Sustainability Through Economic Strengthening, Prevention & Support for Orphans & Vulnerable Children, Youth & other Vulnerable Populations

World Vision, CARE, Catholic Relief Services, Africare, the Salvation Army, Futures Group, and

Expanded Church Response

STEPS OVC

Baseline Survey Report

Report date: August 15, 2012

Cooperative Agreement No:	611-A-00-10-00001-00
Project Dates	12 July 2010 – 11 July 2013
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Cover Photo: Children reading a book at a program supported school © *World Vision Zambia, 2011*

Disclaimer: This study and final report were made possible by the President's Emergency Plan for AIDS Relief and the generous support of the American people through the United States Agency for International Development (USAID) under the terms of Cooperative Agreement No. 611-A-00-10-00001-00. The contents are the responsibility of Futures Group and do not necessarily reflect the views of USAID or the United States Government.

Suggested citation: Jenifer Chapman, Mathew Ngunga, Jolly Kamwanga and Joseph Simbaya (2012). *STEPS OVC Baseline Evaluation Report: Key Findings*. Lusaka, Zambia: Futures Group

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Acknowledgements

This data triangulation was carried out as part of the baseline evaluation of the STEPS OVC program. The STEPS OVC project is funded by the U.S. Agency for International Development, Zambia Mission, and led by World Vision, in collaboration with CARE, Catholic Relief Services (CRS), Africare, the Salvation Army (TSA), Futures Group, the Zambian organization Expanded Church Response (ECR), and more than 300 local community-based organizations and private sector partners.

This study was conceptualized by Futures Group International, with input from all STEPS OVC partners, and our local research partner, the Institute of Economic and Social Research (INESOR), University of Zambia. The report was compiled and written by Dr. Jenifer Chapman and Mathew Ngunga of the Futures Group and Dr. Jolly Kamwanga and Joseph Simbaya of INESOR. Notable mention goes to all the supervisors and research assistants who supported this study – full list available in the appendices.

Executive Summary

Study Objective: To provide baseline information among STEPS OVC beneficiaries on: (a) HIV and AIDS knowledge, attitudes and practices; (b) well-being; and (c) access to/previous uptake of HIV prevention, care, and support services and/or training, as a first step in assessing program impact.

Methods: The research design implemented was a modified quasi-experimental pre-test/post-test study to assess the overall program impact on targeted populations. The survey was conducted in a maximum variation sample of nine districts: Chongwe, Kafue, Kaoma, Mongu, Mumbwa, Kabwe, Nchelenge, Kawambwa, and Solwezi. Orphans and vulnerable children (OVC) and basic care and support (BCS) beneficiaries and community caregivers (CC) were randomly sampled from community and program registers. Community caregivers and field staff helped to identify the selected households. The study was approved by Health Media Labs, Inc., an institutional review board in the United States, and by the Biomedical Research Ethics Committee in Zambia. The baseline survey was conducted from December 2010 to February 2011.

Findings

Child beneficiaries (N[1]=1,869)

Education. The majority (95.2%) of children were currently in school, with no difference between boys and girls. Younger children are more likely to be in school than older children.

Food and Nutrition. In the last four weeks, because there was not enough food in the household, one third of children (32.6%) reported going a whole day and night without eating; 58% reported going to sleep hungry; 67.5% reported eating a smaller meal than they felt they needed; and 72.8% reported eating fewer meals in a day. There were no differences between girls and boys. Older children were less likely to respond with problems of food security.

Clothing. A majority of children (88.5%) reported having two or more sets of clothes. Girls were slightly more likely to report this than boys. Sixty% of children reported having bedding. Just under half (45.8%) of children reported having one or more pairs of shoes. Older children were more likely to report having shoes.

Health. Four in five children surveyed (78.9%) rated their health good to excellent, with no differences by sex or across age groups. Still, more than half of children (53.7%) reported illness in the four weeks prior to survey. Girls were more likely to report illness than boys. The most common illnesses reported were: malaria (36.8%), cough/cold (26.5%), and diarrhea (16.5%). Four in five children reporting illness in the four weeks prior to the survey reported receiving treatment for their last illness, with no differences by sex or across age groups. One in five children (20.7%) reported a previous HIV test. Children aged 16-17 were twice as likely to report having had an HIV test than younger children.

