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ASSESSING IMPLEMENTATION OF BOTSWANA'S PROGRAM FOR ORPHANS AND VULNERABLE CHILDREN

SEPTEMBER 2010

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

The HIV epidemic in Botswana has caused a vast increase in the number of orphans and vulnerable children (OVC) and overstretched traditional family and community support mechanisms. In 2004, Botswana was estimated to have the highest rate of orphanhood in sub-Saharan Africa (UNAIDS et al., 2004). In 2007, there were an estimated 130,000 orphans living in Botswana, approximately 95,000 of whom were orphaned due to AIDS (UNICEF et al., 2009). Losing a parent is not the only source of vulnerability for Botswana's children. Other causes of vulnerability include living in an abusive environment, heading a household or living in a child-headed household, living with a sick parent or guardian, living with HIV, living with a disability, and living outside family care. All of these situations can make children vulnerable to abuse and exploitation, illness, withdrawal from school, and emotional distress and trauma.

In 2010, Task Order 1 of the USAID | Health Policy Initiative, in partnership with the Department of Social Services (DSS) of the Ministry of Local Government (MLG), applied the Program Implementation Barriers Analysis (PIBA) methodology in Botswana to assess policy-related barriers that affect implementation of the country's OVC program. The partners selected the OVC program as the focus of the PIBA analysis because Botswana is in the early stages of implementing two new key policies to guide and strengthen the country's OVC program: the 2008 National Guidelines on the Care of Orphans and Vulnerable Children (Government of Botswana, 2008b) and the updated Children's Act (Government of Botswana, 2009).

PIBA uses a desk review and stakeholder interviews to assess the policy environment related to program implementation by

1. Identifying the policies that govern or affect the program;
2. Ascertaining decisionmakers' support for the program and its guiding policies;
3. Assessing knowledge and utilization of relevant policies among decisionmakers and service providers; and
4. Gathering information about types of services being offered by service providers and how those services are reaching and being perceived by clients (caregivers/parents of OVC).

Following a brief desk review of existing policies, Health Policy Initiative staff surveyed respondents from three stakeholder groups: decisionmakers, program managers and service providers, and OVC caregivers/parents. Data collection took place in two regions—Gaborone and Francistown.

The PIBA findings show that Botswana, through the MLG/DSS and civil society partners, has made progress in advancing OVC programs and services. However, as with all policies and programs, there are barriers to successful implementation. The barriers identified through the PIBA process can be distilled into five key issues and addressed with related recommendations.

1. Implementing OVC programs requires building capacity, particularly for social workers who are responsible for care and support of OVC.
2. Stakeholders lack information about OVC policies, as policy dialogue and dissemination—especially at the local level—has been minimal.
3. OVC policies are not fully operationalized. The National OVC Policy is still in draft form and implementation of existing OVC policies is hampered by operational barriers that result in inefficient use of time, effort, and resources.
4. Better coordinating, referral, and monitoring structures are needed. The Children's Act mandates the creation of national-, district-, and village-level coordination structures, including a national children's council, national children's forum, and village child protection committees. These structures have yet to be established.

5. OVC programs are not completely aligned with national policies, which contain provisions for a range of programs that are often not implemented on the ground.

1. Implementing OVC programs requires building capacity

- Shift administrative/logistical tasks currently assigned to social workers to other district or community workers to enable social workers to spend more time providing care, support, and specialized OVC services (such as trauma counseling and psychosocial support).
- Train social workers and service providers on very early childcare and support.
- Train national, district, and local leaders and officials on the main content of the policies and how they can support implementation. Stakeholders should include *Dikgosi* (village/ward chiefs), magistrates, and police.
- Train community workers, police, magistrates, educators, and community leaders on child rights and protection, basic counseling, and gender-based violence (GBV).

2. Stakeholders lack information about OVC policies

- Expand dissemination of policies—especially the Children’s Act and OVC Guidelines—to the public, including national- and community-level workshops and trainings to strengthen policy implementation.
- Assist *Dikgosi* in leading community-level dissemination activities with a range of stakeholders.

3. OVC policies are not fully operationalized

- Speed up the process of finalizing the National OVC Policy, which should include
 - A clear definition of vulnerable children and strategies to ensure that the most vulnerable are addressed, including children with disabilities; and
 - A guide for what policies are no longer in effect or have been supplanted by the Children’s Act, especially in terms of how they affect OVC.
- Simplify licensing procedures for organizations providing child welfare services and explore redistribution of licensing responsibilities to expedite the process.
- Develop operational guidelines for magistrates to follow in dealing with OVC at risk of violence in the home or continued exposure to perpetrators of violence.
- Establish children’s courts and train magistrates and police on child protection issues.

4. Better coordinating, referral, and monitoring structures are needed

- Establish national- and local-level coordination structures outlined in the 2009 Children’s Act (e.g., national children’s council and village child protection committees) and designate a lead national agency to carry out the process.
- Disseminate information about the designation of District NGO Committees to oversee child protection and care at the district level.
- Improve coordination and collaboration between MLG and Ministry of Health (MOH) in planning and implementing OVC programs and services, including MOH representation on the National Children’s Council and district committees designated for child protection.
- Develop, disseminate, and implement standard OVC assessment and referral guidelines or protocols that include follow-up mechanisms.
- Create, disseminate, and regularly update district-level directories and maps of OVC providers, including the range of services offered.
- Improve linkages to specialized services.
- Assign monitoring functions to local structures, such as village child protection committees.

5. OVC programs are not completely aligned with national policies

- Ensure implementation of a family-centered approach by offering services specifically for OVC caregivers/parents, using innovative approaches like the Marang Child Care Network Trust’s Journey of Life curricula, income-generating programs, succession planning, or material support for women and their households.
- Increase community ownership through development and implementation of community-based approaches, such as awareness raising around OVC issues and available services.
- Operationalize gender mainstreaming as mandated in the National OVC Guidelines. This could include encouraging and promoting men’s involvement in caring for OVC through special community initiatives that address cultural and gender norms.
- Initiate partnership programs whereby communities work with the police and other sectors to address GBV, particularly against OVC.
- Review the nature of OVC interventions, especially those consisting of material or in kind dole-outs vis-à-vis consolidating funds into cash transfer programs that have been shown to work in less developed countries. This could include a study tour to countries that have implemented a consolidated income-transfer system, such as Tanzania.
- Adopt means testing and strategies to ensure that the most vulnerable are reached, including children with disabilities and special needs, and the very young.
- Articulate what constitutes the older OVC “graduation” program to ease transition for OVC as they approach 18, including ways to assist older OVC in tapping existing social welfare and economic programs. This could include prioritizing caregivers of OVC and “older” OVC for income-generating or vocational programs.

Identifying and understanding barriers to implementation can help the government of Botswana, in partnership with its partners and stakeholders, to develop strategies and reform policies, thus minimizing or eliminating barriers. Implementation of the PIBA methodology in Botswana was unique in its incorporation of three sets of stakeholders with different perspectives on OVC program implementation. The barriers and recommendations identified through the Botswana PIBA will be shared with a national OVC reference group, which will use them to develop a policy agenda, along with critical timelines. The reference group will share this report with other decisionmakers and implementers and advocate for implementation of the policy agenda.

ABBREVIATIONS

ART	antiretroviral therapy
BWP	Botswana Pula (local currency)
CBO	community-based organization
CSO	civil society organization
DMSAC	District Multisectoral AIDS Committee
DSS	Department of Social Services (of the Ministry of Local Government)
FBO	faith-based organization
GBV	gender-based violence
HIV	Human immunodeficiency virus
HRU	Health Research Unit (of the Ministry of Health)
IDU	injecting drug user
JLICA	Joint Learning Initiative on Children and HIV/AIDS
LTPA	Long-term Plan of Action
MCCNT	Marang Child Care Network Trust
MLG	Ministry of Local Government
MOESD	Ministry of Education and Skills Development
MOH	Ministry of Health
MOU	memorandum of understanding
NACA	National AIDS Coordinating Agency
NGO	nongovernmental organization
NSA	National Situation Analysis
OVC	orphans and vulnerable children
PEPFAR	The (U.S.) President's Emergency Plan for AIDS Relief
PIBA	Program Implementation Barriers Analysis
PLHIV	people living with HIV
PSS	psychosocial support
RG	OVC Reference Group
S&CD	Social Welfare and Community Development (of district councils)
SIAPC	Social Impact Assessment and Policy Analysis Corporation
SPSS	Statistical Program for the Social Sciences
STPA	Short-Term Plan of Action
UNAIDS	Joint United Nations Programme on HIV
UNICEF	United Nations International Children's Fund
USAID	U.S. Agency for International Development
VCT	voluntary counseling and testing
VDC	village development committee

I. INTRODUCTION

The government of Botswana has made significant strides in mitigating the impact of HIV and AIDS. In 2007, the estimated adult HIV prevalence (24%) was lower than previous years (UNAIDS, 2008). Nevertheless, more efforts are needed to address the impact of the epidemic, as an estimated 11,000 adults and children died of AIDS in Botswana in 2007 (UNAIDS, 2008). The HIV epidemic has also caused an unprecedented increase in the number of orphans and vulnerable children (OVC) (UNAIDS, 2008). In 2004, Botswana was estimated to have the highest rate of orphaning in sub-Saharan Africa (UNAIDS et al., 2004). In 2007, the National Situation Analysis on OVC in Botswana estimated the number of orphans at 137,805,¹ constituting 17.2 percent of the number of children below 18 (Government of Botswana, 2008a). Botswana's total population was 1.76 million in 2008, rising to more than 1.8 million in 2010 (Central Statistics Office, 2005).

In Botswana, an orphan is defined as any child younger than 18 years of age who has lost his/her only parent (in the case of a child of a single parent) or both parents (child of a married couple). According to this definition, there were 51,806 orphans living in Botswana in 2007 (Government of Botswana, 2008a). If the broader international definition of orphanhood is used—any child below the age of 18 who has lost one or both parents—there were an estimated 130,000 orphans living in Botswana in 2007, approximately 95,000 of whom were orphaned due to AIDS (UNICEF et al., 2009).

Botswana's 2008 National Guidelines on the Care of Orphans and Vulnerable Children (hereafter referred to as the National OVC Guidelines) define a vulnerable child as any child under the age of 18 years who lives in an abusive environment, a poverty-stricken family unable to access basic services, or a child-headed household; a child who lives with sick parents or outside family care; or who is HIV positive (Government of Botswana, 2008b). Due to challenges in creating an effective response that corresponds to this broad definition, there are no available estimates of the number of children rendered vulnerable as a result of HIV, poverty, and other causes in Botswana.

Since 2006, Task Order 1 of the USAID | Health Policy Initiative has worked closely with the Government of Botswana and USAID/Botswana to strengthen the OVC policy environment and improve access to high-quality OVC services. In 2010, the Health Policy Initiative, in partnership with the Department of Social Services (DSS) of the Ministry of Local Government (MLG), applied the Program Implementation Barriers Analysis (PIBA) tool in Botswana to assess policy-related barriers that affect implementation of the country's OVC program. The partners selected the OVC program because Botswana is in the early stages of implementing two new key policies to guide and strengthen the country's OVC program: the National Guidelines on the Care of Orphans and Vulnerable Children (2008) and the updated Children's Act (2009). This report describes the PIBA application in Botswana and shares findings and recommendations for strengthening implementation of the OVC program in relation to these policies. This analysis is intended to help inform and build consensus for ongoing efforts to draft a National OVC Policy and finalize the country's Long-term Plan of Action for Orphans and Vulnerable Children.

Program Implementation Barriers Analysis (PIBA) Methodology

The PIBA methodology was created in 2007 following an extensive literature review (Spratt, 2009). The Health Policy Initiative designed the PIBA methodology to identify barriers to implementation of a specific program within the overall HIV response. "Program" refers to the full set of policies, resources, services and activities organized to meet a social need or a country goal (Buckner et al., 1995). In 2007, PIBA was pilot-tested in three Asian countries. In China, the Health Policy Initiative applied the tool to

¹ Based on the international definition of orphans—children under age 18 who have lost one or both parents.

assess access to antiretroviral therapy (ART) by injecting drug users (IDUs). In Indonesia, PIBA was used to analyze implementation of the 100 percent condom use policy. In Vietnam, the PIBA pilot focused on reintegration of OVC placed in orphanages back into communities.

PIBA responds to the question: What are the current and prospective barriers to successful program implementation and how can they be resolved through policy action? Identifying and understanding barriers to implementation can help the government to develop strategies and reform policies to minimize or eliminate barriers. PIBA can be applied where several different policies/guidelines affect program implementation. It also may be applied to a program area where no comprehensive national policy or plan exists (e.g., the country does not have a unified OVC policy but components affecting OVC services exist in different policies). It should be noted that the PIBA approach is focused on the policy basis of programs and should not be considered an exhaustive exploration of all factors affecting program implementation. PIBA assesses the policy environment related to program implementation by

- Identifying the policies that govern or affect the program;
- Ascertaining decisionmakers' support for the program and its guiding policies;
- Assessing knowledge and utilization of relevant policies among decisionmakers and service providers; and
- Gathering information about types of services being offered by service providers and how those services are reaching and being perceived by clients (caregivers/parents of OVC).

The PIBA methodology comprises two steps:

1. A desk review and analysis of the policies and guidelines affecting the program area to identify some of the challenges that can be traced to existing national laws and guidelines or lack thereof, and
2. Interviews with three levels of key stakeholders
 - National and local decisionmakers;
 - Government and nongovernmental program managers and service providers; and
 - Intended beneficiaries.

In the Botswana PIBA application, questions focused on implementation of the national OVC program, with specific reference to the recently adopted Children's Act of 2009 and the 2008 National OVC Guidelines. As described in the methodology section, the research team tailored questions for the three stakeholder groups.

Questions for decisionmakers focused on understanding

- Their current level of knowledge about new OVC policies;
- Decisionmakers' prioritization of OVC issues in relation to other development challenges;
- What they, as decisionmakers, see as their role in implementing the new policies; and
- Their views on the current status of policy implementation.

Questions for program managers and service providers focused on ascertaining

- Their level of knowledge and understanding of OVC policies;
- What OVC services are currently being offered;
- How OVC are identified and assessed;
- What policies guide their service provision efforts;
- To what extent referrals are occurring; and
- How services are being coordinated and supervised.

Interviews with intended beneficiaries (i.e., caregivers/parents) focused on identifying the services that OVC in their care currently receive and services they receive in their roles as caregivers that enable them to improve the support they offer children in their care.

II. METHODOLOGY

The first step of the methodology, the desk review of the policies, focused on the National OVC Guidelines (Government of Botswana, 2008b) and the Children’s Act (Government of Botswana, 2009). The questions guiding this review centered on identifying and understanding which services are to be provided under each policy; who provides the specified service; who is intended to benefit; what the mandated coordination and governance structures are that support the program; and which agencies are mandated to lead policy and program development, resource mobilization, implementation, and monitoring and evaluation. For a complete set of questions that guided this review, see Annex A. In addition, the desk review was informed by information from key reference group partners.

The data collection component of the PIBA application focused on informant interviews with individuals from three key stakeholder categories: (1) national and local decisionmakers, (2) government and nongovernmental (NGO)² program managers and service providers, and (3) caregivers/parents.³ The Health Policy Initiative team adapted the pilot PIBA interview guides to address key issues related to implementation of Botswana’s OVC program. The team created three sets of interview guides (in English and then translated to Setswana) tailored to the respondent categories described above. Design of the interview guides was informed by the desk review of existing laws and policies governing and affecting implementation of the OVC program, as well as input from local partners. While PIBA was designed to elicit analysis of barriers to implementing programs, the interview questions were worded in neutral terms to allow for both positive and negative feedback from the different levels of respondents. Research review boards in Botswana and the United States approved the PIBA methodology and related interview guides (see Annexes B, C, and D for interview guides).

