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The opinions expressed are those of the contributors and do not necessarily reflect the policies or views of UNICEF or the University of Botswana.

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Acronyms

ACSD Accelerated Child Survival and Development
AIDS Acquired Immune Deficiency Syndrome
AU African Union
BAS Botswana AIDS Impact Survey
BFHS Botswana Family Health Survey
BIDPA Botswana Institute for Development Policy Analysis
CAPA Creative and Performing Arts
CMG Child Maintenance Grant
CRC Convention on the Rights of the Child
CSG Child Support Grant
CSO Central Statistics Office
DSS Department of Social Services
FAO Food and Agriculture Organisation
GMP Growth Monitoring and Promotion
HFIAS Household food Insecurity Access Scale
HIAS Household Income and Expenditure Survey
HIV Human Immunodeficiency Virus
ILO International Labour Organisation
IFEC International Programme for the Elimination of Child Labour
IVR Infant Mortality Rate
LFS Labour Force Survey
MFDP Ministry of Finance and Development Planning
MDG Millennium Development Goals
MICS Multiple Indicator Cluster Survey
MLG Ministry of Local Government
MOH Ministry of Health
NACA National AIDS Coordination Agency
NCC National Children’s Council
OVC Orphans and Vulnerable Children
SADC Southern Africa Development Community
SADC Social and Community Development
SSA Sub-Saharan Africa
STI Sexually Transmitted Infections
UN United Nations
UNECA United Nations Economic Commission for Africa
UNICEF United Nations Children’s Fund
UNDP United Nations Population Division
Despite the political commitment and increased government funding to social sectors, better technology, further research, innovations and practical models are required to ensure accelerated implementation of what works for improved child survival and development.

Three years ago, the University of Botswana and UNICEF sought to provide a platform for catalysing research and dialogue among academics, public sector, private sector and civil society implementers to improve the knowledge-base on child related issues. Today this collaboration has resulted in the dissemination of numerous child related research articles through the Thari Ya Bana publication.

The research works documented in this third edition of the publication aims to answer a number of questions, such as: 1) what are the literacy practices embraced by parents, as well as the opportunities and challenges toward enhancing their children’s literacy skills; 2) What are the effects of domestic violence on the boy child; and 3) what are the bottlenecks and inequities that reduce the efficacy of high impact interventions such as vitamin A supplementation?

We are hopeful that the highlighted findings will help to shape ideas that can be put into action by implementers – whether at national level, district level or in communities.

Finally, we wish to thank all who contributed to make this edition possible and invite all of you who were unable to contribute this year to join us in collaborating on next year’s edition. We hope you find the research presented to be of interest and please remember that our children need us to build a better tomorrow and to create an even safer and brighter future for the next generation. We hold their future in our hands.

Prof. C. R. Sathyamoorthi
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University of Botswana

Dr. Doreen Mulenga
Representative
UNICEF
In 2010 some 8 million children died before their fifth birthday.\(^1\) Of this 8 million, 3.7 million deaths were in Sub-Saharan Africa (SSA). Despite the rapid decline in child mortality, far too many children, mainly the most vulnerable and disadvantaged, continue to die from preventable diseases. Significantly reducing preventable child deaths is achievable within a generation through implementation of high-impact, cost-effective interventions for the most vulnerable children and their families.\(^2\) The Child Survival Call to Action\(^3\) reaffirms the commitment to end preventable child deaths. An important aspect of fulfilling this commitment is improving evidence-based programming and real time monitoring.

As part of the country’s efforts to achieve the MDGs and Vision 2016, Botswana developed an Accelerated Child Survival and Development Strategy (ACSD) for the period 2009/2010-2015/2016. The objective of the ACSD is to improve the coverage and quality of high impact interventions on the health and well-being of children and women. Although the impact of implementation of the ACSD on child mortality is yet to be documented, indications from the 2007 survey-based data is that Botswana is unlikely to meet the MDG targets on reducing hunger and child mortality. Over an 11 year period (1996 to 2007), the prevalence of underweight had been reduced by 4% from 17% in 1996 to 13% in 2007.\(^4\) Over the same period, child mortality increased from 45 per 1000 live births in 1996 to 76 per 1000 live births in 2007.\(^5\)


\(^{2}\) UNICEF. 2012. A Promise Renewed Brochure. New York: UNICEF.

\(^{3}\) The Call to Action Goals: 1) Mobilize political leadership to end preventable child deaths; 2) Achieve consensus on a global roadmap highlighting innovative and proven strategies to accelerate reductions in child mortality and; 3) Drive sustained collective action and mutual accountability. Source: http://www.apromiserenewed.org/A_Call_to_Action.html [Retrieved 12 July 2012].


The four articles in this section of the publication contribute to evidence-based programming and monitoring towards improving the well-being of children. Within the section, two articles provide evidence on aspects of child nutrition. The section also features an article that introduces a methodology for real-time district level monitoring and an article that highlights innovations available to promote equitable programmes for mothers and children.

In the first article, Gobotswang and colleagues provide evidence on the coverage, bottlenecks and inequities that reduce the efficacy of two nutrition supplementation programmes – Vitamin A supplementation and Tsabana. Re-analysis of the 2007 Botswana Family Health Survey (BFHS) data reveals that household demographic and economic factors, geographic location and the level of education of care-givers present bottlenecks that affect the coverage and efficacy of supplementation programmes such as Vitamin A and Tsabana.

In the next article by Moalosi, the author assesses the nutrition adequacy of the menus of select early childhood centres in Tlokweng. Assessment of the nutritional content of the food provided at the five centres sampled indicates that meals offered provided limited choice, were limited in variety and were not nutritionally balanced. Given the importance of early childhood nutrition, a key recommendation made is that early childhood centres should employ qualified meal planners to ensure balanced nutritional intake.

The next two articles by Kibassa and Codjia, cover health systems and services more broadly. The first presents the methodology of a health system strengthening approach called D–I–V–A (Diagnose–Intervene–Verify–Adjust) as a tool for real-time district level monitoring for equitable child survival outcomes. The second paper presents the findings from the rapid household survey called Lot Quality Assurance Sampling (LQAS). The survey was implemented in Tutume and Chobe and highlights how real-time district level data collected between national survey periods can be used to identify disparities at district level and inform subsequent responses. The findings reveal that except for full immunization for children by the age of 12 months, both health districts have high unmet needs for key maternal and child survival interventions.
Introduction

Adequate child nutrition plays an important role in achieving the Millennium Development Goals (MDGs) which focuses on reducing child malnutrition and MDG 5 for reducing child mortality by two-thirds between 1992 and 2015. In Botswana, the government in collaboration with UNICEF and other development partners has developed and is in the process of implementing evidenced-based Accelerated Child Survival and Development (ACSD) strategic plan. Vitamin A supplementation and Tsabana (a locally produced food supplement) are amongst the cost-effective nutrition interventions that are used to improve the nutrition situation of children 6–59 months in Botswana.

Traditionally, vitamin A deficiency was associated mainly with eye sight. Xerophthalmia, ketatomalacia, and night blindness are some of the clinical signs of vitamin A deficiency. It is estimated that 190 million children are deficient in vitamin A while half a million children go blind every year in developing countries from Vitamin A deficiency. High mortality rates are recorded within a year after going blind (Renz and Hammond, 2010). The problem is compounded by protein energy malnutrition (PEM) which is the underlying cause of an estimated 3.5 million deaths and account for 35% disease burden globally (Black et al. 2008).

International efforts to fight vitamin A deficiency include the establishment of International Vitamin A Consultative Group (IVACG) that is aimed at promoting food-based approaches and fortification for controlling vitamin A deficiency, as well as enhancing bioavailability (Labadarios, 2005). The dissemination of Vitamin A information through the regular newsletter entitled ‘Sight and Life’ is another international effort whose goal is to fight vitamin A deficiency. Recent investigations have linked vitamin A to the integrity of the immune system. Therefore vitamin A deficiency compromises immunity thus exposing an individual to infections. Lately it has been shown that vitamin A reduces the overall mortality in children 6–59 months. Specifically, vitamin A decreases the risk and severity of childhood infections such as diarrhoea and measles among pre-school children (Imdad et al., 2011; Thurnham, 2011; Bhutta et al., 2008).

The high cost of vitamin A rich foods has led to the introduction of universal vitamin A supplementation across the developing world, especially in Asia and Africa as a way of curbing Vitamin A deficiency. Ensuring that vitamin A supplementation programs reach the target population, remains one of the bottlenecks that need to be overcome. In addition to reaching the target populations, vitamin A supplementation should be utilized by the intended beneficiaries. Since Protein Energy Malnutrition (PEM) increases the vulnerability of children to vitamin A deficiency, some countries also introduced fortified food supplements that are targeted to children of complementary feeding age. In Botswana, a food supplement known as Tsabana was introduced to address the
problem of under-nutrition in children 6–36 months old. Tsabana faces the same challenges as vitamin A supplementation program in terms of reaching the target population and its utilization or coverage (Tanahashi, 1978).

This paper presents evidence on the coverage of these two supplementation programs as well as factors that determine their utilization by children aged 6–59 months. The main goal is to identify bottlenecks and inequities that reduce the efficacy of high impact interventions such as vitamin A supplementation. It is important to identify sub-population groups that benefit from existing nutrition programs and those that fail to access such interventions and the reasons associated with failure to benefit (Hosseinpoor et al., 2011).

Methodology
The findings are drawn from the 2007 Botswana Family Health Survey (BFHS) dataset. The survey was cross sectional and nationally representative covering 2825 under-fives and 10859 households. Detailed sampling and data collection methodology for the BFHS is reported in the Central Statistics Office (CSO) report on the survey (CSO, 2009).

Results and discussions
Vitamin A coverage for children 6–59 months
Results from Table 1, below, show that the coverage of vitamin A is influenced by households’ demographic and economic factors. Specifically 71% of children from households in the richest households said they received vitamin A supplementation compared to 61% from the poorest households.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Vitamin A coverage (6–59 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wealth score</td>
<td></td>
</tr>
<tr>
<td>Poorest</td>
<td>61.0(^a)</td>
</tr>
<tr>
<td>Second</td>
<td>67.5(^a)</td>
</tr>
<tr>
<td>Third</td>
<td>71.9(^a)</td>
</tr>
<tr>
<td>Fourth</td>
<td>66.4(^a)</td>
</tr>
<tr>
<td>Richest</td>
<td>70.8(^b)</td>
</tr>
<tr>
<td>Place of residence</td>
<td></td>
</tr>
<tr>
<td>City/Town</td>
<td>68.4</td>
</tr>
<tr>
<td>Urban village</td>
<td>69.6</td>
</tr>
<tr>
<td>Rural</td>
<td>64.9</td>
</tr>
<tr>
<td>Age of child (months)</td>
<td></td>
</tr>
<tr>
<td>0–11</td>
<td>51.2(^a)</td>
</tr>
<tr>
<td>12–23</td>
<td>63.3(^a)</td>
</tr>
<tr>
<td>24–55</td>
<td>71.3(^a)</td>
</tr>
<tr>
<td>36–47</td>
<td>76.6(^a)</td>
</tr>
<tr>
<td>48–59</td>
<td>65.4(^a)</td>
</tr>
</tbody>
</table>

Table 1: Supplements coverage for children 6–59 months

Variables with different superscript are significantly different at 5%
to 67.5% among the second poorest households who received vitamin A. Caregivers from the wealthiest households are likely to have a better level of health awareness.

In this study the educational background of the principal caregiver appear to have no positive impact in children receiving vitamin A capsules. As shown in Table 1 the only significant difference in vitamin A coverage was between households with caregivers who possessed no education (56.8%) and those with non-formal education (50.0%). It is unclear why caregivers with no education performed better than those with some little education. The findings of our study might suggest that formal education to some extent is a necessary but not a sufficient requirement for improved utilization of vitamin A supplementation program. However the difference in vitamin A coverage between caregivers with secondary education (70%) and those with non-formal education (50%) was significant. In a study in Bangladesh Semba et al (2010) reported a positive relationship between vitamin coverage and level of education. Although the difference was not significant children from households where males were the principal caregivers recorded a 53.1% coverage compared to 67.4% coverage among children from households where females were the caregivers. This was expected since childcare is predominantly performed by female caregivers in a typical African setting. It could also suggest that men were not accessing health services.

When it comes to coverage, age of caregiver was also an important factor. Significantly more (70.5%) children from households with caregivers aged 25–49 years received vitamin A compared to 54.9% among children from households with caregivers aged 50 years and above. This is consistent with reproductive age. In Bangladesh greater maternal age was associated with children receiving high doses of vitamin A capsule (Semba et al., 2010). It is unclear from the data presented why this is the case. When the place of residence was considered urban villages recorded 69.6% vitamin A coverage compared to 64.9% coverage in the rural areas. This is not surprising given the observed difference by educational status that would favour the city/town locality. The difference in vitamin A coverage between the different settlement categories was not significant. Interestingly, gender of a child was also not associated with the coverage of vitamin A supplementation (Table 1). According to the results both the girl and boy child equally benefited from the vitamin A supplementation program.

Vitamin A supplementation is also associated with better nutritional status. A study that examined the coverage of vitamin A capsule in Bangladesh and risk factors associated with non-receipt of vitamin A showed that those who missed vitamin A were more likely to be stunted. The relationship between vitamin A and nutritional status requires further investigations.

**Coverage of Tsabana for children 6–35 months**

Tsabana is a complimentary food that targets children who are 6–35 months. Older children receive fortified precooked maize meal as a food supplement. Leakage of Tsabana was evident since 25.8% of children aged 36–47 months and 12.5% of those aged 48–59 months of the older children were reported to receive Tsabana.
The findings that are not presented in the table show that 42.9% of the children did not receive *Tsabana* either because they were not eligible or missed the ration. The food product was observed in 31.9% of the households visited. The coverage of *Tsabana* was associated with the age of principal caregiver, wealth score, and the level of urbanization (Table 2). Children from older caregivers, poor and rural households were more likely to receive *Tsabana*.

### Table 2: Tsabana coverage by selected socio-economic and demographic factors

<table>
<thead>
<tr>
<th></th>
<th>Coverage of Tsabana (6–35 months)</th>
<th>Coverage of Tsabana (36–59 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wealth score</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poorest</td>
<td>94.3a</td>
<td>20.1</td>
</tr>
<tr>
<td>Second</td>
<td>95.9a</td>
<td>21.7</td>
</tr>
<tr>
<td>Third</td>
<td>93.5a</td>
<td>16.2</td>
</tr>
<tr>
<td>Fourth</td>
<td>85.7b</td>
<td>20.1</td>
</tr>
<tr>
<td>Richest</td>
<td>77.3b</td>
<td>19.4</td>
</tr>
<tr>
<td><strong>Place of residence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City/Town</td>
<td>79.9a</td>
<td>22.9</td>
</tr>
<tr>
<td>Urban village</td>
<td>91.2a</td>
<td>16.0</td>
</tr>
<tr>
<td>Rural</td>
<td>94.0a</td>
<td>21.0</td>
</tr>
<tr>
<td><strong>Age of child (months)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–11</td>
<td>82.2a</td>
<td>—</td>
</tr>
<tr>
<td>12–23</td>
<td>84.6a</td>
<td>—</td>
</tr>
<tr>
<td>24–35</td>
<td>90.5a</td>
<td>—</td>
</tr>
<tr>
<td>36–47</td>
<td>—</td>
<td>25.8a</td>
</tr>
<tr>
<td>48–59</td>
<td>—</td>
<td>12.5b</td>
</tr>
<tr>
<td><strong>Age of caregiver</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 and less</td>
<td>94.3a</td>
<td>20.4</td>
</tr>
<tr>
<td>25–49 yrs</td>
<td>88.4a</td>
<td>19.5</td>
</tr>
<tr>
<td>50 and more</td>
<td>91.4a</td>
<td>19.7</td>
</tr>
<tr>
<td><strong>Gender of child</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>89.9</td>
<td>19.5</td>
</tr>
<tr>
<td>Female</td>
<td>90.8</td>
<td>19.8</td>
</tr>
<tr>
<td><strong>Gender of caretaker</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>90.6</td>
<td>21.9</td>
</tr>
<tr>
<td>Female</td>
<td>90.4</td>
<td>19.6</td>
</tr>
<tr>
<td><strong>Education of caregiver</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No education</td>
<td>92.1</td>
<td>28.3b</td>
</tr>
<tr>
<td>Non formal</td>
<td>94.1</td>
<td>11.8b</td>
</tr>
<tr>
<td>Primary</td>
<td>91.7</td>
<td>19.2b</td>
</tr>
<tr>
<td>Secondary</td>
<td>89.4</td>
<td>17.6b</td>
</tr>
</tbody>
</table>

Variables with different superscript are significantly different at 5%. Figures in red are for estimates where the cell size (n) was low. These need to be interpreted with caution.

**Socio-demographic and economic factors**

Seventy seven percent (77%) of children from the richest households said they received *Tsabana* while 93% accessed *Tsabana* in the poorest households. When socio-economic
factors were considered, the data showed an inverse relationship between wealth ranking, the level of urbanization and the coverage of Tsabana. Areas that were highly urbanized such as towns and cities recorded the lowest coverage of Tsabana (79.9%) while the rural areas experienced the highest coverage of 94% (Table 3).

Both the age of the child and that of the caregiver were associated with the coverage of Tsabana. Children in the 6–11 months age category had the lowest coverage (82.2%) of Tsabana the coverage was highest (94.6%) in the 12–23 months age group. There

<table>
<thead>
<tr>
<th>Wealth score</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>91.3(^a)</td>
<td>2.1(^a)</td>
<td>1.7</td>
<td>2.4</td>
<td>—</td>
</tr>
<tr>
<td>Second</td>
<td>89.9(^a)</td>
<td>1.7(^a)</td>
<td>2.5</td>
<td>4.2</td>
<td>—</td>
</tr>
<tr>
<td>Third</td>
<td>90.9(^a)</td>
<td>3.0(^a)</td>
<td>1.7</td>
<td>1.7</td>
<td>—</td>
</tr>
<tr>
<td>Fourth</td>
<td>79.1(^a)</td>
<td>5.2(^a)</td>
<td>5.2</td>
<td>2.4</td>
<td>2.4(^a)</td>
</tr>
<tr>
<td>Richest</td>
<td>58.5(^a)</td>
<td>14.0(^a)</td>
<td>5.2</td>
<td>—</td>
<td>9.8(^a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Place of residence</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>City/Town</td>
<td>67.0(^a)</td>
<td>11.8(^a)</td>
<td>5.7(^a)</td>
<td>—</td>
<td>7.1(^a)</td>
</tr>
<tr>
<td>Urban</td>
<td>84.5(^a)</td>
<td>4.8(^a)</td>
<td>3.0(^a)</td>
<td>1.8</td>
<td>2.3(^a)</td>
</tr>
<tr>
<td>Rural</td>
<td>88.6(^a)</td>
<td>2.2(^a)</td>
<td>2.2(^a)</td>
<td>3.6</td>
<td>—</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age of child (months)</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–11</td>
<td>89.5(^a)</td>
<td>2.5(^a)</td>
<td>2.5(^a)</td>
<td>1.1</td>
<td>2.2(^a)</td>
</tr>
<tr>
<td>12–23</td>
<td>38.7(^a)</td>
<td>12.9(^bcd)</td>
<td>16.1(^b)</td>
<td>—</td>
<td>12.9(^b)</td>
</tr>
<tr>
<td>24–35</td>
<td>26.3(^a)</td>
<td>24.6(^a)</td>
<td>12.3(^a)</td>
<td>—</td>
<td>12.3(^a)</td>
</tr>
<tr>
<td>36–47</td>
<td>85.4(^a)</td>
<td>3.3(^a)</td>
<td>2.8(^a)</td>
<td>3.0</td>
<td>—</td>
</tr>
<tr>
<td>48–59</td>
<td>88.4(^a)</td>
<td>4.4(^a)</td>
<td>1.5(^a)</td>
<td>3.0</td>
<td>1.2(^a)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age of caregiver</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 and less</td>
<td>86.0</td>
<td>3.2</td>
<td>3.2</td>
<td>3.9</td>
<td>—</td>
</tr>
<tr>
<td>25–49 yrs</td>
<td>81.4</td>
<td>5.3</td>
<td>3.4</td>
<td>2.1</td>
<td>3.4</td>
</tr>
<tr>
<td>50 and more</td>
<td>86.5</td>
<td>5.3</td>
<td>1.8</td>
<td>2.4</td>
<td>—</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender of child</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>81.9</td>
<td>5.3</td>
<td>3.8</td>
<td>2.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Female</td>
<td>84.8</td>
<td>4.2</td>
<td>2.3</td>
<td>2.3</td>
<td>2.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender of caretaker</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>83.3</td>
<td>10.0</td>
<td>3.3</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Female</td>
<td>83.2</td>
<td>4.7</td>
<td>3.1</td>
<td>2.6</td>
<td>2.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education of caregiver</th>
<th>Child not eligible</th>
<th>Child not taken to clinic</th>
<th>Not available phaletshe</th>
<th>Mother want heard of it</th>
<th>Never heard Mother uninterested</th>
</tr>
</thead>
<tbody>
<tr>
<td>No education</td>
<td>87.4</td>
<td>5.6</td>
<td>2.8</td>
<td>—</td>
<td>2.1</td>
</tr>
<tr>
<td>Non formal</td>
<td>81.3</td>
<td>—</td>
<td>6.3</td>
<td>12.5</td>
<td>—</td>
</tr>
<tr>
<td>Primary</td>
<td>86.9</td>
<td>2.5</td>
<td>3.1</td>
<td>2.5</td>
<td>—</td>
</tr>
<tr>
<td>Secondary</td>
<td>80.8</td>
<td>5.8</td>
<td>3.1</td>
<td>2.9</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Variables with different superscript are significantly different at 5%. Figures in red are for estimates where the cell size (n) was low. These need to be interpreted with caution.
was a noticeable decline (90.5%) as children reached the 24–35 months age category. It is possible that when children graduate from immunizations they begin to drift away from the Child Welfare Clinics for monthly Growth Monitoring and Promotion. Demissie et al (2009) have shown that there is a relationship between not receiving vitamin A and incomplete vaccinations. This may also apply for not receiving Tsabana.

The age of caregivers was also an important determinant of Tsabana coverage. Households with the youngest caregivers (24 years or less) recorded the highest coverage of up to 94.3%. The coverage declined significantly to 88.4% among households with caregivers aged 25–49 years before it increased to 91% in households with older caregivers aged 50 years or above. Children from households with caregivers in the 25–49 age category recorded 88.4% coverage compared to 91.4% coverage from households with caregivers within the 50 years and above category. The difference between the two age categories was significant. The difference could be a result of the competing roles that vary between the different age groups. It could also be related to the educational background of the caregiver.

When the level of formal education was considered results showed that households with caregivers without education recorded Tsabana coverage of 94.1% compared to 89.4% coverage from caregivers with some secondary education.

Reasons for not receiving Tsabana

Reasons for not receiving Tsabana were found to be associated with the wealth score, place of residence and age of the child. Children from households in the richest wealth score and city/town areas were more likely to report ‘child not eligible’ as the main reason why children did not receive Tsabana. Of all the reasons mentioned non-eligibility was the main reason children did not receive Tsabana at health facilities (Table 3).

It is interesting to note that 9.8% of the children from households in the highest wealth ranking said they never received Tsabana because mothers never heard of the product; 4.7% of the mothers said they were uninterested in Tsabana. The results further show that 14% children from the richest households compared to 2.1% from the poorest wealth ranking did not receive Tsabana because the children were not taken to the child welfare clinics.

On the other hand 7.1% households in cities/towns indicated that they did not know about Tsabana while 4.2% said they were not interested in Tsabana. Conversely 11.8% of the children from cities/towns did not receive Tsabana because their children were not taken to child welfare clinics. It is unclear from the data as to why children were not taken to monthly child welfare clinics as required.

Conclusions and recommendations

The re-analysis of the 2007 Botswana Family Health Survey III identified a couple of bottlenecks towards reaching the 100% coverage of vitamin A supplementation. Poverty, illiteracy and gender of the principal caregiver had a negative effect on vitamin A
supplementation. Results further showed that children from the rural areas were less likely to receive vitamin A supplementation compared to children from towns and cities. On the other hand, children under the care of persons who were 50 years and above as well as those 24 years of age or younger were less likely to receive vitamin A supplementation. It was encouraging to note that the boy and girl child equally benefited from vitamin A supplementation. In order to enhance equality of access to the program, public health education campaigns targeting the rural remote areas should be intensified. In addition, regular monitoring of the program is critical in assessing progress on the reduction and elimination of access inequalities.

Children aged 6–11 months and those in the 24–35 months age category were less likely to receive Tsabana. Data that is not presented here shows that breastfeeding remains the primary mode of feeding in Botswana at 73% of children who were ever breastfed. Although breastfeeding offers protection there is need for complimentary feeding; the 6–12 months are vulnerable to poor nutrition.

Children under the care of persons aged 25–49 are less likely to receive Tsabana. Part of the reason could be competing social and economic commitments faced by young adult caregivers. This is the same age category that recorded the highest coverage of vitamin A. The results might mean that this age group value vitamin A more than Tsabana. There should be a deliberate effort to develop intervention programs that target working mothers in both the formal and informal sector in order to improve access to Tsabana. In addition, children who are 6–12 months need to be targeted so that they can equally benefit from the food supplement.

Access to vitamin A supplementation is positively associated with higher level of education, better socio-economic status and reproductive age of caregiver. On the other hand, lower educational level and poor socio-economic status relates to increased utilization of Tsabana. It is likely that poorer households value Tsabana more because unlike vitamin A supplementation they can share it with beneficiaries and it also eases household food insecurity.
Nutrition adequacy of menus in early childhood centres: The case of select early childhood centres in Tlokweng

Introduction
A child's early years are important for future health and well-being. Good nutrition during this time lays a healthy foundation for childhood and life (Lenihan, 2004). Diet is one of the key determinants of health and nutritional status. An inadequate diet that is poor in both quality and quantity is one of the reasons why the level of malnutrition in children is high (Kulsum et al, 2008). Therefore food served in early childhood centres is of importance in young children’s health, particularly for children in full day care. According to Briley and Cindy (1999) early childhood centres are centres where children are cared for during the day by a person other than the children’s legal guardians. This task is typically performed by someone outside the children’s immediate family. In today’s era, early childhood centres are very common in urban areas. This is due to increased participation of women in the workforce and the changing family structures. These centres operate for 8 hours or more per working day.

The trend towards increasing reliance on early childhood centres provides expanded opportunities to ensure that young children (2-5 years) are regularly offered nutritious foods that keep them free from hunger, promote their proper growth, and support choices and habits that support good health (Department of Health and children, 2004). Early childhood centres have become an important gatekeeper in early childhood feeding, providing an environment that can promote acceptance of healthy food and delay onset of nutrition related ill health (Jennings, McEvoy & Corish, 2011). Since children spend most of their time in these early childhood centres it is recommended that meals and snacks offered should meet at least 50% of the recommended daily nutrients allowance of children aged 2-5 at the centre (The American Dietetic Association, 2004).

According to the Early Childhood Care and Education policy (2001) of Botswana, a centre that operates up to 5½ hours a day is required to provide children with one snack at an appropriate time while one that operates more than 5 ½ hours a day is required to provide children at least one cooked meal. The policy also stipulate that all food prepared at a centre must meet the nutritional needs of the children. The quality, quantity and timing of the meal shall be suitable for children.

It is very important that menu planners in early childhood centres take into consideration variables such as food quality characteristics (texture, colour and variety), portion size, cooking methods, and variety of dishes. These factors influence children interest in the food served and ultimately nutrient intake (Knight and Kotschevor, 2000, Lenihan, 2004).

Methods of cooking children’s food affect the adequacy of nutrients the food has to offer to meet the nutritional needs of children. For example if most methods of cooking
like boiling are used, often water soluble nutrients are likely to be inadequate as most will dissolve in water. Likewise, if dry methods of cooking like frying are used for most dishes, children will have difficulties digesting some nutrients, not to mention that the fat intake will overtime be too high. The other variable that may affect the nutrient adequacy of menus offered by childcare centres is the portion size of meals served to children. If the serving equipment is not standardized there would be inconsistency in terms of the correct portion size to be served to children and thus compromising their nutritional requirements.

Early childhood centres are valuable in that they stimulate early development of social skills, yet they lag behind in providing nutrient dense meals to children (Moore et al., 2005). The nutritional, health and safety aspect of early childhood centre menus and service in developing countries like Botswana have received less attention from researchers. For instance few/ no studies in urban villages like Tlokweng have explored the nutritional contribution of meals in early childhood centres. The objective of the present study was to examine the nutrient adequacy of menus offered in early childhood centres based on the food quality characteristics (colour, texture and variety), portion size and the methods of cooking used.

**Methodology**

A convenient sample of 5 early childhood centres out of the 8 in Tlokweng was selected. Permission was obtained from centre’s administrators to study the menu of their centres. Participating centre administrators provided copies of the centre menus for examination.

The data collection started with an observational visit to each early childhood centre. An observational checklist was designed to facilitate this process. Menus were collected from the sampled early childhood centre to acquire data concerning the current provision of dishes in the centres.

Furthermore the researcher observed the methods of cooking used (both dry and moist methods) and established the average portion size of food served to children enrolled in these centres (with assistance of the exchange list and the size of the serving spoons used). The characteristics of food quality (such as texture and colour) of the food served were assessed. In addition the nutrient content of average food served per child at lunch was analyzed using the nutritional analysis tool 2.0 software (NAT). The NAT gives users a detailed analysis of the nutrient content of the foods they are eating based on age and gender. Permission to undertake this study was authorized by the University of Botswana.

