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Benchmark assessment of orphaned and vulnerable children in areas of the Zambia Family (ZAMFAM) Project—Brief

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results brief

Benchmark Assessment of Orphaned and Vulnerable Children in Areas of the Zambia Family (ZAMFAM) Project

The U. S. Agency for International Development (USAID) and U. S. President's Emergency Plan for AIDS Relief (PEPFAR) are supporting the Zambia Family (ZAMFAM) project to strengthen comprehensive, integrated service delivery and support to children living with, affected by, or vulnerable to HIV/AIDS in the Lusaka, Copperbelt, Southern, and Central Provinces of Zambia. ZAMFAM is scaling up activities on orphaned and vulnerable children (OVC) in high-priority sites to provide services to 45,000 households and 225,000 vulnerable children each year. The objective of ZAMFAM is to improve the care and resilience of OVC and their households through child- and family-focused services. To inform that effort, Project SOAR conducted a benchmark survey among beneficiaries in the four provinces of the ZAMFAM program. The benchmark survey measured the status and conditions of OVC and their families. The findings outlined in this brief provide a deeper understanding of the needs of OVC families and the gaps in service provision, as well as suggestions for strengthening care and support strategies for OVC in Zambia.[1]

METHODOLOGY

The benchmark assessment was a cross-sectional survey of 2,034 ZAMFAM beneficiary OVC households in project target communities conducted in the Lusaka and Copperbelt Provinces between May and July of 2016 (about a year after roll-out) and in the Central and Southern Provinces between September and October of 2016 (around the time of program initiation). Interviews were conducted with caregivers about themselves and any OVC in the household between the ages of zero and nine years. OVC in the household between the ages of 10 and 17 years were interviewed directly by the

[1]Full report on the benchmark survey is available at: projsoar.org/resources/zamfam-benchmark-report/.

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WHO ARE THE STUDY SUBJECTS?

2,032 Caregivers

- 91% women
- Mean age: 43 years
- 60% married/cohabiting, 26% widowed
- Education: 5.9 mean number of years of schooling—most had difficulty reading a simple sentence in their local language

2,911 OVC, 0–17 years old

- 51% male
- 14% 0–4 years
- 32% 5–9 years
- 54% 10–17 years

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survey team. The study instrument was based on MEASURE Evaluation's "Child, Caregiver & Household Well-being Survey Tools for Orphans & Vulnerable Children Programs," and captured PEPFAR Core OVC Indicators. The analysis is descriptive, reviewing the PEPFAR essential and additional core OVC indicators. The study findings were disaggregated by province, age, sex, and residential status where appropriate.

KEY FINDINGS

Substantial proportions of OVC at benchmark had not been linked to health, administrative, or educational services.

The HIV status of only about half of OVC (53 percent) was known to the caregiver. A slightly higher percentage of OVC caregivers know the status of male OVC; however, this difference is not statistically significant. About half of OVC under five years old had not received the required vaccinations against preventable diseases (47 percent). Among all the OVC, 37 percent reported being too sick to engage in daily activities such as playing or participating in household chores. There were no meaningful differences in the reporting of this indicator between urban and rural areas or by sex.

Only approximately one in ten OVC were reported to have received a birth certificate (9.5 percent), although these numbers increased to one in four for the very youngest cohort, aged 0–4 years (25 percent). This rate reported for birth certificate registration was higher than that reported for children aged under 5 years in the general population, among whom only 4 percent had a birth certificate, according to the 2013–14 Zambia Demographic and Health Survey (ZDHS).

OVC were also not achieving full engagement with the school system, as late entry (only 42 percent enrolled in school at 6 years of age) and early drop-out (25 percent) were observed among 10–17-year-old (adolescent) OVC. Reasons given for missing school included being sick (26 percent) and having no money to meet schooling requirements (31 percent).

An area of concern is the magnitude of economic and food insecurity faced by OVC households and their families.

Half of all households reported an inability to handle unexpected household expenses (50 percent) in the previous 12 months, while specific indicators covering inability to pay for food (43 percent) and education (34 percent) expenses suggest further economic insecurity. The data suggest that household economic and food insecurity, as reported by adolescent OVC, seem to directly translate into limited OVC school attendance ($p<0.01$), as well as skipped and missed meals among household members. Urban households were significantly more affected ($p<0.001$). The data show that approximately 4 percent of OVC aged 4 and under in the sample were undernourished at the time of the survey. This level of undernutrition among OVC was slightly higher than that reported for the general population of similar age in the 2011 Zambian National Nutrition Survey, which indicated undernutrition rates of less than 1 percent.

OVC caregivers and OVC experience limited social support.

More than half of caregivers (53 percent) reported a gap in their social support, e.g., having someone to help with chores if they were sick. Given that a substantial proportion of OVC caregivers were older women it is not surprising that social isolation is an issue faced by this population.

The benchmark data indicate that a very large proportion of adolescent OVC (58 percent) have a gap in at least one of four indicators of social support, with some indication that this may be more of an issue for girls than boys, although the difference by sex was not statistically significant. Overall, 40 percent of adolescent OVC lack confidants whom they feel they can talk with about personal problems and 23 percent lack someone in their lives that demonstratively provides them love and affection. In instances where socio-emotional support was available, children were less likely to miss school ($p<0.028$).