Sexual and Gender Based Violence. Half of children surveyed (54%) reported having previously worked for money. Boys and older children were more likely than girls and younger children to report previous work. Three-quarters of children (74.6%) reported having ever been hit or beaten, with no differences by sex or across age groups. Half of children (49.3%) reported being hit or beaten in the six months prior to the survey. Less than four% (3.5%) of children surveyed reported having ever been forced to have sex, with no differences by sex or across age groups. Nearly two% (1.7%) of boys reported previously forcing someone to have sex.

HIV and AIDS. One quarter of children surveyed (25.9%) reported a belief that families with HIV-positive individuals are treated unkindly by other students. Fifteen% (15.4%) reported a belief that families with HIV-positive individuals are treated unkindly by teachers. Nearly one in three children (27.7%) reported a belief that children who receive free services are treated unkindly by the community. Eighty-four% (83.8%) of children reported having heard of HIV and AIDS. Older children are more likely to have heard of HIV than younger children. Three-quarters of children agreed that HIV cannot be transmitted via witchcraft. Eighty-five% of children (85.5%) agreed that HIV cannot be cured by herbs, and 78.3% agreed that a healthy-looking person can be HIV-positive. Nine in ten children (91.3%) reported a belief that abstinence reduces HIV risk, and 87.5% believe that condom use reduces HIV risk. For all questions, older children (13-15) were most likely to respond correctly.

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[1] In this report, N is used to denote the whole group while n is a partial segment of that group.

Sexual Behavior. One in five children (21.9%) aged 13 and above reported previous sex. Boys and children aged 16-17 were twice as likely to report ever having sex compared to girls and children aged 13-15. The mean age of sexual debut was 12.8 years for boys and 14 years for girls (range: 5-17 years). One-third of children (32.7%) reported talking to their sexual partner about HIV before having sex. One in ten girls (11.8%) aged 13-17 reported having ever been pregnant.

BCS beneficiaries (N=358)

Health. One in ten respondents (11.1%) rated their health "excellent" or "very good," 30.7% rated their health "good," 34.4% rated their health "fair," and 23.9% rated their health "poor."

Food security. Nearly nine in ten respondents reported food insecurity in the four weeks prior to survey. Eighty-six% reported worrying that the household did not have enough food; 88.8% reported that they or another household member had to eat a limited variety of foods due to lack of resources; 86.5% reported that they or another household member had to eat a smaller meal than needed; and 87.4% reported that they or another household member had to eat fewer meals than needed. Two-thirds of respondents (65.5%) reported that at some point during the four weeks prior to survey, there was no food in the household due to lack of resources. A similar proportion (67.5%) reported that they or another household member went to bed hungry. Just under half of respondents (47.4%) reported that they or another household member went a whole day and night without eating.

HIV treatment and adherence. Nearly two-thirds (64.0%) of respondents reported that they were first tested for HIV due to persistent illness. One in five (21.9%) reported being tested just to know their status; 5.8% were tested as part of an antenatal check-up; 2.6% were tested because their spouse tested positive; and 2.3% were tested because their spouse died of suspected AIDS.

Nearly all respondents (97.1%) had heard of medications to treat HIV (anti-retrovirals). Nearly ninety% (86.1%) of respondents reported currently taking anti-retrovirals (ARVs). Two-thirds of respondents taking ARVs reported that they had never missed a dose (65.9%), 13.2% said that they had not missed a dose in over three months, 7.1% reported that they had missed a dose in the last one-three months, 6.1% reported missing at least one dose in the last month (but not the last week), and 7.8% reported missing at least one dose in the last week.

HIV and AIDS knowledge. Nearly three-quarters of respondents (71.6%) correctly responded that a person cannot get HIV from mosquito bites. Less than half of respondents (47.7%) responded correctly that HIV cannot be transmitted by kissing. A vast majority (95.9%) reported that people can protect themselves from HIV by abstaining from sexual intercourse. A similar proportion (93.9%) responded correctly that a person can protect themselves from HIV by using a condom correctly every time they have vaginal sex.

Perceived stigma and discrimination. The majority of respondents (88.0%) reported that they had disclosed their HIV status to at least one person. Nearly eighty% of respondents (79.2%) said that they are careful to whom they disclose their HIV status. Nearly thirty% (29.6%) reported feeling that they are not a good person because they have HIV or AIDS. Just under half (44.7%) agreed with the statement that people living with HIV and AIDS are treated as outcasts.