**Results**

Table 1 below shows that only 1 out of the 5 early childhood centres provided adequate servings of fruits and vegetables; none provided whole grain cereals while 2 out of 5 of the centres provided snacks and milk and milk products respectively.
Table 1: The adequacy of the amount of serving provided per food group

<table>
<thead>
<tr>
<th>Food group</th>
<th>Recommended serving(s)</th>
<th>Centre 1</th>
<th>Centre 2</th>
<th>Centre 3</th>
<th>Centre 4</th>
<th>Centre 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meat, fish and poultry</td>
<td>2</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Milk and milk products</td>
<td>3</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Fruits and vegetables</td>
<td>2–4</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
<tr>
<td>Bread, cereal and potatoes</td>
<td>4</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
<td>■</td>
</tr>
</tbody>
</table>

Key: ■ Adequate □ Inadequate

Table 2: Nutrient analysis of lunch menus provided by early childhood centres relative to the recommended amount

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Centre 1</th>
<th>Centre 2</th>
<th>Centre 3</th>
<th>Centre 4</th>
<th>Centre 5</th>
<th>Recommended amount based on NAT software</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro</td>
<td>15.23 g</td>
<td>33.13 g</td>
<td>13.78 g</td>
<td>18.47 g</td>
<td>12.68 g</td>
<td>26 g</td>
</tr>
<tr>
<td>Fat</td>
<td>10.32 g</td>
<td>2.38 g</td>
<td>1.31 g</td>
<td>6.06 g</td>
<td>9.36 g</td>
<td>63.33 g</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>60.14 g</td>
<td>153.27 g</td>
<td>27.96 g</td>
<td>83.48 g</td>
<td>32.63 g</td>
<td>–</td>
</tr>
<tr>
<td>Calcium</td>
<td>173.18 mg</td>
<td>295.04 mg</td>
<td>206.55 mg</td>
<td>253.35 mg</td>
<td>155.23 mg</td>
<td>800 mg</td>
</tr>
<tr>
<td>Iron</td>
<td>2.32 mg</td>
<td>2.15 mg</td>
<td>2.05 mg</td>
<td>4.42 mg</td>
<td>1.35 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Sodium</td>
<td>485.28 mg</td>
<td>295.04 mg</td>
<td>206.55 mg</td>
<td>253.35 mg</td>
<td>155.23 mg</td>
<td>2400 mg</td>
</tr>
<tr>
<td>Potassium</td>
<td>455.39 mg</td>
<td>355.67 mg</td>
<td>276.86 mg</td>
<td>363.34 mg</td>
<td>289.0 mg</td>
<td>500 mg</td>
</tr>
<tr>
<td>Phosphorus</td>
<td>208.72 mg</td>
<td>189.54 mg</td>
<td>528.6 mg</td>
<td>363.34 mg</td>
<td>289.0 mg</td>
<td>–</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>10004.05 IU</td>
<td>10009.1 IU</td>
<td>2008.89 IU</td>
<td>2008.89 IU</td>
<td>999.12 IU</td>
<td>3000 IU</td>
</tr>
<tr>
<td>Vitamin C</td>
<td>2.63 mg</td>
<td>2.35 mg</td>
<td>3.56 mg</td>
<td>2.15 mg</td>
<td>2.00 mg</td>
<td>40 mg</td>
</tr>
<tr>
<td>Thiamine</td>
<td>0.14 mg</td>
<td>0.12 mg</td>
<td>0.18 mg</td>
<td>0.13 mg</td>
<td>0.10 mg</td>
<td>0.2 mg</td>
</tr>
<tr>
<td>Riboflavin</td>
<td>0.16 mg</td>
<td>0.28 mg</td>
<td>0.55 mg</td>
<td>1.00 mg</td>
<td>0.34 mg</td>
<td>0.3 mg</td>
</tr>
</tbody>
</table>

As displayed in table 2 most of the centres provided inadequate amounts of energy yielding nutrients (fats, protein and carbohydrates) as well as major nutrients and vitamins.

The portion sizes of food served in childhood centres is shown in Table 3. Three out of 5 of the centres provided more portioned food sizes with reference to the exchange list of various food items while 1 out of the 5 centres offered correct and less portion size respectively.

Table 4 shows different food characteristics and methods of cooking that the early childhood centres vary. At least 2 out of 5 of these centres varied (more than twice) the texture and methods of cooking respectively while 2/5 of them also varied the colour several times.
Discussion

Differences in basic meal planning in the 5 early childhood centres studied were observed. The findings have revealed that all of the studied centres provided insufficient amounts relative to the recommended amount of major minerals like iron, calcium and zinc and vitamins. These results are not in disagreement with the results from the study conducted by Neelon et al (2010) who found out that only 19% of the participated child care centres provide sufficient iron and 0% offered sufficient calcium while only 2% of the centres offered sufficient recommended amount of zinc. This may mean that children in care are at risks of poor growth and development. As stipulated by Carriquiry (1999) there is growing evidence that deficiencies of these nutrients (iron, Vitamin B complex, calcium and zinc) are linked to behaviour problems and delays in children’s cognitive development.

On the other hand the results show that most of the centres did not provide the recommended adequate amounts of energy yielding nutrients like fat, carbohydrates and proteins. This on its own has an impact on the child on the basis that the energy requirement of pre-school children is high as they go development. According to the Department of Health and Children (2004), the foods served to children aged 2 years or older should enable them to follow the recommended healthy eating patterns. It has been identified that increasing fruit and vegetable intake in children is important (Department of Health, 2003). Further as identified by the Department of Health (2004), from national diet and nutrition survey for children, one in 5 children do not consume any fruit in a week while the 5 a day campaign recommends the consumption of at least 5 portions of fruits and vegetables a day. However, a common trait in most of the menus is a worrying lack of fresh fruits and vegetables. The obtained results indicate that only 3 in 5 of the childhood centres provide adequate servings per food group. This clearly shows that early childhood centres provide unbalanced diets. This may have a negative impact on the children’s health especially for those who attend a full day care. However these results are in disagreement with the study results conducted by Neelon et al (2010) who found that about 2 out of 5 of the centres studied offered vegetables and fruits to children in care. It is important that plenty of fruits and vegetables and whole grain cereals are to be offered in early childhood centres with sufficient servings.
to ensure the provision of vitamin C to children thus boosting their immune system hence preventing diseases just as clarified by Pilant (1994). Additionally good sources of vitamin A and whole grain need to be offered to children in childhood centres to promote good health. In addition, textures, colour, appearance and tastes of food should be varied at least more than twice a week so as to make food more appetizing and appealing to children.

In children, the appearance of food is important. Food can be made to look more attractive to children by serving a combination of colours and different textures as this may be appealing to children. For example the food can be divided into three or four defined areas of colour on a plate. Children will also appreciate a variety of smooth, crunchy, chewy foods. Additionally children should be encouraged to try different food tastes on a regular basis. However, children may not accept meals containing too many different or new flavours, so new tastes should be introduced one at a time, Lenihan (2004).

Cooking methods also influence children’s dietary intake. Lenihan (2004), suggest that in the preparation of children’s meals a variety of cooking methods should be varied. There should be a regular rotation of dishes prepared by boiling, stewing, roasting, oven-baking, steaming, and poaching or casserole. Frying should be limited as it adds a lot of extra fat to the food hence making food unhealthy for children’s consumption.

Foods should be provided in quantities that balance energy and nutrients with the children’s nutrient needs. According to Pilant (1994). The total energy needs increase slightly with age, although energy needs per kilogram of body weight actually declines gradually during childhood. Energy requirements are also influenced by activity level. Therefore early childhood centres should ensure that children are provided with adequate amounts and combinations of food during their day in care, thus making substantial contributions to prevent hunger and increase nutrition security for the nation’s young children.

Conclusion and recommendations

In conclusion, this study shows that the menus of the sampled early childhood centres fail to supply the recommended nutrients. Also, an effort should be made to include food characteristics (texture, colour and flavour) within their menus more than twice a week. Furthermore the magnitude of discrepancies was high amongst the studied centres. The centres failed to provide the recommended standard portion size of meal for children (2–5) enrolled in these full time centres. In a nutshell, none of the studied centres followed all the recommended factors, that is, provision of food from different food groups, provision of all essential nutrients (energy yielding nutrients, major minerals and vitamins), good portion size and variation of food characteristics.

Based on the observations made in the present case study, the author recommends that a bigger more vigorous study be conducted to study the feeding practices at children in preschool / day care centres to better understand feeding issues.

References


Rapid household surveys to estimate effective coverage for High Impact interventions. The case of Chobe and Tutume health districts

Introduction

In light with the current implementation of the Accelerated Child Survival and Development (ACSD) strategy to reduce child and maternal morbidity and mortality, UNICEF and the Ministry of Health are implementing a health strengthening approach called D-I-V-A which stands for Diagnose–Intervene–Adjust–Verify in Tutume and Chobe. An overview of D-I-V-A is presented in this year’s Thari Ya Bana publication (Codjia P and Kibassa C, 2012). This paper would focus on the rapid household survey used in D-I-V-A as a cornerstone of documenting the situation of high impact interventions at districts level and their catchment areas. This paper aims to describe the use of rapid household survey namely Lot Quality Assurance Sampling (LQAS) to estimate effective coverage for selected high impact interventions in Tutume and Chobe health districts.

Methodology

This section presents a selection of high impact interventions for child and maternal health from the two districts, the related indicator for effective coverage (or a proxy when it was found to be more feasible), the approach used to collect them at household level and analyse the information.

High impact interventions

The six high impact interventions that are reported in this paper are Antenatal Care (ANC), promotion of early initiation of breastfeeding, full immunization at one year, Oral Rehydration Salts (ORS) and Zinc for the management of diarrhoea, promotion of six months exclusive breastfeeding and hand washing. The interventions above reflect the continuum of care services from antenatal care, postnatal care, immunization, community maternal new born and child health to water, sanitation and hygiene services.

Their selection from others not reported in this paper—was made in consultative workshops involving Ministry of Health (MOH) Headquarters programme officers and each district health management team (DHMT) of Tutume and Chobe in February and March 2012. The selection of high impact interventions are based on the following criteria: 1) being nationally prioritized interventions as per the ACSD strategic plan and 2) being problematic and thus relevant at district level according to the DHMTs.

Indicators for effective coverage

According to the Tanahashi model (Tanahashi, 1978), the quality of an intervention and its effective coverage define the effectiveness of the intervention. In this paper, four interventions out of six were assessed against adherence to guidelines while for two interventions, proxies were used (Table 1).
Table 1 presents effective coverage indicators or their proxy used for the six selected high impact interventions.

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Effective coverage indicators (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Care</td>
<td>Mother of children 0–5 months who attended ANC 1 at 3rd months of last pregnancy or earlier.</td>
</tr>
<tr>
<td>Promotion of early initiation of breastfeeding</td>
<td>Infants 0–5 months who were breastfed within one hour of birth.</td>
</tr>
<tr>
<td>Full immunization</td>
<td>Children fully immunized by 12 months.</td>
</tr>
<tr>
<td>Promotion of ORS and Zinc for the management of diarrhoea</td>
<td>Mother of children 0–59 months who know that zinc tablets are used to treat diarrhoea (proxy).</td>
</tr>
<tr>
<td>Promotion of six months exclusive breastfeeding</td>
<td>Infants 0–5 months who were exclusively breastfed in the past 24 hours.</td>
</tr>
<tr>
<td>Hand washing</td>
<td>Mother of children 0–59 months who know the critical five moments to practice hand washing with soap (proxy).</td>
</tr>
</tbody>
</table>

**Data collection**

The collection of indicators for effective coverage was done using a rapid household survey methodology called Lot Quality Assurance Sampling (LQAS). LQAS is a method for assessing a program by analyzing the data produced by a small sample. LQAS was developed in the 1920s for industrial quality control. During the mid-1980s it was adapted to assess health programs. In 1991, a World Health Organization consultation on epidemiological and statistical methods for rapid health assessment indicated that LQAS was a sound and practical methods available (Anker, 1991; Lanata and Black, 1991; Lemeshow and Taber, 1991). The consultation promoted further development and use of LQAS to monitor health programs (ibid).

LQAS works by subdividing a program catchment area (CA). For example a district into smaller areas that deliver health services, the supervision area (SA). A CA consists of a minimum of four SA, although five is preferred. Typically, LQAS uses a sample size of 19 individuals from each SA.

Tutume and Chobe health districts have respectively twelve and three programmatic supervision areas but some re-arrangements needed to be done to reduce the cost of the survey (Tutume) and or to make it feasible (Chobe). In Chobe, the most populated supervision area – Kasane – had to be split into two supervision areas. Chobe health district then became a CA of four SAs. In Tutume, supervision areas geographically nearby were merged making Tutume health districts a program CA of ten SAs (Figure 1).

In this case 4 Chobe SAs and 10 Tutume SAs were used for Chobe and Tutume health districts respectively. This resulted in a sample of 76 respondents for the entire Chobe health district and 190 respondents in Tutume health district. By combining...
data from all SAs per district, managers can determine coverage proportions of the entire catchment area with 95% Confidence Intervals of ±10% for multiple indicators.

<table>
<thead>
<tr>
<th>Chobe catchment area</th>
<th>Tutume catchment area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision areas:</td>
<td>Supervision areas:</td>
</tr>
<tr>
<td>Chobe West</td>
<td>Dukwi</td>
</tr>
<tr>
<td>(Lower) Kasane Town</td>
<td>Nkange</td>
</tr>
<tr>
<td>Plateau and Kazungula</td>
<td>Gweta</td>
</tr>
<tr>
<td>Chobe East</td>
<td>Maintengwe</td>
</tr>
<tr>
<td></td>
<td>Marapong</td>
</tr>
<tr>
<td></td>
<td>Nata</td>
</tr>
</tbody>
</table>

Figure 1: District area and supervision areas

Target groups for Lot Quality Assurance Sampling were mothers of infants 0–5 months, mothers of children 12–23 months and mothers of children 0–59 months. The first group was changed to 0–11 months in Chobe due to the small population size and concerns over finding the required 76 respondents. The questionnaires for each target group were developed and pre-tested; minor but necessary changes to the questionnaires were done before the survey based on the outcomes from the pre-test and training. Questionnaires were in English and sight translated into Setswana (all survey sites except Chobe West) and or Sesubia (only in Chobe West) by the data collectors. Data collectors did translation exercise during the training among themselves and practiced it during the field practical before the survey started.

In each district, data collection teams (each composed of 3–5 members per SA) were trained by experts from Liverpool School of Tropical Medicine (LSTM) on LQAS techniques using the standard LQAS training guide (Valadez et al, 2012). Training also included selection of localities basing on the proportion to size sampling using localities population figures from the 2001 census. Listing of population from the 2011 census was not available at the time of the training. For Chobe district, listed localities or settlements known for the fact that no children and caregivers lived there were removed from the sampling frame; example were wildlife parks or lodges. Segmentation techniques were used to randomly identify the first household to be interviewed at community level. Other themes from the LQAS training include: interview techniques, parallel sampling to sample multiple target group, and data tabulation, analysis and presentation techniques.

Training lasted for four days in each district and included field practicals. Data collection took between five to eight days. During the data collection period, all respondents were informed that the survey was voluntary, carried no obligation and gave their consent before being administered the questionnaire. Transport of data collection teams within each district was provided by the Government of Botswana. Data collection was supervised by LSTM experts. Institute of Development Management (IDM) expert took part in supervision in Chobe and data tabulation, analysis and presentation. After completion of field work, all data collection teams were brought back into a hand
tabulation workshop (three days in Tutume and two in Chobe) to analyse the data manually and present them.

LQAS field work from training of data collectors, data collection and supervision to data analysis and presentation was done within three weeks in each district. Overall preparation and coordination of field work was done by UNICEF Botswana, DHMT coordinators and LSTM experts.

Results – Discussion

LQAS survey sites in Chobe and Tutume, March 2012
A total of 10 and 17 localities were surveyed respectively in Tutume and Chobe. In each health district, data collectors managed to reach the necessary number of filled sets of questionnaires i.e. 190 in Tutume and 76 in Chobe.

Results presented in this section are weighted to population size in each district.

Effective coverage for ANC in Chobe and Tutume, March 2012
It is recommended that pregnant women attend their first ANC visit during the first trimester of the pregnancy. Attending the first ANC visit after the first trimester is defined as late booking.

The data in figure 2 shows that few women with infants at the time of the survey attended ANC 1 in the first three months (first trimester) of pregnancy during their last pregnancy. In Chobe and Tutume, only 25% and 27% of women did respectively attend ANC 1 in the first trimester of their last pregnancy, indicating very high rates of late ANC booking in these districts.

With a national figure of 94% of pregnant women attending at least one ANC visit (CSO, 2009), Tutume and Chobe health districts attendance rates for at least one ANC visit are respectively 100% in Chobe and 98% in Tutume. Figure 2 gives critical information about the timing of ANC 1 in the two districts as most women do attend their first ANC visit late despite living within less than 5 kilometres from a health facility and agreeing that distance is not a factor that prevent them to attend ANC clinics (data not shown). Late initiation of ANC visit pose a threat to the quality of care during pregnancy as late attendees would not complete series of tests and exams required during pregnancy. Also, this might lead to delayed identification and management of pregnancy-related complications.

Effective coverage for the promotion of early initiation of breastfeeding within one hour of birth in Chobe and Tutume, March 2012
Higher rates of breastfeeding within the first hour of life are reported in Chobe (57%) than in Tutume (44%). Compared to the national estimates from the 2007 Botswana Family Health Survey indicating that 40% of new borns were breastfed in the first hour of life, the rates of early initiation of breastfeeding in March 2012 in the two districts are better. For this indicator, there is no evidence that there has been an improvement
or a decline in Chobe and Tutume since 2007 to which current observations can be compared. Since almost all women do attend ANC 1 and almost all children (9 out of 10 in Botswana) are born in health facilities with delivery attended by a skilled birth attendant, quality exposure to promotion of early initiation of breastfeeding should translate into higher rates than those observed in figure 3.

**Effective coverage for full immunization in Chobe and Tutume, March 2012**

Full immunization coverage for children by the age of 12 months are high in both districts (82% in Chobe and 93% in Tutume) though Tutume district displays a higher proportion (19%) of children who were not fully immunized by the time they reached 1 year. Full immunization rate in Tutume (81%) is below the national average of 90% (MOH, 2007).

**Effective coverage for the promotion of ORS and Zinc for the management of diarrhea in Chobe and Tutume, March 2012**

In terms of diarrhoea case management, most mothers (89%) of children less than five years old in Chobe did not know about the need for zinc tablets to treat diarrhoea. Similarly, limited knowledge is noted in Tutume district where 94% of mothers did not know about zinc use for diarrhoea management. As diarrhoea is one of the two most common child killer diseases in Botswana, it is important for mothers and care givers to know about the use of Zinc and ORS in the management of diarrhoea. It is also important to understand why so few women in the two districts reported to be unaware of the need to use zinc to treat diarrhoea and to address the situation. This is of utmost importance as in the past few years increased cases of diarrhoea were reported in Botswana almost every year. Addressing this knowledge gap is also very critical as it limits mother awareness on the way to correctly manage their children’s diarrhoea at home and to request for zinc tablets the same way they would request for ORS and information at health facility.
Effective coverage for the promotion of six months exclusive breastfeeding in Tutume, March 2012

The practice of exclusive breastfeeding among children less than 6 months – a World Health Organization recommended practice – is not common in Tutume (50%). Data for Chobe are not presented in this paper due to limitations during.

Effective coverage for the promotion of hand washing in Chobe and Tutume, March 2012

Though knowledge of proper hand washing practice is well known among mothers of young children in districts (data not shown), only 12% of mothers in Chobe and 17% in Tutume were able to mention the five critical moments for hand washing with soap. The lack of knowledge displayed on the quality dimension of hand washing poses a serious challenge for the prevention of diseases such as diarrhea that could be averted with proper hygiene practices.

Conclusion

Except for full immunization for children by the age of 12 months, both health districts of Chobe and Tutume have high unmet needs (proportion of standards not met) for key maternal and child survival interventions (timely ANC 1, early initiation of breastfeeding, six months exclusive breastfeeding, hand washing, Zinc supplementation in the management of diarrhea). With regards to full immunization in Tutume and also for all other interventions in both districts, it will be interesting to look at the disparities in coverage between supervision areas in each district to see which of them need more or less attention.

This paper showed that using LQAS within D-I-V-A enables both Tutume and Chobe district management teams to collect and analyze information on key household practices and knowledge in a short amount of time (three weeks). Data collected using
this method enables DHMTs to obtain updated information, monitor and report on key maternal and child survival interventions without waiting for national surveys. It allows district health managers to assess the quality (effective coverage) of each of the intervention they prioritize and other determinants of coverage. This approach complements the existing health information system as it gathers information from the community (e.g. people that may or may not use services offered by the health sector) thus giving a complete picture of service utilization.

The methodology used here does not require any special or rare skills to be replicated and districts through their monitoring and evaluation officer have enough capacity to replicate LQAS. By doing so, district can monitor regularly the progress of their efforts in removing the bottlenecks that hinder greater coverage of high impact interventions.

After looking at some of the data generated by LQAS within the ‘D’ of D-I-V-A and setting up a baseline as of March 2012, it is important to analyse all determinants of coverage with other tools proposed within the ‘Diagnose step’, complete the bottleneck and causality analysis to understand why women book late for their first ANC, why aren’t new born breastfed in the first hour of life, why aren’t district coverage of six months exclusive breastfeeding higher and why knowledge on zinc in relation to diarrhoea management and on hand washing critical times are so low in the community. Once the analysis of the bottlenecks and their causes is done, there is a need to identify the solutions and strategies before planning for the activities and next cross sectional assessment to be able to monitor the progress of bottleneck reduction/removal before ultimately seeing changes in effective coverage.

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• Chobe District Commissioner Office.
• Ministry of Health Headquarters: D-I-V-A National Monitoring Team and MOH Management.
• Statistics Botswana.

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A health system strengthening approach for the scaling up and monitoring of health High Impact Interventions with equity at district level

Introduction
Botswana health care system has been delivering several high impact interventions to children and their mothers with high coverage for several years. Immunization and Prevention of Mother to Child Transmission of Human Immunodeficiency Virus programmes are some of the successful examples of Government efforts in maternal and child health. Despite these efforts a small but significant proportion of children and mothers remain unreached by key high impact interventions. Reasons for that include lack to follow-up, as well as issues in service provision and in access/utilization of services by the most vulnerable.

In 2009, The Ministry of Health launched the Accelerated Child Survival and Development Strategy 2009 – 2016 (ACSD) which maps the road towards the achievement of the Millennium Development Goals 4 (reduction of child mortality) and 5 (reduction of maternal mortality) and the realization of VISION 2016 (MOH, 2009). The first two years of operationalization of ACSD strategy has been marked by the implementation of bi-annual Child Health Days (accelerated delivery of key services to all children such as immunization and vitamin A supplements), introduction of new vaccines and capacity building of health workers and managers from several districts.

Now, with less than five years left to reach the most underserved and reduce the burden of diseases and mortality among children and their mothers, the scaling up and monitoring ACSD High Impact Interventions (HIIs) at district level are critical. Victora et al (Lancet, 2006) and a recent study (UNICEF 2010) have stressed that an equity-focused approach will accelerate progress towards the health Millennium Development Goals faster and that it will be more cost-effective and sustainable. The Narrowing the gap report (UNICEF, 2010) identified several steps for an equity focused programming which have informed the development of D–I–V–A (Diagnose–Intervene–Verify–Adjust), a district centred approach – that in complement to the existing ACSD strategy – can facilitate the acceleration of the implementation and monitoring of high impact interventions at district level with equity. The purpose of this paper is to give an overview of the D-I-V-A (Diagnose-Intervene-Verify-Adjust) approach for an equitable acceleration of the implementation and monitoring of health high impact interventions at district level.

Definition of D–I–V–A
As presented in its guidebook, D–I–V–A is a systematic outcome-based approach to equitable programming and real-time monitoring that strengthens the district health system, complementing and building on what exists (UNICEF and MSH, 2012).

D–I–V–A is a four steps approach which application in the health sector leads to strengthened district health systems, built managerial capacity and empowered communities.
According to (UNICEF and MSH, 2012), the specific objectives of D–I–V–A are:
1. To increase quality coverage of ACSD high impact interventions, particularly for disadvantaged populations;
2. To strengthen local health systems by improving the capacity of district management teams, monitoring in real-time, and local data use for timely course correction, and engagement of key partners in improving the health of children and women;
3. To track progress towards equity of access for the most deprived populations.

**Methodology of D–I–V–A**
Implementing D–I–V–A in full implies going through four steps (box 1) in a systematic and a cyclic manner.

**Box 1: Four steps of implementing D–I–V–A**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Identify disparities and analyse barriers to access of services (DIAGNOSE)</td>
</tr>
<tr>
<td>2</td>
<td>Prioritise and implement solutions to overcome identified barriers (INTERVENE)</td>
</tr>
<tr>
<td>3</td>
<td>Monitor, in real-time, progress in reducing bottlenecks (VERIFY)</td>
</tr>
<tr>
<td>4</td>
<td>Adjust solutions and strategies during implementation as needed (ADJUST)</td>
</tr>
</tbody>
</table>

**Step 1 – Diagnosis**
The first step aims at the identification of disparities in interventions coverage and the analysis of barriers to access and utilization of services. It would sometimes require the set-up of a baseline using information available from local health information systems and/or collection of information (UNICEF and MSH, 2012).

For each intervention, information on the three key determinants of coverage – supply, demand and quality – is required.

Supply is defined by what the health system provides to the beneficiaries such as health personnel, health facilities and commodities. Supply determinants can be measured by desk reviews of existing documents and reports but can also be done through the administration of a quick health facility questionnaire.
Demand as another key determinant is looking at the other side of the health system namely health system target populations. Initial utilization and continuous utilization of services are the usual type of indicators that are gathered. Rapid household surveys such as the Lot Quality Assurance Sampling (LQAS) is the method of choice to document utilization of services by targeted population and help identify inequities at sub-district level (catchment areas).

Quality – adherence to protocol and guidelines – is the ultimate determinant of effective coverage. Information on effective coverage is collected through LQAS.

During the diagnosis step, data gathered on the key determinants of coverage for each high impact intervention are analysed and barriers to optimum determinants of coverage are identified (through focus group discussion and key informants interviews within the community). A causality analysis is then conducted to identify root causes of problems that hinder optimal coverage and solutions, strategies are identified to remove these barriers.

**Step 2 – Intervene**

Because the implementation of D–I–V–A in health is targeting sub-national health entities (health districts), the second step of D–I–V–A comprises of the design of health districts operational micro-plans by district health management teams (DHMT) and implementation of solutions that aims at removing the bottlenecks, barriers that have been identified in the step 1 (Diagnose).

The paramount criteria of the ‘intervene step’ is to select local solutions and strategies to overcome barriers within the scope of proven cost-effective interventions. These interventions are commonly called high impact low cost interventions as scientific evidences has shown that their implementation at scale lead to significant reductions in child and maternal morbidity and mortality (Jones, 2003; Bhutta, 2008).

**Step 3 – Verify**

With district operational micro-plans in place and up and running, the third step of D–I–V–A is mainly about monitoring progress in the implementation of district micro-plans. Based on the learning of the ‘Diagnose’ step on the extent on sub-district disparities, district health management teams can now monitor progress regularly made among the underserved populations and make informed decisions for improvement.

The monitoring can be done with approaches and tools used in the diagnose step to ensure comparability of data.

**Step 4 – Adjust**

During this step, an assessment of progress of solutions and strategies planned in previous steps is conducted through quarterly and bi-annual reviews. These periodic reviews give the opportunity to DHMT members and their main counterparts to take stock of the performance of the district and its catchment areas. They also help districts
in keeping track of the progress in reducing bottlenecks and guide decisions on adjustments that are required on the existing operational micro-plan.

As the four steps of D–I–V–A are inter-related, the effective use of the knowledge generated from each step is critical to the next one. The triangulation of source of information from quantitative data (rapid household surveys, health facility survey) to qualitative data (focus group discussion, key informant interviews) with the bottleneck and causality analysis makes it a comprehensive district centred approach for programming with equity.

Conclusion
In concluding this overview on D–I–V–A, we want to re-emphasize on its benefits and touch on some conditions for a successful implementation of D–I–V–A (UNICEF and MSH, 2012).

The implementation of D–I–V–A approach provides a clear picture of coverage of key interventions, at catchment area level and enables an analysis of intervention determinants of coverage and district management performance. Also through local solutions from the district health personnel with inputs from the communities, operational microplans can be developed and be monitored at three levels (activities implementation, bottlenecks reduction and change in coverage).

For D–I–V–A to be successful, the following few considerations need to be taken into account at national and district levels. At a national level, the generic D–I–V–A approach needs to be adapted to the national context so it can add value to existing strategies aiming at the reduction of child and mortality such as the ACSD strategy in Botswana. In addition, national leadership and ownership are required as effective acceleration of the reduction of child and maternal mortality is often a top priority in developing countries that implies special measures and coordinated mobilization of efforts from the national authorities and stakeholders.

At district level, leadership and active participation of a DHMT in the situation analysis that leads to the selection of underserved districts and underserved population within selected district is critical. The endorsement of subsequently developed operational microplans and efforts to mobilize resources for their implementation are needed.

Acknowledgments to: UNICEF Headquarters Health Division (Gabriele Fontana) and UNICEF Eastern and Southern Africa Regional Office (Eric Ribaira) for the orientation provided on D–I–V–A in Gaborone to UNICEF Botswana and the Ministry of Health in December 2011 and for the ongoing support.

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THARIYA BANA / CHILD SURVIVAL
Beyond being a human right, investing in a child’s development from an early age makes good economic sense, contributes to human capital development and promotes social well-being. In the early years of childhood, “the brain is in rapid development, learning and experimentation are at their peaks, and life-long patterns of behaviour are established.” Positive care, support and stimulation during these formative years determines much of a child’s future potential. However, child development practices are often determined by socio-economic and cultural factors that can leave the most vulnerable children without proper support, care and protection. The articles featured in this section cover a broad spectrum of child development issues that relate to early childhood education and psycho-social and physical development.

The article by Trivedi et al. contributes to the evidence base on early literacy development. The authors investigate the extent and nature of parental involvement in the development of reading skills of preschool children. Based on a sample of 100 parents in Gaborone with children aged 2 – 6 years, three aspects of parental involvement, namely: 1) the quality of parental involvement; 2) the frequency of children’s participation in routine learning activities; and 3) the provision of age-appropriate reading materials, are found to be central to children’s reading and early literacy development.

