full course of pre-school education. The current basic education system should be expanded to integrate current infrastructure with a universal model of pre-primary education. Early childhood care and education currently remain a privilege for children in urban areas. The establishment of universal preschools would harmonize the disparities between traditional rural cultural villages and urban areas.

References

Arthur, J. (1998). Institutional practices and the cultural construction of primary school teaching in Botswana. *Comparative Education,* 34(3), 313–332.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice Hall.

Berk, l. E. (2009). *Child development* (8th Ed.). Pearson Education. Inc.

Bigala C.J.B., Monau, R., Seboni, N. (1993). *Learning needs of Botswana Children.* Gaborone: UNICEF.

BOTSWANA MINISTRY OF EDUCATION (1998). *Ministry of Education Policy on HIV/AIDS Education.* Gaborone: Government Printers.

Brody, G. H., Stoneman, Z., & McCoy, J. K. (1994). Contributions of protective and risk factors to literacy and socio-emotional competency in former Head Start children attending kindergarten. *Early Childhood Research Quarterly,* 9, 407-425.

Chilisa, B. (1987). *Who gets ahead in education: A cross-sectional survey of primary, secondary and university students from Mochudi.* Unpublished M. Ed Dissertation. Gaborone: University of Botswana.

Cole, M. (1996). *Cultural Psychology.* Cambridge, MA: Harvard University Press.

Eisenberg, N., Zhou, Q., Spinrad, T. L., Valiente, C., Fabes, R. A., & Liew, J. (2005). Relations among positive parenting, children's effortful control. *Child development,* 76, 1055–1071

Estrada, P., Arsenio, W., Hess, R., & Holloway, S. (1987). Affective quality of the mother-child relationship: Longitudinal consequences for children's school relevant cognitive function. *Developmental Psychology,* 23, 210–215.

Feldman, R. (2007). Parent infant synchrony and the construction of shared timing. Psychological precursor, development outcomes and risk conditions. *Journal of Child Psychology and Psychiatry.* 48, 329–354.

Fuller, B. & Snyder, C (1991). Vocal teachers, silent pupil? LIFE in Botswana classrooms. *Comparative Education Review,* 35. 274–279.

Garmezy, N. (1993). Children in poverty: Resilience despite risk. *Psychiatry,* 56, 27–136.

Gaskins, S. Haight, W & Lancy, D.F (2007). The cultural construction of play. In A. Goncu & S. Gaskins (Eds.), *Play and development: Evolutionary, sociocultural, and functional perspective* (pp. 179). Mahwah, NJ: Erlbaum.

Gonzalez-Mena, J. (1997). *Multicultural Issues in Child Care* (2nd ed.), Mayfield Publishing, California.

Gonzalez-Mena, J. (1993). *The Child in the Family and Community.* Merrill, New York.

Hwang, C. Lamb, M. & Sigel, I. (1996). *Images of Childhood.* Lawrence Erlbaum, Hillsdale, NJ.

Jankie, D. (2001). *Rethinking Setswana literary practices: Towards incorporating community-based and students' experiences in senior secondary classrooms.* Unpublished doctoral dissertation. Madison: University of Wisconsin.

John, M Dambe, M. Polhemus, S. & John, F. (1983). Children's thinking in Botswana. *Boleswa Educational Research Journal.* 2 (1), 5–17.

Kagan, J. (1984). *The Nature of the Child.* New York: Basic Books.

Kann, U Mapolelo, R. & Nlea P. (1989). *The missing children.* Gaborone: National Institute of Research (NIR) unpublished report.

Lee, D. (1959). *Freedom and Culture.* Prentice Hall, Englewood Cliffs, NJ.

Losike-Sedimo, N. C. (1988). Family background and achievement. *Proceedings of the BERA Annual Conference.* Quick Print. Gaborone: Botswana.

Losike-Sedimo, N. C. (1996). Cognitive Development and Child Rearing Practices in Botswana – A challenge for Quality Education. *The Journal of Special Education Research Review,* 1(1).

Losike-Sedimo N. C., & Reglin L. G. (2004). Educational research and indigenous knowledge systems: Application to instructional process in higher learning. Considering learning styles. In Maziboko, E., Sakuti, W., & Gathu G. *Educational Research and Knowledge systems.* MZ: Swaziland. Educational Research Association publication ISBN, 95018831-X (p110–124).

Losike-Sedimo, (2009). The Adolescent: Development, Relationships, and Culture. *Journal of Psychology in Africa.* July issue, 19 (2) pp289–290.

Makgoba, M. W. (1999). *African Renaissance.* Cape Town. Mfube and Tafelberg Publishers.

Mpaphadzi Mishingo. (1985). *Botswana 85: An Official Handbook.* Department of Information and Broadcasting. Government Printers. Botswana.

Mwamwenda, T.S. (1989). *Educational Psychology. An African Perspective* BW: Durban Publishers.

Otaala, B. (1995). Botswana commitment to its children. After JOMTIEN and way forward. *Sixth Boleswa Symposium Proceedings.*

Piaget, J. (1963). *The origin of intelligence in children.* New York, Norton.

Piaget, J. (1930). *The child's conception of the world.* NY: Harcourt Brace & World.

Polhemus, S. & Moorad, F. (1983). Conservation training in small groups. *Boleswa Educational Research Journal* Gaborone Botswana.

Ramahobo L. (1992). *The girl child in Botswana. Educational constraints and prospects.* Gaborone: UNICEF.

Reglin G. L., King, S., Losike-Sedimo, N. C., & Kettere, A. (2003). Barriers to school involvement and strategies to enhance involvement from parents at low performing urban schools (lead article). *The Journal of At-Risk Issues* 9(2), 1-7.
Rogoff, B. (2003). *The cultural nature of human development.* NY: Oxford University Press.

Rogoff, B. & Chavajay, P. (1995). 'What's become of research on the cultural basis of cognitive development?' *American Psychologist,* vol. 50, pp. 859–877.

Rosenthal, M. (2000). 'Home to early childhood service: an ecological perspective', *Children's Issues,* vol.4, no.1, pp. 7-15.

Rosenthal, M. (1999). "Out-of-home child care research: a cultural perspective", *International Journal of Behavioral Development,* vol. 23, no. 2, pp. 477–518.

Scott-Jones, D. (1987). Families and academic achievement: Risk and resilience. In M. C. Wang, M. C. Reynolds & H. J. Walberg (Eds.), *Handbook of special education research and practice: Emerging programs* (Vol. 4, pp. 255–267). Oxford, UK: Pergamon.
Sigel, I. & Kim, M. (1996). 'The answer depends on the question: A conceptual and methodological analysis of parent career believes, behavior interview regarding children's learning', in S. Harkness & C. Super (Eds.) *Parents' Cultural Belief Systems: Their Origins, Expressions and Consequences* (pp240) The Guilford Press, New York.

Taylor, A. R., & Machida, S. (1994). The contribution of parent and peer support to Head Start children's early school adjustment. *Early Childhood Research Quarterly,* 9, 387–405.

Vygotsky, L.S. (1978). *Mind in society. The development of higher mental process.* Cambridge, MA: Harvard University Press.

Vygotsky, L.S. (1986). *Thought and language.* Cambridge, MA: MIT Press.

Traditional education of San Children and how it differs from the modern education system in Botswana.

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Based on a paper delivered at UB San Centre opening seminar, Gaborone, Botswana, April 2010.

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Introduction

We as the San parents do appreciate the opportunity to discuss the things that affect our children's education.

In the days before our children went to school, especially the school as people understand it today, they were also educated. Education is not something that was born today. I think all people had ways to educate their children in the past, before the modern schools were there, but I would like to tell you more about how it was with the San. (We are also known in Botswana as Basarwa or Bushmen but we prefer to be called by the names of our groups, for example the Nc oakhoe, in the Naro language).

Today the kind of education our children receive in the schools does not respect our old ways and do not keep in mind that there was an education system before. This is one of the main reasons our children continue to suffer and often drop out of school. Maybe if you could understand how we taught our children, and would still like to do even today, you might understand better why our children are not progressing as well as they could and why we as parents sometimes do not want to send our children to the schools of today.

San Education of the past

Ours was an education based on how the child should live a life of respect towards his parents, grandparents, uncles, aunts and siblings. Besides knowing what to do to find food, knowing how to live with other people was the most important thing that a child had to learn. Therefore each child, boy or girl, had to be endowed with such education, and with time, and

careful interaction with the child night and day, it led to incredible insight in how to live without conflict, how to share equally with others and how not to step upon or hurt other people. As a child grew up, he or she grew to know the difference between good and bad and soon could distinguish beauty from ugly, not told by others but understanding it with their insight, which we helped to develop in a way of not prescribing but leading, all the time with enormous respect for the child. This is why the child cherished the advice of his elders, but also that of his siblings and all other people in his or her group who were all educators. Children knew they were treated as an important part of the community therefore you would seldom find a child that would rebel against traditional education, as they all wanted to live up to the expectation of who they would become.

Of course the child had no power or authority, and not any liberty or permission to perform tasks that were beyond his or her capabilities and abilities. Care for the child's wellbeing and safety was always one of the biggest concerns. The child was allowed to try out things, however, and to learn by experimenting with those activities deemed safe by his seniors. And these seniors included not only the direct parents and grandparents, but all who lived with the child and had his best interest at heart. Our traditional education treated children as important members of the tribe, and they also had a voice, as egalitarianism was so much part of our life. This way, of including children into the ranks of the group and not treating them as people who lack something or do not know anything, is the big difference between the education of our people which we still try to practice at home, and that which our children receive today at the schools all over the country, especially in the boarding schools.

In the days when we could live just by ourselves, there would not be any chance for a child to partake or even know about the intake of any fermented substances. The San parents living in this day are struggling to live with other people who do these things, therefore we now know the bad effect of such substances, and we have seen that our people's development is held back by things like alcohol and smoking drugs. It is especially terrible and bad for us when taken by our children. However, life of today has done this to us, many of our people now also struggle with these things and this has proven to be very bad for us and for education.

Separate education for boys and girls

In the past the way boys and girls were taught was very different. It still is like that in most cases, especially there where we still have access to our children because they have not been taken away too far from us to continue our own education with them. We taught the boys to be strong and have a mature mind, even at a tender age we started to talk to him about male responsibility, as a boy knew from very young that as he grows up, he would have to know his survival skills in the veld, to support his family and the group. Things like how a woman gets pregnant and how people are born, such topics were not needed for him to know until he came of age. Not like today, when all these issues are discussed with all the children together even if they are not ready for that. We knew that a boy would find these things out by himself between the other men when he was ready to be told, and when he started to have a family of his own, he would learn the rest.

At the right time, each boy would be taken out into the wild to be taught or to be initiated. This period would last for at least one or two weeks, and was such a crucial part of the culture and the child's education that it could not be missed. The reality of today is that the school system does not respect this need or give us this time we need with our boys, and therefore they are far away at schools during the time for initiation and they are left to fend for themselves without proper knowledge or the support of the elders.

Amongst other things the boys were taught during this age was that boys with the potential to become spiritual healers were by now identified and this was the time during which this gift was supposed to be nurtured. To become a man, this was the time there were certain practices and teachings to help them to connect with their centre of deityship. Even myself, as I talk here, I could not experience this initiation, as our lives were already uprooted. But my elders told me about it and its importance in our society, as they had the experience of being some of the boys who still could be initiated or they had had close contact with those who had been initiated. All I understood from this was how important these lessons had been, to build leadership and responsibility, and I have learnt how sad are those who know what they were told, now that no-one values this information and the people who had learnt it anymore. How can education be real if it does not address the heart of a culture? The worst is, as time passes, some of these traditions are being forgotten, lost forever, which is too bad.

Education for a girl child in the past was different and when she was small most of her learning centred around how to look after her family and the clan, how to be a responsible member of a group of people who can fend for themselves in all circumstances. Her most important education phase happened at that very moment when she received her first menstruation. This is still so in most instances today where it is still possible to teach girls in this way. Here is the beginning of a whole education process, and the things taught are so sacred and important that no men are allowed to take part. The whole thing is carried out by the women. This girl initiation still happens in most of the San families and we strongly believe in it because we think that it is the perfect chance and an important moment to talk to the girl, who is now becoming a woman herself. Before she has to enter into the gates of womanhood, she has to go through some life education and learn about the traditional taboos and the reasons they were supposed to be kept. I will not go into these taboos, as we even to this day believe in them and we mix and grind these values and taboos together as the guidance a girl child would need to be a responsible woman, the most important part of her life education. I will only say that if some of these taboos were taken seriously today the problems of our girls and young women would have been less.

But even here, the schools are not on our side, and do not make space or time for this education. The way it is replaced by sexual education in schools also does not touch the whole concept that our traditional education taught, as the knowledge was based on our survival, respect for life, and the taboos and teachings supported that. There is no way the things they learn in school can give them the same value for life nor the respect they gained as an adult in the San community who have gone through that kind of education. It is a real pity.

Another overall important aspect of our traditional education was also to instill the concept of *No Thievery* from a very young age. You can understand that people who lived as closely together as we always had, and who had to share the scarce resources of the veld, they would have to strive to survive on what is in their territory and only their territory. For their survival, they all had to agree to hold and cherish their value system, so that if there was famine in their territory, they would first ask permission to hunt from the territories of the other San group nearby. This would then also imply that they would share with the others their killings and gatherings, before taking it to their clan only.

Can you see how such a life was based on respect, and therefore, it was important to educate children with that kind of sharing values and respect for others' possessions? Can you also see that during those times, there would be no deliberate danger to the children growing up inside such a value system?

The situation today

But what has happened today? We are being told that the education our children should all strive for, and for which they are taken away from us and from our traditional life, would make life better for them. But a lot of very bad things are happening in this world and even in the way this education of today is forwarded to our children! Our children now know too much, and at the same time too little. They know too much about unnecessary things, and they see a lot of bad things, even from those who are supposed to show them the way of good behaviour. They hear a lot of disturbing things and mostly none of our own people are there to help them get insight into the bad things they hear. They end up experiencing adult things at a very young age, things they cannot understand or handle, especially since they do not get any of the community's own ways of education to help put things back in balance. They are out there on their own, being taught other people's values and ways without their own people's guidance or involvement. No wonder many of them become like a loose cannon and are difficult to control, not only by the teachers but even by us, their parents.

How can it be otherwise? People say our children drop out of school because they do not want to learn. People say the San parents are not interested in education. But that is not true. It is just that there is no adult care and no adult interest to shape the future of our children, and help them to serve the bigger purpose and bring them to maturity. The education system does not ask us how our children should be taught and it gives us no way of influencing their lives anymore. Now they are left alone to do what they want to do at any time of their preference. When they are alone and bored, they are being given things to do like watching TV and then they become fascinated by the strange things they see and they try to do what they watch. That is how we used to teach them, by showing them how to do good things. Showing them bad things and leaving them by themselves to try it out is dangerous education, it becomes like a hazardous infection.

There is also the issue of punishment. In the past our children understood why they were punished and how to expect punishment. Now it is given to them in a way that often makes them aggrieved, and also, that punishment can be so severe that the one who had issued the punishment can be tried by the law. This is all because we have lost our borders and we are not consulted, only informed by people who do not understand our ways. Today the children are told they have rights, so many rights, but it is not told to them in a way that they understand the role of these rights, and it makes their parents become powerless, and not respected by the children. At the same time, these parents have lost their understanding of where their traditional education fits in with what their children are learning at school, and in this bewilderment all sides abuse their rights and the children become immune to certain punishments and no longer sensitive to guidance.

I do not want to cast away the importance of the education of today. Our people have to know what others in this country do, and we need to stand next to all others in education and in power. However, what I want to say is that traditional education should be intermingled with contemporary education. The two systems could learn from another, so that the essence of each one of the systems and the good of both could come together and that would mould the children of today the way we all want them to be. Education should make a person proud of who he or she is, and therefore not take them away from their origins and language. If we are to create something meaningful, and build a strong nation, we need to introduce mother tongue education in schools and season the curriculum with information from our cultures. We need a new system of education where every child, no matter his or her background, may feel right at home, respected and recognised.

The blending of lessons learnt from San education systems is not going back to a past that is no longer relevant. Learning from something which was good, and keeping that which has worked when one moves forward, that will bring us an education that will have us all wake up in the morning to find our children already awoken, preparing everything that needs to be done in the morning because they want to participate and want to progress, and they want to listen to us when we speak.

Conclusion

If we speak of education, we are speaking of culture. Contemporary education is western culture, a culture we have all come to rely heavily upon and then we call our own cultures old tradition and call it backward and tend to wave it away. Let us not forget that we are who we are today because of our own cultures. We give our children western culture and teach them other peoples' languages, encourage them to respond to us and to other people in those languages every time. We speak foreign languages to them through mobile phones and we try to use the new languages for writing to our children. But why can we not write letters to them in our own languages? Why cannot the school books teach our children about their own people's past achievements, knowledge and history, but also acknowledge their present contribution to this country?

Not only are we denying our children the privilege of knowledge shared with them through our traditional education but by not asking the authorities to include more of our own knowledge or giving us the time and respect to continue with it ourselves, we deprive our children of their social and cultural roots. Soon we will all be gone, and they will have become confused children, and their children will find themselves to be people without a history. They will read about their past culture in books as if it was about strangers, and will get bored by the little details and forget about it because they are not taught to be proud of it, even at home. This process is happening, and this is dangerous education. Let us all work together to see how the education system in Botswana can honour the people it serves and how it can reflect all cultures. Let us care for all the children in this country as if all of us are equals in a democratic state.

Cultivating sanitary habits among children: insights from a study on school toilets in Botswana.

Introduction

The status of toilets which are available in various communities can be used as an indicator of the country's health status and its commitment to Millennium Development Goals (MDG) related to health and the environment. Toilets tell a story about the environmental, economic, social, and cultural conditions of any community. According to UNICEF (2000a and 2000b), inadequate sanitation facilities and poor hygiene are global problems that directly contribute to the spread of preventable diseases. Similar studies have shown that more than half the world's children's health and lives are at risk due to poor sanitation systems (Chang, 2002; UNICEF, 1997). The sanitation systems extend to public institutions including schools. As such, the risk is likely to be even greater in the school environment where children share toilet facilities. Furthermore, surveys conducted in some developing countries (Chang, 2002; Mara, 2001; UNICEF, 1997), revealed the poor quality of sanitation and hygiene promotion in schools.

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The purpose of this study was to investigate the status of toilets in primary schools in Botswana. More specifically, the objectives of the study were to establish the level of awareness of basic hygiene practices while using toilets among children, identify children's concerns regarding the provision and use of school toilets, and observe and assess the status of toilets in government primary schools.

Methodology

The data were collected in 2006 from five urban areas in Botswana namely Jwaneng, Gaborone, Lobatse, Francistown, and Maun. For each area, 3–4 schools were selected by systematically selecting every third school from the Telecommunication Directory, under the Ministry of Education section. A total of 13 primary schools were selected. The age range of children interviewed was six to thirteen years. One hundred and twenty eight persons including teachers, head-teachers, cleaners and children were interviewed. An observation checklist that consisted of 21 items was developed and used to record the physical condition of the toilets at the time of the visit. A six-item interview guide was also developed and used to collect data from pupils. The items required the children to describe how frequently they used the toilets, their general behaviour when using the toilets, and any challenges they had regarding the design and use of toilets in the schools. In-depth interviews were conducted with school heads, teachers, and cleaners to confirm information given by the children and also to gather information on the management of the school toilets. All interviews were tape recorded and later transcribed verbatim.

The analysis of qualitative data was done using the thematic approach and descriptive statistics to determine frequencies of occurrences of phenomenon.

Findings

The findings of this study are shown below:

The children were asked to describe what they do when they get into a toilet. Their responses were grouped according to practices before, during and after using the toilets as presented in the figures below:

Figure 1 Practices before using the toilet

- Check if the toilet is dirty, wipe the toilet seat
- Check for a clean toilet and use it
- Get toilet paper from teachers
- Put papers on the toilet seat and then sit
- Check for water on the floor and toilet seat for cleanliness
- Wipe toilet seat with their own personal tissue, then sit
- Wipe the toilet even if it is clean, put a layer of tissue on the toilet seat then use it
- Flush before use
- Look for a clean toilet, if not available, they wait until they get home
- Check for a clean toilet if there is none, relieve themselves outside
- Spread newspapers on the seat and then sit
- Wipe the seat and then sit on it, if there is nothing to wipe with, squat.

Figure 2 Practices during use

- Sit on the toilet then urinate or defecate
- Stand at the urinal and urinate
- Squat on top of the toilet seat
- Stand by the urinal to urinate making sure not to mess the floor
- Stand on the seat, making sure that they do not mess the toilet and urinate
- Sit on the toilet and use it without checking

Figure 3 Practices after using the toilet

- Flush, wait to see if everything has gone down, wash hands, then dry them with toilet paper
- Shake water from hands, look in the mirror and fix hair
- Wipe the seat, flush, wash hands and close the door
- Check that they did not mess the toilet
- Wipe themselves, wipe the toilet, flush it, wash hands and leave
- Flush the toilet, check for any mess; if so, look for a stick to push it and try to brush off the mess and then wash hands
- Check for any mess, if there is any, wipe with toilet paper, flush, wash hands and leave it clean for the next user
- Never check to see if they have messed the toilet
- Leave the mess as it is because they are not provided with the brushes and toilet paper to clean it

When asked if anyone taught them how to use the toilets, some children reported that their class teachers, family, cooks, fellow students and prefects teach them about the toilet hygiene. Staff from a local non-governmental organization sometimes visited them and talked about toilet hygiene.

Figure 4 Children's views regarding the design, provision and use of toilet facilities in their schools

- No mirrors
- No toilet tissue
- No soap
- No hand washing basins
- Accessibility problems due to frequent locking of upper class toilets
- No air-freshener
- Design not good for boys; cannot urinate properly since only seats are available, no urinals
- Design allows others to peep at those using the next toilets
- Absence of lights made the toilets scary
- Need for a small camera to capture all students including those who destroy the toilets.
- Too small, need 'normal' seats
- Overflowing of toilets, bad for those classrooms located near the toilets

A few students reported that they did not have problems with the toilets, for example some reported that: "The toilets are good for my size"; "the height is fine"; "they are okay because they are separated into stalls and there is an area to wash hands"; "our toilets are good and

smart"' and "they are okay but need improvements".

In three of the schools, the children reported that the toilets were the same as those they used at home, they were beautiful and they liked them. In another school, they also liked their toilets since they were comfortable, well designed and well ventilated; "It is just that other students damage them", reported one student. However, when asked whether they destroy toilet facilities all the children reported that they did not.

The study also showed that pit latrines are still being used in some schools in Botswana as 18% of the schools visited had both pit and flush or pit only. Staff and students did not share the same facilities; boys' toilets were separate from girls'. Where water is available it was sufficient for use (89%). Maintenance of the toilets was worrying. Forty-three percent (43%) of the toilets were blocked at the time of the visit and the general condition was described as 'bad' or 'horrible'. Ventilation and flies were not major problems since brick mesh and awning windows were mostly used. Most toilets were cleaned only once a day (92%) and observations revealed that the toilets were cleaner during the first half of the morning. In most of the cases, cleaning staff were available to do the cleaning. The supply of toilet paper was inadequate (75%). Soap for washing hands (98%) and sanitary bins (93%) were almost nonexistent. The design of the toilets did not to accommodate children with special needs (97%).

Discussion

Children's experiences with the use of school toilets could become a psychological and physical risk (Vermon, Lundblad, & Hellstrom, 2003). According to Vermon *et al*. if toilets are not clean, girls are forced to crouch when urinating and this creates residual urine that could lead to infections. Lack of cleanliness of toilets and lack of provision of soap deterred a good proportion of children who generally displayed adequate knowledge about how to use toilets to practice good sanitary habits. A problem of this nature could create future adults who do not practice hand washing after toilet use. The children clearly described some appropriate behaviour which safeguards their health when they share toilets, for example, first checking for a clean toilet. If the toilet seat was dirty, they wiped it, spread some paper and then sat down. Quite often, they used their personal toilet paper. Some children further displayed a sense of caring by reporting that after using the toilet, they checked whether they had messed the seat or not and then, depending on provisions, they cleaned it up for the next user. The children were also aware of the need to wash their hands after using the toilets, but prevailing conditions did not always promote this healthy habit.