The assessment team submitted the Botswana application to the Health Research Unit (HRU) of the Ministry of Health (MOH) for their review and approval.⁴ At the same time, an OVC reference group (RG)⁵ was constituted and led by the Director of the DSS of the MLG. Members were drawn from national government and nongovernment agencies working in the areas of child protection, social welfare, and health. The RG was formed to provide more in-depth guidance throughout the research process, such as reviewing the interview guides, serving as interview respondents for Annex B, and reviewing the findings and final report. The RG met formally for the first time on May 4, 2010, when the proposal for the PIBA methodology was presented and discussed, along with the PIBA materials, such as the interview guides. DSS also provided additional support for PIBA, as the DSS Director issued a letter of support addressed to national and local agencies to assist the assessment team in the data collection process.

PIBA was undertaken by a team of Health Policy Initiative staff and consultants in collaboration with the MLG/DSS and the Secretariat of the Marang Child Care Network Trust (MCCNT).⁶ The team selected two main data collection regions—Gaborone and Francistown and their surrounding areas. These regions were selected because both included urban, peri-urban, and rural areas and could therefore provide broader, more diverse contexts of OVC implementation. In Gaborone and surrounding areas, the research team collected data from respondents representing the city’s wards and five other sites: Jwaneng, Kumakwane, Lobatse, Mochudi, and Mogoditshane. In Francistown and surrounding areas, the research team collected data from respondents representing eight sites: Chadibe, Maitengwe, Selepa, Shashe-

² In this report, “NGO” is used to encompass the range of nongovernmental organizations who participated in the assessment, including community-based organizations (CBOs) and faith-based organizations (FBOs).

³ The word “parents” is used throughout this paper to refer to parents of vulnerable children.

⁴ The application for PIBA was combined with that of an OVC costing analysis, which was also conducted by the Health Policy Initiative, Task Order 1. The OVC reference group also guided the OVC costing analysis research process.

⁵ This report lists the names and organizational affiliations of members of the Reference Group in the Acknowledgments.

⁶ MCCNT is a network of more than 80 NGOs, CBOs, and FBOs in Botswana that provide services to OVC.

mooke, Tonota, Tsamaya, Tshesebe, and Tutume. The team conducted the majority of interviews during May 10–21, 2010.

The Health Policy Initiative team used purposive sampling to select respondents in the first two stakeholder categories: (1) decisionmakers and (2) program managers and service providers. The team selected decisionmakers on the basis of their roles related to the OVC program. Respondents for this category included key officials from the MLG, the MOH, and the National AIDS Coordinating Agency (NACA) who play key roles in policy or program directions and budget allocations. Local decisionmakers included district councilors and village chiefs. Respondents also included heads of NGO networks and directors of development organizations who are members of other reference groups or national committees related to HIV and/or OVC.

The research team drew the sample of government program managers and service providers from staff of district councils and other local authorities in the two regions. It selected nongovernmental program managers and service providers from NGOs based in or operating in these regions. For large organizations, the research team interviewed the directors or managers, along with technical staff, including social workers and counselors. In the case of small organizations—nearly all local NGOs—either the program manager or other staff served as the key respondent. The total sample of program managers and service providers came from 15 government offices within the local authorities in Gaborone and Francistown and their surrounding areas and 21 NGOs in the same areas.

For the third stakeholder category (caregivers/parents), the research team worked with social workers to identify and invite caregivers/parents to participate in the interviews. In the rural area, the research team used social workers assigned to villages and wards to distribute information about the interviews to caregivers/parents of OVC and invite them to participate in the interviews by coming to the *kgotla* (the village center or customary court) on a certain day and time. In the urban area, social workers contacted specific caregivers/parents and asked them to participate in the interviews at local community centers. The team interviewed most caregivers/parents in the *kgotla* or community centers and a few in respondents' own homes. A total of 46 parents and caregivers participated in the survey. Table 1 presents the respondent categories, as well as the type of information collected and number of respondents in each category.

Table 1. Respondent categories, Information Collected, and Number of Respondents

Respondent Category	Information Collected	Number of Respondents
Decisionmakers <ul style="list-style-type: none"> • National, district, and local government officials, including <i>Dikgosi</i> (village/ward chiefs) • Directors/heads of NGOs who are members of <i>national</i> policymaking bodies 	<ul style="list-style-type: none"> • Priority given to OVC in comparison with other development challenges; • Perceptions regarding decisionmakers' roles in and support for OVC program and policy implementation; • Knowledge of OVC policy implementation; and • Recommendations for improvement. 	19 national and local decisionmakers from government and nongovernment agencies
Program managers and service providers <ul style="list-style-type: none"> • District Social and Community Development (S&CD) coordinators and social welfare officers • Local authority social workers and other workers • NGO/FBO/CBO coordinators and providers • Community-based workers and volunteers 	<ul style="list-style-type: none"> • Specific services provided to OVC; • Criteria used to identify OVC and assess their need for services; • Characteristics of OVC they serve; • Linkages with and referrals to health and other services; • Coordination, monitoring, and reporting structures; • Their training background; • Resources available and needed; • Policies and guidelines used in providing OVC services; • Support from community networks or groups to assist OVC; and • Recommendations for improvement. 	44 managers and staff of government and NGOs providing OVC services
Caregivers or parents of OVC under the age of 18 years	<ul style="list-style-type: none"> • Age and marital status; • Number of children cared for; • Care and support services provided to OVC; • Characteristics of children receiving OVC services; • Services received by parent/caregivers; • Treatment by others when receiving social welfare services; • Other OVC they know who are not accessing services; and • Recommendations for improvement. 	46 caregivers or parents

Data Analysis

The research team employed both quantitative and qualitative methods to analyze data from the interviews. The team began by reviewing and tallying responses. Data from program managers/service providers and caregivers/parents were encoded using Statistical Package for the Social Sciences (SPSS) data files. SPSS allows incorporation of both quantitative and qualitative information. Use of SPSS enabled the researchers to tally responses and identify which issues and barriers were commonly cited within and across stakeholder categories. While SPSS was employed for this study, other data processing software can be used, such as Excel or Atlas *Ti* (the latter for qualitative data). Due to the small number of respondents in the decisionmaker category and the high degree of variation in respondents' roles and responsibilities, the researchers tallied interview responses manually.

The team reviewed all of the interview responses and analyzed them to identify themes and issues that indicate the presence of barriers to OVC program and policy implementation. Simple frequency tables and cross-tabulations were prepared to support the descriptive analysis. For the most part, respondents did

not directly identify and name barriers as such. Instead, the research team analyzed responses and collected themes to determine broad barriers. As stated earlier, interview questions were worded in neutral terms to allow for both positive and negative feedback. Negative perceptions, concerns, or experiences were often the basis for identifying barriers. Researchers did not establish a minimum frequency to guide the identification of key issues, as this could have eliminated important sources of variability due to the small sample size. Instead, throughout the analysis, researchers noted the number and type of respondents raising specific issues and used this to draw conclusions about barriers to implementation. Due to the small sample size, researchers chose to use numbers rather than percentages when referring to specific responses.

Data Issues and Limitations

There are several methodological issues that should be taken into account when reviewing the PIBA results. First, the sample size for each respondent category was relatively small—19 decisionmakers; 44 program managers/service providers; and 46 caregivers/parents. The sample size was factored into researchers' data analysis techniques, as described above. While sample sizes for the caregiver/parent and program manager/service provider categories were relatively small, they were large enough for researchers to identify common issues and concerns within and across stakeholder categories. Sample size also had limited impact on the decisionmaker category because it reflected the purposefully selective targeting of respondents to ensure that the final sample included individuals who play a key role in decisionmaking.

Issues related to selectivity may have affected results. First, not all respondents who were contacted participated in the interview process. This self-selection affected the composition of the PIBA sample, possibly biasing the interview results. Respondents who agreed to be interviewed may be individuals who are more familiar with the OVC program or have stronger opinions about it, which would lead to underrepresentation of those who are less familiar with the program. In addition, despite multiple efforts to include others, the research team was unable to interview stakeholders such as magistrates. Therefore, the results do not include the perspectives of this key stakeholder group.

Second, choosing research sites that include Gaborone and Francistown raises concerns about whether these areas are representative of Botswana as a whole, as OVC program implementation may face difficult challenges in more rural settings. To address this concern, the research team conducted interviews with informants in rural areas of the two regions. Nevertheless, given their level of urbanization, these two areas may be more advanced in OVC program implementation than other parts of Botswana. This concern does not affect the validity of the concerns raised by respondents in Gaborone and Francistown. It should, however, be taken into consideration when applying the results of this PIBA to the broader national context.

In addition to PIBA size and selectivity, it should be noted that ethical concerns prevented the team from directly interviewing OVC. Interviewing these children and youth could have exposed them to unnecessary risks. Community members may discriminate against OVC, as they are often assumed to be HIV positive. In addition, some community members may discriminate against families supported by welfare. Also, in countries with generalized HIV epidemics (such as Botswana), orphanhood often is associated with HIV and AIDS. Thus, PIBA relied on interviewing OVC caregivers/parents about the services received by children in their care. It is possible, however, that caregivers/parents may not have accurately represented the provision of services to and the needs of the children in their care due to lack of knowledge or bias.

Another potential data limitation involves the adequacy of translation of the interview guides. An experienced translator was contracted to translate the interview guides from English to Setswana. Both

the English and Setswana guides were approved by the MOH's HRU. Nevertheless, variations in the ethnic background and native language of some respondents, particularly in rural areas, may have resulted in differing understanding of questions. Researchers noted this issue only in the interviews of caregivers/parents—all of which were conducted in Setswana. Decisionmakers, program managers, and service providers were predominately interviewed in English.

As in any survey, respondents' biases and backgrounds, as well as interviewer skills and biases, can affect results. To minimize such bias, interviewers were trained on interviewing, including recording respondents' answers verbatim and making no judgments about the veracity or pronounced bias of any statement. Interviewers also read an informed consent statement to each respondent, which guaranteed their anonymity and informed them of their rights. All respondents agreed to be interviewed after this process.

III. POLICY ENVIRONMENT

This section provides a brief history of Botswana's OVC situation and key policies developed over time to strengthen the country's OVC program. It includes an overview of key policies, the issuing authority, intended beneficiaries, responsible organizations and the roles of key providers, and referral/coordination directives.

The HIV epidemic in Botswana has had a negative impact on the welfare of children and placed enormous strain on family and community support structures. The traditional practice of informal adoption of orphans by extended family members in the event of a parent or guardian's death has been challenged by the sheer number of orphans (Government of Botswana, 2008a). Escalating socioeconomic challenges have made it more difficult for extended families to take on orphans without additional financial and social support. At the same time, according to MLG staff, as urban development has progressed, many families have migrated to urban areas and consequently transitioned into nuclear family structures.

In 1981, Botswana's Parliament adopted the Children's Act—Botswana's first policy to protect children from ill treatment, neglect, and other social vulnerabilities (Government of Botswana, 1981a). The Act mainly addressed issues of custody, care, juvenile justice, and aspects of child protection. As the country's sociopolitical challenges progressed, there was a recognized need to revise the Children's Act of 1981 to encompass a rights-based approach for children (Mokabathebe, 2010). For example, the Act stipulated fines for offenses against children, but the small prescribed amount (approximately 100 Botswana *Pula* [BWP] or US\$14) did little to act as a deterrent to the abuse and neglect of children. Implementation and enforcement of the Act was also inconsistent and few parents or guardians were brought before a court for child neglect based on the Act. The following observations were reported to the MLG's Social Welfare Division by field officers/social workers based on their experiences in implementing services for orphans and liaising with communities on the orphan crisis:

- While the Children's Act defined sexual abuse of children as a crime, according to local partners, such abuse was rarely reported because such cases were considered an embarrassment for families.
- Few strategies existed to deal with juvenile offenders, child neglect, or child abuse. Juvenile offenders were often left under the care of their parents/guardians/social workers or, in some cases, sent to prisons.
- In Tswana traditional culture, leaving a young child at home alone or in the care of another child was a common and acceptable practice. Subsequently no guardian was imprisoned. Cases of child molestation were often withdrawn or not reported as these were considered an embarrassment for families; the stakeholders also accommodated or even influenced family decisions to withdraw such cases.

In 1981, Botswana's Parliament also adopted the Destitute Policy, which established guidelines for the identification, registration, and support of orphans. The Destitute Policy outlined guidelines for the provision of social welfare (i.e., food, clothing, shelter, and uniforms) to orphans, as well as food support for households, which included orphans. Implementation of the Destitute Policy (Government of Botswana, 1981b) was placed under the MLG's Social Welfare Division, which later became the Department of Social Services in 2002.

Short-term Plan of Action

In the mid- to late-1990s, Botswana was plagued with many AIDS-related deaths. Seen as the height of the AIDS era, the number of orphans increased at this time. Health practitioners (nurses and family

welfare educators) and social workers, supported by the MOH and MLG, provided home-based care and noted the varying levels of support provided to orphans. To gain an in-depth perspective of the issues on the ground, the MOH conducted a *Rapid Assessment on the Situation of Orphans in Botswana* in 1998 (Muchiru, 1998). Findings showed that orphans experience

- Restricted access to basic needs;
- Violation of their human rights;
- Neglect or inadequate provision of care; and
- Lack of food and shelter.

The assessment showed that even though grandparents or other caregivers often were willing to care for children, they often could not afford to take on the numbers of children who needed help. While there were strong government initiatives to support people living with HIV (PLHIV), at the time, services were not always available to support orphans' basic needs. As the number of orphans continued to rise, it reinforced the need for government to focus on an emerging crisis.

The Rapid Assessment findings informed the drafting of the Short-term Plan of Action for Orphans (STPA), which was adopted by the government in 1999 (Government of Botswana, 1999). The STPA focused on strategic interventions in the areas of policy development, institutional capacity building, delivery of social welfare and other essential services for orphans, and support for community initiatives. The STPA identified food, clothing, toiletries, access to education, and protection from abuse as the priority basic needs of orphans. The STPA also led to the establishment of the Child Care Unit (now known as Child Protection Services) within DSS.

In addition to the Children's Act, the Destitute Policy, and the STPA, it was also noted that a number of other policies guided the care and response of orphans in Botswana. The STPA provided an overview of these policies, the actions they require, and the legal bodies in charge of implementing them as they stood in 1999 (see Annex E for detailed overview) (Government of Botswana, 1999).

Overall, the STPA represented a major shift in Botswana's response to the orphan crisis. An evaluation of the STPA (SIAPAC et al., 2006), commissioned by the MLG, found that the plan helped make orphans a government priority and mobilized government resources to respond to orphans' basic needs. While the STPA represented an important step forward in the country's support for OVC, the evaluation identified several implementation challenges that limited its impact, including the following:

- The STPA focused on food provision and support for basic needs (as defined above), with very little guidance or support for addressing the psychosocial needs of orphans and their families/caregivers.
- Responsibility for implementation was assigned to the MLG. Within MLG, implementation was vested on district councils. Both MLG and district councils have limited resources for social programs and were unable to provide significant funding for OVC programs.
- DSS, responsible for managing a large portfolio of social welfare programs for a variety of groups, has limited financial and human resources, thereby hampering its ability to effectively manage and coordinate the STPA.
- Human resource capacity was an important limiting factor, as few trained psychologists, counselors, or social workers were available to handle cases of child abuse, neglect, and trauma that were referred by communities.
- Quantitative information on the situation of orphans was limited. This lack of baseline data, as well as lack of monitoring and evaluation capacity, made it difficult to quantify and track need for and provision of services.
- The lack of national and operational policies was a major hindrance to implementation.

- Coordination, especially between government and nongovernmental actors, was a major challenge. While many civil society organizations (CSOs) were providing services to orphans, government collaboration with and support for non-state actors was ad hoc, leading to duplication of effort. Also, the roles of various stakeholders lacked clarity. While a referral system was established, it was not very useful, as it was not linked to the registration system.

