

A CASE-STUDY OF OVC CASE MANAGEMENT THROUGH THE ZAMBIA FAMILY (ZAMFAM) PROJECT

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Executive Summary

Zambia's HIV prevalence is currently estimated at 11.1% among adults aged 15–49 years and 1.1% among children aged <15 years²⁰. The Zambia National HIV/AIDS/STI/TB Council estimates that 10% of Zambia's population (over 1.3 million children under age 18 years) are at high risk of being orphaned or vulnerable due to the impact of the HIV epidemic. Since the epidemic began, an estimated 250,000 children and adolescents have already been orphaned as a result of HIV/AIDS. The Zambia Family (ZAMFAM) project's aim is to improve the care and resilience of vulnerable populations while supporting HIV epidemic control in Zambia. Expanded Church Response (ECR) has been implementing the ZAMFAM program since 2015, working with 88 sub-partners including faith/community-based organizations (F/CBOs) and government line ministries.

ZAMFAM used the case management approach which tracks the beneficiary from identification to graduation. The case management cycle involves a ZAMFAM methodology of scaled up community engagement from the first step of orphans and vulnerable children (OVC) identification, followed by assessment, case opening, child and family support planning, support and referral services, monitoring and review and case closure. An assessment process is used to determine the specific needs of each child and household, creating an individualized care plan with action steps to address the areas of highest vulnerability. ZAMFAM directly provides or delivers referrals to existing services to meet the basic needs of OVC through home visits and one-stop delivery points at community level by trained community volunteers (CVs). These services address primary health care which includes HIV prevention, care and treatment, education, psychosocial needs, child protection, nutrition, parenting skills and economic strengthening.

As the project comes to an end in 2020, ECR engaged Population Council (PC), to conduct a qualitative case study of the ZAMFAM program. A case study approach was employed to understand actors, perceptions and document best practices by the ZAMFAM program. Focus group discussions were held with young men and women program beneficiaries as well as with male and female caregivers of beneficiary households. Key informant interviews were held with identified stakeholders who included program staff, representatives of government ministries and ZAMFAM implementing partners. All interviews and focus group discussions were audio recorded and transcribed verbatim in Nvivo soft. Thematic content analysis was used to identify key themes and link them to the study objectives. Results of the assessment indicate that program beneficiaries viewed the ZAMFAM program as having made a positive contribution to the lives of OVC in the communities where ZAMFAM was implemented. Testimonials from beneficiaries' perspectives reflect high knowledge of HIV prevention, care, and management in communities where ZAMFAM was implemented as well as identify educational support that include payment of school fees and provision of school requisites as benefits of the program. Additionally, the beneficiary home visitations from CVs, which provided a comprehensive service package, were also hailed by beneficiaries and key stakeholders.

Perspectives of beneficiaries and stakeholders were sought in addition to a detailed review of key program documentation to identify best practices and lessons for future programming. These best practices are discussed in detail in the report and recommendations are shared. Based on our findings, the study makes the following recommendations for future programming that focuses on OVC and their caregivers as well as CVs.

1. Programs that offer a comprehensive package of services to vulnerable households through one-stop models ensure that program beneficiaries receive the maximum benefit for such outcomes. There is, however, need to identify modalities to incentivize volunteers who are often locals from study communities and upon whom program success is dependent. Investment in training these volunteers is intended to benefit the program beneficiaries and ensure sustainability of the intervention beyond its program life span.
2. Low-cost, high impact interventions, including encouraging the use of local produce for nutritional gain, allow beneficiary communities to continue with the use of such knowledge ensuring sustainability of the interventions. Cooking demonstrations and preservation of local food produce implemented by ZAMFAM in study sites allowed households to maximize nutritional benefits using commodities already available in their communities for the benefit of OVC households and people living with HIV.
3. In managing beneficiary expectations, community programs need to clearly define and communicate to beneficiaries the kind of support to be provided to the community and the criteria to be used for providing such services to the respective households. As was the case with ZAMFAM, volunteers who often support such projects were equipped to identify and respond to needs of OVC utilizing referrals and linkages to other programs or activities when services are not within the project scope. However, linkages and referral

mechanisms should be strengthened between F/CBOs and other service providers for continued service provision.

4. Community Saving Groups have proven to be a useful approach to foster economic prosperity and resiliency at the household level. As such, future programs that introduce these models should consider providing initial capital to enable low earning households access credit for business start-up. In addition to this, we also noted from discussions with caregivers and CVs that groups that were able to combine savings group activities with other income generating activities, like chicken rearing and farming, provided better lending packages to their members. However, there is need to ensure that groups are equipped to develop guidance for screening group members and managing untrustworthy members to prevent them from destabilizing the group.

List of Abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
CSG	Community Savings Groups
CV	community volunteer
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
ECR	Expanded Church Response
F/CBO	faith/community-based organizations
FGD	focus group discussion
GBV	gender-based violence
HIV	human immunodeficiency virus
KII	key informant interview
MCDSS	Ministry of Community Development and Social Services
MoH	Ministry of Health
OVC	orphans and vulnerable children
P3	Public Private Partnerships
PC	Population Council
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
USAID	United States Agency for International Development
ZAMFAM	Zambia Family Project

Introduction

Zambia's HIV prevalence is currently estimated at 11.1% among adults aged 15–49 years and 1.1% among children aged <15 years.¹ The long-term impact of the HIV epidemic in Zambia has been multi-dimensional, with far-reaching consequences to families and entire communities. Literature review has shown that long illnesses of parents/caregivers and even a death experienced as a result of AIDS has been disruptive to household stability and increased vulnerability. Children orphaned due to AIDS are also at higher risk of poor psychosocial development compared to children from non-AIDS households or children orphaned for other reasons.² The Zambia National HIV/AIDS/STI/TB Council estimates that 10% of Zambia's population (over 1.3 million children under age 18 years) is at high risk of being orphaned or vulnerable due to the impact of HIV.³ Since the epidemic began, an estimated 250,000 children and adolescents have already been orphaned as a result of HIV/AIDS.⁴

In a review of orphans and vulnerable children (OVC) services in Zambia, conducted in 2009³, nearly all the 292 organizations working with OVC provided food and nutrition services, responding to one of their most basic needs. Most service provision concentrated on OVC aged 6–17 years with major gaps regarding services provided to children under 5 years. In spite of this apparent service gap, the review found that geographical distribution of services is consistent with the OVC prevalence, as OVC in Copperbelt Province (OVC prevalence: 26.8%) receive the most services in education, food and nutrition, and shelter and care, followed by Southern Province (OVC Prevalence: 13.8%). North-western Province (OVC prevalence: 9.6%) received the least support services in food, nutrition, shelter, and care. Southern, Lusaka, Copperbelt and Central Provinces have the highest number of OVC in Zambia.³

Although there are several organizations providing services for OVC, a systematic review (2009) revealed that case study assessments of OVC intervention packages have been scarce worldwide.⁵ As such, the absence of such data makes it difficult to document best practices, to ensure that future program impact is maximized, and guarantee cost-effectiveness of investments in OVC programming. A few studies in the region have demonstrated the lasting contribution of a qualitative process evaluation on program improvement. For example, an evaluation of the COVida program (service delivery and support for OVC) operating in three provinces in Mozambique traced the pathways between program efforts and outcome improvements, leading to recommendations about the amount of support necessary to improve the situation of OVC.⁸ A similar evaluation of the national Botswana Comprehensive Care and Support for Orphans and Vulnerable Children program in Botswana highlighted which programs were best received by recipients, leading to recommendations for how program investments could be optimized.⁹

Drawing on the same lessons and strengths, the United States Agency for International Development (USAID) through the President's Emergency Plan for AIDS Relief (PEPFAR) has been supporting the Zambia Family (ZAMFAM) program with the aim of improving care and resilience of OVC and people living with HIV (PLHIV) by providing health support services, protection, education and economic strengthening services to children, families and the community to better manage the socio-economic shocks of the HIV/AIDS epidemic. The USAID Zambia Family program was divided into two activities targeting multiple provinces: ZAMFAM Copperbelt-Lusaka and ZAMFAM South-Central. ZAMFAM Copperbelt-Lusaka was implemented by Expanded Church Response (ECR) whereas the ZAMFAM South-Central was implemented by Development of Aid from People to People. ECR has been implementing the ZAMFAM program since 2015. They worked with 88 sub-partners, including faith/community-based organizations (F/CBO) and government ministries to provide services to beneficiaries. Different strategies have been used to provide services to the targeted population.

Program Description

ZAMFAM is a USAID/PEPFAR supported program that aims to improve care and resilience of vulnerable populations, while supporting HIV epidemic control in Zambia by delivering community-centered, comprehensive, integrated, evidence-based programs that strengthen families and communities to meet the holistic needs of OVC and PLHIV. The program objectives included:

1. Improving HIV case finding and disease management among children and adolescents,
2. Strengthening capacity of families and community structures to meet basic needs of vulnerable children and adolescents, especially PLHIV,
3. Strengthening the capacity and ownership of community structures to care for vulnerable children and associated PLHIV,
4. Increasing quality of compassionate care and support services for OVC and their families, and
5. Improving HIV risk avoidance and risk reduction among adolescents.