When asked if anyone taught them about toilet hygiene, the children mentioned that significant people such as parents, teachers, head-teacher, cleaning staff, friends, nurses, cooks, fellow students, other family members and members of the environmental club all talked to them and provided the support that is necessary to cultivate healthy toilet habits. Before the children come to school, parents or adults in the homes they come from should teach and model appropriate behaviour on the use of the toilets, whether consciously or not. Various media in Botswana have highlighted the problem of 'urinating in public', especially among men. Children are quick to pick up such practices and may carry them to the school. In the study, some children reported that they used the bush near the toilets and this finding should not be surprising. Besides contaminating the environment, urinating on open ground spreads diseases. Continued public education is needed in order to discourage such behaviour if health for all is to be achieved by 2015.

The Global Monitoring Report Team (GMRT, 2006), embraces the notion that 'supporting children and their parents during the early years establishes strong foundations for all future learning' (p. 2). This includes learning about basic hygiene, caring about each other and common property which they share with many others. Maintaining clean and safe toilet facilities in addition to teaching children how to use the facility, can contribute to hygienic behaviour, which can lead to lifelong positive habits.

In its review of the status on the MDGs, UNDP (2007) evaluates Botswana's likelihood of meeting Target 20 — the promotion of environmental education and awareness necessary to reduce contamination and achieve sustainable development — as 'potentially', and the supportive environment for achieving this goal is rated 'good'. With less than six years remaining before the target year of 2015, drastic action is needed to realize this goal. Changing attitudes and practices takes time. By 2015, such changes should have reached a stage where it can be said to be sustainable. Fortunately, the findings of this study show that the children are equipped with good hygienic practices if only the policy makers could provide with appropriate well functioning sanitary facilities.

The children in this study raised several concerns regarding the availability of toilet supplies and the design of their toilets. Provisions such as toilet paper, sanitary bins, mirrors, hand washing facilities and soap were generally either inadequate or nonexistent. Twenty-four percent (24%) of the schools did not have hand washing facilities; almost all the toilets visited (98%), did not have soap at the time of the visit; toilet paper was not available in 46% of the toilets while it was found to be inadequate in 29% of the cases. As alternatives, the children were forced to use newspapers, pages from books, and 52% reported that they brought toilet paper from home. Where are the children expected to put other litter, sanitary pads, hair, etc. if sanitary bins are not provided? One BOG Standard Factsheet (2007) stipulates that each cubicle for girls aged eight and over should contain a sanitary disposal unit and each set of group toilets for girls should have a sanitary dispenser.

The children were very much aware of how their toilets should look like. They raised important ergonomic concerns such as the inappropriate size of the toilets in relation to their age, the comfort of the seat, privacy, and absence of urinals especially for the boys. They went on to suggest things like having mirrors, button-type flush systems, and air fresheners. They also suggested toilets which could be accessed quickly and easily should the need arise, and located conveniently from the classrooms. Ninety percent of the schools toilets were found to be inaccessible to those with special needs including the blind and those in wheelchairs. This important aspect should be seriously considered when school toilets are designed. Concerted effort from all stakeholders who have an interest in the health and welfare of children is needed. This includes parents, teachers, relevant government departments, and all development partners such as UNICEF, WHO and others.

Findings were also obtained from observations that were made in the primary schools. While some of the responses were favourable, for example the availability of toilet buildings which were well ventilated, more concerns than positives were heard from the children. The most striking finding was the continuing availability of pit latrines in some schools in Botswana. Given the economic advantage of Botswana as a middle income country, this finding was disturbing. A significant population of Botswana still use pit latrines.

Challenges about emptying full tanks are often reported in the media. This goes hand in hand with making running water available to all the people, whether in the rural or urban areas.

MDG 7, Target 18 aims to reduce by 50% the proportion of people without sustainable access to safe drinking water by 2016. Botswana is evaluated as 'likely' to meet this target given a 'strong' supportive environment. Again, political commitment and use of an integrated approach is vital if Botswana is to make its strides in achieving this goal.

Some pupils raised concerns about privacy when using the toilets. They reported that other students peep through the brick mesh in the walls or doors. Privacy is an important factor to consider during the design and layout of urinals, mirrors, wash basins and windows. Maintenance of the toilets was also found to be worrisome. With forty-three percent of the toilets blocked at the time of the visit and the general condition described as 'bad' or 'horrible', drastic action is needed to make these toilets work. Some reported that they delayed going to the toilet until they got home. This is unhealthy as it causes complications in the body and reduced concentration in school activities if the children do not feel well (Abraham Maslow, in Lefrancois,1999).

Most toilets (92%) were cleaned only once a day. Observations also revealed that the toilets were cleaner during the first half of the morning. It is recommended that the toilets be cleaned at least twice a day in order to keep them presentable. Botswana's warm and dry climate generally allows for brick mesh to be used, hence, ventilation and flies seemed not to present problems. Thirty-eight percent of the toilets visited had brick mesh while 37% had awning windows which allow sufficient air to circulate in and out of the toilets.

Conclusion

The main purpose of this study was to make a critical analysis of the status of toilets in primary schools in Botswana, the children's awareness of basic hygiene practices, behaviour and problems they encounter when using the toilets. Findings revealed that the children in this study were generally aware of basic hygiene protocols regarding the use of toilets. However, the extent to which they practiced them depended on available facilities in the schools. They had clear ideas on the appropriate design of their school toilets and provisions needed. They also raised important ergonomic concerns which need to be considered in future designs if the toilets are to serve the children's physiological and psychological needs. Provision of toilet supplies including hand washing facilities, soap, sanitary bins was inadequate. Pit latrines were in existence and the maintenance of the toilets could be improved.

The above findings challenge the attainment of MDGs related to health, education and the environment. Although UNICEF rates Botswana's supportive environment for achieving these goals as 'strong' and 'good' respectively, government commitment is vital if strides are to be made. It is also important to engage all school personnel and relevant stakeholders in a joint effort to promote high standards of hygiene among school children. Toilet hygiene and education should be emphasized in the primary school curriculum. This can be expanded to include broader sanitation, safety and health issues. The general public should also be continuously sensitized on the need for clean toilets and the importance of modelling correct toilet behaviour to young children. Like theTswana saying *'Leojwa le sale metsi'* (it is easy to bend the twig when it is still growing).

References

BOG (2007) *Promoting better toilets for pupils: Suggestions for good school toilet design.* Retrieved from http://www.bog-standard.org/factsheet_007.aspx on June, 16, 2007.

Chang, S. M. (2002) *Education and law for a hygienic and convenient toilet – Movement for enacting the law of public toilet in Korea.* Korea.

Global Monitoring Report Team (2006) Strong policies to benefit young children, *Journal of Education for International Development* 2:3. Retrieved from http://www.equip123.net/jeid/articles/4/StrongPoliciestoBenefitYoungChildren.dg on January, 9, 2007.

Lefrancois, G. R. (1999) *Psychology for teaching.* 10th edition. Wadworth: United Kingdom.

Mara, D (2001) *Health and sanitation in the developing world.* Paper presented at the World Toilet Summit, Singapore, Malaysia, November 19–21. Retrieved 19 June 2007 from http://www.leeds.ac.uk/civil/ceri/water/tphe/publicat/watsan/toilets.doc

Reuters. (2003) *Dirty school toilets a risk to European children.* Retrieved from http//health.yahoo.com/search/healthnews?lb=s&p=id:34597 on January, 30, 2003.

UNDP (2007) *Millennium Development Goals and Vision 2016.* Retrieved from http://www.unbotswana.org.bw/undp/mdg.html on June, 19, 2007.

UNICEF (1997) *Progress of Nations 1997: Water and sanitation–Progress and Disparity.* Retrieved 30 September 2002 from http://www.unicef.org/pon97/p13a.htm

UNICEF. (2000a) *School sanitation and hygiene education.* Retrieved 30 September 2002 from http://www.unicef.org/programme/wes/info/school.htm

UNICEF. (2000b) *Water alone is not enough.* Retrieved 30 September 2002 from http://www.unicef.org/newline/00pr21.htm

Vermon, S. Lundblad, B. and Hellstrom, A. L. (2003) Children´s experiences of school toilets present a risk to their physical and psychological health. *Child Care, Health & and Development,* 29, 47–53.

Adolescents: the lost generation

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This paper aims to describe some of the challenges faced by adolescents, behaviour issues arising from these and argues that much greater attention should be given to providing support for this potentially vulnerable group of young people.

This is a generation whose plight can be very much likened to the plight of the middle child in a family. Their issues are often ignored because they are not young children and not yet youth, but their issues are often lumped together with those of youth in general. Yet, it is at this very pertinent impressionable age, that human beings develop their specific characteristics that define them as individuals – 'serving as the beginning and root of sexual life, character formation and the capacity to love' (Freud [1966], quoted in Frankel, 1998), and a time during which both their bodies and their brains undergo rapid change (Spear, 2000).

While governments and development partners often focus more on earlier childhood (and perhaps rightly so, given that this helps to set the scene for a better experience of adolescence), the needs of this very vulnerable group are often overlooked. Inconsistent or the total absence of age-segregated data on adolescents create great difficulties in developing programmes and services for this very specific and often needy group. It is the most diverse generation and yet adolescent issues tend to be 'swept under the carpet'.

In Botswana, 38.7% of children aged 12 – 17 are single or double orphans (Botswana AIDS Impact Survey III, 2009); only a third of children in this age group live with both parents (Labour Force Survey data, 2005/06). Almost 13% of children aged 14 – 17 work, often while attending school at the same time (UNICEF, Child Labour Study, to be published). Girls aged 15 – 19 are more than five times as likely as boys to become infected with HIV (BAIS III 2009).

Fortunately, the importance of addressing issues faced by this age group is being realised globally and we are now witnessing a trend towards realising the rights and needs of adolescents. This change in mindset is slow - but it does seem to be happening.

Defining Characteristics of this 'Lost Generation'

While not intending to discuss the underlying influences and driving forces behind these characteristics, this list aims to describe some of the effects of these on the adolescent within his or her environment.

1. Relationships 'matter most'

Nothing is of more importance to adolescents than relationships. Adolescents live in a world increasingly devoid of strong, dependable relationships – and at this time of life the focus of their relationships moves from parents to peers, and eventually to partners. Many are growing up as children of divorce or death, starved of closeness and intimacy as the family has deteriorated. Abusive, neglectful, absent, non-emotional and often busy parents have no time for relationships.

It is because adolescents today have been deprived of intimacy or 'emotional connectedness' that they value it more highly, often seeking it among friends or 'gangs'. The irony is that, even though they value relationships the most they do not have the skills or ability to have true and meaningful relationships.

2. They will do anything to be loved

The adolescent, starved of genuine love, will do anything in his/her quest to find it. If relationships 'matter most', then acceptance by peers who will validate them is vital. They feel they must fit in. Adolescents make decisions on the basis of what it will take to get people to accept them. They often do not stop to consider what is right or wrong, but what they can do to be accepted. Thus, the question they are asking is 'what must I do to be loved'? They are looking for a safe place, where they can feel important and where they can be loved. But at times they do not have the strength of character or adult guidance to assist them in making the correct choices in this regard.

3. Sex is expected

The message put out by the world today is that love is found in sexual intimacy. This message is very powerfully brought forward by the world of movies and music. Sex is viewed as inevitable. Some adolescents are particularly vulnerable to early sexual experiences. A study of South African orphans found that these were 25% more likely to have sex than non-orphans (Thurman *et al,* 2006).

However, adolescents who try to use sex to get love often end up being used and abused in some form or another. This becomes a never-ending vicious cycle.

4. Individualism is valued

Adolescents, trying to develop their own identity, can be very individualistic – at the same time as trying to fit into a crowd. This can be an expression of self-confidence, but can also create considerable tension, as they learn to fend for themselves. They want personal empowerment to be a key factor in their worlds.

5. They lack trust

High levels of divorce and family-break-up internationally, together with the AIDS pandemic, as well as abuse and neglect have significantly impacted on adolescents. It has forced them to grow up very quickly, often leading them into premature and untutored adulthood. Due to being continually let down in some form or the other, most adolescents today have trust issues. In Botswana, the passion killings are a prime symptom of this anomaly where usually male partners kill their girlfriends or wives, often out of misplaced jealousy (eg, if the woman talks to another man (Exner, Thurston, 2009)).

6. They are wary of commitment

Because they have been let down so many times, adolescents tend not to commit themselves to anything, or at best they commit very slowly and warily to a career, a religion or a partner. While the slow development of commitment may be entirely normal in a healthy development (Marcia's (1966) 'identity achievement', after evaluating all options available to them) adolescents who have undergone negative life events in the past (such as bereavement or abuse) may find it difficult to place their trust in other people, or indeed even trust themselves sufficiently to make decisions that impact positively on their lives – Marcia (1966) calls this 'identity moratorium', a phase where adolescents are in crisis because they have not committed to a decision about their future. Thus, they are often accused of having a 'don't care' attitude.

7. They are pessimistic about the future

Given the challenges faced by adolescents, including high rates of divorce or death and family break-up, the AIDS pandemic, abuse and neglect, academic and social pressures can lead to

a pessimistic attitude to life in general. One particularly distressing outcome of this pessimism is the dramatic increase in adolescent suicides globally over recent years (Pelkonen, Marttunen, 2003), with young males in most countries outnumbering female victims.

8. Risky Behaviours

Adverse life experiences such as divorce or death, neglect, broken and bad relationships, including abuse, with their families or peers, as well as peer pressures can lead adolescents to to various forms of (self-) destructive behaviour ranging from drug and alcohol abuse to promiscuity, violence and other negative behaviours, at times to try and 'medicate' the emotional pain they are holding (Spooner, 2009).

Emotional pain and anger often share a symbiotic relationship in these young lives. Combined with substance abuse these factors can easily lead adolescents into impulsive and risky behaviour, including violent crime.

Conclusion

While many adolescents travel safely through this difficult period, the data provided and the list above shows that they face many hazards on their journey – and there may be others not listed above. Thus this article intends to act as a catalyst for us all to move forward and act on the 'Agenda for Adolescents'.

A very concerted and deliberate effort needs to be made by both development partners as well as governments globally, to address the needs of adolescents in particular if we hope to have a generation of well-balanced, level-headed young adults in the not too distant future.

In this regard, UNICEF, Botswana in collaboration with the Government of Botswana and the Private Sector is supporting various projects ranging from the acquisition of Livelihood Skills and HIV/AIDS Prevention Life Skills, the National Life Skills Framework and the Provision of Life Skills and Psycho-Social Skills for HIV positive adolescents.

The project on the acquisition of Livelihood Skills and HIV/AIDS Prevention Life Skills, in collaboration with Barclays Bank Botswana, is part of a global collaboration between UNICEF and Barclays Bank. Approximately 1200 young people are being reached in six districts through this initiative. It has proven to be a highly successful venture and UNICEF is in discussion with both national and international potential partners in a bid to scale up this project.

The National Life Skills Framework is being implemented in collaboration with the Ministry of Education. It is the result of a consensus between all partners, including government and civil society partners that a National Life Skills Framework should be developed, given the many initiatives ongoing in Botswana in relation to Life Skills.

UNICEF's collaboration with the Baylor Centre of Excellence on the provision of Life Skills and Psychosocial Skills for HIV-positive adolescents has proven to be a ground-breaking initiative. All the babies born prior to the availability of PMTCT are now adolescents. As shown in this paper, adolescence comes with many challenges, to which the fact of being HIV-positive adds further complications.

References:

Central Statistics Office (2009) Botswana Aids Impact Survey 2009, Gaborone.

Central Statistics Office (2009) Botswana Family Health Survey 2007, Gaborone.

Central Statistics Office (2007) Labour Force Survey 2005/06, Gaborone.

Exner D, Thurston WE (2009) 'Understanding Passion Killings in Botswana: An Investigation of Media Framing', *Journal of International Women's Studies*, Vol 10 No 4, May 2009.

Freud, A (1966), *The writings of Anna Freud*, Vol 2, *The Ego and the Mechanisms of Defense,* (rev. ed.), New York: International Universities Press, in Frankel R, (1998), *The Adolescent Psyche: Jungian and Winnicottian Perspectives',* Routledge, Hove, UK, p21.

Marcia, J. E., (1966) Development and validation of ego identity status, *Journal of Personality and Social Psychology* 3, pp. 551–558.

Pelkonen M, Marttunen, M (2003) Child and Adolescent Suicide: Epidimiology, Risk Factors and Approaches to Prevention, *Pediatric Drugs,* Adis International, 5:4, pp 243–263.

Spear L P (2000) The adolescent brain and age-related behaviours, *Neuroscience and Bio-Behavioral Reviews,* Elsevier Science, 24:4, pp 417–463.

Seen but not heard? A call for orphans' voices to be heard in Botswana[1]

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Introduction

Since independence, in 1966, Botswana has made significant improvements in child welfare issues. For example, children have access to universal ten years of basic education and they are also provided with free health and social services by the government (Chilisa, Maundeni and Tabulawa, 2002). However, these improvements are now being adversely affected by the HIV scourge and its related consequences on children. The AIDS epidemic has caused a substantial increase in mortality rates among adults of reproductive age — a trend which has left many children as orphans.

Orphanhood is not a new social phenomenon in Botswana. What is new is the unprecedented increase in the number of orphans largely as a result of the HIV and AIDS epidemic. According to the Central Statistics Office (2001), there were 111,812 orphans in Botswana. The high number of orphans in the country has led stakeholders to formulate several strategies to address the multifaceted needs of orphans. One of the strategies is the National Orphan Care Programme that was established in April 1999. However, in 2010, there were only 45, 000 registered orphans (Department of Social Services, 2010).

Botswana is one of the countries that has ratified the two major conventions on Children's Rights, now domesticated in the 2009 Children's Act. These conventions among other things point out that children have a right to be heard as well as to participate in decisions that affect them. However, in the context of Botswana, there is evidence that by and large, participation rights of some orphans are violated. This has far reaching consequences for their wellbeing both in the short and long term. The purpose of this paper is three-fold. First, it highlights how orphans' rights to participate in decisions that affect their lives are violated.

[1]This is an extract from a paper that was presented at BOLESWANA 13th International Biennial Symposium, 27th to 29th July, 2009, University of Botswana.

Second, it discusses the effects of such practices. Lastly, it argues for the need to ensure that orphans' rights are promoted, respected, protected and fulfilled.

The paper starts from the premise that orphans are not a homogeneous group. They vary in terms of age, gender, health status, ethnicity, socio-economic, educational, cultural and religious backgrounds, the nature of relationships they had with parents, as well as the nature of relationships with guardians, siblings, friends and other social network members, just to mention a few. Consequently, their experiences are not homogeneous. Therefore this has implications for the strategies that can be put in place to ensure that their voices are heard. The Ministry of Local Government (1999) defines an orphan as a person below 18 years who has lost one (single parent) or two (married couple) biological or adoptive parents.

How are orphans' participation rights violated in Botswana?
The UN Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC), which Botswana is a party to, are instruments that outline children's rights to survival, development, protection and participation in matters and actions which affect them. Efforts to domesticate these conventions in Botswana laws are fairly recent. For example, it was only in 2009 when the Children's Act was upgraded to reflect the requirements of the two conventions. Because this development is so recent, much still needs to be done to disseminate and implement the Act.

Orphans' rights to participate in decisions that affect their lives are violated in several ways in Botswana. These include: property grabbing that lowers the children's standard of living, lack of social support, subjugation to child labour, violence, sexual abuse, violation of freedom of expression, discrimination and stigma, and removal from school (Senau and Mokgethi, 2008). For the purpose of this paper, the focus is only on challenges that show how orphans' participation rights are violated.

Children are often not given opportunities to express themselves
Throughout sub-Saharan Africa, an estimated 90% of orphaned children live with extended family members (Miller, *et al* 2006). The tradition of fostering by the extended family is a vital coping mechanism because it is culturally acceptable and assumed to be sustainable throughout a child's development, partially because communities will band together to support these households (Deininger, Garcia & Subbarao, 2003). In most cases, children can find stability, love, and emotional support in relatives' homes.

Despite these advantages of kinship care, research has found that sometimes kin fail to give children an opportunity to air their views about their living and school arrangements following parental death. Relocation to new households and transferring to new schools after the parents' death can be traumatic for children. There are also cases where children are uprooted from familiar environments to boarding schools following parental death. Again, such decisions are rarely taken with the children's consent. Instead, the decisions are implemented because they are convenient for caregivers or guardians. The importance of keeping children in stable and familiar environments following parental death should not be overlooked existing literature shows that instability in living arrangements can complicate children's adjustment to traumatic situations (Maundeni, 2002).

The practice of neglecting children's views in terms of deciding their living arrangements can have serious consequences for children's well-being. For instance, it can result in the separation of siblings — a trend that denies orphan siblings the opportunity to provide support to each

other. Not only does failure to listen to children have adverse effects on their wellbeing, it is also a violation of their rights. Article 12 of the Convention on the Rights of the Child states that 'the child has a right to express his or her opinion freely and to have the opinion taken into account in any manner or procedure affecting the child'.

Inadequate attention paid to children's feelings and emotions related to loss

Many critical needs of orphans have been identified in several studies. Amongst those was the need for counselling to enable orphans to cope with the emotional stress of losing parents, to deal with their fears of infection (if parental death is due to HIV/AIDS) and to make informed decisions about their lives. Orphans start to suffer from neglect, including emotional neglect long before they are orphaned. Eventually, as a result of the loss of their parents they go through trauma. The trauma is often exacerbated by the fact that they have to adjust to the new situation with little or no support (Subbarao & Coury, 2004). In Botswana, the physical needs of orphans such as nutrition and health care appear to be treated as the most urgent, forgetting the emotional effects of losing parent(s). The experience is traumatic for children since more often than not guardians assume that children are too young to participate in counselling to express their feelings about parental death. Some children who participated in a study by Daniel (2003) in Botswana reported that they were prevented from attending the funeral and they found it difficult to have a sense of closure. Such an experience is traumatizing for a child and the trauma can go on until adulthood. In some situations, children who experienced this refuse to go to school or show some disturbing behaviours (Daniel, 2003).

Discrimination and stigma

Muchiru (1998) argues that even though all registered orphans are entitled to a regular food basket, it appears that there is resistance to registration because of the ensuing stigma. There is fear that the presence of an orphan would 'type-cast the family as having HIV/AIDS.' Some children are therefore hardly consulted to solicite their opinions. They can either receive less food or are forced to do more work. Exploitation remains a big issue in Botswana even though the government offers support to orphans. Some caretakers only take in the orphans knowing that they can use them to benefit from the orphan care packages that the government provides (UNICEF, 2004).

Property grabbing

Property grabbing is a practice where relatives of the deceased come and claim the land and other property (UNICEF, 2004). Existing literature shows that orphans are hardly consulted when it comes to the division of their parents' property. Thus relatives have a tendency to divide the property without involving orphans. This practice is often exacerbated by the unpopularity of wills in Botswana. There are no national figures that show the extent of property grabbing in Botswana, however, several researchers have noted that property grabbing is one of the major challenges facing orphans in Botswana. Maundeni (2003) argues that property grabbing has become common and it leads to serious consequences for children's access to basic necessities such as shelter and education. The few resources that could be used for education, food and health care, are diverted to providing shelter (McPherson, undated). Moreover, lack of adequate shelter exacerbates the trauma they are already going through.

Children's experiences of property grabbing are exacerbated by several factors. One of them is that people are already living in poverty-stricken environments and see the property of dying relatives as something to boost their lives (Dube, 2001). Secondly, it is fuelled by parents' reluctance to talk to children about property issues because of the myth that discussing such

issues with children may result in children not taking life seriously (Maundeni, 2003).

What could be done to ensure that the voices of orphans are heard?

This paper has shown how orphans' participation rights are violated, as well as the effects of such a violation. Now attention needs to focus on what could be done to ensure that the voices of orphans are heard and that their rights are promoted, respected, protected and fulfilled just like those of other people in the community.

The protection of the rights of all orphans is a necessary element in each society and it implies the performance of duties on the part of everyone. More emphasis should be put in enhancing the democratic rights of orphans. As outlined in the African Charter on the Rights and Welfare of the Child (1990), the situation of most African children remains critical due to unique factors of their socio-economic, cultural and developmental circumstances, exploitation and hunger to a mention a few.