Further empirical contribution to the importance of early childhood development is provided in the article by Tsamaase and Hall. The authors examine the literacy practices of families in Botswana, and shed light on the challenges and opportunities that parents face in developing child literacy. Based on a sample of parents from the University of Botswana Child Development Laboratory, contrary to evidence from similar national studies, reading and writing are found to be a central part of daily family activity in Botswana among partners in this study. These findings substantiate those of Trivedi et al. regarding the importance of parental participation in early childhood literacy.

Children exposed to domestic violence suffer long-term psychological, emotional and behavioural consequences that impact negatively on their current and future well-being. The article by Sinkamba examines the emotional and physical effects of domestic violence on the boy child. The analysis is based on a sample of 60 boys aged 14–18 years from two schools in Selibe Phikwe. The evidence suggests that boys exposed to domestic violence are more likely to display aggressive behaviour, avoid peer relations and use excessive violence to enhance their reputation and self-esteem.

The last article in this section, by Onyewadume and Dhaliwal, provides a descriptive analysis of the extent to which children in major towns and cities engage in physical activity. The authors identify factors that promote or inhibit children’s participation in physical activity and make recommendations for increasing children’s participation. Based on a sample of 300 randomly selected children, aged 9–12, from English-medium and Tswana-medium primary schools in Gaborone and Francistown, the authors find that a significant number of children spent more time in sedentary activities at home and in school. The lack of physical activity at home was due primarily to limited play space in their neighbourhoods. In conclusion, the authors contend that the children sampled did not receive adequate support and encouragement from their parents and schools to increase their level of participation in physical activity.
Parental involvement in the development of reading skills of preschool children

Introduction
Parental involvement includes a wide range of behaviors but generally refers to parents’ use and investment of resources on their children. These investments can take place in or outside of school, with the intention of improving children’s learning. Parental involvement at home can include activities such as discussions about school, helping with homework, and reading with children. The importance of parental involvement as an accelerating and motivating factor in children’s education cannot be overemphasized. Parents and other family members lay the foundation for reading and writing to children before they start school. Reading activities in the home make a considerable contribution to children’s ultimate literacy success. (Dickinson & Tabors, 2001; Makin & Diaz, 2005; Senechal & Lefevre, 2002). According to Snow, Porche, Patton, Tabors and Harry (2007), children enter school with different levels of skills, and these initial differences often affect children’s subsequent language growth, cognitive development, literacy and academic achievement. Children spend the majority of their time under parental care during their initial years of development, and parents have the opportunity for a number of interactions with their children in one-on-one situations. The advent of new technologies and increased socioeconomic changes has changed the role and place of parents in children’s lives. Today, many parents are compelled to spend more time at work than before, and hence are unable to spend time with their children.

Research on the effects of parental involvement in children’s literacy skills has shown a consistent, positive relationship between parents’ engagement in reading story books with children and development of reading skills in children (Weigel, Martin, & Bennett, 2006). The existing evidence, however, is based on studies that were carried out in developed countries. Botswana is perceived as a predominately oral society (Molosiwa, 2006), a factor which is likely to hinder processes that promote children’s reading in preference to talking. In addition, Andrews, Galeforolwe and Ratsoma (2006) observed that many Batswana children grow up in homes which have no reading materials, and homes where not much writing occurs. This culture is, however, gradually changing in view of newer technological and socio-cultural developments including the parents’ role in the upbringing of their children. Many parents are aware of the importance of reading but they do not prioritize it. Increasingly, unqualified caregivers are assisting children with reading while the parents are at work, and this can have negative effects on the child’s literacy acquisition. It is against this background that the researchers found it worthwhile to undertake a study on parental involvement in the development of reading skills of preschool children in Botswana. Results of the study have potential to impact the development of a firm reading foundation of children in Botswana, and consequently contribute towards their future academic achievements and ultimately national development.
The main objective of this study was to investigate the extent and nature of parental involvement in the development of reading skills of preschool children. It was therefore necessary to ask the following research questions in order to address the objective.

1. How often do parents read with their preschool children?
2. Which reading techniques do parents use?
3. What kinds of resources do parents use at home to enhance their preschool children’s reading skills?
4. What kind of feedback do parents get from the children after reading to them?

Methodology

An ethical clearance was obtained from the Ministry of Education and Skills Development before conducting the research. A self-made questionnaire was used to elicit responses regarding parents’ involvement in their children’s reading. A consent form briefing participants about the purpose of the research and their willingness to participate in the research was signed by all the parents. Fourteen of the questions were closed ended and four were open ended. The closed ended questions sought to establish the frequency and nature of reading activities and the resources used. The open ended questions sought the parents’ views about their responses to children’s attempts to read. Due to financial implication and time constraining purposes, sampling was used to select 100 parents who had young children between two and six years of age and lived in Gaborone. Quantitative data were analyzed using SPSS version 18.0 and the open-ended questions were analyzed using the thematic approach.

Findings

Demographic information

Eighty eight percent (88%) of the children were between the ages of 2 and 6 years. Fifty three percent (53%) of these children were girls and forty seven percent (47%) were boys. The majority of the children (74%) were attending preschool and 26% did not attend preschool.

One of the questions required respondents to indicate the person(s) in the home who frequently read to their child. The responses in Figure 1 show that reading to the child was mostly done by parents (52%), followed by siblings (24%), caregivers (20%) and other relatives (4%).

Seventy nine percent (79%) of the parents reported that they had seen their children holding a book and pretending to read. On seeing this gesture the parents responded in different ways. Some:

- Read the book with the child and discussed pictures in the book (19%)
- Encouraged the child to keep reading on their own (15%)
- Asked what the child was reading and asked them to tell the story (23%)
- Gave no response (21%)
- Told the child that he/she was cheating himself (1%) (because the child was too young to read.)
Sixty five percent (65%) of the parents indicated that they preferred to read to their children at bedtime, while twenty nine percent (29%) preferred to read before the child took nap after lunch; and six percent (6%) did not respond to the question. However, only twenty four percent (24%) of the parents read to their children every day, followed by twenty one percent (21%) who indicated that they read whenever they got the chance, four percent (4%) read once in a week. Thirty nine percent (39%) parents indicated that they did not read to their children, and 12% did not give a response.

The majority of parents (62%) used books with big illustrations and pictures, while 18% used any other books. Twenty percent (20%) did not respond.

Parents who read to their children used a combination of styles. The most commonly used styles were lap reading (48%) and finger-pointing (48%). Only thirteen percent of (13%) parents indicated that they read aloud with the child sitting opposite.

The majority of the parents (65%) asked and got feedback from their children after reading to them while twenty nine (29%) reported that they did not ask for any feedback from the child after reading thus did not get the feedback. The feedback came in the following ways. The child:
- Asks for more stories or reading related questions (19)
- Repeats/imitates and remembers what was read to him or her (18)
- Says loudly whatever he or she has learnt (10)
- Interprets the pictures and makes own story (8)
- Links the story with real life experiences (5)
- Asks for a summary of the story (4)

**Discussion and implications**

The above findings indicate that most parents were to some extent involved in reading activities with their children. While 94% of the parents reported that they read to their children, only 24% read with their children on a daily basis. Whether the parents did it consciously or unconsciously, there are numerous benefits that are attributed to early literacy development. Reading activities with children early in their lives contribute considerably to the children’s ultimate literacy success and aptitude of learning in general (Makin & Diaz, 2005; Dickinson & Tabor, 2001). Makin and Diaz (2005) pointed out that reading to a child soon after birth stimulates brain development, facilitates the development of language and speech skills, and promotes bonding with the child. They further explain that when a child is born, “only twenty-five percent of the brain is developed and the rest develops in the first year of life” (p.1). Early stimulation is therefore very important. Kaufmann, Alt and Chapman (2004) are of the opinion that those children who exhibit delays at the onset of schooling are at risk for early academic difficulties and are also more likely to experience grade retention and special education placement. It is therefore vital for parents, government and other stakeholders who deal with children’s welfare to tap into this important information so that they do whatever is possible to facilitate the stimulation of children’s brain development at a tender age. Reading aloud and allowing the child to listen to the stories, playing educational games and simply talking to the child are some of the techniques that can be used.
Oftentimes children are seen pretending to read, for example when the child is seen paging through a book even if it is held upside down, and sometimes mimicking sounds. Pretending to read is an important pre-literacy activity that should be encouraged but is often ignored by parents. One of the parents in this study even remarked to the child that “he was cheating himself” when she saw him pretending to read.

Parents and other family members in this study who included siblings, caregivers (maids), and other relatives helped the children with reading. Mathangwane and Arua (2006) concluded that parents had a positive attitude towards reading, but their support was limited to verbal encouragement. The home environment is, thus, important to the development of a child’s literacy and language skills. Some factors of the home and family such as parents’ income and literacy levels have been shown to be associated with children’s literacy development (e.g. Christian et al., 1998; Snow et al., 1991). In addition, parents’ own literacy habits such as personal enjoyment of reading was also found to help children develop oral language and precursors of literacy (Burgess et al., 2002; Snow et al., 1998). Parents should therefore serve as role models by inculcating a reading culture at home. Exposing children to a home environment that is rich in literacy opportunities is beneficial. Socially disadvantaged families, on the other hand, have fewer or no reading materials, and less time is given to reading activities. Thus children’s ability to read is compromised and this in turn triggers the “continuation of the poverty cycle” (Makin & Diaz, 2005). Parents should therefore strive to create a conducive home environment that encourages children to freely explore and discuss issues of reading with their parents. In case of socially disadvantaged parents, schools should inform the parents about library facilities available in the school and in the community (public libraries).

A nationwide study conducted by Andrews et al. (2006) in Botswana found that very few parents interacted with their children in general life. This interaction could even be more compounded when it comes to reading since some of the parents may not be able to read themselves. Reading, therefore, needs to be promoted to the larger community as an interesting and integral part of a child’s daily routine. However, this will be an enormous undertaking because according to Andrews et al. (2006), among some communities in Botswana the children “have never seen a book or held a pencil before coming to school” (p.49). Transcending this status quo requires enormous human and material resources, and programmes that have potential to change the mind sets of every individual who interacts with children before they go to school. It is therefore recommended that policy makers, educators and other relevant stakeholders should formulate and embark on programmes that strengthen parental involvement in children’s schoolwork in order to promote parent/child book reading from an early age. This will enhance literacy development.

Most parents read a variety of books with their children. Illustrated picture books were popularly used for reading. The parents also used a combination of reading styles chiefly lap reading and finger-pointing. Dickinson and Tabors (2001) are of the opinion that using expressions and gestures while lap reading captures children’s interest and
fosters reading enjoyment. Allowing the children to ask and answer questions, make predictions about the outcomes of the story, or retell and dramatize the story enhances their involvement during reading. That way, they develop logical thinking skills and increase their comprehension and language development (Wasik, 2001).

A small number of parents in this study read aloud to their children. Reading aloud is necessary as it affords the children a chance to hear the sounds and learn how to pronounce them. Allowing the child to sit in close proximity to the reader enables the reader to point at the illustrations and thus captures the child’s attention. Some researchers have reported that joint-book reading was often initiated by the children and not the parents, suggesting that children are interested in book reading (Evans, Fox, Cremasaso & Mickinson, 2004; Frijters, Barron, & Brunello, 2000). Creating a reading routine is also important as it makes the child look forward to reading. In addition, young children are known to adapt well to routine. As such, a reading routine, at whatever time is convenient to both the child and parent, should be established.

Suffice to say then that the style of reading as well as the types of reading materials should change with the developmental level of the child. Parents should expose their children to different cognitively stimulating activities and materials such as books and electronic media. One cost effective way would be for parents to be actively involved in the academic activities of the preschools where their children attend and learn through observation, appropriate ways of interaction and the resources which they need to stimulate cognitive development and literacy in general. This is, however, only possible if the preschools are well resourced, but available studies suggest that most preschools in Botswana do not have trained teachers and are not well equipped (Bose, Trivedi & Monau, 2010). Support programmes that educate the parents about reading techniques to use with children, and the appropriate reading materials for their children are therefore needed.

Children’s ability to read has wider implications than what findings in this study may seem to suggest. Reading is a critical 21st century skill that affects all other learning processes in a child’s academic life. For example, for the child to comprehend mathematics, or be a renowned architect or dentist, they first need to master the basics of reading. Reading skills are also increasingly becoming more important as today’s children’s rely more and more on electronic media including electronic games, the internet and other social media such as Facebook, LinkedIn and twitter to interact with others. In some preschools even in Botswana, children are learning to read and do several activities on a computer. Botswana as a nation should jump onto this bandwagon of early literacy development and lay the foundation of success for its future adults.

**Summary and conclusion**

The main objective of this study was to investigate the extent and nature of parental involvement in the development of reading skills of preschool children. Three aspects of parental involvement have been highlighted as central to children’s reading and ultimately early literacy development. Firstly, is the quality of parental involvement.
Exposing children to a home environment that is rich in literacy opportunities is beneficial to young children’s reading and language development. While most parents showed a positive response when their children simulated reading, a large proportion (21%) did not actively encourage them to go on reading, neither did they read with them. Secondly, the frequency of children’s participation in routine learning activities is important. This is influenced by the amount of time the parents spend reading with their children and the type of child/parent interaction and engagement, for example shared book reading, storytelling and visits to libraries. Thirdly, is the provision of age-appropriate reading materials. The main reading resources that were used by parents in this study were books with big illustrations or pictures and picture charts. Very few parents used or were aware of electronic media. There is need to develop culturally appropriate reading materials.

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Accessed on 02/02/2012.


Opportunities and challenges facing parents in developing children’s literacy skills: A sneak-peek at literacy practices of parents of children enrolled at the University of Botswana Child Development Laboratory

Introduction

Home literacy practices refer to everyday activities that occur in the home, that promote language and writing skills. A considerable number of researchers have gained particular interest in exploring home literacy practices (Sénéchal & LeFvre 2002; Hughes, Schumm & Vaughn, 1999).

Literacy practices are embedded in the framework of everyday life. According to Aram, Most and Mayaffit (2006) most literacy related activities include family interactions and conversations, reading environmental print, storybook reading, joint writing, playing with letters and watching educational television programs. Other researchers (Rodriguez, 2006) have expounded the list of literacy activities to include listening to music and singing, library use and computers. Further, studies (Geiger & Alant, 2005) have revealed that children learn literacy skills by watching the actions of the people in their homes. In particular, “young children pay close attention to what they see the powerful and significant people in their world doing and they imitate behaviors that seem to be important to these people” (McLance & McNamee, 1990, p. 90).

Culture also defines the literacy activities that occur in the family setting. As argued by Barratt-Pugh and Rohr (2000) “literacy activities are mediated through the values, beliefs and behaviors of the child’s culture” (p. 7). Thus, the development of literacy skills occurs as children participate in various daily activities and cultural events.

In essence, research has shown that parents who place greater importance on their children’s literacy and language development, and who value parental role in their children’s development, engage their children in literacy and language enhancing activities on a regular basis (Weigel, Martin, & Bennet 2006). Hence, some of the common examples of activities that are perceived to enhance literacy development include reading books; scribbling, drawing, colouring or writing notes to friends; visiting the library regularly, talking or communicating, and pointing out letters, sounds, signs and labels. One of the interesting dimensions of early literacy research is the accessibility of literacy resources to children. Although ownership of basic literacy materials like paper, pencils, and crayons is perceived important for literacy development, in some cultures it is restricted to school going children (Rodriguez, 2006).

Despite increased interest in early literacy development and the influence of the home environment on children’s development of literacy skills, very few research studies have been conducted in Botswana. Further, studies conducted in Botswana were limited to child rearing practices (Geiger & Alant, 2005); the use of Setswana versus English language; (Molosiwa, 2006) and parents’ attitudes towards reading (Mathangwane &...
Arua, 2006). Even though these studies unveiled crucial information about some aspects of literacy development in Botswana, they fell short of examining what parents do to enhance children’s literacy development.

Also, none of these studies explored literacy development at an early stage, and yet research (Roberts, Jurgens, Burchinal, 2005; Senechal & Lefevre, 2002) has identified the early years as critical to language and literacy development as well as important for children’s future success. Furthermore, the studies carried out in Botswana were mainly conducted in rural areas. Therefore, it was beneficial to find out the practices of the families in an urban area. Hence this research study examined the literacy practices embraced by parents of the University of Botswana Child Development Laboratory in order to gain insight of the opportunities and challenges parents face in enhancing their children’s literacy skills.

Methodology
This paper is part of the study that was carried out in January 2010. The study examined the home literacy practices embraced by parents of the University of Botswana Child Development Laboratory. Purposive sampling was used to obtain a sample of fourteen families of the University of Botswana Child Development Laboratory. The sample frame consisted of families of students (n=4), academic members (n=6) and support staff (n=4). Only one parent from each family was used for the study, hence a total of five fathers and nine mothers participated in the study. The ages of the participants ranged from 23 to 45 years. This study used in-depth interviews with the participants, as well as a brief questionnaire for data collection. The interviews were recorded, transcribed and analyzed in line with the phenomenological approach. The approach was deemed appropriate for this study because first it allowed the researcher to study a small sample of subjects (Creswell, 2009), and secondly, gave the researcher an opportunity to understand the phenomenon from the participants’ perspectives (Bogdan and Biklen, 1998) and provided relevant answers for the study.

Findings and discussion
The findings of the study indicated that the University of Botswana child development laboratory parents actively engaged in various literacy enhancing activities in their family settings. Most of the participants (n=9) reported that they read to their children, a total of eight indicated that they wrote and discussed pictures with children while over half (n=8) of the participants revealed that they played with their children. Further, all participants for the study disclosed that they enhanced their children’s literacy skills by holding back and forth conversations. Other activities used by participants to boost children’s literacy development included singing (n=6), storytelling (n=3), drawing and colouring (n=2), vacation and outdoor activities (n=2) as well as television and educational toys.

Reading and writing
The evidence derived from the study however, suggested that the majority of parents promoted their children’s literacy skills through reading and writing and only a small
percentage did not read to their children. It is also evident that parents of the University of Botswana child development laboratory use reading to children as an interactive activity because the results show that most of them discussed pictures and also pointed and repeated words while reading. These actions accordingly help to sustain children’s interest during reading (Bingham, 2007).

Overall, the findings of this study add a new dimension to earlier research submissions on literacy practices in Botswana. Although the study is limited in its generalizability, it has unearthed an interesting trend of literacy development practice among families in urban settings. The current evidence prompts speculation that some parents do get opportunities to engage their children in various literacy developing activities at home. This resonates well with studies conducted in other regions of the world (Perry & Brown, 2008; & Rodriguez, 2006) which found that reading and writing activities were part of the daily routine in family settings and emphasized that parents should involve different attention arousing actions during reading to avoid boredom (Bingham, 2007).

From the results therefore, it is clear that most of the parents of the University of Botswana child development laboratory understand the importance of reading and writing which has been elucidated by research (Aram, Most & Mayafit, 2006). Reading and writing serves several purposes in children’s development. Other than bringing sheer excitement of spending time with a parent, story reading provides an opportunity to learn new words and follow the order of events (Brock & Rankin, 2008). Apart from reading and writing, this study also unveiled other activities that participants used to groom and nurture literacy development of their young ones. These included play, holding back and forth conversations; singing and storytelling; television watching and computer use; as well as allowing children to participate in household chores.

**Play**

It is not surprising that the majority of the participants identified play as one of the mediums they use to impart literacy skills to their children because previous studies have revealed similar findings. In fact, studies conducted by Geiger and Alant (2005), Molosiwa (2007) revealed that young children in Botswana generally gained literacy skills through play. The results of the current study however, added a new twist to the existing knowledge brought in by previous studies (Geiger & Alant, 2005; Molosiwa 2007) by revealing that play could involve even parents. While previous studies emphasized that children learned literacy skills through playing with siblings or other children, the current study added an interesting dimension by providing evidence that even parents get involved in play activities. This is precisely because research (Brock & Rankin, 2008) has underscored the importance of parental involvement in play activities.

**Back and forth conversations**

All participants revealed that they have back and forth conversations with their pre-school children. The evidence gathered show that participants have daily unstructured conversations with their children. It is also clear that these conversations stemmed out of the discussion of the child’s feelings, the child’s day experiences or could be
provoked by the questions asked by the children. These findings contradict what was discovered earlier by Geiner and Alant (2005). Instead of discouraging children from expressing their opinions and asking questions, the findings revealed that parents of the University of Botswana child development laboratory welcomed children’s questions and felt that questions provided opportunities for learning and expanding children’s vocabulary. Basically, children who are talked to by older people, tend to acquire language skills more quickly than their peers who do not benefit from such opportunities. Therefore, having back and forth communication with children is often seen as a catalyst of literacy development.

Other identified literacy enhancing activities
Among the activities that were revealed by this study, it surfaced that few parents (n=2) promoted children’s literacy skills through singing (n=2), storytelling (n=3), household chores (n=2), vacation and outdoor activities (n=2), and television and educational toys (n=5). The limited usage of the activities listed above may be partly because parents were not aware of their essence in the development of children’s literacy skills. However, engaging children in such activities can aide their literacy skill development. For example, through singing children can acquire knew words and expand their vocabulary as well as learn ordering of words. Similarly, storytelling is perceived as an excellent way of developing children’s literacy skills (Brock & Rankin, 2008).

Although limited research has been conducted on the use of household chores as a learning opportunity for children, some studies (e.g. Akhtar & Jipson, 2001; Rogoff, Paradise, Arauz, Correa-Chavez, & Angelillo, 2003) have revealed that children acquire language skills by observing and imitating others. Likewise, participants of this study revealed that they promoted children’s literacy development by engaging them in household chores and this was illustrated by one participant who said, “also we cook together, I show him this is an apple, this is how we chop it, you know we have to wash it first, and do this... and that... to come up with this. So we are constantly talking during such activities.” Further, family vacations also expose children to new environments and arouse their desire for exploration and enquiry, and this helps them to refine their language skills. Similarly, proper use of television and educational toys can help promote children’s listening and language skills.

Challenges parents face in promoting children’s literacy skills
While the participants revealed various opportunities that they used to facilitate the development of their children’s literacy skills, it became apparent that they also faced challenges. It is clear from the findings that lack of time, gaining children’s interest and acquiring relevant resources were major challenges hindering participants’ attempts to develop children’s literacy skills.

Lack of time
All participants felt that they did not have much time to spend with their children because they all had full-time jobs. According to their responses they have limited time in the evenings and a bit more time during weekends. However, participants said they
were usually too tired to do anything productive with their children. From their views, they faced the same challenge even during weekends due to other family and social commitments. It became clear that participants were grappling with balancing their time among family and employment demands. From the information gathered through the interviews, it also became apparent that parents seemed not to have adequate time to spend with the children mainly because spending time with their children was not in their list of priorities. As one participant confirmed:

“For me the little time I have is used to try and make more money for the family. I know money may not be deemed as more important but it’s very important because we use it every time. The little time we have, we want to use it to make more money.”

Gaining children’s interest
The majority (n=11) of participants stated that they had difficulty keeping their children interested in the activities they plan for their kids. Participants lamented that the preschoolers were unpredictable as some of the time they listened well and participated in the activities planned by parents while other times they refused to partake any activity initiated by their parents or siblings. A general concern was raised that children could not concentrate on the activities parents do with them. One participant had this to say: “It’s very difficult to get his concentration. Most of the time when I start reading, he wants to narrate the story ahead of me... so I realized that he doesn’t have much interest, although I show him pictures and the like, he doesn’t concentrate that much when I read.” Nevertheless, another participant speculated that the parents’ frustration derived from the fact that they often undermined children’s capability.

Lack of resources
Most participants (n=12) felt that they struggled with getting the right resources for their preschool children. They believed that the toys, books and other resources essential for the preschool age group were expensive. Acquisition of resources was alluded to as a minor problem, whereas, choosing the right kind of resources seemed to be a greater challenge for the majority of the participants. This makes sense because for literacy development to take place the resources used should not only be age appropriate but should also be culturally acceptable.

Conclusion and recommendations
Based upon the findings and within the limitations of the study, several conclusions are drawn. First, the findings of the present study present study demonstrated both similarities and differences identified in the existing literature. The study found that reading and writing were embedded in family daily activities. It further indicated that parents of the University of Botswana Child Development Laboratory used various literacy resources to enhance their children’s literacy skills. This is a good sign for children’s early literacy development in general. It is important that children have easy access to books (Makin & Whitehead, 2004) to enable them to interact with print. Apparently, availability of a variety of literacy resources and materials signifies a literacy rich environment, and children who are raised in such settings thrive.

References
These findings therefore, add a different perspective to family literacy research in Botswana as it highlights unexplored practices of families in urban settings. Furthermore, it is apparent that parents of the University of Botswana who participated engaged various unstructured activities to enhance children’s literacy development in their homes. Direct participation of parents in children’s literacy related activities helps children to develop school readiness skills (Farver, Xu, Eppe & Lonigan, 2006). Also, it is clear from research (Bennet, Weigel, & Martin, 2002; Senechal & LeFevre, 2002) that the development of early literacy skills among children sets the stage for future learning. Besides, Oglan & Elcombe (2000) children are capable of developing literacy skills in environments where family members model these skills.

The implication therefore is that availing literacy materials alone is inadequate in developing children’s early literacy skills, but should be coupled with parent participation. In this regard, developing and implementing parent education programs might help parents to improve their participation and current early literacy development practices for improved development of literacy skills among children.

Recommendations

The study has demonstrated both opportunities and challenges that parents encounter in their primitive environment. Therefore, the following recommendations are proposed. First, parenting program should be developed and implemented to address the needs identified by the current study. Families are children’s first educators and play a critical role in young children’s literacy development. Studies have shown that young children’s future success is related to their early literacy experiences (Saracho, 2002) in the home. In essence, family practices determine young children’s literacy skills prior to formal instruction. However, as evidenced by the findings of the current study families may not be aware of the best practices in developing children’s literacy development. Therefore, relevant parent education programs can help families of young children improve their awareness and knowledge of optimal literacy development. By providing families with specific strategies to support their children’s literacy skills, families may increase their understanding of early literacy development. Second, further research on family literacy practices in a different context be conducted, building on this study. For example, it would be desirable to further explore the trends and themes found in the family literacy practices, across other geographic, ethnic, cultural, and socio-economic groups. This will help to identify if the findings of the current study apply to the families of Botswana in general. Thirdly, another logical step in further research would be to conduct a longitudinal study involving children from the families that participated in this study in order to understand the impact of family literacy practices on children’s performance as they progress through the levels of education. Lastly, there is need for large scale research in the country that explores opportunities and challenges facing parents in the development of children’s literacy skills. Findings of the present study are based on a small scale project, therefore, they cannot be generalised to larger settings.

References


Domestic violence and the boy child: Insights from two schools in Botswana

Introduction

Children are highly sensitive to domestic violence, and at any age are able to detect and remember abuse that occurred within the home, whether directed to them or to their caregivers. In addition, children can know about the tension, anger and violence in the home whether or not they witnessed it directly, and whether or not abuse is openly discussed (Senecal, 2002). Existing literature shows that boys who witness their fathers’ abusing their mothers are more likely to inflict more violence on others as adults, while girls who witness maternal abuse may tolerate abuse as adults more than girls who did not (ibid, 2002).

Domestic violence is a devastating social problem that affects every segment of the population. While system responses are primarily targeted toward adult victims of abuse, increased attention is now being focused on children who witness domestic violence. Studies estimate that 10–20 percent of children globally are at risk of exposure to domestic violence (Edleson, 1999). These findings translate into approximately 3.3–10 million children worldwide who witness the abuse of a parent or adult care giver each year. Research also indicates that children exposed to domestic violence are at an increased risk of being abused or neglected (Edleson, 1999).

According to the Department of Social Service, New South Wales, (2003) some children are living in homes where domestic violence is evident. Because of countless strategies for denying or minimizing the abuse there is scanty research done. There are obvious problems in collecting this type of data from children as well as reliability issues from collecting the data from the parents (Margolin, 1998). “Research on children who witness family violence is a special case of counting the hard-to-count and measuring the hard-to-measure…” (Fantuzzo, Boruch, Beriana, Atkins & Marcus, 1997; p.121). It is impossible to identify families affected by domestic violence because traditionally issues of domestic violence are kept secret (Osofsky, 1995). Between 85% to 90% of the time when a violent incident took place in a domestic setting children were present, and children were also abused during the violent incident in about 50% of the cases (James, 1994). It is estimated that child abuse is present in all 35 to 70% of homes where domestic violence is present (O’Keefe, 1995). A study conducted in Canada revealed that children knew about incidents their parents thought they had hidden from them (Jaffe, Wolfe & Wilson, 1990).

Purpose of the study

The study intended to explore the effects of domestic violence on the boy child. It sought to shed light on domestic violence experienced by boys in the society and make policy and research recommendations that would lead to appropriately designed measures that address issues of domestic violence on the boy child. The main
objectives of the study were to examine the extent of domestic violence against the boy child, contributing factors as well as the types and effects of domestic violence that boys are exposed to.

Research methods

The study utilized exploratory research design. A self-administered questionnaire was used to collect data among sixty boys aged 14–18 years. They were selected using stratified sampling technique from a junior secondary and a senior secondary school in Selibe Phikwe. The principles of confidentiality, privacy and anonymity were explained to the respondents. The permission to undertake the study in schools was sought and obtained by providing a written request to respective school headmasters. In addition, guidance and counseling teachers were available for students who needed counseling. All respondents were given an assent for their parents to complete, and consent was sought from the legal guardians and parents of the children. Only those who brought back completed and signed consent forms were asked to sign assent form of their own then given a questionnaire to fill in a classroom. The information given by respondents was deemed confidential and was reported as group data.