Over the life of the project, 111,569 OVC have been supported; 16,322 children and adolescents living with HIV have been supported with care and treatment; and 77,835 parents and caregivers of adolescent girls and young women under the Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS) program have been reached with evidence-based positive parenting skills. In responding to the program objectives, ZAMFAM provided various service packages to program beneficiaries. The services provided under the ZAMFAM program as implemented by ECR include the following:

a) Health Services

- Trained community volunteers (CVs) attached to local health facilities to support OVC with facility navigation, tracing those lost to follow-up, and client-centered services for improved adherence and retention, disclosure, HIV-related testing, and routine healthcare
- Antiretroviral therapy (ART) home delivery/support enrollment of children and adolescents living with HIV on multi-month dispensing
- Adolescents living with HIV support groups
- HIV treatment and viral load literacy
- Nutrition assessment (mid-upper arm circumference) and nutrition literacy through cooking demonstrations and food preservation
- Household hygiene counseling and water, sanitation, and hygiene messages
- HIV prevention, adherence, and sexual and reproductive health (SRH) trainings
- Alcohol and substance abuse prevention and support

b) Child Protection Services

- Screening and monitoring of gender-based violence (GBV)/child sexual abuse in OVC households
- Trauma counseling for GBV/child sexual abuse
- Basic psychosocial counseling
- Referrals for post violence medical care, victim support unit, child protection unit, and paralegal
- Safe space intervention, such as kids and adolescent/youth clubs
- Birth registration support
- Child safeguarding policy development
- Evidence-based positive parenting skills trainings using the *Families Matter!* Program

c) Education Services

- Payment of school fees
- Procurement of school uniform, books, shoes, bags, and school stationary
- Assistance for re-enrollment for children of school age not going to school or dropped out of school due to pregnancy, death of parent or caregiver, or lack of school fees
- Community-based tutoring sessions for children behind in schoolwork due to sickness or taking care of a sickly parent or caregiver
- Progression and performance tracking

- Early childhood development for children under 8 years
- d) Economic Strengthening Services
- Community Savings Groups (CSGs)
 - Financial literacy training for CSGs
 - Business skills training for CSGs
 - Formation of cooperatives
 - Linkages/referrals for social protection services provided by the Department of Community Development and Social Welfare such as the Public Welfare Assistance Scheme, food security packets, social cash transfers, Girls Education and Empowerment Program, and Women's Empowerment Fund
 - Vocational skills training for OVC that graduate the program when they reach 18 years and youth aged 18–24 years in OVC households

The program also collaborated with Ministry of Health (MoH), Ministry of Community Development and Social Services (MCDSS), Ministry of Home Affairs through the Department of National Registration Passport and Citizenship, Child Protection Unit, and Victim Support Unit under Zambia Police, Ministry of Education, Agriculture and the Ministry of Commerce and Trade to support different aspects of the program implementation.

Services provided at the household level were delivered by trained CVs. In collaboration with MoH, CVs were trained using the MoH curriculum that included lay counseling, community compressive childhood and adolescents HIV care, basic nutrition for children and PLHIV, HIV counseling and testing (both rapid and oral quick), adherence and treatment literacy, post-exposure prophylaxis and pre-exposure prophylaxis. Other trainings that CVs were exposed to included: basics of working with OVC in their community, child safeguarding, psychosocial counseling, OVC case management, and data management. ZAMFAM also helped communities establish CSGs and, under the Public Private Partnerships (P3) Initiative, connected these groups with farming food and supplies. These were necessary for reaching program objectives and meeting the households' and beneficiaries' needs.

As program implementation was dependent on the community volunteers engaged, the program developed a clear criterion for F/CBOs sub-granted to use in identifying and engaging the CVs. These CVs were carefully selected in line with ZAMFAM child safeguarding policies based on the following criteria:

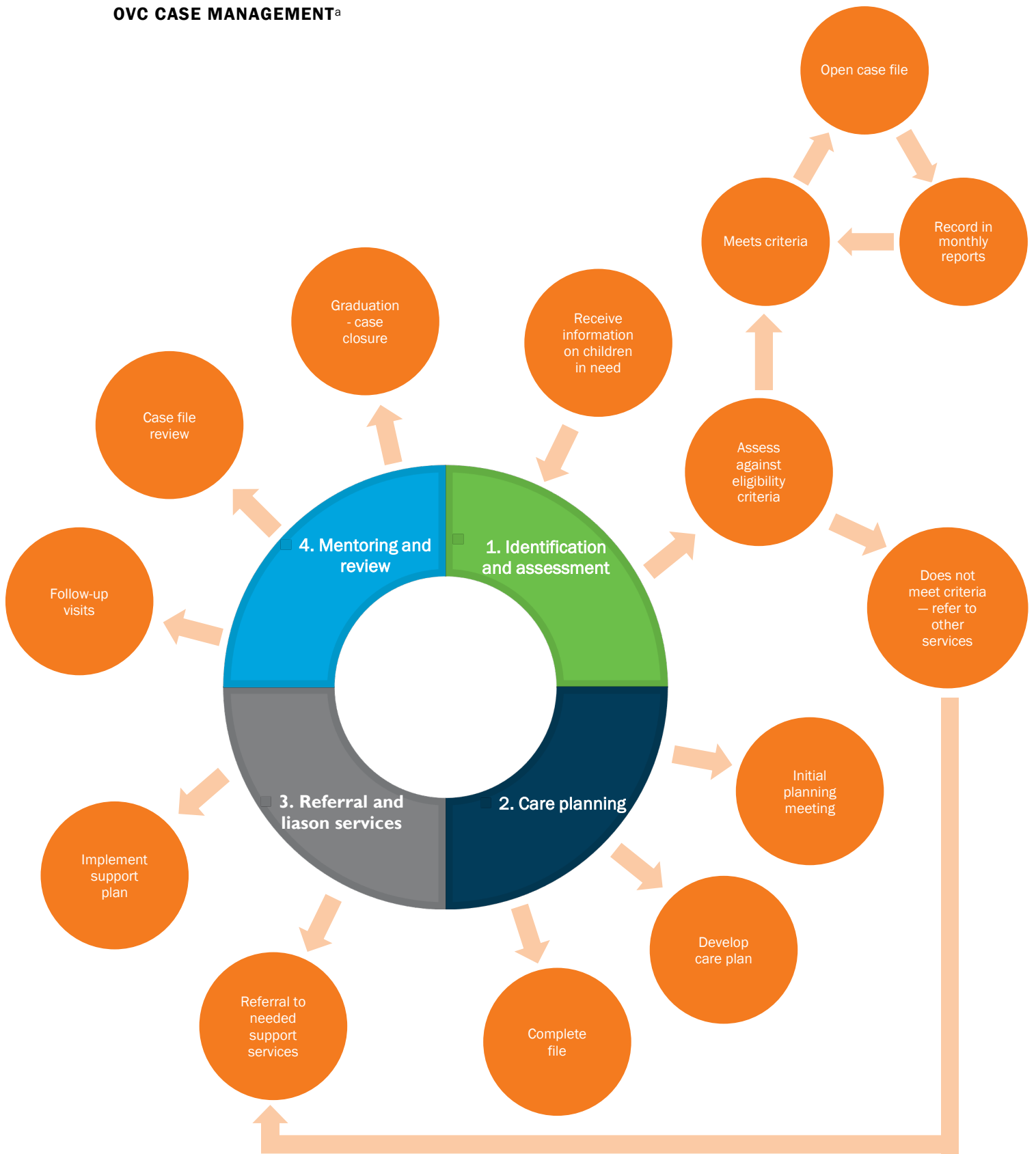
1. Should have no criminal record
2. Should be aged 18 years or older
3. Demonstrates proven commitment to community work
4. Able to communicate, read and write in English or any of the local languages; If they cannot, they are paired with another CV who is able to read and write
5. Lives in the same catchment area as the OVC for whom they are providing a service

CVs were given a transport and lunch refund of 90 Zambian Kwacha every time they attended trainings and program-related meetings. They also received tools to aid their day-to-day work which included umbrellas, gumboots, cell phones, bags, raincoats, t-shirts, bicycles, motor bikes and stationery.

The program conducted monthly meetings for CVs that were used as a platform for supportive supervision, reporting, team building, self-care, sharing best practices and receiving refresher trainings depending on the gaps identified during service provision in the month. District coordinators and data assistants recruited by ZAMFAM verified the services being provided to the OVC and their parents/caregivers including providing day-to-day guidance for challenges faced and reported by CVs. Quarterly district coordination meetings reviewed progress and captured feedback from F/CBOs. Additionally, weekly quality assurance and improvement meetings were introduced within the respective F/CBOs to review the quality of work and data collected.

The ZAMFAM OVC case management approach encompassed the planning, implementation and monitoring of assistance deemed appropriate to a case until the situation improved or was resolved. This approach further involved coordinating delivery of services in the community. These services were either direct—in situations where the CV provided the services—or indirect—in the case of a referral to other support services. Below is a diagrammatic representation of the case management process.