The following recommendations can go a long way in ensuring that orphans' rights are respected and protected. Guardians and society at large need to be sensitised about: the need to listen to children; the importance of talking to children about property issues including the writing of wills as well as the effects of their actions (e.g. discrimination, property grabbing, etc) on the well-being of orphans. They should also be enlightened about children's rights. The sensitization programmes should be executed by teams of multidisciplinary professionals such as social workers, psychologists, counsellors, teachers and lawyers, among others. Moreover, lay people such as chiefs, village development committee members, health committee members, and others that play a role in the welfare of children should also be trained to act as educators at grass roots levels.

Lansdown (1994) pointed out that researchers have identified children as needing to be recognized as participants in society whose rights and responsibilities need to be recognized at all ages. In line with this, there is a need for stakeholders to intensify programmes that sensitise children about their rights. Existing ones are necessary, but not sufficient. These include the 'Talk Back' programme for school-going children that gives them the opportunity to learn and share experiences about various challenges that confront them including HIV/AIDS; as well as psychosocial support programmes offered by various stakeholders. The former are often found in cities and towns, hence many children in the country (especially those staying in remote areas) do not easily access them. Moreover, children living with disabilities are not well catered for by such programmes.

References

Central Statistics Office (2001), *Population and Housing Census,* Department of Printing and Publishing Services, Gaborone.

Chilisa, B., Maundeni, T., and Tabulawa, R., (2002), *National Report on Gendered School Experiences in Botswana.* Submitted to Department for International Development, (DFID), Sussex.

Daniel, M. (2003), Listening to Orphan Voices. In Biakolo, E., Mathangwane, J. & Odallo, D. (Eds) *The Discourse of HIV/AIDS in Africa*. 117-119. UNAIDS, ICT, Pretoria.

Deininger K., Garcia M. & Subbarao K. (2003), *AIDS-induced orphanhood as a systemic shock: magnitude, impact, and program interventions in Africa.* World Bank; 31:1201-1220.

Dube, M. (2001), *'Fighting and Crying with God: Children, Women and HIV/AIDS in Southern Africa'.* Paper Presented at Diakonhjemmet College, School of Nursing, Oslo Norway.

IRIN News (October 2002), *'Botswana: AIDS orphans exploited'.*

Lansdown, G. (1994), 'Children's Rights', in Mayall, (ed). *Childrens' Childhood: Observed and Experience,* (pp 33–44), London, The Falmer Press.

Maundeni, T. (2002), Seen But Not Heard? Focusing on the Needs of Children of Divorced Parents in Botswana. *Childhood*, vol. 9 (3), 277–302.

Maundeni, T. (2003), Cultural Factors in the Spread of HIV/AIDS Among Children and Young People in Botswana. In Biakolo, E., Mathangwane, J. & Odallo, D. (Eds) *The Discourse of HIV/AIDS in Africa.* 133-136. UNAIDS, ICT, Pretoria.

Maundeni, T. (2006). The Silent Survivors of HIV/AIDS: A Quest for Comprehensive Strategies in Botswana. In Kasiram, M., Partab, R. & Dano, B. (ed). *HIV/AIDS in Africa.* 55–63. Print Connection, Durban.

McPherson, D. (Undated). *Property Grabbing and Africa's Orphaned Generation: A Legal Analysis of the Implications of the HIV/AIDS Pandemic for Inheritance by Orphaned Children in Uganda, Kenya, Zambia and Malawi.* Retrieved on 6 October 2010 from http://www.law.utoronto.ca/documents/ihrp/HIV_mcpherson.doc.

Miller, C. M., Gruskin, S., Subramanian, S. V., Rajaraman, D., & Heymann, S. J. (2006), Orphan Care in Botswana's Working Households: Growing Responsibilities in the Absence of Adequate Support. *American Journal of Public Health*, 96 (8), 1429–1435.

Ministry of Local Government–Department of Social Services (1999), *Short Term Plan of Action for Orphans and Vulnerable Children.* Department of Social Services, Gaborone.

Ministry of Local Government–Department of Social Services (2010), *Orphans Statistics for Quarter 4.* Office of Monitoring and Evaluation, Gaborone.

Muchiru, S. M. (1998), *The Rapid Assessment on the Situation of Orphans in Botswana.* Gaborone, Ministry of Health, AIDS/STD Unit.

News from Africa (2003), *Disinheritance plagues Aids orphans,* NewsfromAfrica.org.

Organisation of African Unity (1990), *African Charter on the Rights and Welfare of the Child.* OAU, Addis Ababa.

Senau, K. and Mokgethi, L. (2008), *Provision of Psychosocial Support to Orphans in Gaborone. A Case Study of Salvation Army Psychosocial Support Initiative* (SAPSSI) at Old Naledi. A Research Project Submitted in Partial Fulfillment of the Bachelor of Social Work Programme, University of Botswana, Depertment of Social Work, Gaborone.

Subbarao K. and Coury D. (December 2004), *Reaching out to Africa's Orphans: A Framework for Public Action.* The World Bank.

Subbarao, K., Mattimore, A., Plangemann, K. (2001), *Social Protection of Africa's Orphans and Other Vulnerable Children. Africa Region Human Development Working Paper Series.* Human Development Sector. The World Bank).

UNICEF (2004), *Children on the Brink 2004: A Joint Report of New Orphan Estimates and a Framework for Action.* New York.

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The urban orphan in Botswana: discarding the homogeneity myth

Introduction

Official statistics from Department of Social Services (Monitoring and Evaluation Division, 2010) put the number of registered orphans in Botswana at around 45 000. Slightly over 5200 (around 11%) of these orphans reside in the country's cities and towns, namely Gaborone, Francistown, Selibe-Phikwe, Lobatse, Jwaneng and Sowa. Though government provision for orphans around the country is uniform, the circumstances and challenges facing this population group differ significantly. Orphans in urban areas and rural areas face unique situations consistent with the material conditions of such areas. The urban environment with its characteristic impersonal and detached lifestyles is more alienating to its inhabitants than the rural setting. Orphans in urban centres are thus more prone to anomie than their rural counterparts. The weak informal networks of support, the absence of compassionate elders and the competitive social environment pose unique challenges for the urban orphan. The peculiar socio-economic demands and expectations of the urban environment which may include among others commuter transportation, rented accommodation and costly leisure pursuits, complicate the lives of orphans even further. It is on this basis that creative and imaginative responses to mitigate the challenges of the urban orphan must be sought. It is not enough to assume homogeneity in the life situations of orphans where it does not exist.

Background

Orphans and vulnerable children (OVC) have become a major development challenge in the world and in the SADC region specifically. According to the SADC Strategic Framework and Programme of Action (2008) there are over 16 million orphans in the SADC region, over 6 million of whom are linked to HIV and AIDS. The figures continue to escalate amidst conditions of poverty and underdevelopment. In Botswana, SADC estimates that there are over 150 000 orphans, 120 000 of whom are HIV and AIDS related. Statistics from the Ministry of Local Government (2010) reveals that 45 000 are currently receiving assistance from the Government of Botswana. Around 5 000 of the registered orphans reside in towns and cities of Botswana which include Gaborone, City of Francistown, Selibe-Phikwe, Lobatse, Jwaneng and Sowa. Many others live in the fast urbanizing big villages of Botswana. The Table opposite shows the number of registered orphans in Botswana as of March, 2010.

Literature on orphans in Botswana tends to concentrate mainly on age and gender as critical variables for understanding the situation and vulnerabilities of this population group. Whilst data are available on the geographic location of orphans in Botswana, little has been done to investigate the specific problems presented to orphans by the varying locations in which the orphans are found. Interventions to assist orphans have tended to disregard the special needs of orphans found in different localities. Anecdotal evidence exists that suggest that orphans living in rural and urban areas may face common challenges but the manifestation of such challenges differs significantly. Orphans in rural areas largely contend with extreme poverty that is a feature of such areas. They also lack access to information and opportunities for self-advancement. The rural orphan however, is more likely to derive emotional and psychological satisfaction from the communitarian lifestyles of the traditional village set up.

The urban orphan is also affected by poverty and lack of access to opportunities, but their most pressing problems revolve around value and identity formation, emotional deprivation and coping with a competitive, money obsessed urban environment. The discussion below identifies some of the challenges faced by the urban orphan.

Table 1 **Orphan Statistics 2010**

Districts	Q – 12 /09	January–March 2010 Orphan Stats – Q4		
	Total	Female	Male	**Total**
Gaborone	1767	947	844	1,791
Francistown	1970	1000	1007	2,007
Lobatse	522	259	239	498
Jwaneng	185	79	102	181
Selebi Phikwe	779	396	339	735
Southern	5789	2861	2923	5,784
South East	864	430	427	857
Sowa	21	15	6	21
Kweneng	6041	2917	3051	5,968
Kgatleng	1559	833	828	1,661
Bobirwa	2721	1268	1248	2,516
Boteti	1694	870	820	1,690
Mahalapye	4564	2284	2164	4,448
Serowe	1468	816	709	1,525
Palapye	2567	1248	1238	2,486
Tutume	2422	770	1535	2,305
Tonota	1849	887	938	1,825
North East	2085	1019	1041	2,060
North West	4617	2315	2279	4,594
Chobe	446	224	232	456
Gantsi	725	324	364	688
Charles Hill	362	164	164	328
Kgalagadi	1440	672	720	1,392
Total	**46457**	**22598**	**23218**	**45,816**

Source: Department of Social Services (Monitoring and Evaluation Division, 2010)

Anomie and the alienation of the urban orphan

Urban populations are heterogeneous and they do not necessarily share common cultures, values or life styles. The cultural mosaic that obtains creates confusion on the inhabitants as to what constitutes proper and acceptable conduct. Young people in particular find it difficult to reconcile the myriad messages and cues that are presented to them by the highly diverse inhabitants of urban environments. These complexities of urban societies tend to create a state of 'normlessness' or anomie where there is an acute lack of clarity on the most appropriate or acceptable behaviour and conduct. The situation becomes even more difficult for orphans in the urban areas as they are most likely to reside with guardians who are equally confused as to the appropriate normative behaviour. The situation is further aggravated by the prolonged absence of guardians or caregivers who spend most of the time at work.

The urban orphan in Botswana cannot escape this confusion as the rapid urbanization has been a feature of Botswana's development in the last forty five-years. Sixty percent of Batswana live in urban or semi-urban centres as per the 2001 Census. It is thus logical to conclude that Botswana's urban orphans are susceptible to conditions of anomie and alienation which characterize the life of cities and towns generally. It is interesting to note that discourse on orphans and vulnerable children has tended to ignore this critical factor.

The absent grandmother and the emotional insecurity of the urban orphan

Grandmothers are the foremost caregivers of orphans and vulnerable children in Botswana. In a study commissioned by the Department of Social Services (2008), grandmothers constitute 42.5% of caregivers for OVC between 6 – 12 years, and 35.1% among the OVC aged between 13 – 17 years. At this rate grandmothers are ahead of the pack in terms of caregiving to the orphans and vulnerable children. The demographics of the Botswana population indicate that older people are found more in the rural areas than in the urban areas. Urban areas are mainly populated by the working age population. In actual fact many who retire normally retreat to the rural areas. This would then suggest that grandmothers as caregivers are absent in the urban areas thus depriving urban orphans the emotional support that they render to orphans in rural settings. Older women may not be effective as caregivers as such due to their advanced age but their presence in the family environment offers the orphans emotional security and a psychological fortress that they require after the loss of their parents. Urban orphans are thus more likely to be cared for by younger, highly mobile and less stable caregivers which places them at a greater disadvantage compared to their rural counterparts.

The impersonal community, indifferent neighbours and the urban orphan

Urban communities are segregated, impersonal and generally unsupportive to their members. Informal support networks are normally weak in urban communities. Relationships are formal and the community spirit is low. Individualism reigns supreme in urban environments. The neighbour who is generally benevolent and compassionate in the rural areas is indifferent and disinterested in the affairs of the next person. Genuine concern for the other person, held sacrosanct in the rural areas, is not highly prized in urban areas. Orphans living in the urban areas are much more vulnerable as they can only depend on the formal support networks mainly provided by government and civil society. An analysis of assistance to the orphans should generally factor in this important dynamic.

The cost of living and the economic pressures of the urban orphan

The cost of living in urban areas is high. Accommodation is rented, commuter transport around towns and cities is paid for and leisure pursuits require some money. In rural areas, rented accommodation is rare, walking to different destinations is normal and leisure activities are generally free. The social environment of the urban centres is competitive and as such it puts pressure and burdens on the inhabitants including orphans. An orphan growing up in an urban environment is thus prone to distress arising from the demands of urban life. It is for this reason that urban orphans in Botswana should be accorded assistance consistent with the material conditions obtaining in such localities.

Urban orphans: beyond the homogeneity myth

That there are common challenges that face orphans is not in dispute. What is at issue is the tendency to assume homogeneity in the circumstances and responses to the orphan challenge. The thinking that the analysis of the situation of orphans could be limited to the age and gender variables tends to constrict pathways for addressing the problem of orphans in Botswana. This paper argues that a 'one size fits all' approach to the orphan problem is bound to fail. It is only an approach that appreciates the multiple dislocations and deprivations of orphans as a population group that can effectively address the welfare of orphans. Such an approach should factor in the following:

- The relations of socialization, production and consumption that obtain in particular localities and link them with the lives and situation of orphans. If this fundamental is appreciated, it will then inform structural, organizational, family and individual interventions that are effective and appropriate.

- A re-evaluation of community support structures and informal networks with a view to enhancing their responsiveness to the needs of other community members including orphans.
- A cultivation of interests among civil society groups, Community Based Organizations (CBO) and Faith Based Organizations (FBO) to take active interests in community building, family support and individual care with particular emphasis on orphans.
- A broad understanding of family forms emerging in both urban and rural areas and an identification of appropriate support to be rendered for families to better care for orphans and vulnerable children.
- Sensitization of urban neighbourhoods on the importance of inter-family support and collaboration on a variety of issues including child-rearing.
- Promotion and popularization of alternative care programmes particularly for the urban orphan.
- An assessment of the current material package for orphans with a view to tailoring it to the specific needs of orphans located in different areas.
- Formulation of special leisure and recreation packages for orphans residing in urban localities by local council and civil society organizations.
- Research to unpack the unique challenges faced by orphans in urban, rural as well as remote areas.

Conclusion

Orphans are not homogeneous. One of the most critical aspects of catering for the needs of orphans is to appreciate the socio-economic, structural, community and family dynamics as they obtain in urban or rural areas and how they affect the lives of orphans and vulnerable children. In Botswana, there is a dearth of relevant literature and research on the specific circumstances of urban and rural orphans but from the general literature available, inferences and anecdotal evidence can be gleaned that show the different circumstances of orphans in different localities. It is critical that the discourse on orphans and vulnerable children be expanded beyond the age and gender variables. Assistance to orphans must also be diversified and varied according to the special needs and circumstances of orphans.

References

Ministry of Local Government–Department of Social Services (2008). *National Situation Analysis on Orphans and Vulnerable Children in Botswana,* Department of Social Services, Gaborone.

Ministry of Local Government–Department of Social Services (2010). *Orphans Statistics for Quarter 4,* Office of Monitoring and Evaluation, Gaborone.

Republic of Botswana (2000). *Multiple Indicator Survey: End of Decade Review on the World Summit for Children Goals for 2000,* UNICEF.

SADC (2008). *Comprehensive Care and Support for Orphans, Vulnerable Children and Youth (OVCY) in the Southern African Development Community,* SADC Secretariat, Gaborone.

SADC (2009). *SADC Business plan on Orphans, Vulnerable Children and Youth,* SADC Secretariat, Gaborone.

Child welfare approaches in local authorities: to what extent are they in the best interest of the child?

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Introduction

The Department of Social Services (DSS) is the largest employer of social workers in Botswana. One of its mandates is to provide child welfare services. Ideally the provision of these services should be in a holistic manner, that is the Department should ensure that the needs of Orphans and Vulnerable Children (OVC), or disadvantaged children in the country, are adequately addressed. These needs encompass economic, social and psychological needs. Through the sections of the Orphan Care and the Destitute Persons Programme within the Department of Social and Community Development (S&CD), DSS aims to meet the OVC's needs across the country in their respective district of residence.

Despite these services designed for OVC, gaps exist that bring about complications in the effective delivery of child welfare services in S&CD. This paper therefore focuses on child welfare services provided by the S&CD, explores their effectivess in adequately meeting the

psychosocial needs of OVC, and situates the roles and responsibilities of parents, caregivers and other stakeholders in child care such as teachers and the traditional leadership *(Bogosi)*. The paper also proposes several strategies that could go a long way to ensure that child welfare services in local authorities are provided in a manner that upholds the best interest of the child.

Material support and the psychosocial needs of the child

The department of S&CD through its units of Orphan Care and the Destitute Programme aims to ensure that OVC: get the appropriate nutrition (through provision of food packages or food coupons) and are appropriately clothed by providing them with casual clothing, school wear and blankets. The department assumes full responsibility of a child's educational needs once the child is registered as either an orphan or a needy child. The child's school fees, excursion fees and school's development fees are fully paid for by the department. The main reason why OVC are given this special attention is to ensure that they are not deprived of their rights to education and protection. These two programmes are complementary in the sense that if a child is no longer eligible for help under the Orphan Care Programme but still has certain material needs, the child can be registered under the Destitute Persons Programme. According to the National Situation Analysis on Orphans and Vulnerable Children (2008), 'in Botswana an orphan is a child below 18 years who has lost one (single) or both parents (married couples). These parents are either biological or adoptive. On the other hand the revised Policy on Destitute Persons (2002) defines a needy child as 'a child whose parents are terminally ill and are incapable of caring for the child'. This complementary relationship between the two programs is intended to ensure that no child will be deprived of any of their rights.

To better understand and establish whether services provided for under the two programmes help in any way to meet the psychosocial needs of OVC, one needs to understand the meaning of psychosocial needs. According to Smith (1995), these are needs that encompass the social, emotional, spiritual and mental wellbeing of a child. Abraham Maslow's (1968) (quoted by Papalia and Wendkos, 1993) hierarchy of needs clearly indicates that human needs have different priorities. These needs can be divided into three: basic needs, which include food, shelter and clothing. Needs of safety and belongingness include the need for security, love, affiliation and belonging. The final group of needs encompass esteem and ego. The emphasis here is on the need for a person to achieve or gain recognition, approval and finally to find self-fulfilment and to realise their full potential. Maslow's hierarchy of needs is in pyramid form where he argues that the basic needs have to be met first hence they fall at the bottom of the pyramid, while the ego needs are at the apex of the pyramid and are the last to be fulfilled. However it has to be noted that all these needs are interdependent in the sense that a person has to first meet the lower needs of the hierarchy for them to be able to go up with fulfilling the other needs. Further scholars like Pringle (1993) maintain that fulfilment of basic needs does not necessarily guarantee fulfilment of psychosocial needs. According to Pringle (1993), 'an unhappy child may reject food and, even if he takes it he may fail to thrive'. Pringle's emphasis is on the fact that basic needs like food and shelter alone cannot be the basis of a happy childhood.

The focus of services for children in S&CD has been largely on the provision of material assistance. Parents, caregivers and sometimes the children themselves collect their food rations from shops on monthly basis. It is however worth noting that as a result of the current smart card coupon system, beneficiaries now have a choice on what to buy and where to buy it. This system is not without limitations because in some areas, especially in the rural areas, it is yet to be rolled out. In cases where the children collect their food packages it may be worth asking, 'is this arrangement in the best interest of the child? Have the social workers ever

made any initiative to prepare the children psychologically for the effects of the stigma that the community usually attach to the food packages?' Despite the fact that the sole purpose of these food packages is to help the children, one of their ultimate results is psychological distress on the children. At the beginning of each academic year social workers round up all children registered with the department to establish their educational needs. School uniforms are bought for all school-going children and they are exempted from school fees. Under the current mode of operations the role of the social worker will usually end at this point. There are no comprehensive monitoring and follow up mechanisms in place to ascertain that food given to the OVC is used for the intended purpose of addressing the nutritional needs of the child, nor are there any mechanisms that help the social workers ensure that the school uniform that they give out to the children does not end up on the bodies of caregivers' children while the OVC go to school with old borrowed uniforms. At the beginning of each term S&CD personnel supply children with toiletries. Suppliers normally move around the schools with a list of the children to be helped. The supplier will usually group all the children in full view of the whole school and distribute the goods. These are some of the scenarios that expose children to stigma and scorn from their peers. It is for this reason that some children have been reported to have refused to get their school uniforms and toiletries when delivered at school, but preferred to get them from their social workers. This behaviour clearly indicates that exposing the status of OVC in public areas like a school setting has a negative impact on the self esteem of the children. Children have developed a derogatory label that identifies those on welfare, they are called *'Bana ba ga Mmaboipelego'* (Translated as the 'social worker's children').The question remains, 'are these services in the best interest of the child?'.

Smith (1995) and Pringle (1993) maintain that a happy child is one whose psychosocial needs are fully met. As indicated earlier on, the psychosocial needs of a child revolve around the child's emotional, social, mental and spiritual needs, meaning that all these four aspects have to be fulfilled for a child to attain the status of 'happiness'. One can accept that social work in S&CD adequately addresses the basic needs of OVC, however the question that remains is, 'are all these material supplies contributing in any significant manner to the fulfilment of the children's psychosocial needs?' The answer is no. No because, often guardians and caregivers of these children only go as far as cooking for, bathing and clothing the children. Caregivers rarely have time to focus on the most crucial needs of the children, the need for belongingness, to be loved, recognised and approved. Social workers also rarely have time to establish from both the children and their caregivers their roles in addressing the psychosocial needs of the children. It is very clear that a lot needs to be done in pursuit of 'in the best interest of the child'. There are situations in the field where a child registered with S&CD, attending boarding school, can go for years without a visit from either the social worker or their caregiver, while their classmates get at least one visit by their parents in a term. Imagine the psychological distress of an OVC in this situation. The child's self-esteem may be adversely affected, affecting his/her school work and life in general. It should be noted however, that social workers are often overwhelmed with the heavy work load of their daily duties and the generic practise where there is no specialisation. This situation leaves them with little time to conduct regular home and school visits.

The spiritual needs of OVC

One important aspect of a child's psychosocial needs that has been neglected for quite some time is their spiritual needs. Most caregivers and guardians tend to overlook the spiritual needs of children. This is partly so because they leave children behind when they visit their places of worship as children usually have household chores that they need to finish before the elders come from church. Some elders simply do not pay adequate attention to the spiritual needs of

the children. Dyk (2008) recognises spirituality as 'a broader category within which religious beliefs may or may not function'. He is of the view that spirituality entails among other views, a feeling of connectedness and belonging within the universe. Since it is apparent that few caregivers attach any value to the spiritual needs of the children, one is therefore inclined to ask, 'And what is the role of the social worker?' The author's field experience shows that social workers play a minimal role in meeting the spiritual needs of OVC. The S&CD department does not have programmes in place that are either aimed at directly enriching the spiritual being of the children or sensitising their caregiver on the importance of spirituality in child development.

It is worth noting however, that social workers working for some local authorities facilitate psychosocial support camps for OVC. These are held once a year. Such camps enable OVC to interact with other children living and experiencing similar living conditions to their own. This cannot be dismissed as a futile attempt, but has its limitations. First this only benefits a small number of children at a time, secondly the children's caregivers are never part of these activities and yet they are supposed to be the primary sources of psychosocial care. In this changing society there is a need for caregivers and parents alike to keep up with the changing needs of children. We cannot only rely on the fact that grandparents have been parents before and therefore assume that they can adequately address the psychosocial needs of the current generation of children without professional help.

Schools as sources of psychosocial support for OVC

School going children spend more than half of their day at school. This means that children interact with teachers more than they do with their parents. Pringle (1993), contends that teachers 'stand in *loco parentis* during a large part of the day, so much so, that a deprived child often addresses a teacher to whom he becomes attached as 'mummy''. This statement by Pringle clearly indicates that teachers should play an integral role in the psychosocial care of children. However, teachers' ability to provide effective psychosocial support to OVC is usually hampered by factors such as lack of training on the provision of psychosocial support as well as a high workload (Maundeni, 2006). In most cases when S&CD suppliers give school-going children their uniforms and toiletries teachers are rarely present to witness that. Although there are teachers who specifically deal with children's social welfare issues (guidance and counselling teachers) more often than not their focus is on guidance rather than counselling. It could therefore be concluded that although there are structures in schools which are supposed to be addressing child-welfare issues, much still needs to be done to ensure that issues affecting the well-being of children are adequately addresssed. Currently they are not effective or rather they are not being effectively utilised by school authorities, to the detriment of OVC.