Findings

Demographic characteristics

<table>
<thead>
<tr>
<th>Table 1: Demographic area</th>
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<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>14–15</td>
</tr>
<tr>
<td>16–18</td>
</tr>
<tr>
<td>Year of study</td>
</tr>
<tr>
<td>Form 1</td>
</tr>
<tr>
<td>Form 2</td>
</tr>
<tr>
<td>Form 3</td>
</tr>
<tr>
<td>Work</td>
</tr>
<tr>
<td>Both parents working</td>
</tr>
<tr>
<td>Mother/guardian working</td>
</tr>
<tr>
<td>Father/ guardian working</td>
</tr>
<tr>
<td>Both parents not working</td>
</tr>
<tr>
<td>Parents’ religion</td>
</tr>
<tr>
<td>Christianity</td>
</tr>
<tr>
<td>Muslim</td>
</tr>
<tr>
<td>Do not have a religion</td>
</tr>
</tbody>
</table>

Table 1 show the total number of respondents (60 boys) aged between 14–18 years who participated in the study. Fifty percent of the respondents were aged 14–15 years while the other 50% were aged 16–18 years. The sample consisted of 15 Form 1 students, 15 Form 2, and 30 Form 3 students. Only 46.7% indicated that both of their parents or guardians were working. Furthermore, 65% of the respondents had Christian parents.
Table 2 indicates the response given by boys about actions they took in the event of the domestic violence. It is observed that 65% of the respondents did nothing when exposed to domestic violence. However, 13.3% respondents helped their victimised mothers and only 5% respondents helped their perpetrating father.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequencies n=60</th>
<th>Percentages %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I helped my mother/guardian</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>I helped my father/guardian</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>I did nothing</td>
<td>39</td>
<td>65</td>
</tr>
<tr>
<td>Missing</td>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3 indicates that 96.7% of the respondents said that a child exposed to beatings might resort to beating others at school while the remaining 3.3% disagreed. Moreover, 91.7% of the respondents said that a child exposed to beatings at home resort to violence in the neighbourhood, while the remaining 8.3% disagreed. Furthermore, 80% of the respondents said that a child exposed to beatings at home resort to violence at home against other siblings. Nevertheless, the remaining 20% of the respondents disagreed with such claims. However, the majority are content that child beating at home is a determinant of violence in boys in various settings.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequencies n=60</th>
<th>Percentages %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child beaten at home resort to violence at schools.</td>
<td>58</td>
<td>2</td>
</tr>
<tr>
<td>Child beaten at home resort to violence in neighbourhood.</td>
<td>55</td>
<td>5</td>
</tr>
<tr>
<td>Child beaten at home resort to violence at home.</td>
<td>48</td>
<td>12</td>
</tr>
</tbody>
</table>

When asked about the types of domestic violence they have experienced in their lifetimes, 80% of respondents reported to have experienced physical abuse such as being slapped by their parents or guardians. Furthermore, 73.3% of the respondents depicted emotional abuse such as negative name calling by their parents or guardians. Thirty percent (30%) of the respondents said they were once sexually abused by their parents or guardians. When asked about psychological abuse 51.7% of the respondents indicated that they were once not given food at home by their parents or guardians as a form of punishment.
When asked about the knowledge of the existence of domestic violence in their home, 55 out of 60 (91.6%) respondents reported that their parents or guardians had once fought in their presence. However, 40% of the respondents said they once witnessed parents or guardians shout. Only 66.7% said their parents or guardians once insulted each other in their presence. When asked about the effects of domestic violence experienced in their lifetimes, 93.9% respondents were exposed to the emotional effects of domestic violence. Seventy five (75%) percent stated the physical effects, and only 61.7% experienced the social effects of domestic violence.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequencies n=60</th>
<th>Percentages %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse experienced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td>48</td>
<td>80</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>44</td>
<td>73</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Psychological abuse</td>
<td>31</td>
<td>51.7</td>
</tr>
<tr>
<td>Existence of abuse at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents Fight</td>
<td>55</td>
<td>91.6</td>
</tr>
<tr>
<td>Parents shout</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>Parents insult</td>
<td>36</td>
<td>66.7</td>
</tr>
<tr>
<td>Effects of abuse experienced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional effects</td>
<td>56</td>
<td>93.9</td>
</tr>
<tr>
<td>Physical effects</td>
<td>45</td>
<td>75</td>
</tr>
<tr>
<td>Social effects</td>
<td>37</td>
<td>61.7</td>
</tr>
</tbody>
</table>

With respect to alcohol as contributing factor to domestic violence, 73.3% of the form 4 respondents said alcohol led to domestic violence as they once witnessed spouses and children being abused while the perpetrator was drunk. However, 26.7% of the Form 4 respondents disagreed that alcohol leads to domestic violence as they mentioned that some of the perpetrators they know were not under the influence of alcohol when they abused their spouse and children. Similarly, 60% of the Form 1 respondents and 46.7% of the Form 2s shared the same shared sentiment with the Form 4 respondents who said alcohol is a contributing factor to domestic violence.

**Discussion**

Domestic violence robs children their sense of personal safety because the perpetrator is often someone they know. Their development of gender identities get affected in some way. Moreover, fear and vulnerability replace the basic trust on boys which they need in order to thrive and develop. Children not only lose their trust on family safety, but also see the rest of their world as unsafe because the aggressor and the victim are people that the children turn to for support. Therefore, the supportive and nurturing system of the child are disrupted. In addition, boys would have to psychologically
choose whether to feel helpless or to identify with the aggressor (Margolin, 1998). It is not surprising that some children find it safer to identify with the more physically and economically powerful. The outcome is that boys become violent, aggressive, and antisocial in their interactions with others. Some boys actively participate in the abuse when caregivers fight or take over the role of being the head of household after separation from their fathers as indicated in the study that some boys were helping their perpetrating fathers. Aggression becomes their dominant model of problem solving, and they adopt this method themselves to achieve what they want (Calson, 1990).

According to the findings, a majority of respondents indicated that an abused boy might turn to abuse other children at school, in the neighborhood and at home. The reasons given were that the boy turns to imitate the experiences from his upbringing, from his home environment. The other reason was that there is lot of peer pressure for boys to be involved in violent actions at school and in the neighborhood. This is also in agreement with findings from Volpe (1996) that boys who experienced abuse want to show the aggressiveness, violence and antisocial behavior in their interactions with others. Briggs and Hawkins (1997) note that social learning theory suggests that the experience of growing up in a violent family teaches children that violence is an integral part of family life, children management and partner behavior. Moreover, the boy may want to be recognized and given respect by his peers through his behavior and to achieve what he wants. Additionally, the child feels that the whole world is not safe, as he has lost basic security provision at home and hence externalized negative emotions are displayed.

The emotional and physical effects of domestic violence on the boy child need to be examined. It is vital to check the age of the child when she/he experienced the abuse because boys show different traits at different age stages. Indicators to be examined on the adolescent boys according to Pahl (1985) and Volpe (1996) include: vacillation between eagerness to please and hostility; developmental delays; inadequate social skill development; poor social skills; being a drug / alcohol addict, sexual acting out, and being suicidal may also emerge in boys. Furthermore, dating relationships may reflect violence learned or witnessed from home (Calson, 1009; Volpe, 1999). On contrary, research findings do not indicate age as a major factor to be considered to determine different traits of abuse. Some respondents indicated similar indicators while in different age groups.

It is common for a boy child who suffers from short term domestic violence to have eating and sleeping disorders, headaches, ulcers, depression, and anxiety resulting from the trauma of witnessing abuse. The boy child tends to cry a lot, feel sick, that is, having stomach and headaches, and trouble talking (for example, the child might stammer); wet the bed; feel frightened; learned helplessness (Mersch, 2006). Similarly, three respondents depicted bed wetting, helplessness and depression when their parents started to abuse them. One of them stated that when the mother started to abuse him he would wet the bed without knowing the cause and he used to have no interest in sports activities he loved.
There is a thin line between long and short-term effects of domestic violence as the effects start from short term and progress to long-term. Men who were abused by a parent when they were children may experience more depression and post-traumatic stress disorder symptoms as adults than boys who were not abused by their parents (Mersch, 2006). Nevertheless, the researchers did not establish that men who had been physically abused by their parents as boys have had a higher number of lifetime sexual partners, more legal problems or more incarceration. The child may suffer poor health, low self-esteem and have poor impulse control. It is also common for the child to experience academic problems (ibid, 2006).

Conclusion and recommendations

The study has shown that domestic violence has massive effects on the boy child. In addition, domestic violence has a detrimental impact on boys regarding their relationships within the family. It also affects other relationships and potential support networks and friendships are affected too. These effects can be short and long term, and are also visible to the larger society.

The discussion above indicated that the boy child is aware of the different types of abuse, and that they have been exposed to such. The discussion also revealed that if children are exposed to a certain kind of behaviour, they are likely to model it. This is supported by the social learning theory which states that when a person observes someone doing something that person copies it. As a result, domestic violence on the boy child may lead to the boy child being an abuser due to the observation he gets from his home environment. Based on the findings of this study there is a need for more comprehensive research in Botswana regarding domestic violence and the boy child. Intervention strategies need to be put in place to assist affected boys particularly in schools. Government and NGOs should work together in formulating, monitoring, and evaluating domestic violence policies that include both the boy and girl child, and creating working committees involving all stakeholders.

References


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Conclusion and recommendations

The study has shown that domestic violence has massive effects on the boy child. In addition, domestic violence has a detrimental impact on boys regarding their relationships within the family. It also affects other relationships and potential support networks and friendships are affected too. These effects can be short and long term, and are also visible to the larger society.

The discussion above indicated that the boy child is aware of the different types of abuse, and that they have been exposed to such. The discussion also revealed that if children are exposed to a certain kind of behaviour, they are likely to model it. This is supported by the social learning theory which states that when a person observes someone doing something that person copies it. As a result, domestic violence on the boy child may lead to the boy child being an abuser due to the observation he gets from his home environment. Based on the findings of this study there is a need for more comprehensive research in Botswana regarding domestic violence and the boy child. Intervention strategies need to be put in place to assist affected boys particularly in schools. Government and NGOs should work together in formulating, monitoring, and evaluating domestic violence policies that include both the boy and girl child, and creating working committees involving all stakeholders.
Children’s physical activity survey in major Botswana towns and cities: Implications for child development

Introduction and background information
According to the U.S. Center for Disease Control and Prevention (2011), obesity remains the most common health problem among children and adolescents in developed countries, and continues to increase in prevalence due primarily to poor diet, caloric excess, and decreasing physical activity. Developing countries, particularly those experiencing rapid economic development with concurrent change in lifestyle, are not spared of this debilitative disease. With accompanying change in lifestyle comes lack of quality time for children by parents, fast food addictions because mothers no more have time to prepare balanced meals for their children, families are constantly on the move, sedentary habits occasioned by an increasingly automated society and driving children to and from school (Livingstone, 2011; Mountjoy et al., 2011; Veitch, Salmon & Ball, 2008). Also with development comes governments’ policy shift in favor of the utilization of hitherto available playgrounds for sprawling new buildings and estates, wide multi-carriage roads and industrial enclaves.

The child’s right to play and recreational activities (United Nations, 1990) is not being given adequate priority by communities, governments and other social institutions around the globe (Shackel, 2011). Schools further encourage sedentariness in children by cutting down on physical education lessons and recreational activity periods to have more time for children to do very well in academic subjects (Shackel). A recent study by Wrotniak et al. (2012) found high prevalence of overweight and obesity among adolescents in Botswana. These come with comorbidities like hypertension, mental disorders (like depression, attention deficit disorders), metabolic disorders (such as hypothyroidism, hyperinsulinism, type 2 diabetes mellitus), hyperlipidemia, sleep apnea, asthma, joint pain, Blount’s disease and ventilricular hypertrophy among others (Jerrell & Sakarcan, 2009; Livingstone, 2011). If this trend is not quickly addressed, this generation may expect to live shorter lives and be less productive than their parents.

This paper presents findings of a study that aimed to explore the nature of physical activity engagement among children in major Botswana towns and cities, as well as identify factors that promote or inhibit their participation in the activities. Recommendations were then proffered towards achieving an increased level of participation in physical activities among the children.

Methodology
This study determined present practices or opinions of a specified population (Thomas, Nelson & Silverman, 2005), made use of three hundred and forty-six pupils from English – and Tswana – medium primary schools in Gaborone, Francistown, Lobatse and Jwaneng following a multistage cluster sampling technique. This technique was recommended by Cochran (1977) and Thomas et al. (2005) for use when a sampling
frame does not exist and the population is spread over a wide geographical area. Again, to ensure the generalization of the results of this study to the rest of the major towns in the country, and hence achieve external validation, the representative sample had to reflect the characteristics of primary schools in all the major towns and cities in the entire country. This position was supported by Russo (2003) noting that the representative sample of a study must reflect the characteristics of the entire population of the study to achieve external validation. According to Kline (1994), samples must not only be representative but must be of sufficient size to produce reliable factors. The Central Statistics Office (Republic of Botswana, 2007) gave the population of primary six children as Gaborone – 1757; Francistown – 933; Jwaneng – 196 and Lobatse – 389 (Total = 3275).

Using standard formula: \( n = \frac{1}{4} \left( \frac{Z_{\alpha/2}}{E} \right)^2 \left[ 1 - \frac{n}{N} \right] \), by Freund, Mohr and Wilson (2010) and a margin of error of 2.5% and confidence level of 95%, the required sample size was found to be 344.

In a data with a clear factor structure, samples of 100 were quite sufficient. If factor analyses are carried out with factors smaller than these, all results need replication in other samples (Kline, 1994). This study therefore satisfies this criterion. Table 1 shows how the sample sizes were proportionally allocated:

<table>
<thead>
<tr>
<th>Town/City</th>
<th>English Medium School</th>
<th>Tswana Medium School</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaborone</td>
<td>93</td>
<td>93</td>
<td>186</td>
</tr>
<tr>
<td>Francistown</td>
<td>49</td>
<td>49</td>
<td>98</td>
</tr>
<tr>
<td>Lobatse</td>
<td>21</td>
<td>20</td>
<td>41</td>
</tr>
<tr>
<td>Jwaneng</td>
<td>11</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>174</td>
<td>172</td>
<td>346</td>
</tr>
</tbody>
</table>

**Instrumentation**

Because no statistical evidence is required for content validity (Thomas et al., 2005), the content validity of the questionnaire was established through wide consultation with textbooks, journals and the Internet in the relevant areas of the study. A 27-item, closed and open-ended, questionnaire known as the Botswana Children’s Physical Activity Survey Questionnaire (B.C.P.A.S.Q.) was developed and distributed among 50 English – and 50 Tswana – medium primary school pupils in Gaborone who were not included in the final survey. The Setswana translation was done by five native speakers who passed Setswana at O’Level; with their final output reviewed by a graduate in the Setswana language.

Data from this pilot testing of the questionnaire were factor-analyzed using the IBM SPSS version 20. The principal component analysis presented five main components.
extracted from the questionnaire. The data were further analyzed using Varimax rotation with Kaiser normalization. The rotated component matrix showed 6 converged iterations ranging from –.182 to .890. A reliability statistic of the Cronbach’s Alpha was then computed on the 27-item questionnaire yielding a correlation coefficient of .781. Kline (1994) observed that whenever an orthogonal simple structure rotation is desired, the varimax technique aims at maximising the sum of variances of squared loadings in the columns of the factor matrix; producing loadings which are either high or near zero. This is one of the critical features of simple structures. Kline noted that a clever feature of varimax is that the procedure is applied to the loadings squared rather than the actual loadings. Supporting this decision, Thomas et al. (2005) agreed that internal consistency reliability coefficient could be obtained using the coefficient alpha technique. Out of the 27 items, which constituted the pilot questionnaire, 19 items were loaded across the 6 converged iterations. A careful study of the 6 iterations revealed the following sub-themes or underlying concepts of the study:

(a) The nature of school physical activity.
(b) The nature of physical activity outside children’s home environment.
(c) Gender variations of home physical activity involvement.
(d) The nature of playground around children’s home environment.
(e) Factors promoting or hindering after-school play by children.

The factor analysis technique assisted in the identification of the underlying concepts of the study (Norusis, 2009). With a high reliability coefficient of .781, the questionnaire could be said to have a high internal consistency; which according to Thomas et al. (2005), is an integral part of the wider validity issue because it reflects the degree to which the measuring instrument is free of error variance. A revised version of the questionnaire was then developed using the 19 items loaded by the Varimax rotation. The remaining 8 items were dropped from the final questionnaire.

**Data collection and analysis**

Two research assistants were trained on data-collection techniques. These and the researchers distributed and retrieved the final version of the questionnaire from pupils in the selected schools. Chi-square statistic from IBM SPSS Statistics version 20 was used for analysis. Alpha was set at .05.

**Ethical considerations:** Approval for the study was granted by the Research and Ethics Committees of both the University of Botswana and the Botswana Ministry of Education and Skills Development. In line with international practice, the researchers solicited the informed consent of parents whose children volunteered to participate in the study as well as obtained the informed assent of the children. In addition, prior to obtaining the informed assent, the questionnaire was read in English or Setswana, in the respective schools and classes of the participants. Pupils were encouraged to ask questions. Participants were assured there were no risks involved in taking part and that whatever information they offered would be confidentially treated; no information would be divulged without their permission except for research purposes. They were also informed that their participation in the study was voluntary, and they were free to withdraw from participating anytime during the conduct of the research.
Findings

The result in table 2 shows a significant relationship ($p < 0.05$) between type of school (English –or Tswana– medium) and the choice of response on the duration of physical activity in the schools. While all the children in the English medium schools (EMSs) noted that they engaged in two-weekly periods of physical activity, as such schools made it a point of duty to undertake at least 2 periods of physical activity per day, those in the Tswana medium schools (TMSs) stated that they did not engage in school physical activity program.

Table 2: Pearson Chi-square statistics on the relationship between type of school and nature of weekly physical activity periods in schools. ($N = 174$ English medium school pupils; $172$ Tswana medium school pupils).

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig.</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a No significant relationship between school-type (English/Tswana medium) and choice of response on duration of weekly school physical activity.</td>
<td>346.000</td>
<td>1</td>
<td>.000</td>
<td>Significant relationship (Sig. rel.)</td>
</tr>
</tbody>
</table>

Except for not agreeing to playing on side-walks and on tarred, gravel or dusty areas around their homes by both EMS and TMS children ($p > 0.05$), all other tested variables in table 3 were significantly related ($p < 0.05$) to the school-type. For instance, significantly more children attending TMSs played outside their home environments.

Table 3: Pearson Chi-square statistics on the relationship between type of school and nature of physical activity engaged in at home. ($N = 174$ English medium school pupils; $172$ Tswana medium school pupils).

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig.</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a Engaging in free play outside home environment.</td>
<td>23.370</td>
<td>3</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>b Duration of play outside home environment.</td>
<td>36.406</td>
<td>5</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>c Playing in small land-space outside home.</td>
<td>20.375</td>
<td>4</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>d Playing on side-walks around the home.</td>
<td>7.996</td>
<td>4</td>
<td>.092</td>
<td>No sig. rel.</td>
</tr>
<tr>
<td>e Playing in front of home, corridor, staircase.</td>
<td>13.161</td>
<td>4</td>
<td>.011</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>f Playing in big land-space outside home.</td>
<td>17.789</td>
<td>4</td>
<td>.001</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>g Playing on tarred/gravel/dust road around home.</td>
<td>9.379</td>
<td>4</td>
<td>.052</td>
<td>No sig. rel.</td>
</tr>
<tr>
<td>h Only watching Televisions, Videos, Movies or playing indoor games (e.g. Computer games) inside the house.</td>
<td>74.569</td>
<td>4</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
</tbody>
</table>
after returning from school than children attending EMSs. They also played outside for longer hours than their EMS counterparts. Also, most TMS children strongly agreed that they played in small land-spaces close to their homes. While most EMS children agreed that they played in front of their homes, along corridors and staircases, most TMS children disagreed. Despite agreeing that they played around their houses, most TMS children disagreed that their playgrounds were large. While majority of the EMS children disagreed that their playgrounds were large. While majority of the EMS children agreed that they mostly watch TV, videos, movies or play indoor games after returning from school, most TMS children disagreed.

Table 4 shows the results of the relationships between types of school and factors that promote or inhibit children’s engagement in physical activities outside their homes. (N = 174 English medium school pupils; 172 Tswana medium school pupils).

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No significant relationship between school-type (English/Tswana medium) and ...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Inadequate outside space for use as playground.</td>
<td>27.645</td>
<td>4</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>b Houses that are too closely built together.</td>
<td>24.747</td>
<td>4</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>c Too many vehicles passing dangerously close to playgrounds.</td>
<td>22.901</td>
<td>4</td>
<td>.000</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>d Parents’ insistence on children’s engagement in after-school lessons/home-work.</td>
<td>19.009</td>
<td>4</td>
<td>.001</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>e Parents’ refusal for outside play, by children, for fear of being hit by moving vehicles.</td>
<td>5.506</td>
<td>4</td>
<td>.239</td>
<td>No sig. rel.</td>
</tr>
<tr>
<td>f Parents’ refusal for outside play, by children, for fear of being kidnapped.</td>
<td>10.481</td>
<td>4</td>
<td>.033</td>
<td>Sig. rel.</td>
</tr>
<tr>
<td>g Lack of parental encouragement/motivation for children to play in their neighborhood.</td>
<td>19.705</td>
<td>4</td>
<td>.001</td>
<td>Sig. rel.</td>
</tr>
</tbody>
</table>

Table 4: Pearson Chi-square statistics on the relationship between types of school and factors that promote or inhibit children’s engagement in physical activities outside their homes. (N = 174 English medium school pupils; 172 Tswana medium school pupils).

In deference to the TMS children, more EMS children disagreed that inadequate outside space for use as playground, closely built houses, too many vehicles passing dangerously close to playgrounds, fear of being kidnapped and lack of parental encouragement or motivation for play in the neighborhood were the main factors that prevented them from engaging in adequate free play outside their homes. However, both groups of children did not accept the argument that parents’ refusal to allow free play in the neighborhood was due to fears that children might be hit by moving vehicles. The EMS and TMS children strongly agreed and agreed respectively that a probable reason why their parents frowned at their free play in their neighborhoods was due to parents’ insistence on children’s engagement in after-school lessons or home-works.
Apart from the variables presented in table 5, all other variables had no significant relationship with the gender of the children. More girls than boys were of the opinion that they played less than 30mins. daily in their neighborhoods, of strong opinion that they did not play on tarred, gravel or dusty roads and that parents did not allow them to play in their neighborhoods because of kidnappers or other criminally-minded persons.

### Discussion

Primary schools in Botswana are guided by the Creative and Performing Arts (CAPA) syllabus designed by the Ministry of Education and Skills Development (2005) to meet the requirements of the Revised National Policy on Education (Government Paper no. 2 of 1994). Its content spans a whole lot of subjects including Art and craft, Design and technology, Home economics, Business studies, Drama, Dance, Music, and Physical education: with a time allocation of at least four hours per week. It is therefore not clear how meaningful skill acquisition can take place weekly in all these components; particularly with regards to a practical component like physical education which requires that skills are acquired through repetitive practice sessions by the pupils. Weeks go by in the TMSs without an organized outdoor physical activity class. It was therefore not surprising that the children stated that they did not have physical activity classes; probably because they found it difficult to recall the very few times they were outdoors for practical physical activity lessons. From the results of this study, it was clear that the Ministry of Education and Skills Development needs to reconsider the enormous benefits that children can derive from the inclusion of adequate time for play and sporting activities. Rather than include physical education in the CAPA category/cluster, physical activity classes must be made to stand alone for at least three times a week on the primary school time-table. According to Shackel (2011), undervaluing of play in urban communities has led to the erosion of structured and free-play time in schools to benefit of other school subjects. Conducting a review of literature spanning 1966 to 2007 on the relationship between academic performance and participation in school-based physical activities and sport, Trudeau and Shephard (2008) noted that physical activity has positive influence on concentration, memory, intellectual performance and classroom behaviors of the children. They concluded that given competent teachers, physical activity can be added to the school curriculum by taking

<table>
<thead>
<tr>
<th>Hypothesis</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig.</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Duration of play outside home environment</td>
<td>14.177</td>
<td>5</td>
<td>.015</td>
</tr>
<tr>
<td>b</td>
<td>Playing on tarred/gravel/dust road around home</td>
<td>10.879</td>
<td>4</td>
<td>.028</td>
</tr>
<tr>
<td>c</td>
<td>Parents’ refusal for outside play by children, for fear of being kidnapped</td>
<td>10.463</td>
<td>4</td>
<td>.033</td>
</tr>
</tbody>
</table>

### Table 5: Pearson Chi-square statistics on the relationship between the gender of children and nature of physical activity engaged in at home. (N = 160 Boys; 186 Girls.)
some time allocated to other subjects without risk of hindering students’ academic achievement; whereas reducing the time allocated to daily physical activity in order to add such time to other school subjects does not enhance pupils’ grades in those subjects and may, in fact, be detrimental to their health.

Despite the very limited time for outdoor physical activity class in the TMSs, some parents still restrict their children from playing in the neighborhood after school hours. Also from the study, it was obvious that most parents of children in EMSs preferred to confine their children indoors, watching televisions, videos, movies, playing indoor games or attending to extra lessons or home works. Research has shown that with increasing inactivity or sedentariness comes lowered fitness level and high injury risk, negative psycho-social behaviors, childhood obesity, diabetes, heart diseases, and other chronic ailments (Livingstone, 2011; Mountjoy et al., 2012; Trudeau & Shephard, 2008; Veitch et al., 2010). On the other hand, when children are physically very active, a lot of health and developmental benefits accrue to them. Such benefits include current and lifelong health of the child (Livingstone; Veitch et al., 2008), a healthy body weight and composition with a reduction in the risk of chronic diseases over childhood and adolescence (Ding & Hu, 2010; Hills, Okely & Baur, 2010; Must & Tybor, 2005), reduced depression and anxiety (Mountjoy et al.) and better self-esteem and body image (Nelson & Gordon-Larsen, 2006). Hence, school administrators, parents and the relevant Ministry of Education and Skills Development officials must join hands together to achieve and maintain a very active level of participation in physical activities among the children.

Conclusion
From the results of the study, it was clear that most of the children did not have adequate support, guidance and encouragement from their parents, the school and the Ministry towards increasing their levels of participation in physical activities. The results, among others, showed that a significant number of children played in the very little spaces in their neighborhoods. Also, the outdoor physical activity program in the TMSs has been stifled by the variegated, content-packed CAPA recommended by the Ministry of Education and Skills Development; while Administrators and Physical Education teachers in the EMSs have found better ways of making sure that their children engage in outdoor physical activity programs weekly.

Recommendations
Parents, school authorities and the Ministry of Education and Skills Development should work hand-in-hand to increase the level of outdoor physical activity participation of the pupils both at home and in school, irrespective of whether they attend English or Tswana medium schools. Parents must create quality time to spend with their children and monitor their activity level and calorie intake to avoid having children with obese conditions. Government policies concerning infrastructural development should take into consideration the activity spaces needed by children to engage in free play in their neighborhoods for a healthy populace. Government, through Town Planners and Engineers must create and equip recreational parks and sports grounds in many places around cities and towns in Botswana.
Every child has the right to protection. However, worldwide children continue to suffer various violations that are under-recognised and experience under-reported barriers that undermine their rights to survival, development and participation. In many countries, as is the case in Botswana, national laws and policies exist to protect the rights of children. However, the enforcement, implementation and monitoring of these various instruments remains a major constraint. Insufficient attention is given to juvenile offenders, the majority of whom do not enjoy their right to protection and the opportunity to reform and re-integrate into society. Two articles in this section of the publication contribute to the much needed body of research on child protection issues of juvenile justice and child labour in Botswana. The physical, psychological and social effects of child right violations, such as child labour and children in conflict with the law, have lifelong consequences that perpetuate inter-generational poverty. The third article focuses on the equally important issue of child protection through the empowerment of children and communities.

The article by Semommung et. al. contributes to the evidence base for improved juvenile justice for children that come into conflict with the law. The authors assess the juvenile justice system in Botswana and the challenges and constraints that children in conflict with the law face. The authors contend that although the Children’s Act of 2009 speaks to the rights of children in conflict with the law, immense challenges and constraints exist for both the juvenile justice system and the children that come into conflict with the law. These challenges and constraints will require urgent attention if the rights of children in conflict with the law are to be realised. Implementation of the recommendations of the Plan of Action for Programming on Justice for Children in Botswana (2011–2014) affords opportunities towards realisation of the rights of children in conflict with the law, ensuring that they are treated in a manner that promotes their sense of dignity and worth.

Child labour is a poorly documented issue in Botswana. Nevertheless, various newspaper articles allude to extensive cases of exploitation in Botswana. The article by Jacques and Machete makes two key contributions to research on child labour in Botswana. First, the authors document and present the outcomes and lessons learned from a Childline–ILO project, the International Programme for the Elimination of Child Labour (IPEC), implemented between 2010 and 2012 to addresses child labour in the North East District of Botswana. Second, based on the findings of the project, the authors make five recommendations that constitute the ‘backbone’ of an integrated family centred response to child labour.

The objectives of the project were to facilitate family and institutional capacity building, prevent children at risk from becoming child labourers and reintegrate child labourers into education and society. Although all objectives were not met, the findings of the project contribute to the evidence base with which to design and implement integrated child labour interventions that address the multi-dimensional nature of the problem.

The final article in this section, by Maundeni and Jacques, documents the use of Kgotla meetings to empower children and their communities in the context of realisation of the Children’s Act of 2009. Based on lessons learned from the process, the authors contend that Kgotla meetings, addressed by the National Children’s Council, are a powerful mechanism that empowers both children and their communities. A key recommendation put forward is that the approach be adopted country wide.

Juvenile justice in Botswana: Challenges and constraints facing children in conflict with the law

Introduction

Botswana’s 1981 Children’s Act preceded the Convention on the Rights of the Child (CRC) and many of the international juvenile justice legal instruments such as the Riyadh Guidelines, Beijing Rules and Tokyo Rules, but it was still a progressive piece of legislation that sought to protect the rights of children. Its limitations judged against international norms and standards are evident but that should not take away the good intentions and the spirit with which it was enacted. The 1981 Act did not make provision for legal representation for juvenile offenders in court nor did it provide for appeal of the decision of the magistrate. In the past, the High Court, which dealt with serious offences, did not apply the 1981 Children’s Act when dealing with matters pertaining to juveniles who had committed serious offences instead it applied the Penal Code. As such, these young offenders were subjected to the same treatment as adults in the High Court.

