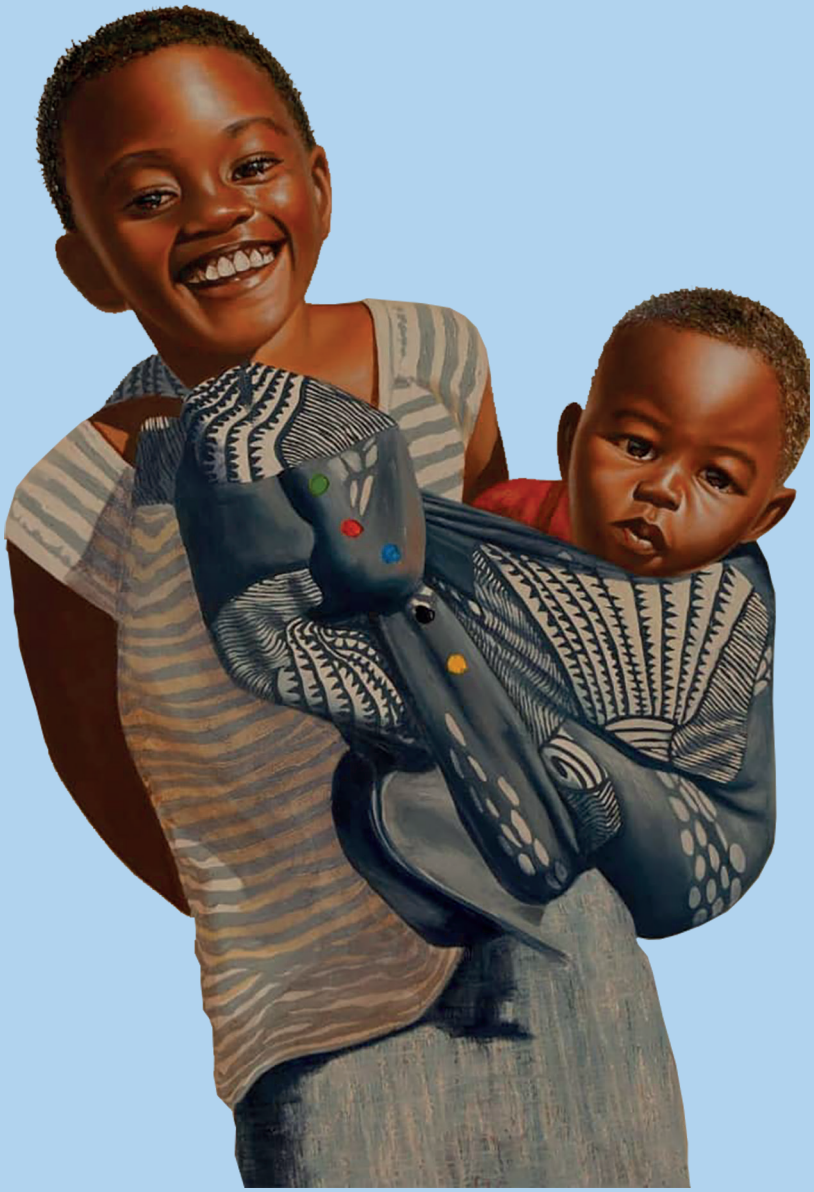
REPUBLIC OF BOTSWANA

MINISTRY OF LOCAL GOVERNMENT AND RURAL DEVELOPMENT
DEPARTMENT OF SOCIAL PROTECTION



NATIONAL SITUATION ANALYSIS ON ORPHANS AND VULNERABLE CHILDREN IN BOTSWANA

EXECUTIVE SUMMARY REPORT 2019

Cover art by Wilson Ngoni:

"*I want all governments to be like birds. A bird takes care of its eggs until they hatch, and then takes care of its nestlings until they can fly. But who is the government? It's us the people. Let's take care of our children so they grow into better citizens*."

This report is made possible by the generous support of the American people through the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID), under Cooperative Agreement AID-OAA-A-14-00061. The contents are the responsibility of the Coordinating Comprehensive Care for Children (4Children) project and do not necessarily reflect the views of USAID or the United States Government.

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List of Acronyms

4Children	Coordinating Comprehensive Care for Children
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
BAIS	Botswana AIDS Impact Survey
BIDPA	Botswana Institute for Development Policy Analysis
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
CHBC	Community Home-based Care
CRC	Convention on the Rights of the Child
CRS	Catholic Relief Services
CSO	Civil society organization
DCPC	District Child Protection Committee
DSP	Department of Social Protection
EA	Enumeration Area
EDC	Electronic Data Collection
FGD	Focus group discussion
G&C	Guidance and Counseling (teachers)
GoB	Government of Botswana
HH	Household
HIES	Household Income and Expenditure Survey
HIV	Human immunodeficiency virus
HRDD	Health Research and Development Division
KII	Key informant interviews
MLGRD	Ministry of Local Government and Rural Development
MoHW	Ministry of Health and Wellness
NCC	National Children's Council
NCCF	National Children's Consultative Forum
NGO	Non-governmental organization
NSLERHV	National Survey on Life Experiences and Risk of HIV Infection among 13-24 year-old Males and Females in Botswana
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PSS	Psychosocial support
QCI	Quality Control Interviewers
REPSSI	Regional Psychosocial Support Initiative
RG	Reference Group
S&CD	Social and Community Development
SOP	Standard Operating Procedures
SRH	Sexual and reproductive health
SW	Social worker
TQ	Ten Questions (disability screening tool)
TOR	Terms of Reference
TWG	Technical working group
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCPC	Village Child Protection Committee
YRBBSS2	Second Botswana Youth Risk Behavioural and Biological Surveillance Survey

Foreword

The Ministry of Local Government and Rural Development (MLGRD) through the Department of Social Protection (DSP) and the Social and Community Development (S&CD) at Local Authorities, has been implementing the Orphan Care Program over the last 20 years. Interventions under the programme, which are principally guided by the Short Term Plan of Action for Orphans and the National Plan of Action for Orphans and Vulnerable Children (2010-2016) are aimed at mitigating the immediate effects of orphan hood through the provision of basic needs to orphaned children. With the broader aim of further managing the orphan crisis, other programmes through which the number of orphans has been kept in check continue to be implemented. These include Antiretroviral Therapy (ART) programme as well as the TREAT ALL strategy for persons living with HIV which have further improved the quality of lives of most infected parents.

Experience has indicated that even though the number of orphans has been consistently declining, it has become evident that there are several other vulnerabilities that children face such as child neglect, drug and alcohol abuse, trafficking, child abuse, domestic violence, poverty, and natural disasters, to name just a few. These emerging needs for children have challenged the current government programs to be more inclusive and to move toward planning for OVC within a broader child protection framework so as to adequately provide protection to all children in different circumstances as prescribed in the Children's Act 2009.

The National Situation Analysis, therefore, comes at a time when the Department of Social Protection continues to engage different stakeholders in an effort to finalize the Orphan and Vulnerable Children Policy, which has long been planned. This study will be an indispensable tool with which we can appropriately develop interventions that will address specific critical emerging needs of orphans and other vulnerable children in a comprehensive, well-coordinated and responsive approach.

The Situation Analysis targeted nationally-representative survey of households with children between the ages of 0 and 17 years; and a qualitative research component (also conducted nationally), which focused on key issues and populations of particular interest to MLGRD-DSP.

A lot of effort was put in designing, implementation and packaging of this study. The United States Government (USG) through its President Emergency Plan for AIDS Relief (PEPF AR) which provided the funds for this study is specially acknowledged for making it possible to generate the amount of data that is so critical for programming. Furthermore, the children, parents, caregivers and communities that participated, contributed immensely towards the success of the project. Also the vital support of our development partners, stakeholders, as well as the respondents will forever be appreciated with much gratitude. The production of this report could not have been possible without their dedication, sacrifice and commitment towards advancing the protection of our children.