OVC CASE MANAGEMENT^a



^aAdapted from Case Management Guidance by UNICEF and Keeping Children Safe

Study Methodology

A case study approach was employed to qualitatively explore the ZAMFAM program. The goal of the case study was to better understand actors, perceptions, and document best practices by ZAMFAM program, especially as it relates to the how the program affected OVC and their households. The case study was intended to identify and document best practices and lessons learned. Objectives of the case study were:

1. To explore OVC and caregivers' views and perspectives on the services provided by ZAMFAM in the four main program domains including health, child protection, education, and economic strengthening.
2. To explore ZAMFAM program effects on beneficiary households from the stakeholders' perspectives.
3. To better understand how the program was implemented and identify best practices.

STUDY PARTICIPANTS AND RECRUITMENT

The study sampling frame included a list of all OVC beneficiaries, male and female, living in the project catchment area aged 13–17 and those 18+ based on the selection criteria. Written consent by all study participants was obtained and parental permission and assent were obtained for participants younger than 18 years. The stakeholder study participants were purposively selected for the key informant interviews (KIIs) based upon specific criteria, which included:

1. Specialist knowledge of the ZAMFAM program,
2. Basic understanding of the ZAMFAM community catchment area in general, and
3. Capacity and willingness to participate in the study.

The above criteria enabled the study to select individual participants who would be most likely to contribute appropriate data, both in terms of relevance and depth. KIIs allowed for the documentation of stakeholders' perspectives while also validating the data obtained from beneficiaries and their caregivers in in-depth interviews and focus group discussions (FGDs).

The study participants had to be proficient in at least one of the three study languages (English, Bemba, or Nyanja). Specific eligibility for respondents is included in Table 1.

TABLE 1 Respondent Eligibility Criteria

Category	Criteria	Data Gathering Activity
OVC	<ol style="list-style-type: none"> 1. OVC beneficiaries aged 13–17 were purposively sampled from information provided via program databases by ECR 2. The study team over-sampled to cater for respondents who could not be reached at the time 	Focus group discussions
Caregiver (parent/guardian)	<ol style="list-style-type: none"> 1. Aged 18 years or older 2. Currently providing care to a child (younger than 17 years) 3. Living in adverse conditions (defined as HIV positive, chronically ill, or orphaned) 4. Has an OVC either living in their household or was identified by the OVC as their primary caregiver 	Focus group discussions

Stakeholders	<ol style="list-style-type: none"> 1. Respondents were conveniently sampled based on recommendations from ECR based on their level of knowledge on the program 2. Respondents had to be familiar with the program, involved in providing support, and provided oversight in the implementation of ZAMFAM <p>Respondents included:</p> <ol style="list-style-type: none"> 1. ECR staff who were directly involved in the delivery of services on the ZAMFAM program 2. CVs who worked with CBOs implementing the ZAMFAM program 3. Representatives of government ministries, including MCDSS and MoH 4. Staff of F/CBOs that were sub-grantees of the program 5. Local authorities that actively participated in the service delivery of the ZAMFAM Program 	Key informant interviews
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SAMPLE SIZE AND DATA COLLECTION

Focus group discussions and key informant interviews were conducted in two study sites (Lusaka and Chingola) between December 2019 and January 2020. A total of 12 FGDs were conducted with 58 OVC and 44 caregivers. Additionally, 14 KIs were conducted with stakeholders in the two study sites. The FGDs were stratified by sex and age (13–14 years in one FGD, 15–17 years in another). The study team also conducted desk review of the ZAMFAM progress reports, success stories, and routine data from 2016 to 2019 recorded by ECR.

TABLE 2 Data Collection Table

District	OVC aged 13-14 (FGDs)	OVC aged 15-17 (FGDs)	Caregivers aged 18+ (FGDs)	Stakeholder KIs
Lusaka	2 (males=1, females=1)	2 (males=1, females=1)	2	6
Chingola	2 (males=1, females=1)	2 (males=1, females=1)	2	8

DATA MANAGEMENT AND ANALYSIS

Audio recordings for FGDs and KIs were transcribed verbatim and PC analysts reviewed and verified all transcripts against the original audio recordings to assess transcription and translation accuracy. After validation, transcripts were imported into NVivo 12 Pro software (QSR International Pty Ltd) to facilitate data management and contextual analysis. After independently coding two preliminary transcripts using questions in the interview guide, PC research staff identified themes during team briefings after which the team developed a codebook both inductively and deductively across the main thematic areas. The research team then reviewed each of the independently coded transcripts against the codebook to ensure inter-rater reliability and modified the codebook to remove unnecessary codes, combine relevant codes, and agree on a definition for each code to apply to the remaining transcripts.

The analysts adopted selective coding techniques, as described in Corbin et.al, to relate codes and sub-codes.⁶ Main codes were created based on the objectives of the study and the sub-codes were based on what was reported in the transcripts. After the final codebook and corresponding definitions were agreed upon, four PC research staff used the codebook to code the remaining transcripts. Excerpts were then extracted from NVivo and the analysts prepared a summary report while analyzing the data and identifying star quotes.

ETHICS

The study was approved by the PC Institutional Review Board and the local ERES Converge Institutional Review Board prior to study commencement. Administrative approval was obtained from the National Health Research Authority. Research assistants who are trained in research ethics and well-versed in study design and methodology conducted the interviews. The interviewers provided study details and obtained written consent and assent from participants prior to initiating the interview. All interviews were conducted in a private location.

Results

BACKGROUND CHARACTERISTICS OF ZAMFAM PROGRAM AREAS

The study team conducted research in Chingola district on the Copperbelt and Lusaka and Kafue districts in Lusaka Province. Respondents shared their views about attributes of the communities they came from and some of the challenges experienced in their communities that made interventions like ZAMFAM necessary.

Unemployment

Caregivers as well as the OVC highlighted that unemployment was a major concern in their respective communities, as a lot of young people and the heads of households did not have the means of earning a living. FGD participants reported different challenges that existed in the communities where they lived. Most parents/caregivers to OVC are either out of employment or are retirees, making it hard if not impossible to support the OVC both at home and at school.

“I am a widower and blind. I struggle a lot to pay land rates and sponsor my children to school. For instance, my daughter has been accepted to study nursing, but I don’t have money to pay for her [tuition]. There is another child in Lusaka who needs money to pay in boarding school, but I don’t have that money.” – Male caregiver, Chingola

Education challenges

Participants also reported challenges with school attendance in their communities. School dropout was reported and affected both girls and boys. Participants noted that boys dropped out of school after failing an exam or class or were influenced by their peers who are not in school, while girls would often drop out of school due to pregnancy.

“Like girls our age, you will find someone writes an exam and passes, but when schools open, she is found to be pregnant. She will stop school and get married like that.” – Female OVC 15–17 years old, Lusaka

“...when children fail in grade 9 both boys and girls end up in marriages, or if the parents fail to pay [their school fees, they drop out of school].” – Male OVC 15–17 years old, Chingola

Substance abuse and violence

Robbery, fights, alcohol, and substance abuse amongst adolescents were identified by beneficiaries as challenges in their communities. Participants perceived that these issues arose from young people not having enough to do as well as peer pressure. These challenges made it more likely for adolescents to drop out of school.

“There is a lot of violence. Stone dealers, theft and fighting are the order of the day.” – Male caregiver, Chingola

“...dobo [illegal smoked drug] has become a nuisance. They really smoke weed. You would be surprised to find a small child smoking weed, it could be a girl or a boy, but girls not that much. You would find a small boy smoking weed.” – Female OVC 15–17 years old, Lusaka

Adolescent pregnancy, early marriage, and prostitution

Some FGD participants in study districts mentioned that prostitution, teenage pregnancy, and early marriage were concerns in their communities.

“I see a lot of boys and girls running away from their homes. Children aged 12, 13 and 14 are married, they become pregnant and have children.” – Female OVC 15–17 years old, Chingola

RESULTS BY STUDY OBJECTIVE

This section provides an overview of our findings for the ZAMFAM program. Results will be shared in order of the objectives of the study earlier discussed.

Objective 1: To explore OVC and caregivers' views and perspectives on the services provided by ZAMFAM in the four main program domains including health, child protection, education, and economic strengthening

Cognizant of the challenges already discussed in the communities where the program was implemented, ZAMFAM invested in several interventions aimed at improving livelihoods for program beneficiaries. Health and HIV-related challenges arising from adolescent pregnancy, prostitution, and early marriages were previously identified as challenges. Child protection services were also available to address issues linked to early marriages and sexual abuse in addition to psychosocial counseling and other services. Additionally, in addressing unemployment and education challenges, economic strengthening approaches and providing educational support responded to community needs. Child protection services also provided trainings for OVC caregivers to address some of the



Child protection awareness. Photo credit: ECR

identified needs, including issues of teenage pregnancy and child marriages. Caregivers were trained in ART adherence, parenting skills using the Families Matters! Program approach, economic strengthening, and basic nutrition, especially for PLHIV. These trainings were a platform for beneficiaries and their caregivers to receive HIV knowledge and may have influenced general HIV knowledge levels in the communities. OVC were provided life skills training and received sexual reproductive health talks during youth clubs and adolescent clubs. These were necessary for reaching program objectives and meeting the needs of households and beneficiaries.