While Botswana has made impressive progress in meeting the requirements of the Convention on the Rights of the Child, the major milestone was the passing of the Children’s Act 2009. The Children’s Act and its implementation is more than just domesticating the CRC – these are purposeful actions taken with a full resolve to create a Botswana fit for children. This implies that each child is entitled to the enjoyment of all rights irrespective of their sex, social status, ethnicity, religion or disabilities.

The legislative reform process that culminated in the enactment of the Children’s Act 2009 has addressed some of the limitations of the 1981 Act. The Children’s Act 2009 makes adequate provision for the observance of basic procedural legal safeguards for treatment of alleged offenders contained in both the Constitution and other legislation in Botswana such as the Magistrate Court Act and the High Court Rules. Such procedural safeguards, include, among other things the right to be tried separately from adult criminals; the right to the presence of a guardian/ parent; the right to privacy; and the right to humane treatment.

The legal safeguards accorded to children as per the Children’s Act 2009 largely conform to those contained in international juvenile justice instruments. There are, however, some limitations in the 2009 Act pertaining to juvenile offenders and some glaring omissions in practice that require some scrutiny. For instance, the current Children’s Act does not provide for adequate non-custodial measures for juvenile offenders. It gives explicit recognition to imprisonment and corporal punishment which are discouraged by international child protection legal instruments. Practical challenges and constraints in delivering juvenile justice revolves around limited non-institutional disposition measures; absence of diversion; pre-trial detention and absence of requisite infrastructure; poor access to justice; delayed disposal of cases; absence of procedural...
guidelines and stakeholder confusion; ill-treatment of juvenile offenders in schools and public spaces; inadequate victims support systems; neglect and lack of preparation of child witnesses; undefined community and indigenous support systems. This article discusses juvenile justice issues drawn from the study on Mapping and Analysis of the Justice for Children in Botswana which was commissioned by the Department of Social Services and supported by United Nations Children’s Fund (UNICEF) in 2010.

**Research methods**

The study is largely qualitative in design.

**Review of secondary sources of data which included:**

a. Literature researches on studies done in respect to children in conflict with the law.

b. An overview of national laws, subsidiary legislation, relevant regulations and guidelines related to children.

c. Reports from institutions dealing with children in conflict with the law – which included Department of Prisons and Rehabilitation, Ikago Centre, the Police, some Community Development, Administration of Justice.

**Review and analysis of existing reports specified in the consultancy included:**

a. Review of Magistrates courts, probation and After Care Services for children in Botswana. (Department of Social Services 2009).


**Content Analysis:**

This mainly comprised of an in depth analysis of the following:

a. Intake sheets used by social workers.

b. Social enquiry reports produced for courts.

c. Probation Progress Reports.

d. Judgments involving children in conflict with the law.

e. Rules and Regulations of juvenile facilities.

**Interviews with Stakeholders**

a. The Police

b. Directorate of Public Prosecutors

c. Magistrates

d. Judges

e. Staff of Ikago Center

f. Staff of Moshupa Boys Prison

g. Social workers

h. Chiefs and Customary Court Officials.

**Focused group discussions with:**

a. Trainees at Ikago Centre.

b. Trainees at Bana ba Metsi.
Juvenile Justice Stakeholder Workshop
The workshop brought together juvenile justice stakeholders to dialogue on the challenges and prospects for developing Botswana’s juvenile justice system and prioritizing programming for the period 2011 - 2014.

Findings of the study
The study on Mapping and Analysis of the Justice for Children in Botswana yielded the challenges and constraints of juvenile justice in Botswana as presented below:

Limited non-institutional disposition measures
The range of disposition measures available in the Children’s Act 2009 is limited if due regard is given to the variety of disposition that could be made available as they appear in the international legal instruments such as the United Nations Rules for Non-Custodial measures (Tokyo Rules) and the United Nations Standard Minimum Rules for the Administration of Juvenile Justice. The Children’s Act 2009 does not include such disposition measures as diversion, financial penalties, compensation, restitution, verbal sanctions, expropriation orders, suspended nor deferred sentence and house arrest. The limited range of disposition measures clearly restricts presiding officers as to the range of sentencing options. Magistrates felt constrained and hamstrung by the limited disposition alternatives.

Absence of diversion
Diversion allows for matters involving juvenile offenders to be handled outside the normal court or trial process. It involves the police, prosecutors, probation officers/social workers and other critical stakeholders coming together to study the matter and use their discretion to divert it from the regular trial process. The absence of diversion means that children who have committed petty offences could be subjected to the court process at greater financial cost to the state and psychological distress for the child and his/her parents or guardians. Diversion has been identified by stakeholders as a serious legislative omission that needs to be addressed in the law relating to children in conflict with the law.

Pre-trial detention and absence of requisite infrastructure
The international standards and norms discourage pre-trial detention of child offenders. Where such is done, it should be a matter of last resort and the detention should be for the shortest possible time in a secure facility that is not shared with adult offenders. In Botswana, pre-trial detention of alleged juvenile offenders seems to be common and due to lack of suitable facilities, most of those detained may end up mixing with adult offenders. This is mainly because there are no special cells designed for children. The absence of attendance centers, youth shelters and day care services for children in conflict with the law leaves open the possibility of detention and other inappropriate punishments.

Lack of access to justice
The guarantee of legal safeguards as provided in the Constitution and the Children’s
Act 2009 is not an end in itself. There is need to ensure that people irrespective of their economic status are able to benefit from such guarantees. The issue of legal representation is one that requires greater scrutiny in this respect. The study revealed that children who commit crimes especially those from economically underprivileged families cannot afford to engage a legal representative. This then renders obsolete the provision that allows legal representation in the children’s court. Many juvenile offenders need legal representation but they cannot afford to pay for such a service. It is hoped that the legal aid pilot project which is currently implemented by the Attorney General’s chambers would address these concerns.

Delayed disposal of cases
The backlog of cases in Botswana’s judicial system has inevitably affected juvenile offenders. For instance, interviews with stakeholders reveal that some matters involving children take up to five years before they could be disposed of by courts. The effects of this are, among others, that the children affected would attain the age of eighteen (18) before they are put through a trial. When this happens such a child would be tried as an adult though he/she had committed a crime as a child. In this way the special rights and treatment accorded to the child is lost. The magistrate in passing sentence however may accept age as a mitigating factor. The delay in disposing of matters related to children disadvantages them greatly. This clearly illustrates and confirms the old legal adage that says that “justice delayed is justice denied”. This issue requires special attention and all steps must be taken to ensure that matters involving children are disposed of speedily to avert the articulated disadvantages.

Absence of procedural guidelines and stakeholder confusion
The implementation of the law pertaining to children involves different stakeholders with diverse training, experiences and backgrounds. Interviews with such stakeholders revealed that there is no common understanding of the processes and procedures that are followed from apprehending the alleged juvenile offender to the ultimate disposition of the matter. At times, stakeholders conflict on what constitute proper legal procedures. For instance, the police and social workers differ on whether or not a court order is necessary before a social enquiry report could be written or not. Similarly, magistrates, social workers and the police do not have a common understanding as to when a magistrate should receive or use the report produced by the probation officer. Probation officers are untrained and they generally confess incompetence with respect to handling matters pertaining to juvenile offenders. These differences require clearly articulated regulations, guidelines and protocols to supplement existing legislation. Such guidelines and protocols would help bring clarity in the process of handling juvenile offenders.

Ill-treatment of child offenders in schools and public spaces
The existing law does not provide details on how to handle juvenile offenders who are in schools or other public spaces. It was generally felt that apprehension of juveniles in schools by the police (uniformed police) has a negative bearing on the child in that it immediately stigmatizes a child as a criminal. It was felt that an approach should be
devised which involves the police, school authorities and the social workers that guide the smooth handling of child offenders in a school environment. The details of such approaches can be worked out by the listed stakeholders.

**Inadequate victims support systems**
The law pertaining to children in Botswana does not spell out in clear terms the support available to victims of crime. Stakeholders are generally ignorant about the available options to assist victims of crime. The major concentration is on the juvenile offender. It should be noted that victims of crime go through serious emotional and psychological challenges that require attention. Victim support is thus necessary and in some instances it may have to be extended to relatives of the victim. A victim support strategy should be worked out to fill this gap in the justice system. A system of restitution and compensation for victims of crime is one practice that is lacking in our justice for children process.

**Neglect and lack of preparation of child witnesses**
In the justice system, children may appear in court, not as offenders, or victims but as witnesses. As witnesses, children require protection from the potential damaging effects of an intense or hostile cross examination either from perpetrators, their legal representatives or prosecutors. It is critical that all who take part in a trial involving a child witness are sensitized to the vulnerabilities and sensitivities of a child either as an offender, victim or witness. The need to prepare child witnesses for trial is as such paramount. The extent to which this obtains in the judicial system in Botswana is difficult to establish at the present time. Stakeholders in this study indicate that preparation is not always done but in cases where a child seems to have difficulty in the court environment assistance is sought from the social workers. There is no requirement for the preparation for child witnesses in our legislation.

**Undefined community and indigenous support systems**
The research has revealed that there are no clear roles that communities are assigned with respect to addressing issues of juvenile justice. Traditional leaders including Headmen of Arbitration come into contact with children who are in conflict with the law in the course of their work. They work with the police and social workers in some instances to informally dispose of cases by warning perpetrators and advising them against criminal conduct. In some cases, parents approach traditional authorities to request them to administer corporal punishment to their offending children particularly over petty crimes such as common theft, common nuisance and use of insulting language. The traditional authorities would normally oblige and ask parents or relatives to administer such strokes of the cane in their presence. The Children’s Act 2009 does not assign traditional leaders such powers. Traditional leaders on the other hand insist that they will continue to play a part in addressing issues involving children in conflict with the law. The indigenous responses are non-custodial and largely emphasize verbal sanctions. These responses are used in communities but they generally lack official recognition or support.
Recommendations

The challenges and constraints outlined earlier with regard to the juvenile justice system invite creative responses to address the broad area of juvenile justice. Some of the suggested recommendations contained in the report of the study on Mapping and Analysis of the Justice for Children in Botswana are highlighted below.

First there is need to develop a clearly articulated juvenile crime prevention strategy that details the roles and responsibilities of parents, schools, community structures and civil society organizations. Secondly, regulations, guidelines and protocols for handling children in conflict with the law are crucial and need to be put in place. These should cover children in detention facilities, the handling of alleged child offenders in public spaces, community and indigenous support for children in conflict with the law, probation issues; child victim support systems and the preparation of child witnesses. Third, there is need for a paradigm shift from retributive orientation to restorative and rehabilitative models of dealing with children in conflict with the law. Fourth, a mid-term review of the Children's Act of 2009 to incorporate a range of non-institutional intervention models is critical. Moreover provision for the training of personnel involved in justice for children such as social workers, police officers, judicial officers, prosecutors, probation officers and teachers should be well-articulated in the revised Act. In addition there is need to strengthen partnerships and collaboration between stakeholders involved with children in conflict with the law. Lastly, an over-arching monitoring and evaluation framework on justice for children broadly and on juvenile justice specifically be developed and implemented as a matter of urgency.

Conclusion

The challenges and constraints facing the juvenile justice system in Botswana are immense. They require urgent attention and robust action if positive results are to be achieved. The 1981 Children’s Act did not achieve much in terms of improving the welfare of children in conflict with the law because appropriate resources were not mobilized for it to meet its set objectives. Three years into the implementation of the Children’s Act 2009 not much has been achieved. On the basis of this, it is critical for the Department of Social Services (that has the portfolio responsibility for children in conflict with the law) to act swiftly to incorporate recommendations of this study and others in the justice for children arena.

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Dickensian workhouses, ‘Botswana farms’, and exploitation of children: Childline and ILO’s experience of present day child labour practices in the country

Introduction

The Victorian era in 19th century England was characterised by the use of children in helping to develop the economy. The life of a young worker was, in essence, the life of a slave (Pakditawan, 2002). Government set up workhouses in many of the major cities and there adults and children (several of the latter being orphans or vulnerable children) lived a life of deprivation performing menial tasks such as picking out old ropes for rethreading. They were at times farmed out to mill and factory owners where they engaged in repetitive and sometimes back breaking work for many hours a day. In the workhouses themselves they were also subjected to harsh discipline and punishment by whipping and fed on a poor and meagre diet consisting mostly of small portions of gruel and bread. Some were apprenticed to private business owners such as blacksmiths and undertakers, but the conditions were often harsh and the hours long.

Charles Dickens, in his ground breaking novel ‘Oliver Twist’, dramatised and embellished the suffering of young Oliver born to a destitute woman in a workhouse and orphaned at birth. Although the environment and many of the circumstances of children affected by poverty and abuse in Botswana are not identical to those of Victorian England the nub of the suffering and the outcome of the experience are somewhat redolent of English history. Cultural influences play a definitive role in the Botswana situation. The intrinsic dynamism of culture must be the focus of analytical attempts to steer the society towards preferred outcomes for its young people.

Child labour, often ignored by societies and governments, is a form of child abuse that can be most detrimental to a young person’s growth and development. Frequently it is taken for granted, by children and their families, as a way of life and integral to the social functioning of communities. According to the Global Report on Child Labour (International Labour Organization [ILO], 2010), 65.1 million children in sub-Saharan Africa are child labourers. This translates into one in every four children in the region. The commitment by African member states to the ILO Convention to Eliminate Child Labour by 2015 is, therefore, most commendable. UNICEF’s World Fit for Children strategy that seeks to protect children from economic exploitation and from the performance of work that is hazardous, interfering with their education or harmful to their health or physical, mental, spiritual, oral or social development, is also significant (UNICEF, 2011).

The Botswana 2005/06 Labour Force Survey included responses from more than 7000 children aged 7–17 years out of a total of approximately 20,000 interviewees and established that 8.5% of the children were engaged in economic activities. Although the report notes that the prevalence of child labour in Botswana is relatively low in comparison with other countries in sub-Saharan Africa, this does not signify that the problem should not be afforded serious attention.
Child labour is difficult to define but corresponds to the belief that it involves a process of identifying work activities that are harmful to children such as: where there is a risk of physical harm, where the child’s educational opportunities are threatened, and where there is risk of exploitation (Procek, 2006). Furthermore, due to its secretive nature, the available statistics might be only the tip of the iceberg!

Details about the phenomenon are not well documented in Botswana. Inadequate information and lack of explicit definitions of child labour in the Employment Act of 2010 also have implications for compliance with the law. Interpretation of what constitutes harmful work for children is still left to individual perception and definition. The situation is likely to be more serious than it appears given the impact of the HIV and AIDS epidemic and economic recessionary forces on numbers of children in need of care and protection, household poverty, and issues associated with unemployment. The Botswana National Census of 2011 found that children under the age of 18 years constitute 41% of the population. Furthermore, children living with grandparents account for 40% of the total child population, while those living with non-related care-givers represent 32% of the child population (Central Statistics Office, 2012). The latter arguably experience many challenges related to poverty, isolation from meaningful participation in society, and the impact of HIV and AIDS including heading families and being subjected to exploitative labour.

The Botswana Labour Force Survey Report (2005/06) (UNICEF, 2011) indicated high levels of school performance and moderate amounts of home chores for children but these averages conceal the fact that smaller percentages of the population are responsible for relatively large amounts of work. That is, 8.5% of children performed 24.3 hours of work in a week and had only 80% school attendance which is below the standard for a positive developmental environment (ibid). The Central Statistics Office (2012) also noted that progression rates indicate that many school age children do not complete their education placing them at higher risk of involvement in child labour. Despite numbers of social service programmes for orphans and vulnerable children, some children (of all ages) still fall through the cracks inherent in the safety nets (Childline, 2012).

Childline Botswana participated in a project initiated by the International Labour Organisation (ILO) through its International Programme for the Elimination of Child Labour (IPEC) initiative between 2010 and 2012. Interventions used incorporated withdrawal of children from work situations, associated networking and co-ordination activities, and enabling the provision of support services such as those related to health, nutrition, shelter, counselling, and the payment of stipends.

Objectives, methods, and findings
The first objective was to build capacity of the organisation (Childline) and communities in order to combat child labour in the North East District of the country. In working towards this objective a team of five members of staff intervened in suspected cases involving child labour through, inter alia, engaging all relevant stakeholders in addressing...
the children’s plight. This also included mainstreaming issues through provision of
guidance on appropriate actions via a 24 hour toll free helpline. Furthermore, community
leaders such as chiefs, village development committee members, social workers, and
teachers played a crucial role through sensitisation and assistance of outreach officers
in identifying potential beneficiaries. These groups formed local child labour committees
in each catchment area. After the closure of the project related efforts were to be
sustained through such individuals and structures.

The second objective was to remove 200 child labourers from the agricultural and
commercial sexual exploitation sectors and reintegrate them into mainstream society.
This was only partially achieved through the removal of 67 children from child labour
in the agriculture and CSEC sectors. Although the number removed from agricultural
labour was relatively small, 58 from a targeted 9 were enabled to escape from an
environment of sexual exploitation. Some of these children were placed with relatives,
others in boarding schools, and one was accommodated in a women’s shelter project.

The sexual exploitation of children (girls and some boys) was found, in the rural
catchment areas of the North East District, to involve mostly older men working on
farms or in the construction industry as labourers. The children were generally from
poor backgrounds and lacked parental support and guidance, both financial and social.
The allure was the money they were given. In urban areas the children came from high
density, low income communities and a small number had been forced into having
sex with family members in exchange for continued financial support. It was found that
three children had been held as sexual captives by, respectively, their biological father,
their stepfather, and their uncle. Although not specifically part of the project, it was
acknowledged that interfamilial sexual abuse is also an issue requiring redress.

Some girl children living in urban areas and engaging in commercial sex were not
necessarily from poverty stricken families but mostly from female headed households.
The men with whom they consorted were civil servants (police officers, members of
the defence force, and teachers), miners, truck and taxi drivers, and self-employed
business men. Most of the children had dropped out of school in order to engage in
these practices and all were reintegrated into the education system through the project.
The three boys in this group (aged 15– 17) were involved in intergenerational sex with
older women for financial support.

Teachers made a considerable contribution to the project although labour inspectors
made only a limited attempt to provide identification of children working in the
agricultural sector. However, community and child labour committee leaders went
beyond the call of duty and were instrumental in providing information about child
labour on the farms.

The third objective of preventing children from being absorbed into the labour market
was not fully realised as only 261 of a targeted 400 were assisted, but it was
surpassed with regard to the prevention of boys being involved in sexual exploitation
practices. This was particularly true of younger siblings of those abused by ‘sugar mummies’ who were referred for social work intervention. This was a significant outcome and one that will hopefully be reinforced through a better informed environment in the future. Psychosocial support was provided to all the children by the project social worker and local council social workers. A number of the children were placed in boarding schools where teachers were alerted to their special needs. Material support was also organised for those in need of such assistance.

The fourth objective was reintegration of child labourers into formal education and vocational training centres. This was related to registration of children who had dropped out of the educational system as a result of labour demands and new registration of children who had never been to school but were working or at risk of being involved in labour practices. This proved to be relatively successful. Most of the children originated from cattle posts where they were taking care of small herd livestock. They tended to begin working while living with their parents but then moved on to find their own work. Some would be abandoned by parents. None had signed a contract and they were living in a state of servitude, provided only with food and a minimal amount and standard of shelter. Others were involved in odd jobs on farms with only a verbal agreement regarding termination between them and their employer.

With regard to this objective, a significant issue was that all the children removed from the agricultural sector were from poverty stricken families but none were enrolled in social welfare programmes as these were primarily for orphaned children or needy students. As they were neither, they ‘fell through the cracks’ as, first, they had parents and thus could not register as orphans and second, to register as needy students their parents should have been designated as destitute. As the parents were mainly in the 20 to 40 age bracket they would be deemed fit and capable of caring for their children. They are therefore unlikely to be registered as destitute. Under these circumstances social welfare officers are reluctant to assist and, furthermore, are constrained by existing guidelines for supporting needy children, an obvious gap in the present policy. However, poverty and lack of parental guidance at home forced many who were in the educational system to leave school and look for work. In a large number of cases that was on the same farm where the parents worked but the farmers usually maintained that they employed only the adults and not the children and thus there was little (if any) extra payment for their services.

Some mothers were willing to leave the farms and reside in the village with their school going children but poverty would frequently drive them back to the rural area. This meant that the children would be pursuing their education but living alone in the village. This sometimes resulted in another form of child labour whereby the oldest would care for younger siblings and simultaneously attempt to attend school. In the result they became the target of schoolmates’ banter and, if they went back to the farms, they would not trust anyone who tried to convince them to return to school. This led, in many instances, to them growing up bitter and resentful of mainstream society (Childline, 2012).
Several steps were taken to achieve, both directly and indirectly, this educational objective. The outreach officers and child labour committees recruited and formed in catchment areas were trained with a view to their being in place even after the conclusion of the initial project. Likewise it was planned that vulnerable children’s camps, two of which were organised as part of the project, would become institutionalised for vulnerable children in the district. The camps helped to raise the children’s levels of self-esteem and those who attended the two demonstrated increased self-confidence at the second placement.

Talk shows on topics related to child labour and the best interests of children that had been planned as part of the project were, for logistical reasons, replaced by presentations made by outreach officers at Kgolá meetings. Puppet shows were conducted at schools in all catchment area and these were found to be an innovative method of enhancing understanding of child labour issues and awareness of existing avenues of assistance.

Several children were provided with counselling by the project social worker and the realisation of a lack of previous involvement by social workers in the district was noted as a cause for concern. Potential statutory foster parents (in line with the provisions of the Children’s Act of 2009) were identified but were unwilling to participate without financial assistance. This reinforced the concern of Childline and the National Children’s Council (NCC) that the lack of a foster grant, in terms of the legislation, may compromise the desire and potential ability of those willing to become formal foster carers. This will be pursued by the NCC in its quest for the realization of the best interests of the children of Botswana. Social workers from catchment areas were trained as trainers of foster parents as it is envisaged that the programme as a whole will be rolled out in the near future. Childline, in association with the Department of Social Services (DSS) in the Ministry of Local Government, is currently (September 2012) involved in piloting the foster care programme for children residing in the agency’s Place of Safety. It is hoped that the success of this pilot project will pave the way for future similarly effective character building exercises for vulnerable children and their care-givers in general.

The final objective was to ensure self-sustenance of the families of vulnerable children and this proved to be a challenge which could only be assessed beyond the actual timelines of the project itself. However, the main success factor proved to be community participation and ownership of the programme. Community leaders showed themselves to be the main pillars of the project, easing its acceptance and enabling its implementation. Evidence of the efficacy of leadership subsisted in the fact that two of the child labour committees were chaired by their respective chiefs, granting credibility and support, not only for the programme itself but for the acceptance of the principle behind the paramount concern of the best interests of the child. Furthermore, a piece of land belonging to the village development committee in Tsamaya was given to the project for child beneficiaries to engage in income generating activities, especially ploughing for commercial purposes. This was to be a trial through which every family proving its commitment could go further in undertaking individual initiatives. The task could not be completed before project closure but it is to be hoped that local
communities and the positive leadership that was displayed in this instance would enable the scheme to be further developed and extended to other areas in the future.

**Challenges, constraints, and lessons learned**

Although Childline failed to meet its target for prevention and withdrawal of children involved in child labour situations in the North East District, significant strides were made in raising awareness of the problem in the region. With regard to the sexual exploitation of children, indications are that it is a much larger issue than previously perceived or admitted by the country. It has thus raised the spectre of the problem to the status of one requiring immediate and substantive redress.

Structural abuse of children including issues of lack of adequate remuneration for them and their parents and failure to acknowledge children’s rights as stipulated in the United Nations Charter on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and the Botswana Children’s Act of 2009, is a cause for concern. Furthermore, as a society more attention should be paid to unacceptable realities such as intergenerational sex and children’s exposure to HIV and other sexually transmitted infections.

A considerable challenge was the role assigned to DSS which was defined as that of supporting partner rather than a key player in the process. As the custodian of children’s rights and rehabilitation, the Department would have been able to provide much needed technical assistance rather than acting simply as an advisory body. Direct action by DSS in the planning and implementation of the project, it was felt, would have been highly beneficial to its outcomes.

The timeline for the project was felt to be too short especially with regard to the rehabilitation of children reintegrated into the educational system and the families of all those removed from circumstances associated with child labour. The time factor was also problematic in relation to stakeholder participation and the assumption of ownership of the programme. This might prove to compromise sustainability after the conclusion of the project cycle and moving forward into an uncertain future.

Childline believed that a quantitative (as opposed to a qualitative) approach to the problem of child labour might not have been appropriate in this instance where lessons learned have to be translated into long-term strategies for intervention. The relatively large number of children involved in the project tended to overshadow the difference it made in the life of each individual child. In hindsight, a longitudinal study embracing the observation of fewer children removed from a child labour environment, re-integrated in schools, and rehabilitated within assisted family units over an extended period of time would have produced more definitive results.

In hindsight, stakeholders on the ground should have had input in the project design and planning process. This would have enhanced initial and on-going participation and resource sharing with, for example, programmes for orphaned and vulnerable children.
(OVC). The initial stages of any project design should include those already involved in some way in the issues being addressed. They have the experience, the knowledge, and also their own vision of what could be done which can be incorporated at the planning stage. This might appear to be at odds with what this project is seeking to achieve but, in the result, could have proven to be the appropriate direction to take. Involving stakeholders from the planning stage would also ensure that envisaged intervention strategies would include the very people who can enable the sustainability of the project.

An overriding matter demanding future action was identified, during the progression of the project, as that of domestic labour involving children. It was found that, increasingly, children are being employed as domestic servants in the informal sector under the guise of helping with ‘household chores’. This is an accepted norm in many communities with a large number of children working alongside their family members during school hours and thus missing out on a considerable amount of study time. They are also employed as virtual domestic servants with the justification of helping out a family (related or unrelated to them) in need. This involves, especially, migration of children from poor families with a large number of offspring from rural to urban areas. The children are ostensibly taken in to help reduce the burden on poverty stricken families. They are often paid very little and subjected to various forms of abuse. The ultimate aim of recruitment is thus exploitation.

Based on the foregoing, children are effectively denied their right to: education; leisure, play, and recreation; appropriate parental guidance; and protection against harmful labour practices (Bill of Child Rights, Children’s Act No. 8 of 2009). This is in direct contravention of Botswana’s legislative standards and principles.

Recommendations
The family, as the ultimate custodian, is the integral unit insofar as child rehabilitation is concerned. Any project that aims at rehabilitating children should, first and foremost, examine the family situation and plan for the parents/caregivers to be assisted through education, direct help, and enhancement of self-esteem. Rehabilitation of children to the exclusion of carers is an exercise in futility. Thus, projects for children must include provision for parents in order to achieve a holistic approach.

Secondly, family strengthening projects (such as those conducted by SOS Children Villages in Botswana) should be rolled out at national level. These include training and monitoring of care-givers and the wellbeing of children. Third, the statutory foster care programme as formulated in the Children’s Act of 2009 should be implemented without delay and linked to the family strengthening project.

Fourth, stakeholders on the ground should have input in future time-bound project design and activity planning. This would ensure sustainability beyond the project cycle. Fifth, international agencies involved in project development should include government, civil society, and private sector organisations at all stages of the process. Sixth, the
Children’s Act of 2009 and other laws pertaining to the rights of children should form the backdrop to the development of a child friendly nation in Botswana in order that the younger generation may constitute the envisaged just and caring society of the future. Lastly, stringent efforts should be made by all sectors of government, civil society, and the population as a whole to curb the exploitation of children. In this regard, the education system, both formal and informal, should include material addressing related issues.

**Conclusion**

There are some similarities between the 19th century workhouse system in England, represented by Charles Dickens in his account of the life of Oliver Twist, and child labour practices in Botswana. Interestingly, Dickens himself made a connection between his own world and the African experience in relation to the situation of Oliver Twist. He referred to the ruling classes who practised in-humanitarianism in the guise of moral and religious rectitude and cited many, particularly missionaries, who took services to the poor of the underdeveloped world while being oblivious to conditions on the home front. In 1848 he wrote of the need for widening circles of social enlightenment to spread out from London. ‘...like ripples flowing out from a stone dropped into the ocean of ignorance... The work at home must be completed thoroughly or there is no hope abroad’ (Dickens 1848: The Niger Expedition, Examiner 19 August, quoted by Flint, 1986:23).

The situation in the United Kingdom is very different today. Botswana too, has policies and programmes in place which make it a model for many other developing societies. However, there are still lessons to be learned with regard to the well-being of children. Those involved in work activities, especially, should be given back a childhood located within a caring, nurturing, and stimulating environment. The alternative will see negative influences perpetuated and handed down from one generation to the next. These will stanch the flow of growth inducing “social serotonin” and inhibit the generation of positive energy necessary to enhance the halo effect of Botswana’s overall policy on social development.

**References**


"...and a little child shall lead them": Utilising Kgotla meetings to empower children and the communities that nurture them

Introduction

In March 1995 Botswana acceded to the United Nations Convention on the Rights of the Child. Subsequently a conscious attempt has been made to domesticate the values enshrined in the Convention through their translation into national legislative instruments. In the process the Children’s Act of 2009 replaced that of 1981 in a deliberate move to streamline provisions for children whose rights and wellbeing are increasingly challenged by issues related to postmodern influences (mindsets around social change) and the effects of HIV and AIDS. One of the outcomes was the formation of the National Children’s Council which took a definitive decision to sensitise communities on the spirit and provisions of the Act in order to enhance its implementation at local level through the village kgotla system. Although this is an ongoing process several meetings have already been held and the purpose of this paper is to document some of the emerging issues which will provide guidance during continuing application of the law for children. The paper describes the Kgotla system and the rationale for utilizing it in this instance. It highlights culturally sensitive procedures involved in arranging the meetings and lessons learned through subsequent dialogue at grassroots level. Lastly, it attempts to utilize the valuable data gathered through the process of information exchange to chart a way forward in the best interests of the children of Botswana.