HIV-related risk behavior. Half of respondents (47.4%) reported sex in the last six months, with males much more likely than females. Just over half of respondents (51.6%) reported a regular sex partner, with males much more likely to report a regular sex partner than females. The vast majority of respondents (92.9%) reported that they had disclosed their HIV status to their regular partner/s. Knowledge about partners' HIV status is evidently reciprocal: rates of disclosure of own status were much lower (68.2%) among those reporting that they did not know their partners' HIV status.

Less than five% (4.7%) of respondents reported sex with a casual partner in the last six months. Eleven female respondents (5.0%) reported receiving money or another item of value in exchange for sex in the last six months.

Gender-based violence. One-third of respondents (32.6%) reported being hit or beaten by their spouse/sexual partner. Nearly twenty% (18.9%) of female respondents reported that they have been forced to have sex by their husband or someone else, of whom 32.8% reported forced sex by their husband or someone else in the last 12 months.

More than one-third of respondents (36.7%) agreed or strongly agreed with the statement that a husband is justified to hit or beat his wife. Half of all respondents (48.6%) agreed or strongly agreed with the statement that if a husband wants to have sex, his wife is not supposed to refuse.

Community Caregivers (N=406)

Job responsibilities. The mean number of households visited by caregivers was 12.5 (median=10). Nearly half of caregivers surveyed reported that they visited their clients weekly (47.3%), 27.4% reported visiting clients monthly, and 15.9% reported visiting clients more than once per week (N=402). Overall, 28.7% of caregivers sampled indicated that they visited five or more different client households the week prior to survey, with 27.7% and 33.2% indicating that they visited three-four different households and one-two different households respectively, and 10.5% reporting that they did not visit any household the week prior to survey (range: 0-30). The majority of caregivers surveyed (84.6%) reported that they travel between client households on foot, with 15.1% traveling by bicycle.

Services provided and training. Three-quarters of caregivers reported providing child health assessments and psycho-social counseling for children; but less than one-third reported providing household HIV counseling and testing, and HIV post-exposure prophylaxis (referral). Significant training gaps appear, with up to one-third of caregivers providing services, not having received training to provide that service.

Types of information provided by caregivers. Nearly all caregivers reported providing information on sexual prevention of HIV (91.2%); on the other hand, only 41.2% reported providing information on HIV post-exposure prophylaxis. Between two-thirds and three-quarters of all those providing information had received training in this area. Significant training gaps appear, especially around child immunizations, family planning, and HIV post-exposure prophylaxis.

Confidence in role as caregiver. The vast majority of community caregivers (94.9%) reported that they were comfortable discussing sexual prevention of HIV with adult beneficiaries; 93.5% reported that they were comfortable discussing sexual prevention with beneficiaries under 18 years old. Most community caregivers (92.7%) reported comfort in discussing birth spacing and family planning. Four-fifths of caregivers (81.9%) reported that they felt equipped to support clients in adhering to their HIV treatment. A majority of caregivers (92.8%) reported that they knew where to refer a client living with HIV for medication. Nearly eighty-five% (84.4%) reported that they felt comfortable supporting clients and their families to prepare for death.

HIV testing and HIV and AIDS knowledge. More than four-fifths of community caregivers (82.5%) reported ever having had an HIV test. A majority of respondents (88.5%) correctly responded that a person cannot get HIV from mosquito bites. Two-thirds of respondents (67.4%) responded correctly that HIV cannot be transmitted by kissing. A majority (93.0%) reported that people can protect themselves from HIV by abstaining from sexual intercourse. A similar proportion (91.8%) responded correctly that a person can protect themselves from HIV by using a condom correctly every time they have vaginal sex. Overall, knowledge on modes of transmission was relatively high among caregivers.

Attitudes and values. The vast majority of caregivers (96.7%) reported a belief that if a pupil is HIV+ but not sick, they should be allowed to continue attending school. Similarly, 97.0% reported that if a teacher is HIV+ but not sick, they should be allowed to continue teaching. Just over one-quarter (29.6%) reported that people living in households where one or more household member is living with HIV are treated unkindly by the community, and that households who receive free services are treated unkindly by community (25.1%). Nine in ten community caregivers (90.7%) felt that children aged 15-18 should be taught to use condoms correctly to protect themselves from HIV. Fifty-eight of community caregivers believe that children aged 10-14 should be taught to use condoms correctly.

