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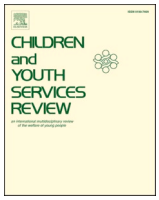

The evolution of priority for the care of orphans and vulnerable children in Zambia☆

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ABSTRACT

Given the severe impacts of the HIV/AIDS epidemic and chronic poverty, the care of orphans and other vulnerable children (OVC) is a significant national issue in Zambia. This article examines the evolution of governance and policy for the care of OVC and identifies the factors that have shaped Zambia's priority for and capacity to address this issue. We find Zambia's policy for family reintegration of OVC has been strengthened in the last decade, driven by international actor engagement, gradual efforts to improve child welfare and protection more broadly, and data gathered on gaps in children's care facilities. However, government commitment and governance for the care of OVC remain weak given historical impacts of economic and health crises, which have eroded the traditional kinship care system, amplified capacity gaps, and consequently led to significant dependence on international actors. Together, these influences have fragmented and weakened governance of the issue. Proponents will need to address three challenges to enhance state commitment and governance for OVC care. First, government capacity to address OVC care needs to be augmented so that it can exercise effective coordination and hold other actors to account. Second, policy to address underlying drivers of vulnerability needs to be enhanced, to avert the very problems that put children at risk in the first place. Third, networks that link OVC care actors need to be more inclusive to improve the quality of policymaking and implementation, and to enable these networks to push the government to strengthen its commitment to this sector.

1. Introduction

The care of orphans and other vulnerable children (OVC) is a significant national issue in Zambia, affecting many children and families. Poverty, child abandonment, death of a parent, abuse and maltreatment, disability of the child or the primary caregivers within the family, and imprisonment of a parent are the main drivers of children being cared for outside their home (MCDSS, 2017). Based on the 2013–2014 Zambia Demographic and Health Survey, approximately 11 percent of children below the age of 18 are orphaned, with one or both parents dead. Approximately 18.9 % of children under the age of 18 do not live with either biological parent, and about 24.7 % of households are caring for children who are not their biological children of the household head (Central Statistical Office, 2015). There are 1.66 million children estimated to live in kinship care, and an additional 6,413 children residing in residential care in Zambia (UNICEF, 2021).

Despite the burden and severity, state commitment and capacity to address the care of OVC remains relatively low. Drawing on interviews and document analysis, we investigate the evolution and effectiveness of the OVC care system in Zambia, with attention to the factors that have facilitated and hindered state priority and governance for addressing this issue over time. By OVC care system, we mean the set of arrangements within a country designed to ensure the care and protection of children who have lost one or both parents, or who have experienced or are at risk of some form of serious harm or neglect (Shawar & Shiffman, 2023).

This article is part of a research project on the governance of OVC care systems in low-income countries (Shawar et al., 2025; Shiffman and Min, 2025; Walakira et al., 2025; Shiffman et al. 2025). In the sections that follow we analyze the forces that have shaped the OVC care system in Zambia over time. After describing the study's methodology, we provide a narrative history of the evolution of OVC care policies and

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systems in the country, including the current state of policy and governance for the care of OVC. We conclude by drawing on an analytical framework to point to the factors driving the OVC care system's evolution and discussing implications for strategies to enhance Zambia's OVC care system.

2. Methods

This research is a qualitative, historical case study (Yin, 2018). Drawing on an analytical framework that identifies key political factors shaping OVC care systems, we analyzed data gleaned from documents and key informant interviews to assemble the history of OVC care policy and initiatives in Zambia and identify the factors that have shaped the evolution and effectiveness of its OVC care system.

2.1. Framework for analysis

To conduct the analysis, we used the research project's organizing framework on political factors shaping OVC care systems (Shawar et al., 2025). The framework consists of three categories of factors—policymaking, governance, and context—each with sub-components. Policymaking refers to the content and production of national legislation, regulations and strategies for OVC care and protection. It consists of two elements: policy content is the actual substance of policy; policy process concerns how policy is made. Governance refers to the quality of collective action on OVC care and protection. It consists of four elements namely: i) commitment, ii) leadership, iii) coordination; and iv) capacity. Commitment pertains to the extent to which government and other national actors prioritize the issue and set up strong accountability mechanisms. Leadership concerns whether or not strong individuals and institutions exist to guide action on the issue. Coordination pertains to the extent to which government, international, non-governmental and community actors work together on the issue. And capacity refers to the skills, resources, and motivation of relevant agencies within the government bureaucracy that carry out policy. The third category—context—pertains to the socioeconomic and political environment in which OVC care systems are situated, and that shapes both the problems the systems must address, and the effectiveness of the systems themselves. It consists of two primary elements – social values and social problems. Social values pertain to the beliefs families and communities hold that shape their practices with respect to care and protection of OVC, such as attitudes on kinship care. Societal problems pertain to large-scale political, socioeconomic and health difficulties—for instance pandemics—that shape the problems OVC care systems must address.

2.2. Documents

We collected and reviewed 118 documents, including peer-reviewed publications, international and domestic organizational reports, government strategy and policy documents, and some media reports. We identified these documents from google scholar, organizational and government agency websites, and via the recommendations provided to us by key informant interviews. Key words employed in our search included: Zambia in combination with children's care, social protection, child protection, orphans and other vulnerable children, family-based care, kinship care, residential care, facility-based care, and/or orphanages, as well as policy, governance, commitment, capacity, norms, economy, poverty, and/or HIV/AIDs. We also included targeted searches of particular websites and organizations, including the Better Care Network, UNICEF Zambia, Ministry of Community Development and Social Services.

2.3. Key informant interviews

We also conducted 27 interviews with individuals directly involved in or with expertise on OVC care in Zambia between August 2021 and September 2022. Key informants were initially purposefully selected, based on their position within key organizations or agencies of interest, and identification from peer-reviewed and grey literature. We also selected key informants via snowball method, in which we asked key informants to recommend individuals most knowledgeable about OVC care in Zambia. Table 1 lists the affiliations of respondents. Respondents were policymakers, decisionmakers, advocates, service providers and researchers working in government agencies, intentional organizations, domestic non-governmental organizations, universities, and children's homes. All interviews were conducted in English; 20 were conducted in-person and 7 were conducted online via zoom. Drawing on the policy framework utilized in this project (Shawar et al., 2025), we developed an interview guide that sought to probe respondents on three key areas: 1) policymaking (i.e., policy content and development related to OVC care); 2) governance (i.e., state and societal capacity to address and implement OVC care policy); and 3) context (i.e., current and historical developments and norms that have shaped how society perceives OVC and their care). The interview questions were largely open-ended, and we tailored questions based on the expertise and experience of the respondent. However, several questions were consistently asked (i.e., their involvement in Zambia's OVC care system and their perceptions around its effectiveness). Each interview lasted about one hour and was transcribed with respondent permission. We continued interviews until we reached theoretical saturation (Faulkner & Trotter, 2017)—the point at which we identified no new themes from additional interviews.

2.4. Analysis

We triangulated the literature and key informant interview data to create a historical timeline and narrative on the policy and governance for OVC care in Zambia—including major developments, policies, and structures that influenced the evolution or effectiveness of state policy and response to needs of OVC. We employed a thematic analysis (Braun et al., 2024). Drawing on the analytical framework, we coded the data under three large categories concerning policymaking, governance, and context, and then further coded deductively using factors from the framework, but also inductively, capturing themes that did not neatly fit within the identified framework of factors. Each respondent was assigned a key informant number and cited in the findings accordingly.

Data collection, analysis, and presentation were handled according to ethics review protocols approved by the University of Zambia (Lusaka, Zambia) and Johns Hopkins University (Baltimore, MD, USA), which deemed this research exempt after full IRB review.