The Government of Botswana remains committed to making Botswana a country fit for children. This is demonstrated through the adoption of numerous initiatives including: the ratification of the United Nations Convention on the Rights of the Child (CRC) in 1995; the passing of the Children’s Act No.8 of 2009; the setting up of the National Children’s Council (NCC), the National Children’s Consultative Forum as well as Village Child Protection Committees and the social protection programmes that target orphaned and vulnerable children, destitute households, and the elderly. The government and its partners have also facilitated research on several child welfare issues.

As previously mentioned, one of the efforts that government made to promote the wellbeing of children in the country is the establishment of the NCC whose mandate is to coordinate, support, monitor, ensure, and guide the implementation of sectoral ministries’ interventions as they relate to or impact children; advocate for a child centered approach to legislation, policies, strategies, and programmes; and advocate for a substantive share of national resources to be allocated to child related projects. One of the activities that the NCC carried out to achieve its goals was addressing Kgotla meetings in selected villages that aimed to inform communities about the Council’s existence and mandate; dialogue with parents, guardians, community members, and leaders about issues affecting the wellbeing of local children; and to inform communities about the new Children’s Act of 2009.
The Kgotla system and the rationale for utilizing it to empower communities’ in nurturing children

The word ‘Kgotla’ refers to the highest public meeting, community council or traditional law court in a village (Moumakwa, 2010). The forum is usually headed by the village chief (kgosi) and this could be the paramount chief or the regent chief. A chief is a hereditary leader of a tribe or village and therefore has authority, respect, and privilege among his people. The chief is assisted by deputies/headmen and principal advisors who are also largely men. The installation of the kgosi has to be approved by the government in accordance with the Constitution of Botswana.

The spirit of the Kgotla promotes peace, harmony, unity, and democratic values through uniting and building the social fabric of local communities in the country. It is the only traditional court in which the rule of customary law is implemented. Such law should not be incompatible with the provisions of statutory law or contrary to morality, humanity or natural justice (Bogosi Act Chapter 41:01). Thus, Botswana functions under two parallel legislative systems both of which are intended to contribute to the country’s peaceful functioning within an environment defined by democratic values (Tsie, 1996). The roots of Botswana’s peace, stability, and democracy may be said to reside in Setswana traditions exemplified by the Kgotla system (Maundeni, 2004).

The Kgotla institution plays a vital role in modern day Botswana through addressing conflict within and between communities, pioneering candid liaison between communities and the state, and providing a solid template for interaction and socialization in villages and towns. Fundamental human values of respect (botho) and inclusiveness promote an atmosphere conducive to the replacement of pettiness and individualism.

Furthermore, the Kgotla system is defined by the spirit of restorative justice involving co-operation, negotiation, reconciliation, and mutual understanding (Moumakwa, 2010). The physical structure is open, with few walls, denoting a spirit of inclusiveness. Human rights, peoples’ interests, and a philosophy of consultation (therisanyo) provided the impetus for the National Children’s Council to consider this venue to introduce the Children’s Act of 2009 to villagers in Botswana. It proved to be a wise choice for empowering communities that nurture children for several reasons. First, the Kgotla is an assembly courtyard at which tribal issues are discussed and major decisions taken. It is a forum for free exchange of ideas and views within a democratic environment. Every member of the community is free to attend Kgotla meetings and comment or ask questions regarding issues that are presented. Second, the head of the Kgotla is a chief and thus well respected by the people. Third, chiefs are custodians of culture, making it essential for them to be part of an audience that is empowered and sensitised in relation to the wellbeing of children. Fourth, the Kgotla is regularly used as a place where child welfare cases (such as juvenile delinquency and child maintenance) are addressed making it an ideal forum for discussion of children’s issues at local level.

1. The word ‘his’ is used deliberately because, from time immemorial, the position of chieftainship was only reserved for men. It was only in the late 2000s that women were allowed to occupy such positions. At the time of writing there were 31 chiefs and only 4 female ones.
Culturally sensitive procedures involved in preparing for the Kgotla meetings
The process of arranging the Kgotla meetings entailed several procedures:

- Calling or sometimes travelling to the various villages² to request chiefs to permit the NCC to hold meetings in their villages. In some, this request was not granted as the chiefs asserted that they do not allow Kgotla meetings to be held during the ploughing season when people are busy in the fields.

- Writing formal letters of request and personally delivering them.

- Using loud hailers (several days before the proposed meetings) to inform communities about the forthcoming gathering and then repeating the process the day before the meeting to remind them about the event.

- Paying each chief a courtesy call (about 30 minutes before the time of the scheduled meeting) to introduce members of the Council. This facilitated rapport between the NCC team and the chief/s and was also a demonstration of respect. Moreover, it enabled NCC members to learn about the chief’s views regarding pertinent child welfare issues. Consequently, the team was able to exercise caution when referring to such issues during the Kgotla meeting itself.

There were about four or five presentations at each of the five villages where the gatherings were held. All were preceded by a prayer,³ introduction of guests, and welcome remarks by the chief himself. Topics covered include a brief description of the NCC, an overview of major sections of the Children’s Act, and current challenges faced by children. Sections that were highlighted were those that focus on the Bill of Rights for Children; responsibilities of children, parents, guardians, and the community at large; alternative care for children; and offences committed by children and corresponding penalties. The audience was invited to make comments and ask questions following the presentations.

These proved to be diverse, multifaceted, and pertinent to the situation of children in Botswana’s local communities. They are discussed in the following section under the heading of lessons learned in order that the NCC could, in the future, help to drive programmes that are relevant to the children of Botswana.

Lessons learned through the process
Several issues were raised during the kgotla meetings which identified areas requiring attention and future action. These contributed to the knowledge base of the council with regard to the perceptions of local communities in relation to children’s rights and responsibilities. These are discussed below.

Dangers faced by children in the community
The first lesson that the NCC learned is that many children face dangers that compromise their wellbeing. Incest was one such issue and concern was raised by some participants who reported that cases of this nature are on the increase. However,
mechanisms for addressing the problem seem ineffective as perpetrators are not always taken to task about the matter. Instances were described where parents and guardians shield abusers because the latter are the breadwinners and providers who prevent the family from descending into poverty.

One of the participants, a retired primary school head teacher, said: "...when I was a teacher, many years ago, I used to see children who were sexually abused by their own relatives. I used to do my best to ensure that such children got assistance, but in most cases, my efforts proved futile because the very parents who were supposed to protect children would protect the perpetrators and deny that the abuse took place; ...some would even threaten the child to the effect that if the perpetrator goes to jail, the child will be the one who was going to support the family materially ...I just hope that the new Children’s Act that you are talking about will help to ensure that perpetrators are taken to task..."

Cases of babies being thrown into pit latrines by parents who could not afford to raise or support them were also discussed. It was noted that this is an area of concern as these were obviously unwanted offspring which, in an era of HIV and AIDS, suggests that unprotected sex is still a threatening issue. The presenting team encouraged communities to report offences relating to children to the relevant authorities. It was stated that the current Children’s Act bestows upon parents and guardians the responsibility of doing whatever they can to protect young people. In the child friendly children’s courts the position of the social worker is significant as an intermediary between young people and the criminal justice system. The emphasis of the new legislation is that community members should be the eyes and ears of children in need of care.

Remuneration for ‘volunteering’
The second lesson that the NCC learned is that communities want to be paid for taking part in activities that are categorised as ‘voluntary’. These include serving on child protection committees and acting as foster parents. Section 33 of the Children’s Act states that communities should establish child protection committees which are responsible for educating people about possible neglect or abuse of children and monitoring the welfare of all children in their area of operation.

The audience (both males and females) felt that, in this era of rising living costs, it would be difficult to find people who are prepared to work on a voluntary basis. Existing literature (cf. Rankopo, Osei-Hwedie, & Modie-Moroka, Un dated; Lindsey, Hirschfeld, Tlou, & Ncube, 2003) shows that the majority of volunteers in the country are low-income and illiterate older women. Generally, young people and men are less inclined to volunteer their services. In Botswana the belief is that, as breadwinners and heads or potential heads of households, men must engage in gainful employment or activities that accrue monetary or material returns. The fact that most people who volunteer are female increases the burden of care on women in resource poor environments where they are unable to provide for their own and their families’ needs.
Children’s engagement in delinquent behaviour/criminal activities

The third lesson that was learned is that some children deliberately engage in delinquent acts because they believe that they are covered by the law since they do not have the capacity for criminal responsibility. Concern was also expressed about some adults who use children in criminal activities such as the sale of illegal drugs. One community member said:

“...when these children are questioned by the police, they say that some adults requested them to sell such drugs in exchange for money. Because the law is lenient with children, those children are usually not imprisoned. Yet, the sale of illegal drugs is a serious offence ...So something should be done about these scenarios, otherwise we are going to see more and more children being used by adults to commit crimes.”

A related issue that was raised concerned adults who allow children to access places that sell alcohol. Participants felt that this encouraged young people to engage in substance abuse. Others stated that children do not always voluntarily visit alcohol outlets but are sent by adults to buy alcoholic beverages. Yet others associated children’s use of alcohol with the fact that there has never been a law that prohibits the sale of traditional beer in homes and this has facilitated children’s easy access to alcoholic drinks. It should however be noted that at the time of writing this paper (June 2012), the government has taken a decision to stop the sale of alcohol in homes. This move was met with resistance by home brewers and thus its successful implementation remains in doubt.

A Village Development Committee member in one of the meetings recommended that chiefs be given the authority to discipline children in their communities as has been the case in the past. One community member believed that there are no laws regulating who can access bars and that children (under the age of 18) do consume alcohol. It was stated that, in some communities, traders who sell liquor or cigarettes to children were having their licenses withdrawn. The suggestion was made that identity documents of purchasers should be demanded as the chiefs contended that some parents were not taking responsibility for their children’s wellbeing.

Societal resistance to issues/approaches perceived as being in conflict with culture

The fourth lesson learned was that there is a level of resistance to issues and approaches that are viewed as clashing with culture. These issues include children’s rights as well as gender equality and women’s empowerment. Participants associated children’s and women’s rights movements with children’s antisocial behaviour. One of them said:

“The reason why children in Botswana today disrespect their fathers is because mothers have a tendency to team up with children to oppose their fathers who seek to exert authority. Mothers say they and their children have rights so when fathers try to discipline children, the mothers tell them that the fathers are violating their rights...and so fathers are powerless. It looks like fathers don’t have rights ...only mothers and children have rights...”
Members of the community reported that some unmarried women ‘chase away’ the fathers of their children when they express the desire to be involved in the child’s life. They were informed that the Children’s Act now highlights the fact that biological parents, whether married or not, have responsibility for raising their children. The fact that the father’s name (irrespective of a legal union) should appear on the child’s birth certificate, stimulated discussion on the advantages and disadvantages of the situation. On the one hand, some contended that if the name of the father who has not married the child’s mother appears in the child’s birth certificate, this will help to curtail the practice of men having children outside of wedlock. On the contrary, others felt that this would cause conflict in families particularly when married women learn that their husbands’ names have been appended to the birth certificate of children born outside wedlock.

**Behaviour of orphaned children**

The fifth lesson learned was that some community members decried the behaviour of orphans, suggesting that they were difficult to control because they are ‘spoiled’ by government. This was particularly apparent with regard to the attitude of some towards their state sponsored food basket which they believed should not be shared with others. This is a thorny issue as, in reality, the programme does serve registered orphans although it should be appreciated that they reside within related families. Striking a balance between ensuring their wellbeing and sharing resources in the family (while decrying abuse or neglect) is a challenge for social workers in the country.

**Foster care and adoption issues**

The sixth lesson concerned statutory foster care that entails a legal process of removing a child from an unsuitable home environment through the children’s court system and placing him or her with foster parents. These individuals would have applied, through local authorities, to be included in the programme and, subject to initial screening, would proceed through a process of training and finally monitoring (when children are placed in their care). This is a temporary arrangement, unlike adoption, although it could result in long term care.

Community members displayed interest in the programme but expressed concern about the lack of financial assistance. It is believed by many social workers that a foster grant, as available in other countries, for example, the United Kingdom and South Africa, would enhance the possibility of the process being successful in Botswana. However, government has yet to agree to this and the fact that the programme is about to be implemented means that a decision will have to be made in the near future.

One community member commented that she provided informal foster care to children whose parents were “not at all grateful”. This prompted a discussion about statutory foster care where the parents might be even more ungrateful (or openly hostile) following the legal removal of the child from their care. Community members were informed about the importance of training foster parents to handle, inter alia, situations of this nature and also to understand the need for the social worker’s help in restructuring the birth family of the foster child.
Community members were particularly interested in the difference between foster care and adoption. It was explained that the former is temporary and the latter permanent, involving the child taking the adoptive family’s name. The issue of reconstruction of families of origin, with a view to returning the foster child to their care, was clarified. Interestingly, the concept of residential care, as provided by SOS Children’s Villages and Mpule Kvelagobe Centre, was at times incorrectly labelled as foster care, even by social workers themselves. It was explained that institutions provide residential care while people taking children into their own homes provide foster care.

Denial of children’s right to education
The seventh lesson learned concerned the fact that there are some instances of uncooperative parents who do not provide appropriate care for their children. Some social workers narrated that it was their responsibility to write periodic reports on such cases. The NCC members shared the fact that denying a child access to an acceptable standard of education, for example, carries a fine of not less than P5000.00 and not more than P10 000.00 according to the Children’s Act. It was felt that the Village Child Protection Committees established by the Act would provide some of the answers to questions related to such occurrences as well as the issue of delinquent behaviour by children.

Disciplining children
Finally, it was observed that concepts of discipline and abuse were confused by some community members. They argued that government signs international protocols without considering the unique needs of the people of Botswana. Comments were made regarding children who are on drugs and who dress inappropriately. They believed that the chiefs should have more power to discipline these children as had been the case in the past.

Conclusion
Based on lessons learned, it is recommended that Kgotla meetings addressed by the NCC should be extended to all parts of the country. This will enable the Council to disseminate information to all communities about the Children’s Act; to obtain a comprehensive picture of key issues affecting the wellbeing of children; and to empower communities in the judicious management of matters affecting the lives of their children.

Kgotla meetings addressed by NCC members yielded rich information pertaining to perceptions of community leaders and members regarding children’s rights and responsibilities and their position vis-a-vis the law, authority figures, and their families. Further gatherings of this nature across the country will no doubt provide new insights as well as further support for prevailing attitudes. The conclusion that may be reached is that attention should be paid to grassroots emotions, beliefs, and practices regarding the lives of children and those with whom they interact on an ongoing basis. The law is only as effective as the level and quality of its implementation and there should be an appreciation of the fact that legal processes are, by their very nature, dynamic. ‘Not in stone’ should be their byword and ‘forever’ anathema to their acceptability and relevance.
In 2011, the estimated HIV prevalence among the 15–49 year old antenatal population in Botswana was 30.4%.\(^1\) Botswana’s National Strategic Framework II (2010–2016) identifies the drivers of the epidemic to be: multiple and concurrent sexual partnerships; low rates of male circumcision; adolescent and intergenerational sex; gender inequalities and violence; substance abuse, in particular alcohol; and stigma and discrimination.\(^2\)

The overall goal of the national response is the prevention of new HIV infection by 2016, towards attainment of an AIDS free generation (ibid). Although Botswana is unlikely to meet its goal of no new infections by 2016, it is possible to achieve an AIDS free generation. This will require prevention of mother-to-child transmission (PMTCT) of HIV; increased support for families and children made vulnerable by HIV/AIDS; and reducing HIV risks and vulnerability among adolescents.\(^3\) The articles in this section of the publication present research on HIV prevention from two dimensions.

Contributing towards evidence-based HIV and AIDS prevention programmes for adolescents, Ntshwarang and Malinga-Musamba, present findings of a qualitative analysis of abstinence hurdles that adolescents face in Botswana. Approximately 80–96 adolescents aged 14–17 years from urban, semi-urban and rural schools were purposively sampled for the analysis. The findings suggest that socio-cultural beliefs and practices coupled with peer pressure are key obstacles to abstinence among adolescents. In order to address these challenges, HIV prevention strategies need to include awareness at community level and the strengthening of adolescent knowledge on abstinence and sexual reproductive health.

The article by Kgosi explores the experiences, problems and challenges faced by poor HIV positive parents who live and care for their children in poor housing conditions in Gaborone. The author adopts a case study approach, covering a sample of 26 parents. Her findings suggest that HIV positive parents have unique housing needs related to both their physical and mental health status, that if not met pose barriers to effective HIV prevention, management and care.
Abstinence hurdles among adolescents in selected areas of Botswana

Introduction

Adolescence is a challenging stage for most children. At this stage, children grapple with physical, emotional, and social changes. These changes are exemplified by the clarification of sexual values and experimentation with sexual behaviors (Kabiru & Ezeh, 2007). Decisions taken at this stage can impact negatively on a person’s life opportunities, behavioral patterns and health (Lakshmi, 2007). In Botswana, HIV prevalence rate is high and adolescents are challenged to make good decisions regarding HIV prevention. The national HIV prevalence rate has increased from 17.1% in 2004 to 17.6% in 2008 (Republic of Botswana 2009). Even though the 15 to 19 age group had the lowest incidence rate of 0.7%, they are exposed to many risk factors despite high level of knowledge on HIV and AIDS. In this group, perceived vulnerability and lack of abstinence are high. Abstinence is one of the major HIV and AIDS prevention strategies advocated, especially in the prevention of sexually transmitted infections such as HIV. Abstinence is a component of the ABC (Abstain, Be faithful, and use Condoms) approach adopted by the President’s Emergency Plan For AIDS Relief (PEPFAR), a program funded to address the HIV/AIDS pandemic (Kabiru & Ezeh, 2007). It is one of the behavioral strategies and priority methods for preventing pregnancy, HIV, and STI among adolescents (Iriyama et al 2007). The National Strategic Plan for Scaling up HIV prevention in Botswana (2000-2010) has recommended the delay of sexual debut among adolescents by one full year, (from about 18 to 19 years) as one of the strategic goals to prevent the spread of HIV. The National AIDS Coordinating Agency [NACA] (2003) has also emphasized the need to encourage abstinence among young people by encouraging stakeholders to promote avoidance of premarital sex among the youth.

Even though programs have been designed to address sexual health with attention on delaying sexual initiation, and promoting secondary virginity, abstinence is the main recommended strategy for prevention of STIs among adolescents. However recent studies indicate that the average age at first sexual intercourse was 14 years while the median was 15 years. Moreover other research reports such as the Botswana Global School based Health Survey and the Botswana AIDS Impact Survey II show that half of Batswana youth are sexually active before 18 years and thus particularly susceptible to unwanted pregnancies and STIs including HIV infection.

Therefore, adolescents have been found to be vulnerable and there are factors that predispose them to risky sexual behaviors (Kabiru & Ezeh, 2007). Lakshmi et al (2007) argue that the vulnerability of adolescents is from societal factors that adversely affect their ability to exert control over their health. They go on to mention that some of the societal factors include cultural norms, laws or societal practices and beliefs that act as barriers to essential prevention messages. Moreover, in their systematic summary of the scientific adolescent health research literature, Buhi and Goodson (2007) indicated
that family or parental support is a risk factor for early sexual onset. They argued that decreased supervision was significantly associated with earlier initiation. Moreover, it was found out that abstinence has not been embraced by all adolescents. Boys evoke beliefs that are imbedded in the culture and reconstruct them into their language to force their peers to engage in sexual risk behavior (Iriyama et al 2007). UNICEF (2009) reported that adolescents believed that abstinence was unhealthy and could lead to virgin disease and painful erection. The chapter therefore reports on abstinence hurdles among female and male school going adolescents in Botswana.

Methodology
The data used in the chapter is derived from an ongoing partnership project between the University of Pennsylvania and University of Botswana funded by the National Institute of Health, U.S.A. Its overall goal is to build capacity for HIV/STD prevention research on Batswana adolescents aged 14–17 years. Students were recruited from community junior secondary schools in Botswana. Three districts were purposively selected as well as 2 junior secondary schools per district. Purposive sampling was used to allow the researchers to have close proximity to sites where data was to be collected and for purposes of accessibility and close monitoring. All in all, 6 schools were selected. Teachers assisted in the recruitment of students based on students’ ability to articulate issues relating to HIV and AIDS and whether students represented the diverse background and lifestyles of all students that attend the school. Data was collected from eight focus group interviews in urban, semi-urban and rural schools. Before data collection, tools were piloted in schools not used in the sample. Each focus group had ten to twelve participants. There were 3 females-only groups, 3 males-only groups and 2 mixed sex groups.

Some data from the larger study was solicited from both focused group discussions and a pre-focus group questionnaire. Participants responded to an elicitation questionnaire with 21 open ended questions on behavioural, normative and control beliefs about abstinence, condom use and having one sexual partner. Thematic approach was used to analyse the data. Transcripts of focus group discussions and pre-focus group questionnaire were read to identify the messages that adolescents alluded to as barriers to abstinence.

Results
Both pre-focus group questionnaire and FGDs revealed that adolescents are faced with several challenges that discourage them to abstain from sexual activities. Both male and female adolescents narrated stories that related to why they find it difficult to abstain. The data was organised according to behavioural, normative and control beliefs. For this chapter the authors focus on behavioural and normative beliefs only.

Behavioural beliefs are convictions about the results of engaging in a particular action. The beliefs that adolescents talked about were pleasure, skill acquisition, and illness. Adolescents reported that they fail to abstain mainly because engaging in sexual activities is pleasurable and indicates that one is human. Some of the respondents emphasised the belief by saying:
“Depriving people of sex is abusive because it is human nature to have sex and because it is emotionally healthy, stabilizing and pleasurable.” (Female)
“You are going to miss the enjoyment” (Male)
“You don’t get to enjoy sex” (Male)

Some adolescents also believed that for one to acquire skills to utilise later in life, they have to practice now. They reported that they do not abstain because engaging in sexual activities at an earlier age equips them with skills of managing relationships, and of how to engage in sexual activities. Some adolescents responded as follows:
“You may not be able to manage a relationship”. (Female)
“You may not know or have experienced a relationship”. (Female)
“You will not know how funny it is”. (Male)
“You will not know skill of having sex when you grow up”. (Male)

Moreover, both female and male adolescents reported that they did not abstain because staying for a long time without having sex can expose them to diseases and cause inability to have children. For example some respondents lamented:
“One may suffer for example, like boys, they will suffer from erection” (Male)
“In men there is something called erection and it is painful” (Male)
“There is a virgin disease which can lead to infertility” (Female)

Furthermore, adolescents identified normative beliefs that lead to their inability to abstain. Normative beliefs are convictions about whether significant figures would be supportive or not supportive of performing a specific behaviour. Adolescents indicated normative referents such as peers, parents, and teachers. However, they cited that even though some of the older people such as parents and teachers may encourage them to abstain, their peers are their primary referents. They narrated that their peers especially those who have experienced sex, encourage them not to abstain. The quotes below are examples from both female and male adolescents which reflect their experiences with their peers regarding sex. The quotes also indicate that adolescents care about what their peers say and do.
“You might regret having not had it (sex) in the future; you might feel left out because everyone is having sex”. (Female)
‘One gets mocked/ teased about being a virgin’. (Female)
‘Some people think it is not normal, and others are forced or influenced by their peers into having sex’. (Male)
‘If your friends have had sex and you are the only one left, they will laugh at you’. (Male)

Discussion
Even though there are adolescents who embrace abstinence, the findings above reveal that there are those who do not. Buhi and Goodson (2007) found out that abstinence has not been embraced by all adolescents. Adolescents’ behavioral beliefs towards abstinence are linked to the benefits of sex. Adolescents do not abstain because they believe sex has benefits. The benefits are pleasure, skill acquisition, avoidance of illness and fear of being laughed at by peers. So adolescents prefer to have sex because they
do not want to miss out on the benefits.

Other adolescents’ perceive sex as part of nature and thus believe that adolescents should not be ashamed to engage in sex. Abstinence is seen by adolescents as a barrier to fulfilling human nature. The tendency to associate sex with pleasure misleads some of the adolescents who want to abstain in the sense that they think that they miss out the opportunity to enjoy themselves if they do not have sex. The emphasis on sex as pleasure may be a result of the discourse of sex as food in the society (Chilisa et al 2011). For example, findings from the same study indicate that adolescents call sex “sweets”. So abstinence is seen as denying oneself the opportunity to have pleasure, enjoy life and be emotionally stable. Other findings from the same study indicate that the girl’s body is marked as a basic need, a necessity and an irresistible attraction for boys and men (Chilisa et al 2011). This therefore increases young people’s likelihood of developing more interest in sexual activities.

Moreover, adolescents believe that when they have sex at a younger age, they are able to learn skills for future use when they are adults. They think that abstinence denies them the opportunity to experiment with sex, which they think can help them acquire important skills in this area as well as in managing sexual relationships. Adolescents’ beliefs about skill acquisition could be linked to Lakshmi et al (2007)’s point that some of the societal factors such as cultural norms, societal practices and beliefs act as barriers to essential prevention messages. For example, the results indicate that adolescents assume that getting involved in sexual relationships early on is important because it enables them to gain experience on how to perform during sexual intercourse. The idea could be derived from the culturally derived expressions used in reference to sex, such as those which liken sex to food (Chilisa et al 2011). According to Chilisa et al (2011:135) “the female body is constructed as food to be “consumed” by men and boys.” One could conclude that as a result of the metaphor, adolescents do not abstain in order that they may learn how to make and eat the ‘food’.

Further, the perception of abstinence as the cause of illness and sex as a prevention and healing mechanism by some adolescents is a stumbling block to abstinence. Abstinence has been negatively associated with girl’s virgin disease. Adolescents associate the virgin disease with infertility and birth complications whereas boys’ failure to abstain is mainly linked to painful erection. A similar finding was also reported by UNICEF (2009) that adolescents believed that abstinence was unhealthy and could lead to virgin disease and painful erection. This is a hurdle because a lot of adolescents who do not have reliable information and knowledge about sex end up having sex at an early age to prevent infertility.

Girls’ failure to dismiss the information surrounding infertility and abstinence is worsened by the cultural expectations that a woman should be able to bear children. In some communities early child bearing and marriage at a young age is accepted (Chilisa 2006). Hence the fear of bareness defies any chances of abstinence. According to Iriyama et al (2007) adolescents, especially boys have a tendency to evoke beliefs that are imbedded
in the culture and reconstruct them into their language to force their peers to engage in sexually risky behavior. The myth that boys will have a painful erection if they stay for a long time without sex is a barrier to abstinence. Therefore general message from the adolescents is that boys engage in sexual intercourse to prevent and heal painful erection. Similar social functions of sex were also identified by Ntseane & Preece (2005) and Chilisa etal (2011). On one hand Ntseane & Preece (2005) have indicated that justification of sex between girls with older male sex partners in some communities and population groups has been that it cleanses and heals. That is to say the young girls are perceived to be the medicine that cleanses and heals the older partner. On the other hand Chilisa et al (2011) reported that adolescents emphasized that boys and girls viewed sex as an activity that kept one healthy and fit. As such, these beliefs that even the older generations adheres to, make adolescents believe that indeed to abstain from sexual activities will lead to some health complications.

Besides adolescent being influenced by older people in their communities, peer pressure is also prevalent. Negative peer pressure is one of the major barriers to abstinence among adolescents. The literature has indicated that peer pressure is key to adolescents’ decisions about whether to abstain or not (Malinga 2010). Adolescents expressed that they are more likely to listen to their peers than their parents and teachers hence peers are the primary factor in their failure to abstain. The findings of the study have indicated that adolescents who have experienced sex are highly regarded by their peers whereas those who abstain are marginalized and stigmatized. Adolescents who abstain are usually laughed at, teased or mocked for their virginity status. They are also labeled as abnormal by those who are sexually active and sometimes they may be denied membership to social groups or gangs. Therefore, those who are desperate for a sense of belonging are forced to engage in sexual activities to please their peers and get recognition, as was argued by Pilane et al (2011) that adolescents easily succumb to group pressure. The findings of this study on peer pressure corroborate those reported in the study on HIV and STIs prevention strategies for 10–14 year old church-going adolescents in Botswana which found out that peer pressure coerces teenagers to please their friends who might have different religious beliefs (Pilane et al 2011). According to Ntshwarang (2010) adolescents’ reliance on their peers can be associated with the failure of the school, family and community to provide children with adequate and reliable information on sex matters.

Conclusion

From the discussion, it is evident that adolescents who may want to abstain are faced with societal and peer challenges. The findings indicate that the society adheres to some cultural beliefs that need to be changed. Therefore it is very crucial to develop strategies that can enhance community’s knowledge on risky sexual behaviors and on how they can be avoided. HIV prevention strategies should focus more on the larger community, as these are the people who adolescents look up to for guidance. They are also responsible for socialization of adolescents and influencing them on decisions that they make. Lastly, existing programs and strategies need to be strengthened so that adolescents can be equipped with adequate and reliable information on abstinence and sex related issues.

References


The experience of living and caring for children in poor housing: Insights from HIV infected parents in Gaborone

Introduction

The primary and essential function of housing is to provide a safe and sheltered space. Therefore appropriate housing is absolutely fundamental to the health and well-being of all individuals. The importance of shelter is outlined in the Universal Declaration of Human Rights of 1948:

‘Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services’ (UN, 1948: Article 25(1)).

Healthy housing, together with good sanitation, healthy food, clean water and clothing, are basic human requirements (Ranson, 1991: viii). Increasingly, housing is recognized as a fundamental determinant of health and a major public health issue (Dunn, 2002). Research has shown that good quality housing is associated with favourable health outcomes (Evans et al, 2003). Poor housing has been demonstrated to increase vulnerability to infections, exacerbate illnesses and increase the need for health support (CAHM, 2007). On contrary, good housing has the capacity to positively influence good health outcomes (Dunn, 2002). While many people around the world especially those in developed countries are able to choose their housing, there are some who struggle to secure adequate housing because of lack of income. Consequently, they end up living in poor housing conditions. Among the population who live in poor housing conditions, are those who are poor and living with HIV and AIDS.