Overall, the STPA evaluation found that, while nearly all eligible orphans were reached with food packages, services other than food support were not reaching them. The STPA evaluation made the following key recommendations:

- Conduct a national situation analysis on orphans and children made vulnerable by HIV and AIDS.
- Maintain STPA activities until a long-term plan of action is in place.
- Improve the policy environment in the following ways:
 - Develop a national OVC policy and OVC guidelines;
 - Design a monitoring and evaluation framework;
 - Update the Children’s Act; and
 - Review current policies to make provisions for children orphaned due to AIDS.
- Strengthen the relationship between government and nongovernmental actors.
- Shift from an exclusive focus on orphans to a broader OVC focus.
- Facilitate the availability of data to inform policy, planning, and program development.

Most notably, multisectoral stakeholders who attended the STPA evaluation consultative workshop agreed to adopt the broader focus of “orphans and vulnerable children” for Botswana rather than continuing to focus just on orphans.

National OVC Situation Analysis

The STPA evaluation stressed the need to collect baseline information to inform the development of national OVC policies and programs and to strengthen monitoring and evaluation. In 2007, the government conducted the *National Situation Analysis on Orphans and Vulnerable Children in Botswana* to provide some of this information. Key findings of the National Situational Analysis (NSA) include the following:

- OVC programs and services continued to be guided by the STPA in the absence of new OVC guidelines or policies.
- While the majority of OVC appeared to be happy in the households in which they were living, a quarter had unmet psychosocial needs.
- There were too few social workers, and a large proportion of their time was taken up by overseeing food basket distribution, leaving them less time to devote to supporting OVC and caregivers.
- There was a lack of coordination among various implementers and service providers.
- Caregivers often lacked counseling and parenting skills.
- There were gaps in succession planning,⁷ as OVC were not always consulted during the succession planning process and succession plans were not always followed.
- There was a limited level of public knowledge about other programs for vulnerable children and the linkages and differences between such programs and those for orphans.
- There was considerable untapped potential for NGOs, including FBOs, and CBOs, to provide services and support to OVC.

⁷ Succession planning involves a process by which parents plan for a child’s future in the event of a parent’s death. This can include appointing a legal guardian, writing wills, and creating memory books to provide children with a family history.

2008 National OVC Guidelines

One key recommendation of the STPA evaluation was to include vulnerable children in future policies and guidelines, rather than focusing only on orphans. Continuing its efforts to advance the OVC program, MLG/DSS approved the National OVC Guidelines (Government of Botswana, 2008b) in 2008 and its companion document, the National Monitoring and Evaluation Framework for OVC (Government of Botswana, 2008c). These documents helped organizations and stakeholders to develop, implement, and assess program responses to address OVC needs. The National OVC Guidelines address issues relating to vulnerable children as well as orphans. As such, the guidelines represent a shift away from previous policies (such as the STPA)—that included only orphans, not vulnerable children—and toward a more comprehensive approach to OVC. This shift, however, will not have been officially sanctioned by the government of Botswana until the National OVC Policy (currently in draft form) has been finalized and adopted by Parliament.

Definition of vulnerable child

Any child under the age of 18 years who lives in an abusive environment, a poverty-stricken family unable to access basic services, or a child-headed household; a child who lives with sick parents or outside family care; or who is HIV positive.

—National OVC Guidelines
(Government of Botswana, 2008b)

Botswana’s National OVC Guidelines emphasize five programming principles based on the recommendations set forth by UNAIDS, UNICEF, and USAID in *Children on the Brink, 2004* and the *Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF et al., 2004), including the following:

- Strengthen family capacity to care for OVC by prolonging the lives of parents and providing economic, psychosocial (PSS), and other support;
- Mobilize and support community-based responses;
- Ensure OVC access to “essential services, including education, health care, birth registration, and others”;
- Ensure that governments protect the most vulnerable children through improved policies and by channeling resources to families and communities; and
- Create a supportive environment for children and families affected by HIV through awareness raising, advocacy, and social mobilization at all levels.

The OVC Guidelines (particularly Section 11) specify the roles of key stakeholders. Under the guidelines, the MLG—through the DSS—is responsible for developing a National OVC Policy and coordinating OVC service providers. The S&CD department in district government councils is responsible for implementing OVC activities in accordance with the National OVC Policy and other legislation. Box 1 details the OVC-specific functions of these two main government agencies. The DSS maintains a coordination role, including close monitoring and supervision. The S&CD department⁸ (of district councils) identifies and assesses OVC and their needs and ensures provision of services and training and sensitization of key stakeholders.

⁸ The complete name of the Social and Community Development department of district councils is Social Welfare and Community Development. From this point on, this paper refers to it as S&CD, as it is more commonly known in Botswana.

Box I. Key Stakeholder Functions, According to the 2008 OVC Guidelines

DSS

- Maintain close monitoring and supervision to ensure the child's best interest
- Coordinate service providers to support communities to deal with OVC effectively
- Ensure that OVC activities are implemented per the Children's Act and other relevant policies
- Ensure protection of OVC property rights, per the Children's Act
- Encourage formal foster care and adoption of OVC, as stipulated in the Children's Act
- Take leadership in advocacy and public relations for OVC
- Provide legal protection for OVC
- Develop an OVC data bank
- Mainstream OVC issues at all levels
- Link groups to resource systems for support
- Prepare communities for technical interventions
- Contribute to the creation of social development policy

S&CD of local/district councils

- Identify, register, and categorize OVC
- Assess OVC
- Protect and promote OVC survival, developmental, protection, and participation rights
- Train communities on the care and protection of OVC
- Sensitize communities on OVC through guidance and counseling
- Provide food baskets to OVC and their families
- Provide minimal relief services to OVC and their community members
- Provide shelter, school uniforms, private clothing, toiletry, rental, transport fares, and other basic needs

NACA is responsible for coordinating and supervising organizations that implement HIV activities, some of which involve or provide services to OVC who are HIV positive or affected by HIV. The MOH's various child intervention programs, implemented through the Department of Public Health, are intended to benefit all children, including OVC. Several sections of guidelines note the importance of health referrals and community involvement. The assigned role for the Ministry of Education and Skills Development (MOESD) is to promote retention and reintroduction of OVC into the educational system and facilitate the development of local networks of support between schools and communities. The guidelines also note the role played by CSOs in complementing government efforts and the importance of partnerships between government and civil society.

Since approval of the guidelines, the DSS has formed and trained district NGO committees to assist in coordinating implementation of national OVC policies at the community level. The DSS signed a Memorandum of Understanding (MOU) with the MCCNT in 2008 to provide assistance to OVC service providers at the local level and improve coordination of OVC programs implemented by CSOs. MCCNT also received funding from DSS to undertake OVC activities, including capacity building of local service providers. MCCNT was originally established to support the network's member CSOs and provide high-quality services to OVC. Through the MOU, MCCNT can complement government efforts and support various CSOs in providing care and support to OVC, not just MCCNT members. In 2008, the DSS also developed a PSS Training Manual, and in 2010, User-Friendly Guidelines on Care of Orphan and Vulnerable Children. DSS, in partnership with MCCNT, have used these materials to train government and NGO providers of OVC services.

Children's Act of 2009

On June 16, 2009, Botswana's Parliament approved the Children's Act of 2009, which is now the legal framework guiding Botswana's OVC program. A significant policy update from the 1981 law, the new Children's Act includes a Bill of Child Rights that guarantees children 17 fundamental rights. The Act also includes provisions on parental duties and rights, community and government support to parents, children in need of protection, alternative care of children, foster care, and children in conflict with the law. In addition, fines stipulated in the Act include significant penalties for non-compliance, such as charges as high as BWP 50,000 (approximately US\$6,970) and/or imprisonment for offences under the Act. These penalties stand in stark contrast to those outlined in the 1981 Children's Act, which, as described above, included fines of approximately BWP 100 (approximately US\$14).

The revised Act also mandates the creation of structures to support implementation and enforcement of its provisions, including the National Children's Council; the Children's Consultative Forum; Children's Courts; Commissioners of Child Welfare; and homes, schools, and institutions for the reception of children. The Act specifies the functions and composition of each of these structures. The law also mandates that every community establish a Village Child Protection Committee to educate the community about the neglect, ill treatment, and abuse of children and monitor the welfare of children in the community. The Act does not specify which district structure will coordinate child welfare issues. It may be that existing bodies such as the District Multisectoral AIDS Committees (DMSAC) or District NGO Committees will continue to include or absorb OVC or child welfare concerns.

The composition of the National Children's Council includes the Permanent Secretaries of the MLG, the Ministry of Labor and Home Affairs, and the MOESD, as well as the Attorney General. While the Act recognizes the multisectoral nature of OVC programs and services, several sections focus on the duties and responsibilities of social workers (who are under the supervision of MLG/DSS) and the MLG, which serves as the lead Ministry in the OVC response.

Under the Act, social workers are assigned a variety of responsibilities, including supporting parents and caregivers in the community, advising *kgotla* meetings, investigating cases of abuse or neglect, investigating the conduct and home environment of children accused of crimes, appearing before children's courts, applying for and executing protection orders, and assisting in arranging alternative care for children where needed. The Act specifies fines and punitive sanctions for social workers who fail to carry out these duties properly. As social workers in Botswana provide social welfare support to all vulnerable and needy sectors of the population (not just OVC and their caregivers/parents), this raises a concern as to whether they will be able to successfully carry out the duties and responsibilities assigned to them under the Children's Act. This concern is heightened by the fact that the 2008 Situation Analysis found that there were too few social workers to carry out existing responsibilities at the time.

In summary, Botswana now has two important official documents in place—the National OVC Guidelines and the 2009 Children's Act—to guide the protection and welfare of children in general, and OVC in particular. The next section presents interview findings that provide a picture of the current state of OVC service provision and barriers to service provision and program scale-up, as the MLG begins rolling out the Guidelines and the Act. These findings can also inform current efforts to draft the OVC Long-term Plan of Action (LTPA) and finalize the draft National OVC Policy.

IV. INTERVIEW FINDINGS

Decisionmakers' Perspectives on OVC Programs

The 19 decisionmakers who were interviewed included seven directors or senior officials of national government ministries and agencies (MLG/DSS, MOH, and NACA); two heads of national NGO networks (who are also members of child welfare or HIV reference groups, policymaking, or evaluation committees); four district/city council members; and six *Dikgosi* (village/ward chiefs). All national government officials and NGO leaders were based in Gaborone. Thirteen of the decisionmakers were men and six were women.

The interview questions for decisionmakers focused on the level of priority they give to OVC compared with other development challenges; their knowledge of the new government policies affecting the care and support of OVC; their perceived roles and responsibilities regarding the new child welfare and OVC policies; and recommendations for strengthening support for the OVC program at the national, district, and local government levels and among community groups. Nearly all (14 of 19) attached high priority to Botswana's OVC problem, either on par with HIV, poverty, and/or economic problems, or second only to HIV and/or poverty.

Decisionmakers from various levels, whether national, district, or local, tended to define their roles in policy implementation as involving awareness raising and educating people and/or other key stakeholders about the new policies affecting OVC. While citing policy dissemination and education as important next steps, three high-level national government officials also emphasized their policy formulation roles and the need to engage political leaders and the bureaucracy to take difficult but potentially more sustainable OVC policy initiatives, such as means-testing and steps to reduce dependence on government benefits, as government resources are limited. The two heads of NGO networks described their implementation roles primarily in terms of educating or supporting their other nongovernmental partners. On the other hand, village leaders emphasized educating members of their communities on what services or benefits the policies provide.

National and local decisionmakers identified three main barriers to OVC program implementation:

1. Limited knowledge and understanding of policies at the local level
2. Lack of consultation with local authorities regarding policymaking and implementation
3. Limited resources and inefficiencies in resource use

Limited knowledge and understanding of policies⁹ at the local level

When asked about their knowledge of new policies on children's rights and OVC care and support, 15 decisionmakers immediately named the Children's Act of 2009. Five of these were decisionmakers from national government agencies and nongovernment networks who also described themselves as very familiar with both the Children's Act and the National OVC guidelines, as they were involved in policy development or consultations regarding the two policies.

In contrast, there were noticeable gaps in knowledge of the new policies among district and local officials. Although they had heard of the Act, district or city officials admitted little knowledge about the two new policies. All six village decisionmakers reported that they had heard only of the Children's Act or knew some of its directives but they had not seen the law. A local chief of a rural area stated, "I do not know much except that I always hear on the radio and newspapers about the new Children's Act. I have not seen it."

⁹ Policies refer specifically to the Children's Act and the National OVC Guidelines.

The knowledge gap at the local level is even more pronounced when the OVC Guidelines are considered. No local official cited the Guidelines; one chief said he has never really heard of them. The only respondents who mentioned the OVC Guidelines were district/city S&CD staff, which is to be expected, as they are the main counterparts of DSS at the district level. As such, they are more likely to have received copies or some information about the Guidelines.

Decisionmakers, especially at the district and local levels, cited lack of adequate training and dissemination of the new policies as the main reasons for limited local knowledge about the policies or their non-implementation. A head of S&CD expressed concern about the lack of training in using the OVC Guidelines: "...It has been in place for some time...copies were sent to the councils—there was no consultation, without dissemination and explanation.... Guidelines provide more information, like definitions of vulnerable children... not guiding services for vulnerable children with new guidelines."

"The Act is being implemented but needs to be disseminated. Concentration has been on social workers and maybe the police—I feel we need to expand dissemination. It's very critical that health workers understand these. This will strengthen their advocacy role."

—Female, government ministry

"Development of guidelines, policies, and Act and just sending to people—it doesn't work much. Dialogue so they can ask questions, even challenge, and internalize it.

—Female, government ministry

"The government dispenses documents and doesn't follow up. The guidelines have been there for a while. They get documents and don't read (them)... Social workers and health workers don't know what it (the Children's Act and the Guidelines) is or at least the Children's Act. If they have to go to court, they will have read it, but others...I wouldn't be surprised if they are still using the old one. They are relying on DSS. Social workers don't have it and they don't care."

—Female, director of OVC organization

Comparable sentiments about the lack of orientation or training on the new policies emerged from three other district councilors who were interviewed. A new city councilor stated that "...nobody bothers to take us through (the new government policies focusing on children)..." All six village decisionmakers also mentioned a lack of dissemination and dialogue about the new policies. A rural *Kgosi* emphasized that: "*Dikgosi* are the ones implementing but *Dikgosi* can only implement if given first priority to be taught about it."

On the other hand, district and local decisionmakers either think the two policies are not being implemented or do not know of either policy's implementation status. Two councilors candidly admitted that they need to go out and learn more about what is going on regarding OVC services.

Lack of consultation with local authorities regarding policymaking and implementation

All six village chiefs who were interviewed emphasized the failure of policymakers to include them in dialogue during OVC policy development. A *Kgosi* opined that "Policymaking should not be driven by people at the top. It should be based on what people at the community want and believe." Furthermore, three national government and two district officials also cited a lack of wide consultation in OVC policy development.

Some of the *Dikgosi* also expressed concerns about the government's and NGO providers' limited efforts to consult them regarding policy and program implementation. As one *Kgosi* mentioned, only social workers or NGOs are involved in training to implement various development programs, yet the *Kgosi* is expected to be the leader of local development efforts.

Limited resources and inefficiencies in resource use

All nine decisionmakers from national government agencies and lead NGO networks variously expressed concern about the limited OVC resources. These respondents cited government-wide budget cuts and competing priorities; a high demand for OVC services, especially food baskets; limited numbers of social workers; and the challenge of reaching intended beneficiaries in rural and remote areas. Some of the high-level national officials stressed the need to assess OVC program-related costs, especially for food baskets, vis-à-vis effectiveness and efficiency. Some also suggested introducing means testing to prioritize recipients on the basis of need.