3. Results

3.1. Five periods of Zambia's OVC care system

We identify five key periods that mark distinct developments in Zambia's OVC care system (see Table 2 for a timeline of events). Prior to 1964, there was a rapid rise of industrialization and migration, and institutional care was introduced by missionaries, which collectively undermined the traditionally strong kinship care system. Between 1964 and 1990, post-independence, the state enjoyed a period of economic prosperity and centering of family and community values, which enabled state advancements in child protection and welfare. Beginning in 1991, the harsh impacts from both economic and HIV/AIDS pandemic crises drove up the number of OVC, placed severe burden on the traditional kinship care system, diverted the state's attention away from addressing child welfare and protection challenges, and led to a growing number of institutional care arrangements. Beginning in 2002, the state, with significant funding support from international actors, began to address the social and economic impacts of the crises via policy and initiatives dedicated to child welfare and protection. Since 2014, a flurry of policies and programs dedicated to OVC care—and specifically family

Table 1
Key Informant Numbers.

Government
1. Ministry of Community Development and Social Services (MCDSS), National Level
2. Ministry of Community Development and Social Services (MCDSS), National level
3. Ministry of Community Development and Social Services (MCDSS), National level
4. Ministry of Community Development and Social Services (MCDSS), Provincial level
5. Ministry of Community Development and Social Services (MCDSS), District level
6. Victim Support Unit, National level
7. Community Welfare Health Assistant
Academic/Research
8. University of Zambia
International organizations
9. UNICEF
10. Save The Children, community level
11. Save the Children, community level
12. Save the Children, Community level
13. International Organisation for Migration
14. Social Workers Association Of Zambia
15. Catholic Medical Mission Board (CMMB)
16. Catholic Medical Mission Board (CMMB), Community level
17. Catholic Relief Services
Local organizations
18. Zambia Law Development Commission
Child care facilities
19. Child Care Facility –Chamba Valley Township
20. Child Care Facility – Matero Township
21. Child Care Facility- Kamwala Township
22. Child Care Facility- Kamanga Township
23. Child Care Facility- Kabwata Township
24. Child Care Facility- Chelstone Township
25. Child Care Facility- Avondale Township
26. Child Care Facility-Chilenje Township
27. Child Care Facility- Chalala Township

re-integration—has been introduced.

3.2. Pre-1964: Colonial era—undermining of kinship care

Prior to 1964, before Zambia's independence, there were traditionally strong kinship care practices. However, these practices were strained given colonialism and the rapid rise of industrialization and migration during the colonial era. Colonial missionaries, beginning in the 1900s, established multiple orphanages throughout the country—mostly connected to religious initiatives, such as the White Fathers' Missionary Society, located in the Northern Province and Copperbelt provinces of Northern Rhodesia (Mbewe, 2012). At around the same time, the number of OVC rose rapidly with the commencement of mining activity; many workers left their families behind, leading to fractured family structures, with children often growing up without one or both parents (Sicaults, 1963). The labor migrations also affected traditional African values and customs, as families arriving in urban areas increasingly became less connected with extended families in the villages. Urbanization and industrialization also gave rise to several social problems in many newly created shanty compounds, including extreme poverty, poor sanitation, and illness — conditions that further increased the vulnerability of children and families (Noyoo, 2021). Together, this put pressure on and led to some undoing of traditional kinship care customs (Northern Rhodesian Government, 1955, p. 364).

3.3. 1964–1990: Kaunda era—expansion of the child welfare regime

The Republic of Zambia was established in 1964; from 1964 through 1990—during the tenure of Zambia's first President Kenneth Kaunda—the promotion of Humanism and Zambianisation ideology and the country's economic prosperity, rekindled emphasis on traditional kinship care practices and development of policies and services that benefited the population's social welfare, including OVC.

3.3.1. Zambian Humanism and Zambianisation

Upon taking office, President Kaunda mobilized citizens around the twin goals of nation-building and socio-economic development (Baylies & Szeftel, 1984), promoting the socialist United National Independence Party's (UNIP) motto 'One Zambia-One Nation'(Mwangala, 2009). President Kaunda fiercely promoted Zambianisation and Humanism ideology through national television and policy development. The former, an effort to remove racialized hierarchies and unequal structural forces designed and promoted by prior British colonialism; the latter, a Christian, non-capitalist ideology that seeks to maintain African traditions and cooperation while promoting economic growth (Kaunda, 1974). Zambian Humanism rests on values of man-centeredness, communalism, the extended family-system, and reciprocal obligation; it blames urbanization and the Western World's influence on loosening the ties of the extended family (Kaunda, 1974; Molteno, 1973). President Kaunda encouraged community leaders to revert to the ideals of traditional African society:

> "We have got to be man-centered, truly man-centered. That life I keep referring to in the village is 'the key'…We have got to translate it at the national level" (Meebelo, 1973).

3.3.2. A period of economic prosperity & expansion of social services

The first decade of the country's independence was also marked by economic prosperity. This was largely driven by increases in copper prices from 1964 to 1970, as well as the government's nationalization of industries between 1968 and 1971 (Clark & Allison, 1989). By 1969, 80 % of the economy became under state control given state nationalism of all private retail, transport, and manufacturing firms in the country (Clark & Allison, 1989). The public sector rapidly expanded; state workers grew from 22,500 in 1964 to 51,000 in 1969 (Pausewang & Hedlund, 1986). In sub-Saharan Africa, Zambia held the highest employment rate, and its per capita income was second highest (Clark & Allison, 1989).

Together, the state's economic prosperity and the embrace of

Table 2
Timeline of relevant developments in OVC care.