Caregiver well-being. The vast majority (92.3%) of respondents strongly agreed that they are able to handle their responsibilities in the available time (N=396). Nearly all (96.7%) of community caregivers surveyed agreed or strongly agreed that even with their caregiving responsibilities, they still had adequate time for themselves.

Recommendations

The results of this baseline study suggest the following recommendations for further programming, including but not limited to:

- The findings show exemplary levels of school enrolment, but as the children grow older, retention appears to drop. Consequently, it is recommended that exploration of interventions that mitigate school drop-out rates, as well as further exploration into improving educational performance, quality of education and sustainability of educational support, should be undertaken.
- Households at different levels of food insecurity require specific support that meets their unique needs. In cases of severe food insecurity, more urgent interventions may be provided to individuals and households, some of which may require facility-based care. Interventions that respond to the characteristics of mild, moderate, and severe food insecurity need to be employed.
- Interventions to support victims of physical, sexual, and gender-based violence are needed, including the identification of organizations providing high-quality support services, the establishment of local referral networks, and training of community caregivers to adequately identify and respond to issues of physical, sexual, and gender-based violence.
- Economic security interventions should respond to distinct vulnerabilities of families, rather than of individuals, which may include longer-term assistance, programs that strengthen money management, or interventions that aim to diversify and grow income.
- HIV misconceptions and myths are still prevalent. To close gaps in comprehensive understanding of HIV transmission and prevention, interventions that include education on these issues are recommended for both youth and adult beneficiaries. HIV education messages should seek to dispel misunderstandings, and prevention of mother-to-child transmission (PMTCT) messages should be more rigorously integrated into program interventions. Community caregivers' knowledge of HIV transmission and prevention should also be improved.
- To address the significant caregiver training gaps identified by this study, caregivers should be trained in all services and information areas, with refresher training and training for newly hired caregivers routinely provided. Caregivers should also be further enabled in their role as primary data collectors through training on monitoring and evaluation (M&E), client monitoring, data use, and the Child Status Index (CSI) for outcome monitoring and case management. Additional support should be provided to caregivers to improve their understanding of HIV transmission, prevention, detection and treatment.
- Regarding program design, management, coordination and sustainability, key informants recommended improved collaboration among programs to overcome issues of duplication, poor program referrals and linkages, and lack of ownership. These improved coordination efforts should focus on government, service providers, and community. Key informants also believed stakeholders and programs could benefit from improved information on unmet need and service delivery mapping, and they noted a need to improve information quality and flow at various levels.

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List of Abbreviations

ART	Antiretroviral therapy
ARVs	Anti-retrovirals
BCS	Basic care and support
CDC	U.S. Centers for Disease Control
CSI	Child Status Index
DATF	District AIDS Task Force
DHMT	District Health Management Team
ECR	Expanded Church Response
FANTA	Food and nutritional technical assistance
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HFIAP	Household Food Insecurity Access Prevalence
HIV and AIDS	Human immune-deficiency virus / acquired immune-deficiency syndrome
IRB	Institutional review board
ITN	Insecticide-treated net
LLINS	Long lasting insecticide nets
M&E	Monitoring & Evaluation
OVC	Orphans and vulnerable children
PLHIV	People living with HIV and AIDS
PMTCT	Prevention of mother-to-child transmission
RAPIDS	Reaching HIV/AIDS Affected People with Integrated Development and Support
S&D	Stigma and discrimination
STEPS OVC	Sustainability through Economic Strengthening, Prevention and Support to OVC, Youth and Other Vulnerable Populations
SUCCESS	Scaling-Up Community Care to Enhance Social Safety-nets
USAID	United States Agency for International Development
USG	United States government
ZDHS	Zambia Demographic and Health Survey

1 Background

The Sustainability Through Economic Strengthening, Prevention and Support to Orphans and Vulnerable Children, Youth and Other Vulnerable Populations (STEPS OVC) Program in Zambia provides HIV prevention, care and support services to OVC, people living with HIV and AIDS (PLHIV) and their caregivers in all 72 districts of Zambia. Launched in July 2010, STEPS OVC is a three year program funded by USAID as part of the United States government's (USG) bilateral support to the Government of the Republic of Zambia (GRZ). The program is implemented by World Vision in collaboration with CARE, Catholic Relief Services (CRS), Africare, the Salvation Army (TSA), Futures Group, the Zambian organization Expanded Church Response (ECR), and more than 300 local community-based organizations and private sector partners.