We remain indebted to your continued support.

Botlogile Tshireletso
Assistant Minister,
Ministry of Local Government and Rural Development

Acknowledgements

The National Situation Analysis on Orphans and Vulnerable Children in Botswana 2019 was made possible through the dedicated effort and passion of many stakeholders that hold children's issues with the highest esteem.

The Ministry of Local Government and Rural Development (MLGRD)'s Department of Social Protection (DSP) extends its gratitude to the United States Government (USG) through USAID Botswana and the President's Emergency Plan for AIDS Relief (PEPFAR) for availing the funds for the study. DSP is especially grateful for the technical support, direction and selfless service PEPFAR offered through Ms. Mosarwa Segwabe who is the Deputy Health Office Director/ OVC Advisor, Ms. Martha Skiles the Strategic Information and Health Financing Advisor and Ms. Segametsi Duge, the Monitoring and Evaluation Specialist throughout this period.

Different Ministries have tremendously contributed to the success of this study as members of the Reference Group (RG) and the Technical Working Group (TWG) and for this we are indebted to them. In this regard, special thanks goes to Ministry of Health and Wellness Department of Public Health, Department of AIDS Prevention and Care, NACA (now NAHPA); Ministry of Defence, Justice and Security (Botswana Police Service and Department of Public Prosecutions); and Ministry of Basic Education (Department Special Support Services) as well as the Attorney General's Chambers.

Civil Society Organisations (CSOs) remain a significant partner to complement government's efforts towards advancing the child protection mandate. Appreciation goes to Childline Botswana; Project Concern International (PCI); Botswana Council of Churches; Marang Child Care Network Trust; Botswana Council for Non -Governmental Organisations (BOCONGO); Ark 'n Mark Trust; SOS Children's Villages Botswana; Masiela Trust Fund; Botswana Christian AIDS Intervention Programme (BOCAIP) and Regional Psychosocial Support Initiative (REPSSI).

We are grateful to Statistics Botswana for their much needed expertise and direction during this project. The University of Botswana and Botho University also played a pivotal role in this process and we will continually cherish them as our key partners in child welfare programming and policy reform.

We will forever be grateful to the Development Partners who walked this journey with us; UNAIDS, UNFPA, UNICEF and US Peace Corps.

We acknowledge the commitment of all social workers from the different Local Authorities who facilitated the researchers during the different stages of the project; your contribution is invaluable. All the children, parents, caregivers, service providers and community leaders deserve the utmost thanks from us because without their participation in the project; it would not have taken off at all.

We are eternally appreciative of the financial support from Project Concern International (PCI) that sponsored the printing of the National Situation Analysis on Orphans and Vulnerable Children in Botswana 2019 report and launch materials; with you as a partner achieving child protection is feasible.

Special appreciation goes to Mary Mosenke and Kenaleone Ramoroka for their outstanding work on the difficult task of back-translating the questionnaires, and to Mr. Wilson Ngoni, the artistic brain behind the beautiful picture on the cover of the report; your art speaks volumes and we are grateful for your involvement.

The 4Children formidable team led by Mr Tom Ventimiglia, Karen Doll, Karen Megazzini, Lynette Mudekunye and Tom Scialfa, together with Professors Keitseope Nthomang and Tapologo Maundeni, and with locally committed support from Ms. Scholastica Williams, who worked tirelessly and under difficult timelines to ensure success of the project; 4Children is undeniably for child protection.

Finally, DSP is grateful to its philanthropic staff members from the different divisions who through their vigour and dedication ensured the coordination of the project.

Indeed, the Setswana proverb that says ***"Setshwarwa ke ntsa pedi ga se thata"*** (loosely translated ***"If we all work together nothing is impossible")*** came to life throughout this project.

Thank you All.

Hamilton Mogatusi
Director,
Department of Social Protection, MLGRD

1. EXECUTIVE SUMMARY

1.1 Rationale and Objectives for the National Situation Analysis on OVC

Botswana has a well-established commitment to protecting and safeguarding the well-being of its children. A variety of policies, plans, legal instruments, structures, and programs have been put in place to guide this effort and, in particular, to guide the country's response to the needs of orphans, vulnerable children, and the families caring for them.

In 2007, a national Situation Analysis on orphans and vulnerable children (OVC) was carried out, for the purpose of describing the well-being status of OVC and guiding services and programming for vulnerable children. Now 10 years later, the situation of OVC in the country has changed significantly. This is due to many factors, including the passing of the Children's Act of 2009, development and implementation of the National Plan of Action on the Care of Orphans and Vulnerable Children (2010-2016), implementation of a range of other response measures, led by the Ministry of Local Government and Rural Development, Department of Social Protection (MLGRD-DSP), and adoption of a treat-all strategy for those with HIV, which has greatly reduced morbidity and mortality due to AIDS.

To provide an updated picture on the current situation of OVC, adolescents, and their caregivers, the Government of Botswana (GoB), through the MLGRD-DSP, has conducted a second National Situation Analysis on OVC in Botswana, with financial and technical support from the United States Agency for International Development (USAID)/Botswana. The overarching aim is to examine the needs and vulnerabilities of OVC, assess the range and relevance of services provided, highlight successes and challenges in serving this population, and identify gaps which need to be addressed. Specific objectives included in the Terms of Reference (TOR) for the National Situation Analysis on OVC were as follows:

1. To measure the magnitude and implications of the OVC situation in Botswana;
2. To establish the extent to which selected recommendations from the 2007 national situation analysis on OVC in Botswana have been implemented;
3. To establish if the right people are being reached with the right services at the right time;
4. To understand the needs of adolescent OVC (in and out of school); appropriate interventions; the best way to reach them with services; and the best way to prepare them for successful graduation from welfare support; and
5. To document and analyze the current response by all partners (GoB, private sector, and development partners) to the situation of OVC including identifying the gaps and bottlenecks in implementation.

Results from the Situation Analysis are intended to assist the MLGRD to determine the extent to which the needs of OVC are being met and whether or not services provided by various partners remain relevant, culturally sensitive, and context specific and to inform the development of programs, plans, and advocacy strategies – including a National Plan of Action for OVC post-2016 and a National OVC Policy – for an improved, national OVC response.

1.2 Planning and Oversight

The Situation Analysis on OVC was planned and led by MLGRD-DSP, including drafting of the study's TOR, overseeing the development of study protocols and data collection tools, and mobilizing the participation of government ministries and departments, civil society, development partners, relevant umbrella organizations, and study communities. MLGRD-DSP established a Technical Working Group

(TWG) and Reference Group (RG), responsible primarily for providing technical advice, ensuring relevance and compliance, and approving the study's tools, inception report, and final report. It is envisaged that the TWG and RG will also participate in the dissemination of study findings and development of the response plan.

Key study domains, highest priority indicators, detailed study protocols, and data collection instruments were agreed collaboratively with MLGRD-DSP, USAID, the TWG, and the study's implementing partner, the Coordinating Comprehensive Care for Children project (4Children). After review and approval by the RG, finalized protocols and data collection instruments in English and Setswana were approved by the Health Research and Development Division (HRDD) of the Ministry of Health and Wellness (MOHW).

4Children contracted 5 AM Holdings (Pty) Ltd. to carry out the household survey data collection and data entry, while a team of content and research experts from the University of Botswana, Regional Psychosocial Support Initiative (REPSSI), and 4Children carried out the qualitative research component data collection and analysis.