Year	Policy or strategy description
Period 1. Pre-1964: Colonial era—undermining of the kinship care system	
1950	First allocation of funds by the Government towards the construction of orphanages by missionaries
1951	Second allocation of funds by the Government towards the construction of orphanages by missionaries
1953	The Probation of Offenders Act—provided for the probation of offenders
1956	The Juvenile Act—provided for the custody and protection of juveniles in need of care and correction of juvenile delinquents
1956	The Adoption Act—provided for the making and registration of adoption orders, the registration and control of adoption societies, and the supervision of adopted children by the Commissioner for Juvenile Welfare in certain cases
Period 2. 1964–1990: Kaunda era—expansion of child welfare regime	
1964	Republic of Zambia established; first President Kenneth Kaunda promotes Humanism ideology
1964—1970	Economic prosperity largely driven by increases in copper prices as well as the government's nationalization of industries
1966	Faculty of Humanities and Social Sciences opened at the University of Zambia, introducing high quality social work courses
1969—1971	Expansion of child welfare through increased government funding towards education, health and recreation services for children
1970 s	Onset of economic crisis
1980	Adoption of rural economic diversification policy
1980 s	First HIV case was recorded in the country
Period 3. 1991–2001: Rise of crises era—increasing reliance on institutional care	
1991	Change of Government from a one-party state to a multiparty system
1991	The Ministry of Community Development and Social Services (MCDSS) established
1995	The Affiliation and Maintenance of Children Act—consolidates the law relating to the maintenance of children to bring the law of Zambia into conformity with the United Nations Convention on the Rights of the Child (1989), to which Zambia is a State Party
2001	Ministry of Community Development and Social Services (MCDSS) initiates children's care reforms through the Child Care Upgrading Programme
2001	Movement for Multi-Party Democracy presidential candidate Levy Mwanawasa wins election
Period 4. 2002–2013: Emergence of the social welfare regime response	
2003	The social cash transfer scheme launched
2006	The National Child Policy developed—aimed to address existing challenges facing children in Zambia such as orphanhood, vulnerability to sexual and gender-based violence, disabilities and HIV and AIDS
2011	The Ministry of Community Development, Mother and Child Health (MCDMCH) was established through a Presidential decree
2011	Anti-Gender Based Violence Act No. 1 of 2011
2013	The Child Care Upgrading Programme—promotes family-based care, family preservation, and response interventions implemented under the Children in Families (CIF) Initiative
Period 5. Since 2014: The rise of children's care reform policy	
2014	Development and launch of Minimum Standards of Care of Child Care Facilities, Regulations and Procedures
2014	Children in Families Technical Working Group established
2015	The National Child Policy—amended to more comprehensively address alternative care among other child protection issues
2016–2017	Nationwide Assessment of residential care facilities is undertaken, finding many facilities do not meet Minimum Standards of Care
2017	Alternative Care and Reintegration Guidelines developed
2017	Alternative Care Case Management tools and standard operating procedures developed
2017	MCDSS establishes the National Alternative Care Technical Working Group
2018	University of Zambia develops curriculum for in- and pre-service short courses on alternative care and case management
2019	Children in Families Plus (CIF +) is piloted in Lusaka District to enhance the collaboration of stakeholders, led by MCDSS and CIF partners, to reintegrate 200 children
2019	Electronic case management and information management systems are introduced for children receiving care and protection services
2019	Launch of the Communication and Advocacy Strategy on promoting family-based care with a costed implementation plan
2019	The National Framework for the Care of Children in Need of Care and the draft Children's Code Bill
2019	National Standards for the Accreditation and Authorization of Adoption Agencies, in line with provisions of the 1993 Hague Convention on Intercountry Adoptions
2019	A practical in-service short course on alternative care and case management is implemented
2020	Guidance note is produced for emergency alternative care for children during COVID-19
2020	Community Dialogue Toolkit on family-based care is developed
2021	A national campaign begins to promote family-based care
2021	Documentation begins of facility-run services for care leavers to inform the development of a national care leavers' strategy
2021	Free Education Policy—abolished school fees from both primary and secondary education
2022	The Child Code Act no. 12 of 2022—consolidated various laws that concern the welfare of children in Zambia to ensure that children's rights are upheld, respected, and protected

Kaunda's Humanism ideology led to improvement in the population's living standards, expansion of social and child welfare services, and strengthening of traditional family-based care practices for OVCs (Mbewe, 2012; Sun, 2019). In 1966, social services made up approximately 27 % of the central government's capital expenditure (IBRD, 1972). The number of people in secondary schools increased from 2,500 in 1960 to 54,000 in 1971 (Hobson et al., 2024). The adoption of free education and health policies supported communal and family-based care systems (Kaunda, 1974; Mbewe, 2012). In addition, the Department of Social Welfare provided public assistance and child care, but also enforced policy promoting extended family responsibility (Mbewe, 2012; Sun, 2019). There was also a rise in voluntary organizations, which provided recreational training, health, and child welfare (Brooks & Nyirenda, 1987).

However, Zambia's economic and political landscape began to shift in the 1970 s. In 1971, President Kaunda transformed Zambia into a one-party state when he was threatened by the African National Congress (ANC) and other factions, and by 1974, copper (Zambia's major export) prices fell sharply on the world market (Rakner, 1991). The economy began to deteriorate. Between 1975 and 1990, Zambia experienced a 30 percent decline in real per capita growth (World Bank, 1990).

3.4. 1991–2001: Rise of crises and increasing reliance on institutional care

Widespread protests over the economy's deterioration led to multiparty elections on October 31, 1991; President Fredrick Jacob Chiluba from the Movement for Multi-party Democracy (MMD) was elected (Van Donge, 1995). The period between 1991 and 2001, during President Chiluba's leadership, was characterized by a rapid rise of OVC and increased reliance on facility-based care—a function of the state's severe economic deterioration and the HIV/AIDS pandemic.

While the country's economic deterioration began around the mid-1970 s, the impacts were fully felt in the 1990 s (Whitworth, 2015). The displacement of Kaunda's Humanism ideology in favor of President Chiluba's economic liberalization and privatization policies worsened the economy. Spending on public and social services were slashed, unemployment ballooned, poverty levels skyrocketed, and the free education policy was abandoned (McCulloch et al., 2001; Wolkenhauer, 2022). By 1998, overall poverty was measured at 72.9 percent and extreme poverty at 57.9 percent (UNDP, 2001). The economic crisis was

made worse by the rapid spread of HIV/AIDS. While the first HIV case was recorded in the country in the early 1980 s, the number of cases jumped from about 36,707, in 1985 to 914,691 in 2005 (Qiao et al., 2018). During this period, half of all households lived in extreme poverty and/or were severely impacted by the HIV/AIDS epidemic (Foster & Williamson, 2000).

Together, the economic and health crises rapidly increased the number of OVC. In 1991, there were 35,000 children living on the street in Lusaka; by 1998 there were more than 90,000 (Daley, 1998). In 1992, 12 % of all households had one or more orphaned children in Zambia. This percentage increased to 18 % by 1996 and further rose to 21 % by 2002 (Central Statistical Office of Zambia, 2003). Some of the OVC experienced HIV-related health challenges, compounding their vulnerability (Chama et al., 2012; Reijer, 2013).

The growing number of orphans overwhelmed traditionally strong kinship family structures, leaving fewer families capable of caring for OVC (Foster, 2002; Haworth, 1991). More children lived on the street, the number of child-headed households rose significantly, and there was increased reliance on facility-based care (Chama et al., 2012; Mukuka et al., 2002). Many children also dropped out of school due to lack of financial support which was worsened by medical and funeral expenses, as well as the need to care for sick family members (Nampanya-Serpell, 2000).

3.5. 2002–2013: Social welfare regime response

In reaction to the severe economic and health crises impacts and the rapid proliferation of OVC (Reijer, 2013), the government shifted its orientation toward the provision of social safety nets beginning in 2002, following the 2001 election of President Mwanawasa. Over the next decade, the introduction of the social cash transfer program, the influx of funding from external donors in response to the HIV/AIDs epidemic and the cancellation of the state debt bolstered the government's ability to introduce social welfare services and policies dedicated to the care of OVC (Noyoo, 2021).

3.5.1. Introduction of the social cash transfer program, rise of foreign funding and state debt cancelation

Three key factors helped support the government's increased initiatives dedicated to the care of OVC during this time. First was the commencement of the social cash transfer scheme in 2003. This began as a pilot program in the Kalomo District with the support of the Ministry of Community Development and Social Services (MCDSS) and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (the German development agency, previously known as GTZ) (Seidenfeld et al., 2014).

Second was the involvement of foreign donors, which rapidly rose in response to the HIV/AIDS epidemic. From 1997 to 2007, USAID funded a $17 million initiative to address the educational and psychosocial needs of OVC and their caregivers (FHI, 2007). In 2003, Zambia Orphans Aid was started by women in the World Bank in response to the orphan crisis in Zambia (ZOA, 2024). Beginning in 2004, the U.S. government, through the establishment of the President's Emergency Plan for AIDS Relief (PEPFAR), provided a total of $6.7 billion dollars over two decades, to support Zambia's national HIV response (Zambia, 2023). Beyond supporting Zambians with lifesaving medications, the fund supported initiatives such as the Zambia Family program to address the increasing number of OVC (L. Phiri et al., 2020)—a number that grew by 13 % (1,302,307, and to 1,603,928) between 2004 and 2008 (Boston University, 2009). Through such support, OVC increasingly accessed care and other critical services in facility-based arrangements (Dunn, 2007).