“They helped us a lot, like the program of people knowing their status, there were self-testing kits, As you know, some people feel uncomfortable to go and test from the clinic—that’s how we were helped. The feeding programs were also very helpful, they demonstrated using a rapper which had colors like green, yellow and red. This was meant to show people how to monitor the growth of a child. Most people have children, but they don’t know how to take care of them or what to feed them on. This program was meant to teach the women how to monitor growth in children.” —Male caregiver, Lusaka

High knowledge of HIV acquisition, testing, and treatment among beneficiaries

The study found that knowledge of HIV transmission and testing services was high and respondents linked this to the HIV prevention training and home-based HIV testing services. During home visits, beneficiaries reported that CVs provided information on HIV prevention, care, and treatment. The program trained CVs on the Community Comprehensive Childhood and Adolescent Care package for caregivers and children. Puberty and sex were also discussed with OVC at household visits and during the adolescent and youth club meetings. OVC cited various sources of information about sex and puberty including ECR, schools, DREAMS programming, and family members.

OVC across the study sites were able to show their understanding of how HIV is acquired, transmitted, and treated. In discussing HIV risk reduction, OVC were able to share what they learned, which included using condoms when having sex and having one sexual partner. An FGD participant noted that when one has a girlfriend, there is need to go for HIV testing before you start having sex.

“Safe sex is being safe from contracting diseases or having unplanned pregnancies. Use a condom if you don’t want to contract diseases, use pills to prevent unplanned pregnancies and be faithful to one sexual partner to avoid contracting diseases like HIV/AIDS and syphilis.” — Female OVC 15–17 years old, Chingola

“[HIV] is contracted in many ways, such as when you use sharp things. Also, at the hospital after women give birth, if the doctor is not well trained, they transfer the virus to the baby when cutting the umbilical cord...” — Male OVC 15–17 years old, Chingola

Following trainings in HIV testing and counseling for both rapid and oral quick tests that CVs participated in, test kits were provided to community volunteers by the MoH. The community-based testing model made it easier for people to test for HIV as individuals were tested from households. OVC sampled mentioned a number of places where one could go to for HIV testing, such as clinics and at school, while others mentioned that they have people that come to their homes for HIV testing.

“...from the people who conduct door-to-door HIV testing, schools and DREAMS. People from the clinic usually follow us in our homes and schools to tell us to avoid engaging in sexual intercourse.” — Female OVC 15–17 years old, Chingola

ZAMFAM also conducted escorted referrals for beneficiaries who tested HIV positive in the community and children and adults already on ART to access required ART services, such as enhanced adherence counseling. The work aids provided to the CVs were intended to help complete referrals and follow-ups to ensure the beneficiaries on medication are adhering to their treatment.⁷

Program beneficiaries highly valued the psychosocial and emotional support of the ZAMFAM program

As CVs conducted beneficiary home visitation, they provided counseling services including child abuse counseling and psychosocial and adherence counseling support. Beneficiaries highly valued the psychological and social support of OVC and caregivers and felt that programming that caters to the psychosocial needs of OVC was essential to supporting vulnerable households. The study found that psychosocial support was mainly provided through home visits where CVs provided direct services and referrals for additional care if required. Caregivers felt very positive about the psychosocial support provided, as many stated that it helped them share the OVC's HIV status with them. Some of the respondents appreciated the counseling on child nutrition that helped them monitor the growth of their children and ensure they were healthy. Other participants mentioned that they appreciated the encouragements the community volunteers gave regarding ART adherence. Respondents identified receiving emotional support, as well as the reassurance that ECR would assist them if they encountered challenges as a useful component of the program.



OVC case management CV during household visit. Photo credit: ECR

“The moment they arrived at my home, I felt free to talk to them about what I was going through, including my health... This made it easy for us, even when we visited the clinic, because we did not have to stay on a queue. Instead, they would easily recognize us and attend to us.” — Female caregiver, Lusaka

“Their visits have made us see things in a different perspective, especially about HIV/AIDS. They have helped us support our children in school.” — Female caregiver, Chingola

Caregivers felt support received from ZAMFAM in addressing child abuse and child labor was an important aspect of the program design

Caregivers expressed knowledge on where to report when a child is abused, adding that CVs raised awareness on child protection and on how to prevent and respond to violence, like defilement, rape and child labor, against children. Caregivers were sensitized regarding the rights of children and how best to protect them from all forms of

abuse. From FGDs with caregivers and OVC, it was noted that there was a lot of support available for victims of sexual and gender-based violence at health facilities and that several F/CBOs had also joined in providing support.

“There are usually cases like that, but they are not reported. At times we just hear rumors and investigate because it’s rare that such cases are reported. When you come across such a child, you refer them to the hospital because this is where the NGOs [non-governmental organizations] have opened some centers in hospitals and clinics where we can take such cases. They have really been of help in terms of counseling of GBV cases...” — Male caregiver, Lusaka

“Currently, there are rights protecting children. Hence, beating them is an offence. It’s even better to just punish that child with cleaning around the school or cleaning the walls. The punishment should not be too hard, like uprooting a tree.” — Male caregiver, Lusaka

Community Savings Groups provided much needed financing for caregivers and their OVC needs

Beneficiaries felt the economic strengthening programming undertaken by ECR was highly beneficial to their financial stability, but given the severity of their needs, they identified several challenges where greater support was required. Through use of Community Savings Group approaches, caregivers were encouraged to open saving groups that did not rely on the program for sustainability. CVs supported the formation of CSGs to ensure the households they served had access to credit if needed. Caregivers were linked to these savings groups as a way of supporting them to manage their household economic status. Some caregivers reported benefiting from these savings groups through the ability to mitigate financial risks by saving, borrowing money when they needed it, and repaying their loans on time. Caregivers relied on savings groups for things like children’s school fees, medical bills and establishing businesses. Additionally, these savings groups gave them an opportunity to share and exchange ideas, encouraging community interaction and cohesion.



CSG holding a savings meeting. Photo credit: ECR

“Especially during school time for the children, that’s when we like sharing. We pay school fees for the children because you cannot manage to save alone. So, it is as if they [savings group] are keeping [the money] for you... each member goes away with something small to help children with school requirements.” — Female caregiver, Lusaka

“They have inspired us to be self-reliant by introducing saving groups to us. We can save money on our own...” — Female caregiver, Chingola

“ZAMFAM has helped us to open these saving groups so that we don’t rely on them entirely. Because they will not always be there, it’s better to sustain ourselves. It’s really necessary to be part of these groups...” — Male caregiver, Lusaka

Although the CSGs were identified as an essential tool for household economic stability, community members also identified some challenges. These groups were solely run by community members and there was an increased risk of members defaulting on payments. Despite ZAMFAM trainings on screening and inclusion criteria for membership, respondents felt some members were dishonest and exploited the group, taking large loans without intent to repay them. Respondents also felt that resources raised by the group were insufficient and programs such as ZAMFAM needed to provide some initial capital to ensure members could get substantial loans.

“Some people get a loan and fail to pay it back, so the challenge comes once someone gets and fails to pay back because you must think of how to recover that money.” — Male caregiver, Lusaka

“...the challenge in our group is the amount of money being contributed. People earn differently. Hence, those who would want big businesses find it difficult to improve because their savings are small. We are asking ZAMFAM if it is possible for them to contribute to these saving groups for us to improve.” – Male caregiver, Lusaka

Beneficiaries greatly valued educational support, although more needed to be done

Beneficiaries felt the educational support provided by ECR was instrumental in helping many children complete secondary school, though they noted the support provided was sometimes insufficient to meet demand. The ZAMFAM program supported OVC with various educational programs delivered by partner F/CBOs such as skills-building and direct education support based on those who were more in need in that quarter than others due to limited funding. Education support was provided in the form of payment of school fees and purchase of school supplies such as books, shoes, and uniforms. Both OVC and their caregivers frequently mentioned receiving educational support. The study noted that respondents were more likely to talk about educational support when discussing the services provided under the ZAMFAM program as opposed to the other support services. Some of the respondents reported that it was difficult for children in the communities to complete secondary schooling and that children are forced to stay home due to inadequate resources at the household level. However, caregivers noted with the support received under ZAMFAM, their children were able to complete secondary education while some OVC were sponsored to attend vocational training like carpentry and tailoring.

“They have been so much helpful. Before, you would find that a child makes it to grade 10, but then due to lack of sponsorship they will just drop out. When ZAMFAM came in, most people were assisted to complete secondary school. Even school dropouts have been reached with tertiary education programs like carpentry, tailoring, and computer lessons.” – Male caregiver, Lusaka

“We want to thank ZAMFAM for the services that they are rendering like paying for our school fees, giving us books, shoes and uniforms. We urge them to continue so that we are able to complete our education.” – Male OVC 13–14 years old, Lusaka

Caregivers also reported that their children are now able to fully concentrate in school knowing that the risk of being expelled for not paying school fees has been reduced.