The overall goal of STEPS OVC is to provide broad, effective support for HIV prevention and behavior change initiatives to reduce HIV transmission while helping Zambia develop the ability to care for and support OVC, at-risk youth and adults, and other vulnerable populations more effectively, efficiently, and sustainably. The program has three objectives:

- Ensure that individuals, households, and communities affected by HIV and AIDS access effective, gender-sensitive, high-quality HIV prevention, including HIV counseling and testing, male circumcision, and prevention of mother-to-child transmission (PMTCT)
- Strengthen the continuum of effective, efficient, and sustainable HIV prevention, care, and support. Improve efficiency, sustainability, and Zambian leadership of HIV and AIDS-related services, including engagement with the private sector.

STEPS OVC partners are implementing multiple activities through multi-faceted intervention approaches to achieve these objectives. The interventions range from building the capacity of local partners, caregivers, and communities to care for their vulnerable members, to providing services directly to individuals to meet their basic needs. However, the ultimate goal is to ensure that target populations have access to comprehensive HIV prevention, care, and support services and maintain a continuum of quality care that improves their well-being.

To better ensure that STEPS OVC program interventions meet the needs of beneficiaries and lead to improved population well-being over time, the program designed and implemented a program evaluation. This report presents the baseline evaluation findings.

2 Research Question and Hypotheses

2.1 Research Question

This baseline survey focused on adults and children receiving or listed to start receiving HIV prevention, care, and support services through the STEPS OVC program and on community caregivers providing services to STEPS OVC beneficiaries. The research question guiding this survey was: *What are the characteristics of the individuals targeted by the STEPS OVC program in terms of: (a) HIV and AIDS knowledge, attitudes and practices; (b) well-being; and (c) access to/previous uptake of HIV prevention, care, and support services?*

2.2 Hypotheses

The overall hypothesis of the study is that respondents exposed to the interventions will show improvements on measures of well-being and HIV knowledge, attitudes, and practices. Supporting this are four specific hypotheses:

1. Exposure to HIV prevention, care, and support interventions in a particular domain will be associated with better health outcomes in that domain (e.g., HIV care interventions will improve HIV care outcomes).
2. Exposure to HIV prevention, care, and support interventions will be associated with better well-being outcomes for those exposed to those interventions (e.g., HIV care interventions may enhance psychosocial well-being).
3. Those exposed to a greater number of HIV prevention, care, and support interventions will fare better on measures of well-being and HIV knowledge, attitudes, and practices outcomes than those exposed to fewer services.
4. Those exposed to more intensive levels of interventions (i.e., higher frequency) will fare better on measures of well-being and HIV knowledge, attitudes, and practices than those exposed to less frequent or less intensive interventions.

3 Survey Methodology

The research design implemented was a modified quasi-experimental pre-test/post-test study to assess the overall program impact on target populations. The intervention group consisted of OVC and home-based care beneficiaries and community caregivers randomly sampled from program registers in sampled districts. The baseline survey was conducted from December 2010 to February 2011; a follow-up evaluation will be conducted toward the end of the project (2013) in areas where STEPS OVC partners are operating.

3.1 Study Setting

The STEPS OVC project is implemented by more than 300 local organizations operating in all 72 districts in Zambia. The baseline survey was conducted in a maximum variation sample of nine districts: Chongwe, Kafue, Kaoma, Mongu, Mumbwa, Kabwe, Nchelenge, Kawambwa, and Solwezi (see **Table 1**). These districts were chosen in collaboration with partners and are diverse in terms of HIV prevalence, location (i.e., rural or urban), types of services provided by STEPS OVC partners, and inclusion in previous projects (e.g. Reaching HIV/AIDS Affected People with Integrated Development and Support, Scaling-Up Community Care to Enhance Social Safety-nets).