While national government decisionmakers expressed concern about financial resources and competing priorities, district and local authorities raised the issue of inefficiencies in provision of benefits. In their roles, district and local officials are in a position to directly observe or receive feedback on how resources, such as food baskets, are being used. Three *Dikgosi* raised the problem of abuse of the food baskets, reporting that caregivers sometimes focus on getting the food baskets to sell their contents, or older children themselves sell the baskets. One *Kgosi* mentioned that some accredited suppliers have included fewer or poor-quality items in the baskets.

When discussing resources, the two heads of national NGO networks discussed competing priorities that the government faces when making budget decisions and when examining inefficiencies in the use of government resources. A female head of a large NGO network said: “Government is spending money (but) children’s lives aren’t changing ... need to deal with caregivers (who) abuse resources. Need community mobilization with caregivers. Orphans should be means-tested. Government needs to talk about resources ... (who is benefiting). People who benefit are the suppliers ... they will tender this year (but) not provide to beneficiaries ... need monitoring.” A male decisionmaker representing another large NGO network expressed a similar concern, citing inefficiencies at the local level. He raised the problem of district council politicians’ use of resources that should be better used to benefit OVC.

Decisionmakers’ recommendations to address barriers

Interviewers asked decisionmakers for suggestions on how to improve OVC program implementation. Respondents advanced the following recommendations:

- National government officials should call for multisectoral dialogues at different levels so that all sectors understand their roles in the OVC program under the 2009 Children’s Act and the National OVC Guidelines. National officials should attend the dialogues at the district and village levels for mutual consultation, feedback, and learning.
- Officials should make the planning and policy development processes more participatory. This was recommended not just for new OVC policies but for the policymaking process in general.
- The government should ensure that national officers travel to the countryside to hear and see the implementation of the law, identify challenges, and develop recommendations for action.
- Officials need to assess the cost-effectiveness and efficiency of OVC interventions and implement means testing as a basis for service provision.

Program Managers and Service Providers’ Perspectives on OVC Programs

The PIBA team interviewed 44 respondents from 15 government agencies and 22 NGOs providing OVC services (11 males and 33 females). The sample included 13 social workers or social welfare officers; 11 work for city/district councils but many are assigned to specific wards or villages. The remaining two work for NGOs. Annex F provides an organizational profile of NGOs that participated in the interviews in the research regions. Many of the NGOs are small, usually consisting only of the head of the organization and two or three other workers and/or volunteers.

Current state of OVC service provision

To gain a better understanding of the range of services currently offered to OVC and their caregivers/parents, this PIBA included specific questions on service provision for program manager and service provider respondents. This subsection provides an overview of the responses given by OVC program managers and service providers, including the type of services being offered and accessed, taking into account referrals and coordination among services.

Types of services provided to OVC. According to these program managers and service providers, their organizations provide a range of care and support services for OVC in Botswana. Table 2 shows the types of services offered by respondents' organizations. The data have been disaggregated to show services provided by 15 district/local government agencies and 22 NGOs.

The most common services offered by organizations providing care and support to OVC include psychosocial counseling, educational support, and material support (see Table 2). With psychosocial support cited as a service offered by most organizations, it is not surprising that individuals surveyed include psychosocial training as one of the most important elements for training people who care for OVC. Similarly, respondents included the psychosocial element as one of the most challenging aspects of working with OVC.

All three services—psychosocial counseling, educational support, and material support for personal care—were ranked similarly as the most common offered by government providers. While many NGOs reported providing PSS; education assistance; and material support (including clothing, shoes, personal hygiene products, and blankets), the numbers of NGOs providing youth/sports club development, health-related assistance, and food support also were substantial. The large numbers of NGOs providing additional OVC services likely resulted from NGOs often having external funding. Also, the DSS and S&CD departments had responded to the STPA evaluation, which recommended that government departments mobilize and train NGOs and community organizations in OVC service provision, including counseling.

While provision of food baskets is a major government intervention, 12 NGOs in the sample also offer feeding programs while children are at their centers. They described these programs as different from the government food baskets. As one female center manager said, “Children are fed only at the center. During weekends and out of school, children starve.” This respondent did not say if this is due to neglect or poverty, but information gathered from other respondents indicates that it could be both.

Least commonly offered services include institutional care, temporary housing/foster care, and assistance in obtaining birth certificates. Since Botswana's OVC response has focused on supporting local and community-based programs, it is logical that few organizations offer institutional care for OVC. Nevertheless, some OVC program managers and social workers felt that there should be an increased investment in children's institutions, villages, or temporary housing for foster care, while three others expressed the opposing opinion that communities and relatives should take care of OVC.

Table 2. Types of Services Provided to OVC, by Type of Organization

Service Provided	Number of Organizations (n=37)	Number of District/local Government Agencies (n=15)	Number of NGOs (n=22)
Institutional care	4	1	3
Temporary housing/foster care	8	5	3
Obtain birth certificates/assist caregiver/parent in obtaining certificates ¹⁰	12	7	5
Daycare/nursery	14	2	12
Vocational training/income-generating activities	16	6	10
Access to legal protection	19	9	10
Register orphans/assist caregivers/parents in registering orphans ¹¹	20	9	11
Provision of food basket/feeding services	22	10	12
Health-related services	24	9	15
Youth clubs/ sports	25	7	18
Material support/personal care	26	15	11
Educational support	27	12	15
Psychosocial support/counseling	30	12	18

Identifying OVC, referring, and assessing need for services. According to service providers, organizations identify OVC either through assessments made by social workers, counselors, or the organizations or workers themselves, or through referrals by other workers. A range of stakeholders provide identification, referrals, and initial needs assessments, including social workers, S&CD, school counselors, health workers, *Dikgosi*, and village development committees (VDCs). In a few instances, magistrates or police officials fill these roles. Nearly 30 service providers cited assessments that largely take the form of the organization’s specific assessment format—some include home visits and others require documentation, such as parents’ death certificates.

A range of people—including caregivers/parents, social workers, and guidance counselors—also help determine what services or assistance OVC need based on the child’s background; education; or socioeconomic, health, or behavioral characteristics. These program managers and service providers make assessments based on specific tools, intake forms, and observations by social workers under S&CD and the DSS. This is in line with the OVC guidelines, which require the S&CD to be primarily in charge of assessing OVC. S&CD departments often work with schools, counselors, other government workers, and NGOs to assess a child’s needs.

¹⁰ Other than the OVC’s parents or legal guardians, only social workers can legally obtain birth certificates for OVC. NGOs assist in these efforts by accompanying or referring caregivers/parents to social workers; providing transport; photocopying support; or helping caregivers/parents to obtain supporting documents.

¹¹ One of the main tasks of government social workers is to register orphans so they can receive government-subsidized benefits such as food or education support. NGOs provide assistance by referring or counseling caregivers/parents to register an orphan with social workers.

Some S&CD officers and social workers referred to an assessment tool they use, which serves as a basis for preparing the OVC’s confidential case file that is maintained by the social worker in charge. Based on these assessments, social workers prepare social inquiry reports to assist government agencies/officials (e.g., magistrates) and NGOs in providing services to OVC. One respondent noted the importance of such assessments, saying that “not all OVC need the same care and support.”

Service providers’ descriptions of the type of children with whom they work demonstrated the range of OVC needs, especially based on key characteristics, like health status, parent status, and socioeconomic background. Box 2 provides a compilation of words service providers use to describe children who access their services. This list paints a picture of the multitude of issues that can surface during OVC needs assessments.

Types of services provided to caregivers/parents.

Of the 37 government and nongovernment agencies providing services to OVC, 22 also provide services to the caregivers/parents of OVC (see Table 3). The most common services provided to caregivers and parents are psychosocial support and facilitating dialogue between caregivers/parents and OVC on issues such as HIV status and treatment adherence, educational matters, and disabilities.¹² These findings reflect DSS and NGO partners’ efforts to incorporate psychosocial counseling into various training programs for OVC service providers. While the number of organizations providing direct services to caregivers/parents of OVC is not as large as those providing support to OVC, these services reflect Botswana’s multisectoral efforts to move toward a more family-focused approach in OVC service provision.

Box 2. Who Is Being Served?

Children’s Profile According to Service Providers

- Boys and girls
- Children and youth up to age 18
- Abandoned children
- Orphans
- HIV-positive children/youth, some on ART
- Abused—physically, emotionally, sexually
- Malnourished
- Disabled
- Mentally ill
- Poorly educated
- Poor (have no school uniforms and lack food at home)
- From female-headed households
- From child-headed households
- Lack transportation
- Poor shelter

Nearly equal numbers of government and NGOs provide home-based care and vocational training. On the other hand, succession planning is the least common service offered to caregivers/parents. Such assistance, though limited, tends to be provided by workers of government agencies rather than NGOs. There are more NGOs, however, that assist support groups for caregivers and parents.

¹² Only in sites specific to children with disabilities.

Table 3. Number of Organizations Providing Services to Caregivers/parents of OVC, by Type of Service

Service Provided	Number of Organizations Providing Services to Caregivers/parents (n=37)	Number of District/local Government Agencies Providing Services to Caregivers/parents (n=15)	Number of NGOs Providing Services to Caregivers/parents (n=21)
Succession planning/wills	6	4	2
Support groups	11	3	8
Vocational opportunities/ income-generating activities	13	6	7
Home-based care	15	7	8
Facilitated dialogue between OVC and caregivers	18	8	10
Psychosocial support/ counseling	22	10	12

Program implementation barriers

Questions asked of program managers and service providers included criteria for identifying OVC and assessing their need for services, the characteristics of OVC they serve, linkages with and referrals to health and other social services, coordination and monitoring/reporting structures, training background, resources available and needed, policies and guidelines used in providing services, and support from community groups to assist OVC.

The interviews with program managers and service providers revealed nine key barriers:

1. Lack of clear criteria for identifying vulnerable children
2. Inadequate referral systems for OVC services
3. Lack of graduation programs for OVC and their families
4. Inadequate policy understanding, dissemination, and training
5. Lack of community awareness and ownership
6. OVC programs remain child focused
7. Limited resources for social workers to meet demand for services
8. Lack of clarity about licensing guidelines and cumbersome licensing processes
9. Weak coordination and monitoring/evaluation structures

Lack of clear criteria for identifying vulnerable children. The lack of clear criteria and a standardized method for identifying vulnerable children is a key barrier to OVC services. Program managers and coordinators of national/local organizations for children with special needs and disabilities raised questions about the definition of vulnerable children and whether disabled children are currently classified as vulnerable. The same point is raised regarding how to deal with children who have been sexually abused.

“The issue of abuse...some are culturally based; still a secret, very hard to penetrate. They can’t reveal they’ve been impregnated by an uncle. If charges of defilement are reported, the caregiver drops it. Our policies contradict each other. We don’t know which policy to use [in case of defilement].”

–Female social worker

Inadequate referral systems for OVC services. OVC needs are by nature multisectoral, encompassing sectors such as education, health, legal, and social (such as psychosocial support). Few service providers can offer services that meet all of these needs. Therefore, it is important to have strong referral systems in place to ensure that OVC can access needed services. Healthcare was the most common referral (30 of 44 respondents), since few service providers offer direct health services such as pediatric HIV testing and ART. Other referrals for OVC included services such as PSS, education, legal protection, shelter, or rehabilitation support. When providing referrals, 17 of the 44 respondents said they rely on their own observations and judgments. One social welfare officer explained: “[I will refer] If the child is not well or looks not well but caregiver is not taking the child to the health center.” In addition, 10 respondents take into account their organization’s capacity to deal with the problem and the availability of services elsewhere.

Several NGO program managers and service providers expressed concerns about the lack of clear and functional referral mechanisms and systems. Specific concerns included the limited number of social workers and resulting delays in responding to requests for assessments, referrals, or follow-up and the lack of clear guidance on roles and responsibilities related to service referrals (i.e., who can confirm that a child is eligible for food support, who can refer, who is responsible for follow-up, who coordinates to ensure that OVC receive comprehensive and continuous care and support, etc.).

“DSS and S&CD delay to act on referral cases.”
–Female coordinator, rural FBO

“Change the referral system because social workers have a lot to do. They often attend cases late.”
–Female NGO worker

“Follow-up visits are made by the coordinator or teachers since social workers complain of their workload.”
–Male coordinator, city-based NGO

Lack of graduation programs for OVC and their families. Some NGO program managers and service providers pointed to the need for well-funded and coordinated “graduation” efforts for OVC as they approach age 18, citing needs such as vocational training, life skills education, job internships with private companies, and PSS. Respondents cited the pressure for older children to adapt to more mature roles and become more able to fend for themselves, even with limited or no support from relatives who are also poor. One male OVC program manager from a small NGO said that most OVC drop out of school, and that the government should recognize this, exempt OVC from restrictions on re-enrollment, and pay for their education to give them a second chance to obtain needed skills.

Inadequate policy understanding, dissemination, and training. The majority of program managers and service providers cited limited dissemination of new policies and lack of training as major challenges to OVC service provision. Respondents pointed out that it is not enough to approve, publish, and distribute new policies. Policymakers and program managers need to discuss and train service providers and other stakeholders—down to the community level—on how to apply these policies. They noted that OVC service needs are multisectoral in nature and there is a need to target a range of sectors, including the police, the courts, *Dikgosi*, health workers, and local government officials in dissemination and training.

“Police need to learn to respond to rape cases... Social workers need training to do the right job and not the food basket job... Social workers, police, and clinics need to understand their roles.”
–Female head of an OVC organization

When asked what policies they currently use in providing OVC care and support services, program managers and service providers often cited several. The wide array of policies that OVC workers have to draw upon reflects the different types of children that providers support and the different policies that they

This includes OVC who are still in school, which can make it difficult for them to continue if they are accustomed to tuition or transport assistance.

Lack of community awareness and ownership. Despite the fact that the new policies and guidelines call for a community-driven approach to OVC care and support, interview responses pointed to the lack of community awareness and ownership of programs and services for these children and youth. Almost half of all the program managers and service providers pointed to the absence of efforts to conduct community education and mobilization campaigns.

Some respondents also noted the need to raise community awareness of available OVC services. A social worker from a rural area suggested that there should be an “open day” for the community to find out the different services that organizations offer. A female supervisor of an OVC center cited the need to foster a sense of community ownership: “We have to sensitize community because at some times they think [the OVC center] is the [OVC’s] own thing—they need to know it’s their thing... they only care if they benefit something.”

While several program managers and providers cited their lack of financial or human resources to address the varied needs of OVC, they also mentioned receiving limited support from the community. Areas where support was needed included community-driven efforts to counter stigma, identifying deserted or abused children, or disseminating information or other campaigns to encourage participation in various development programs that require people’s time or attention.

Program managers and service providers, specifically social workers, said that communities can do more to help care for OVC, such as assisting child-headed households. They suggested that structures such as VDCs can make additional efforts to identify people who may need assistance and facilitate access to OVC services.

OVC programs remain child focused. As previously described, Botswana’s OVC program remains child focused, and despite some PSS, there is a lack of care and support services for OVC caregivers/parents. As the data in Table 3 indicated, home-based care for HIV-positive caregivers/parents is provided by less than half of OVC service delivery organizations. Thirteen of 37 organizations in the sample provide vocational training and income-generating opportunities for caregivers/parents. Some program managers and service providers explained that caregivers/parents are given food or material support (e.g., blankets) if they qualify as destitute. Some of the service providers had never thought of supporting caregivers/parents. A female worker at an OVC care institution said, “We didn’t know that was done.” Other providers had offered such services but had to stop due to a lack of funding. More than half of the respondents expressed a desire to provide services for caregivers but need funding to do so. Some even had specific plans, such as awareness-raising workshops, but have not been able to hold them.

Limited ability of social workers to meet demand for services. One of the main barriers to effective implementation of Botswana’s OVC program is limited resources (time, skills, transport, etc.) for social workers to meet the high demand for their services. This is due to a high ratio of clients to social workers; their lack of specialized skills; and the numerous responsibilities assigned to social workers, including administrative duties.