“The program has really helped me in the sense that it has reduced the burden of soliciting funds to send some of the orphans that I look after to school, because I used to struggle a lot. Some children have managed to finish grade 12 as a result of the aid they were receiving from ECR.” – Male caregiver, Chingola

Despite positive sentiments expressed by the caregivers about the educational support offered to OVC, there are some OVC and caregivers that felt that the support given was insufficient to meet all their educational needs. Some felt that they did not receive the support intended for them in full. While others felt that the support arrived late, after school terms began, thereby affecting the children. Additionally, one caregiver complained that despite being enrolled in the program, they never received any support while other caregivers said that they were only supported for half of the school fees.

“Before we would receive full support, even for those attending college, but not anymore. We are now just getting half support...” – Male OVC 15–17 years old, Lusaka

“[Organization X] pays for our school fees, but not for everything. At times the money doesn’t even come on time, by the time it comes it’s too late. At times we are even chased at school because the money doesn’t come.” – Male OVC 15–17 years old, Lusaka

“Funding comes in quarters, not at once. So, whenever we have a problem, we go to one of the coordinators at a CBO. If there is an emergency, they help... so long as they have what you are asking for, they will give it out, if it’s books or anything.” – Male caregiver, Lusaka

“When we joined there wasn’t much happening. This is the second year now, and I have not received anything.” – Male caregiver, Lusaka

“They have helped me by giving me books, but because I registered in 2016, they only gave me books once.” – Female OVC 15–17 years old, Lusaka

Beneficiaries equipped to use local produce for maximum nutritional benefit

Caregivers valued the nutritional support provided through ECR. Cooking demonstrations were conducted under the program and their main target groups were PLHIV, under-nourished children, children under five, and pregnant women. MoH monitoring teams incorporated some community volunteers from the project and helped to monitor growth of children under five at community health facilities. Parents/caregivers were empowered to prepare local foods in a way that ensured families derive the most nutritional benefit. This knowledge was greatly appreciated as parents/caregivers reported that the nutrition program, which was done by conducting cooking demonstrations as well as using a wrap (chitenge) to monitor child growth, helped them take care of their children.

“The feeding programs were also very helpful; they demonstrated using a wrap which had colors like green, yellow and red. This was meant to show people how to monitor the growth of a child. Most people have children, but they don’t know how to take care of them or what to feed them.” — Male caregiver, Lusaka



Nutritional assessment using mid-upper arm circumference tape.
Photo credit: ECR

Objective 2: To explore ZAMFAM program effects on beneficiary households from the stakeholders’ perspectives

Stakeholders interviewed for the study included respondents from ECR, government ministries including MCDSS and MoH, and F/CBOs. Local authorities that actively participated in the service delivery of the ZAMFAM program were also included. Respondents had worked with the community where the study was implemented between 2 and 13 years. The perspectives from these partners helped provide robust insight into how services were delivered, as government ministries and F/CBOs were instrumental to the program’s operations. Stakeholders felt largely positively about the approach to service delivery and impact of the ZAMFAM program. They provided insight into the instrumental role CVs played in determining both the program’s greatest successes and challenges. The views and perspectives of stakeholders are described in detail below.

Collaboration between ZAMFAM and government departments improved outcomes for HIV care and management as well as child protection

Stakeholders observed the close working relationship between ZAMFAM and MoH to improve access to HIV services and provide a wide range of support to PLHIV and their families. The MoH trained CVs in HIV testing and referral to identify HIV-positive OVC during home visits and refer them to the clinic for treatment. MoH provided test kits and information, education and communication materials and ensured that referrals made by CVs received care. Stakeholders noted that CVs made an impact in supporting ART adherence and new initiations on ART. CVs worked with health facilities to contact OVC who missed and had stopped coming for ART appointments and encouraged them to resume treatment. Health talks were organized for PLHIV and caregivers of HIV-positive OVC to learn about the health needs of these children.

Additionally, stakeholders reiterated the importance of supporting the additional physical and psychosocial needs of PLHIV. CVs were trained to provide nutritional support services via cooking demonstrations and growth monitoring. They have also successfully formed support groups for HIV-positive OVC and adults, which provided an opportunity for greater emotional support and information exchange.

“For those with malnourished HIV positive children, we help them with nutrition services like cooking demos and food preservation... we distributed seeds for yellow maize (the one rich in vitamin A) and sweet potato seedlings to address food security. And for others, especially where we were implementing DREAMS, we equipped them with parenting skills.” — Stakeholder, Lusaka

“We get a lot of support from Ministry of Health for trainers of community volunteers because we use their curriculum for training. They also provide the HIV testing kits and the personnel to conduct the test. We are able to refer children for treatment who we find positive. Since we have our volunteers attached in the health facilities, we are able to follow up with children missing appointments. Volunteers bring them to the facility where they are put back on treatment.” – Stakeholder, Lusaka

ZAMFAM’s successful collaboration with government was further praised with MCDSS with respect to child protection.

“Then in terms of GBV activities, we always go to the victims. For example, if we have a GBV case and the child needs to be removed from that household and taken to a safe household, we always reach out to them.” – Stakeholder, Chingola

ZAMFAM trainings equipped community volunteers to link OVC to the full package of services required

The recruitment and training of CVs was a collaborative effort between ECR, MoH, other line ministries, local F/CBOs, and health clinics. ZAMFAM identified and registered CVs in conjunction with MoH by utilizing registers from local F/CBOs. CVs were recruited to work in the area where they lived, and their familiarity with the community made logistics easier. ZAMFAM invested in trainings for community volunteers for full-service provision for beneficiaries. This resulted in OVC recruited under the program receiving care and support to match their needs. Stakeholders reported that CVs work with health facilities in ART, tuberculosis, and under-five departments to help identify HIV-positive OVC/cases for CVs to follow up and ensure they receive the treatment and care required.

“The caregivers are identified and registered by the CBOs. Then we provide training to them on how they are supposed to identify the children and what type of care and the support they are supposed to provide to them. The curriculum we are using is the Ministry of Health curriculum...” – Stakeholder, Lusaka

“Recruitment was done in conjunction with the Ministry of Health because most of the facilities where ART is being provided have specially trained pediatric providers. Those are the individuals we normally work with. These providers work closely with parents whose children are tested positive.” – Stakeholder, Lusaka

CVs were trained on tracing suspected lost to follow-up and adherence support in addition to being trained to register HIV-positive children at health facilities. Stakeholders observed how this training in conjunction with their knowledge of the community equipped CVs to be effective links between OVC and the services they needed. In this way, some F/CBOs were reported to work hand in hand with health facilities to help identify those suspected lost to follow-up and get them back in treatment and care.

“...you find that in the community they will find someone is HIV positive and refer that person to us as the [health] facility so that we initiate him/her on ART. There are also people in the community who start treatment but are suspected lost to follow-up. So [Organization X] has people that go into the community to trace clients lost to follow-up.” – Stakeholder, Lusaka

Livelihood improvement approaches had positive impacts on household economic resilience

Key informants were also asked to share their perspectives on program approaches for improved livelihoods in the ZAMFAM program. Stakeholders reported that the saving groups and trainings for caregivers managing savings and entrepreneurial skills had a positive impact on their economic resilience. ZAMFAM facilitated the transformation of saving groups into cooperatives and helped register the groups with the Ministry of Commerce which provided additional resources to the groups and helped secure their future success beyond the duration of the program. The program also linked caregivers to the social cash transfer scheme and to organizations that built capacity on how to utilize the money received. The social cash transfer scheme is a government program that provides in-kind cash transfers to under-resourced populations to promote quality social welfare services, reduce juvenile delinquency, and alleviate poverty.

“We made sure parents of children in the program join these economic strengthening groups. This has helped the parents to save. Not only that, we started registering these groups into cooperatives through the government offices. Once they are registered, they would receive seeds, fertilizer, and things like that. Also, we’ve been having trainings

for the Community Savings Group members on entrepreneurship, how to come up with different businesses, and things like that for them to generate an income. Different types of trainings have been done because when you look at the design of this project, it's more interested in capacity building where you try to build the family's resilience." — Stakeholder, Chingola

"Some guardians are on the social cash transfer scheme with Community Development [MCDSS]. They were also linked to organizations where they were taught how to invest this money into businesses." — Stakeholder, Lusaka

Stakeholders views on program challenges

Stakeholders noted various challenges experienced in supporting or implementing the ZAMFAM program. The ZAMFAM program interventions relied on community volunteers to achieve program outputs, and while this approach contributed to many of the program's successes, most of the implementing organizations noted challenges as well. Stakeholders identified low literacy levels among volunteers as a challenge that affected data quality for the program. Also, training CVs required significant investments of time, money, and resources by F/CBOs, but not all trained volunteers remained active during the life of the program. F/CBOs found that some volunteers leave the program once they find an alternative form of livelihood. When CVs dropped out, new CVs were recruited and required capacity building due to their limited training. Additionally, some stakeholders observed that organizations began to compete for volunteers by raising reimbursement rates to attract greater interest. The competition and conflict between organizations working towards similar goals whilst relying on volunteer staff made it difficult for program implementation.