Table 1: Sampled districts

Province	Districts	Partners
Central	Mumbwa	World Vision, CRS
	Kabwe	Africare, The Salvation Army, CARE
Lusaka	Chongwe	World Vision, Africare
	Kafue	ECR, Africare
North Western	Solwezi	World Vision, CRS
Western	Mongu	World Vision, CRS
	Kaoma	CARE
Luapula	Kawambwa	World Vision
	Nchelenge	Africare, World Vision

3.2 Sampling

Study participants were drawn from the beneficiaries of the project in the sampled districts. Targeted population groups included OVC, BCS, and community caregivers. Program staff (District Facilitators), and government staff (District AIDS Coordinators and District Commissioners) were interviewed as key informants.

A multi-stage cluster sampling approach was applied[2] to sample provinces, districts, and households. The sampling frame assumed an equal distribution of the sampled population by sex. **Table 2** shows the required and actual sample sizes for the different respondent categories of the baseline study.

Table 2: Sample size

Type of Respondent	Estimated # on Entire Register	Number in Sampled Districts	Margin of Error (%)	Confidence Level (%)	Required Sample	Actual Sample
OVC (11-17 years)	133,200	8,571	3	95	2,099	1,964
BCS beneficiaries	100,000	2,906	5	95	383	358
Community Caregivers	19,000	3,485	5	95	377	406
Key Informants	-	-	-	-	27	21

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[2] Turner, A.G., Magnani, R.J. and Shuaib, M. (1996). *“A Not Quite as Quick but Much Cleaner Alternative to the Expanded Programme on Immunization (EPI) Cluster Survey Design.”* International Journal of Epidemiology, 25(1), pp. 198-203.

OVC and home-based care (BCS) beneficiaries and community caregivers were randomly sampled from community and program registers to ensure representation from different partners in the targeted districts. The study team conducted pre-study visits to each sample district to validate the sampling frame.

Key informants were carefully selected. STEPS OVC program staff reached out to key informants highlighted in the protocol and established availability interviews. If these individuals were unavailable for interview, they were replaced with someone in a similar position.

3.3 Recruitment of Study Participants

3.3.1 Recruitment of OVC and BCS beneficiaries

As above, from 8,571 OVC and 2,906 BCS in the sampled districts, 2,099 OVC and 383 BCS beneficiaries were randomly sampled from partner registers. Once participants had been selected in a given community, community caregivers and other field staff supported the study team by identifying the selected households.

In recognition of the sensitivities surrounding people receiving BCS given their HIV sero-status, extra caution was exercised to ensure privacy. For every BCS client who was sampled, the community caregivers first contacted the BCS client and asked them whether they were willing to participate in the study. Consenting clients were asked to meet an interviewer at a location of their choice, where the CC introduced the study research assistant to the consenting BCS client and left. The community caregiver was required to leave to ensure the client’s privacy.

If the selected respondent (or child’s caregiver in the case of OVC) was not available or did not consent to participate, the interviewer would make an appointment to return to conduct the interview, preferably the next day. Two additional visits were made before the OVC or BCS client was considered unable to be contacted for the survey. To ensure consistency in replacement of households, non-response cases were defined at three levels: (1) non-response due to non-contact; (2) non-response due to refusal to cooperate; and (3) non-response due to inability to participate (see **Table 3**).[3] The study had a response rate of 75.3%.

Table 3: Household Replacement Procedures

Type of non-response	Action	Responsible
Non-response due to non-contact	1st visit – Leave message on appointment date, if caregiver has phone number of sampled Head of household, confirm the appointment on the phone 2nd visit – Take similar action as above and if call was made to Head of household, establish reasons for not being available for interview 3rd visit – Inform researcher to replace Household with the next household on the sampling frame	Data collector/ caregiver
Non-response due to refusal to cooperate	Inform researcher so as replace household with the next household on the sampling frame	Data collector/ Caregiver/ Researcher
Non-response due to inability to participate, e.g., inability to complete the questionnaire	Inform researcher about the problem to allow for relevant action to be suggested	Data collector/ Caregiver/ Researcher

The study team recognized the need to ensure low non-response rates, so data collectors were trained to do repeated call backs[4] and to leave messages[5] and to ensure that the entry to the household was with a caregiver who provided the initial introduction.