1.3 Methodology

The National Situation Analysis on OVC consists of two main components: a nationally-representative survey of households with children between the ages of 0 and 17 years, and a qualitative research component, also conducted nationally. Both components of the study were carried out in accordance with the HRDD-approved study protocol. The protocol outlined procedures for ensuring adherence to required ethical considerations, included informed consent/assent, confidentiality, anonymity, participation risks and benefits, and child protection measures.

Primary data collection took place between September and November 2017.

Household Survey

The household survey was designed to provide an estimate of the proportion of children ages 0-17 years who meet the definition of "orphan" or "vulnerable". In addition, it aims to describe the characteristics and vulnerabilities of OVC and adolescents, in relation to their health and nutritional status, education and livelihoods, psychosocial/ emotional health and social behavior, child protection and labor, family care, and economic status. Finally, the survey enables an assessment of the availability and use of social support services at household level, including those provided through the social welfare workforce.

A two-stage, stratified sampling methodology was used to identify eligible households to participate in the survey. From all Enumeration Areas (EA) in the country, 129 EAs were randomly selected to be included, and 127 EAs were enumerated, including 28 from the cities/towns stratum, 48 from urban villages, and 51 from rural villages. In the 127 enumerated EAs, a total of 2,344 eligible households were randomly selected for interview. Of these, 2,094 households were interviewed. The overall household-level response rate was 89.3% (response rates by stratum were 78.1%, 91.5%, and 94.4% for cities/town, urban villages, and rural villages, respectively).

Survey questionnaires were administered to the heads of households with children below the age of 18 years, to the primary caregivers of children in the household, and to children between the ages of 13 to 17 years. Over 3,000 respondents were interviewed in the 2,094 households. The respondents include 2,360 caregivers and 700 adolescents (13-17 years of age). The caregivers were interviewed about a total of 4,768 children 0-17 years. Children between the ages of 6 to 59 months had their mid-

upper arm circumference (MUAC) measured. Caregiver response rates were close to 100%, while adolescent response rates ranged from 83% in cities/towns to just over 88% in rural villages.

Data were collected electronically on Android tablets pre-programmed with the English and Setswana versions of the questionnaires, using SurveyToGo data collection software. All statistical analyses were generated using the Statistical Package for the Social Sciences (SPSS). Scope and budget did not allow for extensive multivariate or hierarchical analyses during the preparation of this report, although such analyses are feasible in the future.

Qualitative Research

Qualitative research was carried out to provide more detailed information on populations and topics of particular interest to MLGRD-DSP. Key populations of interest include children living outside family settings (children spending time on the streets and children living in institutional care, in remote area/settlement hostels, and in reformation centres for youth) as well as adolescent OVC. Among others, key topics of interest include the social welfare workforce and their role in providing OVC services, and the effectiveness and gaps in implementing the response to OVC through other stakeholders, including civil society, private sector, and donors.

A list of priority study sites for the qualitative research was finalized in coordination with the MLGRD-DSP and the TWG. Qualitative data were collected from all ten rural districts (Central, Chobe, Ghanzi, Kgatleng, Kgalagadi, Kweneng, Ngamiland, Northeast, Southern, and Southeast) and from six urban districts (Gaborone, Francistown, Jwaneng, Lobatse, Orapa, and Selebi-Phikwe). At each study site, key informant interviews (KII) and focus group discussions (FGD) were held with service providers, government and civil society representatives, village leadership, child-focused structures such child protection committees, parents/caregivers, and older children (13 years and above). In addition, KII were held with national-level respondents, including representatives from MLGRD-DSP and other relevant government ministries and departments, donors, and CSOs.

In total, 137 KII and 84 FGD were held, with a total of 765 respondents participating. All KII and FGD were transcribed and reviewed by the qualitative research team. Key themes, relationships, issues, and notable outliers were extracted and summarized for further discussion, validation, and summary as findings and conclusions.

1.4 Limitations

The realities of available budget and time influenced the study methodologies and place some limitations on the findings. For example, due to the need to balance budget and sample size considerations, the household survey was not powered to provide district-level estimates, and as a consequence, comparisons between districts cannot be made. On the qualitative research side, not every site or facility of interest could be visited, and so findings from those which were visited cannot necessarily be generalized to every place in the country.

This study's estimate of the magnitude of vulnerability among children is limited both by the fact that estimates of vulnerability due to abuse and HIV status were not made, to avoid duplication with other recent studies, and by the lack of harmonized operational definitions for some vulnerability criteria. Comparing vulnerability estimates with the 2007 Situation Analysis on OVC, for example, is limited by differences in how the poverty and illness criteria were defined in the two studies.

Other important study limitations include the general absence of documentation around service delivery and outcomes, which presented a significant data collection challenge to the qualitative research team in particular, and inclusion in the household survey of adolescents only up to the age

of 17 (those 18 years and older were not included); thus issues which are more pronounced in older adolescents or young adults, were not adequately explored.

1.5 Findings: Magnitude of the Situation of Orphans and Vulnerable Children

Magnitude of the OVC Situation – Orphans

Results from the household survey indicate that approximately 15.4% of children in Botswana are orphans according to the most commonly used international definition (a child under 18 years of age whose mother, father, or both are deceased). Using the Botswana government definition (child of a single parent – mother or father – who has died, or child in a two-parent household where both parents have died), the survey finds that 6.1% of children are orphans. These estimates are in line with those of other studies, including the previous Situation Analysis on OVC (which estimated that 6.5% and 17.2% of children were orphans by the Botswana and international definitions, respectively).

Orphans by either definition are more likely to be female and to be living in urban or rural villages. Differences by age group are also significant, with older children being more likely to be orphans than younger children. Children living in cities/towns are less likely than those in rural or urban villages to be orphans. A higher percentage of children in single-headed households (male or female-headed) are orphans than those in households with both male and female parents/caregivers.

Magnitude of the OVC Situation – Vulnerable Children

The definition of a vulnerable child in Botswana includes those who live in an abusive environment, in a poverty-stricken family unable to access basic services, in a child-headed household, with sick parent(s) or guardian(s), outside family care, or with HIV. The household survey provides estimates of the number of children meeting some of these vulnerability criteria, including children living in poverty and without access to basic services, children living in a child-headed household, and children living with a sick parent or guardian. In addition, the qualitative research component explores the situation of children living outside of family care, including those who spend time on the streets, and those who live in residential care facilities, remote area hostels, centers for children living with disabilities, and facilities for those in conflict with the law.

None of the households sampled in the survey are headed by children (the previous Situation Analysis found only two), indicating that this phenomenon remains rare in Botswana. The number of children living outside family care is also relatively small, but this Situation Analysis confirms that they experience a wide range of vulnerabilities, as highlighted below.

A much higher proportion of children, approximately one in three, are estimated to be vulnerable based on household-level poverty and lack of access to services or because of living with a chronically ill parent or caregiver. Likewise, although the Situation Analysis does not seek to measure the scale, many children are vulnerable due to abuse and/or HIV. Though the number of new HIV infections among children has been on the decline, the result of successful prevention and treatment interventions, the most recent Botswana AIDS Impact Survey (BAIS IV) estimates that 5.0% of children 10-19 years and 4.3% of children 5-9 years are living with HIV. Similarly, violence against children, including physical, sexual, and emotional abuse, is under-reported but is not rare.

Magnitude of the OVC Situation – Orphans and Vulnerable Children

Based on estimates from the household survey, approximately 35% of children are orphans or vulnerable children (including almost 3% who are both orphaned and vulnerable), while 65% of children are non-OVC. These estimates do not include children who live in an abusive environment, are HIV-positive, or live outside family care.