Third was the cancellation of the state's debt. About $3.8 billion dollars (more than 50 %) was written off in April 2005, when Zambia became eligible for debt forgiveness from the multilateral aid agencies under the 'Heavily Indebted Poor Countries' initiative after adhering to strict austerity conditions (IMF, 2005). The resources that were previously earmarked for debt servicing were re-distributed to education, health, and social welfare sectors, which helped drive the state's social welfare response during this time.

3.5.2. The emergence of a social welfare response

Consequently, policies related to children's care reform began to emerge. While some policies pre-dated the introduction of the social cash transfer program, influx of foreign funding, and state debt cancellation (i.e., the Ministry of Community Development and Social Services initiated in 2001 the Child Care Upgrading Programme, which strengthened government oversight of residential care (UNICEF, 2021), the first National Child Policy was developed in 2006 to help promote coordination and provide policy guidance on, for example, the supervision and training of social workers and placement of children in care (UNICEF, 2021). National guidelines on children's homes and the National Communication Strategy on Sexual and Gender-Based violence were also developed (Januario et al., 2016; Njamba, 2015). However, implementation of these initiatives was weak. The funding allocated covered as little as one-tenth of the ideal funding needed (K300 million in 2021, or US$15 per annum per child), and the programs did not reach enough of the target population to have a significant impact on food security, poverty, and overall vulnerability (UNICEF, 2023a).

3.6. Since 2014: Rise of children's care reform policy

Since 2014, a dramatic shift in policy approach from facility-based care to family reintegration occurred. This was driven by the emergence of data around children's care facilities, adoption of more policies dedicated to improving the welfare and protection of vulnerable populations, and collaborative efforts between the government and external actors who advanced deinstitutionalization—the process of transitioning children from institutional settings, such as orphanages, to family and community-based care.

Emergent data on the poor state of care within institutional arrangements was critical to driving the policy shift to family reintegration. In December 2015, the Ministry of Community Development and Social Services, in partnership with UNICEF, commissioned a nationwide assessment of all 189 child care facilities across the country—a decision prompted by the lack of baseline data to evaluate to the National Minimum Standards of Care for Child Care Facilities, launched in 2014 (Ministry of Community Development, 2014). The assessment found a sobering reality: many facilities did not meet Minimum Standards of Care, particularly in relation to management capacity, record keeping, care planning, and quality of care provision (MCDSS, 2017). Gatekeeping mechanisms were also found to be weak or non-existent; only two-thirds of children who were admitted into institutional care did so with signed consent by parents or guardians (MCDSS, 2017). Consequently, the Government committed to using the assessment data to "inform efforts ….to strengthen the alternative care system in the country," (MCDSS, 2017) reiterating that child care facilities are an interim measure, employed only when other means of OVC care are unavailable.

Second, the introduction of several policies that helped improve the conditions of OVC and vulnerable families helped enable the policy shift to family reintegration. This included the 2014 National Social Protection Policy (Republic of Zambia, 2014), which sought to improve the well-being of vulnerable Zambians across social assistance, social security, livelihoods and protection; the amendment of the National Youth Policy in 2015, which sought to bridge gaps and tackle challenges in youth development (Ministry of Youth and Sport, 2015); and the revised 2015 National Child Policy (originally from 2006) (MCDSS, 2015), which called on state and non-state actors to work together in protecting children from violations and vulnerabilities and promoted services to prevent family separation, in addition to kinship care, foster care, and adoption over residential care (UNICEF, 2018; UNICEF, 2021).

Finally, the government's close partnership with global actors who advanced deinstitutionalization—a care reform strategy that seeks to replace institution-based care with family-based care, was critical to the family reintegration policy shift. Beginning in 2010, deinstitutionalization became core to several global development commitments (OHCHR, 2022; United Nations, 2010, 2019, 2021). At the same time, several key external actors holding these policy ideas—such as UNICEF, GHR Foundation, Save the Children, and Catholic Relief Services—became increasingly involved in the development of policies, establishment of governance structures, and implementation of assessments and programs that advanced family reintegration in Zambia.

In 2014, GHR Foundation supported the establishment of the Children in Families (CIF) Initiative—an effort to strengthen programs dedicated to family preservation via MCDSS and a consortium of NGOs, including UNICEF, Save the Children, Catholic Relief Services, Catholic Medical Missions Board, Christian Alliance for Children Everywhere and the Zambia Association for Sisterhoods. In parallel, the Children in Families Technical Working Group was established under the leadership of MCDSS and in partnership with UNICEF and other NGOs to strengthen coordination and pilot the delivery of collaborative efforts to promote family preservation and family-based alternative care interventions (Better Care Network, 2016). Through this effort, a Zambia National Consultation workshop on the theme 'Accelerating Children's Care Reform' was conducted in May 2016. Workshop participants concluded:

> "[There is a] clear sense from the meeting that the focus for care reform has now shifted to the prevention of separation of children from their families and away from a reliance on institutions" (Better Care Network, 2016).

A slew of family-based care guidelines, initiatives, and government structures followed (summarized in Table 3), including the 2017 Alternative Care and Reintegration Guidelines, 2019 Children in Families Plus (CIF +) initiative, 2019 National Framework for the Care of Children in Need of Care, and 2020 Guidelines to Strengthen the Social Service Workforce for Child Protection (UNICEF, 2019).

However, the onset of the 2020 COVID-19 crisis set back some of the nascent progress that had been made on children's care reform. For example, a rapid health impact assessment of COVID-19 on families with children with disabilities in Lusaka showed many families experienced food insecurity (79 %), housing instability (67 %), stress (36 %), and increased risk of child separation and neglect (18 %) (Hearst et al., 2021). This period was also marked by high levels of external borrowing, debt, and alleged abuse of social cash transfer funds (J. Phiri, 2022).

Nonetheless, the election of President Hichilema in 2021 ushered in two landmark policies: the Free Education Policy in 2021 and the Children's Code Act in 2022 (Machinyise et al., 2023). The former enabled children who had dropped out of school due to poverty to resume schooling; the latter consolidated laws providing for the rights and welfare of children, harmonized the definition of a child, and domesticated the Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child and the Hague Convention on Inter Country Adoption (Save the Children, 2021; UNICEF, 2021). There was also a significant reform to the national governance arrangements for OVC care: the Department of Child Development was moved in 2021 from the Ministry of Youth and Child Development to the MCDSS to harmonize OVC care systems and services (MCDSS, 2024).

3.7. Present state of priority

Zambia's current policy for OVC care—especially with respect to family reintegration—is relatively strong notwithstanding some deficiencies.

Table 3
Children's alternative care reform: policy shift to family reintegration.