The role of *Bogosi* (Traditional Leadership) in child welfare

Traditionally the institution of *Bogosi* or traditional leadership is one of the pivotal institutions in community development and care for the disadvantaged members of the society. However in recent years *Bogosi* has lost some of its societal roles. This institution is however still one of the most influential in many developmental issues. Despite the institution's importance in the society, *Bogosi* does not have a clearly defined role on child welfare services. As the guiding institution in our societies *Bogosi* should have been mandated with a clear policy role like the institutions of Village Development and Social Welfare Committees. Because of its current status *Bogosi* does not play a visible role in the care of children in our society.

Example of a field case on care and support of OVC

To illustrate this position more clearly a field example will be essential. Some five years ago

while working as a social welfare officer in the Southern District, the author worked with a family of five siblings who were orphaned, aged 16, 13, 11, 10 and 5 respectively. Their single mother died of HIV/AIDS related illnesses when the youngest child was two years. After the death of the mother all these children were registered as orphans and received food packages and other school needs. Because their mother had a home, the orphans were placed under the care of their aunt, then aged 25 years. There was no social worker in the village, which is about 100 kilometres from the district head office where the author was located. The monitoring of food rations and other material supplies was carried out by a ration clerk who would visit the village once in every two months. After almost two years on welfare, it became clear that the eldest boy child had been out of school for a year and was herding his uncle's cattle, while the eldest child worked for the same uncle as a maid. The 3 younger siblings were left with their aunt in their mothers' home. The aunt was said to be spending most of her time in Lobatse and only came home at the end of the month to collect food packages. After collecting them she would divide them between herself and the orphans. Clothes and school uniforms that were given out to the orphans were passed to their aunt's children and in turn the orphans would get old ones from their cousins. This situation prevailed for about two years. Thus, these children were disadvantaged because, first the children were separated, secondly the material help meant for them never benefited them and thirdly the youngest children were staying alone. Because of resource and staff problems that have always affected the S&CD department, the plight of these children was only discovered after their uncle wanted to sell their mother's home and a concerned community member came to report to the department.

Conclusion and the way forward

This paper has discussed the set-up in the S&CD department with a particular emphasis on the department's child welfare services and their contribution in fulfilling the psychosocial needs of OVC. It has also highlighted the roles of other stakeholders like teachers, *Dikgosi* (traditional leaders within *Bogosi*), parents and guardians. The paper has also shown conclusively that although S&CD has good material support programmes, their impact on the psychosocial needs of the children is not adequate. Pringle (1993) observed that 'it has become evident that problems of emotional, social and educational malfunctioning will not be solved by improvements in health and in standards of living alone, these make satisfactory family and community life more likely but do not ensure it'. Pringle's position is that emotional issues of children need more than a monthly food package, but children's emotional, social, and spiritual needs equally need to be fulfilled. That is only when their psychosocial needs can be fulfilled.

Therefore there is a need for:

- Implementation of the statutory foster care programme. Through this programme children in need of care will at least be in the custody of people who have been identified and trained on the holistic approach of child care.
- S&CD social workers in collaboration with teachers and caregivers need to have a close working relationship that will oversee and facilitate training of both teachers and caregivers on the psychosocial needs of children.
- Practices like supplying OVC with school uniforms and toiletries from the back of trucks and children collecting their own food rations need to be replaced with more emotion-friendly ways that will uphold the best interest of the child.
- *Dikgosi* should be recognised by statute as commissioners of child welfare, contrary to the current position in which the Children's Act of 2009 only recognises the Magistrate and the District Commissioner as the child welfare commissioners. *Dikgosi* are better positioned to deal with issues of child welfare since almost every village in Botswana has a *Kgosi*.

References:

Maundeni, T. (2006), The Silent Survivors of HIV/AIDS: A Quest for Comprehensive Strategies in Botswana. In Kasiram, M., Partab, R., and Dano, B. (Eds) *HIV/AIDS in Africa: The not so silent presence* (pp 55–64), Print Connection, Durban.

Ministry of Local Government–Department of Social Services (2002), *Revised Policy on Destitute Persons.* Government Printer, Gaborone.

Van Alta, D. (2008), *HIV/AIDS Care and Counselling A multidisciplinary approach.* Cape Town. Pearson Education.

Papalia D E & Olds Wendkos S. (1992), *Human Development.* USA. McGraw-Hill.

Pringle Kellmer M. (1993), *The Needs of Children.* New York. Routledge.

Republic of Botswana, (2008), *National Situation Analysis on Orphans and vulnerable Children in Botswana.*

Republic of Botswana, (2009) *Children's Act,* Government Printer. Gaborone.

Smith H. (1995), *Unhappy Children. Reasons and Remedies.* New York. Free Association Books.

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Child trafficking in Botswana

Introduction

Child trafficking is a serious concern worldwide and Botswana is no exception. The purpose of this paper therefore is to give an update on child trafficking responses in Botswana. The United Nations Protocol – also known as the *Palermo Protocol* – defines child trafficking as 'the recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation'. Botswana is said to be a source, transit and destination country (United States Department of State, *Trafficking in Persons Report of 2010)*. The same report states that many children are trafficked internally to work as house maids and herdboys.

Despite the fact that Botswana is said to be a source, transit and destination area, there is generally a lack of awareness and understanding of child trafficking among children and people working with children. This can contribute to trafficked children not being given the appropriate protection and support.

Legal responses to child trafficking

Ratification of International and Regional Rights Instruments

Botswana has ratified: the United Nations Convention Against Transnational Organized Crime as well as its supplementary Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children, the United Nations Convention on the Rights of the Child, The African Charter on the Rights and Welfare of the Child, the ILO Convention (C138) and the ILO Worst Forms of Child Labour (C182).

In Botswana there is no specific law on child trafficking but there are some aspects of trafficking in different pieces of legislation:

- *Botswana Children's Act (2009)*
  The 2009 Children's Act section 24 provides for the child's right to be protected from harmful labour practices, be they physical, emotional, or moral. Section 25 further protects children from sexual exploitation including prostitution and pornography. Sub-section 3 further places parents or any other person at liability for conniving with another person for the sexual exploitation of children. Within the Act there is also a penalty for trafficking children (section 114).

- *Botswana Penal Code*
  The Penal code section 144 outlaws abduction of a person of any age by second parties for sexual exploitation. Any person found guilty of that offence is guilty and liable to imprisonment not exceeding 7 years. Section 145 states that 'any person who unlawfully takes an unmarried person under the age of 16 years out of the custody of her mother or father or other person having the lawful care or charge of her, and against the will of such mother or father or other person, is guilty of an offence'. Section 150 outlaws the procurement of persons for sexual exploitation either in Botswana or elsewhere. The subsequent sub-section outlaws the procurement of persons through both false pretences and coercion.

- *The Botswana Employment Act*
  Section 54 of the Employment Act (1982) requires that any person who recruits persons for work needs to have a valid recruiter's licence. Section 61 of the same Act prohibits the recruitment of any child or young person, while section 105 of the Act prohibits the

employment of children in any capacity apart from some limited exceptions. Sub-section 2 allows for the employment of children above 14 years provided they are not attending school and are employed in work that is not harmful to them.

National campaign

On realising the general lack of awareness on child trafficking issues, the Ministry of Local Government in partnership with Childline Botswana, UNICEF, Ministry of Education and Skills Development, Ministry of Labour and Home Affairs, Ministry of Youth. Sport and Culture, the International Labour Organization, Botswana Police Service, Women's Religious Association and Women Against Rape embarked on a national campaign on Child Trafficking. This was officially launched on 8 June 2010, with a media briefing on the campaign on the same day. Subsequently the event was aired on radio and articles about the campaign and the launch were published in the media. The campaign activities include, among others, awareness raising, training for stakeholders, development of a protocol on management of child trafficking cases and provision of services for survivors. It targets both children and adults.

Following the constitution of the national committee overseeing the campaign, a capacity building workshop was run for stakeholders in April 2010, followed by an outreach activity on child trafficking targeting children in May 2010. The event included speeches, a march, competitions for poetry, drama, public speaking, art, debates and a live radio programme. Some children were interviewed and asked to suggest ways of combatting child trafficking. They said that awareness raising is key to the elimination of child trafficking, and that parents need to be educated on child trafficking. Other recommendations included educating children about child trafficking and also enacting laws which are responsive and effective in combatting child trafficking. The event was attended by 290 participants, including 260 children.

As part of the campaign, Childline, with the support of UNICEF, produced Information, Education and Communication (IEC) materials which were distributed in villages along border posts, the airport, border gates and other public places. Some radio programmes on child trafficking were also aired. A Child Trafficking Communication Strategy has also been drafted.

In addition three training workshops for service providers in Gaborone, Lobatse and Palapye were run in June and July 2010. The facilitators included officers from the Department of Social Services, UNICEF, The Immigration Department, Tribal Administration and Childline. The 91 participants reached included teachers, social workers, immigration officers, officers from the Botswana United Revenue Service, Tribal Administration officers, chiefs, police officers, NGO representatives and media representatives. The workshop covered topics such as rights instruments, responses, mode of operation for traffickers, key concepts to child trafficking, approaches to child trafficking, types and nature of child trafficking, contributing and risk factors of child trafficking and management of child trafficking cases.

Conclusion

In conclusion, while applauding the efforts made to address child trafficking, there is still a need to intensify awareness raising campaigns, increase capacity building of stakeholders, strengthen laws, initiate cross border agreements and undertake research on child trafficking. The need for research on child-trafficking has been echoed by the Committee on the Elimination of Discrimination against Women. The committee requested the country to conduct a study in order to assess the prevalence of trafficking in women and girls as well as to identify the root causes of child trafficking.

References

Botswana Employment Act No. 29 of 1982 (Chapter 47:01, *Laws of Botswana*).

Committee for the Elimination of Discrimination against women, 2010, *CEDAW/C/BOT/CO/3*, retrieved from http://www2.ohchr.org/english/bodies/cedaw/cedaws45.htm

Botswana Children's Act No 8 of 2009.

Botswana Penal Code, (Chapter 8:01, Act 5 of 1998, *Laws of Botswana).*

United States Department of State, *Trafficking in Persons Report 2010 – Botswana,* retrieved from: http://www.unhcr.org/refworld/docid/4c188406c.html (accessed 19 August 2010).

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Juvenile offenders and the criminal justice system in Botswana: exploring the restorative approach

Introduction

Children and juveniles coming into contact with the criminal justice system, whether as accused persons, victims or witnesses are a special and vulnerable group. They are least able to appreciate the process due to their cognitive development and lack of understanding of the procedures. The intimidating presence of the court room and its officers does not make the problem better. Furthermore, the Botswana criminal system is adversarial. This means that the prosecution and accused engage in a contest where they endeavour to prove their case by calling witnesses to give oral testimony as well as cross-examining (asking questions of) the witnesses called by the opponent. While juvenile justice in Botswana involves a slight variation from the mainstream criminal justice system, the variations are minimal. The system remains formal and the rules of procedure and evidence are similar to the mainstream criminal justice system. The judgements and sentences imposed by the present juvenile system are punishment– and rehabilitation-oriented. The contemporary view, however, supports the notion that restorative justice programmes for young offenders produce positive outcomes as opposed to present formal systems (Walgrave, 2004). With restorative justice, the offender is made to take responsibility for her actions and to make amends. The primary aim is to reintegrate the offender into the community. Restorative justice offers the offender an opportunity to see the error of his or her ways, make amends and avoid the trauma of a full-blown trial.

This paper recommends the incorporation of restorative justice into the juvenile justice system of Botswana. In this regard, where the victim and the offender agree, the restorative approach should be explored as an option.

The nature of the present juvenile justice system

Juvenile justice in Botswana is governed by the Children's Act (Chapter 28:04 of the Laws of Botswana), revised as at 2009, which provides for Juvenile Courts which operate apart from adult courts. The Act sets up Juvenile Courts to deal with persons between the ages of 14 to 17 who are accused of criminal conduct. Such persons are referred to as juveniles. Persons below the age of 14 generally do not have criminal responsibility (except in exceptional cases) and they usually appear in Children's Courts where their delinquencies and welfare are given attention. Therefore, it is those between the ages of 14 to 17 who usually appear in Juvenile Courts on criminal charges.

Unfortunately, the juvenile justice system is wholly inadequate. Rather than catering for the specific needs and vulnerabilities of juveniles, it tends to apply the same substantive and procedural rules applicable in adult courts. There are only a few legal provisions that take the status of juveniles into account. These include excluding the public from trials conducted in such courts; requiring offenders to appear with their parents or guardians; requiring that offenders be placed under the supervision of a probation officer; the possibility of sending offenders to schools of industry instead of prison. It must be noted that the role of the parents and guardians, (such as assisting the offender during the trial) has not been clarified by the legal system. In practice, no such assistance occurs. Further, the system is sometimes characterised by incarceration during the period that the offender is waiting to be charged to court. Sometimes, incarceration of the offender extends throughout the trial. The trial itself might be characterised by delays and postponements thereby making the period of incarceration rather prolonged.

The system also involves the formal process of oral evidence. In this regard, the offender sits in court and sees witness after witness enter the witness box, take the oath and give evidence against her. The solemnity of this process is undoubtedly intimidating to the young mind. After the testimony of each witness, the offender will have to cross-examine them if she is not represented by a lawyer. The bulk of the populace cannot afford legal representation. While judicial officers have a general duty to assist unrepresented persons, this cannot be matched with the detailed attention that a lawyer will attach to the defence of her client. Therefore, young offenders often have to conduct their own cross-examination. The purpose of cross-examination, broadly speaking, is to dispute what the witnesses have said and to challenge the witness's testimony. Any evidence that is not contested is taken as admitted by the offender. Obviously, most young offenders hardly understand the purpose of cross-examination and mostly ask a few irrelevant questions. It must be noted, however, that recently built magistrates courts have been allocated special rooms for cases involving children and juveniles. Some of the trappings of the usual courts do not form part of these rooms. They do not have witnesses boxes, docks (a special box where the offender sits throughout the trial), nor does the judicial officer sit on a high pedestal (giving her an intimidating presence). This is a step in the right direction and to some extent lessens the intimidating atmosphere of court room. However, these rooms cannot be said to be child-friendly courts. For example, there are no facilities to shield child witnesses and victims from unfavourable cross-examination. Clearly, the present system still does not really suit the special vulnerabilities of the young offender. It cannot be overemphasised that alternatives need to be explored in relation to the processing of young offenders who interact with the criminal justice system. In this regard, restorative justice provides a viable option.

The nature of restorative justice

Restorative justice involves a process of mediation or family group conferencing wherein the offender is brought face to face with her victim in order to possibly apologise, to take responsibility for her action and to take action to repair the harm caused (DeVore & Gentilcore, 1999). At the heart of the process are meditation and family group conferences. Family group conferences are meetings held between the offender and the victim. Representatives of their families and members of the community would also attend. The participants engage in discussion with a view of reaching an agreement as to what the offender should do to repair the harm she has caused. Essentially, reconciliation of the victim and offender, and restitution, are the primary goals. The offender is given an opportunity to take responsibility for her actions. The acceptance of accountability on the part of the offender should be voluntary. Consequently, he or she reduces the consequences of the offence by engaging in socially constructive activities or the payment of reparation (Meier, 2004). If the offender and victim had a pre-existing relationship, attempts are made to heal that relationship. If they were previously strangers, the process will seek to reduce any anger or fear that was caused by the offence (Blackwell & Cunningham, 2004). A significant part of the process is that the offender is made to understand the harm that her action has caused to the victim and the community, while the victim learns about what caused the offender to commit the crime.

Restorative justice differs from the present criminal justice system in that the latter focuses of the violation of state laws and the prosecution aims to establish the guilt of the offender. The victim and offender are unable to meaningfully participate in the process and at the end of the day, one side wins and the other loses (Carruthers, 2004). Restorative justice on the other hand lays emphasis on the injury caused to the victim and the community, as well as the plight of the offender. The aim is to repair the injury and reintegrate the offender into the society. The focus, therefore, moves away from the interests of the state and its laws, to that of the

offender, victim and community. A healing process favourable to both the offender and victim are negotiated, rather than imposed (Carruthers, 2004; Blackwell & Cunningham, 2004). The aim is to ensure that the offender is made to understand what is happening, that she feels supported and that she participates in decision making. Also, the offender and victim should not feel stigmatised or excluded by the process. More importantly, the outcome of the process must be accepted by all the participants (Morris, 2004).

The benefits of restorative justice

Research shows that restorative justice achieves greater offender and victim satisfaction as both their interests are addressed (Walgrave, 2004; Carruthers, 2004). It addresses the position of the offender as a person in need of assistance and fosters her social reintegration. The verdict is therefore based on the needs of the offender rather than the nature of the offence. Rather than seeing young offenders as helpless persons in need of rehabilitation or punishment, it sees them as persons who are accountable for their misbehaviour (Walgrave, 2004). Restorative justice also provides an answer to a criticism of mainstream criminal justice system. Proponents of 'victims' movements' state that the criminal justice system merely uses victims as witnesses and then abandons them. Restorative justice on the other hand caters for the needs of victims as well the needs of offenders.

Criminal justice systems are effective if they are able to reduce crime. Communities that have applied restorative justice have recorded positive outcomes. Research has shown less re-offending among those who have been through restorative justice (Walgrave, 2004; Sherman & Strang, 1997; Carruthers, 2004). Offenders show a better understanding of the system and feel fairly treated and are able to accept the outcome of the process. Processes that enable young offenders to take responsibility for their actions generate a feeling of remorse and a feeling of being forgiven are likely to reduce the chances of reoffending (Morris, 2004).

It is now well-known and there is empirical evidence that harsh punishments do not serve as deterrent (Lab, 1992; Sherman, 1993; Nagin, 1998). Also, in the mainstream justice system, judicial officers deal with juvenile offenders on a one-stop basis and move on. With restorative justice on the other hand, parents, brother, sisters, uncles and other members of the community play a continuous role in re-integrating the offender into the community. This enables the community to monitor the offender, while guaranteeing a feeling of acceptance on the part of the offender. Happily, the basis for the restorative approach exists in Botswana. The society has a strong social and communal dialogue wherein members of the family and community play a key role in addressing social issues. It is not unheard of, therefore, that families of offenders and victims try to work out settlements when one of them has committed a wrong (Cole, 2008). Perhaps, the next step should be the formalisation of restorative justice and the provision of legislative and institutional structures that will support the system.

Implementing restorative justice in Botswana

Restorative justice models vary from country to country. Models also usually vary from region to region within a particular country. What is required at the moment is a general acceptance of the principles of restorative justice rather than the details of applicable models. Restorative justice should therefore be incorporated into the juvenile justice system, particularly in respect of offences that are not aggravating in nature. This will necessarily require legislative changes. This can be done by simply adding enabling and procedural provisions to the Children's Act 2009. The legislation should provide for mediation prior to a juvenile being charged to court, if the offender and victim agree. In other words, mediation must be voluntary. If the parties agree to mediation, the matter will be referred to an independent mediator who will be

supplied with all the facts of the case. Preferably, the prosecutor should have the duty to raise the issue of mediation with the parties. The legislation may further impose a duty on defence counsel and judicial officers to encourage restorative justice. Social workers will naturally play a key role in the process. It might also be necessary to appoint a restorative justice coordinator in each district to facilitate the process. This will place the prosecutor in the background, thereby creating some form of neutrality. Alternatively, social workers could facilitate the mediation process. This will obviously require proper training and an increase in manpower. The legislation must also make it possible for mediation to take place at any stage of the trial, but before judgement is delivered. This will necessarily involve an interruption of the trial. At the end of mediation, the matter will be referred back to the prosecutor or the court as the case may be. The prosecutor can then withdraw the charge if satisfied with the mediation process. Alternatively, the outcome of the process may be recorded by the mediator and filed with the prosecutor or the court. The trial may proceed in the usual way, if mediation fails.

Conclusion

The primary purpose of juvenile justice is to assist offenders and reintegrate them into their societies. This aim is consistent with restorative justice. The main functions of restorative justice are to encourage the offender to acknowledge accountability for the harm done to the victim and community, to provide for the interests of the victim, and to reintegrate the offender into the community. Restorative justice provides for education to which young offenders are receptive. Also, fewer offenders will end up in court or in custody. Young offenders will have an option to opt out of a full-blown trial where victims consent to mediation. Restorative justice has proved an effective tool in reducing crime and re-offending and should serve Botswana well.

The good news is that the social fabric of the country is based on strong inter-communal dialogue. The challenges are that the institutional framework will have to be put in place. The police, social workers, prosecutors and legal practitioners will have to receive some training. Legislative steps must be taken to formally implement victim-offender dialogue as part of the juvenile justice system. This does not necessarily demand significant allocation of funds. In any case, the potential benefits of the system demand its timely implementation.

References

Blackwell, B.S. & Cunningham, D.L (2004). Taking the Punishment out of the Process: From Substantive Justice Through Procedural Justice to Restorative Justice. *Law and Contemporary Problems,* 67(4), 59–86.

Carruthers, D. (2004). Restorative Justice in New Zealand. *Journal of the Commonwealth Magistrates' and Judges' Association,* 15(4), 14–20.

Cole, R.J.V. (2008). Some Modern Expressions of the Non-Punitive African Criminal Justice System. *Commonwealth Judicial Journal,* 17(3), 13–15.

DeVore, D. & Gentilcore, K. (1999). Balanced and Restorative Justice and Educational Programming for Youth At-Risk. *The Clearing House,* 73(2), 96–100.

Lab, S.P. (1992). *Crime Prevention: Approaches, Practices, and Evaluations* (2nd ed.). Cincinnati: Anderson.

Meier, B. (2004). Alternatives to Imprisonment in the German Criminal Justice System. *Federal Sentencing Reporter,* 16 (3), 222–231.

Morris, A. (2004) Restorative Justice in New Zealand. *Crime and Justice,* 31, 243–292.

Nagin, D.S. (1998). Deterrence and Incapacitation. In M. Tonry (Ed.), *The Handbook of Crime and Punishment* (pp. 345–368). Oxford: Oxford University Press.

Sherman, L. (1993). Defiance, Deterrence and Irrelevance: A Theory of the Criminal Sanction. *Journal of Research in Crime and Delinquency,* 30, 445–473.

Sherman, L. & Strang, H. (1997). *Restorative Justice and Deterring Crime* (Working paper 4). Canberra, Australia: Australian National University.

Walgrave, L. (2004). Restoration in Youth Justice. *Crime and Justice,* 31, 543–597.

The Children's Act No. 8 of 2009 and the juvenile justice system in Botswana

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This article discusses the Children's Act 2009 and juvenile justice system in Botswana. It also provides some statistical data on children in conflict with law to reflect the magnitude of the problem. Finally, it will highlight some impediments on the full implementation of the Children's Act.

In the quest to domesticate the United Nations Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child, Parliament passed the Children's Act in April 2009. The main objective of this Act is to promote the well-being of children, their families and communities. The Act explicitly states that it is:

'An Act to make provision for the promotion and protection of the rights of the child; for the promotion of the physical, emotional, intellectual and social development and general well–being of children; for the protection and care of children; for the establishment of structures to provide for the care, support, protection and rehabilitation of children; and for matters connected therewith.' *(Preamble, Children's Act 2009)'*

The Children's Act 2009 sets out the objectives and guiding principles, the overriding principle being that in the performance of the functions of the various authorities tasked with the protection and care of children, the best interests of the child must be given paramount consideration.

Part XIV of the Act seeks to ensure that children are not traumatized in cases where they are victims or perpetrators of crime by, amongst other things, providing that they be tried in informal court settings and do not come face to face with those accused of causing them harm.