1.6 Findings: Situation of Orphans and Vulnerable Children, Adolescents, and Caregivers

Households with Orphans and Vulnerable Children

According to the household survey, approximately one in ten households in Botswana has an orphan, while three in ten have a child who meets the criteria of being vulnerable due to living in poverty (lowest wealth quintile) or with an ill parent or caregiver. Bivariate analyses show statistically significant associations between such households and several common characteristics, such as rural or urban village location, the absence of any adults who attended primary school, and being headed by a single female or male (without spouse or partner in the house).

Households which have orphans (using the Botswana definition) and/or vulnerable children or both (either a child who is both orphaned and vulnerable or at least one orphaned child and one vulnerable child), have characteristics that differ in some important ways than households with no orphans or vulnerable children.

For example, a much higher percentage of households with orphans and/or vulnerable children are without finished roofing, floors, and walls than are households with no OVC, and they are less likely to be fully protected from the elements. Similarly, households with orphans and/or vulnerable children are much less likely than those with no OVC to have access to electricity or gas for cooking, and to own material assets such as appliances (TV, radio, refrigerator, mobile phone) and vehicles, including bicycles or cars. A surprising result is that the percentage of households that own land and livestock is greater among orphan and/or vulnerable households than it is among non-OVC households.

Dietary diversity scores are considerably lower in households with an orphan and/or vulnerable child present, compared to those with no OVC. Similarly, households with orphans and/or vulnerable children have much higher proportions experiencing moderate and severe hunger than those with no OVC.

A slightly higher proportion of households with orphans and/or vulnerable children rate themselves as less secure financially than they were in the previous year compared to those without OVC. However, the ability to pay for household expenses on food, school, or unexpected needs such as urgent medical expenses or household repairs varies. While households without OVC are most likely to report being able to pay for food expenses, households with orphans are slightly more likely to report being able to pay for school-related expenses and for other unexpected expenses. This is possibly influenced by receipt of government support in orphan households. Unsurprisingly, poorer households are least likely to be able to pay.

Participation in savings or lending groups, such as *motshelo*, farmers' associations, or women's groups, is highest among households with no OVC and those with a sick guardian, followed by those with orphans. Households with vulnerable children due to poverty and those with both orphans and vulnerable children are least likely to be participating; this follows given that this was a criteria which factors into the wealth index used to identify vulnerable (poverty-stricken) children. Across all types of households, those participating in savings and lending groups are less likely to experience moderate to severe hunger than those not participating in such groups.

The Situation of Orphans and Vulnerable Children

Children in Households

The 4,768 children under the age of 18 years included in the household survey are categorized as follows:

- Orphans, regardless of their vulnerability status;
- Vulnerable by virtue of living in a household in the lowest wealth quintile, regardless of their orphan status (and regardless of whether they are also vulnerable due to living with a sick parent or caregiver);
- Vulnerable by virtue of living with a chronically ill parent or caregiver, regardless of orphan status, but not including children living in households in the lowest wealth quintile;
- Both orphan and vulnerable (either type);
- Neither an orphan nor vulnerable (either type).

There are quantifiable differences between orphans and vulnerable children and children who are not orphans or vulnerable. Across most domains of access and well-being, and with only a few exceptions, orphans and vulnerable children are worse off than other children. For example, the results of the household survey show that:

- Orphans and vulnerable children are less likely than non-orphans and non-vulnerable children to have their basic needs met (to live in good housing, not experience hunger, and have basic material essentials such as clothing and something to sleep on). Children in lowest wealth quintile households are least likely to have their basic needs met. Across all OVC status categories, households in rural villages have the lowest percentage of children with basic needs met, while those in cities/towns have the highest percentage.
- School enrollment rates, including in early childhood development activities, are lower for all groups of orphans and vulnerable children. In addition, a higher proportion of orphans, vulnerable children, and those who are both orphan and vulnerable have dropped out of school compared to non-OVC. Orphans and vulnerable children, on the other hand, have lower rates of grade repetition than non-OVC. Similarly, the proportion of children missing school during the last week is lower among orphans and those who are orphan and vulnerable compared to non-OVC. Children with a sick guardian, however, have much higher rates of missing school than the average.
- Orphans and poverty-stricken vulnerable children are more likely to be moderately or severely malnourished (although the rates are very low overall, and statistical significance testing is not possible due to the small numbers).
- Orphans and those who are both orphaned and vulnerable are less likely to be vaccinated against the common childhood diseases (or to be able to provide documentation to verify vaccination).
- Children with an ill parent or caregiver are most likely to be reported as being too sick to participate in daily activities, with a relatively high proportion of poverty-stricken children also being reported as being sick. Male children are significantly more likely to be reported as sick than female children.
- Orphans and vulnerable children are less likely to have been tested for HIV and to have their HIV status known by a caregiver. Orphans are least likely to have been tested and to have known HIV status; those who are both orphaned and vulnerable have even lower rates. Aside from OVC status, the children least likely to have tested are female, living in rural villages, and not living with a parent.

- Orphans and vulnerable children are more likely than non-OVC to screen positive for developmental delays or physical impairments (disabilities), although the study does not attempt to quantify the proportion of children with disabilities.
- Orphans and vulnerable children score poorer on most measures of psychosocial/emotional health, using scales that assess conduct problems, hyperactivity/inattention, emotional symptoms, peer relationship problems, and social problems.
- Orphans and vulnerable children are less likely to have birth certificates. Boys, and children in rural villages, children in single-headed households, and children not living with a parent in the household are all less likely to have a birth certificate.
- Children with ill parents or guardians are most likely to be engaged in household chores or other work, followed by orphans, while children in poverty-stricken homes are least likely to be engaged. Among those who work, around 15% work under some type of more dangerous condition, such as carrying heavy loads, working with dangerous tools or machinery, or being exposed to environmental hazards. Very few caregivers report that their child works at night, or that work interferes with a child's school attendance, and fewer than one percent of children are reported by their caregivers to be engaged in any activities included in the UN definition of the Worst Forms of Child Labour.
- Approximately half of caregivers think that hitting or beating a child is appropriate when a child needs to be disciplined or controlled, with little difference by the orphan or vulnerability status of their children. However, a higher percentage of caregivers with orphans or with both orphans and vulnerable children in their care report caretaking behaviors that might be considered reflective of neglect, compared to those with no OVC and compared to those caregivers with children defined as vulnerable.

Children Living Outside Family Care

Many of the most vulnerable children do not live in family settings. These include children who live or spend time on the streets, children who live in residential care facilities, children who live in centers for people with disabilities, children who live (during the school year) in remote area development hostels, and children who have been placed in detention or reformation centers.

Quantitative data were not collected from children who live outside of a family or household setting, but qualitative research, consisting of KII and FGD with service providers and older children in these environments, was carried out to provide a picture of their characteristics and needs and the services being provided to them.

Children in the Streets – Compared to other countries, Botswana has relatively few locations with a visible population of children who live or spend time on the streets. Nevertheless, children who spend time on the street – including those found by the qualitative research team in Jwaneng, Ghanzi, and Letlhakane – are among the most marginalized, vulnerable, and neglected of children, and usually come from families facing multiple, intersecting vulnerabilities. Of those who spend time in the streets, only a small percentage live there on a full-time basis. While some are orphans, most have living parents or other relatives. The households from which they come, however, are often characterized by poverty, neglect, abuse, or violence, and these are key factors in the decision to be on the streets. Children spending time on the streets suffer from numerous forms of abuse and social problems, including abuse and isolation from the public, physical violence, hunger, alcohol and drug abuse, sexual abuse and exploitation, and exploitation for cheap labour. Some are still attending school, but many have dropped out of school (and/or the remote area hostels). A majority are male, and between the ages of 10 and 18 years.