Children's care reform policy, initiatives, and governance structures		
2017	Alternative Care and Reintegration Guidelines	Provided a step-by-step guide in the provision of emergency care, reintegration, kinship and foster care as well as adoption
2017	Alternative Care Case Management tools and Standard Operating Procedures	Inform the development of broader child and family welfare statutory and non-statutory case management system
2017	National Alternative Care Technical Working Group	Established to support more harmonized and coordinated implementation of alternative care programs within the broader child and family welfare system
2018	Curriculum for alternative care and case management	University of Zambia (UNZA) engaged to develop in-and pre-service short courses
2019	Children in Families Plus (CIF +)	Led by MCDSS and CIF partners and piloted in Lusaka District to enhance the collaboration of stakeholders to reintegrate 200 children from children's care facilities
2019	Electronic case management and information management systems	Introduced by MCDSS for children receiving care and protection services
2019	National Advocacy and Communication Strategy on Promoting Family-based Care in Zambia	Created by MCDSS with the aim of 1) reducing the risk of children being separated from their families and placed in institutional care; and 2) increasing the number of children transitioning from institutional to family-based care
2019	The National Framework for the Care of Children in Need of Care	Created by MCDSS, with the aim of outlining the continuum of care options for children in need of care. This policy states that family preservation should be prioritized. For children in need of alternative care, institutional care should be used only as a last resort and for the shortest period possible, and children should instead be placed in kinship or foster care
2019	National Standards for the Accreditation and Authorization of Adoption Agencies	Adopted to provide formal process by which an Adoption Agency seeks to be licensed by the Zambian Government to undertake authorized procedures associated with adoptions, in line with provisions of the 1993 Hague Convention on Intercountry Adoptions
2019	A practical in-service short course on alternative care and case management is implemented	
2020	Guidance note is produced for emergency alternative care for children during COVID-19	
2020	Community Dialogue Toolkit on family-based care is developed	
2021	A national campaign begins to promote family-based care	
2021	Documentation begins of facility-run services for care leavers to inform the development of a national care leavers' strategy	
2022	The Child Code Act no. 12	Consolidated various laws that concern the welfare of children in Zambia to ensure that children's rights are upheld, respected, and protected

3.7.1. Recent strengthening of policies

There have been significant advancements in the number and content of the policies dedicated to OVC, especially since 2012 and culminating with the landmark passing of the 2022 Children's Code Bill. Over time, there was a marked policy shift from emphasis on kinship care under Kaunda's leadership to facility-based care and institutional upgrading in the early 2000 s, to family reintegration in the last decade.

Zambia's recent family reintegration policy—an approach of transitioning a separated child, often following a child welfare intervention, back to his or her family—was largely shaped by the emergence of a network concerned with the problem, encompassing external donors, international organizations, and government officials beginning in 2010. With significant contribution from UNICEF and GHR Foundation, civil society partners under the leadership of MCDSS, came together to establish pilot projects that showed it was possible to provide placements for OVC outside of facilities, devise alternative care policy, and push forward the Children's Code Bill in 2022. Most critical to this was the CIF + initiative, which was designed to improve child integration processes formerly addressed in isolation and without clear coordination (Mulenga & Michelo, 2018). Respondents noted UNICEF's critical role in the sector:

> "I think in terms of statutory functions actually we have relied heavily on partners like UNICEF. UNICEF has always, always been there for the Ministry as in always, always…UNICEF is always our friend…re-integration guidelines we relied on [UNICEF]…they provided huge support" (IDI, Gov 6).

The extensive support of external actors, along with the global discourse on deinstitutionalization—which embraces a shift from caring for OVC in institutions to families (Shawar & Shiffman 2023)—drove Zambia's policy shift to family reintegration. Several recent policies and guidelines, such as Zambia's Alternative Care and Re-Integration Guidelines, borrowed language and ideas from several global documents, including the UN Guidelines for the Alternative Care of Children, which promotes deinstitutionalization, and the United Nations Convention on the Rights of the Child, which emphasizes the importance of the family (MGCD, 2012).

3.7.2. Remaining policy deficiencies

Despite the proliferation and strengthening of policies for OVC care, there remain some challenges regarding both policy content and process. With respect to policy content, there has been limited guidance on how to prevent OVC from going to childcare facilities, as well as how to implement reintegration of OVC into families. For example, the 2017 Alternative Care and Reintegration Guidelines (UNICEF & USAID, 2018) do not state "how it [reintegration] would be done, when it would be done, who would do what, and the cost of implementation" (Mulenga & Michelo, 2018). There is also a lack of overarching, cross-sectoral, standard operating procedures for case management, which has affected follow-up and feedback mechanisms in delivering OVC care and made it difficult to coordinate access to services that span across social welfare, health, justice and education (MCDSS, 2018). In addition, many existing policies and programs insufficiently address underlying drivers of child risk. Little attention is given to address the top reasons that lead to the placement of children in residential care facilities: 1) poverty, 2) death of a parent, 3) disability or chronic illness of the children, 4) abuse, maltreatment, or neglect, 5) disability or chronic illness of a household member, and 6) inability to cope with rebellious child behaviors (Januario et al., 2016). Also, reintegration guidelines do not adequately consider how to deal with hostile home environments for children and there are no legal regulations on how to deal with parents who neglect children or refuse to accept children once they leave care facilities. Finally, the way in which children's care policies have been developed has alienated those working in children's care facilities. They perceived the policy development process to be largely driven by the government in collaboration with external actors and not consultative. For example, they noted that 'consultative' workshops on the 2017 Alternative Care and Reintegration Guidelines were guided by an already predefined agenda from funders, and that they were only invited to their launching. One respondent indicated that she stopped attending consultative meetings on the subject because of this top-down approach to policy change:

> "The problem is the agenda is being pushed from there [donors]…I stopped attending those [meetings], because it is like, what is the point? I know they have got an agenda, they want to push it, and they are going to convince us. It is not us convincing them, it is them convincing us" (KII, Child Care Facility 5).

3.8. Present state of implementation

Despite the recent emergence of relatively strong national policies dedicated to OVC care—although with some noted challenges, state commitment to and implementation of this policy remains weak. This is driven by the state's heavy dependence on non-state actors in the child protection sector, limited coordination among involved stakeholders, significant workforce capacity gaps, the impacts of the health and economic crises, and the erosion of traditional family norms and the state's kinship care system over time. Combined, these factors have resulted in the sector not reaching its full potential in caring for the OVC in the country, despite recent strengthening of policy.

3.8.1. Minimal state funding and heavy dependence on non-state actors

The severe impacts of the health and economic crises combined with the consequences of economic liberalization policy, structural adjustment programs, and the influx of external support beginning in the 1990 s, has contributed to the government's minimal and inconsistent funding for the care of OVC and heavy dependence on non-state actors. Although allocation to overall child protection programs—in a wider sense—accounted for 5.4 percent of GDP and 17.06 percent of the total budget, core interventions[2] only account for 0.6 percent of the total national budget and 3.7 percent of the broad child protection budget in 2023 (UNICEF, 2023b).

According to UNICEF, the existing government allocations to this sector are unlikely to have major impacts on child protection outcomes given that most of the funds do not target the core child protection interventions (UNICEF, 2023b). Furthermore, there is no standard schedule for remitting the funds, which affects planning and implementation of children's care activities (Davis et al., 2016; Kampamba et al., 2019). A respondent noted the sporadic nature of the funding:

> "It is not adequate, [but also] it is not even standard. We [are supposed to] get allocations quarterly, [but] it comes as a surprise. We have allocations that may come once a year." (IDI, Child Care facility 1).

The state's lack of investment and ownership of the sector has contributed to the sector's disproportionate reliance on non-state donors. Most funding for child care facilities comes from external, non-state donors (MCDSS, 2017). Individuals mainly living outside Zambia are the highest contributors at 43.7 %, followed by church groups (39.5 %), and international NGOs (26.1 %). Much smaller allocations are provided by bilateral donors (13.4 %), Zambian companies (10.9 %), international companies (3.4 %), and Zambian NGOs (2.5 %). Only 8.4 % received funding from the Government (MCDSS, 2017). Facility

[2] The core interventions include guidance and counselling services, child safeguarding, school related gender based violence, community based sexual and gender based violence, adolescent sexual and reproductive health, ending child marriage, birth registration, children in contact with the law including alternative care services, adoption and family preservation, child and family social welfare support as well as international treaties and protocols.

managers expressed concern over their reliance on external donors:

> "The donors, 90 % of them are external funders…The donor will tell you, 'I am going to give you 90 % of your total budget.' Then the 10 %, you have to look for this money locally. The challenge is that these child welfare institutions, most of them are not even able to raise that 10 %, not because they are lazy and they do not want to, but the local environment is just not supportive" (IDI, CSO 5).