During various segments of their interviews, the majority of respondents said that the number of social workers is not sufficient to respond to the large numbers of beneficiaries they need to serve. This point was especially raised by providers assigned to rural areas or working in villages. An S&CD program manager stated that one social worker usually takes care of three villages, whereas a social worker in a village under the program manager’s jurisdiction stated that she attends to as many as 5 villages due to the high demand for different types of social welfare services.

In addition, social workers are responsible for a broad spectrum of social welfare services, such as eldercare, assistance to the handicapped, support for destitute families, support for victims of domestic violence, assisting juvenile delinquents, providing substance abuse interventions, and other family-related services. In part due to the broad nature of their responsibilities, the majority of social workers admitted to not having the time or the specialized training and skills needed to attend to OVC-related issues. For example, they are not always equipped to deal with more intensive PSS, such as cases of children who are victims of rape or are dealing with the deaths of parents and their own HIV status.

Social workers' responsibilities also include community development and administration, including food basket management. During the PIBA interviews, some social workers said they have had to deliver food baskets to the homes of OVC because caregivers/parents were too sick or unable to travel to pick them up and limited resources precluded other forms of delivery.

Lack of clarity about licensing guidelines and cumbersome licensing processes. Some NGO respondents identified several challenges related to licensing guidelines and procedures that affect their ability to provide OVC services. The Children's Act states that any organization working with children needs a license to do so. Organizations must meet a certain set of criteria to qualify for the license. Respondents expressed confusion about the content of licensing guidelines and concerns about the lengthy and cumbersome nature of the licensing process.

Some OVC institution managers expressed concern about the contents of the licensing guidelines, pointing out that the requirements did not necessarily align with the realities of service provision—specifically the requirement for each institution to have a “sick room” and a fire extinguisher in each room. In addition, some CBOs are so small that they do not have a separate room for counseling children privately. Other program managers complained about needing to return to the S&CD several times to resubmit applications because various other documents were requested by the government office. Still others reported that the processing of licenses were delayed because no social workers were available to inspect their NGO centers, as social workers were busy attending to the beneficiaries they serve, conducting assessments, managing food baskets, or attending to other administrative duties. These managers emphasized that OVC are ultimately the ones being negatively affected by such administrative delays.

“OVC services need to be supported; the right people should be placed in these centers like trained and qualified social workers and psychologists.”

—Female director of OVC organization

“We need more social workers targeted at dealing with challenges of OVC.”

—Male OVC center worker

“...counseling—they've gone through trauma; they present with behavior we don't understand. We struggle to find time to counsel. Here, social workers are administrative, so they don't receive counseling a lot but we know they need it.”

—Female worker, OVC care institution

“The staff need to be more specialized. Everyone does general social work. We need a child psychologist.”

—District social welfare officer

“They refer to us rather than us referring to them, which is a problem (in the case of rape, referring to S&CD).”

—Female head of OVC organization

“Making NGOs aware of DSS policies—they change so much. When we became registered, we were guinea pigs. They didn't know how to deal with us because we aren't daycare.”

—Female head of OVC organization

“Develop clear guidelines for licensing. Even if already registered, (our NGO) still needs to be licensed. We didn't know that.”

—Male director of OVC organization

Weak coordination and monitoring and evaluation structures. Interviewers asked program managers and workers several questions related to coordination. The diversity of responses to these questions indicates the absence of clearly defined coordination and information-sharing systems.

When asked how program managers and service providers inform each other of their activities, respondents cited a variety of mechanisms for sharing information: 11 respondents referred to meetings of the DMSAC, which coordinates all HIV activities, and 13 mentioned government multisectoral committees. Other cited mechanisms for sharing information included district/city council NGO meetings, *kgotla* meetings or community events, multisectoral child welfare committees, and ward extension teams. Some respondents stated that they rely on workshops to inform them of others' activities (7), call meetings themselves to keep abreast of what others are doing (6), or reach out in an ad hoc manner to other providers (5).

At the local level, there is a lack of clarity about coordination mechanisms and reporting structures for OVC programs. This includes mechanisms and structures for overseeing OVC activities to maximize resources, reach more children, and avoid duplication of efforts or unnecessary competition. This lack of clarity affects government workers as well as NGOs. Some respondents mentioned the DSS in this regard, and 10 others named existing district government structures, including S&CD, DMSACs, child welfare committees, and NGO forums. Village structures were cited by seven respondents as lacking coordination mechanisms; these included the VDC, village/ward extension teams, and the *Dikgosi*. Five service providers (two from government agencies and three from NGOs/FBOs) responded that only NGO/FBO coordination structures exist. A local NGO program manager stated that "... (We are) trying to work hand in hand with *kgotla*, but generally work independently." Four respondents said that they do not know what coordination structures exist and three respondents (a government service provider and two NGO workers) stated that "No coordination structures exist."

Similar responses elicited by the question on what monitoring and reporting structures exist at the local or district level to track progress and achievements of the OVC program also reveal the absence of a clear or functioning system. Despite approval of the OVC Monitoring and Evaluation Framework in 2008 along with the 2008 Guidelines, providers in the districts containing Botswana's two largest urban areas still are unclear on what and to whom they should report. As a local councilor stated, "Monitoring and evaluation is a problem." A government worker said that "There needs to be a body to report to at the local level... someone to report to at the district level."

Caregivers/parents' Perspectives on OVC Programs

The research team interviewed 46 caregivers/parents of OVC overall—two male and 44 female. Of the 46 individuals in the sample, 17 were taking care of orphans only, four housed only vulnerable children, and the rest housed a mix of both orphans and vulnerable children. Of the two male caregivers, one was single and one married; one was over 60 years old and the other was around 50. Of the 44 female caregivers/parents, 12 were less than 40 years of age, 22 were 40–59 years old, and 10 were 60 years old and over. In terms of marital status, 26 women were single, nine were currently married, and eight were widowed. More demographics are presented here than for the other respondent categories to illustrate the personal and social circumstances faced by caregivers/parents, which can affect their ability to access OVC services. Overall, a relatively large portion of the burden of care for OVC falls on women, especially single women (see Box 3).

Box 3. Who Takes Care of OVC?

Parents/caregiver Profile from Interview Respondents

- Female
- Ages 40–60
- Most are single
- Caring for an average of about 3–4 children (including their own)
- Unemployed
- Receive no services in role as caregiver

not being a tangible service, it may be that the service or the child’s emotional or psychosocial needs still are not fully appreciated by caregivers/parents. It is also likely that OVC receive PSS outside of the home, from guidance counselors at school or during clinic visits.

Some of the dissatisfaction or concerns mentioned by caregivers/parents focused on adequacy of the benefits, especially the food baskets. Eight caregivers/parents noted that in terms of clothing, the government only provides school uniforms. These respondents said they cannot afford to buy other, “private” clothes for the children they care for. Another respondent referred to delays in receiving clothing, saying “I am not working, so it becomes a challenge to me if the government delays buying clothes to these children because I have no money to buy for them.” Six caregivers or parents expressed concern about educational support. One respondent said that there is a long process for obtaining support for school fees. Five respondents said that there are extra charges or expenses associated with attending school that are not provided, which makes it difficult for caregivers/parents to take care of the OVC. This can include transportation, school trips, and payments to the parents and teachers association.

However, many of the caregivers/parents expressed their thanks to the government for their assistance in caring for OVC. These respondents said that without the food basket and other support from the government, they would be in very bad circumstances because they have no other means of support. They were very grateful and did not express much negativity about the services offered.

“My child is getting enough help from the government and we are given the food basket. The government provides uniforms for my child, which would have been difficult for me.”

—Single woman, 40s, urban

“I would like to thank my government for helping me take care of those children because it helped me a lot.”

—Widowed woman, 50s, rural

“My daughter died in 2007; I’m thankful the government is helping with the orphans since my daughter died and is the one who could be helping me raise my kids.”

—Single woman, 50s, urban

Program implementation barriers

This section explores responses from caregivers/parents that elicited the following three key barriers to OVC program implementation:

1. Limited understanding of criteria used to apportion benefits to children
2. Low level of support and services for caregivers/parents
3. Differential treatment from community

Limited understanding of criteria used to apportion benefits to children. A little more than half of the 46 caregivers/parents expressed dissatisfaction with the benefits OVC receive. Fifteen of them questioned what criteria or guidelines social workers and other providers use as a basis for food basket provision. Most of them expressed concern about orphans in their care receiving food baskets while their own children do not receive any support even if the family is poor.

It should be noted that three government social workers described the food basket as an entitlement that all orphans must receive (one cited the STPA as mandating food basket provision to all orphans). However, some caregivers/parents reported that, while they care for numerous children, only one or two receive such benefits. Two caregivers explained that social workers had to limit the food baskets their OVC could receive because they needed to apportion the baskets to other orphans. In one case, four orphans in the house will have to make do with two baskets, despite their needs. The findings show that seven caregivers with five or more children under their care reported that only one child in their

respective families receives a food basket. As one female respondent summed it up, “[The government] should support all my five children because the government is only taking care of my two children.”

Low level of support and services for caregivers/parents. Caregiver/parent interview findings confirm information gathered from program managers and service providers—OVC services largely focus on children, with limited services offered to caregivers and parents. Caregivers/parents reported receiving very few services for themselves in their role as OVC caregivers. The majority of them (31 of 46) said they do not receive any services, but about one-third said they receive counseling support, mostly from social workers and church-sponsored OVC programs. Nine caregivers/parents expressed a need for training or employment opportunities instead of only the food or material support that their families receive.

Of those who do receive services, several perceived social workers’ attitudes as judgmental, resulting in a low level of support to assist them in accessing services. Five caregivers/parents referred to negative experiences with social workers as affecting their desire and ability to access services. For example, one respondent said that social workers told a child’s mother that she is still young and that she should go find a job to take care of her son. In this case, the respondent said that the social worker did not provide the mother with any assistance.

“The government should not discriminate, but the problem is with the people—civil servants are the ones who are asked to help the people but they discriminate.”

—Widowed woman, 60s, urban

“The community-based social worker has the attitude because sometimes when you talk to him he does not show that he cares and does not listen to what you are saying. I have a fear of asking for help from him.”

—Single woman, 40s, rural

Caregivers/parents of OVC recommended the following to address the problems and barriers they raised regarding services to the children under their care and to themselves as heads of households or families attending to OVC:

- Improve services (e.g., interactions with social workers) and clarify why some orphans or poor children receive benefits like food support while others do not.
- Implement a uniform card system that will enable caregivers and parents to buy food and select materials for OVC directly from different merchants. It appears that the card system was piloted in some areas, while other areas continue to contract out food baskets to accredited merchants, some of whom place poor quality products in the baskets that are then distributed to OVC recipients by social workers and other local providers.

Differential treatment from community.

Caregivers/parents’ responses on whether the community treats them differently for receiving government or other support services was mixed. Nearly half of the respondents (19) said they do or have received some form of differential treatment because their families receive OVC-related services. Some of these respondents said that their neighbors are often jealous of the services they receive. A widowed urban woman said, “Yes, jealousy is all over. People will be jealous because we are getting the help.”

“I took care of the boy who was from the San tribe...one day I took him to the clinic and everyone there was whispering. I could tell that they were talking about us. They kept on asking “Is he your child, what happened?” because his other eye was not working properly.”

—Single woman, 30s, urban

Other respondents said that community members equate their getting government assistance with poverty and lack of efficacy. As a single urban woman said, “Yes, people look down on me because I get help from the government. They think I can’t do anything for myself.” Another single urban woman pointed to

discrimination, saying, “Yes, they call them poor, they undermine ...sometimes I will do other girls’ hair but they will say it’s not good and don’t want to pay...People say we can’t do anything for ourselves.” Other respondents said that they or the children they care for are called names or people laugh at them.

On the other hand, just slightly fewer caregivers/parents (17) said that either they haven’t received different treatment or that their communities have been supportive of them. A single urban woman said, “No, the neighbors are happy the government is helping me with the kids.” The rest of the respondents either didn’t know or weren’t aware of any differential treatment.

When caregivers/parents were asked if they know of other children who can benefit from services but are not able to access them, the majority said no (28) and 18 said yes. This shows that caregivers/parents believe that most people are accessing services to help them. Accordingly, they believe that if someone is not receiving services, it may be their own fault. As one respondent said, “If there is someone who is not getting the help, it’s because they didn’t go ask for help.” For those who do not receive assistance, many caregivers/parents attributed that to fear, embarrassment, or a lack of information.

While it is a positive sign that a large number of the respondents are not aware of or do not experience any differential treatment, it is significant that almost half of them had stories about stigma or discrimination and others reported that potential beneficiaries do not access services out of fear. Botswana appears to have progressed significantly with addressing the HIV epidemic and focusing more on the needs of OVC; however, the country needs to focus more of its efforts on increasing community support for OVC and their caregivers/parents, especially those in dire need.

V. DISCUSSION AND RECOMMENDATIONS

This section explores the implications of the interview findings, including discussion of international standards and strategies for effective OVC programming, along with providing recommendations.

Developed by a global partnership of donors and country partners, *The Framework for the Protection, Care, and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS* (UNICEF et al., 2004) stresses the need for a coordinated response from a broad array of government agencies, NGOs, FBOs, and community institutions. Rather than targeting children living with HIV or AIDS or orphaned as a result of it, recommendations center on a broad response directed to vulnerable children in communities where they reside, and integrated into other programs to promote child welfare and reduce poverty. Since then, many countries have aimed for child-focused, family-centered, community-driven programs for OVC.

More recently, following a review of international documents and studies on children, HIV and AIDS, and poverty, the Joint Learning Initiative on Children and HIV/AIDS (JLICA) learning group (2009) emphasized the need for an integrated approach to tackling the HIV epidemic and OVC problem. Their recommendations revolve around a social protection agenda and an approach that encompasses four lines of action:

- Supporting children through families
- Strengthening community action that backstops families
- Addressing poverty through a national social protection framework
- Delivering integrated, family-centered services to meet children's needs

Botswana is largely in line with these international standards, beginning with the STPA. The STPA includes the following principles, which are drawn from the global partners' Framework (UNICEF et al., 2004):

- Strengthening family capacity
- Mobilizing and supporting community-based responses
- Ensuring OVC access to essential services, including education, healthcare, birth registration, and others
- Ensuring child protection, improved policies, and resources channeled to families and communities, and creating a supportive environment through awareness raising, advocacy, and social mobilization

Botswana has made significant progress to improve the OVC policy environment through the approval of two landmark national policies. The Children's Act of 2009—primarily drawn from the *Convention on the Rights of the Child* (U.N. General Assembly, 1989) and the *African Charter on the Rights and Welfare of the Child* (Organization of African Unity, 1990)—provides the overarching legal framework for the country's program for OVC care and support, emphasizing legal and social protection for children. The 2008 Guidelines derive significant inspiration from UNICEF's Framework (2004). As a result, Botswana has most of the significant national policy components needed to guide its OVC program.