"Some of the challenges we have encountered looking at the communities we work include the literacy levels of some of the community volunteers we work with. Most of the community volunteers who are hardworking have low literacy levels... to some extent that poses a challenge in terms of data collection." — Stakeholder, Chingola

"...there is competition now in terms of monetary incentives, because they are not standardized. You may find that some organizations are giving their volunteers more money." — Stakeholder, Lusaka

"The challenge is that volunteering is quite a difficult job. You may train someone today, and then they decide to quit. You may train a good number along the way." — Stakeholder, Chingola

From the outset of the program, some stakeholders observed that the training with CVs felt rushed, with insufficient time to explain the program and plan with CVs before implementation began. This meant in some cases, district implementors who included F/CBOs were not fully aware of how to target beneficiaries and properly deliver services. In addition, some partners noted that funding delays hindered implementation progress.

"We are usually not given enough time to plan, we are told right there and then that they will be an activity." — Stakeholder, Chingola

"At times funding was received late. We needed to implement the activities that had already been budgeted for, but [funding] was received late. The demand was high, especially for educational support, and the budget was too small to meet the demand at the grassroots." — Stakeholder, Chingola

An observation was noted that implementation of the program in an environment where community expectations for services were high had become difficult. These "soft" services such as psychosocial support were not perceived by stakeholders as a type of service. Stakeholders felt that community members preferred tangible services such as payment of school fees or provision of food items as "true" services and placed greater value on these.

"The challenge that we had was that they had high expectations. They thought we had come to save them. They expected handouts, like mealie meal and all. Surprisingly, most of the services we provided were psychosocial. It's only words, only encouragements. They would say 'mwisa fye pano tapali nefyo muletapo', meaning 'you always come empty handed.' ...ZAMFAM had a target, and at times we did not meet their full needs, especially for education support. Some will even say 'stop coming here because you have not provided us with this and that.'" — Stakeholder, Chingola

Sustainability of program interventions

ECR worked closely with several stakeholders to engage ZAMFAM program beneficiaries in the transition process for sustainability of program interventions. Transition meetings were held with parents/caregivers of OVC, CVs and key

stakeholders to adequately plan and prepare for transition and sustainability of project activities. Stakeholders felt that the program would be sustainable as it was delivered through already existing community structures such as F/CBOs and churches. The respondents felt that the program built local capacity to ensure that OVC continued to receive support from F/CBOs and churches in their communities. Some respondents also applauded links established with government ministries like MCDSS, as this ensured ownership of program activities as well as data for future use by government.

“...sustainable in the sense that ZAMFAM has been working within local structures. The CBOs are based in the community. The churches will always be there and will continue to support children. ZAMFAM has built their capacity so even if the project comes to an end, they will continue providing those services to the children. Challenges would only exist for services that require funds.” – Stakeholder, Lusaka

“...sustainability used to be a problem because you would find an organization would just come in and then it ends, but I think lately there has been a strategy with how to exit. Measures are put in place to help the community take ownership of these programs, from inception right up to the end, so even if ZAMFAM leaves they can continue with the programs... but if transfers are done and new people come in then sustainability would become an issue.” – Stakeholder, Lusaka

“...having some sustainable program so they had a land that they were supposed to utilize, that land in terms of farming, chicken rearing and the like. So, for the CVs... they should be leading the example to be sustainable and to show the other families. So, for those who are in the SILC [savings] groups have got their savings they have started doing some chicken rearing, yes so from there we are encouraging them to say you should continue because you shouldn't just stop here.” – Stakeholder, Chingola

Objective 3: To better understand how the program was implemented and identify best practices

The ZAMFAM program helped to strengthen the capacity for both families and caregivers of OVC living with HIV. The findings from the qualitative interviews and the review of program documents helped identify best practices based on innovative and unique program elements as well as document lessons learned based on challenges faced and overcome by ZAMFAM in reaching program beneficiaries.

Best practices

- 1. ZAMFAM's investment in trainings for community volunteers and caregivers of OVC ensured full-service provision for beneficiaries.** As highlighted earlier in the report, ZAMFAM conducted a series of trainings with community volunteers and caregivers of OVC. CVs received training in OVC case management, which resulted in more comprehensive care and support that was tailored to match the unique needs of each OVC recruited to the program. Caregivers also received trainings in ART adherence, parenting skills, economic strengthening, and basic nutrition, particularly nutrition for PLHIV. This approach to building capacity at community and household levels enabled caregivers to manage the challenges faced by OVC during and beyond the program's duration and provided referral options to trained CVs.
- 2. One stop approach to program delivery ensured that beneficiaries received a wide range of services during a single visitation.** As CVs conducted beneficiary home visits, they were able to provide a variety of services to each household. These included health, child protection, education support, and economic strengthening services. The scope of services CVs were trained to provide reflected the diverse, concurrent needs of OVC and their households.
- 3. Routine meetings between program implementers and community volunteers were essential for progress review and documenting.** Monthly meetings with CVs were conducted to provide mentorships opportunities on OVC care/support, quality improvement (including data collection and reporting), sharing best practices, and developing plans to address identified gaps in the implementation of the project. This approach allowed for data validation for reporting as well as provided a platform for highlighting core interventions to be undertaken in preparation for close out of the project.
- 4. Regular coordination meetings between ZAMFAM and other projects and government meetings were necessary for mapping stakeholders and joint planning for wellbeing of communities served.** District coordination meetings

were held on a quarterly basis with F/CBOs, stakeholders, and partners to share activities conducted and share best practices and challenges faced. These meetings also enabled F/CBOs to engage in service mapping as well as create linkages with other organizations making service referrals across programs possible. A marked benefit of the success of this collaboration with government line ministries and partners working with HIV care and treatment was that OVC under ZAMFAM were linked to HIV testing, treatment, and prevention services. The Ministry of Health also supported cooking demonstrations and food preservation activities using locally available food items in communities of program implementation.

5. **Engaging program beneficiaries and stakeholders in the transition process is crucial for sustainability of program interventions.** Transition meetings were held with parents/caregivers of OVC, CVs and key stakeholders in order to adequately plan and prepare for the sustainability of project activities after the program concludes. These meetings ensured that caregivers were encouraged to actively participate in CSGs to strengthen their economical capacity to continue supporting their children.
6. **The *Families Matter!* and *Faith Matters* Program approaches were greatly applauded approaches to meet the needs of adolescents and their caregivers in providing support and guidance for OVC.** The *Families Matter!* Program is a 5-session, evidence-based behavioral intervention designed for parents and other primary caregivers of children aged 9–12 to promote positive parenting and effective parent/child communication about sexuality and sexual risk reduction. The curriculum was designed to meeting the needs of both parents and their children to promote positive parenting practices and effective parent-child communication about sex-related issues and sexual risk reduction. The *Faith Matters* Program targets faith-based leaders to support OVC in helping them understand the needs and pressures of OVC and allow for them to feel comfortable to address these needs. The programs were well received by both the OVC and their caregivers as well as the church leaders who committed to incorporating messages from the programs into their biblical counseling sessions and youth health talks whenever they took place. Parents also reported feeling increasingly comfortable discussing sexual health matters with their children and felt able to disclose HIV statuses to HIV positive OVC. Review of program progress reports showed that a notable number of men became more involved in parenting, reported reduced harsh and abusive parenting, and reported skills in identifying signs of child sexual abuse following the *Families Matter!* Program.
7. **Use of the growth monitoring chitenge for mothers in program communities introduced in collaboration with the Breakthrough ACTION Project was a useful tool for empowering families (particularly mothers) in tracking growth for children under two.** CVs were provided with growth monitoring wraps (chitenges) to distribute to the mothers of children under 2 which proved to be a practical tool to empower mothers to track the growth of their children. The mothers were taught how to use the growth monitoring chitenge to monitor the “healthy” and “unhealthy” development/growth of their babies.

Lessons learned

1. The program noted that several HIV positive beneficiaries do not access HIV care and treatment from the health facilities in their areas of residence. This has made size estimation of HIV-positive adolescents difficult in the various catchment areas. In the future, programs should be prepared with additional resources and personnel to account for mapping where adolescents from particular catchment areas prefer to seek services. This will help implementers identify service needs including the need for confidentiality by beneficiaries to not be identified as living with HIV in their community.
2. Despite the national guidance to test and treat, the program noted that not all new HIV-positive OVC initiate ART immediately after testing due to various myths and misconceptions that were identified by implementers. Some of these misconceptions included community perceptions about taking medication only when someone becomes unwell and weak. Linkages at clinics between HIV testing and treatment services must be strengthened. Additionally, community-level interventions can work to address long-term behavior change by promoting ART adherence and address myths and misconceptions through sensitizations and encouragements as they were delivered in the ZAMFAM model.
3. The Community Savings Groups and P3 initiatives were successful in supporting household economic strengthening approaches and stability in high-poverty settings. The CSG approach ensured that households had access to increased household income, while the P3 initiative improved access to food supplement and

farming input. Community programs must be designed to integrate these approaches to economic strengthening.