One consequence of the over-reliance on non-state funding is the limited sustainability and scale up of services for OVC (Goma, 2021; Yanila, 2021). Non-state funding dependence also affects reintegration implementation. Fear by some children's care facilities that they may lose funding if more children are reintegrated has made some facility staff discourage children from leaving the facilities. One respondent explained:

> "They have to show the numbers, and the numbers are what justify the funding. So children…are taken into institutions, because the government is not enforcing the gatekeeping mechanism. So you end up having organizations bring in children that were not supposed to be separated from their parents, from their families" (IDI, Child Care facility 4).

3.8.2. Limited coordination

The historical dependence on non-state actors helped improve coordination mechanisms for actors concerned with OVC care in some ways, but it has also contributed to the sector's fragmented landscape, which has resulted in less than effective provision of OVC care. Recent efforts to improve coordination, such as the Children in Families Technical Working Group in 2014 and Alternative Care Reform Platforms in 2017, have been largely funded and technically supported by external donors and implementing partners. The spaces have provided stakeholders an opportunity to share lessons, provide referrals of children in need of child protection services, and jointly develop policies such as National Child Safeguarding Framework.

Nevertheless, there remain significant coordination difficulties among civil society organizations (CSO) involved in OVC care. There is inadequate learning and limited sharing of best practices among the CSOs, and failure by some to adopt and implement agreed standard guidelines on the care of OVC including how to prevent recruiting OVC in children homes (Malisase, 2021; Moonga, 2015). Some CSOs do not engage in collective activities for fear of exposing their inefficiencies, while others cite little incentive or advantage to work together. In addition, work among CSOs is disjointed because each partner is not obliged to be accountable to the existing structured groups due to different donor obligations and objectives (Jmulenga & Michelo, 2018). One respondent described the dismal state of coordination:

> "Nothing is working…Each one for themselves I would say. It's unfortunate. We have tried so many times to have networks, to create opportunities for meeting collaborations and it's not working…. Many facilities do not do what they preach with great maturity. You will find that they are not willing to cooperate" (IDI, Child Care facility 4).

Other coordination difficulties stem from the nature of the issue. Care of OVC spans social welfare, security, justice, health, nutrition, and education services. Many government ministries and departments are involved, including: the Ministry of Community Development and Social Services, the Ministry of Youth, Sport and Arts, the Ministry of Home Affairs and Internal Security, the Ministry of Justice, the Ministry of Health, the Judiciary, the Ministry of Education, the Ministry of Local Government and Rural Development, and the National Prosecutions Authority and Human Rights Commission. There are difficulties communicating across these agencies, which has shaped challenges in identification, monitoring and evaluation of child protection programs, and implementing the National Child Policy. It has also resulted in fragmented allocations to the child protection budget (Malisase, 2021). One respondent noted the fracturing of the budget for OVC care as a result:

> "Where is the money coming from? Sometimes it is the Ministry of Finance, sometimes it is the Department of Social Welfare. We do not even know who does what" (IDI, Child Care facility 1).

Inadequate coordination has also challenged the implementation of OVC care policy. Before 2021, both the Department of Social Welfare under the MCDSS and Department of Child Development under the Ministry of Youth, Sport and Arts (then known as the Ministry of Youth, Sports, and Child Development) conducted similar activities such as coordination of child protection, organization of stakeholder meetings on child welfare, monitoring of children's care services, and empowerment activities. The overlap in responsibilities often resulted in duplication of tasks, role conflict, and reporting challenges among stakeholders in the two agencies, as well as with the local, non-state actors they interacted with (Mulenga & Michelo, 2018). In 2021, the government underwent a realignment, designating MCDSS, and specifically the Department of Child Development, as lead on the coordination and implementation of care for OVC and moved the Department of Child Development under MCDSS (UNICEF, 2023a). While the movement of the Department of Child Development to the MCDSS had helped to reduce inter-ministry fragmentation, there is now concern over intra-ministry fragmentation since both the Department of Social Welfare and Department of Child Development deliver similar services (IDI, Gov 2).

3.8.3. Inadequate capacity

The historical impacts of the economic and health crises have also contributed to the state's current human resource capacity gaps in providing quality care to OVC. There are insufficient numbers of social workers due to limited finances (Pruce, 2023; Sakala et al., 2022). There are only 244 government social service workers—a government social service worker to population ratio of 1 to 59,584 (Global Social Service Workforce Alliance, 2021). Limited social worker staffing has been exacerbated by high turnover due to unfavorable working conditions. This has contributed to the failure to develop care plans and other necessary documentation. One government social worker explained:

> "We, as the ministry, are overwhelmed…We're like an octopus, we are everywhere. Sometimes it may mean that we have a lot of cases or clients that might fall through the cracks because we can only do so much because we may not be able to serve everybody" (IDI, Gov 4).

In addition to there being few social workers, some are not comprehensively trained (Mumbuna, 2019). Also, caregivers often have inadequate funding and skills to address the complex needs of OVC and their families, especially during family reunification processes (Mumbuna, 2019). Respondents discussed the human resources limitations:

> "We are told [government social workers] are overwhelmed with work and the staff is not adequate. When you go to the Department, sometimes just a student, an intern student would be there at the office. If not, maybe one staff' (IDI, Child care facility 1).

There is also limited availability of finances and transport to conduct outreach activities. Inconsistent incentives for Community Welfare Action Committees (CWACs) have affected their motivation to regularly conduct their work (Goma, 2021). Also, limited availability of social workers, community development officers and CWACs have affected fair distribution of tasks and responsibilities (UNICEF & USAID, 2018). Consequently, many children's care facility workers perceived the responsibilities of government social workers to be shirked and displaced onto them:

"They [government social workers] will tell you they do not have a vehicle, they do not have transport when it comes to bringing a child that has been taken to their office…[And they provide] no transport to take the child to trace the family" (IDI, Child care facility 1).

In addition, there is poor data management. Data in some social welfare offices are kept in paper-based format, which has affected the timely retrieval of data and planning processes. Some children's care facilities have incomplete data sets—making it difficult to, for example, locate children's relatives, which has affected reintegration of children (Januario et al., 2016).

3.8.4. Devastating impacts of health and economic crises

The impacts of chronic poverty and the HIV/AIDS epidemic, both of which began in the 1980 s, continue to drive risks among OVC and vulnerable families, as well as place significant burden on the state's commitment and capacity to effectively govern OVC care. As of 2018, there were 62, 000 children living with HIV and 60 % of children were identified as poor considering the national poverty line (MNDP, 2018; Munthali et al., 2020). Vulnerabilities among children were compounded further in the wake of COVID-19, given loss of business, unemployment, and death of caregivers (Mathew et al., 2020). Between March 1, 2020 and January 15, 2022, 73,000 primary caregivers were lost due to COVID-19, resulting in approximately 70,000 COVID-19-associated orphans in Zambia (World Bank, 2022). The number of children affected by COVID-19 orphanhood nearly doubled over six months from July 2021 through December 2021, compared to the first 12 months of the pandemic (Joint Estimates and Action, 2022).