Concluding observations on juvenile justice in Botswana

In 2004, in its Concluding Observations on Botswana's Initial CRC Report the UN Committee on the Rights of the Child expressed concern that the juvenile system in Botswana was not compatible with the provisions and principles of the Convention. It was especially concerned about the fact that the age of criminal responsibility, fixed at 8 years, was too low and recommended under paragraph 61 that the State party should:

a. 'Ensure the full implementation of juvenile justice standards and, in particular, articles 37, 39 and 40 of the Convention, as well as the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules, 1985) and the United Nations Guidelines for the Prevention of Juvenile Delinquency (The Riyadh Guidelines, 1990);
b. Raise the age of criminal responsibility to an internationally acceptable standard;
c. Ensure that detained children are always separated from adults, and that deprivation of liberty is used as a last resort, for the shortest appropriate time and in appropriate conditions;
d. Improve training programmes on relevant international standards for all professionals involved with the system of juvenile justice; and
e. Seek technical assistance in developing and enforcing the juvenile justice system from, inter alia, UNICEF and the Office of the High Commissioner for Human Rights (OHCHR).'

The Children's Act 2009 exempts all children under fourteen (14) years from any criminal responsibility unless it can be proven beyond reasonable doubt that at the time of committing the offence the child had the capacity to know that he or she ought not to do so (Section 82 (1), Children's Act 2009). The new Act entitles parties to the proceedings of the Children's Courts legal representation of their own choice at their own expenses: where the person involved in the proceedings of the Children's Court cannot afford legal representation, the state shall provide a counsel (Section 95 (1 and 2) of the Children's Act).

During pre-trial, the Botswana Police Service is the entry point for all matters pertaining to children in conflict with law. The Table 1.1 below shows the number of child offenders dealt with by the Police and found guilty in Juvenile Courts and the High Court between 1998 and 2006.

Table 1.1 Children in conflict with law by gender (1998–2006)

Gender	1998	1999	2000	2001	2002	2003	2004	2005	2006
Boys	723	975	854	345	175	341	697	1,083	699
Girls	76	233	129	58	26	82	191	174	88
Totals	**799**	**1,208**	**983**	**403**	**201**	**423**	**888**	**1,257**	**787**

Source: Botswana Police Service, 2010

The juvenile justice system in Botswana, which predominantly deals with boys as reflected in Table 1.1 above, does not operate in conformity with the international standards particularly with regard to restorative justice, prevention of juvenile delinquency, and the administering of corporal punishment to juvenile offenders. For instance, the Riyadh Guidelines (United Nations, 1990) provide that the child who is in conflict with the law has the right to be treated fairly so that he or she could be re-integrated back into society. Moreover, the Beijing Rules (United Nations, 1985) are a set of rules that also guide the establishment of a responsive and restorative juvenile justice system that meets the developmental needs of children in conflict with the law. The other set of rules is the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (United Nations, 1990). These rules provide for the need to reduce deprivation of children's liberty and emphasize the need for their social integration.

Botswana needs to comprehensively focus on prevention measures to ensure that children do not infringe the law, by involving families and communities in their care, as is required by international standards. The Children's Act (section 33) provides for the establishment of Village Child Protection Committees, whose role is to, among other things:

a. 'educate their respective communities about the neglect, ill-treatment, exploitation or other abuse of children, and to promote, amongst members of those communities, such education; and **b.** monitor the welfare of children in their respective communities.'

This will go a long way in reducing mischievous behaviours and delinquency among children and adolescents in the long term.

In conclusion, it can be said that the juvenile justice system is not friendly to children who are in conflict with the penal law in Botswana. This is precipitated by the fact that there are no child friendly courts and child protection units under the Botswana Police Service. Moreover, the implementation of the Children's Act 2009 to deal with matters pertaining to juvenile justice is likely to encounter problems; partly because some of the existing laws are in conflict with this new piece of legislation, such as the Penal Code and Criminal Procedure and Evidence Act.

References:

Republic of Botswana (2009) *Children's Act, 2009,* Government Printer, Gaborone.

United Nations Committee on the Rights of the Child (2004), *Concluding Observations on Botswana's Initial CRC Report.*

United Nations Guidelines for the Prevention of Juvenile Delinquency ('The Riyadh Guidelines'), adopted and proclaimed by General Assembly Resolution 45/112, 14 December 1990.

United Nations Rules for the Protection of Juveniles Deprived of their Liberty, adopted by General Assembly Resolution 45/113 on 14 December 1990.

United Nations Standard Minimum Rules for the Administration of Juvenile Justice ('The Beijing Rules'), adopted by General Assembly Resolution 40/33 of 29 November 1985.

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Making clinic visits more enjoyable and educational for HIV-positive children: a descriptive review of the Botswana-Baylor morning playgroup programme

Introduction

A study conducted in Namibia and Tanzania regarding the educational needs of HIV-positive learners found that existing problems within the educational system were exacerbated for HIV-positive children. Every child interviewed in the study mentioned personal and continued experience with the negative consequences of disclosure and expressed that they felt that they were safer if they chose to remain silent (Badcock-Walters *et al,* 2008). These fears resulted from intolerant attitudes towards those infected with HIV in schools and at home, peer pressure, and a lack of support from the education sector, including school staff (Badcock-Walters *et al,* 2008).

The Botswana-Baylor Children's Clinical Centre of Excellence (COE) has identified similar needs among its patients for physical, emotional, and educational stimulation during extended waiting times. To address this need, the Botswana-Baylor COE established the Morning Playgroup in 2008 to promote healthy child development for HIV-positive children by creating opportunities for them to interact with their peers and improve their social skills through recreational and educational interventions, ultimately leading to improved clinical and mental health outcomes as well as a healthy transition into adolescence. Volunteers facilitate Morning Playgroup activities including structured play, reading, arts and crafts, and hygiene promotion.

The Morning Playgroup is managed by volunteers and operates from Monday to Friday, 9:30 to 11:00a.m. Ongoing activities include physical education, arts and culture appreciation, hygiene promotion, and guided reading. Of the 1,741 children who have participated from

January to July 2010, 908 were boys and 833 were girls. While the average age of these children is ten years old, Morning Playgroup will often have patients as young as two and as old as seventeen in attendance. Programme evaluations indicated that the most liked activities amongst the child participants were reading aloud (90%), circle games (87%), and painting (83%).

Morning Playgroup has different themes for each day of the week, which include dental hygiene, exercise, arts and culture, reading, and free play. The children are encouraged to participate in a friendly and open environment geared towards giving them the opportunity to learn and grow without fear of stigma. It is a way of showing the children that they are no different from any other kid their age despite their living situation and current state of health.

A descriptive programmatic review of the Morning Playgroup activities was conducted from January to July 2010, including a review of written evaluations by volunteers and child participants. Face-to-face interviews with volunteers were also conducted, through which they expressed their thoughts and opinions about Morning Playgroup.

Findings of the review

The waiting room at the Botswana-Baylor Children's Clinical Centre of Excellence contains several rows of chairs on a tiled floor and little else. There is nothing to break up the monotony of waiting and the children, with their energy and enthusiasm, feel this lack of stimulation more prominently than their older counterparts, as indicated by the following quotes from some of our volunteers:

- *"It's not easy for kids to interact with each other in the waiting room. There isn't much space and play isn't encouraged indoors."*
- *"Whenever we bring out toys they (the patients) follow us out. It can even attract other Princess Marina Hospital patients."*

However, many of the volunteers reported seeing positive changes with the children who attended Morning Playgroup:

- *"Kids come in shy, but once they start playing they get more confident and start taking part."*
- *"We give them an excuse to run around outside and socialize."*

Some of our volunteers commented on the educational benefits for the children attending Morning Playgroup:

- *"This isn't just for play."*
- *"You'll find that some parents don't encourage them to read. Some of them really love reading with us, but don't have anything at home."*
- *"Board games are important. We want parents to buy their kids board games to encourage mental growth. These aren't expensive and are worth saving up for."*

Discussion

Research over the past several years has identified a need for increased educational and social support for HIV-positive learners. Botswana's HIV prevalence rate of 24.4% for adults and 5% for children, the second highest in the world, means that the country faces an intensified need to support vulnerable children affected by the epidemic (NACA Botswana, 2010). Some of the negative impacts on these children are loss of family and identity, increased malnutrition, poorer health outcomes, loss of educational opportunities, forced migration, homelessness, vagrancy and crime, increased poverty, and fewer vocational opportunities. These negative

impacts increase the vulnerability of young people who are HIV-positive and can, in turn, hinder their ability to succeed in school and in life.

A study conducted in Namibia and Tanzania confirmed that the home environment of HIV-positive children is a complicating factor in their lives and is not always conducive to learning (Badcock-Walters *et al,* 2008, 5). It also found that stigma and discrimination have substantial negative implications for HIV-positive learners.

HIV-positive children face special needs which are often left unaddressed by the school system and their families. Patients at the Botswana-Baylor COE are not exempt from these needs. Many children who attend the COE struggle to meet expectations within Botswana's educational system. Children attend the clinic for appointments once every one to three months and adolescents attend once every four to six weeks. Each time they have appointments, students usually take the entire day off of school. For these young learners, many of whom are already struggling academically, regularly missing school for clinical appointments places them at a further disadvantage to other students. Additionally, during clinical visits children often face long waiting times, and are generally faced with boredom for hours.

Conclusion

By providing HIV-positive children with fun and educational experiences, the Morning Play Group helps to contribute to healthy physical, emotional, and educational development. It facilitates an overall positive clinical experience for children and improves health outcomes.

Goals for 2011 include procuring funds for a full-time Volunteer Coordinator, programme supplies, volunteer appreciation incentives and refreshments for the Caregiver Classes. We also plan to continue our recruitment of volunteers, particularly amongst local Batswana.

References

Badcock-Walters, P., Anning, V., Heard, W., & Kvalsvig, J. (2008). *Supporting the Educational Needs of HIV-Positive Learners: Lessons from Namibia and Tanzania. ESART,* Retrieved from http://unesdoc.unesco.org/images/0017/001786/178601eb.pdf

NACA Botswana. *Botswana –2010 Country Progress Report* (2010). Retrieved from http://www.unaids.org/en/CountryResponses/Countries/botswana.asp.

Attitudes and beliefs about abstinence: adolescents' perspectives

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Introduction

Adolescents' sexual health has attracted a lot of research on factors that predispose adolescents to risky sexual behaviours (Kabiru & Ezeh, 2007). Adolescence is a transitional period of physical, emotional, and social maturation which is often characterized by the clarification of sexual values and experimentation with sexual behaviours (Konde-Lule, Wawer, Sewakambo, *et al.,* 1997; Kabiru & Ezeh, 2007). Decisions taken at this stage can influence a person's life opportunities, behavioural patterns and health negatively (Lakshmi Gupta, & Kumar, 2007). Adolescents often act within the context of social and cultural influences which act as barriers to essential prevention messages and also adversely affect their ability to exert control over their health (Lakshmi et al., 2000).

To prevent the spread of HIV, the National Strategic Plan for Scaling up HIV prevention in Botswana (2000–2010) emphasized that the sexual debut among adolescents be delayed by one year. This came up after the Botswana AIDS Impact Survey II reported that half of Batswana youth were sexually active before 18. Kabiru & Ezeh (2007) argue that there is a paucity of studies that examine characteristics of young people who choose to abstain. Their central argument is that adolescents' views should be looked into, to inform HIV and STI

prevention messages and programmes that best target this group. This chapter, therefore, reports on adolescents' attitudes and beliefs about abstinence, and uses the theory of planned behaviour to identify adolescents' beliefs regarding their intentions to abstain or not to abstain. Finally, it will highlight areas that need to be looked into when formulating the intervention programmes that would influence them to abstain.

Methods

The data used in the chapter is derived from an ongoing partnership project between the University of Pennsylvania and the University of Botswana. The project is funded by the National Institutes of Health in the USA. Its overall goal is to build capacity for HIV/STD Prevention Research on Batswana Adolescents aged 14 – 17 years. The aim of the study is to identify mediators of family and school influences on adolescents' sexually-risky behaviours and to design theory-driven family school interventions that are age and culturally appropriate for the group. Students were recruited from community junior secondary schools in Botswana. A total of 2 junior secondary schools per district were purposively selected considering the geographical location as one of the guiding factors resulting in 6 schools selected. Teachers assisted in the recruitment of students based on the students' ability to articulate issues relating to HIV and AIDS and whether students represented the diverse backgrounds and lifestyles of all students that attend the school.

Data were collected in eight focus group interviews in semi-urban and urban schools. Only students whose parents had granted consent and students who had also signed the consent form were scheduled to participate. Data collection tools were piloted in schools not used in the sample. Each focus group had ten to twelve participants. Before the focus group interviews, students responded to a pre-focus group questionnaire that sought their demographic data and response to an elicitation questionnaire with 21 open ended questions on behavioural, normative and control beliefs about abstinence, condom use and having one sexual partner. The focus group guides for students were informed by the concepts in the Theory of Planned Behaviour (Ajzen, 2006). There were 3 females' only groups, 3 males' only groups and 2 mixed sex groups. A total of 104 students participated in the focus group interviews. This chapter reports on adolescents' views on abstinence. Transcripts of focus group discussion were read to identify the messages that described the sexual world-views of adolescents related to abstinence.

Results

Findings from both the focus group discussions and pre-focus group behaviour, normative and control beliefs questions revealed that adolescents are knowledgeable about sexual activities and abstinence. It was also evident that adolescents are engaging in risky behaviours even though they are aware of the dangers of engaging in them. The data were organized according to behavioural, normative and control beliefs. These were identified and were seen to be the fuelling agents for adolescents' attitudes on whether to abstain or engage in sexual behaviours. These issues are discussed in detail below.

Behavioural beliefs

Behavioural beliefs are beliefs about the consequences of engaging in the behaviour. Behavioural beliefs are influenced by prevention beliefs, hedonistic beliefs and partner reaction beliefs (Jemmott *et al,* 2001). To elicit behavioural beliefs the following questions were asked: what is good about abstaining? What is bad about abstaining? Behavioural beliefs regarding abstinence were identified through the pre-focus questionnaires and focus group discussions. Adolescents reported conflicting messages as to whether abstinence is a good

behaviour to engage in or not. Some of the adolescents' responses are as follows:

- Respondent 3 (female): *"You don't catch any sexual transmitted diseases and it prevents unwanted pregnancy."*
- Respondent 6 (female): *"You achieve what you want to be in life in such a way that if you don't abstain you might fall pregnant and become disturbed to continue with your education."*
- Respondent 12 (male): *"You don't have a chance of getting infected by STD's."*

Adolescents also reported that their parents and teachers encourage them to abstain until they get married. However, their peers, the media and magazines were passing a contradicting message from the one they receive from their parents and teachers. Some were also of the view that abstaining is a risky behaviour because they suffer from 'painful erection and virgin disease.' Some of the quotes from adolescents are as follows:

- Respondent 3 (female): *"You might regret having not had it in the future; you might feel left out because everyone is having sex."*
- Respondent 5 (female): *"You will not know how funny it is."*
- Respondent 6 (male): *"One may suffer, e.g. like boys, they will suffer from erection."*
- Respondent 9 (female): *"A person may have to battle to overcome sexual desires especially if he/she had experienced sex before."*
- Respondent 15 (male): *"You will not know the skill of having sex when you grow up."*

As seen from the quotes, abstinence was described as good as it protects one against unwanted pregnancy and contracting sexually transmitted infection (STIs) including HIV. On the other hand, it was seen as a hindrance for one to have fun and gain skills in handling sexual relationships.

Normative beliefs

Normative beliefs are beliefs about whether specific referents would approve or disapprove of the person engaging in a behaviour (Ajzen & Fishbein, 1980). To elicit normative beliefs, two questions are asked. Who would approve of adolescents abstaining? Who would disapprove of adolescents abstaining?

The key normative referents cited by the adolescents were parents, teachers, church leaders and peers. Peer pressure was cited as a major force for adolescents' decision of whether to abstain or not. Some adolescents mentioned that some parents would approve of their children to engage in sexual activities. This is so because the adolescents reported that some parents depend on their children to provide for them. They encourage the children to have love relationships with older men who will give them money for sex. They also say that people who are poor cannot abstain because they want to have sex to maintain or take care of the family, meaning that they will turn into prostitutes or sex slaves. Both girls and boys reveal that by consistently listening to the music and songs that talk about sex, one may end up being tempted to have sex which can lead to the failure to abstain. Old songs such as, *"setlogolo ntsha ditlhogo"*, also encourages uncles to seek sexual favours from their nieces.

Control beliefs

Control beliefs are beliefs about the factors that would facilitate the person's ability to perform the behaviour or impede the person's ability to perform the behaviour (Ajzen & Fishbein, 1980). Questions asked were; what makes it easy to abstain from sex? What makes it difficult to abstain from sex?

Some adolescents mentioned concerns over abstaining from sexual activities. Female adolescents reported that there is a story circulated by boys about a disease called "virgin disease." Virgin disease was said to strike girls only and its symptoms include severe pains during sexual intercourse and overwhelming excitement that could lead to death. On the other hand, boys were said to suffer from a painful erection.

Some statements by some of the interviewed adolescents are as follows:

- Respondent 2 (female): *"Girls who abstain will suffer from a virgin disease."*
- Respondent 3 (male): *"If a guy does not have sex regularly he will go crazy or mad."*
- Respondent 6 (female): *"I have heard that when a person goes for a long time without having sex, the pubic part will just close and sexual organs will become dysfunctional."*
- Respondent 10 (male): *"If one abstains from sex he/she will not be healthy and fit."*

Gender differences were also indentified in control beliefs. For example, female adolescents reported concern about their ability to refuse to have sex. They reported that there is pressure not to abstain from sex because of their male partners. It is reported that there is fear of losing the opposite sex partner. On the other hand, male adolescents reported that they are afraid of the painful erection hence they cannot abstain.

They indicated that their peers contribute a lot to their failure to abstain. For example; girls reported that boys often tease and call them by degrading names such as "bitch" or *"letamo"* (dam) if they do not want to engage in sexual relationships with them. The word *"letamo"* (dam) is usually used to refer to a girl who is said to have had sexual intercourse with many boys and men such that her vagina has become big, an indication that having sex with her would no longer be pleasurable. For example, one female respondent indicated that;
"Ha re gana go dumela basimane ba re bitsa maina, Ba re bitsa bo le bitch, bo letamo"
If we refuse to go out with boys, they call us names like bitch and dams.

Discussion

This study identified some significant factors that come from peers, family and society that influence Batswana adolescents' sexual risk related behaviour. The beliefs that were identified are behavioural, control and normative. These beliefs influence adolescents' pre-marital sexual behaviours.

Behavioural beliefs

Adolescents are more likely to abstain if they evaluate the behaviour positively. Results of this study suggest that adolescents had conflicting messages about whether abstaining is good or bad behaviour. Most adolescents associated abstinence with prevention of health problems such as STIs, HIV infection and pregnancy. This is supported by the health belief model which posits that adolescents are more likely to adopt safer sexual behaviours if they perceive that they are susceptible to HIV infection (Iriyama *et al,* 2007). Some adolescents also stated that when one abstains, they would be able to finish their education. This was also evident in the Petosa & Jackson (1991) study where adolescents with perceived susceptibility were likely to have increased safer sex intentions including abstinence.

Iriyama, Nakahara, Jimba, Ichikawa & Wakai, (2007) indicated that adolescents who have different viewpoints compared to those above are likely to engage in sexual relationships. The UNICEF (2009) study found that adolescents reported that they believed that maintaining virginity was unhealthy and could lead to virgin disease. They also reported that abstaining

can lead to reduction of the birth canal and make it difficult for girls to have a baby. In addition it results in painful sexual intercourse in the future (UNICEF, 2009). Such beliefs therefore showed that some adolescents do not have intentions to remain abstinent. Intervention programmes should therefore address these beliefs.

Normative beliefs

UNICEF (2009) indicated that adolescents are more likely to abstain from sexual intercourse if they think that a specific referent person would approve or disapprove of the behaviour. Adolescents also indicated that peer pressure is paramount in their decision making as to whether to have sex or not. Even though parents were reported by adolescents as encouraging abstinence, there are some parents who were encouraging their female children to engage in sexual relations with older people as a way of providing and sustaining the family. Songs like, *"setlogolo ntsha ditlhogo"* may reinforce the normative belief about adult-child sexual relationships. This kind of song reinforces the normative belief that makes adolescents powerless to refuse to have sex with older people because they consider that the community approves that they should have sex with their uncles. Adolescents in the study estimated that about 75% of adolescents are having sex.

Control beliefs

A type of control belief was identified that is similar to those identified by Hutchison, Jemmott, Wood *et al* (2007) in their study of Jamaican adolescents. The control belief is negotiation belief that adolescents will be able to persuade their partners to abstain from sexual activities. This belief was prominent with female adolescents. Hutchison *et al* (2007) reported inability to negotiate abstinence with boyfriends. In addition, females reported that if they told their partners that they had opted for abstinence, the partners would leave and find another girlfriend. Gender differences in control beliefs were hence noted. Some of the distresses mentioned are related to peer pressure, that is, one wanting to be accepted into the peer-social network and wanting to sustain relationships with the opposite sex.

UNICEF (2009) shows that boys were significantly less likely to abstain compared to girls and started sex at an earlier age than girls (NACA, 2004). As boys came up with stories about the virgin disease, this reveals that they want to persuade girls to engage in sexual activities. The talks about virgin disease and painful erection, however, pass a general message for both boys and girls that sex keeps one 'healthy and fit' and prevents diseases associated with sexual organs. This argument brought forward by Botswana adolescents that sex is perceived by boys as healing is similar with what Ntseane (2004) found in her study. She reports that sex is perceived in some communities and population groups as a cleansing and healing mechanism. In addition, for some communities in Sub-Saharan Africa, social norms often condone or even force young people to engage in sexual activity by encouraging early childbearing and male promiscuity and failing to condemn sexual relationships between older men and younger girls (Swart-Kruger & Richter (1997), Ntseane (2004), Chilisa, Dube-Shomanah, Tsheko, & Bontshetse, (2005)).

However, it should be indicated that adolescents present conflicting messages about abstinence. On the one hand, abstinence is viewed as leading to physical and mental problems and making some parts of the body malfunction. This therefore indicates that adolescents are more likely to engage in sexual activities to remain healthy both physically and mentally (Chilisa, Mmonadibe, Malinga & Ellece (forthcoming)). They also argue that such behaviours which are passed by peers influence adolescents more and undermine any informed advice from parents, teachers and health workers. This therefore calls for a concerted effort to educate

adolescents in order for them to influence others positively (Chilisa, *et al,* forthcoming).

Conclusions and recommendations

The behavioural, normative and control beliefs identified in this study are critical to inform the intervention that will be put into place for adolescents. Programmes will need to address issues and the myths that adolescents are struggling with. Sexual abstinence has been introduced as a priority method for HIV/AIDS and STIs prevention among adolescents. In most countries including Botswana, abstinence is a component of the ABC (Abstain, Be faithful, and use Condoms) approach adopted by PEPFAR, a programme funded to address the HIV/AIDS pandemic (Kabiru & Ezeh, 2007). As such, this study will contribute to identifying the beliefs that adolescents have which influences them to abstain or not to.

Some beliefs that were identified were that adolescents view abstinence as a health problem and that it makes some parts of the body malfunction. Such information therefore indicates that there is a gap in the knowledge about how the human body functions; therefore serves as a wake-up call for a programme that can educate adolescents about the human reproductive system and diseases associated with it. In addition, programmes should be designed to address sexual health with attention on delaying sexual initiation as well as to develop appropriate measures to raise awareness and empower young people to negotiate abstinence.

This study captured indigenous knowledge which is available in communities that adolescents live in. With this indigenous knowledge, it is evident that the society is implicated in adolescents' perception and attitudes towards sex. Such experiences call for school based interventions together with community based programmes to persuade community acceptance and involvement in encouraging adolescents to refrain from sexual risky behaviours. Such a programme should be culturally sensitive in addressing issues that were brought by adolescents.

References

Ajzen I (2006), *Theory of Planned Behaviour,* retrieved from internet 28 September 2010, http://www.people.umass.edu/aizen/tpb.diag.html.

Ajzen, I. Fishbein, M. (1980). *Understanding Attitudes and Predicting Social. Behavior.* Englewood Cliffs, NJ, Prentice-Hall

Chilisa, B., Mmonadibe, P., Malinga, T. & Ellece, S. (forthcoming). *Indigenous Research. Methods: Language, Texts and Stories in the Construction of Adolescents Sexual Behaviours*

Chilisa, B., Dube-Shomanah, M., Tsheko, N. & Bontshetse, M. (2005). *The voices and identities of Botswana school children, Gender HIV/AIDS and life skills in education.* Nairobi: UNICEF.