The GoB has no specialized services targeting children living in the streets, but a few NGOs and private individuals provide services. Social workers, the police, and teachers also interact regularly with these children. Government interventions have largely been limited to occasional repatriation efforts (taking children living in the street back to their homes or to care facilities, such as remote area hostels).

Children in Residential Care - Botswana has a small number of residential care facilities (RCF) established for the provision of care to orphans or children separated from their families and without other suitable family-centered care alternatives. The placement of children in residential care is discouraged, except in cases where children cannot or should not (for the protection of the child) be taken care of by their families. As a result, Botswana has very few children living in RCFs. The qualitative research team visited all seven of the major RCFs as identified by the MLGRD-DSP, with a combined caseload of around 500 children. While in the past a majority of children accommodated in RCFs were orphans, main causes of admission to the RCFs now include abuse, neglect, abandonment, and, more recently, child trafficking cases.

Most RCFs have adopted models of care – such as a "village" or family setup where children live in family-like groups with round-the-clock care provided by a house mother or aunt – which attempt to minimize the negative impacts of institutional care. The RCFs generally provide comprehensive care services (with gaps noted in psychosocial support and counseling and other services for survivors of abuse and trafficking or those with physical or mental disabilities) and employ trained staff who have requisite qualifications and are guided by standard operating procedures and codes of conduct. Many also work directly with families of vulnerable children so as to prevent separation of children and placement in centres.

Many RCF staff concede that even in the best-run facilities, children still miss out on the stability, emotional support, and love that a family can provide. Moreover, despite the aim of providing care on a temporary basis, RCFs are in fact serving as long-term care providers for many children, some of whom are spending their entire childhoods (and sometimes beyond) in the centres, often with minimal family contact. This is due to difficulties faced in tracing families and placing children back in their families, especially in cases of abuse or neglect, and to the infrequent use of alternative care options aside from kinship care, such as foster care or adoption.

Children in Centres for the Disabled - Botswana also has a small number of care facilities for children living with disabilities (CLWD). The qualitative research team visited six of these organizations, which are providing live-in or day services for children with learning disabilities, visual and hearing impairment, and other disabilities such as autism, cerebral palsy, Down syndrome, epilepsy, and others. In addition to the centers providing dedicated care services to CLWD, the GoB has established classes for children with special needs, attached to a few schools. Children at these schools are still under family-based care.

Although it is not known how many children in Botswana are living with disabilities, it is widely reported that there are many children with disabilities who are not able to access appropriate care, especially among those living in remote and rural areas. A shortage of centers for children living with disabilities or special needs, preference for integrating CLWD into mainstream schools rather than isolating them from communities, a shortage of disability assessment services, inability of some centers to provide differentiated care for children of different levels or types of disability, and poor family engagement and support all contribute to many CLWD not receiving needed or timely care.

Children in Remote Area Development Hostels - The Remote Area Dwellers (RAD) hostels cater for children of families who live in very small, remote settlements or who live on ranches, farms, or cattle posts, without government schools (and often other development services). The RAD hostels provide

boarding facilities for primary school-age children, who live away from home during the school term. When the Situation Analysis was conducted, there were 24 remote area hostels in the country, with a combined capacity of just under 5,000 children, both males and females. During the Situation Analysis, site visits were made to 17 of the 24. Children living in the hostels mostly range in age from five or six years to around 17 years, though students as old as 21 years are found in some hostels.

The hostels provide educational access to children who may not otherwise have the opportunity to attend school. For the most part, they also meet other basic needs of the students, such as health care, nutritional support, and clothing, often at a standard at least as high as conditions in many of the home areas. Some children as well as hostel and school staff feel that they are better cared for in the hostels than they are at home, and some children who do not live at the hostels feel that children in the hostels are better off. In the majority of places for which data are available, however, school performance of the children living at the hostel is below that of other children attending the same school.

The hostel approach raises a number of serious concerns for the well-being of children. These include the separation of children from their families at very young ages. In addition, the hostels lack best practice features of residential care arrangements (living in "family style" small groups, consistent caregivers, age-grouping, community integration, and strong family connections). In a few places, hostels are also used as places to accommodate children with behavioral or other "social problems" including those removed from the streets, with no provisions made for meeting the special needs of these children, nor for protecting the well-being of the other children or the staff. Limited engagement by government social workers or community development officers, limited child welfare training for staff, and limited meaningful psychosocial support services also negatively impact child well-being in most remote area hostels, even in those with very committed and hard-working staff.

Children in Conflict with the Law - Two facilities accommodate (male) children in conflict with the law. Such children are seldom held on remand, but if they are, it is at the Moshupa Center, a boy's reformation center, which was not able to be accessed by the research team. The team visited Ikago center, a government-run rehabilitation facility for adolescent males in conflict with the law. It has a capacity of 100 residents, but since its inception, the number of children in the center has never exceeded 50; at the time of data collection, there were only ten residents (between the ages of 14 and 19).

Ikago residents are housed for the duration of their placement, typically between two and three years. Approaches to rehabilitation include a limited set of skills training, counselling, spiritual enhancement, and education about alcohol, drugs, and risk behaviors. Academic instruction is not provided, and residents note that their days are often spent in loneliness and boredom. Contact with family members is also limited, though some residents are allowed home visits for demonstrating good behavior. No information is available on recidivism rates.

An overarching challenge around justice for children in Botswana is that there is little priority given to children in the legal system. In spite of the law being clear about neglect, sexual abuse, and other offenses against children, cases involving children, whether as a witness or offender, are not prioritized. Workload issues and/or a lack of knowledge about procedures limit the ability of some social workers to provide appropriate counsel and assist children and their families to navigate the legal system. Efforts are being made, through training and setting up of specialized child-focused departments, to improve services for children in conflict with the law or otherwise in the justice system.

Adolescent OVC

In addition to the findings above, which include adolescents, 700 adolescents (ages 13-17 years) were also interviewed during the household survey, about food security, psychosocial health and social support, social media use, HIV knowledge, HIV testing, sexual behavior, use of alcohol and drugs, and access to training and other support services. Key findings from the adolescent interviews include:

- The experience of hunger (having to eat smaller meals than needed, skip meals, go to sleep hungry, or spend the whole day and night without eating) is most commonly reported among adolescents in poverty-stricken households, followed by those who are both orphan and vulnerable, and orphans. Males, adolescents living in rural or urban villages, and those not living with parents are all more likely to experience moderate or severe hunger.
- Orphans and vulnerable children are more likely than non-OVC to report being pregnant or having ever been pregnant. However, non-OVC are more likely to report receiving SRH services than orphans and vulnerable children. Males and older adolescents are more likely to report receiving SRH services.
- About 10% of adolescents say they have never heard about HIV and AIDS or do not know if they have. Non-OVC have better knowledge on HIV than orphans and vulnerable children. Males, those in rural areas, younger adolescents, and those not living with parents generally have lower knowledge levels compared to females, those in urban areas, older adolescents, and those living with at least one parent.
- Those who are both orphan and vulnerable are least likely to have been tested for HIV and to know their results. Orphans and/or vulnerable adolescent children are also less likely than non-OVC to know where to get an HIV test and where to go if they are found to be HIV-positive. Again, those who are both orphan and vulnerable are least likely to have this knowledge. Females and those living in rural villages are less likely than males or those in urban villages and cities/towns to have ever tested, receive results, or know where to go for testing or treatment.
- Rates of self-reported use of alcohol, cigarettes, and drugs are considerably lower than found in other studies. Based on fairly small sample sizes, by OVC status, children with a sick guardian have the highest rates of alcohol use, followed by non-OVC, and then by orphans.
- Access to the internet and social media is much lower among all categories of orphans and vulnerable adolescent children than among non-OVC, with lowest access among children in poverty-stricken households. Internet use is significantly higher among males, older adolescents, and those in cities/towns, followed by those in urban villages.
- Overall, only a small percentage of adolescents are characterized by low self-esteem or an absence of hopes and dreams, but the proportion is much higher among orphans and vulnerable adolescent children than among non-OVC. Similarly, while overall levels of unhappiness and dissatisfaction are low, orphans and vulnerable children have much higher levels than non-OVC. Children living with a sick parent or caregiver are an exception to this pattern.
- Orphans and vulnerable children report receiving much lower levels of social and emotional support than do non-OVC (based on whether they have people in their lives who show them love and affection, provide advice, assist them with their chores when they are sick, and with whom they do interesting things). Those not living with a parent perceive lower levels of support than those who are.
- Many adolescents say they do not feel safe at home or in their community, some or all of the time; the proportion of orphans and vulnerable children who do not feel safe in their homes is

significantly higher than among non-OVC. Notably, nearly a third of orphans feel a lack of safety at home. Orphans are also least likely to express feelings of safety in their community.