In addition, Zambia's GDP contracted by 3.5 %, food prices rose sharply, and the national poverty rate rose to 57.6 % in 2020 (from 55.8 % in 2019), acutely impacting the country's rural populations (World Bank, 2022). In 2021, only half of children who were in school prior to the pandemic were engaging in learning after schools closed (World Bank, 2022). Food security also worsened, with high proportions of households reporting skipping meals or running out of food (World Bank, 2022). Consequently, some biological parents became unable to care for their children. Several respondents, including a government representative, noted chronic poverty as a root problem perpetuating the number of children in need of care (IDI, Gov 2).

The COVID-19 pandemic increased child labor, with an increasing number of children forced to sell products to contribute to the household income (Mathew et al., 2020). In addition, domestic violence against children increased given the closing of schools and children being confined within their homes for longer periods (Chavula et al., 2023; Moon et al., 2023). The closing of schools also resulted in more cases of transactional sex and early pregnancies (Shepherd et al., 2022). The pandemic also caused family reintegration policy implementation challenges, as more children were unexpectedly referred to children's care facilities:

"With the coming in of the COVID pandemic, we had expected certain activities to go down, like the number of children being referred to facilities. But instead, what happened was the opposite… We had increased reports of violence against children, we had increased reports of children straying from homes and joining their friends on the streets" (IDI, Child Care Facility 2).

In other cases, children were reported not willing to go back to their homes due to concerns that they might not have enough food and other basic requirements. Respondents discussed cases of extended families or biological parents being unwilling or incapable of assuming care of OVC given insufficient support provided to meet the basic needs of caring for a child. The pandemic also limited the monitoring of the facilities due to mobility restrictions:

"They were not able to undertake inspection because of COVID… [Instead doing so] on a remote [basis]. They made phone calls, but that is not adequate [because] sometimes people can shield things [when] you are not there physically. You can be asking questions and they will be telling you everything is okay when in actual fact it is not" (IDI, Gov 6).

Stakeholders also reported being unable to conduct key activities, such as proper record keeping, house visits, provision of counseling services, as well as community outreach such as re-integration activities and vulnerability assessment. This was compounded by staff burnout, sickness, and death. One respondent noted the pandemic impact:

"When most offices were shut down or working on rotations, the integration was next to impossible to achieve. We would want to report and [tell the government social workers]: 'We want you to come along with us because there is a need for family conferencing before a child is reintegrated.' The response we will get is: 'I am not in the office this week so maybe next week.' And then you go next week, and they say no, they are spraying this week, so no one is in the office. It was a lot of work that kept on being pushed back" (IDI, Child Care Facility 5).

3.8.5. Erosion of traditional family norms and kinship care

Traditional norms around care of OVC within the extended family have eroded over time—especially given the impact of the HIV/AIDS epidemic and economic crises, layered with modernization, urbanization and the adoption of structural programs and economic liberalization political ideology. Combined, these developments have posed significant difficulties in the current implementation of family reintegration children's care policies. These difficulties are reflected in the rise in households that are incapable of providing children with quality care because of high levels of alcohol abuse, partner separation, violence and neglect (UNICEF, 2021).

One barrier to alternative care reform policies is the widespread culture of silence and tolerance of corporal punishment. Several respondents noted how cultural and religious beliefs often drive child abuse, which put children at risk of separation. Some community and religious leaders discourage families from reporting sexual and physical violence to the police as they prefer that such cases be handled by the traditional courts or church committees. In cases where the perpetrators of violence are breadwinners, reporting of cases to the police is discouraged for fear of affecting financial stability in the family (Mutambo, 2023). Also, religious beliefs shape implementation of childcare reforms. Specifically, children's care facilities managed by Christian groups typically perceive that looking after children in a facility is part of a fulfillment of their faith (Hembling & Kline, 2016). In 2017, faith-based organizations owned 22.44 percent of children's care facilities (MCDSS, 2017). A respondent noted how faith-based facilities have posed challenges to family reintegration:

"I think it's an abomination that…there are still institutions that still want to replace the family…especially religious organizations. Especially religious organizations will have the attitude [of] 'they are our children, these are my children.' Once you have that attitude it's very difficult to separate with the child and let him go to the family, so it's like you are jeopardizing your own efforts." (IDI, Child Facility 8).

Finally, the practice of fostering and adoption through formal state mechanisms is rare and socially undesirable, posing some difficulties for children's care reform policy. In 2015, only 46 children were fostered and 8 children were adopted via formal mechanisms, and 13.5 percent of children's care facilities had children declared free for adoption (MCDSS, 2017).

4. Discussion

Despite some progress in the last decade in policymaking for OVC care, Zambia has not adequately addressed the care needs of the

country's many OVC. The factors that underpin the state's shortcomings correspond to the three categories in the framework, concerning: 1) policymaking (sub-categories of policy content and policy process), 2) governance (subcategories of commitment, leadership, coordination and capacity), and 3) context (with sub-categories of social values and societal problems). We summarize the findings according to the framework (see Table 4).

Table 4
Findings on Zambia's National OVC Care System.

Category of factors	Factor	Findings—In Zambia:
Policymaking	**1. Policy content**	• The Zambian government has developed a set of policies for children's care with relatively strong content, such as the 2022 Child Code Act.
	2. Policy process	• Policymaking process has largely been dominated by international actors, leaving some domestic stakeholders—particularly those working in children's care facilities—feeling left out.
Governance	**3. Commitment**	• There is insufficient government commitment to OVC care. • There is heavy dependence on external donors, which has curtailed government monetary commitments to the care of OVCs, and fragmented governance given the lack of strong government ownership of the sector.
	4. Leadership	• There is weak institutional leadership, a function of the historical placement in multiple government agencies and high turnover of agency leadership.
	5. Coordination	• Concerned actors largely work in silos. • There is little government oversight in monitoring and coordinating across facilities and families and limited interest by facilities and service providers to share their experiences and approaches among themselves. • However, there are recent efforts to improve coordination—i.e., creation of the Alternative Care Reform Platform and Children in Families Technical working group.
	6. Capacity	• There is a limited number of social workers, which has circumscribed the state's ability to conduct inspections of children's care homes, facilitate family reintegration, manage referral and adoption processes, and deliver other child protection services.
Context	**7. Social values**	• The impact of modernization and urbanization have led to the gradual breakdown of the extended family and kinship care systems in preference for nuclear families. • The tolerance of corporal punishment, as well as promotion and creation of children's care facilities as a means of religious fulfillment, have undermined efforts to address child vulnerability risks as well as family re-integration efforts.
	8. Societal problems	• High poverty levels and HIV/AIDS have had long-standing impacts on population vulnerability, driving up the number of OVC, and pushing the informal traditional kinship care system to over-capacity.

Framework adapted from Shawar et al., 2025.

4.1. Policymaking

The Zambian government has developed a set of policies for children's care with relatively strong *content* (factor 1). The robust set of policies is largely a function of an influx of funding from international agencies and funders, who have pushed the state to address its long-standing economic and social problems including the HIV/AIDS orphan crisis. In the last decade, the government has worked in close collaboration with international agencies and funders to develop and promote family reintegration policy. This has culminated in the enactment of the 2022 Child Code Act, which comprehensively addresses child wellbeing, strengthens the prevention of violence, abuse and neglect of children, and resolves contradictions that existed among some prior child protection policies. Through this policy, and the recent enactment of the 2021 Free Education Policy, the vulnerabilities of children are increasingly addressed via comprehensive policy frameworks, as is the right to social protection—a right enshrined in the Bill of Rights of the Constitution of Zambia and part of the country's long-term Vision 2030.