Hutchinson, K. M., Jemmott Sweet, L., Wood, E. B., Hewitt, H., Kawha, E., Waldron, N., Bonaparte, B. (2000). Culture specific factors contributing to HIV risk among Jamaican adolescents. *Journal of the Association of Nurses in AIDS Care,* 18(2), pp. 35–47.

Iriyama S., Nakahara, S., Jimba, M., Ichikawa, M. & Wakai, S. (2007). AIDS Health Beliefs and Intentions for Sexual Abstinence among male Adolescents in Kathmandu, Nepal: A Test of Perceived Severity and Susceptibility. *Journal of the Royal Institute of Public Health.* 121, 64–72.

Kabiru, C. W. & Ezeh, A. (2007). Factors Associated with Sexual Abstinence among Adolescents in Four Sub-Saharan African Countries. *African Journal of Reproductive Health,* 11(3) 111–132.

Konde-Lule, J. K , Wawer, M.J., Sewakambo, N. K., Serwada, D., Kelly, R., Li, C., Gray, R. H., and Kigongo, D. (1997). Adolescents, sexual behaviour and HIV-1 in rural Rakai district, Uganda. *AIDS,* 11(6), 791–799.

Lakshmi, P. V. M., Gupta, N. & Kumar, R. (2007). Psychosocial Predictors of Adolescent Sexual Behaviour. *Indian Journal of Pediatrics,* 74, 923–926.

NACA. (2004). *Botswana AIDS Impact Survey II: Popular Report.* Gaborone, Ministry of Health.

NACA. (2000). *National Strategic Plan for Scaling up HIV prevention in Botswana 2000–2010.* Gaborone, Ministry of Health.

Ntseane, P.G. (2004). Cultural dimensions of sexuality: Empowerment challenge for HIV/AIDS prevention in Botswana. Paper presented at the International Seminar/ Workshop on *Learning and Empowerment: Key Issues in strategies for HIV/AIDS Prevention* held in Chiangmai, Thailand.

Petosa, R. & Jackson, K. (1991). Using the health belief model to predict safer sex intentions among adolescents. *Health Education Quarterly,* 18: 463–76.

Swart-Kruger, J. & Richter, L.M. (1997). AIDS-related knowledge, attitudes and behaviour among South African street youth: Reflections on power, sexuality and the autonomous self. *Social Science and Medicine* 45(6), 957–966.

UNICEF (2009). *Baseline rapid assessment survey of HIV and AIDS prevention knowledge among adolescents in Botswana.* Gaborone: UNICEF.

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A qualitative study of gender violence and sexual risk behaviours among adolescents in Botswana

Introduction

Media reports and research studies indicate that gender violence, especially sexual abuse, has increased, making adolescents more vulnerable to HIV infection (UNICEF 2005). In some communities in Sub-Saharan Africa, social norms often condone or even force young people into sexual activity by encouraging early childbearing, male promiscuity and failing to condemn sexual relationships between older men and younger girls (Chilisa 2006; Ntseane and Preece, 2005). A study in Botswana among in and out of school adolescents indicated that 21% of the respondents in Selebi Phikwe, Kang and Mahalapye reported a forced sexual debut and that female adolescents tend to experience more sexual coercion when compared to male adolescents (WHO 2001). Furthermore, gender-based violence also has negative consequences on the sexual behaviour of adolescents because adolescents who have experienced violence are more likely to engage in risky sexual behaviours such as using drugs, alcohol and having sex without using a condom (Berenson, Wiemann, McCombs, 2001). To give further insight into the gender dynamics and how they contribute to adolescents' HIV infection the study this paper is derived from used storytelling to solicit data on gender violence and other sexual risk behaviours. Specifically this method was used to capture respondents' experiences or knowledge of experiences that others went through and to penetrate into the depths of adolescents' experience. The aims of the study were to examine socio-cultural, family and school influences on adolescents' sexual behaviour; identify intermediaries of family and school influences on adolescents sexual risk behaviours; to design theory driven family and school interventions that are age and culturally appropriate for the group and finally, to pilot test if the interventions have efficacy.

Methodology

This paper uses data from ongoing HIV/STD Prevention Research on Batswana Adolescents aged 14 – 17 to explore the nature and scope of gender violence among adolescents at junior secondary schools. It is a partnership project between the University of Pennsylvania and University of Botswana funded by National Institutes for Health, USA. The study is exploratory and employs a qualitative approach. Three districts, Gaborone (urban); Molepolole (semi-urban) in the Kweneng district and South East (rural), were selected using purposive sampling because of their close proximity to Gaborone for purposes of accessibility and close monitoring. Two junior secondary schools in each district were selected purposively, resulting in a total of six schools being selected. Purposive sampling was chosen on the basis that it allows the researcher to sample until the point of saturation (Denzin & Lincoln, 2000). Data were solicited from 15 focus group interviews with students and each focus group had 10 – 12 participants. There were 5 mixed, 5 female and 5 male focus group discussions. The teachers assisted with the recruitment of students aged 14 to 17 years in Forms One to Three based on their assessment of the students' ability to articulate issues relating to HIV and AIDS and also based on representivity of the diverse backgrounds and lifestyles of students that attend the school. Only interested students whose parents gave assent for their participation took part in the study. To solicit data on gender violence and adolescents' risky sexual behaviours proverbs, sayings and songs were used. Participants were also asked to tell a story that they know that involved forced sex and other stories that they have heard that may lead adolescents to indulge in risky sexual behaviours. The thematic approach was used to analyze the data, whereas the narrative analysis reviewed what could be learnt from the stories told by the students on adolescent lifestyles, sexual behaviour, condom use, multiple partners, decision making and gender violence.

Findings

Listening to the stories narrated by the respondents, it was observed that despite several challenges facing the adolescents there was a lack of proper communication channels for the adolescents to voice their concerns and challenges. The stories related by female students concerned gender violence which manifested itself through unwanted touches, use of vulgar language to embarrass the victim and use of force to make the victim comply with the demands of the perpetrator. Female and male adolescents narrated stories related to adolescents' attitudes and beliefs towards abstinence, condom use, multiple partners, and gender violence to demonstrate how adolescents engage in HIV/AIDS-risky sexual behaviours. These issues are discussed in detail below.

Attitudes and beliefs towards abstinence

Participants reported that maintaining virginity was unhealthy and could lead to "virgin disease" or affect one's chances of procreation and lack of skill of having sex when one grew older. It could also lead to reduction of the size of the birth canal or make it difficult for one to have a child or sex in the future. In reference to erection some male respondents stated that it was a sign of deficiency in sex and that and that one has to engage in sexual intercourse immediately, failure of which will lead to pain. Some described it as "pleasing pain". One of the male respondents said: *"In men there is something called erection and it is painful".*

During focus group discussions it was clear that sexual risk behaviour was also rooted in the context of differing degrees of power within relationships and gender norms regarding sexual behaviour. One of the females in the girls' only groups referred to unequal power play between partners in a sexual relationship. She indicated that it was difficult to abstain from sexual intercourse because of the pressure to maintain the relationship. This is how the female respondent phrased it:
"Maybe the partner you have wants to have sex and you are afraid to say no that you will lose him/her."

Attitudes and beliefs towards multiple sex partners

Adolescents' stories also indicated that they do not engage in monogamous relationships. The majority of participants related stories of the people they know who have more than one sexual partner, including their peers, friends, family members and people from the community. From their perspective, adolescents tend to have multiple partners for various reasons such as security (to have a 'backup' when one is 'dumped'), to please their peers and to have multiple benefits. Multiple partners are also meant to meet adolescents' multiple needs because having one partner may not give everything they want. One male student related a story about his friend who dated 3 girls in the same school but not all were aware of the cheating. One female student indicated that one-partner relationships were monotonous because one would get used to the partner's behaviour and therefore it was preferable to have different experiences. A 15 year old female student from a girls' focus group said:
"If you have one partner when your partner hurts your feelings, there will be no one to turn to; you can't eat only one thing every day. You have to taste all kinds."

According to the girl above it seems to be alright for girls too to have multiple partners. The boys also concurred with the girls' view by emphasizing that promiscuity is culturally accepted. For example a 17 year old boy in one of the focus groups said:
"Our culture influences men and boys to be promiscuous through proverbs because they encourage them to have multiple partners, for example Monna selepe o a adimanwa, [which] means that as a boy I am entitled to more than one girl."

The messages being communicated by these attitudes and beliefs is an indication that it is okay for both girls and boys to have several partners. As such, they greatly influence how adolescents should behave sexually and also shape the social attitudes about how to view promiscuous behaviour.

Attitudes and beliefs towards condom use

Most of the respondents also reported that they had heard stories that male condoms have worms, bad odour, are irritating, too greasy and that if one uses it he or she develops a rash on their private parts. A 17 year old female respondent reported:
"Nna ke utlwile gotwe ke yone e gakatsang mogare le bolwetse" (I have heard that condoms increase HIV infections and AIDS).

The respondents admitted that some of these stories have the potential to discourage adolescents from using condoms. Most of the respondents indicated that boys usually come up with stories to convince girls not to use a condom during sexual intercourse. For example one 16 year old female respondent said:
"Basimane mo sekolong ba thola ba re bolelela gore condom e kgona go salela mo mosetsaneng" (Boys in school always tell us that a condom can remain in the girls' private parts after sexual intercourse).

Gender violence

Through the focus group discussions it was evident that the construction and reinforcement of gender norms, power dynamics, sexual coercion, verbal, physical and sexual abuse in schools and the community are obstacles in HIV and AIDS prevention among adolescents. The stories told by respondents revealed that adolescents, especially females, are more often victims of gender violence compared to boys. Several participants talked about cases they know where young girls were raped by men who were older than them, and that some of them were their relatives. One female respondent stated that during a music event at school a young man handled her roughly by forcing her to dance with him. When she resisted the other female students jeered at her for behaving as a "street person". She indicated that usually young female students felt that whoever was violated asked for it, was loose and enjoyed the attention she received. The perpetrator, when realizing that the victim was resistant, threatened to tell his gang members to gang rape her and that there was nothing she could do about it. This was an indication that sex could be used as a means of oppression.

Adolescents also reported that sexual coercion in the form of unwanted touches, incest, rape and defilement is also perpetuated by relatives and people that are known to them. For example, a female participant indicated that her male cousin made sexual advances towards her but she was able to resist the temptation because she did not like the way he touched her. The respondent said:
"He was older and my parents had given him the responsibility of caring for me. Instead he touched me and tickled my waist".

Another female student knew a friend who dropped out of school due to pregnancy by her uncle but was not sure whether the girl was forced into or condoned the relationship. One respondent related an incident where she found an uncle sexually abusing his five-year-old orphaned niece. The perpetrator threatened the respondent and warned her never to visit the home again. The respondent then reported the perpetrator to the social welfare department who reported the case to the police and the perpetrator was jailed for defilement.

However focus group discussions with adolescents also indicated that nowadays intergenerational relationships seem to be an accepted norm among adolescent girls and boys. They engage in these relationships for financial and material gain. Another important issue that put adolescents at risk of HIV and STI infections related to negotiation surrounding use of condoms and sexual activity. Female adolescents reported that pressure and forcible sex with peers and older male sexual male partners was very common. This was also reinforced by respondents – the following proverb came out consistently in the discussions: *"Ga di nke di etelelwa pele ke manamagadi"* They (a herd) are never led by females.

Adolescent boys invoked the proverb to substantiate why a boy should initiate a love relationship and make decisions on when to have sex, how and when to have sex, and whether condoms can be used. The proverb is gendered and gives power to boys and men. It suggests that adolescent girls cannot have a say on whether they want to abstain or not.

Discussion

Despite attempts by the government to have health and sex education, guidance and counselling curricula in the schools, the school environment tends to be an area where students learn more sexual risk behaviours because that is where they interact mostly with their peers. The focus group discussions indicated that gender violence, in the form of rape, defilement, multiple partners, lack of condom use are still indicative of risky behaviour among adolescents in schools. The outcomes tend to overlap with investigations by Gallant and Maticka-Tyndale (2004; UNICEF 2006). The results also indicate that gender violence, especially against female adolescents, is still a barrier to HIV/STD prevention among adolescents.

Female adolescents in schools tend to become victims of gender violence when compared to their male counterparts, as indicated by some of the respondents' stories. This is partly due to male students playing a major role in supporting risky sexual behaviours by verbally, emotionally or physically abusing them if they do not conform to their code of conduct. It is evident that these kinds of attitudes somehow encourage female students to engage in sexual relationships, have multiple sexual partners, and have sex without using condoms for fear of being victimized. This is also perpetuated by the fact that there is failure to a certain extent on the part of the school, family and the community to protect them from abuse. Women and female children often become victims of gender-based violence in the pretense of cultural practices and norms which ultimately lead to the spread of HIV and AIDS (Maundeni 2003). Stories told by respondents indicate that adolescents are victims of unwanted touching, rape and defilement in the schools, at home by relatives, and that the community sometimes condones cultural sayings and metaphors that encourage risky sexual behaviours. The respondents who narrated stories of sexual abuse and forced sex indicated that sometimes the victims were unable to tell their parents, guardians or teachers about the abuse.

This study also revealed that female adolescents do not have a final voice in making decisions about sex, and that they are often the ones who have to make decisions that lead to sexual risky behaviours such as having unprotected sex to maintain relationships – a phenomenon that was also evident in previous research studies on sexual relations among young people in developing countries (WHO 2001). Moreover, adolescent girls highlighted their struggle in dealing with intergenerational sex. Intergenerational sex that occurs among relatives often sends messages to adolescents that having sex with an older person is acceptable, for example the situation of the uncle abusing a 5 year old orphaned girl that was narrated by one of the respondents. The Botswana AIDS Impact Survey II (BAIS II) (Republic of Botswana 2004) and UNICEF (2009) studies also show that girls are more likely than boys to have

sexual intercourse with older partners. The adolescents however see it as a means of control and oppression.

In addition, there is evidence of a perceived inability to negotiate condom use by female adolescents with their boyfriends, especially when they are older than them. Such relationships with older male partners and even with coercive relationships are common in Botswana as is indicated by the Republic of Botswana (2004) and UNICEF (2009) studies.

Some of the risky sexual behaviours are a result of the cultural norms, practices and believes about condom use, multiple partners and abstinence. Furthermore false stories and myths about the use of condoms, abstinence (virginity) and multiple partners put both male and female adolescents at risk. The failure of social norms to condemn such practices that put people at risk has influence early sexual debut and male promiscuity (Chilisa, 2006; Ntseane and Preece, 2005). It also tends to recap the theory of planned behaviour (which guides the larger study that this paper draws data from) where normative and control beliefs influence individuals' perceptions about the particular behaviour, which in turn are influenced by the judgment of significant others, i.e. where pressure from either parents, friends or significant others play an important role in decisions on when to indulge in sex. These multiple issues that involve adolescents' sexuality and sexual behaviour tend to expose more female adolescents to risky sexual behaviours compared to their male counterparts. The results of this qualitative study may speak to the differing prevalence and incident rates among female and male teenagers in Botswana. The Botswana AIDS Impact Survey III (Republic of Botswana 2009) also indicates that the HIV incidence rates for people aged 15–19 years for males and females were 0.50 and 0.78 while the prevalence rates were 2.4 and 5.0 respectively.

Conclusion

There are several ways, including sexual coercion, in which ideas about sex and gender create circumstances of greater HIV risk among adolescents. Females are at a greater risk of HIV sexual risk behaviours as a result of exposure to gendered violence. Furthermore, peer norms and the boys' construction of masculinity also play a major role in increasing vulnerability to sexual risk behaviours. The study findings indicate that more aggressive HIV and AIDS prevention programmes that are age, gender and culturally sensitive are needed to prevent HIV transmission among adolescents. The fact that female adolescents continue to experience defilement and rape calls for review of the relevant legal penalty. There is a need for specific programmes for boys in schools to reinforce knowledge about gender issues, and to help them develop positive attitudes towards their female counterparts. Furthermore, research that targets perpetrators to explore intergenerational sexual relationships, particularly relating to incest and other sexual relationships involving older people from the same kinship and younger people, is also necessary.

References

Berenson, A.B., Wiemann C.M., and McCombs, S. (2001). Exposure to violence and associated health risk behaviours among adolescent girls. *Archives of Paediatrics and Adolescent Medicine* 155(11), 1238–42.

Chilisa, B. (2006). Sex education: subjugated Discourses and Adolescents' Voices. In Skelton, C., Francis, B., and Symulyan L. (Eds). *The Sage Handbook of Gender and Education,* 249–261 London: Sage Publications.

Denzin, N. K. and Lincoln, Y. S. (Eds). (2000). *Handbook of Qualitative Research.* London: Sage Publication.

Gallant, M. and Maticka-Tyndale, E. (2004). School-based HIV prevention programmes for African youth, *Social Science & Medicine* 58(7), 1337–1351
.

Maundeni, T. (2003). Cultural Factors in the spread of HIV/AIDS among children in Botswana. In E. Biakolo, J. Mathangwane, and D. Odallo, (Eds). *The Discourse of HIV/AIDS in Africa,* 133–136. Pretoria: UNAIDS.

Ntseane, P.G., and Preece, J. (2005). Cultural dimensions of sexuality: empowerment challenges for HIV/AIDS prevention in Botswana. *Development Southern Africa,* 22(3), 347–363.

Republic of Botswana. (2004). *Botswana AIDS Impact Survey II: Popular Report.* Gaborone: Central Statistics Office.

Republic of Botswana. (2009). *Preliminary Botswana HIV/AIDS impact survey III results.* Gaborone: Central Statistics Office, Gaborone.

UNICEF. (2009) *Towards Universal Access. Scaling up Priority HIV/AIDS Interventions in the Health Sector. Progress Report.* Geneva: WHO.

UNICEF. (2006). *The State of the World's Children: 2006.* Geneva: WHO.

UNICEF. (2005). *Annual Report.* Gaborone: UNICEF.

WHO. (2001). *Sexual relations among young people in developing countries: evidence from WHO case studies.* Geneva: WHO, Department of Reproductive Health and Research.

Girl child prostitution in Africa: the case of Botswana

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Introduction

The practice of commercial sexual exploitation of children has become a global problem and a booming multi-billion dollar industry whose manifestations vary from society to society. In the Southern Africa region there is little information on the nature and extent of child prostitution. The danger of inadequate information on the subject at national level has the unintended consequence of trivializing an otherwise crucial problem, thereby letting this horrendous business flourish at a huge social cost. This paper attempts to add voice to the growing body of international research on child prostitution by focusing attention on Botswana, one of the fastest growing middle income countries in Southern Africa. The study aimed at exploring stakeholders's perceptions of the extent of girl child prostitution in Botswana, its forms, causes, impact and existing children's legislation. The paper also recommends ways in which girl child prostitution can be minimized.

Background

UNICEF (2000) reports that large numbers of children are being trafficked in West and Central Africa, for domestic work, sexual exploitation and to work in farms and shops. The commercial sexual exploitation of children (CSEC) is a fundamental violation of children's rights. It comprises sexual abuse by the adult and remuneration in cash or kind to the child or a third person or persons (ECPAT International, 1996). The child is treated as a commercial object. This constitutes a form of coercion and violence against children and amounts to forced labour and a contemporary form of slavery. CSEC exists to some degree in every society. However, there has been a rapid expansion of CSEC in the last decade, making it a problem of global proportions. Although it is impossible to verify the number of children involved in CSEC, research and anecdotal evidence show a continuous increase (Child Wise, Australia 2003). Large well-organized child sex industries have emerged in the poorer nations of Asia, Africa, Latin America, and more recently, in Eastern Europe, the Pacific Region and Indo-China. Estes and Weiner (2001) argue that economic globalization, internationalization and free trade has brought with them an unanticipated set of social problems. One of their findings is that between 244,000 and 325,000 American children and youth are at risk of becoming victims of CSEC each year. There are several interrelated forms of CSEC, namely child pornography and child trafficking for sexual purposes, sex tourism and child prostitution.

Child prostitution is a situation where a child is forced to have some sexual activity with a man or a woman in exchange for money and other forms of payments. It is an accepted fact that child prostitutes are found in virtually every country, including the United States, France, United Kingdom, Germany and Japan (ECPAT, 2001).

According to ECPAT International (2001) Childline, one of the NGOs in Botswana reported the existence of child prostitution at the border between South Africa and Botswana, where young girls from the surrounding areas engaged in survival sex to subsidize family income. Many of the girls were suspected to be orphans running child headed households (ECPAT, 2001). Most sex buyers in this area were truck drivers on their way to and from South Africa. Young sex workers were often visible outside hotels and nightclubs of main cities and tourists areas of the country. Reports of sexual exploitation, abuse, and criminal sexual assault are increasing, and public awareness of the problem is generally growing. ECPAT International (2001) found out that although CSEC is growing worldwide, in some regions such as southern Africa, information on CSEC is inadequate, if not scarce. There is deep-rooted secrecy, denial and a pervasive silence that make issues of CSEC complex.

Resulting from the lack of information at national level on the extent of child prostitution in Botswana, this problem can be trivialized. Human Rights are universal to all human beings including children. All human beings must enjoy civil, political, economic, social and cultural rights. Children must enjoy human rights that are appropriate to their status as minors such as the right to special care and protection. The girl child is particularly vulnerable to certain human rights violations such as economic and sexual exploitation, prostitution and trafficking. The rights of children, including the girl child, are clearly set out in the United Nations Convention on the Rights of the Child which Botswana signed and ratified. According to Article 34 of the CRC, "State Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes State Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent: a) the inducement or coercion of a child to engage in any unlawful sexual activity; b) the exploitative use of children in prostitution or other unlawful sexual practices; c) the exploitative use of children in pornographic performances and materials."

This study attempts to contribute to the small-scale studies that have been undertaken by focusing attention on girl child prostitution in Botswana. The study targeted key informants such as social workers, traditional chiefs, parents, teachers, special NGOs who deal with children, brothel owners and the girls themselves.

Methodology:
This study employed a qualitative and cross-sectional design aimed at capturing a one-off picture of the nature of girl child prostitution in Botswana from different targeted individuals and institutions. As an exploratory study, our target was key institutions that deal with children's issues such as non-governmental organizations and government departments. Targeting key informants on child prostitution the study concentrated in four areas: Gaborone, Maun, Francistown, and Letlhakeng. In-depth interviews were conducted with social workers, the police, bed and breakfast lodge operators, and the girls themselves. The data were analyzed manually through subjecting the interviews to content and thematic analysis guided by the study's major objectives.

Findings
Perceptions of the extent of girl child prostitution
The study sought to establish whether or not girl child prostitution exists in Botswana. Almost all the respondents had either heard, were aware of its existence, or had seen the girls at various spots. They directed the researchers where to find the girls. One of the key informants, a social worker, told the researchers that girl child prostitution is sometimes hidden under child sexual abuse. This happens when parents are getting money or other forms of assistance from the perpetrator – hence the reluctance to see him brought to book. The same goes for rape cases where parents would say, "we will settle it at home". In such scenarios, the issue is settled according to the interests of the parents and the perpetrator and not the 'victim'. In Francistown, the researchers saw numerous girls waiting for men on key streets and bars. When a man driving along the streets stops, girls rush towards both sides of the car so that the man picks whoever he wants. In other sections of the city, girls could be seen queueing up waiting for their turn. The police confirmed the presence of these girls at night and how in the absence of a law on prostitution, they charge them with vagabond and rogue behaviour which does not help matters.

The researchers learnt about the different charges for sex from the interviewees which differed according to whether the girl child was a foreigner or a citizen; whether it is protected sex

or unprotected sex; whether the buyer was a foreigner or a citizen; white or non white. The price ranged from P5 to P100 or more depending on the status of the buyer.

Interviewees revealed that girl child prostitution also existed in areas of Botswana other than the research locations. The areas included Lobatse and Kang. In Kang, researchers were told that school girls can be seen in the morning coming out of big trucks and going straight to school from the trucks. Therefore, although we cannot give precise figures on the extent of girl child prostitution in Botswana, it is increasingly clear that it is a growing problem.

Forms of girl child prostitution

Several forms of girl child prostitution were found – the most common was street prostitution. *Street prostitution* is where the girls solicit customers, while waiting at street corners or walking up and down the street until a customer is found. This kind of prostitution was mostly reported in Gaborone, Francistown and Maun. The majority of the girls were aged between 16 and 19 years and above. There could be girls who were aged 15 years or even younger, especially in some instances where primary school (standard sevens) children are involved. Some school girls saved the combi/bus fare that the parents gave them so that they could buy chips or sweets by paying combi fares with sex.