4. Coordination of different programs with conflicting timelines that are expected to leverage each other with regard to meeting program targets makes collaboration difficult between programs. The ZAMFAM program's integration with other partners, including DREAMS, resulted in delays and lapses in program implementation resulting from their different implementation timelines.
5. Transitioning beneficiaries from predecessor programs presents challenges when partner organizations that recruited those beneficiaries are not part of the new program. Initially, the ZAMFAM program experienced delays in transitioning OVC program beneficiaries from partner organizations until cooperative agreements were signed. Future programming should prioritize engaging all relevant stakeholders as early as possible prior to implementation.
6. Community volunteers often volunteer on multiple programs and as such, are over-burdened, resulting in failure to achieve program specific targets. The ZAMFAM program experienced this with CVs as they were supporting other programs being implemented in their catchment areas. Creative thought about how to incentivize volunteers and promote greater coordination between volunteer-driven programs is essential. Guidelines from government ministries on volunteer-based programs is likely necessary to ensure the sustainable future of community volunteer-based programs.

Limitations

Interpretation of the study findings are limited by the qualitative nature of the study. While qualitative methods gather feedback on the program, they cannot quantify program effects or impact and thus, the findings from field interviews and focus group discussions should not be interpreted as such.

This study did not pose any physical risks associated with a physical procedure or intervention, such as obtaining tissue or blood samples. Primarily, this study ensured informed consent and confidentiality of responses. The study was entirely voluntary and study participants were made to understand that they were free to withdraw from the study at any given time during the interviews.

Conclusions and Recommendations

The objective of the study was to explore OVC, caregiver and stakeholder's perspectives on the effect of the ZAMFAM program and document best practices and lessons learned. Overall, the ZAMFAM program was viewed as having made a positive contribution to the lives of OVC by the study participants included as part of this assessment. The most notable success from beneficiaries' perspectives was the educational support received, which included support for school fees, books, and supplies. It was widely expressed that this form of support helped beneficiaries stay in school and complete their studies. Another support of note was the home visits received from CVs, which were viewed as an essential form of emotional support. These visits were described by program beneficiaries as addressing multiple topics at the household including HIV counseling and testing, nutritional counseling, emotional support, and ART adherence counseling when required.

The study noted that exposure to and retention of messages around HIV prevention and safe sex was high amongst OVC interviewed. Stakeholders commended the collaboration between ZAMFAM implementing partners and government agencies as it was thought to ensure the sustainability of program activities beyond the life of ZAMFAM.

Based on these study findings, the following recommendations are made for future programming that focuses on OVC, caregivers of OVC, and community volunteers.

- Programs that offer a comprehensive package of services to vulnerable households through one-stop models ensure that program beneficiaries receive the maximum benefit for such outcomes. However, there is need to incentivize volunteer retention throughout the life of the program to capitalize on the investments made training the volunteers.
- Low-cost, high impact interventions including encouraging the use of local produce for nutritional gain allow beneficiary communities to continue with the use of such knowledge, thus ensuring sustainability of interventions. Cooking demonstrations and preservation of local food produce implemented by ZAMFAM in study sites allowed households to maximize the nutritional benefit using commodities already available in their communities for the benefit of OVC households and PLHIV.
- In managing beneficiary expectations, community programs need to clearly define and communicate to beneficiaries the support to be provided to the community and criteria for provided services to respective households. As was the case with ZAMFAM, volunteers who often support such projects should be equipped to identify and respond to the needs of OVC utilizing referrals and linkages to other programs or activities when services are not within the project scope.
- Community Savings Groups proved to be a useful approach to foster economic prosperity and resiliency at the household level. As such, future programs that introduce these models should consider providing initial capital to enable low earning communities access credit for business start-up. In addition to this, the study also noted from discussions with caregivers and community volunteers that groups that were able to combine saving group activities with other income generating activities like chicken rearing and farming provided better lending packages to their members. However, there is need to ensure that groups are equipped to develop guidance for screening group members and managing untrustworthy members from destabilizing the group.

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Annexes

ANNEX 1 ZAMFAM Focus Group Discussion Guide for OVC (13-17)

1. Welcome, consent process, and introduction

a. Welcome

Good morning/afternoon/evening and welcome to our session.

Thanks for taking the time to join us and to talk ZAMFAM. We are seeking your views and experiences in terms of psychosocial support, child protection, food and nutrition, HIV care and support, education support, health and economic strengthening as well as the referral system. My name is _____ and assisting me is _____. The goal of this study is to better understand, and document best practices, innovative, unique, effective and high learning impact approaches and practices done by ZAMFAM on the services they have been providing during the period of the ZAMFAM program.

b. Consent Process

As a group, we are going to go over the informed Assent form before we start our focus group to be sure that you understand why we are having this focus group and to be sure that you voluntarily want to participate.

c. About the focus group

- I. Has anyone participated in a focus group before? Explain that focus groups are being used more and more to gain information to further inform future trials, study planning, etc.
- II. You are the experts: we learn from you (positive and negative). You have been invited to participate because you have important knowledge, experiences, needs, or perspectives that we hope to learn more about as a result of our discussion today in this focus group.
- III. We are not trying to get everyone to agree or achieve consensus, rather, we're gathering information. It is okay if you have different opinions and ideas than the other persons in the group. It is our goal to better understand, and document best practices, innovative, unique, effective and high learning impact approaches and practices done by ZAMFAM on the different services they provided during the program implementation.

2. Focus group logistics and ground rules

a. Logistics

- I. Focus group will last about two hours (120 minutes)
- II. Feel free to move around.
- III. Where is the bathroom? Exit?
- IV. Help yourself to refreshments

b. Ground Rules

- I. Everyone should participate and only one person talks at a time
- II. It is important for us to hear everyone's ideas and opinions
- III. There are no right or wrong answers to questions – just ideas, experiences and opinions, which are all valuable
- IV. The session will be audio recorded to help us gather more detailed information about your responses than the handwritten notes that will be taken by investigators, and it will allow us to double check our data for accuracy (if session is audio recorded, which is depending on consent from individual participants).
- V. Stay with the group, please don't have side conversations, and speak clearly to increase recording quality
- VI. Turn off or silence cell phones.
- VII. Enjoy the discussions

Ask the group if there are any questions before we get started and address those questions.

Turn on Tape Recorder

Focus Group Questions:

As discussion begins, make sure to give people time to think before answering the questions and don't move too quickly.

1. Tell me about your experience living in this community. Are there specific things that you like in this community?
2. What are some things that aren't so good about this community?
3. Do we have clinics and schools in this community? How far are the clinics? How about schools?
4. If a person is sick in this community, where can s/he go for assistance or for help?

Probe:

- a. Are there people who can help in the community?
- b. What type of help can they offer?
- c. When is it acceptable for a child to be beaten at school and at home?
- d. How do children's bodies change over time (puberty change) and who taught you about this?

Probe for:

- a. Teacher?
 - b. Family?
 - c. Household member?
5. What do you know about sex? (Sexual questions can only be asked to children aged 15–17 years).

Probe for:

- a. What age can someone start having sex?
 - b. How many sexual partners can one have?
 - c. What are the best practices for safe sex?
6. Do people in our community aged like us (15-17 years) drink alcohol? (beer, spirits)

Probe for:

- a. How often do they do that?
7. I have a few short questions on a disease called HIV/AIDS. What do we know about it?
 - a. Where can one go for HIV testing in this community?
 - b. Who talked to you about it?
 - c. If someone is HIV+, where can they go to get help in our community. Are there organizations that help young PLHIV? What are the names of these organizations and what help do they give?
 - d. How can people reduce the chances of getting infected? Where did we learn this from?
 - e. How many of you know your HIV status? Do not tell us what it is but just lift your hand.
 8. I would like to find out about school and the challenges we face. What challenges do we face when it comes to school related issues? What organizations have been assisting you with support in school? Please describe the support that has been given to you. Do you think this has benefited in any way?
 - a. What makes people drop out of school and what help was given if someone dropped out of school and who would offer such help?

Probe for:

- a. School fees
- b. Books
- c. School uniforms

Who offered you any of these items or services?

Probe for:

- a. Psychosocial support or care from a home visitor or social worker
 - b. Health care from a health professional
 - c. Vitamin A supplement from an organization
 - d. Supplemental, emergency feeding
9. Now we would like to learn about any issues people experience because of their HIV status.
- a. How are people who are HIV+ treated in the community?
 - b. How are they treated by family members?
10. Do you have anything else that we have not covered in this discussion that you feel is important about the ZAMFAM program?

That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us.

ANNEX 2 ZAMFAM Focus Group Discussion Guide for Caregivers

Introduction

Welcome

Good morning/afternoon/evening and welcome to our session.

Thanks for taking the time to join us and to talk about the Zambia Family project (ZAMFAM). My name is _____ and assisting me is _____. The purpose of the case study is to (a) Strengthen capacity of families and community structures to meet basic needs of orphans and vulnerable children, especially PLHIV, (b) Strengthen the capacity and ownership of community structures to care for orphans and vulnerable children. (c) Increase quality of compassionate care and support services for OVC and their families, (d) Improve HIV case finding and disease management among children and adolescents. And (e) Improve HIV risk avoidance and risk reduction among adolescents.