Caregivers of OVC

A total of 2,360 caregivers of children were interviewed in the household survey. About 90% were female, and they ranged in age from under 20 to over 70 years. Around three-quarters were caring for one or two children, while others were caring for three or more children. Around one-third of caregivers were married or living with a partner, while more than half had never been married.

The caregivers are categorized according to whether any of the children under their care are orphans, vulnerable (according to either the poverty criteria or the sick parent or caregiver criteria), both orphaned and vulnerable, or neither orphan nor vulnerable (non-OVC).

The level of support experienced by caregivers is assessed on a scale based on four questions about whether they have people in their lives who show them love and affection (affectionate support), provide advice (emotional support), can assist them in case they are sick (tangible support), and with whom they can do interesting things (social support). Caregiver stress is also assessed on a (non-validated) scale, based on 14 questions about their experiences and feelings about being a caregiver. Based on responses to all questions, caregivers are categorized as likely to have little or no support or else to have higher levels of support, and are categorized separately as having low, moderate, or high risk of caregiving stress.

The level of support experienced by caregivers (based on a scale measuring affectionate support, emotional support, tangible support, and social support) is lowest among those who are caring for orphans and/or vulnerable children. Moreover, levels of caregiver stress are higher among these caregivers than among those without OVC. Caregivers with both orphans and vulnerable children under their care report the lowest levels of support and highest stress levels. They are also most likely to report being too tired or too sick to participate in daily activities.

1.7 Findings: Response to the OVC Situation

Government

The GoB leads a strong, multi-sectoral response to the situation of orphans and vulnerable children in Botswana, supported by civil society and other development partners. A major achievement since the 2007 Situation Analysis on OVC was the passing of the Children's Act, 2009, which deals substantively with the needs of vulnerable children, including those in need of protection. Among other outcomes, the Children's Act of 2009 established a high-level, multi-sectoral National Children's Council (NCC), the National Children's Consultative Forum (NCCF), and Child Protection Committees with government and community representation. All of these structures have experienced challenges in carrying out their prescribed responsibilities, including challenges related to role definition, levels of participation and functionality, and training. Nevertheless, they have also contributed to a range of important achievements such as raising awareness about the needs of vulnerable children, prioritizing child welfare in the development agenda, and promoting initiatives for the protection, care, and support of children and their caregivers, including advocacy for legislation change and enforcement of the Children's Act.

The OVC response is led by the MLGRD, but involves many other government ministries such as the Ministry of Health and Welfare (MOHW); Ministry of Basic Education; Ministry of Tertiary Education, Research, Science and Technology; and Ministry of Youth, Sports and Culture (MYSC), as well as the Police Service and other government personnel. Supporting MLGRD efforts, they provide services specifically targeted to vulnerable children, such as those who are HIV-affected, live in low-income

households, and have certain types of disabilities or other special needs. In addition, free or subsidized schooling, school feeding programs, and the post-secondary dispensation program all directly benefit orphans and vulnerable children.

MLGRD fulfills its mandate to provide for the well-being of children through policy direction, administrative and financial support, capacity building, supervision of social services, and coordination of other actors serving OVC. MLGRD also provides direct services, such as operating facilities for children living outside of family care. It also oversees government social protection programs which provide assistance packages to orphans or other needy children or their families. Key among these are the Orphan Care Program and assistance for Needy Students and Children in Need of Care. Other OVC are supported indirectly through the participation of their households in other safety net programs, such as the Destitute Persons Program, Old Age Pension, and *Ipeleleng*, a pay-for-work program targeting the poor. The RAD Program, managed through the MLGRD-DCD, promotes access of remote area dwellers to basic development infrastructure and services for OVC, including education, livelihood support, and other initiatives aimed at reducing the social and economic marginalization of populations living in these areas.

Between 2008 and 2017, the total number of orphans and vulnerable children served under the Orphan and Needy Children programs has seen an overall decline, from a high of over 80,000 in 2010 to fewer than 65,000 in 2017. The number of orphans registered under the Orphan Care Program has declined each year for the past ten years, while the number of vulnerable children (needy students and other children in need of care) has been on the increase. Declines in the number of orphans supported under the Orphan Care Support program reflect decreases in available funding, but also may be a result of the success in Botswana's ART program, which in keeping people living with HIV alive has resulted in fewer children being orphaned.

Results from the household survey indicate that a substantial proportion of households with an orphan and/or vulnerable child access any type of government social protection program (between 39% and 54%, depending on the type of household). About 28% of households with an orphan child receive support through the Orphan Care program specifically. It is noteworthy that a fairly sizable portion of non-OVC households – around 20% – also access social protection, which may be due to a level of poverty or vulnerability, or may not. Aside from targeting and resource challenges, other reported challenges facing these programs include difficulties in graduating recipients from social support, misuse by recipients of their benefit packages, unintended consequences such as splitting up orphaned siblings among more than one household in order to maximize benefits, duplication of efforts with CSOs, creation of dependency, and limited involvement of communities in providing needed care and services for OVC.

Civil Society Organizations, the Private Sector, and Development Partners

Non-governmental organizations (NGOs), including national and international organizations, networks, community-based organizations (CBOs), and faith-based organizations (FBOs), are providing a wide range of services to OVC in Botswana. Many were set up in the earlier stages of the HIV crisis and began with a focus on serving children who had lost parents. Most have now shifted from a focus on orphanhood to the use of other vulnerability criteria, but due to the predominance of HIV and AIDS as a factor influencing vulnerability, and the availability of HIV/AIDS-focused funding, much of the OVC programming carried out by NGOs is oriented to children and adolescents considered at risk of HIV, those living with HIV, and those from HIV-affected households. NGOs also provide a substantial portion of services for children who live or spend time in the streets, disabled children, and those in residential care.

A wide range of services are provided by civil society organizations (CSOs) to OVC and their families, to support implementation of government policies and action plans guiding the response. They focus mainly on services that the GoB has prioritized and is limited in providing on its own, and as such complement rather than duplicate GoB efforts. CSOs provide direct material support and services as well as indirect support services, such as capacity building, advocacy, community education and mobilization, and referrals for services by government or other providers. Some OVC service needs have been better addressed than others; examples are access to material support including food, access to HIV testing and treatment services, life skills training, and some types of psychosocial support. On the other hand, OVC programming gaps exist in areas such as assistance to children reaching the age of 18, household economic strengthening, and programming to effectively address emotional and psychosocial support needs. In addition, emerging trends demanding a greater focus in OVC programming include sexual abuse and violence, alcohol and drug abuse, and child trafficking.