With the foregoing perspectives in mind, it is important to examine the significance of the PIBA findings. These findings show that Botswana, through the MLG/DSS and civil society partners, has made progress in advancing OVC programs and services. However, as with all policies and programs, there are barriers to successful implementation. The barriers identified through the PIBA process can be distilled into five key issues:

1. Lack of capacity to implement OVC programs
2. Stakeholders' lack of information about OVC policies

3. Lack of operationalized OVC policies
4. Weak coordinating, referral, and monitoring structures
5. Lack of alignment of OVC programs with national policies

Lack of capacity to implement OVC programs

Findings demonstrate that there is limited human resource capacity to implement OVC programs. For the most part, OVC service provision in Botswana continues to rely heavily on social workers. Their responsibilities include assessing and identifying OVC, managing food basket distribution, providing referrals or attending to OVC referred for more intensive counseling, field-checking compliance with licensing requirements, processing applications for licenses to operate child welfare services, coordination, monitoring, and so on. Thus, social workers attend to a mix of technical and administrative matters. Interview respondents cited instances of social workers unable to attend to technical duties such as needs assessment, counseling, or referrals because they had to attend to food basket provision. It may be that much responsibility is placed on them for overseeing and distributing the food baskets, as this component appears to be the government's most expensive program for children, after pediatric HIV testing and ART.¹³

Botswana's draft Social Development Framework (Government of Botswana, forthcoming) estimates that one rural social worker, on average, serves about 537 registered beneficiaries from various age groups, compared to a ratio of one to 118 in urban areas (using data from the University of Botswana graduates in social work). The draft Framework also notes that fewer than half of either social work bachelor degree holders or diploma recipients are working in local authorities. Social workers' job descriptions from various MLG documents further reveal the broad spectrum of social welfare services for which they are responsible, including eldercare, assistance to the handicapped, support for destitute families, support for victims of domestic violence, assisting juvenile delinquents, overseeing substance abuse interventions, and providing other family-related services. Social workers' responsibilities also include community development and administration, including food basket management.

In addition, a review of the Children's Act and the OVC Guidelines indicates that many directives are addressed to social workers. A description of their various duties and responsibilities can reach several pages in length. Government social workers were called "generic" social workers by many respondents because they have generalized training and attend to the destitute and many needy sectors of the population, including families, children, youth, adults, elderly, and those with special needs and disabilities.

Government services could undertake task shifting of basic OVC function—orphans registration, accessing legal protection, or educational support provision, referral oversight, and follow-up—to NGOs who specialize in OVC care and support. In this model, a designated senior social worker could provide technical oversight and referrals for more intensive or sensitive psychosocial support to OVC (e.g., for orphans; HIV-positive children; or victims of rape, incest, or abuse) and other needy sectors of the population. The building blocks of such a structure may already exist in cities but need to be defined more clearly.

In such a model, all local service providers of government agencies (e.g., health workers, police, magistrates) will need specialized training to strengthen their capacity to implement OVC programs, as will NGOs. This means that the DSS will need to assess capabilities of the various providers and then develop a training program to ensure that they can assume social workers' roles in some basic functions.

¹³ This statement came from interviews with NACA and MOH officials during OVC costing analysis meetings with Health Policy Initiative staff.

Recommendations include the following:

- Shift administrative/logistical tasks currently assigned to social workers to other district or community workers to enable social workers to spend more time providing care, support, and specialized OVC services (such as trauma counseling and psychosocial support).
- Train social workers and service providers on very early childcare and support.
- Train national, district, and local leaders and officials on the main content of the policies and how they can support implementation. Stakeholders should include *Dikgosi*, magistrates, and police.
- Training community workers, police, magistrates, educators, and community leaders on child rights and protection, basic counseling, and GBV.

Stakeholders' lack of information about OVC policies

The previous discussion on the OVC policy environment broadly describes Botswana's efforts to address its OVC problem through national policy and program initiatives. Over time, these efforts have led to the approval of the National OVC Guidelines and the Children's Act. While some may have questions about specific directives of these policies, the policies provide the necessary social protection framework and main parameters for providing services to OVC. However, policy implementation is only partially proceeding, as the Children's Act is still new and full country roll-out is still taking place. At present, policy dialogue and dissemination are minimal, especially at the local level. Indeed, local decisionmakers cited a lack of stakeholder consultation in formulating the two national policies, and local respondents admitted to a very limited knowledge or understanding of them. Even after the policies were approved, there was very limited dissemination and training to ensure stakeholder understanding of the content and how to implement these policies.

Barriers related to policy dissemination and learning are surmountable, but addressing them requires initiative, effort, and time. Key stakeholders led by the DSS and district S&CDs must plan and conduct orientation workshops regarding the Children's Act and the OVC Guidelines to discuss the roles that various stakeholders can play in implementation. Considering the different needs of OVC and the array of providers and organizations that can provide care and support services, these forums must be multisectoral and held at national, district, and village levels. Such forums also should be avenues for engaging OVC leaders or groups, encouraging their participation in policy implementation and stimulating their interest in the establishment of national and local structures, such as children's forums, as mandated in the Children's Act.

Recommendations include the following:

- Expand dissemination of policies—especially the Children's Act and OVC Guidelines—to the public, including national- and community-level workshops and trainings to strengthen policy implementation and build wider ownership of OVC programs and services; and
- Assist *Dikgosi* in leading community-level dissemination activities with a range of stakeholders.

Lack of operationalized OVC policies

While Botswana's policy environment for addressing OVC issues is quite strong, gaps remain. These include the need for addressing barriers stemming from an absence of specific policies and creating operational guidelines to implement existing policies.

National policy change. At the national policy level, the draft National OVC Policy needs to be finalized and approved. It includes a clear definition of vulnerable children and should provide the mandate for an integrated orphan and vulnerable children program (rather than separate vertical programs for orphans, destitute children, and other categories of children in need) to ensure that the most vulnerable are addressed, including children with disabilities and special needs. Considering that several childcare-

related laws, policies, and regulations had been issued in the past, the government needs to designate a specific agency to coordinate the various national policies affecting children, clearly stating which policies are no longer in effect or which have been supplanted by more recent Acts of Parliament or government policies. Such harmonization can be a key component of the National OVC Policy, which is currently under discussion in Parliament.

Operational policy development. Findings also revealed several operational barriers that result in unnecessary losses of time and effort, as well as inefficient use of resources. A key step to removing these barriers involves developing and issuing operational directives or guidelines, primarily at the ministerial or departmental level. Several of these issues are discussed below, while policy issues related to service referral, inter-agency coordination, and monitoring and evaluation are discussed separately in relation to another barrier.

- *Lack of clear policy for apportioning benefits to OVC.* Interview findings reveal a need for better criteria for providing benefits to OVC in the context of dwindling resources. National decisionmakers raised concerns about the global economic crisis and Botswana's resources, while program managers and service providers cited instances in which benefits such as the food baskets or vouchers provided to orphans were misused by caregivers/parents. According to caregivers/parents, especially poor ones caring for multiple children (including their own), benefits such as food baskets are often lifelines. It appears that with limited resources, social workers often have to make decisions about which families or which children should receive food baskets. As a result, the Government of Botswana needs to seriously consider formulating and implementing a targeting policy that involves means testing to ensure that frontline service providers can direct scarce, subsidized resources to the most needy and vulnerable sectors of the OVC population. These resources could take the form of pre-determined or in-kind provision of specific goods such as food baskets, or direct cash disbursements so that families can decide how to use their own funds.
- *Children's courts, including related procedures and required skills, have not been established.* While the Children's Act provides clear and specific stipulations about child-appropriate environments and procedures in courts, it was clear from the interviews that Children's Courts do not yet exist in Botswana. Numerous respondents reported that magistrates still require abused children to confront their alleged abusers in court. The absence of structures to protect children from such experiences presents barriers to reporting abuses to legal authorities but, more importantly, also can inflict severe trauma on abused children, causing further harm. In addition, this type of confrontation may place children at risk for further abuse. This is a particular concern with young girls, who are placed at further risk for acquiring HIV or suffering other negative health affects. While the Attorney General is likely to issue implementing guidelines and regulations, it is important to ensure that all relevant parties—magistrates, the police, juvenile delinquency officers, medical examiners, and other related workers—are trained on various children's issues. Furthermore, law schools and training programs for existing lawyers and barristers should incorporate child protection issues into their curricula.
- *Cumbersome licensing processes.* The Children's Act mandates licensing for service providers of OVC care and support services. Interview respondents cited delays because S&CD staff were unclear about documents required from applicants and social workers. Furthermore, S&CD staff, who are already swamped with responsibilities, often need to do additional work to verify licensing requirements and process the paperwork. Aside from causing providers and service organizations to waste time unnecessarily in following up or processing papers, delays in granting licenses ultimately penalize children, who miss out on much needed care. Service providers recommended simplifying licensing procedures and for the DSS and S&CD to redistribute licensing

responsibilities to other workers to expedite the process. The licensing process also can be explained more fully during multisectoral policy dialogues to orient key stakeholders about the policy, or licensing officials could produce a graphic poster explaining the process for placement in DSS and council premises. The latter would also facilitate understanding, especially for those from community-based organizations who may not easily understand the legal wording of the Children's Act.

Recommendations include the following:

- Speed up the process of finalizing the National OVC Policy, which should include
 - A clear definition of vulnerable children and strategies to ensure that the most vulnerable are addressed, including children with disabilities; and
 - A guide for what policies are no longer in effect or have been supplanted by the Children's Act, especially in terms of how they affect OVC.
- Simplify licensing procedures for organizations providing child welfare services and explore redistribution of licensing responsibilities to expedite the process.
- Develop operational guidelines for magistrates to follow in dealing with OVC at risk of violence in the home or continued exposure to perpetrators of violence.
- Establish children's courts and train magistrates and police on child protection issues.

Weak coordinating, referral, and monitoring structures

The Children's Act mandates the creation of national, district, and village-level coordination structures, including the National Children's Council, the National Children's Forum, and Village Child Protection Committees. These structures have yet to be established. Since OVC organizations are currently providing services, it is important that such coordination structures are established as soon as possible. Coordination structures can help avoid duplication, plan activities in a more strategic way, maximize limited financial and human resources, and ensure that limited resources go to where they are most needed. Such entities also can perform or oversee critical monitoring and evaluation functions that are sorely needed to improve program planning and implementation.

The PIBA team noted two issues related to coordination provisions under the Children's Act of 2009. First, the MOH is absent from the different ministries mandated to comprise the National Children's Council. While this may be due to the social protection emphasis of the Act or may be an inadvertent error, it is clear that the MOH belongs on the Council, as health affects social development, and vice versa. Coordination and collaboration between the MLG and MOH in planning and implementing OVC programs and services are deemed necessary. The second issue refers to the omission of a child protection or coordinating council or committee at the district level. The MLG has already identified NGO Committees as the structure that will undertake child protection functions at this level. This MLG decision needs to be widely disseminated; government and service providers interviewed during the PIBA survey were unclear about which structure coordinates OVC activities in the districts. The JLICA international review (2009) showed that district committees in countries that have succeeded in advancing their OVC programs have played a key role in reinforcing alignment of services and benefits according to government priorities. They have also helped to ensure a child-focused, family-centered, community-driven approach to providing OVC services.

Findings also reveal that there is no clear OVC assessment and referral system, other than relying primarily on government social workers. The heavy burden on social workers has already been discussed; they perform or are expected to perform a range of duties: OVC needs assessment, making referrals to other providers, serving as the referral provider for PSS, submitting monitoring reports, and coordinating the various OVC activities in the community where they are assigned. Considering the different service providers and organizations operating in various communities and villages, the government needs to

consider referral mechanisms other than social workers to ensure that social workers can best serve in their roles of giving technical care and support services for OVC. Other countries have used referral coordinators, including local CBOs selected by the communities themselves (for example, see USAID et al., 2007). Botswana can examine these promising mechanisms to improve linkages to specialized services and ensure that these are linked to key services such as health and education.

Recommendations include the following:

- Establish national and local coordination structures outlined in the 2009 Children’s Act (e.g., national children’s council and village child protection committees) and designate a lead national agency to carry out the process.
- Disseminate information about the designation of District NGO Committees to oversee child protection and care at the district level.
- Improve coordination and collaboration between MLG and MOH in planning and implementing OVC programs and services, including MOH representation on the National Children’s Council and district committees designated for child protection.
- Develop, disseminate, and implement standard OVC assessment and referral guidelines or protocols that include follow-up mechanisms.
- Create, disseminate, and regularly update district-level directories and maps of OVC providers, including the range of services offered.
- Improve linkages to specialized services.
- Assign monitoring functions to local structures, such as Village Child Protection Committees.

Lack of alignment of OVC programs with national policies

Findings demonstrate that while national OVC policies contain provisions for a range of programs, these often are not implemented on the ground. For example, according to the findings, OVC programs remain child focused, rather than family centered or community driven. In addition, it appears that gender has not been mainstreamed, as recommended in the National OVC Guidelines. Furthermore, there is still a lack of programs for very young OVC and those who turn 18, the age at which OVC benefits are curtailed.

OVC programs remain child focused. Interview findings show that Botswana’s OVC program remains primarily child focused. While certain OVC-related services—especially PSS—are provided to and are being received by caregivers/parents, the focus seems to be only on improving parenting abilities to care for OVC. While this support is important to caregivers/parents, they should receive a broader range of services to ensure a family-centered approach. Many of the interviewed caregivers/parents attested to their poverty status, including dependence on food baskets or an inability to pay school or clothing expenses. Very few have had access to training or economic opportunities. As such, they have been unable to establish meaningful livelihood options as an alternative to receiving food baskets and other social welfare benefits. A recent country review (JLICA, 2009) noted that economic strengthening of families is the missing key in many country programs. PSS, social, and education programs need to be accompanied by a foundation of economic security. This should be one major thrust of the family-centered approach. The MLG and other ministries, including Labour and Social Affairs, have livelihood training programs that caregivers/parents should be able to access.

It also appears that much more needs to be done to mobilize and involve existing village and community structures, even the *kgotla*, in organizing the community to address the OVC problem. Findings revealed that there is still great dependence on external structures such as the DSS or S&CD. This includes S&CD social workers assigned to villages and wards, who have a great number of responsibilities and tasks. For example, they are relied upon to identify orphans or needy children or respond to their needs. Enabling community structures to identify OVC and their needs and harnessing these structures to support service provision and monitoring can help ensure that OVC receive local services and benefits.

Community-driven identification of the most vulnerable children and monitoring of their needs and the services they have accessed is critical to determine who should receive benefits. This is especially important in a context of limited resources and potential budget cuts at the national level. Many of the program managers, service providers, and caregivers/parents said that the food basket is a benefit that all orphans should receive, regardless of their family's economic situation. However, national officials may need to make decisions regarding beneficiaries. This could include instituting means testing to ensure that scarce, subsidized services and benefits are targeted only to the most vulnerable and needy children and families. The government should assess the effectiveness and efficiency of the current approach that involves the provision of defined material goods (food, clothing, or other materials) and should monitor how these goods have reached the poorest and the most vulnerable children and families. Implementing and ensuring an approach like means testing requires local understanding and ownership, and community-driven efforts to identify, support, and monitor those most in need.

In addition, the government can consider alternatives such as cash transfers adapted to the Botswana culture and context. Based on evidence collected from numerous documents from various countries, JLICA (2009) recommends cash disbursements to individuals or households identified as highly vulnerable. Such approaches have demonstrated benefits to children's nutrition, health, and education (Acacia Consultants, 2007). Mexico's conditional transfer program sets conditions for receiving income, such as children's regular school attendance, routine visits by family members to health clinics, and participation in an improved nutrition program. Examples in Africa include the unconditional income transfers to households living in extreme poverty or child poverty grants used in South Africa. Even Botswana's old age pension program has been cited as potentially benefiting OVC. Income transfers have been demonstrated as efficient means of giving families dignity in choosing where to spend money and altering spending strategies as needs change. Income transfers delivered to female members of households have been shown to be very successful especially in Latin American programs. While middle-income countries such as Brazil, Mexico, and South Africa have complex financial infrastructures, cash transfers have also been managed successfully in low-income countries with weak infrastructures, such as Bangladesh, Mozambique and Nicaragua; in areas of high HIV prevalence, cash transfers can be done on the basis of poverty, not HIV status (JLICA, 2009).

OVC programs have not implemented gender mainstreaming. Botswana's OVC Guidelines state that "It is vital that, in developing and applying OVC activities, gender be considered at every stage." As such, the Guidelines call for gender mainstreaming in OVC programs. While this PIBA did not include a specific focus on gender, the findings reveal that OVC programs can pay more attention to gender mainstreaming.