Parent-sanctioned prostitution is another form where poor parents gave their young daughters to grown-up men to stay with and use them for sex in return for money or food. The girl could be as young as 13 years. This form was mostly reported in Maun.

Selling sex at lodges, hotels, bars and night clubs is another form of prostitution. This is where men booked rooms in lodges and hotels, then brought in girls for sex. Some girls hung around outside bars and night clubs because they were not allowed in due to their age. They then got picked up by men/buyers to the rooms that were already booked.

In *disguised girl child prostitution* non-citizen girls lined up in front of big stores for piece jobs of cleaning washing, ironing but the major occupation is sex. In *long-distance truck drivers' prostitution* girls loitered around places where trucks stopped for a long time and mostly around shops and restaurants. The girls knew where the truck drivers got their evening meal and that was where they paraded. This happenned mostly in Gaborone and Maun. Finally, the *tree prostitution* was found in Maun and Francistown. In Francistown, the identified tree was where the girls were picked up, and in Maun it was where the sex took place.

Perceptions of causes of girl child prostitution

Respondents associated girl child prostitution with several causes, such as poverty; the desire to have modern luxury goods; migration and unemployment; culture and religion; myths; peer pressure and moral decay. These are intertwined and complex factors which conspire to push girls into prostitution. Most of the interviewees attributed the girl child prostitution in Francistown, Maun and Gaborone to poverty. This is in line with findings of de Olivera (2008) who argued that the major reason why girls are compelled to practice prostitution is poverty. Lack of viable economic opportunities combined with rising expectations and the desire to acquire modern goods is another cause of girl child prostitution. Those who want to achieve a certain lifestyle but are not able to do so, through acceptable means, may find themselves doing things they otherwise would not do.

General family problems such as broken homes, death of parents when the children are still young (in the absence of a reliable guardian to care for them) were also associated with

prostitution. Respondents asserted that some parents have a tendency of encouraging young girls to engage in sexual encounters with older men in exchange for support of the family. Young girls are forced to do so against their will. This is not unique to Botswana. Some girls are forced to leave the rural areas and migrate to Maun, Francistown and Gaborone with the hope of finding jobs to support their parents back home. Failure to secure jobs forces them to learn from other girls who are already involved in the sex trade in town to join prostitution and earn cash (to support their families or buy items they want, including food). The need to eat and pay for rent and the thought of the situation back home in the rural areas leave them with no choice but to fall prey to prostitution.

There is also an erroneously held belief that if an HIV-positive person has sex with a virgin he will be cured of the virus. This seems to encourage many men to frequent streets and bars or other places where they can get young virgins desperate for money.

Peer pressure and fun are given as reasons for the girl child prostitution problem, especially among school girls. The researchers were given examples of school girls who fell prey to prostitution because their friends pressurize them to 'enjoy'. Hence the increasing tendency among girls to sleep with taxi drivers and conductors so that they enjoy free transport.

Impact of Girl Child Prostitution
Several negative consequences were identified. These include: STIs and transmission of the HIV/AIDS virus, unwanted pregnancies, rape, psychological effects, and finally drugs and alcohol abuse.

Girls practicing prostitution in Botswana are more at risk of contracting sexually transmitted infections due to their engagement in sex with many people. This is made worse by some customers preferring sex without condoms for which they are prepared to pay more money. Unwanted or unplanned pregnancies are another consequence of prostitution on the girl child. It was reported that some girls had become pregnant without knowing exactly who the father of their children is. Some girls have been raped while waiting at a street corner or walking up and down a street. They have been assaulted, made to suffer all sorts of acts of violence and, at times, murder. News of prostitute girls and women being killed by serial killers have always been reported in the media although not much was reported by our interviewees.

Social workers interviewed stressed the unpleasant psychological consequences of prostitution on the girl-child. They asserted that prostitution is degrading and lowers the self-esteem of the girl and even of the customers.

Existing Laws
The study found that there is no specific law that deals with prostitution in Botswana. This makes it difficult to define prostitution and let alone girl child prostitution. This also creates problems for the police who arrest girls at night but are unable to use any stiff fine to deter the trade because there is no law to guide them. The cultures and sub-cultures of the different Batswana communities do not make things any better either.

As the study took place before the Children's Act of 1981 was revised in 2009, the researchers focused on the Children's Act of 1981. They were aware of the relevant parts of the Act plus some sections of the Penal Code and Acts relating to children and women which could be invoked to protect the girl child or prosecute the offender. The Children's Act 1981 (CAP.28:04) Part IV made a provision for the prevention of neglect and ill-treatment of

children. It specifically touched on prostitution in section 12(1), under corruption of children. It is encouraging to note that there have been developments in the enactment of the Children's Act of 2009 which provides the legal framework for the safety, protection of children and prosecution of offenders of children.

The other Act which has not yet been revised is the Adoption of Children Act 1952 (CAP.28:01). This Act was found to have the potential to perpetuate sexual abuse of the child in a way because Section 14(a) permits the adoptive parent or his/her relatives to marry the adopted child as long as the child is old enough to be married. Also according to Section 14 'The adoption of a person shall not prohibit under criminal sanction any carnal intercourse between that person and any other person, which would not have been so prohibited if the adoption had not taken place'. This can influence people to adopt the girl child for the reason of having sexual intercourse with her.

The study therefore noted that the legal framework as it was at the time of collecting data for this paper was not helpful in terms of protecting the girl child as well as deterring girl child prostitution.

Conclusion and recommendations

This study aimed at exploring stakeholders' perceptions of the nature of child prostitution in Botswana. From the discussion above, we can make the following conclusions: girl child prostitution exists in the three sites visited – Gaborone, Francistown and Maun – in a more visible manner than in the rural village of Letlhakeng; there are various forms of girl child prostitution like street, lodges/hotels, parent-sanctioned, disguised, tree and truck prostitution; the causes of girl child prostitution include poverty, desire for modern goods, lack of parental care and orphan-hood, some aspects of cultural/tradition, migration to urban areas, alcohol, myths on HIV/AIDS transmission, peer pressure and moral decay; the impact of girl child prostitution includes transmission of STDs and HIV/AIDS, unwanted pregnancies, rape, murder and negative psychological consequences; at the time of collecting data for this study, there was no specific law on prostitution in Botswana except parts of some pieces of legislation including the penal code which made peripheral references to the girl child. The UN Convention on the Rights of the Child (CRC) is therefore an important instrument which the Children's Act 2009 has domesticated.

On the basis of the findings from this study, the following recommendations could go a long way in addressing the problem of girl child prostitution:

- A comprehensive and country-wide study needs to be undertaken to establish the volume and extent of girl child prostitution in Botswana;
- There is a need to develop a comprehensive legal framework for prostitution in order to ensure that various actors understand and know how to act on the subject;
- Finally, there is a need for a massive public awareness campaign targeting school children, parents and chiefs about the dangers of girl child prostitution and ways in which parents can help their children to desist from prostitution.

References

Child wise Australia (2003). *Sexual Exploitation of Children and Adolescents in Tourism* ECPAT International Bangkok.

De Olivera (2008). *Exploitation of Children in Prostitution: Thematic Paper Report of the World Congress III Against Sexual Exploitation of Children and Adolescents.* ECPAT International Bangkok, Thailand.

ECPAT (1996). *Children are not for sale.* ECPAT International Bangkok, Thailand.

ECPAT (2001). *Child Pornography and Sexual Exploitation of Children.* ECOAT International Bangkok, Thailand.

Estes Weiner (2001). *The Commercial Sexual Exploitation of Children in the US.* International Business Times, US.

UNICEF (2000) *The Progress of Nations.* UNICEF New York.

List of relevant Statutes

The Botswana Children's Act 1981 (Cap. 28: 04)
The Botswana Children's Act 2009 No 8
The Deserted Wives and Children's Act (Cap 28:03)
The Adoption of Children Act of 1952 (CAP.28:01)
The Penal Code (Cap.081)
The Marriage Act of 2001 (CAP. 29:01)
The United Nations Convention on the Rights of the Child

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Botswana Teen Club: a model of excellence for the provision of peer support to HIV-positive adolescents

Introduction

The roll-out of anti-retroviral treatment (ART) programmes in Botswana and other Sub-Saharan African (SSA) countries has made it possible for large numbers of perinatally HIV-infected infants to reach adolescence (Fielden *et al,* 2006). However, in Botswana and other SSA countries, HIV/AIDS treatment, care, and support programmes are organized around adult and paediatric care, neglecting the specialized needs of adolescents (AIDS Support Organization & Population Council, 2007). Moreover, many programmes assume that HIV-infected young people remain sexually inactive and therefore fail to address their need for comprehensive sexual and reproductive health information and services (Birungi *et al,* 2007). Providing proper care for HIV-positive adolescents requires strong social support – by families, peers and adult role models – to encourage medication adherence, disclosure, proper nutrition and other healthy behaviours (Li, 2009). This paper provides an overview of the Botswana Teen Club programme, a model for the provision of peer support for HIV-positive adolescents, including comprehensive psychosocial and reproductive health care and support. The Botswana Teen Club programme is a network of peer support groups for HIV-positive Batswana adolescents. Monthly Teen Club meetings were first instituted at the Botswana-Baylor Children's Clinical Centre of Excellence in 2005.

An Overview of the Botswana-Baylor Children's Clinical Centre of Excellence

The Botswana-Baylor COE is a member of the Baylor International Paediatric Aids Initiative (BIPAI). BIPAI was founded in 1996 by Dr. Mark Kline at Baylor Medical College (Houston, USA) and is now the largest university-based programme worldwide dedicated to improving the health and lives of HIV-positive children. In partnership with local governments, BIPAI consists of a network of ten Centres of Excellence across Africa.

The first Baylor COE on the African continent was opened in 2003 at Princess Marina Hospital in Gaborone, Botswana. At the time of writing this paper in 2010, more than 2,000 children and adolescents at the Botswana-Baylor COE were receiving treatment; fewer children were being hospitalized because of HIV/AIDS-related illnesses and even fewer were dying. In fact, the clinic's mortality rate has been below 1% since 2006, most recently reaching 0.3% for the period of July 2009-June 2010. The Botswana-Baylor COE treats infants, children, and adolescents, as well as their family members. The number of adolescents in Botswana under care is increasing rapidly, primarily as a result of children who were born with HIV surviving into their teenage years. Though the challenge of addressing the needs of a rapidly growing HIV-positive adolescent population is daunting, the Botswana-Baylor COE has risen to the challenge and has already spearheaded a number of medical and psychosocial interventions for its teen patients, including a comprehensive Adolescent Programme and network of Teen Club peer support groups.

Botswana-Baylor COE Adolescent Programme

Derived from the Latin verb adolescere (to grow into maturity), adolescence is a period of great change. This second decade of life is one of the most complex transitions of human development, its breathtaking pace of growth and change second only to that of infancy. Physically, children experience rapid growth spurts and become sexually mature. Demands of culture, gender, globalization and poverty have pushed millions of adolescents prematurely into adult roles and responsibilities. HIV/AIDS, urbanization and rising unemployment have dramatically undermined the education and development of many adolescents. As traditional

social networks unravel, the structure of families is reshaped and sometimes demolished, and the capacity of family and community support systems shrinks. With their world often lacking safety, consistency and structure, adolescents are left to make difficult choices, largely on their own. These challenges are compounded for adolescents living with HIV.

The Botswana-Baylor COE Adolescent Programme started in 2005 with only 23 teenagers. The adolescent population in the COE has continued to grow and at the time of writing this paper, over 400 teenagers were receiving treatment. Based on age-stratification data collected from the client population, the average age of paediatric patients was just over 10 years old. In the next few years, when the 9 and 10 year olds reach adolescence, the age makeup of the patient population will shift dramatically towards the teenage years. It is estimated that by 2012 the COE will have over 1,000 teenagers. Furthermore, recent records indicated that over 2,000 teenagers were enrolled in Botswana's National Anti-Retroviral (ARV) Programme. By the end of 2011, a conservative estimate of Botswana's teen ARV needs indicates that over 4,000 adolescents will need ARVs nationwide. In addition to medical treatment, these teens will need specialized care and support to help them overcome the hurdles of puberty and adolescence.

Overview of Teen Club

In 2005, the first Teen Club for HIV-positive adolescents in Botswana was started at the Botswana-Baylor COE. The mission of Teen Club is 'to empower HIV-positive adolescents to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, adult role-modelling and structured activities, ultimately leading to improved clinical and mental health outcomes as well as a healthy transition into adulthood.' The Gaborone Teen Club currently has over 200 active members and attendance is growing every month. Teen Club events occur on Saturdays and have included large group games, drama activities, pool parties, safaris, movie nights, and art sessions. Educational components are also incorporated into the Teen Club events including topics on HIV education, life skills, college preparation, personal finance management and goal-setting. We strive to give each teenager the opportunity to normalize their social experiences and to improve their outlook on life.

Teen Club satellite expansion

Expansion of satellite Teen Clubs to outreach sites will allow adolescents who are not currently enrolled in the Gaborone COE to benefit from the Teen Club model. We are currently partnering with Non-Governmental Organizations (NGOs) and ARV hospitals in the following towns and villages to implement satellite Teen Clubs:

1. Francistown: Light & Courage Centre Trust, Nyangabgwe Referral Hospital (formed October 2008)
2. Molepolole: Hope Worldwide Botswana, Scottish Livingstone Hospital (formed November 2008)
3. Mochudi: Stepping Stones International, Deborah Retief Memorial Hospital (formed September 2008)
4. Mahalapye: Mothers' Union Orphan Care Centre, Mahalapye District Hospital (formed May 2009)
5. Maun: Bana Ba Letsatsi, Letsholathebe District Hospital (formed November 2009)

As detailed in a memorandum of understanding between the involved parties, each partner agrees to support Teen Club activities in the following manner:

- Botswana-Baylor Children's Clinical Centre of Excellence: provides funding for teen

transport and meals, training for adult volunteers, and administrative oversight.
- NGO Partner: serves as primary implementing body of satellite Teen Club, coordinates and screens adult volunteers, submits receipts, attendance records and event summaries to Botswana-Baylor COE.
- ARV Hospital: provides referrals for HIV-positive adolescents to attend satellite Teen Club events as well as medical follow-up and counselling for Teen Club members.

Partnering with NGOs and healthcare partners at the local level has allowed the Botswana-Baylor COE to decentralize its psychosocial care and support interventions for adolescents, namely Teen Club, to various towns and villages throughout Botswana. At the time of writing this paper, the enrolment of active Teen Club members nationwide was over 500 adolescents.

Outcome

An evaluation of the Teen Club showed that the programme enabled the participants to become better at handling their daily lives, getting along with their family and peers, performing academically, coping with the challenges of life, accepting their HIV status, adhering to their medications, practicing life skills and report having more hope for their future. Participants have called for increased support to reduce risk-taking behaviours such as unprotected sex and alcohol and drug abuse. Participants have also expressed a need for information and guidance on healthy disclosure as very few participants have admitted to disclosing their serostatus to a friend or romantic partner. Anecdotal evidence strongly suggests that Teen Club plays an important role in normalizing the lives of the teens enrolled.

Recommendations and way forward

In the 2008 Annual Report of the Botswana-Baylor COE, Executive Director Prof. Gabriel Anabwani wrote, "Among the challenges that lay ahead, the need to prepare for the care of the ever increasing population of adolescents and young adults who are living with HIV and AIDS stands out most. We must pool our resources and discover better methods to help these most vulnerable members of our community. This is the challenge of our time; it is also the opportunity of our age." Indeed, Botswana is not alone in facing the phenomenon of an increasing adolescent HIV population; all of Southern Africa will need to rise up to meet this challenge. If safety nets in the form of psychosocial support interventions such as Teen Club are not put in place throughout the region in the very near future, many of these adolescents may be condemned to treatment failure, thereby reversing the great strides that countries such as Botswana have made in combatting paediatric HIV.

Our experiences at the Botswana-Baylor Children's Clinical Centre of Excellence have shown us that adolescent HIV clients can benefit greatly from adolescent-focused services, frequent follow-up with continuity physicians and intensified individual psychosocial support with social workers and psychologists. It is also important to encourage healthy disclosure and ongoing life skills education and to implement peer support and mentoring programmes, such as Teen Club. Positive living must be stressed at every clinic visit.

Clearly, rapidly increasing numbers of HIV-positive adolescents create unique challenges for healthcare providers, but our experience has shown that comprehensive, adolescent-focused services can foster successful transitions into adulthood for HIV-positive youth. However, our achievements at the Botswana-Baylor COE are not solely our own and are not an end in themselves. Indeed, they are not even the beginning of the end as we are just beginning to comprehend the ramifications of the maturation of large numbers of paediatric HIV clients on ARVs into adolescence. Since many sub-Saharan countries lag behind Botswana in the

provision of universal ART, this phenomenon will continue for the foreseeable future, delayed in some countries more than others, but is nonetheless inevitable. Public, private and governmental entities in all southern African countries must work together to address this pressing issue.

Our primary goals for the near future are to develop an Adolescent Centre that will provide a variety of drop-in services such as counselling, tutoring, life skills education and recreational activities; to establish new satellite Teen Club sites; to hire additional staff commensurate with the growth of our programme; and to continue developing various curricula and toolkits based on best practices developed regarding the care and support of HIV-positive adolescents. We look forward to nurturing our existing relationships with donors and satellite site partners as well as pursuing new partnerships to expand the scope and reach of the Teen Club programme. We intend to be nothing less than a model of excellence for the provision of psychosocial support to HIV-positive adolescents and we look forward to working with partners both locally and regionally to expand the Teen Club model throughout sub-Saharan Africa.

References

AIDS Support Organization (TASO) and Population Council (2007), *Understanding and addressing the sexual and reproductive health needs of young people perinatally infected with HIV in Uganda*. Nairobi, TASO and Population Council.

Birungi H, Mugisha J.F, Nyombi J. (2007), Sexuality of young people perinatally infected with HIV: A neglected element in HIV/AIDS programming in Uganda. *Exchange Magazine;* 3:7 – 9.

Fielden S.J, Shecter L, Chapman G.E, et al. (2006), Growing up: Perspectives of children, families and service providers regarding the needs of older children with perinatally-acquired HIV. *AIDS Care:* 18:1050 –3.

Li, Rachel. (2009), Growing up on HAART: The experiences and needs of HIV positive adolescents in care and treatment in the Western Cape Province of South Africa. *Working paper no. 249*. Cape Town, South Africa: Centre for Social Science Research, University of Cape Town.

The case for children's budgeting in Botswana

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Introduction

This chapter argues the case for child-friendly budgeting in Botswana where budget reform has assumed pride of place in public discourse. Chiefly, this development is accentuated by the fact that the world over, it is beyond contestation that access to economic resources is disproportionately shared among adult males and females and children, with the latter often getting the rawest deal. Thus, children fare the worst because they are voiceless when it comes to public resource allocation; yet, paradoxically, they comprise significant proportions of the population. Therefore, they disproportionately suffer economic disenfranchisement as sufficiently instanced by child poverty, child prostitution and child labour. Lately, the global financial crisis has necessitated that budget cuts be effected in social services which affect children directly. Inarguably, while Botswana has passed child-friendly laws and ratified supranational conventions, child-friendliness in resource allocation by way of Children's Budgeting (CB) is not provided for in law. Instructively, the constitution, the supreme law of Botswana, does not guarantee children's economic rights. Therefore, there is a need to institute budget reforms to provide for the enactment of a Budget Act and institutionalisation of CB and affirmative action to enable children to participate in decision-making bodies (e.g. parliament) to ensure that budgeting addresses child-specific issues.

At the outset, it is important to define a child because so doing will define the universe of the discourse given the fact that different countries define a child differently. In the context of Botswana, as per the Children's Act (2009), 'a child' means a person who is under the age of 18 (ROB, 2009). Having defined the child in the context of Botswana, it is appropriate to ask,

'why budget for children?'. Before one answers this question, a few facts are worth restating. A budget is a primary public allocation tool in the sense that if individuals are in need of goods and services that the free market can neither provide nor provide in sufficient quantities, they turn to the government for public provision. Thus, public resource allocation centres on questions such as 'who gets what?'. Regrettably, children are voiceless and vulnerable in public resource allocation and therefore need special protection. Hence, CB is one of the primary instruments that can be used to actuate children's economic rights, including ideals of the UN Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC). Importantly, what is a children's budget? Notably, this is not a separate budget for children (Van Bueren, 1999); in fact "it is an attempt to examine what resources government is allocating to programmes that benefit children, and whether these programmes adequately reflect the needs of children" (Azeem, 2003, p. 2). To this end, when speaking at the commemoration of the 2010 Day of the African Child, the Minister of Local Government, Lebonaamang Mokalake, underscored the primacy of CB saying "... budgeting for children would offer an opportunity of influencing allocations directed towards child programmes" (BOPA, 2010, p. 8).

Unfortunately, traditional budgets do not specifically mention men, women, boys, girls or children. Hence, given the deficiency of traditional budgets and the fact that children are voiceless in public resource allocation, the need for children's budgeting cannot be exaggerated.

Children's rights and budgeting

As stated previously, budgets are primary allocation tools that society can deploy to cater for the specific economic needs of children. To this end, at a supranational level, children's rights are provided for in the United Nations Convention on the Rights of the Child (ratified by the Government of Botswana in 1995) and the African Charter on the Rights and Welfare of the Child. Notably, both instruments spell out the civil, political, economic, social and cultural rights of children and enjoin states to act in the best interest of the child. At the local level, the relevant instrument is the Children's Act [2009] (ROB, 2009). The Child Welfare Unit, located in the Department of Social Services, coordinates a national strategy for children. Notably, although the Children's Act provides for children's rights, it does not go far enough in terms of seeking economic justice for the marginalised constituency. Simply put, the Act does not provide for CB.

Botswana's child-friendliness

As it is well known, African governments can be tall on pledges but short on delivery; thus, they have an unparallelled record in regard to ratifying child-focused international treaties and conventions. However, outcomes, in terms of domesticating treaties and conventions, are often not laudable and vary markedly between governments. Amongst an array of child-friendliness measures, the African Report on Child Well-being provides an insight into the well-being of children in Africa and assesses the extent to which governments meet their obligations by way of a child-friendliness index that was developed by the African Child Policy Forum (ACPF, 2008). The Report was simultaneously launched in Nairobi and Amsterdam on 20 November 2008. Thus, the ACPF Report is a useful resource for judging African governments in regard to their national and international obligations. To this end, the ACPF report rated the Government of Botswana 15 out 52 on the child-friendliness index due to two reasons: (i) commitment in allocating a relatively high share of its national budget to provide for the basic needs of children; and (ii) success in achieving relatively favourable well-being outcomes (*ibid*). The ACPF favourable ratings notwithstanding, the report does

not address pertinent child-specific questions such as CB and budget effectiveness (that is, how well a programme achieved its goals and objectives in regard to children's programmes? [see Garsombke & Schrad, 1999 on effectiveness]). Thus, the following questions are key: (i) to what extent are children involved in public budgeting?; (ii) do budgetary allocations reflect the children's preferences?; and (iii) do large budgetary allocations necessarily translate into budget effectiveness?

To this end, despite considerable budgetary allocations, children in Botswana suffer from a lot of socio-economic ills, which are sufficiently instanced by child poverty, child labour and child prostitution. Notably, there are various poverty studies, including the 2009 Poverty Map (Moseki, 2009) and 2009 UNDP Human Development Report (UNDP, 2009). Both reports showed that there are considerable pockets of poverty and that the Human Poverty Index of Botswana is 22.9% (ibid). Unfortunately, both reports are not disaggregated by age groups but it is inarguable that children, due to their vulnerability, are over-represented in the 22.9% of the citizens who are poor. Notably, poverty affects age groups differently; hence, poverty affects children differently from adults in that it has different causes and effects (CHIP, 2004; UNDP, 2004). Principally, poverty leads to malnutrition, as well as various coping behaviours such as child prostitution. To exemplify this, in a study carried out by the Botswana Press Agency in Gaborone in early August 2010, young girls reported that they resorted to prostitution for economic reasons (Batlotleng, 2010). One interviewee put it concretely saying, "I wish I could stop doing it but it is only a call of nature, something I just need to do to put food on the table" (*ibid*, p. 18).