Some important challenges are noted in the civil society response to OVC. Although examples exist of collaboration between CSOs and government, evidenced by MOUs, funding and human resource support, and training, many areas needing improvement in the working relationship are also evident, including in the areas of coordination, supervision, compliance, resourcing, and reporting. Many CSOs are not actively monitoring, evaluating, or documenting the results of their work beyond counting of beneficiaries or inputs provided. Data is also unavailable at government level on indicators of CSO service quality, results, or cost-effectiveness. The lack of documentation and evidence for impact is widely noted as a key gap in the provision of OVC services by civil society.

Some geographic areas have no active, OVC-serving CSOs at all or are served only by very small CSOs with limited capacity. A notable gap exists in reaching children who live in commercial farms, ranches, and cattle posts, where access by both government and by CSOs is limited and sometimes refused by private farm owners. Where OVC-focused CSOs are operating, there are sometimes no effective systems in place to ensure complementarity of services with those provided by government. In some cases, government social workers, community structures, and CSOs collaborate to ensure that vulnerable children are referred according to their identified needs and the availability of services. In others, differing vulnerability definitions and assessment tools result in duplication of processes (e.g., CSOs and government both doing their own vulnerability assessments in the same geographic area) or gaps in services. Given the lack of a standardized definition of vulnerability, and the absence of an OVC database, it is not possible to determine the proportion of OVC who are being reached with government, non-governmental, or a combination of services.

The two main, external supporters of the response to the situation of OVC in Botswana are USAID, supported by PEPFAR, and UNICEF. USAID supports the largest CSO-led OVC project in the country, whose focus is largely on HIV and which is being implemented in a relatively few geographic areas identified as having the greatest HIV burden, in line with PEPFAR priorities. Given high HIV risk, USAID's support to OVC programming includes an increased focus on adolescent girls and young women (AGYW), to ensure their access to a combination prevention package which goes beyond HIV and health and includes education, social protection, economic strengthening, improved parenting practices, and other family- and community-level interventions. UNICEF works across social protection, health, WASH, education, and child protection; the latter includes a focus on birth registration, sexual exploitation and abuse, and justice for children.

Separate from the NGO and donor community, Botswana's private sector has also been engaged to some extent in the response to the situation of OVC, primarily through the provision of financial or in-kind support to the efforts of government and civil society. For the most part, such support is short-

term (frequently one-off), and private sector support for OVC work constitutes only a very small percentage of resources supporting the OVC response.

1.8 Findings: The Social Welfare Workforce

The social welfare workforce (including social workers, community development officers, and volunteer level workers) plays a critical role in providing support and services to OVC. Several recommendations from the 2007 Situation Analysis on OVC touched on this critical role and the importance of the social welfare workforce in ensuring that the needs of OVC are adequately and appropriately responded to. The workforce is employed in a variety of settings, including the public sector, parastatal organizations, NGOs, and other social welfare agencies, and is engaged in many different sectors, including social protection and welfare, health, security (e.g. police, prisons), education, etc.

The Situation Analysis focused primarily on government social workers, the majority of whom are employed by local authorities (district, town, and city councils). Government social workers have a wide range of responsibilities, including statutory responsibilities related to child protection and care. Other responsibilities include linking vulnerable populations with education, health care, social protection, or welfare services. Social workers are responsible for the implementation of a variety of laws, policies, and programs which impact on the well-being of vulnerable children and families, including the Orphan Care Program, the Revised National Policy on Destitute Persons (2002), various poverty eradication efforts, community home-based care initiatives, the RADP, and other community development programs.

Despite the critical role played by social workers and their evident commitment to this role, they are faced with numerous challenges and frustrations. For example, their broad scope of responsibilities, as well as an emphasis on delivering social welfare packages, has resulted in many social workers focusing a majority of their time and efforts on provision of material support and administrative duties related to these programs (e.g. conducting eligibility assessments and overseeing procurement and distribution of material support), and less on other core social work functions, such as addressing issues such as abuse, violence and exploitation of children. Many social workers perceive that their professional training is not being fully utilized and, moreover, that the focus on social safety nets creates dependency and undermines efforts to promote resiliency and self-sufficiency.

The mismatch between social worker training and their actual responsibilities is compounded by other challenges. Under-staffing at all levels can compromise the quality of services and impact the ability of the workforce to carry out its mandates, both at individual and department level. Numerous other frustrations are experienced by social workers and lead to generally low levels of job satisfaction. These include insufficient in-service training or professional development to help social workers cope with new responsibilities, a lack of supportive supervision, work overload and burnout, inadequate logistical support and poor working conditions, including security and safety concerns, and a lack of appreciation by clients and supervisors.

1.9 Findings: Progress in Psychosocial Support and Succession Planning Programming

Two key recommendations from the 2007 Situation Analysis on OVC related to improving psychosocial support (PSS) services to OVC and strengthening programming on succession planning. Both the household survey and the qualitative research explored the situation of OVC related to PSS and succession planning, including achievements and gaps.

Psychosocial Support

The critical need for PSS services for orphans and other vulnerable children is widely-recognized, and since 2007 the GoB and its partners have supported a range of program interventions, capacity building, and advocacy initiatives related to PSS. Among others, these extensive efforts have included training for service providers from government and non-governmental organizations, the introduction of Guidance and Counselling (G&C) units and classes into primary and secondary schools, PSS camps or retreats, facility- and community-based PSS services targeting children and adolescents living with HIV, national PSS Forums, and other family-, community-, school-, and peer-based support initiatives. Many have shown to be having a positive impact on children in need.

In spite of the considerable efforts, however, significant gaps and challenges persist. The existing PSS initiatives are limited in scope, both in terms of geographic coverage as well as in reaching all of those in need. Monitoring of the quality of services and evaluation of impact is often lacking. Children with particularly acute needs for PSS, including survivors of abuse or violence, and children who are living with HIV, living with disabilities, in conflict with the law, separated from their families, or abusing alcohol or drugs, are among those least likely to have access to effective PSS.

A central challenge in the country's efforts to provide PSS to OVC is an over-reliance on certain cadres, such as social workers and G&C teachers, for providing PSS. Many of them have not been provided the skills they need to carry out this mandate, and in any case, these cadres are already overburdened and overwhelmed with other responsibilities. Parents, caregivers, and other family members have not been adequately strengthened to provide the first line of care, guidance, and protection which serves as the foundation for psychosocial well-being.

Succession Planning

One aspect of succession planning—related to inheritance of property—is addressed in the Children`s Act of 2009 and was discussed during nation-wide sensitization on the Act. Provisions are made in the Act to ensure that children inherit "adequately" following the death of a parent, even in the absence of a will, with penalties specified for those who dispossess a child of his or her inheritance. The court system has demonstrated its willingness to enforce these provisions. Otherwise, little has been done in response to the 2007 Situation Analysis recommendation to support the development of a comprehensive succession planning program in the country. Household survey results show that legal support for succession planning is rarely accessed, but more commonly among households with no OVC. Most PSS training does not include succession planning, in spite of the impact of the lack of such planning on the material and psychosocial well-being of children.

1.10 Conclusion: Areas for Attention

The Situation Analysis on OVC aims not only to quantify the magnitude and describe the characteristics and situation of orphans and vulnerable children, but also importantly to establish if the right services are being provided to those who most need them. This study confirms that orphans lag significantly behind their non-orphan peers in many categories of well-being. Results also show that children meeting various vulnerability criteria, including being in poverty-stricken homes or in homes with a chronically ill parent or caregiver, as well as those not living in a family setting, are in several domains doing less well than orphans. Particularly in a context of limited resources, ***determining which children are most needy***, and which services are and should be reaching them in order to facilitate the most positive impacts, must continually be under review.