The OVC Guidelines specify that one form of gender mainstreaming is to increase and strengthen men's participation in OVC programming. Findings reveal that like many other countries, women in Botswana primarily fill the role of caregiver/provider for OVC. Only two of the 46 caregivers/parents interviewed were men. However, many of the women interviewed are married, so it is possible that their partners assist in the caregiving role. Nevertheless, it is clear that OVC program implementers should examine men's participation in caregiving and design strategies for overcoming gender norms and roles that may inhibit this participation. This is particularly the case within the context of promoting family-centered OVC approaches. Family-centered approaches to OVC programming should include promotion of gender equity related to caregiving. This can include encouraging and promoting men's involvement in caring for OVC through special community initiatives that address cultural and gender norms.

Within families, women are typically caregivers to children in the household. In this role, single and widowed caregivers/parents, in particular, may miss out on opportunities to improve their socioeconomic status. In some cases, girls and young women have had to sacrifice educational opportunities to care for

siblings or other relatives. This can serve to reinforce their lower socioeconomic status, making it difficult for them to obtain jobs later on. In addition, education status is correlated with girls' and women's health. Girls' secondary education is associated with a multitude of health benefits in addition to those associated with delayed marriage and fertility: decreased infant and child mortality, higher immunization rates, improved household nutrition, and lower rates of domestic violence (Murphy and Carr, 2007).

It is not clear from the interviews how or if OVC program managers and service providers design gender-sensitive programs, taking into account issues such as gender-based violence, early marriage, and inheritance rights. To do so, program managers and service providers must maintain sex-disaggregated data on clients served and analyze any potential gender-related issues that affect access to services.

Lack of programs for very young OVC and for those “graduating” from the OVC program. The PIBA interviews reveal program managers' and service providers' concerns that there are still very few “graduation” programs or services to prepare older OVC for turning 18—the age at which they are no longer eligible for mandated benefits—or for youth who turn 18 and graduate out of OVC benefits. However, the concern about “graduating” appears to be a misunderstanding. Interviews with DSS indicate that OVC who are 18 years and over and who remain vulnerable or destitute are transferred to the Destitute Program. The draft Social Development Framework also mentions additional programs and resources for older youth—the Youth Development Fund, the Citizen Entrepreneurial Development Agency, and the Young Farmers' Fund (Government of Botswana, forthcoming). Based on the PIBA interviews, these programs do not appear to be well known among government and nongovernment workers providing services to OVC and their caregivers/parents.

While government or NGO programs for livelihood or vocational training may already exist, it is important to ensure that OVC are counted among the priority beneficiaries of such programs. Moreover, the DSS should review and update its current training programs to ensure that as OVC grow older and approach age 18, they are trained in life and technical skills. DSS can also take steps to ensure that OVC benefit from gradual transition programs funded and supported by government, NGOs, or school partnerships with business groups, or are exposed to the entrepreneurial programs identified in the preceding paragraph. Recognizing the need for strengthening support for older OVC, policymakers are currently considering including more appropriate and comprehensive graduation programs in the forthcoming National OVC Policy and LTPA.

In a different vein, after reviewing the age ranges of OVC for which interview respondents provide services, it is clear that there is a lack of services for OVC under three years old. While several organizations reported serving children ages 0–17, their early childhood development programs are mostly daycare and pre-school services for children ages two to six or three to six. As Engle's review of national plans of action for OVC in sub-Saharan Africa (2008) showed, very little attention has been given to the youngest OVC. While the youngest children constitute a small proportion of the OVC population, they are also the least resilient. They have the highest need for physical and emotional nurturing, yet are often the most invisible to program planners, as their needs are assumed to be met by food distribution or healthcare services. Engle (2008) proposed integrating programs for the youngest children with those intended to empower and protect women, especially the most vulnerable and the poorest, as young children's benefits and rights are closely linked to the status of women.

Recommendations include the following:

- Ensure implementation of a family-centered approach by offering services specifically for OVC caregivers/parents, using innovative approaches like MCCNT's Journey of Life curricula, income-generating programs, succession planning, or material support for women and their households.

- Increase community ownership through development and implementation of community-based approaches, such as awareness raising around OVC issues and available services.
- Operationalize gender mainstreaming as mandated in the National OVC Guidelines. This could include encouraging and promoting men’s involvement in caring for OVC through special community initiatives that address cultural and gender norms.
- Initiate partnership programs whereby communities work with police and other sectors to address GBV, particularly against OVC.
- Review the nature of OVC interventions, especially those consisting of material or in kind dole-outs vis-à-vis consolidating funds into the kinds of cash transfer programs shown to work in less developed countries. This could include a study tour to countries that have implemented a consolidated income-transfer system, such as Tanzania.
- Adopt means testing and strategies to ensure that the most vulnerable are reached, including children with disabilities and special needs, and the very young.
- Articulate what constitutes the older OVC “graduation” program to ease transition for OVC as they approach 18, including ways to assist older OVC in tapping existing social welfare and economic programs. This could include prioritizing caregivers of OVC and “older” OVC for income-generating or vocational programs.

VII. NEXT STEPS

Identifying and understanding barriers to implementation can help the government to develop strategies and reform policies, thus minimizing or eliminating barriers. PIBA in Botswana was unique in its incorporation of three sets of stakeholders with different perspectives on OVC program implementation. Through the consolidation of stakeholder feedback, the Health Policy Initiative identified numerous specific barriers to the implementation of OVC programs and services. In consultation with local partners, the project was able to identify a range of potential policy actions to address these barriers.

The barriers and recommendations identified through the Botswana PIBA methodology will be shared with the reference group, which they will use to develop a policy agenda, along with critical timelines. In addition, the reference group will receive similar information from the OVC costing analysis, also undertaken by the Health Policy Initiative. The reference group will share both of these reports with other decisionmakers and implementers and advocate for implementation of the policy agenda.

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ANNEX A. GUIDING QUESTIONS FOR BACKGROUND POLICY ANALYSIS

- Name of policy
- Authority/body that issued the policy
- What does the policy document state regarding the following:
 - What types of OVC services should the facility/provider provide?
 - How is each type of service to be provided?
 - Who (which provider) is allowed to provide each type of service? What qualifications are required of providers?
 - Where (in which facilities) and when are these services to be provided?
 - Who (which agency/provider) oversees service provision to ensure access and quality?
 - Who are the intended clients/beneficiaries of these services? How are they identified? What does the document specify as the characteristics of target recipients (e.g., age, sex, poverty status, location, family characteristics, etc.)?
 - Are there policy provisions/directives on provision of services that place heavy or unfair burden on certain individuals or groups because of their characteristics (e.g., their sex, age, occupation, health or HIV status, family background, personal practices)? If yes, what provisions are these? Who are most affected?
 - What does the policy stipulate to counter stigma and discrimination against children infected, at risk, or suspected of being affected by HIV?
 - What policy provisions affect financial, human, or physical resources (e.g., an annual government budget line item, central/ local drug procurement, local government share)? What policy provisions affect management and service structures related to the provision of OVC services (e.g., inter-agency coordination, monitoring/ evaluation)?
- What does the policy document say regarding referral to another facility if a service is not available in a facility? For example:
 - What are the responsibilities of the referring provider to ensure that the intended beneficiary receives needed services at the referral facility?
 - What are the responsibilities of the referral unit and provider to ensure that the intended beneficiary is followed up after receiving referral services?
 - Who ensures continuity of care for the beneficiary when different types of services are provided by a different facility or type of provider?

ANNEX B. QUESTIONNAIRE FOR NATIONAL AND LOCAL DECISIONMAKERS

Before each interview: Ask decisionmaker to read and make a check on the informed consent form and then collect the form before starting the interview.

Introducing the interview:

“Good morning/afternoon. I am here on behalf of the Futures Group, an international development organization, and the USAID | Health Policy Initiative, a project that works with governments to improve implementation of policies and programs. As you were informed earlier, we are working with the Government of Botswana to identify problems regarding services for OVC. Before asking questions, I want to assure you again that we will safeguard the identities of all respondents of this study. If we use any of your statements in the report, we will cite the source of the statement only as “parent” or “caregiver.” If you have any concerns about the interview process or about your statements being kept in strict confidence, please call the number I’ve given you to speak with Wame Jallow, country coordinator for the Futures Group. This interview should take about 45–60 minutes.”

Unique ID number of respondent: _____ (copy number on consent form)

Male _____ Female _____ (check if respondent is male or female)

Age of respondent: _____

Date(s) of interview: _____

Time started: _____

Time ended: _____

Interviewer/facilitator: _____

Type of decisionmaker: _____

- 1) How would you prioritize the situation of orphans and vulnerable children (OVC) in relation to other development challenges?
 - a) What are some other challenges?
- 2) What do you know about the new government policies focusing on children’s rights and addressing the care and support of OVC?
 - a) What do you think about these policies?
- 3) What do you think is your role related to implementing the new Children’s Act and the OVC Guidelines?
- 4) In your opinion, to what extent are the new Children’s Act and the OVC Guidelines being implemented?
 - a) What is being implemented?
 - b) What is not being implemented?
- 5) How do you think the different levels of government can help strengthen implementation of OVC programs?
 - a) National
 - b) District
 - c) Local/village
- 6) How do you think local community organizations or groups can help strengthen implementation of OVC programs?

7) Is there anything else you'd like to tell me about OVC policies and/or programming in Botswana?

Thank you very much for your time. This information will assist us in providing information on OVC programs to the government of Botswana.

ANNEX C. QUESTIONNAIRE FOR PROGRAM MANAGERS AND SERVICES PROVIDERS

Name of Organization: _____
Complete Address: _____
Area(s) served by Organization: _____
Provider Interview Number: _____
Position or title: _____
___ Male ___ Female

Usual place(s) of assignment (*please indicate if worker is assigned only to this health center or is also assigned to other health centers*) _____

Date(s) of interview: _____
Time started: _____
Interviewer/facilitator: _____
Note taker (if different from interviewer): _____

Before each interview: Ask provider to read and make a check on the informed consent form and then collect the form before starting the interview.

Introducing the interview:

“Good morning/afternoon. I am here on behalf of the Futures Group, an international development organization, and the USAID | Health Policy Initiative, a project that works with governments to improve implementation of policies and programs. As you were informed earlier, we are working with the Government of Botswana to identify problems regarding services for OVC. Before asking questions, I want to assure you again that we will safeguard the identities of all respondents of this study. If we use any of your statements in the report, we will cite the source of the statement only as “parent” or “caregiver.” If you have any concerns about the interview process or about your statements being kept in strict confidence, please call the number I’ve given you to speak with Wame Jallow, country coordinator for the Futures Group. This interview should take about 45–60 minutes.”

OVC Services Provided by Respondent

1. What care and support services for orphans and vulnerable children does your organization provide? *Please listen to respondent and circle the letter that corresponds to what provider mentions. If a specific service is not listed, describe it in the space provided for “Other.”*

Specific services provided to orphans and vulnerable children (OVC):

- a. Registration of orphans
- b. Obtaining birth certificates for children
- c. Protecting children’s rights or facilitating access to legal protection (e.g., for orphans’ inheritance, to protect abandoned/neglected/abused children)
- d. Food basket provision or distribution
- e. Providing material support and personal care (e.g., ensuring that child receives clothing support or hygiene products, advising child on proper hygiene)
- f. Providing daycare/nursery facilities for very young OVC
- g. Providing institutional care for orphans and abandoned children (*This response applies only to those who run or work in orphanages*)
- h. Providing temporary housing/dwelling/foster care for OVC
- i. Assistance in accessing education support (e.g., assisting OVC in enrollment or to obtain support for tuition, uniform, school supplies, schooling allowances)

- j. Psychosocial counseling – individual or group counseling
- k. Organizing/supporting youth clubs, sports clubs for OVC
- l. Arranging/facilitating vocational training and/or income-generating opportunities for adolescents and older children
- m. Health-related services (esp. identifying OVC in need of healthcare or assisting health providers in following up a child’s healthcare or ensuring treatment adherence)

OTHER, *Specify:*

Any general comments (*please include any comments respondents make about the services here*):

Services for caregivers/parents of OVC

- a. Assisting in home-based care for parents, caregivers, OVC, other family members
- b. Assisting in the development of succession plans and wills
- c. Organizing/facilitating support group for caregivers/parents
- d. Arranging/facilitating vocational/livelihood and/or income-generating opportunities for caregivers/parents and older household members
- e. Psychosocial counseling for caregivers/parents
- f. Facilitating dialogue between caregivers/parents and OVC (e.g., to deal with child’s HIV status, to handle parent’s severe illness or death in the family)

OTHER, *Specify:*

- 2. How and when do you (or your organization) determine if a child is an orphan or a vulnerable child? Write down verbatim response:
- 3. How and when do you (or your organization) determine what care and support services an orphan or vulnerable child needs? Write down verbatim response:
- 4. What training on the care and support of OVC have you attended? Who provided it and when did it take place?
- 5. In your opinion, what training qualifications should community workers have to be allowed to provide care and support to OVC?
- 6. What are the main characteristics of the OVC currently under your care and support? (*Write down VERBATIM response, e.g., children’s ages, health status, orphanhood, caregivers/parents’ economic or home situation, etc.*)
- 7. Which aspect(s) of OVC care and support do you consider most challenging (*e.g., counseling the parent/caregiver to get the child tested for HIV, helping child and parent/caregiver deal with child’s HIV+ status, lack of resources, low support from leaders*)?
- 8. Are there mentors or technical supervisors who guide you and other community-based workers in providing care, support, and counseling for OVC? *Please circle letter.*
 - a. Yes, mentors/supervisors are available to guide me
 - b. No, there are no mentors/supervisors available to guide me

Other community workers and referrals

- 1. What other workers or groups provide care and support to OVC in this community?
- 2. What other facilities or providers have you referred OVC to? For what services (e.g., referral for health diagnosis, legal protection, schooling assistance, etc.)?
- 3. What criteria do you use to refer OVC to other facilities or providers?

4. If an orphan or vulnerable child has been referred to a health facility, which community worker makes sure that the child receives care in the health facility and follow-up care in the child's home?
5. Do health center staff members refer OVC to you for OVC's social and personal needs?
 Yes.... If yes, Please give examples:
 No.... If no, why do they not refer OVC to you?
6. What services or referrals have you made to help the caregivers/parents of OVC?
7. How do you and other workers or groups who are also involved in care and support of OVC in the community inform or know about each other's activities?

Contextual factors

1. What social, political, geographic, or economic factors that are present in your area limit or prevent caregivers/parents of OVC from accessing care and support services for these children (e.g., common perception that OVC are HIV+, stigma against HIV and OVC, local leaders do not think OVC are a major problem, most OVC families live in remote areas, limited resources to deal with the problem)?

2. What family-related factors constrain caregivers/parents of OVC in accessing care and support services for the children under their care (e.g., fear that people will condemn the parents and OVC, parent's illness, poverty, low education, lack of information on services)?

3. What do you think should be done at the community level to remove these constraints?

Resources

Let us now talk about financial, human, and other resources.

1. What resources (financial, human, physical, etc.) do you or your organization currently have to provide OVC care and support? *Enter information into column A of table.*
2. What additional resources do you need to improve access to OVC care and support and improve the quality of support? *Enter information into column B of table.*

Types of resources (including examples of each type)	Please specify – see examples in the first column	
	a) Resources currently available to provide OVC care and support	b) Additional resources needed to improve access to and quality of OVC services
Funding/financing (e.g., national govt. allocation, local govt. budget, provision of transport allowances)		
Human resources (e.g., more		

<i>social workers, more accredited community-based workers, training for OVC support groups, training on HIV counseling)</i>		
<i>Supplies (e.g., hobby kits, school kits, home schooling kits)</i>		
<i>Equipment (e.g., new computer to store records, TV for community education, motor bike or van for social workers to visit remote areas once a week, sound system)</i>		
<i>Infrastructure (e.g., a separate room for counseling, a bigger room for group classes or counseling, a children's daycare, a playground near the daycare center)</i>		
<i>Other resources</i>		

Coordination and policy guidance

1. What support from national or regional government or nongovernment agencies or bodies does your organization receive in order to provide OVC services (*e.g., training, funds for information campaign*)?