We are meeting with persons who are caregivers (parents) of children who were or are beneficiaries of this program. We would like to talk to you today to understand your experiences about the ZAMFAM program. We are seeking your thoughts and ideas to help us make future programs better and also see how the current one worked.

We are both from Population Council and working with ECR and the Ministry of Community Development and Social Services. The information you are going to give is will be used to make future programs better and improve the social services of especially for orphan and vulnerable children. We asked you to participate because you have been in this program and you know better how it worked and you understand it better than we do.

Explanation of the process

Has anyone ever participated in a focus group before? Focus group discussions are being used more and more often in social and human services research.

About focus groups

- We learn from you (positive and negative)
- Not trying to achieve consensus, we're gathering information
- No virtue in long lists: we're looking for priorities

In this project, we are doing both in-depth interviews and focus group discussions. The reason for using both of these tools is that we can get more in-depth information from a smaller group of people in focus groups. This allows us to understand the context behind the answers given and helps us explore topics in more detail than we can do in a written survey.

Logistics

- Focus group will last about two hours (120 minutes)
- Feel free to move around
- Where is the bathroom? Exit?
- Help yourself to refreshments

Ground Rules

Can we suggest some ground rules?

- Everyone should participate.
- Information provided in the focus group must be kept confidential
- Stay with the group and please don't have side conversations
- Turn off cell phones if possible
- Have fun

Materials and supplies for focus groups

- Attendance sheet
- Consent forms (one copy for participants, one copy for the team)
- Evaluation sheets, one for each participant
- Name tents
- Pads & Pencils for each participant
- Focus Group Discussion Guide for Facilitator
- 1 recording device
- Batteries for recording device
- Permanent marker for marking tapes with FGD name, facility, and date
- Notebook for notetaking
- Refreshments

Turn on Tape Recorder

Ask the group if there are any questions before we get started and address those questions.

Introductions

Go around table: job here, where you were born

Discussion begins, make sure to give people time to think before answering the questions and don't move too quickly. Use the probes to make sure that all issues are addressed but move on when you feel you are starting to hear repetitive information.

Questions

1. Let's start the discussion by talking about what makes this community a good place. What are some of the positive aspects of living in this community?
2. What are some things that aren't so good about this as a place?
3. I would want to know about what you would do or where you would go when you need money?

Probe for:

- a. Household expenditures on food
 - b. Education expenditures
 - c. Healthcare
 - d. Shelter
4. How did you join the ZAMFAM program? What factors contributed to your decision to want to join?
 5. Some of the things the project was doing was to strengthen capacities of households to meet basic needs of OVC living with, affected by, or vulnerable to HIV/AIDS. Specific efforts include (see probes): How did they help you?

Probes:

- a. Door to door visitations
- b. Household economic strengthening (Household expenditures on food, education, healthcare, shelter)
- c. Promoting positive parent involvement

- d. Health and nutrition education (Household food security)
6. How did the program improve the wellbeing of children through provision of and access to quality care and support services?

Probes:

- a. Promotion of schooling?
 - b. Linkages to HIV prevention, care and support?
 - c. Linkages to psychosocial care and treatment?
 - d. Referrals for child social and legal protection activities?
7. How has the program helped you? or do you feel the program helped you? In what ways?
8. When is it acceptable for a husband to beat his wife?

Probe for:

- a. She goes out without telling him
 - b. She is not looking after their children
 - c. She argues with him
 - d. She refuses to have sex with him
 - e. She burns the food
9. When do you think it is acceptable for a child to be beaten at school or at home? Did you attend the parenting course offered by the ZAMFAM? How has it improved your understanding of parenting? Has it in any way impacted your situation at home, in terms of communication with your children and provide for your children?
10. How would you look at a person who would come to teach adolescents about condom use in our communities?
11. How has the program assisted you to improve your economic situation at your household? What group are you part of? Do you think it is necessary to belong to these groups?
12. What things would you want done differently if the program was to come back?

That concludes our focus group. Thank you so much for coming and sharing your thoughts and opinions with us. We have a short evaluation form that we would like you to fill out if you have time. If you have additional information that you did not get to say in the focus group, please feel free to write it on this evaluation form.

ANNEX 3 In-Depth Interview Guide for Stakeholders

Purpose (For interviewer reference; does not need to be read out loud to participant): The aim of this in-depth interview guide is to understand the organization involvement in the ZAMFAM program for OVC that was conducted by ECR. We are interested in understanding who influences their decisions, what makes it easier or harder for them to prevent HIV, get tested, and engage in HIV care and treatment successfully. We are especially interested in how your organization worked with ECR in implementing these services

Introduction

Research Assistant Note: Introduce the study in your own words, being sure to include this information:

The aim of this is to better understand and document best practices, innovative, unique, effective and high learning impact approaches and practices done by ZAMFAM on OVC Case Management and equipping Families with improved Communication through Families Matter! Program.

Research Assistant Note: Remind the participant about some key points of the informed consent:

- There are no right or wrong answers, all opinions and ideas are important to us.
- Participation is voluntary; refusal to answer questions will not affect his/her job.
- The discussion is confidential and no one outside of the study team will be able to link his/her responses to them personally.

Confirm readiness to start.

- How long have you been doing this work?
- How did you end up in your current role?
- How many staff work there?
- What type of work do you do or what type of services do you provide?
 - If applicable (e.g. for health care workers):
 - Does your work focus on either HIV prevention or treatment?
 - Do you provide other services?
 - If yes, what types of services?

Theme 1: Background Questions (5 minutes)

I would first like to ask you some background questions. These questions will help us understand more about your work and your role in the community.

1. To get us started, please tell me about the work you do.
2. What is the community like where you do this work?
3. Do you have other important roles in this community, aside from your work?
4. What is your organizational/work setting like?
 - a. How many of your clients/the people that you serve are aged 0-9?
 - b. What type of work do you do with these age group?
 - c. How many of your clients/the people that you serve are aged 10 – 18?
 - d. What type of work do you do with this age group?
 - e. What is their home environment like? Who do they live with?
 - f. Do most of them go to school? When do they leave school, and why?

- g. How do they spend their time when they are not in school?
 - h. Ask about change at home, school and how they spend their time
 - i. At what ages do these changes start happening?
 - Develop family care plans, conduct health care and food and nutrition
 - Psychosocial support
 - Refer clients for PMTCT services ne/assessments.
 - Provide Infant and Young Child Feeding.
 - Identify and refer children in need of supplemental feeding.
 - Referrals
 - Collaborate with health facilities on health campaigns and outreach activities
 - Refer clients for PMTCT services
 - Refer clients for HIV testing services
5. What types of clients do you see or what types of people do you serve?

Theme 2: Life Experiences of OVC

- 6. Tell me about the lives of OVC where you work. Let's start with the ones aged 10-14 or so:
- 7. What's different about the lives of older ones (15-18), as they move into their late teens and early twenties?
- 8. Thinking about the Caregivers that you work with in your community. How did you identify and register HIV+ children at health facilities, and conduct follow ups to ensure early recruitment and retention in ART programs?

Research Assistant Note: If the participant has trouble answering, probe about some of the following topics:

- 9. What about the work you did with health facilities? How did you work with the health facility?

Research Assistant Note: If the participant has trouble answering, probe about some of the following topics:

- 10. How was your organization able to do the following:
 - a. Collaborate with health facilities on health campaigns and outreach activities (e.g. child health week)
 - b. Provide pediatric counseling to families/parents living with HIV positive children pr
 - c. Through peer education, scale up quality youth HIV prevention and SRH services, and involve parents, based on the Total control of the Epidemic
 - d. Strengthen youth friendly corners at health facilities and refer youth to SRH services
 - e. Form support groups for adults with different needs and link them to health facilities for other services
 - f. Trained community volunteers provide home-based care (adherence support, palliative care) for PLHIV
 - g. Expand HIV Testing & Counseling (HTC) opportunities for families through strengthened referrals to HTC services, home-based testing activities or mobile VCT

Theme 3: Collaboration with ECR and MCDSW/MoH

- 11. What kind support and involvement did you get from ECR and MCDSW/MoH in terms of
 - a. Implementing the OVC minimum standards once finalized by MCDSW
 - b. Attending community-level coordination meetings with public structures led by MCDSW
 - c. Attaching trained community volunteers to clinics to support health activities at clinics and in the community

12. What challenges did you face during this whole time that you worked on ZAMFAM?
13. What challenges do you have with logistics?
14. What challenges do you have with community volunteers you engaged?
15. What challenges did you have with Caregivers? Did they have any fears? If so, what are they and how did you address them?
16. What fears did they have about reactions within the community?

Theme 4: Wrap-up (2 minutes)

I want to thank you for doing this interview with me. Is there anything you'd like to add about the topics we've discussed? Is there anything you thought would come up in our discussion but didn't? Do you have any questions for me?