Results of the household survey show that many of the recipients of the Orphan Care program are households which are not caring for orphans. Households with orphans make up only about half (51%)

of the household recipients of the Orphan Care program. Like Orphan Care, the Destitute Persons program is also accessed by households without vulnerable children as defined in this study. A number of factors may be at play, and further exploration is needed. It is possible that all or many of household recipients of these programs have real needs, but the ***targeting of social protection assistance*** needs to be examined routinely to ensure that assistance is reaching the intended beneficiaries.

In addition to social protection access, attention should be addressed to the gaps in access by orphans and other vulnerable children to other critical support services. Rates of ***school enrollment*** (including early childhood development programs) among orphans and children in poverty-stricken homes is low, in spite of a range of educational support services. Very few adolescents report accessing ***adolescent-focused health services*** or support from social workers. ***Adolescent access to training opportunities*** is also limited, especially among those in rural villages, and vulnerable youth report finding it difficult to navigate the process for applying to the government fund established to create ***sustainable employment opportunities for young people***, even though there is a stated focus on those who are out of school, unemployed, or otherwise marginalized. Relatively few households report accessing ***victim support services*** or legal counsel (although the households most likely to access such services are those with vulnerable children).

Psychosocial support services for children are another area requiring continued attention. A shift in the way such services are provided needs to occur, with greater emphasis given to the foundational role of the family, with support from the surrounding community. This also means that the caregivers of OVC must be supported to enhance their own psychosocial wellbeing, as they can only give support if they themselves are well. In addition, PSS should be viewed as an on-going process, rather than as once-off activities. PSS should be incorporated into the organization and processes of communities and institutions in contact with children, rather than assigned to individuals. PSS for school children, for example, should not be the responsibility only of a single G&C teacher, but should be approached continuously in how a school is organized, how it relates to parents, caregivers, and other services, and how every teacher teaches, disciplines, and supports children. This requires close collaboration and coordination between a range of service providers such as social workers, schools, health providers, police, and CSOs, all of whom are working with children and have a role in providing PSS.

Children living outside family care present a particular challenge in the response to OVC in Botswana. On the positive side, it could be argued that the extensive safety net of government social assistance programs is playing an important role in enabling children who would otherwise end up in residential care or spending time on the streets to stay in school and in their homes. Moreover, some models of care, such as those being implemented or piloted by most RCFs, demonstrate an active commitment to the use of improved, evidence-based alternative care for vulnerable children instead of a reliance on large-scale, institutional models of care.

However, significant gaps in programming for children living outside family care need urgent attention. A very important challenge facing RCFs relates to the length of time most children spend at the centre. This requires attention to addressing weak linkages between RCFs and the social workers who are legally responsible for child placement processes, and to working with the families to prepare children and their families for successful ***reintegration***. The critical task of reintegrating children who have ended up in the streets or in conflict with the law back into their homes of origin or other appropriate family-based settings is also a neglected component of work with these populations. ***Alternative care options*** which could be further developed, promoted, and used include short-term emergency care, independent living initiatives, fostering, and adoption, as well as appropriate family strengthening (i.e., prevention) services.

Many significant concerns continue to surround the operation of the RAD hostels. Many of these concerns have been noted previously, and unfortunately, important prior recommendations have not been implemented. The intention to ensure access to education for all is commendable, and it is clear that the context within which these hostels operate is challenging and complex. But the success of the objective behind the remote area hostels is questionable, and the negative impacts of the effort are too significant to ignore.

Some relatively simple, achievable, and critical modifications must be made to ***align the hostels with Botswana's own Inclusive Education Policy and with evidence-based, best practices in residential care***. Among them are to adopt a transition to 'family-like' small group-home models already in use in many other settings in Botswana. The remote area hostels should not be used as places to off-load other vulnerable children, such as those removed from street-settings. Efforts should be made to increase involvement by family members and the cultural community of the learners in the operation of the hostels, as well as to increase the frequency of contact between children and their families. Serious consideration needs to be made for looking at potentially ***more suitable educational models***, in consultation with affected communities.

Children living with disabilities are a neglected group, and many children in need are never identified and linked to services. This is especially the case for children living in areas further from specialized disability assessment services and the few care facilities which exist, and for those with more serious disabilities. Key areas needing consideration include adding additional resource centers to improve ***access of CLWD to assessment and timely referral services***, improving ***household-level awareness and capacity-building***, and increasing higher-level support from government in terms of ***standard-setting, specialized technical support, and monitoring***.

Finally, while Botswana has taken a number of important and progressive steps to try to improve the treatment of children in conflict with the law, the country's sole facility for the ***rehabilitation of juvenile offenders*** is far from achieving its aim of rehabilitating or otherwise benefiting the young men there. The absence of continuing academic instruction, extremely limited opportunities for meaningful skills training, limited attention to counseling, and lack of ongoing involvement of family members, including around preparations for return to family living, all need attention in order to assure the value of the center in a system of justice aiming to benefit young men in need. That no diversion or rehabilitation program exists at all for ***girls and young women in conflict with the law*** is another glaring gap.

The ***social welfare workforce*** serves largely as the frontline in the response to the situation of OVC. Numerous challenges and frustrations face social workers and others in this workforce. Their issues are not new, having been noted previously, but with insufficient progress. Ensuring a more satisfied and effective workforce requires concrete action to be taken in many areas, including ensuring adequate numbers of social workers and other cadres; clearer definition of the roles and responsibilities of different cadres in the social welfare workforce and more rational distribution of responsibilities to match qualifications with functions; ensuring minimum qualifications of those working with children and a process for licensing; providing in-service training and other opportunities for professional development, including in emergent issues such as child trafficking; consideration for specialization in social work training; improving supportive supervision or complementary models such as peer supervision; improving conditions of service and supportive work resources; and addressing concerns on safety and well-being of the workforce.

There is room for ***strengthening collaboration and coordination*** with others who are also playing a role in the OVC response, including those in CSOs, teachers, and police. CSOs, for example, have an

important role to play in meeting the high level of need for services to orphans and other vulnerable children in Botswana. To take advantage of the comparative advantages of government and civil society, MLGRD in particular has a key role to play in making more room for discussion and strategic collaboration with all CSOs. This should involve not only those CSOs who are directly funded by government, and should aim at defining roles and responsibilities to reduce duplication of efforts, ensure better harmonization of approaches, and meet the need for guidelines, standards, monitoring, and support from government. Such efforts would strengthen the response and allow more to be achieved.

Botswana has expended considerable effort and expense in establishing and training village- and district-level child protection committees throughout the country. Their potential as structures central to the aims of awareness-raising, coordination, and facilitation of needed child protection services, however, is far from being fully realized. With some exceptions, most committees are not active, due to a number of factors including insufficient demand for their services, support for their work, and in some cases understanding of their role. In order to broaden and ***sustain the impact of the VCPCs and DCPCs***, a review of the fundamentals of their mandate, requirements for support, and links to other child-focused actors is needed.

In a similar way, findings from the household survey show that orphan and vulnerable households are not helpless and are often willing to do what is necessary to ensure proper care for their children, in spite of limited resources. Overall, however, there is fairly limited ***involvement of communities in providing needed care and services for OVC***. A major driver behind the limited involvement of communities in providing for the care of OVC is dependency, which is at many levels critically linked to the OVC situation response. While the benefits of Botswana's comprehensive social protection program are evident and meaningful, they have also engendered in many Batswana a sense that they should be taken care of by government. For those, such as orphans, who have grown up relying on government support, ***achieving self-sufficiency*** is difficult. The fact that so many refer to OVC as "the government's children" is a sign of an imbalance which needs to be addressed and corrected.

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