2. What structures for coordination currently exist at the local level to oversee OVC services provided by various local child health, welfare, and development services (*e.g., village child committee, child protection services*)?

3. What monitoring and reporting structures exist at the local or district level to track the progress and achievements of the local or district OVC program?

4. What structure or authority does not yet exist but is needed to strengthen OVC services at the local level (e.g., a child health officer in the local government, a children or OVC representative in local AIDS committee)?

5. In your opinion, what policies and programs related to OVC services or coordination of services need to be changed to improve services and attract more caregivers/parents and children to the OVC program?

6. What policies and guidelines do you use in providing care and support services to OVC? Do you have copies of these policies and guidelines here with you? May I see them so I can copy their titles? Complete names of policies and guidelines/norms cited by respondent:

Interviewer please check:

Respondent was able to present copies of the policies/guidelines _____

Respondent had no copies of the policies/guidelines _____

7. In your opinion, are your colleagues in this organization familiar with these OVC policies and guidelines (circle answer)?

- a. Yes
- b. No

8. In your opinion, are the different community organizations in this area familiar with these OVC policies and guidelines (circle answer)?

- a. Yes
- b. No

9. In your opinion, are local officials and leaders familiar with these policies and guidelines (circle answer)?

- a. Yes
- b. No

10. In your opinion, are these OVC policies and guidelines easy to understand and follow (check answer)?

- a. ____ Yes
- b. ____ No → If no, which aspect(s) is/are hard to understand and follow?

11. In your opinion, are local officials and community workers supportive of these OVC policies and guidelines (circle answer)?

- a. Yes
- b. No

12. Please suggest other ways to help community workers like you improve access to and use of OVC services. _____

13. Is there anything else you'd like to share about OVC services or about this interview?

Your interview has ended. We are very grateful that you took the time to speak with us. THANK YOU VERY MUCH!

Time interview ended: _____

ANNEX D. QUESTIONNAIRE FOR CAREGIVERS/PARENTS

Village where parent/caregiver and OVC reside: _____

Unique ID number of respondent: _____ (*copy number on Consent Form*)

Male ___ Female _____ (*check if respondent is male or female*)

Age of respondent: _____

Date(s) of interview: _____

Time started: _____

Time ended: _____

Interviewer/facilitator: _____

Before each interview: *Ask caregiver/parent to read and make a check on the informed consent form and then collect the form before starting the interview.*

Introducing the interview:

“Good morning/afternoon. I am here on behalf of the Futures Group, an international development organization, and the USAID | Health Policy Initiative, a project that works with governments to improve implementation of policies and programs. As you were informed earlier, we are working with the Government of Botswana to identify problems regarding services for OVC. Before asking questions, I want to assure you again that we will safeguard the identities of all respondents of this study. If we use any of your statements in the report, we will cite the source of the statement only as “parent” or “caregiver.” If you have any concerns about the interview process or about your statements being kept in strict confidence, please call the number I’ve given you to speak with Wame Jallow, country coordinator for the Futures Group. This interview should take about 45–60 minutes.”

Note to Interviewer: All instructions are in italics. Even if the questionnaire provides pre-coded response categories, please write down in the blank spaces provided near each question any additional comments, explanations, or concerns that the respondent states. If you need more space to write down these additional comments, please use the reverse side of the questionnaire or additional sheets. All these are needed to ensure that no relevant or important information is left out.

- 1) If it is okay with you, please tell me whether you are single, currently married, widowed, divorced, or separated?

- 2) Please tell me how many children you take care of. _____

How old are each of the children? _____

Are they boys or girls? (*Indicate number of each*)

I hope it is okay with you if I ask some general information about your children or the children under your care. How many of these children under 18 years of age are yours (by birth) and how many among them have you adopted or taken under your care?

_____ Number of children who are respondent’s children by birth

_____ Number of children who are respondent's children by formal adoption

_____ Number of children who respondent took into care

3)

a) What assistance, support, or services have your children (or the children under your care) received from local organizations or others?

Please check all boxes that apply. Specify services in the blanks provided.

- Birth registration
- Education (e.g., tuition, book, transport) _____
- Healthcare
- Shelter (e.g., temporary dwelling)
- Clothing, shoes _____
- Food and nutrition support (e.g., food basket)
- Child care, daycare
- Child protection/legal services _____
- Psychosocial counseling
- Youth club, teen group _____
- Financial support, cash allowances
- Other, pls. specify _____
- Other, pls. specify _____
- Other, pls. specify _____

For each service mentioned, please specify the following in the table below:

- i) Which organization or worker provides this specific service to your children? What type of organization is this (government, NGO, religious, community group, neighbors etc.)? *(column b)*
- ii) Which among the children in your household or those that you care for are mainly benefitting from this service? *(column c)*
- iii) Are you satisfied with the service your children have received? *(column d)*

a) Service for children received by OVC in the family	b) Type of organization or worker providing the service (who provided the service?)	c) Which among the children in your family (or care) are benefitting from this service (boys, girls, ages)?	d) Are you satisfied with the specific service that your child/children has received?

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4) Based on your own family's needs and experiences, what needs to be done to improve the services that your children (or children under your care) receive? In what way?

5) Based on your own family's needs and experiences, what services do your children need that are not available in the community?

6)

a) What assistance or support have you as a parent or caregiver received to be able to take care of your children?

Please specify service or support in the blanks provided.

- Health referral or care
- Vocational or livelihood training
- Social protection or legal services (e.g., to file application for child support)
- _____
- Financial support, cash allowance _____
- Child care (e.g., when caregiver is sick or has to go somewhere, someone else takes care of the children or prepares meals) _____
- Counseling
- Social club formed/organized for OVC caregivers/parents _____
- _____
- Other, pls. specify _____
- Other, pls. specify _____

For each service mentioned above, please ask the following in the table below:

- i) Which organization or individual assisted you? What type of organization is this (government, NGO, religious, community group, neighbors, etc.)? (column b)*
- ii) Were/are you satisfied with this assistance or support? (column c)*

Type of assistance/support provided to parent/caregiver	Type of organization or worker providing the service (who provided the service)?	Were/are you satisfied with this assistance or support?

Your interview has ended. We are very grateful that you took the time to speak with us. THANK YOU VERY MUCH!

ANNEX E. OVERVIEW OF STATUTES RELATED TO CARE AND PROTECTION OF OVC

Legal Statute	Action Required	Lead Body
Children's Act (1981)	<ul style="list-style-type: none"> Identify forms of child abuse and establish a register of them Protect orphans from abuse and neglect Protect their rights to inheritance Remove child at risk to places of safety Protect their human rights 	<ul style="list-style-type: none"> S&CD Commissioner of Child Welfare Police NGOs/CBOs
Destitute Policy (1981)	<ul style="list-style-type: none"> Identify and register all orphans Identify, register, and support needy orphans Identify, register, and support orphans in need of special care Provide social welfare (i.e., food, clothing, shelter, and uniforms) to orphans Support foster parents with food rations Increase food rations in households where the number of orphans exceeds four 	<ul style="list-style-type: none"> Social Welfare Division
Adoption Act	<ul style="list-style-type: none"> Incorporate the rights of the adopted in the new home Protect adopted children from abuse Facilitate adoption for needy orphans 	<ul style="list-style-type: none"> Juvenile Courts S&CD
Deserted Wives and Children Protection Act	<ul style="list-style-type: none"> Provide for the care of orphans in case of re-marriages and co-habitation of surviving spouse Protect orphans from parents who neglect or refuse to maintain them 	<ul style="list-style-type: none"> Juvenile Courts S&CD
Affiliations Proceedings Act	<ul style="list-style-type: none"> Enforce the maintenance of orphans by responsible parents 	<ul style="list-style-type: none"> Commissioner of Child Welfare
Marriage Act	<ul style="list-style-type: none"> Inheritance of children born out of marriage and of co-habiting parents 	<ul style="list-style-type: none"> Courts S&CD
Employment Act	<ul style="list-style-type: none"> Protect orphans from being used as cheap labor 	<ul style="list-style-type: none"> S&CD

ANNEX F. ORGANIZATIONAL PROFILE OF INTERVIEWED NGOs

	Organizational Profile
1 ¹⁴	FBO providing support for orphan registration, material support, PSS, and youth clubs. Serves local, rural community only. <ul style="list-style-type: none"> • Staffing: coordinator, counselor assisted by volunteers (number not specified) • Funding: Faith members' contributions
2	NGO serving 10 villages with pre-school daycare and after-school activities for children 3–16 years old. Services include orphan registration, education support (including tutoring), youth clubs, healthcare and outreach, including HIV testing and referral, and PSS. Also provides sewing and gym classes for mothers while children are in the center. Works closely with VDCs. Peer educators work at the community level to know families and their needs. <ul style="list-style-type: none"> • Staffing: manager, five peer educators, four VCT counselors, one vocational trainer, eight caregivers, one assistant, one driver • Funding: International donors and a philanthropist, but ending soon
3	NGO providing materials and education support, PSS, sports and youth clubs, and vocational training. Based in rural community. <ul style="list-style-type: none"> • Staffing: Not specified, but the coordinator cited organization's reliance on community volunteers • Funding: International donors and government subsidies
4	FBO providing daycare and education for children 2–6 years old. Services include food and material support, transport to and from school, and PSS. Based in a rural district. <ul style="list-style-type: none"> • Staffing: Coordinator, administrator, one counselor, two pre-school teachers, two assistant teachers • Funding: International donors, private sector donations, students' fees
5	NGO assisting primarily HIV-positive adults by providing daycare and educational support for clients' young children. Located in the city. <ul style="list-style-type: none"> • Staffing: Social workers and care assistants (number not specified) • Funding: PEPFAR, churches, and private businesses
6	FBO providing social protection of children 11–18 years old, education support, vocational training, clubs and camps, and PSS. City-based for local children. <ul style="list-style-type: none"> ▪ Staff: Coordinator and unspecified number of counselors ▪ Funding: PEPFAR
7	Large NGO providing food and material support, vocational training, mentoring children and organizing sports/youth clubs to about 1,000 OVC 3–15 years of age. Also trains other NGOs. City-based but serving surrounding areas. <ul style="list-style-type: none"> • Staffing: Not specified but includes workers trained in community organizing • Funding: Government and international donors
8	NGO providing orphan registration, legal protection, daycare, temporary housing, education services, PSS, youth clubs, and vocational training to children with hearing disabilities. Located in the city but serving various districts. <ul style="list-style-type: none"> • Staffing: Coordinator, unspecified number of teachers and counselors • Funding: Government and donors

¹⁴ To maintain confidentiality and ensure anonymity, the table lists nongovernment organizations chronologically by numbers only to ensure that the names, titles, organizations, and addresses of interview respondents remain confidential.

9	<p>FBO providing orphan registration, assistance in obtaining birth certificates, food and materials support, legal protection of children, pre-school program for children ages 0–7 years and 8–18 years old, education support, vocational training, clubs and camps, and PSS. City-based but serving children from various districts.</p> <ul style="list-style-type: none"> • Staffing: Project-funded manager, social worker, and volunteers • Funding: PEPFAR
10	<p>City-based NGO providing institutional and foster care for children 0–15 years old, mostly orphans. Services include legal protection, daycare, materials and education support, PSS, organizing youth clubs, and vocational training. Serves children from all over the country.</p> <ul style="list-style-type: none"> • Staffing: Manager, and unspecified number of staff • Funding: National government subsidy and international donors
11	<p>CBO providing community and home-based care for poor families with HIV-positive members. Services include daycare, pre-school education, PSS, and healthcare, including HIV testing and transport to health facility. Based in rural district.</p> <ul style="list-style-type: none"> • Staff: Coordinator, two pre-school teachers, one assistant pre-school teacher • Funding: Donors, church groups, from fees charged for pre-school services
12	<p>NGO providing daycare services, PSS, and organizing youth clubs.</p> <ul style="list-style-type: none"> • Staffing: no information. Only a volunteer daycare provider was present • Funding: no information
13	<p>FBO providing complete institutional care but only for about 10 children. Services include orphan registration, helping parents obtain birth certificates, education, health, food and materials support, PSS, and youth clubs. Based in a city.</p> <ul style="list-style-type: none"> • Staffing: Administrator, assistants, housemother, administrative support staff, and volunteers • Funding: Trust donated by a philanthropist and donations from members of the faith
14	<p>CBO for women’s empowerment providing assistance for orphan registration, obtaining birth certificates, food and materials support, after-school services, education, PSS, youth clubs, vocational training, and internship placement. Peri-urban location serving the district.</p> <ul style="list-style-type: none"> • Staffing: Part-time staff only • Funding: Trust fund of a large NGO network that gets international donors
15	<p>Newly established NGO serving children 13–18 years old. Services include social protection, education assistance, and supporting youth clubs. Serves peri-urban area.</p> <ul style="list-style-type: none"> • Staffing: Director and counselor • Funding: Applying for funding
16	<p>FBO providing home-based care for PLHIV. Services for children include assisting caregivers to obtain children’s birth certificates and getting food baskets, daycare, materials support, education assistance, and PSS. Assists health workers in HIV-positive children’s treatment adherence and monthly transport to health centers. Urban location serving local area and surrounding areas.</p> <ul style="list-style-type: none"> • Staffing: 14 including coordinator, two supervisors, four counselors, two teachers, administrative support staff, and three volunteers • Funding: Philanthropist’s trust and donations from members of the faith

17	<p>NGO assisting poor youths 12–18 years old. Services include legal protection, education support, livelihood training, internship placement, and PSS. City-based but serving surrounding areas.</p> <ul style="list-style-type: none"> • Staffing: Manager, one counselor, one peer education coordinator, administrative support staff, and volunteers (from the country or overseas) • Funding: U.S. embassy, other donors, private companies, individual sponsors
18	<p>FBO providing daycare and feeding of children whose parents are ill. Services also included orphan registration, supporting children’s education, youth clubs, PSS, transporting children to health facilities, and livelihood training. Started as home-based care for PLHIV, but expanded to include services for children. Serves peri-urban district and surrounding areas.</p> <ul style="list-style-type: none"> • Staffing: Manager, social worker, four teachers, four assistant teachers, two caregivers, one counselor, administrative support staff • Funding: International church groups members’ donations
19	<p>NGO assisting children with disabilities, most of whom are poor. Services include special education, school feeding, social/legal protection, PSS, organizing clubs, and transport to and from the center. Peri-urban location serving community and surrounding areas.</p> <ul style="list-style-type: none"> • Staffing: Coordinator, two special education teachers, one assistant teacher, one counselor, administrative support staff • Funding: Donors, government subsidies, and parents’ contributions.
20	<p>Government-supported NGO providing in-center feeding, material and education support, foster care, and PSS to 55 disabled children ages 6–18 (majority are ages 12–18). Twenty-two percent are on ART. Peri-urban facility for children from different parts of Botswana.</p> <ul style="list-style-type: none"> • Staffing: Director, one rehabilitation technician, one matron, and five housemothers • Funding: Subsidies provided by different government agencies
21	<p>NGO providing institutional and foster care for children 0–18 years old with disabilities. Services include material and education support, and PSS. Based in city.</p> <ul style="list-style-type: none"> • Staffing: Manager, 165 staff including social workers and counselors • Funding: International donors (60%) and government subsidies (40%)
22	<p>NGO rehabilitation center for children with disabilities. Services include orphan registration, daycare facilities, temporary housing, support for education and youth clubs, vocational training, and PSS. Peri-urban location but serves whole country.</p> <ul style="list-style-type: none"> • Staffing: Manager, one social worker, five physiotherapists, two occupational therapists, one technician, two housemothers • Funding: Government and community donations

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