Low income people living with HIV have a range of specific accommodation needs hence their housing contributes to their healthcare challenges including non-adherence to treatment, relationship problems, as well as financial pressure. Poor housing makes it difficult for people living with HIV and AIDS (PLWHAs) to lead a healthy lifestyle, such as eating regular healthy meals, getting enough sleep and being able to keep clean. Consequently, their immune system may become compromised more quickly than it otherwise would be.

Housing problems faced by HIV positive parents are largely due to poverty. Being poor and HIV positive undermines children and family wellbeing. Poor housing among PLWHAs has been reported to be a challenge to many poor households around the world (Aidala, 2006; Aidala and Sumartojo, 2007). However in Botswana this is an area that has received little attention. Yet the housing problem transcends the basic need for shelter that is reported in many studies because the combination of poverty, HIV positive status and caring for children increases its complexity. The socio-economic needs of the family, the need for additional sanitary living space to accommodate the children and the specific needs of PLWHAs are the other dimensions that need attention. Debates have demonstrated that stable and sanitary housing has an increased potential to improve the quality of life of people battling HIV and AIDS (Aidala et al, 2000).
More recently, studies have shown that HIV positive parents continue to cope with discrimination, stigma, poverty, as well as other everyday issues of life (Antle et al. 2001; Salter Goldie et al. 2000). These unique experiences, concerns and challenges negatively impact their physical and mental health and quality of life. The costs associated with caring for children and supporting their participation in schooling and other essential development activities can cause severe financial stress in low income households. For households affected by HIV, these pressures may amplify the challenges of parenting in poverty. According to Antle et al. (2001), mothers, in particular, may subordinate their own health care needs to the needs of their children. These authors further point out that this could lead to competing subsistence needs and caregiver roles that have been found to adversely influence health care access for women living with HIV and AIDS.

In this paper the author explores the experiences and challenges faced by twenty six poor HIV positive parents who are living and caring for children in poor and overcrowded housing in Gaborone. The paper further explores the strategies poor HIV positive parents adopted to respond to the challenges.

**Research methods**

A case study using 26 poor HIV positive parents purposively selected was conducted in Gaborone and nearby areas including Mogoditshane and Tlokweng villages. Within Gaborone, the choice of case study areas was influenced by the central aim of the research which is to analyse housing problems faced by HIV infected parents. Cases of HIV infected parents were obtained with the help of snowball sampling technique from five support groups for people living with HIV and AIDS. The support groups’ coordinators assisted with the recruitment of the participants of PLWHA through the extensiveness of their social network, experience and personal relationships with people living with HIV and AIDS in the community.

A substantial amount of data was collected through in-depth interviews. The interview was the most suitable method for the study as it provided a platform in which experiences through personal accounts and opinions could be narrated. However, the researcher took into consideration reservations surrounding personal accounts: that while they may be a genuine reflection of people’s experiences, personal accounts can also be inaccurate and there might be circumstances or events that surround these experiences which the respondents may not be aware of.

**Ethical considerations**

Studying people living with HIV and AIDS is naturally sensitive and to some extent controversial due to the stigma and discrimination attached to the disease. Other researchers have shown the difficulty of doing research studies related to HIV and AIDS elsewhere. Kiai, et al (2002) indicated that it is difficult to identify people infected and affected by HIV and AIDS without ethical hindrance. Therefore, the researcher anticipated that issues and problems that required ethical justification will be inevitable and hence the need for ethical pre-arrangements. Prior to the field work, ethical clearance was obtained through the Cardiff University School of Planning Ethics.
Committee to indicate that the school has considered the study and approved that it observes and meets the required ethical standards of research. Throughout the data collection process, the researcher was guided by the contention that ethical decisions are not defined in terms of what is advantageous to the researcher or the study but they are concerned with what is right or just in the interest of the participants in the research. The researcher designed and administered a ‘consent form’ which was signed by all participants for informed consent prior to the interview. This process guaranteed to the research participants that participation in the interview was a choice, free from any element of deceit, duress or similar unfair inducement or manipulation (May 2001; Bloor and Wood 2006). Furthermore, research participants were given the latitude to retract consent at any stage of the interview.

Data analysis
Data were analyzed using thematic analysis. The following steps were taken to analyze the data: transcripts were coded using the participants’ own words and phrases and without preconceived classification; the participants’ language or phrases were examined, categorized and recurrent themes were identified. Recurrent themes are similar and consistent ways people think about, and give accounts concerning particular issues. Examples of repetition, explanation, justification, and vernacular terms were highlighted. These were then coded with a key word or phrase that captured the essence of the content, and were taken to constitute emergent themes.

Results and discussion
In order to understand the housing problems faced by poor parents living with HIV and AIDS, it is necessary to distinguish the various types of dwellings they used, based on the assumption that the housing quality and conditions that are apparent in the housing used has an influence on their health as well as the health of their children. Kumar (2001) observed that cities in developing countries are home to a heterogeneous mix of tenures: owners, landlords, tenants and sharers. The study identified three distinct housing forms used for accommodation by PLWHAs and their children. These are sorted according to these tenure types summarized in Table 1.

<table>
<thead>
<tr>
<th>Tenure type</th>
<th>Total number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renting</td>
<td>7</td>
</tr>
<tr>
<td>Rent free</td>
<td></td>
</tr>
<tr>
<td>Family home</td>
<td>8</td>
</tr>
<tr>
<td>Partner/boyfriend’s house</td>
<td>2</td>
</tr>
<tr>
<td>Temporary housing</td>
<td>2</td>
</tr>
<tr>
<td>Owner occupation</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
</tr>
</tbody>
</table>

Source: author’s compilation
Urban shelter has become a problem in most cities in developing countries around the world although the housing problem is more visible among poor people. All people need affordable and sanitary housing (Peng, 1989; Datta and Jones, 2001).

The data reflected that poor PLWHAs and their children lived in various settings which were shared and mostly rent-free as outlined below:

i. Sharing with a partner/boyfriend: some female PLWHAs have become dependent on male partners in order to satisfy their housing need,

ii. Living in a family home - kinship relations in a context of an acute housing need and in time of illness are particularly important as they provide the social, emotional support and housing support,

iii. Living in a rent free temporary shack in other peoples’ plots: some of the poor people find it difficult to afford even the cheapest houses in the housing market therefore they resort to living in poor quality temporary shelters known as shacks.

The effect of living in poor housing on PLWHAs
Sanitary housing influences the general health to people especially for PLWHAs whose health is already vulnerable. One parent HIV positive highlighted her need for safe and sanitary housing by saying:

“...When a person is sick, housing becomes a crucial need, the patient needs a clean, spacious, private and sanitary space for themselves and the people taking care of them...Most low income people live in crowded multipurpose rooms with their families and several other households within the same crowded plots in the urban areas...Hygiene and environmental quality are usually compromised in such conditions” (Saone, aged 35).

Although poor PLWHAs are not concentrated on their own in a single geographical area, they live amongst other poor people who are not randomly distributed throughout the city. However, according to Gwebu (2003) poor people are concentrated in the most devastated neighbourhoods commonly characterized by the problems of overcrowding and congestion. These have the potential to compromise their already vulnerable health and socio-economic position. The challenges are discussed below to demonstrate their impact on the health of the poor HIV positive parents as well as the influence they pose on raising and caring for their children.

Overcrowding within a shared room
Overcrowding is associated with low space per person, high occupancy rates, cohabitation by different families and a high number of single units in one plot (UN-Habitat, 2003:11). Overcrowding has been a problem in low income neighbourhoods in Botswana as reported by Government of Botswana (2000): in 1989 there was an average of 3.34 households within SHHA plots, compared to the desired national average of 1.49 households per plot. PLWHA in this study complained about congestion caused by ‘too many people’ in their housing environments. Consequently, this high level of sharing posed a negative impact on the health of PLWHA as well as the children who share these facilities and environments with them.
There is no standard measure of overcrowding within the bedroom in Botswana; however there are many international definitions used elsewhere. The definition for overcrowding used in this study is derived from the UN-Habitat (2003: 12), which states that a maximum of two people per habitable room. A dwelling is overcrowded when there are more than two people sharing a room. Most PLWHAs shared the bedroom with several other people hence the high occupancy rate reflected in Table 2.

<table>
<thead>
<tr>
<th>Number of people sharing room including PLWA</th>
<th>Description of room occupants</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Single adult</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>A couple or single adult with one child</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>Couple with a child or single adult with two children</td>
<td>5</td>
</tr>
<tr>
<td>4+</td>
<td>Adults and children</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>26</td>
</tr>
</tbody>
</table>

Source: author’s compilation

In this study, the number of people sharing a room with PLWHAs ranged from one to nine. This problem could be attributed to the observation that HIV and AIDS increases the household size for some poor families. Some families are now caring for their own children as well as HIV and AIDS orphans in limited housing spaces, while others have to take in an HIV positive relative. For instance, a single mother and guardian to two of her late sister’s sons had this to say:

“I share the bedroom with my daughter and my late sister’s two sons and there is no privacy at all. If I had the means, I would build myself a separate room on the plot and leave the one I am using for the boys, but I don’t have the finance to do that” (Kaone. Aged 37).

The level of crowding has a direct bearing on the housing quality and the health of the occupants. According to Marsh et al (1999), overcrowding has the potential to increase vulnerability to airborne infections including some respiratory infections such as tuberculosis as well as enteric diseases such as diarrhoea, both of which are often more frequent in overcrowded houses. Tuberculosis is one of the common opportunistic diseases associated with HIV and AIDS in Botswana. In the case that PLWHAs develop any of the aforementioned opportunistic infections, the risk of transmitting the infection to other occupants sharing the room will be heightened. The spread of such diseases is further facilitated by the widespread lack of personal and environmental hygiene, which is inevitable in overcrowded room spaces. Furthermore, it is important to note that other factors such as poverty and poor nutrition faced by parents in this study could act as catalysts to the health problems.

Sharing space undermines the privacy needs of both the PLWHAs and the children as was evident in this study through all the people sharing the space complaining about
the lack of privacy in their shared space. Respondents complained that when they fall sick, their health status is likely to be known by all the people sharing the housing space. This is because the living arrangement in shared plots and house compromises private living and could contribute to PLWHAs being stigmatised by the people sharing the house and the plot.

Furthermore, some participants indicated that living in overcrowded rooms obstruct them to negotiate space for their personal activities. A 35 years old single mother who shared the bedroom with her 14 year old son said:

“The whole issue of sharing the house is a challenge to me because I need my personal space for me and my son …Sharing a bedroom with my son is another challenge mainly because of our gender difference. There isn’t much I can do about it but I feel the pressure and also see that he is feeling the pressure as well, he is a teenager now. Sharing a room with my son gets into my personal life as a young woman; I can’t invite my partner nor visit him for a sleepover because I have to be exemplary to my son…”

The narrative upholds Krieger et al (2002)’s point that overcrowding can contribute in the same way to the mental and physical health of PLWHAs consequently exacerbating the stress already caused by ill-health and poverty.

Other problems associated with overcrowding highlighted by PLWA include the emotional stress associated with living in a poor, noisy, stressful and an unpleasant setting. For instance, some of PLWA with teenage children in this study have highlighted that their teenage children resort to sleep over or even move in with their boyfriends to avoid and reduce the overcrowding. A 46 years old respondent lamented:

“My teenage daughters don’t like it here and are always away at their boyfriends’ houses. I used to be uncomfortable with it but I have since given up. There is no use on feeling stressed about it because at least they feel safe and live a better life with the boyfriends than here at home with all these many people…”

The findings of the study reflect that poor people in desperate housing situations adopt desperate measures to cope with their problems although they are aware of the long term consequences. Drimmie (2002) and Braubach and Savelsberg (2009) observed that lack of stable housing directly impacts on the ability of people living in poverty to reduce health risks; particularly the risky behaviours that make them susceptible to the infection and spread of HIV/AIDS.

**Recommendations**

There is an urgent need to recognize that housing affects the health and other social determinants of health such as poverty. It is therefore imperative to acknowledge and understand that housing is a key component of the HIV intervention plans for poor PLWHAs and their children. Housing for PLWHAs needs to be understood as a sound health care investment. The provision of housing and services must be in the forefront of the housing and social policy discussions.
If Botswana is to tackle the spread and treatment of HIV and AIDS in the society, lack of adequate housing must be addressed as a barrier to effective HIV prevention, management and care. It is crucial for departments dealing with social welfare for families and children to address the need for stable housing for poor people living with HIV and AIDS in order to effectively support HIV positive parents and their children.

The fact that housing needs are common among poor parents with young children is a good reason for child welfare experts to pay more attention to housing. Child welfare professionals should be aware of the various forms of housing assistance that might be available to these families and develop partnerships with other institutions, such as housing authorities. Partnerships with housing agencies are essential to ensuring that families have priority access to housing assistance. Access to housing allows families to be safe for children.

**Conclusion**

This paper has concluded that the lack of adequate housing must be addressed as a barrier to effective HIV prevention, management and care. Housing is not a luxury; it’s a necessity. With stable and safe housing comes better health and healthier habits, especially for people living with HIV and AIDS and their children. HIV infected parents, in particular mothers, may have unique housing needs that are related to both their physical and mental health. This suggests that there is a need to develop a deeper understanding of how HIV and housing instability are implicated within the overall parenting experience.

**References**


Social policy, and by extension social protection, is fundamentally about ensuring human well-being. The Convention on the Rights of the Child (CRC) recognises the rights of all children to social security, including social insurance and to an adequate standard of living. However, children’s rights to survival, development and health are constantly challenged by underdeveloped or underperforming social protection systems.\(^1\) Children’s physical/biological vulnerabilities, their dependence on adults for their well-being and their lack of voice requires appropriate social protection policy and programmatic responses that address the practical and strategic needs of children and the caregivers on whom they depend.\(^2\) Developing integrated social protection systems, complemented by quality social services that are child sensitive, is therefore pivotal to the realisation of children’s rights and to ensuring their well-being.\(^3\) In Botswana, a number of social protection policies and programmes exist to address the well-being of all Batswana. In order to realise the rights of all children, and in particular the most vulnerable, it is important that interventions in place are in the best interest of the child and are sensitive to the age, gender and developmental needs of children. The articles in this section of the publication address issues of children’s rights, the psychosocial well-being of grieving youth and the social protection and integration of street children.

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In the first article, Bothale discusses the challenges of securing the socio-economic rights of children in Botswana. The author contends that although several milestones have been achieved, and Botswana is signatory to various child friendly laws and conventions and has passed nationally equivalent laws, a gap exists between the intention behind these laws and realisation of the rights of children.

In the article that follows, Emmanuel et al. reflect on the importance of psychosocial support for grieving adolescents. The authors make two important observations. First, providing intense and emotionally healing therapeutic learning approaches can transform and empower adolescents in the transition into adulthood. Secondly, strategic partnerships with NGOs can help address critical gaps in the national response for children and adolescents in Botswana.

The article by Mangwegape et al. addresses an under-researched and under-supported issue in Botswana – that of social protection for children on the street. The authors document and provide lessons learned from the Hope Mission project ‘Enhancement of rehabilitation care for street children at Bokaa’ as a best practice model for the provision of institutional rehabilitative care for children on the streets. Evidence from the project suggests that the provision of quality needs-based care and services facilitate successful rehabilitation and reintegration of children back into their families and the community. Strategic partnership between NGOs, the community and the government is recommended as an important aspect of providing quality rehabilitative care and support. The authors conclude with a call for policy makers to formulate policies and guidelines that establish minimum standards of care for the rehabilitation of children on the streets in institutional care.
Introduction
This chapter discusses the realisation of children’s socio-economic rights (e.g., basic nutrition, health and education) in Botswana. It starts from the premise that children are a vulnerable group, hence, they present negative macroeconomic variables such as child poverty, child labour and child malnutrition. In recognition of their vulnerability, governments ratify children-friendly and children-protecting conventions and charters; e.g., the Convention on the Rights of the Child (CRC) and African Charter on the Rights and Welfare of the Child (ACRWC), to guarantee their socio-economic rights. Similarly, Botswana has ratified these instruments; e.g., she acceded to the CRC in 1995, and also passed the Children’s Act. However, for rights to be asserted, they must be justiciable (or enforceable), particularly, through reporting obligations as stipulated under the CRC and ACRWC. Using state reports, this chapter discusses Botswana’s compliance with the CRC and ACRWC reporting requirements and makes recommendations.

Background
Children, that is persons under the age of 18 in Botswana (Republic of Botswana [RoB], 2009), are a vulnerable group, hence, they present negative macroeconomic variables such as child poverty, child labour and child malnutrition. Therefore, they need special protection to protect, promote and fulfill their socio-economic rights (United Nations Children’s Fund [UNICEF], 2005a). Given the universality of children’s vulnerabilities, governments pass laws and sign children-friendly and children-protecting covenants and charters to guarantee their socio-economic rights. Similarly, Botswana passed the Children’s Act in 2009 (RoB, 2009) and also ratified supranational children-friendly and children-protecting covenants and charters. To illustrate, she acceded to the CRC and ACRWC in 1995 and 2001 respectively. Child protection is the portfolio responsibility of the Ministry of Local Government (MLG) under the Department of Social Services (DSS). The DSS is divided into eight divisions but for the purpose of this article, attention shall be focused on the Division of Child Protection Services (DCPS). Amongst others, the DCPS provides advocacy for Children’s Rights, Child Protection and Orphan Care (MLG, 2011). One of its chief functions is the development of policies and acts on the protection of children; e.g., the Children’s Act (ibid). Hence, it is deductible from the foregoing that the Ministry of Local Government, through the DSS and DCPS, bears the responsibility to, amongst others, protect, promote and fulfill children’s socio-economic rights. The legal instrument that enables the Ministry to execute this task is the Children’s Act.

The Children’s Act
The Act was passed in 2009 and came into effect on 19 June 2009. This is an Act to make provision for the promotion and protection of the rights of children; for the promotion of the physical, emotional, intellectual and social development and general
wellbeing of children; for the protection and care of children; for the establishment of structures that provide for the care, support, protection and rehabilitation of children; and for matters connected therewith (RoB, 2009, p.4). The Children’s Bill of Rights is provided in sections 9 through 26 and it supplements the rights that are set out in chapter II of the Constitution of Botswana. Amongst others, the Children’s Bill of Rights includes the following rights: right to life; right to a name; right to nationality; right to health; right to shelter; right to clothing; right to education; right to freedom of expression; and right to protection against harmful labour practices.

It is deducible from the foregoing that the Children’s Bill of Rights lists rights whose intention is to, amongst others, protect, promote and fulfill children’s socio-economic rights in Botswana. While this is commendable, it is possible for a country to be exceptionally tall on signing children-friendly and children-protecting covenants and charters and passing children-friendly laws but exceptionally short on delivering expected outcomes. Hence, the justiciability [realisation] of children’s socio-economic rights is paramount; otherwise, there will always be a gap between intentions and outcomes. To ensure the justiciability of children’s socio-economic rights, both the CRC and ACRWC have been domesticated into the Children’s Act.

**CRC and ACRWC**

Both the CRC (Convention on the Rights of the Child) and ACRWC (African Charter on the Rights and Welfare of the Child) are international children-friendly and children-protecting covenants and instruments. The CRC is the first legally-binding international instrument that incorporates the full range of human rights: civil, cultural, economic, political and social rights (UNICEF, 2005a). The CRC provides international norms and standards for realizing the full potential of children (UNICEF-Botswana, 2012). The CRC was adopted and opened for signature, ratification and accession through General Assembly resolution 44/25 of 20 November 1989 and, in accordance with article 49, entered into force on 2 September 1990 (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2007). However, it is notable that concerns with children’s vulnerabilities preceded the CRC; e.g., the Geneva Declaration of the Rights of the Child of 1924 and Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 (ibid). The CRC has 54 articles and two Optional Protocols and spells out basic human rights that children everywhere have; e.g., the right to survival and development; and the right to participate (UNICEF, 2005a). The CRC has 54 articles and two Optional Protocols and spells out basic human rights that children everywhere have; e.g., the right to survival and develop to the fullest; and protection from harmful influences, abuse and exploitation (UNICEF, 2005b).

The ACRWC entered into force on 29 November 1999 and it is based on the Declaration on the Rights and Welfare of the African Child that was adopted by the then Organisation of African Unity in Monrovia (Liberia) in July 1979 (Organisation of African Unity [OAU], 1990). The Declaration recognised the need to take appropriate measures to promote and protect the rights and welfare of the African Child. It is worthy of mention
that Africa is the only continent with a region-specific child rights instrument (African Committee of Experts on the Rights and Welfare of the Child [ACERWC], 2012). The ACRWC, just like the Declaration, is premised on the fact that African Children face a host of problems due to a combination of socio-economic, cultural and traditional factors, coupled with developmental circumstances, natural disasters, armed conflicts, exploitation and hunger. Largely due to physical and mental immaturity, they need special safeguards and care (ibid). The ACRWC is composed of 48 articles, including the following: obligation of State Parties (the members will action the Charter by passing and amending laws; [1] and best interests of the child [15].

To ensure the justiciability of children’s socio-economic rights, both the CRC and ACRWC have been domesticated into the Children’s Act. Thus, it is notable that Botswana acceded to the Convention on the Rights of the Child (CRC) in March 1995, with a reservation on Article 1, and acceded to the AU’s African Charter on the Rights and Welfare on the Child (ACRWC) in 2001 (UNICEF, 2011). In addition, she acceded to the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography in 2003 and also ratified the Optional Protocol to the CRC on the involvement of Children in Armed Conflict in 2004 (ibid).

In carrying out its CRC mandate, the DSS is assisted by non-state actors, particularly, UNICEF. In this respect, the UNICEF’s mission is to advocate for the protection of children’s rights, to help meet their basic needs and to expand their opportunities to reach their full potential (UNICEF, 2005a). In carrying out its job, UNICEF is guided by provisions and principles of the CRC (ibid). Currently, UNICEF-Botswana provides technical support in the form of a consultant. The officer, who is at Director-level in DSS and whose salary is paid for by UNICEF, is tasked with helping the DSS to implement the Children’s Act. In addition, UNICEF undertakes studies on children’s issues and, afterwards, presents same to law-makers in order to lobby them on children’s issues. To illustrate, in 2011, UNICEF-Botswana conducted a situation analysis of children and their families in Botswana (UNICEF, 2011). The study analysed disparities in child well-being, the causes of such disparities and the capacities required to respond and “was undertaken from the perspective of both the children themselves and of those who have duties and obligations towards them” (ibid, p.vi). In addition, it made policy recommendations to improve children’s wellbeing. The same happened on 29 March 2012 when the UNICEF Representative, Doreen Mulenga, made a presentation to parliament on the implementation of the CRC (UNICEF, 2012).

**Justiciability of children’s socio-economic rights**

It is futile to grant children’s socio-economic rights if same are not justiciable. Thus, for the children to assert their rights, it is imperative that same be justiciable. Confirmedly, Hill (1992, p. 17) holds that ‘asserting rights... depends on their being justiciable; only in this way can they be claimed to be rights and to be realisable’. Although there is controversy regarding the justiciability of socio-economic rights as to be subject to adjudication and enforcement (Addo, 1992; Hill, 1992; Pieterse, 2004), it is futile to grant rights that are not justiciable.
Justiciability comes in two variants; (i) adversarial; and (ii) inquisitorial (Addo, 1992). Under adversarial justiciability, the beneficiary of socio-economic rights must file a complaint in court alleging that his/her rights have been violated. Afterwards, the violator; e.g., the state, will be afforded an opportunity to provide a defence. In the ultimate, a determination will be made as to whether a violation occurred and remedial action will be recommended (ibid). Inquisitorial justiciability involves the institution of an enquiry mechanism and involves an examination of state reports. This is obligation-based for it involves review mechanisms such as those undertaken by independent bodies; e.g., UN Committee on Economic, Social and Cultural Rights and Human Rights Watch, when they examine state reports (Riedel, 1999). Thus, the purpose of inquisitorial justiciability is to judge the extent to which contracting parties have complied with their human rights undertakings (Addo, 1992). Hence, if they fall short of their undertakings, they are informed and remedial action is recommended. Regarding both the CRC and ACRWC, the applicable justiciability is inquisitorial. In regard to the CRC, the Committee on the Rights of the Child adopted reporting procedures in October 1994 (UN Committee on the Rights of the Child, 1994). The procedures include some of the following:

i. General guidelines for reporting.
ii. Examination of state parties’ reports.
iii. Procedures for follow-up action.
iv. Procedure in relation to overdue reports (ibid).

Similarly, article 43 of the ACRWC [Reporting Procedure] provides for inquisitorial justiciability (OAU, 1990). Thus, the article provides that state parties produce initial reports within two years of entry into force of the ACRWC and that subsequent reports are to follow every three years.

Challenges in realising children’s socio-economic rights in Botswana

It stands to common reason that the asserting of socio-economic rights necessitates their justiciability. As stated before, both the CRC (article 44) and ACRWC (article 43) have explicit reporting mechanisms and, therefore, state parties are enjoined to be in full compliance with their reporting obligations. In this regard, the all-important question is, ‘is Botswana compliant with her reporting obligations?’ To answer this question, a review of state reports to both the UN Committee on the Rights of the Child and African Committee of Experts on the Rights and Welfare of the Child is imperative. A review of these documents suggests that Botswana faces serious problems reporting to both the UN Committee on the Rights of the Child and African Committee of Experts on the Rights and Welfare of the Child. To illustrate, Botswana submitted the initial CRC report on 10 January 2003 (RoB, 2003). Since she acceded to the CRC in 1995, it meant that the initial report was supposed to be submitted in 1997. Hence, the late submission was in contravention of article 44 (1) of the CRC (for confirmation of the late reporting, see UN Committee on the Rights of the Child, 2004). In addition, when the government submitted the initial CRC report, it was advised to submit the second and third reports as a consolidated report by 15 April 2007 in order to help it catch up with its reporting obligations, therefore, be in full compliance with CRC reporting
obligations (ibid). The government did not heed the advice because the draft reports were only produced in January 2009 and have since been referred to the Attorney General’s Chambers. Relatedly, the Assistant Minister of Local Government, Maxwell Motowane, promised parliament on 29 March 2012 that all outstanding CRC reports will be submitted during the July sitting (UNICEF, 2012).

Similarly, a review of ACRWC reporting documents shows that Botswana is failing in her reporting obligations to the African Committee of Experts on the Rights and Welfare of the Child. Since she acceded to the ACRWC in 2001, she was supposed to submit the initial report in 2003. She is yet to do so because the report is still in draft form. Notably, article 43 of the ACRWC provides that within two years of the entry into force of the Charter, the government must submit the initial report and subsequent reports are to follow every three years. Thus, the government is failing in this regard.

Way forward
It is inarguable that granting children’s socio-economic rights without an inquisitorial justiciability mechanism is futile. Thus, rights must be asserted and for one to assert rights, they must lend themselves to justiciability. Under the CRC and ACRWC, the justiciability of children’s rights is provided for through reporting mechanisms as per articles 44 and 43 respectively. A document analysis shows that Botswana is in breach of her CRC and ACRWC reporting obligations, hence, immediate actions are needed.

i Culture of record-keeping; poor recording-keeping is a systemic problem as sufficiently evidenced by perennial complaints by the Auditor General, therefore, a culture of good recording-keeping is imperative. This will significantly assist with reporting obligations.

ii Children’s Programmes Officer; it is imperative that such an officer be appointed in non-Ministry of Local Government Ministries to collect data on children’s programmes and forward them to the Ministry of Local Government.

iii Children’s Act Regulations; these are needed to operationalise the Children’s Act but they are yet to be developed. Hence, swift action is needed on the same.

iv Disaggregated Budget; while the national budget is aggregated for efficiency reasons, it is important to break down Ministerial budgets to show components specifically relating to children’s programmes. Thus, this must be done under a regime of children’s budgeting (see Botlhale, 2012).

v Accounting Officer’s Accountability; that Botswana is doing very poorly regarding her reporting obligations is solely attributable to lack of decisive action by Accounting Officers (Permanent Secretaries to be specific) in both the Ministry of Local Government and other Ministries. Thus, they should be held accountable and, accordingly, sanctioned for government’s failure to comply with reporting obligations.

vi Constitutional entrenchment of children’s socio-economic rights; taking a leaf from South Africa, Namibia, Ghana and Uganda (see Mubangizi, 2006, Verma, 2005), these rights must be entrenched into the constitution to ensure maximum justiciability.
Conclusion

Botswana must be commended for ratifying children-friendly and children-protecting instruments such as the CRC and ACRWC that guarantee children’s socio-economic rights. However, for rights to be asserted, they must be justiciable, particularly, through reporting obligations. Unfortunately, Botswana is in breach of CRC and ACRWC reporting obligations, particularly, the ACRWC’s initial report is outstanding. Moving forward, there is a need to improve on reporting obligations if Botswana is to be children-friendly as she often professes.

References


A typology of the provision of psychotherapy to newly grief-stricken adolescents in Botswana

Introduction

At the end of 2011, the world celebrated the levelling of HIV prevalence and the success of treatment in containing new HIV infection (UNAIDS, 2011). The impact of the epidemic will nonetheless persist for some decades to come. Interventions that have made some significant impact on children’s lives in Botswana are seeking to sustain policy responsiveness until the epidemic is completely brought to an end. In spite of these gains a significant gap in the national response has not been adequately addressed by government and other stakeholders. That gap is the provision of psychosocial support to orphans and vulnerable children, especially newly grief-stricken adolescents (Ministry of Local Government (MLG), 2011; Emmanuel et al., 2011). Although parents now live longer as a result of universal anti-retroviral treatment in Botswana, a significant number of deaths are still attributable to AIDS.1

There are a number of factors that hinder the full realisation of the rights of children and adolescents to development, protection and participation in Botswana. The 2008 Botswana AIDS Impact Survey report reveals that as children grow older they are more likely to be orphaned. For example, only 6.7% of children aged 0–4 years were orphans in 2008, compared with 28.9% for 15–17 year olds (Central Statistics Office (CSO), 2009). This presents a significant challenge to adolescents. Overall, 111,567 (16.2%)2 of all children in Botswana are orphans. Only 28.7% of all children live with both mother and father; 39.3% live with mother only; 3.2% live with father only; and 28.8% live with non-biological parents. Nearly 40 percent of all orphans live with their grandparents. Only 31.2% of households with orphans received free external support (CSO, 2009).