Nonetheless, the policymaking *process* (factor 2) has compromised policy implementation effectiveness. On the one hand, the funding and technical expertise of international agencies and funders has been essential for the development and promotion of policies and initiatives dedicated to children's care. However, the policymaking process has largely been dominated by international actors, leaving some domestic stakeholders—in particular those working in children's care facilities—feeling left out. The limited involvement and incorporation of the experiences and expertise of those at the front lines —for example, consideration of some contextual drivers such as high poverty and abuse in some households—has contributed to the stymied implementation of children's care reform policy. Policy implementation progress is slow without the buy-in and understanding of caregivers, providers, and children's care facility staff—those carrying out the policy.

4.2. Governance

The government's governance—as reflected in its commitment, quality of collective action, and capacity to address children's care—has been the major limitation to addressing the care needs of the country's OVC. The government's insufficient *commitment* (factor 3) is reflected in its small, although growing, allocation to core child protection programs. The government has largely relied on the historical and continued influx of funding to this sector from external donors such as PEPFAR, USAID, and Global Fund, in their efforts to help address the impact of the HIV/AIDS epidemic. In the same way, a majority of children's care facilities are supported by external donors. In consequence, the heavy dependence on external donors has curtailed government monetary commitments to the care of OVCs, and fragmented governance given the lack of strong government ownership of the sector.

There is also weak institutional *leadership* (factor 4) for the care of OVC. The historical placement in multiple government agencies and high turnover of agency leadership has contributed to this. Historically, both the Department of Social Welfare under the MCDSS and Department of Child Development under the Ministry of Youth, Sport and Arts conducted similar activities, leading to duplication of tasks, role conflict, and reporting challenges among stakeholders in the two agencies, as well as with the local, non-state actors they interacted with. While the 2021 movement of the Department of Child Development to the MCDSS had helped to reduce inter-ministry fragmentation, intra-ministry fragmentation is now a potential concern given their delivery of similar services.

In addition, *coordination* (factor 5) among involved children's care actors is inadequate. Despite recent efforts to improve coordination—i.e., with the creation of the Alternative Care Reform Platform and Children in Families Technical working group—concerned actors largely work in silos. There is little government oversight in monitoring and coordinating across facilities and families and limited interest by

facilities and service providers to share their experiences and approaches among themselves. With respect to coordinating family reintegration, there are rarely discussions about reintegration plans with government social workers, facility staff, families, and care leavers, with formal transition or preparation process rarely conducted.

Finally, there is little workforce and system *capacity* (factor 6) to carry out policy and deliver children's care as it is written. The limited number of social workers, which has been exacerbated by high turn-over due to poor working conditions, has circumscribed the state's ability to conduct inspections of children's care homes, facilitate family reintegration, manage referral and adoption processes, and deliver other child protection services. As a result, children's care facilities and vulnerable families are rarely visited and services for OVC are inadequately overseen, compromising the quality of care and enforcement of children's care reform guidelines and policy.

4.3. Context

The challenges that Zambia's children's care system faces can't be understood without due attention to contextual factors. The *social values* (factor 7) of the population have been shaped by the country's economic and health crises, including the replacement of Humanism ideology with economic liberalization policy in the 1990 s. In addition, the impact of modernization and urbanization have led to the gradual breakdown of the extended family and kinship care systems in preference for nuclear families. Furthermore, tolerance of corporal punishment (although outlawed in the Children's Code Act of 2022), as well as promotion and creation of children's care facilities as a means of religious fulfillment, have undermined efforts to address child vulnerability risks as well as family re-integration efforts. *Social problems* (factor 8), and in particular, high poverty levels and HIV/AIDS have also had long-standing impacts on population vulnerability, driving up the number of OVC, and pushing the informal traditional kinship care system to over-capacity. These issues were only further exacerbated by the recent COVID-19 pandemic.

5. Conclusion

Zambia's policy for OVC care, and particularly family reintegration has been strengthened in the last decade, driven by international actor engagement, gradual efforts to improve child welfare and protection more broadly (i.e., the social cash transfer scheme and recent free education policy), and more available data on OVC populations. However, political commitment and policy implementation for OVC care remains weak given historical impacts of chronic poverty and the HIV/AIDs epidemic, along with more recent compounding impacts of the COVID-19 pandemic, which have eroded the traditional kinship care system, amplified capacity gaps, and consequently led to significant dependence on international actors. These challenges point to three primary implications for sustaining progress: addressing state capacity deficiencies, developing policy that addresses underlying drivers of risk, and ensuring that children's care networks include all relevant stakeholders.

First, efforts should be dedicated to building state capacity and ownership of the sector. While the involvement and funding of external donors have helped support the Department of Social Welfare under the MCDSS, state officials need greater bandwidth to carry out and oversee the policies they develop and implement. The consistent presence of MCDSS is needed in the courts, children's care facilities, and the homes of vulnerable families. A strong state agency will help to transcend the current fragmentation of the sector—which is pushed in myriad directions by hundreds of foreign donors and individual philanthropists. With adequate resources and dedicated training opportunities, officials and social workers at MCDSS can build legitimacy among domestic children's care stakeholders, better hold them to account, and coordinate their efforts to address the needs of OVC.

Second, there is a critical need for developing policy and initiatives that seek to address the underlying drivers that result in vulnerability for families and children. While enactment of the 2022 Children's Code Act and 2021 Free Education policy is evidence of momentum in this regard, children's care stakeholders have largely focused, in the last decade, on family reintegration policy to the neglect of preventing child vulnerability in the first place. Without improving the situations of vulnerable families, existing child reintegration policy and initiatives will not work as intended. Accordingly, proponents need to advocate for policies and government commitments that adequately support families facing or at risk of experiencing poverty, inadequate access to education and healthcare, and abuse and neglect. Only by enhancing social welfare programs (such as social cash transfer programs) and linking them to current child reintegration initiatives can the state provide sustainable care solutions for OVC.

Finally, children's care networks need to be strengthened. Unlike most other low- and middle-income countries, Zambia has a distinct advantage in that children's care networks, such as Children in Families Technical Working Group and Alternative Care Reform Platforms, have been established. Moreover, by bringing together the government, external donors, implementing partners, and domestic associations, the networks have facilitated the coordination of initiatives, the referral of children to child protection services, and policy advocacy. However, a weakness of these networks is insufficient inclusivity: they lack representation from those working in children's care facilities, researchers working on child protection, several key faith-based organizations, and the families of vulnerable children. Broadening membership would better enable the networks to create policies and guidance responsive to the needs of OVC, as well as the stakeholders at the frontlines who carry out policy—the social workers, children's care facility staff, and caregivers. An inclusive network would also improve policy implementation by creating informal coordination mechanisms, augmenting accountability, and enhancing a sense of ownership of the programs and policies by those involved.

Another benefit of a more inclusive network might be its emergence as a political force. Currently, the children's care system is fragmented and heavily reliant on external donors. Children's care facilities largely work in silos, each having their own donors and mandates, and government bureaucrats and social workers are stretched thin, unable to adequately oversee policy implementation. A unified coalition of children's care actors might be able to push the state to act—exerting pressure on it to reduce dependence on international donors, and to improve its commitments to and ownership of the sector.

Zambia has in place effective policies for OVC care, and networks that link many concerned actors. If the country can leverage these strengths and meet the challenges of enhancing state capacity, enacting policies that address underlying risk, and augmenting network inclusivity, significant improvement in outcomes for OVC is well within reach.

Author statement

Both authors (joint first authors), jointly contributed to the study design, data collection, analysis and interpretation of the data, writing of the manuscript, and multiple rounds of revisions. We both give final approval of the manuscript revision submitted.

Declaration of competing interest

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Data availability

The data that has been used is confidential.

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