Related to the preceding, poverty-induced child labour has been documented in Botswana. Botswana has ratified a number of International Labour Organisation's Conventions, including C138 (Minimum Age Convention which sets the minimum employment age at 15) and C182 (Worst Forms of Child Labour Convention) in 1997 and 2000 respectively, and has also adopted the National Action Programme towards the Elimination of Child Labour in Botswana in 2008. Nonetheless, child labour exists. At a July 2007 conference, 'Reducing Exploitive Child Labour in Southern Africa (RECLISA)', aiming to explore the causes and current status of child labour in Botswana, it was reported that research has confirmed the existence of child labour (Chwaane, 2007). Confirming this, on 23 June 2010, the International Labour Organization's National Child Labour Elimination Project Coordinator, Marianyana Selelo, told Yarona News that the 2005/06 Botswana Labour Force Survey (CSO, 2006) concluded that there are high numbers of child labour cases (Yarona, 2010). Finally, in August 2010, the Minister of Labour and Home Affairs, Peter Siele, told a kgotla meeting in Selibe Phikwe that child labour is rampant in Botswana and that more than 25,000 children work as labourers at cattleposts, lands and in remote areas (Hulela, 2010). Thus, he decried their fate saying, "these children are being denied an immense opportunity to go to school and are instead being forced to perform duties that are deemed to be child labour by international standards" (*ibid*, p. 1).

As previously stated, these problems occur in the face of huge budgetary allocations for children's programmes. Since outcomes do not match intentions, it is legitimate to ask, 'why is there budget ineffectiveness in regard to children's programmes?'. Although there are many possible causes of budget ineffectiveness, the absence of the beneficiaries' voice is key. Importantly, how do adult budget decision-makers mainstream children into resource allocation? Largely, they do not; given the fact that existing mechanisms do not mainstream children into public resource allocation exercises, the case for CB in Botswana cannot be over-exaggerated.

The case for children's budgeting

It is inarguable that Botswana allocates substantial public resources to cater for children's needs. However, allocating money for child-specific needs is not enough because there is a need to involve the beneficiaries of the programmes. Thus, it is commonsense that the beneficiaries, through participatory budgeting, identify projects and interventions that will address their specific needs. Therefore, it is important that popular participation, including children's participation, be infused into the budgetary process; particularly for a constituency that is most vulnerable and voiceless. This is crucial because popular participation in the budget process in Botswana is largely limited (see Phirinyane, 2005; Kerapeletswe and Shilimela, 2008); instructively, even Members of Parliament (MPs) sometimes feel excluded from the process (see BOPA, 2007).

Hence, as much as Local Government Minister, Lebonaamang Mokalake, stated that much is being done to advance the children's welfare in Botswana in terms of education, health care and general welfare (BOPA, 2010), it is unclear what informs the government's decision to allocate money towards children's programmes. In addition, the Department of Social Services neither holds pre-budget consultations with children nor undertakes Public Expenditure Tracking Surveys (PETS) to investigate the impact of the budget on children's programmes. Based on the foregoing, one can plausibly conclude that children are largely excluded from budget formulation. Thus, adult budget decision-makers assume the role of a benevolent authoritarian; but it is not necessarily true that this would correctly estimate the budgetary needs and priorities of children. To this end, this paternalistic attitude by adult budgeters leads to budget ineffectiveness.

Thus, although the government has spent considerable resources in the past 44 years (1966–2010) to advance children's welfare in terms of education, health care and general welfare, some macroeconomic indicators such as child poverty suggest that budget effectiveness is wanting. Hence, given the fact that Botswana uses performance-based budgeting that links inputs, output, outcome and impact variables, it is important to ensure that budgetary outlays result in effective outcomes. Notably, while there are numerous causes of budget ineffectiveness, the lack of beneficiaries' participation (children's participation in this case) is an overarching one in the sense that adult budget decision-makers, in playing benevolent authoritarian, may miss the beneficiaries' priorities. Thus one way to ensure budget effectiveness is to involve children as budgeters to ensure that the budget addresses their specific needs.

The way forward

Given the fact that children are largely voiceless in the public allocation process in Botswana, there is a need for a change of tactics by way of budget reforms. Thus, primarily, the reforms must entail participatory budgeting (see UN–Habitat, 2004 on participatory budgeting). Importantly, participatory budgeting is not a preserve of adults; children, as bona fide members of the community, should also benefit from the process. To this end, Latin America, particularly Brazil, offers valuable lessons. For example, the Barra Mansa project, located in Barra Mansa in the state of Rio de Janeiro and founded in 1998, involves 18 boys and 18 girls elected by their peers into a Children's Participatory Budget Council [CPBC] to ensure that the municipality addresses their specific needs (Guerra, 2002). Hence, whatever amount is allocated to the municipality, the child councillors ensure that part of it is allotted to children-specific programmes. Similarly, another lesson in CB from Latin America is provided by Cabannes (2006). This study relates to Cotachi (Ecador); Barra Mansa; Icapui (Brazil) and Cuidad Guyana (Venezuela).

Should the above lessons be copied wholesale as if they are an embryo transplant? No; as evidenced by lessons from the IMF-instigated Structural Adjustment Programmes and prescriptions of the Washington Consensus, copy-catism without regard to local conditions can be catastrophic. Thus, one can only copy general lessons. All the same, the usefulness of participatory budgeting, as manifested in CB, is universal. In the context of Botswana, there is a need to adopt the CPBC model at village, council and national levels.

At the village level, children can be engaged through the Village Development Committees (VDCs). A VDC is composed of ten members who are elected at the *kgotla;* among other duties, it identifies village needs and problems. Thus, children and youths can make inputs into the development planning and budgeting process if their representatives can be appointed as ex officio members because, legally, they are too young to be elected into VDCs. Similarly, in urban areas, children can be appointed as ex officio members of Ward Development Committees (WDCs). At district levels, the system of nominated Councillors allows the Minister of Local Government to nominate persons with special skills to serve in the councils. Thus, the Minister should nominate children into councils because they possess a special skill; they can competently represent their peers. Lastly, at a national level, there exists a facility of four specially-elected MPs. Thus, it would be prudent to reserve one place for children to ensure that the development planning and budgeting regime in Botswana is child-friendly.

Conclusion

This chapter has argued that budgeting is an important public allocation tool that answers the all-important question, 'who gets what?'. However, research has demonstrated that economic resources are inequitably shared between men, women and children and the latter fare the worst due to voicelessness and vulnerability. Hence, children suffer economic disenfranchisement as exemplified by child poverty, child prostitution and child labour. Therefore, this necessitates affirmative action to protect voiceless and vulnerable members of society. To this end, while the government has passed child-friendly laws and ratified supra-national conventions and therefore scores highly in regard to child-friendliness, this is not evident in the outcomes of resource allocation. Chiefly, CB is not provided for in law; even the constitution of Botswana does not guarantee children's economic rights. Thus, adults budget on behalf of children with virtually no input from the intended beneficiaries. In consequence, despite considerable budgetary allocations for children's programmes, budgetary effectiveness is largely wanting as evidenced by adverse macroeconomic indicators such as child poverty. Hence, the chapter recommends the following: (i) entrenching children's budgeting in the constitution; (ii) promulgation of a Budget Act to provide for the publication of a pre-budget statement and monthly budget reports (also giving progress on the children's budget); and (iii) appointing children as budget decision-makers to ensure that budgeting is child-friendly as happens in Brazil. Thus, the above will go a long way towards ensuring budget effectiveness and delivering on the goals of Vision 2016, Millennium Development Goals, CRC and ACRWC.

References

ACPF (African Child Policy Forum) (2008), The African Report on Child Wellbeing 2008: *How child-friendly are African governments?* Retrieved on 29 August 2010 from http://www.africanchildinfo.net/africanreport08/

Azeem, V. (2003), *The budget and children in Ghana.* Speech delivered at the multi-sectoral meeting on the National Programme of Action for Children (2003 – 2013), 14 October 2003.

Batlotleng, B. (2010, 23 August), When there's no other way... *Daily News,* p. 18.

BOPA (Botswana Press Agency) (2007, 14 February), Parliament wants to play an active role. *Daily News,* p. 4.

BOPA. (2010, 18 June), Government commits to children welfare. *Daily News,* p. 8.

Cabannes, Y. (2006),Children and young people build participatory democracy in Latin American cities. *Environment and Urbanization,* 18, 195-218.

CSO (Central Statistics Office) (2006), *Botswana Labour Force Survey* 2005/06 Gaborone: Government Printers.

CHIP (Childhood Poverty Research and Policy Center) (2004) Children and poverty - some questions answered. *CHIP Briefing 1: Children and Poverty.* Retrieved on 29 August 2010 from http://www.childhoodpoverty.org/index.php/action=documentfeed/doctype=pdf/id=46/

Chwaane, T. (2007, 4 July), Child labour a result of poverty. *Mmegi,* p. 4.

Garsombke, H. & Schrad, J. (1999), *Performance measurement systems: results from a city and state survey.* Chicago, IL: Government Finance Officers Association.

Guerra, E. (2002), Citizenship knows no age: children's participation in the governance and municipal budget of Barra Mansa, Brazil. *Environment & Urbanization,* 14(2), 71 – 84.

Hulela, K. (2010, 3 August), Child labour rampant. *Daily News,* p. 1.

Kerapeletswe, C.K. & Shilimela, R. (2008), *Budget processes and transparency in Southern and Eastern African countries; a comparative study for the Southern and Eastern Africa Policy Research.* SEAPREN Working Paper No. 8.

Moseki. T. (2009, 30 October), Study uncovers "pockets of severe poverty" within Botswana districts. *Mmegi,* p. 4.

Phirinyane, M. (2005), Botswana. In Claassens, M. & A. van Zyl (Eds.), *Budget Transparency and Participation 2: Nine African Case Studies* (pp. 55-85). Johannesburg: The Institute for Democracy in South Africa.

ROB (Republic of Botswana), (2009). *Children's Act.* Gaborone: Government Printer.

UNDP (United Nations Development Programme) (2009), *Human Development Report, 2009.* New York: UNDP.

UNDP. (2004), *Dollar a day, how much does it say?* Retrieved from http://www.undp.org/povertycentre/newsletters/infocus4sep04eng.pdf on 29 August 2010.

Van Bueren, G. (1999), Alleviating poverty through the Constitutional Court. *South African Journal on Human Rights,* 15, 52 – 74.

UN-Habitat. (2004), *72 Frequently Asked Questions about Participatory Budgeting.* Retrieved from http://www.internationalbudget.org/themes/PB/72QuestionsaboutPB.pdf. on 30 August 2010.

Yarona. (2010), *Child labour rampant in Botswana.* (23 June). Retrieved from http://www.yaronafm.co.bw/news/child-labour-rampant-in-botswana-3/ on 30 August 2010.

Social protection and children

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This paper aims to explain why children need not only access to education and health care, but also to social protection mechanisms, which can contribute considerably to overcoming some of the challenges faced particularly by vulnerable children.

While 'social protection' can be seen to include health care and education provision (eg EU COM 2000/0379), more commonly it is understood as referring to social transfers (payments in cash or kind) to people who are either vulnerable or likely to be vulnerable (such as older people), by the state or via social insurance systems. There may also be market– or community-based social protection interventions. Increasingly, African countries are developing their own models of social protection, on a regional or national basis, with or without the support of international donors, to protect their vulnerable populations against risks including hunger or the inability to earn an income.

These programmes support, amongst others, the UN Convention on the Rights of the Child, which in its Article 27 (1) requires States Parties to 'recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development'. While the parents have the primary responsibility for this, States Parties should (Article 27(3)) 'in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing'.

A comprehensive social protection system should include four broad sets of interventions (UNICEF, 2008, p v):

- Protective programmes that offer relief from economic and social deprivation, such as social transfer programmes;
- Preventive programmes that are put in place before a shock occurs, such as pensions systems or health insurance;
- Promotive programmes that enhance assets, human capital and income earning capacities of individuals and families, such as the provision of livestock;
- Transformative programmes which address power imbalances and reduce social exclusion.

Social protection has been shown, in many countries, to considerably improve the lives of children and their families. In South Africa social pensions increased the income of the poorest 5% of the population by 50%. Studies in Zambia, Ethiopia and Mexico have shown increased nutritional status among children from families receiving social transfers. Children are more likely to attend school, and families may invest in productive assets (all UNICEF, 2008, pp27–28).

In Botswana children are generally well provided for: 91.8% of children aged 7 to 14 go to school (Central Statistics Office [CSO], 2009), the Prevention of Maternal Transmission to Child Treatment (PMTCT) system now reduces transmission of HIV from mother to child in 99% of cases (Harvard Botswana Partnership, 2010). Free health care is available to all Botswana children who need it, education is free for needy children, with a small co-payment for other children, nutrition support (including infant formula) is intended to be provided to all under-fives attending clinics, and school meals are free for those attending school. Botswana has an extensive orphan support package, as well as a range of other social protection interventions, including pensions for the over-65s, support for destitute and chronically ill persons, and for a number of other small groups.

However, Botswana children also face a number of issues: the country has almost 118,000 orphans (CSO, Botswana AIDS IMPACT Survey III [BAIS III], 2008). Despite the social protection programmes the poverty rate of families with children is higher than average, at 33.2% (CSO, HIES 2002/03 data). Child mortality has remained stubbornly high between 2000 and 2007 at 56 and 57 respectively for infants, and 76 for under-fives (CSO, BFHS 2007) despite the advances of PMTCT in that period. The rate of malnutrition has increased in the same period from 12.5% to 13.5% for underweight children (and from 23.5% to 26.5% for stunting – CSO, BFHS, 2007). 41.5% of people (including children) living in rural areas do not have sanitation facilities (CSO, BFHS 2007). 8.5% of children work (CSO, Labour Force Survey 2005/06), often long hours. Many families living in remote areas suffer from long-term, structural poverty in the absence of employment or other income-generating opportunities. At a wider level, Botswana is the third most unequal country in the world, measured by the Gini Coefficient (United Nations, 2009), in terms of income equality (Namibia is the most unequal, followed by South Africa). This level of inequality makes it particularly difficult to spread the benefits of economic growth across the population.

To assist the Government of Botswana in improving outcomes for her most vulnerable and disadvantaged children, UNICEF Botswana Country Office has supported the Department of Social Services in developing a Social Development Policy Framework. 'Social development' is defined as 'a process of planned social change designed to promote the well-being of the population as a whole in conjunction with a dynamic process of economic development' (Midgley, 1995, p25). The framework, developed on this premise, should contribute not only to poverty reduction, but also enable Botswana to continue her economic development. The draft policy framework is currently undergoing consultation throughout Botswana.

In addition UNICEF Botswana Country Office is working with the Ministry of Finance and Development Planning in carrying out a series of rapid assessments of the impact of the economic crisis in five livelihood zones in Botswana, including Gaborone, Jwaneng, Ghanzi, Kasane and the Tuli Block. These studies use household surveys using a panel of households who will be revisited during each assessment, as well as focus groups and local observations. The results of these studies will serve to inform the Government of Botswana on the impact of the economic crisis in different environment, and provide information for further policy developments.

References

Central Statistics Office. (2003) *Household Income and Expenditure Survey,* Gaborone.

Central Statistics Office. (2009) *Botswana Family Health Survey 2007,* Gaborone.

Central Statistics Office. (2009) *Botswana Aids Impact Survey 2008,* Gaborone.

European Union. (2000) *Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions Social policy agenda,* COM/2000/0379 final, retrieved from internet 27 September 2010 http://eur-lex.europa.eu/smartapi/cgi/sga_doc?smartapi!celexplus!prod!DocNumber&lg=en&type_doc=COMfinal&an_doc=2000&nu_doc=379.

Harvard Botswana Partnership, *AIDS Drug Combinations Given to Pregnant Women Block 99 Percent of HIV Transmission to Breastfed Babies,* retrieved from internet 27 September 2010, http://www.hsph.harvard.edu/news/press-releases/2010-releases/aids-drugs-pregnant-women-block-transmission-hiv.html.

Midgley, J. (1995) *Social development: the developmental perspective in social welfare.* London: Sage Publications.

UNICEF. (2008) *Social Protection in Eastern and Southern Africa: A Framework and Strategy for UNICEF*, Kenya.

UN Convention on the Rights of the Child, 1989, retrieved from internet 27 September 2010 http://www2.ohchr.org/english/law/crc.htm

United Nations (2009), Economy and Inequality, *Human Development Report 2009,* retrieved from internet 27 September 2010http://hdrstats.undp.org/en/indicators/161.html

Botswana children's statistics

Acronyms

BFHS – Botswana Family Health Survey (Central Statistics Office, 2009)

BAIS – Botswana AIDS Impact Survey (Central Statistics Office, 2009)

MICS – Multiple Indicator Cluster Survey

NCHS – National Center of Health Statistics (US-based)

WHO – World Health Organisation

UNGASS – United Nations General Assembly Special Session (on HIV and AIDS)

Indicator	Baseline Year	Total (baseline Year)	Latest Year	Total (latest)	Male	Female	Urban	Rural	Data Source	Trend (▲ BETTER ▼ WORSE)
Child Survival										
Under-five mortality rate per 1000	1996	75.0	2007	76.0			72.0	96.0	MICS 2000, BFHS IV	
Infant mortality rate per 1000	1996	57.0	2007	57.0			54.0	70.0	MICS 2000, BFHS IV	
Neo-natal mortality rate per 1000			2007	34.2			24.2	41.6	BFHS IV	
Maternal mortality ratio per 100,000	2005	157.9	2008	198.0					Central Statistics Office, Stats Brief 2009/17	▼
Education										
Primary school net enrolment ratio %	2002	89.7	2006	89.2	87.2	91.1			Education Stats Brief 2009 Education Statistics 2006	
Primary school net attendance rate %	2000	85.7	2007	86.9	85.5	88.2	89.2	84.8	MICS 2000, BFHS IV	
Survival rate to last grade of primary school (administrative data) %	1999	81.8	2006	82	77.4	85.9			Education Statistics 1999 Education Statistics 2006	
Secondary school net enrolment ratio %			2006	62.2	56.5	67.8			Education Statistics 2006	
Youth literacy rate (15–24 years) %	2003	94.1	2008	95.1	93.8	96.3			http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx	

Indicator	Baseline Year	Total (baseline Year)	Latest Year	Total (latest)	Male	Female	Urban	Rural	Data Source	Trend ▲ BETTER ▼ WORSE
Nutrition										
Underweight - moderate and severe (NCHS/WHO) %	2000	12.5	2007	13.5	13.9	13.1	9.3	16	MICS 2000, BFHS IV	▼
Underweight - severe (NCHS/WHO) %	2000	2.4	2007	3.0	3.1	2.9	1.4	4.0	MICS 2000, BFHS IV	▼
Stunting – moderate and severe (NCHS/WHO) %	2000	23.1	2007	25.9	28.5	23.2	19.6	29.1	MICS 2000, BFHS IV	▼
Stunting – severe (NCHS/WHO) %	2000	7.9	2007	11.0	11.7	10.4	5.9	13.4	MICS 2000, BFHS IV	▼
Wasting – moderate and severe (NCHS/WHO) %	2000	5.0	2007	7.2	7.7	6.6	5.3	8.2	MICS 2000, BFHS IV	▼
Wasting – severe (NCHS/WHO) %	2000	1.1	2007	2.7	2.4	2.9	1.9	3.1	MICS 2000, BFHS IV	▼
Iodized salt consumption %	2000	66.0	2007	65.2			75.5	55.1	MICS 2000, BFHS IV	
Timely initiation of breastfeeding %			2007	40.0			41.2	37.5	BFHS IV	
Exclusive breastfeeding rate (<6 months) %			2007	20.3	17.4	23.7	12.0	21.1	BFHS IV	
Timely complementary feeding rate (6–9 months) %	2000	57.0	2007	45.5	48.4	42.3	42.3	47.5	MICS 2000, BFHS IV	▼
Continued breastfeeding rate at one year (12–15 months) %	2000	53.4	2007	36.3	35.4	37.3	39.2	33.5	MICS 2000, BFHS IV	▼
Continued breastfeeding rate at (20–23 months) %	2000	10.7	2007	5.9	8.0	4.1	4.8	6.7	MICS 2000, BFHS IV	
Child Health Care										
Under fives with diarrhoea receiving oral rehydration therapy (ORS packets or recommended homemade fluids or increased fluids) with continued feeding %	2000	95.8	2007	68.0	68.5	67.6	69.6	65.9	MICS 2000, BFHS IV	▼
Care seeking for suspected pneumonia %	2000	14.0	2007	86.2	86.2	86.1	96.6	87.1	MICS 2000, BFHS IV	▲
Antibiotic treatment of suspected pneumonia %			2007	37.2	33.5	42.9	44.2	42.0	BFHS IV	
Under fives sleeping under insecticide treated nets (ITNs) %			2007	6.1					Malaria Indicator Survey	
Under fives with fever receiving any antimalarial medicine %			2007	10.1					Malaria Indicator Survey	
Maternal Health Care										
Contraceptive prevalence rate %	2000	44.1	2007			52.8	58.7	48.4	MICS 2000, BFHS IV	▲
Antenatal care (at least one visit) %	2000	96.8	2007			94.1	94.8	94.1	MICS 2000, BFHS IV	▼
Antenatal care (at least four visits) %			2007			73.3	77.3	69.7	BFHS IV	
Skilled attendant at birth %	2000	98.5	2007			94.6	99.3	90.2	MICS 2000, BFHS IV	▼
Institutional deliveries %			2007			93.8	99.1	88.2	BFHS IV	
Low birthweight %	2000	8.0	2007	13.1			12.0	13.4	MICS 2000, BFHS IV	▼
Water and Sanitation										
Use of improved drinking water sources %	2000	96.5	2007	96.1			99.8	91.3	MICS 2000, BFHS 2007	
Use of improved sanitation facilities %	2000	83.7	2007	79.8			99.4	58.3	BFHS IV	▼

Indicator	Baseline Year	Total (baseline Year)	Latest Year	Total (latest)	Male	Female	Urban	Rural	Data Source	Trend ▲ BETTER ▼ WORSE
Child Protection										
Birth registration – children under 5 who are registered %	2000	59.2	2007	72.2	71.8	72.7	85.2	66.9	MICS 2000, BFHS IV	▲
Child labour – children aged 5–14 who are engaged in child labour %			2005	9					Labour Force Survey 2005/06	
Child disability – children aged 5–9 with at least one of the reported disabilities %			2001	1.7	1.95	3.38			Census 2001. Dissemination Seminar 2003	
HIV and AIDS										
Correct knowledge and no misconceptions about HIV and AIDS (15-24) – all five correct %			2008	42.1					UNGASS Progress Report 2010	
Sex before the age of 15 years (15–24) %	2001	0	2008	3.5					UNGASS Progress Report 2010	
Condom use at last higher-risk sex with non-marital, non-cohabiting partner (15–19) %	2001	84.5	2008		95.6	83.0			BIAS I, BIAS III	▲
Condom use at last higher-risk sex with non-marital, non-cohabiting partner (20–24) %			2008		90.7	81.0			BIAS III	
Sex with more than one partner in past year (15–19) %	2001	0.3	2008		33.3	12.9			BIAS I, BIAS III	▼
Sex with more than one partner in past year (20–24) %			2008		36.0	15.7			BAIS III	
Condom use at last sex among those with more than one sexual partner in past year (15-19) %			2008	87.5	95.6	83.3	85.8	78.8	BAIS III	
Condom use at last sex among those with more than one sexual partner in past year (20-24) %			2008	85.8	90.7	81.4	85.8	78.8	BAIS III	
HIV and AIDS (Orphans)										
Non-orphan school attendance rate (10–14) – total %			2008	89.2	88.3	90.1			BAIS III	
Orphan school attendance ratio (10–14) – total %			2008	85.9	84.3	87.4			BAIS III	
Support for orphans and vulnerable children (0–17 years) affected by AIDS %			2009	31.2					UNGASS 2010	
Support for orphans and vulnerable children (0–4 years) affected by AIDS – Total %			2008	11.4					BAIS III	
Support for orphans and vulnerable children (5–9 years) affected by AIDS – Total %			2008	24.1					BAIS III	
Support for orphans and vulnerable children (10–14 years) affected by AIDS – Total %			2008	29.1					BAIS III	
Support for orphans and vulnerable children (15–17 years) affected by AIDS – Total %			2008	30.4					BAIS III	

Notes