CONCLUSION AND RECOMMENDATIONS

The analysis of PEPFAR's essential and core indicators reveals some gaps and opportunities for enhanced programming for OVC families, many of which are already being directly addressed in the design of the USAID-supported ZAMFAM project. A notable gain is the increase in birth certificate registration for the 0–5-year-olds in the ZAMFAM districts as compared to the rates for the same ages reported by the ZDHS, although levels from both are still low. Below are recommendations for programming, and monitoring, evaluation, and research based on the findings of the benchmark study. In addition, we also report on the feedback from implementing partners (IPs) on using the findings to inform their OVC interventions.

Program recommendations

- Consider the specific needs of older women serving as caregivers to OVC. These women often have little or no formal education and are in need of socio-emotional support and guidance in accessing public services for themselves and those under their charge. Such women need to maintain their own health, individual capacities, and economic productivity as they age.
- Address the gap in linking OVC to family- and household-based HIV testing and counseling. Zambia's national guidelines recommend HTC of all children and adolescents whose status is unknown. Mobilization for index-client-referral testing for OVC families or screening for high HIV risk and linking to testing might be considered, as well as exploring the feasibility of regular HIV self-testing among higher risk OVC, for example, adolescent girls and young women.
- Given the high prevalence of food insecurity, consider sustainable approaches to ensuring continuous access to food for urban households through economic empowerment, as well as improved agricultural production and increased animal husbandry in rural areas.
- Link OVC households to health care through improved linkages to health facilities or outreach efforts. This would address significant gaps in the health needs of OVC including low vaccination rates and high rates of sickness, likely due to exposure to infectious disease and unsanitary conditions, and potentially compounded by poor nutrition.
- Address resource constraints of OVC families in meeting educational expenses. While irregular attendance was driven somewhat by sickness or other reasons, it was, rather, late enrollment and early drop-out that were the drivers of irregular school attendance.
- Include parenting practices in future OVC programs. Acceptability of the role of harsh physical discipline among the parents/caregivers and a lack of socio-emotional support reported by adolescent OVC require focused attention. Programs directed toward improving parental disciplinary practices and norms and parental-child interactions and communications, as well as mentor-based efforts external to the household, could contribute toward more positive outcomes for OVC.

Monitoring, evaluation, and research

- As is noted in PEPFAR's monitoring and evaluation guidelines, continual measurement of these indicators over time is necessary (ideally biennially) for fully assessing progress in the indicators and, to some degree, program impact. In addition, more rigorous assessments are needed to attribute changes to specific OVC programs.
- A more refined understanding of the economics of OVC households (production, consumption, income, and assets) would be informative for fully delineating how to address economic insecurity in the household. A more detailed assessment of household production would be informative to further improvement of OVC programming. Qualitative research focusing on resilience of OVC households and their adaptation to internal and external economic stressors and shocks would be programmatically informative.
- The data suggest a need for a more detailed and nuanced monitoring and evaluation of OVC household nutritional intake and outcomes. Additional efforts to explore the potential hidden effects of undernutrition on child physical and cognitive development, which

impede improvement in health and educational outcomes, would be constructive, while cost-benefit assessments of potential nutritional interventions would suggest promising directions for programs and policies.

- Best practices for sensitizing and educating caregivers about the emotional needs of adolescents and methods for enhancing familial relationships and connections is limited in the Zambian context. Understanding how these connections influence mental health among OVC households, and how these impact educational and health outcomes and economic productivity, is nascent at best.
- Understanding the interplay between socio-emotional connectedness and risk behaviors for HIV-negative children and care and treatment behaviors for HIV-positive children would represent an important step toward adequately responding to the global notion of "leaving no one behind," and Zambia's effort to attain the 90–90–90 goals.

Follow-up actions proposed by IPs

- Use disaggregated data to identify most at-risk OVC populations for enhanced and appropriately tailored program interventions
- Further train community volunteers to enhance assessment of social, psychological, and emotional needs of caregivers, with a view to strengthening their capacity to provide a comprehensive range of services to caregivers
- Train lay counselors to conduct index-client-referral HIV testing to reach children and adolescents with unknown HIV status to increase knowledge of their status and contribute toward reaching the 90–90–90 goals.
- Make efforts to help OVC know where and how to access antiretroviral treatment (ART) services, especially within integrated care services.
- Strengthen linkages and referral networks between ART providers and communities to support the continuum of care.
- Screen the nutritional status of children ages 0 to 15 years and provide nutritional services through community- and faith-based organizations and volunteers.
- Strengthen existing community savings groups and create new ones, continuing to provide mentorships until the groups are self-sustaining.
- Further train community volunteers to facilitate birth registration for OVC, with follow up by IPs to improve issuance of birth certificates.
- Engage chiefs, headmen, and relevant local authorities working with appropriate government ministries in efforts to develop and strengthen community development plans toward sustainably responding to OVC needs.

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