By 2005, the adult population in Botswana was barely able to cope with the impact of HIV and AIDS. They resorted to denial, involution (turning away), expediency and cultural silence. Coping strategies, at the time, inflicted hidden wounds on children which were likely to cause further social unraveling as they transit into adulthood. Involution, instead of preserving the socio-cultural status quo, was harming future generations and threatening the survival of both culture and children. It therefore suggested that fresh and innovative perspectives should be introduced as the experiences of orphaned children had exposed the weaknesses and limitations of adult-coping strategies, which were self-defeating and harmful to children and adolescents (Daniel, 2005). In view of the magnitude of the problem, the absence of enhanced psychosocial skills at family/caregiver and community levels to cope with the overwhelming burden of loss left much to be desired.

This paper reflects on lessons learned in the course of the implementation of an innovative and culturally-sensitive approach aimed at improving the wellbeing of newly grief-stricken school-going adolescents aged between 12 and 17 years in Botswana.3

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1. Although death from AIDS was reported to have accounted for only 20.8% of deaths in BAIS II 2008, it is important to note also that not all cases are reported as such.

2. A higher percentage of 21.7% for children who have lost one or both parents is reported in the Botswana Family Health Survey 2007. This may be due to the methodology of the survey and the manner in which the question was asked.

3. Adolescents in Junior Secondary School mostly, with a few spillovers from out-of-school or specially referred cases.
It draws on an innovative approach that promotes equity and explores how partnerships can be optimised to accelerate implementation of innovations. These will reach most marginalised and underserved populations and improve the resilience of families and communities affected by AIDS and loss (UNICEF, 2012). The paper focuses on promoting the methodology for grief recovery and completion whereby grief-stricken adolescents ‘Let Go’ of grief and ‘Move On’. There is evidence to show that the implementation of intensive and emotionally healing therapeutic learning approaches can transform and empower adolescents in their transition to adulthood. These echoes are examined through the outcome of a partnership between the Department of Social Services in the Ministry of Local Government, Ark and Mark Trust and UNICEF in 10 districts in Botswana from 2006 to 2012.

The conceptual framework

EARTH psychotherapy for grief-stricken adolescents is the innovative work of Ark and Mark Trust. It was adopted by government for scaling up in 2006. ‘EARTH’ stands for Empathy based, Action oriented, Relationship building, Transformative and Healthy therapy. There are key elements within this initiative that determine its success as shown in Figure 1 below. A summary of the key elements is as follows:

a. Enrolment: Newly grief-stricken adolescents are mostly enrolled in collaboration with social workers who provide services at the district and community levels. A resource pool is continuously maintained through training of trainers programmes on the EARTH methodology for social workers, family, caregivers and ‘Bommabanas’ or community volunteers who follow up and follow through until grief-stricken adolescents reach the competition stage.

b. Wilderness Therapeutic Retreat: Grief-stricken adolescents are taken through a 16 day wilderness therapeutic retreat, in cohorts of 40 and in batches during school holidays. The retreat utilises therapeutic techniques that are carefully and creatively combined with western therapeutic approaches while embracing and encouraging Setswana cultural traditions of empowering adolescents for transition to adulthood. It is marked by traditional rites of affirmation of transformation and the formation of kinship bonds that help them to collectively face and overcome their challenges and to ‘Move On’.

c. Psychosocial Support and Follow up: This is provided through home visits over a period of 3 years. Families and caregivers, who have been equipped with the necessary skills, support and promote kinship group activities and participation. During this period, activities to promote active kinship participation and engagement of adolescents in crafts, creative and expressive arts and self-reflection sessions are planned and executed over a period of 12 month with community support.

d. Completion: After 3 years of follow up, graduates of the therapeutic programme are expected to recover and ‘Let Go’ of grief and ‘Move On’. Some move on to college, higher education or employment, while those who drop out of school are

4. The community volunteers are mothers called ‘Bommabanas’.
5. The 3 years cover the period during which the adolescent is in junior secondary school.
6. Specifically, grief-stricken adolescents accept the reality of loss and learn to constructively deal with the new reality.
enrolled in a 12 months skills-acquisition programme that promotes environmental conservation and generates income for themselves and their caregivers. This programme is called ‘Lentswe la Tlhogo’, and includes community reforestation, gardening and briquettes production. This has been proven to strengthen kinship bonds, the capacity to cope and resilience for positive adaptation, social cohesion, healing and empowerment. At this stage, formerly grief-stricken adolescents ‘Move On’ with their life pursuits as they transit to adulthood.

e. Advocacy and Partnerships: The beneficiary community and caregivers are the primary stakeholders in advocacy and partnership. The community is there when the newly grief-stricken adolescents are enrolled and they are there when they return after graduating from the wilderness retreat. They are a critical link in the success of this initiative. The community and caregivers would organise official reception ceremonies for the return of the adolescents as an affirmation of their commitment to ensure that these adolescents make it through to the completion phase. At these ceremonies, the community and caregivers vow to watch over the adolescents and to guide and keep them on track until they ‘Let Go’ of grief and ‘Move On’. Other stakeholders and networking partners include the public and private sectors, civil society, volunteers and development partners who provide resources and technical support at various stages of the implementation process.

Finally, monitoring and evaluation play a critical role in the success of the initiative, as shown in Figure 1. Lessons learnt at every stage are fed back to improve programme design, implementation and follow up.

**Figure 1: Conceptual framework for the transformation and empowerment of newly grief-striken adolescents in Botswana through psychotherapeutic approaches**

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Advocacy and partnerships
Beneficiary Community and Caregivers, 10 District Councils, Ministry of Local Government (Department of Social Services), UNICEF, United States Government, International Interns, Richmond Secondary School Canada, Bamangwato Concession Ltd (BCL) and Botswana-Baylor Children’s Clinical Center of Excellence.

Source: Authors 2012
Interventions

The application of the EARTH methodology was positively identified by government as an initiative that would fill a critical gap in the national response for adolescents in Botswana. This was the impetus needed by Ark and Mark Trust to commence implementation without delay. Once started, it expanded its coverage as shown in Figure 2 below.

The cooperation of the district councils, the social workers and the beneficiary communities has been very important in the ownership, implementation, and scale up this initiative. Although resources were mobilised in 2006, actual implementation started in 2007. Thereafter, the coverage increased from 1 village to 93 villages, 1 district to 10 districts, and from 21 adolescents to more than 10,000 newly grief-stricken adolescents in Botswana.

As shown in Figures 3 and 4, over, the mean age of the adolescents in the intervention is 15.7 years. Participation by boys in the programme seems to have only marginally upstaged girls’ participation. In 2011, a total of 2,742 newly grief-stricken adolescents (39.8% girls) participated in nine 16–day wilderness therapeutic retreats in 5 districts: Kgatleng, Hukuntsi, South East, Okavango and Boteti. Furthermore 888 adolescents (54.27% girls) who received therapy in previous years in 10 districts were followed up and assessed in the range of 6 months, 18 months and 3 year batches after the retreats. The wilderness therapeutic retreats over the years were conducted at the district level and were held concurrently during school holidays.

In early 2012, a National Wilderness Therapeutic Retreat Campsite was opened in Tuli Block. It has the capacity to accommodate 200 adolescents at a time. With the establishment of this permanent campsite, the challenges previously experienced with
Ark and Mark Trust is in the process of strengthening its monitoring and evaluation system. The data presented here were drawn from some sample records that disaggregated participation by age and sex between 2010 and 2011.

Data collection, documentation and reporting will be overcome as all activities will be coordinated from one site rather than several, as was the case with the districts.

Furthermore, 5,013 families and caregivers have been empowered with psychotherapeutic and psychosocial skills to provide support to the adolescents. The programme has, so far, empowered 103 government social workers with skills on EARTH methodology and provided 56 ‘Bommabanas’ or community volunteers with the relevant skills to follow up on the graduates of the programmes for 3 years. In addition to skills provision, regular refresher workshops are held with social workers, families, caregivers and ‘Bommabanas’ to obtain feedback and to affirm skills. A UNICEF supported end-of-project documentation on child and HIV-sensitive social protection.

![Figure 3: Sample data on adolescent participation in the EARTH therapy programme by age](image1)

![Figure 4: Sample data on adolescent participation in the EARTH therapy programme by sex](image2)
in the eastern and southern Africa region conducted by the Institute of Development Studies in early 2011 concluded that the programme is transformative and indicates of positive impact on adolescents in both the short and long term (Roelen et al., 2011).

**Lessons learned**

Government’s committed partnership with the Ark and Mark Trust shows recognition of the importance of the role NGOs play in addressing critical gaps in the national response for children and adolescents in Botswana. This is also confirmed in a recent study sponsored by the European Union on financial sustainability strategies and civil society organisations (EU–GoB, 2012). Although the partnerships are diverse, this innovative and transformative approach is promoting community resilience, ownership and sustainability within a public–private partnership framework. This is further strongly reinforced by the adaptation and assimilation of positive cultural practices that have strengthened community commitment towards positive transformative change in the lives of newly grief-stricken adolescents in Botswana.

**Recommendations**

It is essential to recognise the linkages and the two-directional and complementary interdependencies between NGO activities and government programmes in social work, education or health. This is important in meeting the critical needs of children where government does not have the total capacity to do so. It is an initiative that should be institutionalised through governments’ promotion of the scaling up of an enabling environment through activities such as the wilderness therapeutic retreats. In the result a narrowing of the gap caused by inequities among children and adolescents in Botswana will be achieved.

Government should motivate and ensure the sustained commitment of social workers who have been trained to implement the EARTH methodology. It was evident during the end-of-project documentation process conducted by the Institute of Development Studies in 2011 that the social workers engaged in the provision of this essential service do not have the capacity to do so. It is an initiative that should be institutionalised through governments’ promotion of the scaling up of an enabling environment through activities such as the wilderness therapeutic retreats. In the result a narrowing of the gap caused by inequities among children and adolescents in Botswana will be achieved.

The EARTH methodology approach is a budding initiative with potential for scaling up in other youth and adolescent programmes in country. The opening of a permanent national campsite for wilderness retreats provides the opportunity for government and other stakeholders to commit resources and to optimise the use of the Campsite and related services for the benefit of all children and adolescents in Botswana. Efforts are currently being directed at strengthening the programme’s monitoring and evaluation system in view of the anticipated scaling up process. The successes of this initiative need to be documented and shared so that refinement can be made and ongoing development ensured.

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Introduction
“The phenomenon of street children, an offspring of the modern urban environment, represents one of humanity’s most complex and serious challenges...” (Leroux, 1994 in Le Roux & Smith 1998 p. 683). According to the United Nations Children’s Fund (UNICEF 2011) statistics reveal an alarming increase in the number of street children in urban streets around the world, from 100 million in 1989, to around 10 billion in 2001. These alarming numbers are found both in developed and developing countries and yet few steps have been taken to address the issue. In Africa alone about 1.5 million children aged 13 – 16 years are street children. Botswana is not an exception although there are no objective estimates of street children that have been reported. However, considerable numbers of street children are seen even on a quick glance of the city or towns (Solani, D, 2002, Campbell & Ntsabane, 1995). According to the Department of Social Services (DSS, 2011), Gaborone records estimated the number of vulnerable children at about 35 647 in September 2011. These vulnerable children included street children, orphans, needy and disabled children. As a result of the outcry by the UN convention on the rights of the child which called on countries to address the issues surrounding vulnerable children, Botswana Government also challenged communities, public and private sectors, to partake in children’s issues. Various organizations attempted to respond to the government’s request by establishing rehabilitation centers targeting street children. The Bible Life Ministries as a Christian organization became one of the church organs that responded to this call by establishing a rehabilitation program for street children called Hope Mission back in 2004. So far two centers have been established in the country. One center is in Bokaa village in Kgatleng district and it accommodates boys only. The other center which is very new is in Maun, which is tailored for girls only. Since the inception of the program, not much has been documented about its effectiveness in rehabilitation and reintegration of children back into the communities. Apparently, the rehabilitation centres appear to have been established solemnly for provision of shelter for children, rather than for the valuable delivery of rehabilitative care.

In this paper, the authors provide an overview of the best practice model for the provision of rehabilitation care for institutionalized street children. The practice model was established and implemented by Family Nurse Practitioner students from the Institute of Health Sciences–Gaborone, as part of their service learning activity. The model was initiated at Hope Mission Rehabilitation in Bokaa village about 25 kilometers from Gaborone city in response to the results of the needs assessment conducted by Family Nurse Practitioner Students.

Overview of Hope Mission Rehabilitation Center
Hope Mission Rehabilitation Center was established in 2000, under the auspices of
Bible Life Ministries. The center was established to strengthen the low-income communities and families through rehabilitation, re-education and re-integration of street children in various parts of the country like Bokaa, and Maun. The main services offered in this center include accommodation, counseling, life skills, street outreach and re-schooling. The program’s strategy is to address children’s emotional, physical, and mental needs and as well as to provide them with love and spiritual revival. Children are identified through community outreach services. Some children are brought by parents for rehabilitation care, (Personal communication with Sibanda, V, October 4th, 2011).

Hope Mission is a non-profit organization which is reliant on donations from the church community, government and individuals to run the centers. As the running of the Bokaa Hope Mission center depends on donations, the center is often faced with challenges of inadequate resources in the provision of high quality, effective rehabilitation care to children. Rehabilitation of street children requires staff skilled in communication, counseling and survival skills. At the time of writing this paper, the center operated with inexperienced staff due to inadequate resources. It was operating with retired primary school teachers who were volunteers and had minimum basic skills in counseling, survival skills as well as substance abuse. In addition the center did not have adequate rehabilitation equipment for institutionalized children. The basic necessities such as clothing, nutritious meals, clothing, conducive school/learning environment or residential environment were also below standard. For example, the residential area was over-crowded, some classes were offered in the hallway or out in the open area, while the laundry and ablution area were inadequate. The accommodation area was so crowded that it posed a high risk for communicable diseases such as pulmonary tuberculosis and skin conditions (ringworms, scabies).

Despite the challenges faced by the center, it was continuing to expand to other regions of the country and continued to increase its total number of enrolment. At the time of writing this paper, the center had expanded to other regions of the country such as Gaborone, Gantsi, Palapye and Maun, and the Hope Mission in Bokaa had a population of 18 children aged between 12 years and 21 years and nine (9) staff members (2 administrators, 3 teachers, boarding master, cooks and cleaners). All the 18 children and the boarding master were accommodated in a small 2 roomed house with little or no space to move around. (Personal communication with Sibanda, V., October 4th, 2011).

The centre offered primary school education up to standard seven (7), and secondary school going children were often re-integrated into government secondary schools. It was staffed with primary school teachers who were very keen to teach but were not well equipped to deal with vulnerable children, particularly the runaway kids. Similarly, administrative staff also did not possess adequate professional skills in counseling and rehabilitative care. Furthermore, the center was not well equipped with appropriate rehabilitation equipment/resources that could be utilized by both the institutionalized children and staff. The institution used to have a social worker who volunteered her services but has since stopped assisting the center due to unexplained reasons (personal communication with Sibanda, 12th January, 2012).
Therefore, the rehabilitation process had been altered due to the absence of skilled personnel. There were no rehabilitation guidelines in place to guide staff and students. The challenges of the center were compounded by the fact that parents were reluctant to get involved in the rehabilitative care of their children. Parents were said to forfeit meetings when called to share children’s progress and thus children regressed when coming from school holidays. Behavior change amongst the children was also a challenge as the older ones constantly escaped the compound and indulge in drug and alcohol use, while some of those released to go home on school vacation often brought drugs and substances to the center when they reported back to the center.

With reference to the goals of the center and the multitudes of challenges faced by the center, there is need for a well-structured rehabilitative care if these children are to be successfully reintegrated back into their families and into the community. However, with the good part the center has done to children by getting them off the streets and keeping them in one area for rehabilitation, there is need to improve their rehabilitation center by building capacity of staff in rehabilitation approaches.

Project implementation

Overview of project implementers

This is a biennial activity during which Family Nurse Practitioner (FNP) students – from Institute of Health Sciences – Gaborone are required to engage in a graded service learning/community based education project. The project is aimed at building in the FNP students a sense of civic responsibility; promote interdependence through partnership of FNP program with the community and other relevant stakeholders. Over and above that, the project is aimed at ensuring that FNP students put into practice what they learnt in class, by engaging in project management and learning how to address the identified community needs. Students throughout the project are required to reflect on their practices and to receive feedback from experienced faculty and community agencies, which eventually contributes to improved knowledge, appreciation of nurse practitioner roles and improved project development and clinical skills. Students choose an activity from a variety of previous clinical placements such as school health, individual patient consultations, hospice care etc. This year the project was identified while students were providing primary care services to adolescent clients in Hope Mission Rehabilitation Center – Boka. During clinical attachment students identified a number of problems such as poor personal hygiene, skin conditions such ringworms, poor physical development among Hope Mission children. A SWOT analysis of the center was conducted after all the children received comprehensive medical examination and appropriate medical care. The results of SWOT analysis helped shape the initial implementation of the project.

The key strengths and weaknesses identified on SWOT analysis was that the center was well appreciated by community as some children were brought in to the center by parents; staff was highly committed in rehabilitating children. The weakness included poor infrastructure, poor funding and the use of unskilled personnel, hence the urgent need for strengthening of the rehabilitative care.
Steps in project implementation

The project was divided into four phases as guided by training package on ‘Working with Street Children – Module 10’ developed by WHO, 2000. The phases entailed:

A. Needs Assessment: Community needs were identified while students were on practicum attachment for clinical courses on primary care of children and adolescents, and sexual and reproductive health. A SWOT analysis was later conducted after permission was sort from the center manager. This was followed by the development of the project plan to address the needs identified at the center. Critical issues identified included:

i. Basic Needs/Individual Needs
   a. Delayed physical Development (delayed adolescent development stage)
   b. Poor Personal hygiene, as evidenced by skin conditions
   c. Report of inadequate and unbalanced meals in the center
   d. Insufficient basic necessities such as clothing, toiletries, blankets
   e. Overcrowding and risk for spread of communicable disease

ii. Community Needs
   a. Poor interpersonal relations/interaction among children and staff
   b. Lack of clear rehabilitation guidelines
   c. Limited rehabilitation resources
   d. The use of unskilled personnel in the provision of rehabilitative services
   e. Report of poor parental involvement in rehabilitation of children
   f. Limited access to services such as counseling services, routine medical screening services, rehabilitation care and other resources.

B. Planning and Resource Mobilization: A client centered planning and resource mobilization was instituted, during which students met regularly with hope mission staff to prioritize needs and develop a plan of activities geared towards addressing the identified needs. The resource mobilization activities included raising funds to purchase rehabilitation supplies such as books, identifying organizations or individuals who could volunteer to facilitate skill building seminar for children, their parents and Hope Mission staff, and as well as identifying individuals who could assist in the development of brochure to guide staff on how to deal with street children from the time they are institutionalized up to the day they are reintegrated into their families.

C. The third step was the implementation of key activities such as educational talks on personal hygiene, drugs and substance use, communication skills and others. During the project implementation stage, FNP students met with children to establish rapport and a trusting relationship by engaging in a non-threatening soccer game. The purpose was for children to open up and interact freely, strengthen positive reinforcement or feedback, instill discipline and teamwork. The second activity entailed another formal meeting where children received education on the effect of drug and alcohol use, good personal hygiene and how to keep their rooms, food and water clean. A team from police service (Drug and Diamond squad) delivered an educational talk on the effect of drug and alcohol use. The other encounter with children included involving children in life skill lessons in the form of soccer game and mind stimulating games (monopoly,
chess, and scrabble). The purpose of engaging in various games was to motivate children to feel more positive about themselves and for them to feel accepted and loved by the community. These activities were highly appreciated by children as indicated by one of the children in his vote of thanks speech when he pointed out that “he never thought he could play monopoly or chess as he has all along been thinking that it was meant for children from rich families”. For positive reinforcement and teamwork, a picture of children after playing soccer was taken, framed and hanged on the wall at hope mission office for the team to be appreciated by visitors. Photography and picture enlargement was a donation from Fast-net printing company. To continue promoting the suitable use of children’s free time, children were also donated books through the help of C.N.A stores to establish a library.

Lastly, Family Nurse Practitioners organized a skill building seminar for staff and parents. The purpose of the seminar was to assist Hope Mission achieve their vision of creating a brighter future for children and their families. The workshop focused mainly on steps to rehabilitating a street child; how to identify a child involved in the use of drugs and alcohol and other risky behaviors; factors contributing to streetism in children; and the role responsibilities of parents, children and staff in the rehabilitation of street children. Facilitators from various organizations dealing with vulnerable children such as Baratang Holdings were invited to facilitate the discussions. The project was furthered by the support of University of Louisville (USA), which helped with teaching on mindful listening, the use of meditation in stress management and how staff–children interaction contributed to the outcome of children’s future. Children were taught about how to manage other bullying kids, and as well as how to respond to being bullied. They were further trained on how to build their self-esteem. Moreover, brochures printed in Setswana and English, were developed for staff and children from the two workshops.

Donations of blankets, toiletries, books for the library and other mind stimulating games were given out on the last day of the project, where community members such as the chief Village Development committee members, teachers from secondary and primary schools, UNICEF, Ministry of Health were invited to grace the occasion. The purpose of inviting community members was to help them feel that they own the problem of street children as well as to raise public and political awareness about issues surrounding street children; and to make the community aware of the tremendous work of voluntary organizations in the provision of support to our needy children in the country. The purpose was also to appeal to community, individuals, and families to introspect on how much they are contributing to the welfare of children as it has already been stated by one politician when he/she appealed to the community that: “Children are not mini persons with mini rights. Our attitudes to children define who we are. A society which fails its children is a society which has failed itself” (Boer-Buquicchio, M. 2007)

D. Outcome: An informal evaluation of the project revealed that services were highly appreciated by children, Hope Mission staff, parents and community representative. Throughout the implementation of the project, children, staff and parents were interacting very well. Participants have indicated the need for similar interactive
workshops that bring children, parents and staff to one setting. Hope Mission expressed the need for the FNP students to continue with similar activities in future and also requested that they be linked with invited facilitators for future consultation and networking. There is strong evidence that a well structured rehabilitative care provided by professionals with wide range professional skills is critical if street children are to be rehabilitated and integrated into the mainstream society.

Recommendations and way forward

Street children have special needs; therefore they require facilities which are well equipped to provide services to children with special needs. Provision of high quality needs based care or services, ensures quick adjustment or recovery and ultimately a successful rehabilitation and reintegration of children back into the community. Quality rehabilitation care reduces the chance of children relapsing into their state of streetism, drug and alcohol abuse and delinquent behavior (Silva, 1999). Bible life ministries, is doing a wonderful job to provide rehabilitation for street children, however, community and government support is required to ensure that the services rendered are of high standard to improve the lives of street children. Government should support non-governmental organizations which are caring for these children to help them better their services by either providing financial support or human resources such as social workers and psychologists on regular basis

Clearly with an ever increasing number of street children whose hopes of quality lives are degraded by streetism and also engage in acts that endanger the larger society (Mufune 2000), there is need for well-coordinated and adequately resourced centers for street children to control these. Policies and monitoring mechanisms should be instituted to ensure that rehabilitation centers meet the minimum rehabilitation standard for all institutionalized children.

The involvement of parents at the rehabilitation center should be enhanced to facilitate smooth transition to their homes upon discharge from the center. It will also give caretakers the opportunity to help parents improve their parenting skills.

With issues surrounding quality rehabilitative services of street children, there is need for a well-structured rehabilitative and adequately resourced program. This could be achieved through partnerships between training institutions and community-based rehabilitation centers (WHO 1988). This arrangement will enable maximum utilization of resources available in tertiary institutions. Strengthening interdisciplinary community based training allows all training institutions to come to one sitting, identify community needs and plan for community projects as a team (Weaver 2001). For example, centers like Hope Mission rehabilitation will be more effective if they are routinely supported by disciplines such as nursing, social work, counseling and education engaged students in structured community projects. This approach also ensures sustainability, accessibility and consistency in the delivery of services to resource constrained organizations. The partnerships will also enhance the training of the professionals in the participating training institutions.

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Other contributors to the project:

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In the countdown to 2015, worldwide monitoring of progress towards achieving the MDGs and nationally equivalent goals, such as Vision 2016 in Botswana, has been a key priority. As the timelines for attaining these goals draws nearer, monitoring achievements against set goals and lessons learnt to date constitute important contributions towards the post 2015 and 2016 development agenda.

Experiences to date point to the need for enhanced complementarity between routine real-time monitoring and population based surveys. In the last 2 decades survey data has become a rich source of information for cross-sectional analysis providing valuable demographic and social data. In the national context, survey data of note that have provided valuable information on the well-being of children in Botswana include the Household Income and Expenditure Survey (HIES) now expanded to the Botswana Core Welfare Indicator Survey (BCIWS); the Labour Force survey (LFS); the Botswana AIDS Impact Surveys (BAIS); the Botswana Demographic Survey (BDS) and the Botswana Family Health Survey (BFHS).

While these household surveys offer a wealth of data, a key shortcoming is timing, in terms of their inability to provide rapid timely information where interventions are required in response to the impact of aggregate shocks on vulnerable households.1 Second, such surveys are designed to be representative at the national level and not at district level, the implications of which are that district level disparities are often masked (ibid). Finally, population based surveys often exclude or under represent very vulnerable populations. These information shortcomings have been glaringly highlighted in the context of the recent food, fuel and financial crisis (ibid).

Consequently, while cross-sectional survey data provides valuable information on the well-being of various populations such as children, taking an equity focus will require greater emphasis on real-time monitoring for the most vulnerable children. Facilitating a post 2015/2016 ‘World Fit for Children’ will require highly disaggregated data that will allow for greater focus on the most marginalised. This will require complementarity between innovative means of real-time monitoring and population based surveys.

District level monitoring in Botswana is limited, both in terms of survey and real time data to facilitate monitoring at this level. Based on existing national survey data this section of the report highlights some of the district level disparities that exist. This reanalysis is based on a secondary analysis2 of various national surveys that was undertaken in 2011. The surveys in question are:

1. the Botswana AIDS Impact Surveys (BAIS) I, II and III;3
2. the Botswana Demographic Survey (2006) and;
3. the Botswana Family Health Survey IV (2007).

The secondary analysis entailed disaggregation of the data by age, wealth deciles, gender, geographical location, orphan status and education. Last year’s publication of Thari ya Bana presented highlights of the key findings of the analysis. The findings presented here are an analysis of district level disparities regarding child survival,
Data on children: complementarity between real time data and survey data

development and protection. The various surveys discussed above are national level surveys and not district level surveys. It is therefore important to keep in mind that due to the small sample sizes at district level, the findings presented here are purely indicative of disparities that exist.

Child survival: Over the years Botswana has invested substantially in minimising child mortality from vaccine preventable diseases through its Expanded Programme on Immunization. Consequently immunization rates in Botswana are impressive with 98% of children under 5 vaccinated against BCG (Bacillus Calmette-Guérin) and 95% against Diphtheria, Pertussis and Tetanus (DPT1). In addition, there is negligible difference in the level of immunizations for different wealth deciles, orphans and between rural and urban areas. The current rate of immunization is representative of equitable delivery of these health services.

![Figure 1: Measles immunization rates by district, 2007](source: BFHS IV 2007)

Although immunization rates against measles (76% nationally) is also high, a greater proportion of children in Botswana are least likely to be immunized against measles. In addition, while immunization rates for measles at district level are still good, as can be seen in Figure 1 above, delivery in Francistown, Ngamiland and Ghanzi is some 7% less than the average rate of immunization. It is not possible to decipher the reasons for this disparity from national level data such as the BFHS IV from which this analysis is drawn. An appreciation of the cause of this disparity is only possible from district level data.

The article by Kibassa and Codjia (2012) presented in the child survival section of this publication highlights the importance of such data. The authors demonstrate how the use of real time district level monitoring can complement survey data leading towards
improvements to district level child survival interventions. For example the findings coming out of the district level monitoring carried out for Tutume and Chobe provide valuable insights on how to improve child survival in these two districts. Amongst others,⁵ based on the DIVA methodology as outlined in the article, the authors found that 89% and 94% of mothers in Chobe and Tutume respectively, did not know about the use of zinc for diarrhoea management (see Figure 2). Critical information such as this provides district health teams the evidence base with which to effect awareness creation interventions to address current information gaps regarding diarrhoea management in the two districts.

**Child development:** In 2007 at a national level some 32% of children were not living with their biological parent. This situation was more prevalent in rural areas than in urban areas. An analysis of the situation at district level indicates that the districts with the greatest proportion of children living with non-biological parents are Barolong, Ngwaketse West, Central Bobonong, Central Boteti and North East district. For all these districts, more than 40% of children lived with non-biological parents.

**Child protection:** At a national level 28% of children do not have birth certificates. Distinct urban disparities exist, with higher levels of birth registration in urban areas as compared to rural areas. Taking the analysis lower to the district level indicates that the greatest disparities are in Ngamiland North, with some 48% of children without birth certificates. Conducting district level analysis as was done in the article by Codjia and Kibassa (2012), could provide valuable insights into why this particular district has such a high percentage of unregistered births, and could allow for evidence based policy and programme responses to address the issue.
Conclusion

While national level data remains an important aspect of evidence based policy, undertaking district level surveys complemented with innovative approaches to real-time monitoring offers invaluable timely data to inform policy making and programming.

References


### Annex A: a summary of various child indicators

<table>
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<tr>
<th>Indicator</th>
<th>Baseline Year</th>
<th>Total (Baseline year)</th>
<th>Latest Year</th>
<th>Latest National average</th>
<th>Male</th>
<th>Female</th>
<th>Urban</th>
<th>Rural</th>
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### Nutrition

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