3.3.2 Recruitment of Community Caregivers

Similar to the recruitment of OVC and BCS clients, once the districts were identified, community caregivers were randomly selected from the register of active community caregivers. From a list of 3,485 in the sampled districts, 377 community caregivers were randomly selected using the random

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[3] Groves R.M., Couper M.P. (1998). *Nonresponse in Household Surveys.* New York: Wiley.

[4] Groves, R.M., D.A. Dillman, J. Eltinge and R. Little (eds.) (2001). *Survey Non-response*. New York: John Wiley and Sons.

[5] Xu M, Bates B.J., Schwietzer J.C. (1993). *The Impact of Public Messages on Survey Participation in Answering Machine Households.* Public Opinion Quarterly

function in Microsoft Excel. Once the community caregivers had been selected in a given community, site coordinators and other field staff supported the study team by identifying the selected community caregiver households. A similar replacement strategy to OVC and BCS respondents was identified for community caregivers.

3.3.3 Recruitment of Key Informants

Field project staff either visited or called the key informant's office in advance to secure the appointment. When listed individuals were not available for interview after multiple attempts, they were replaced with informants in similar positions. Key informants interviewed included program staff (District Facilitators) and government staff (District AIDS coordinators and District Commissioners).

3.4 Data Collection

3.4.1 Survey Instruments

In order to reflect the intended target recipients of the different STEPS OVC interventions, five data collection instruments were developed for and administered to the different groups:

1. Trained CC questionnaire
2. OVC beneficiary questionnaire (ages 11-17)[6]
3. Basic Care and Support (BCS) beneficiary questionnaire (also referred to as Home Based Care (HBC) or Adult Beneficiary questionnaire)
4. Key Informant Guide for partner and GRZ staff
5. Head of Household Questionnaire

Survey tools included validated scales such as the Strengths and Difficulties Questionnaire,[7] the U.S. Centers for Disease Control (CDC) Quality of Life Questionnaire,[8] and the Food and Nutritional Technical Assistance (FANTA) household food insecurity access scale.[9] Many questions were taken from other survey tools, including the 2007 Demographic and Health Survey (DHS), the 2009 Zambia Sexual Behaviour Survey tool, and OVC program evaluation tools used previously in Zambia, Nigeria, Tanzania, and Kenya. The questionnaires (numbers 1-3 above) included a module on HIV and AIDS knowledge, attitudes, and practices for respondents aged 13 and over. Instruments were developed and reviewed in English before being translated into the following local languages prevalent in the sampled districts: Bemba, Kaonde, Tonga, and Silozi.

The translated questionnaires had both the local language and English with preference of the respondent determining the language of the interview.

The key informant interview guide focused on program implementation successes and challenges, capacity, and transition and program sustainability; all interviews were conducted in English.

3.4.2 Data Collection Procedures

The study team was divided into three groups, each comprised of a supervisor, a researcher, and 12 research assistants. Each team spent 20 days in the field, with research assistants conducting an average of five interviews with OVC or BCS beneficiaries per day. Key informant interviews were conducted by the researchers with the support of the supervisors.

For the most part, interviews took place at the residence of selected beneficiaries. Since the school term had begun when the study was underway, many children could not be located at their households; therefore, some were interviewed at community schools with prior consent of their parents/guardians. For these children, caregivers visited sampled households and sought consent to allow children to be interviewed.

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[6] Following recommendation by the Research Ethics Committee, only children aged 11 to 18 years were included in the study.
[7] www.sdqinfo.com/
[8] http://www.cdc.gov/hrqol/hrqol14_measure.htm
[9] http://www.fantaproject.org/publications/hfias_intro.shtml

Informed Consent

All selected beneficiaries were informed, prior to consenting, that their participation is voluntary and does not affect their eligibility to receive services from the programs now or in the future.

At the start of all interviews, participants were informed orally of the purpose and nature of the study and its expected risks and benefits. Because of low literacy levels, the interviewer requested verbal consent of the participant to conduct the interview. If verbal consent was given, the interviewer signed the consent form for the participant.

Adults provided consent for themselves and the children under their care to participate in the survey. In line with conventional standards of interviewing young children, child participants were required to give assent to participate in the survey.[10]

As part of the consent procedures, beneficiaries were informed that the data collected would be held in strict confidence. To ensure that the beneficiary was aware that the survey includes questions on highly personal and sensitive topics, the interviewer forewarned the beneficiary that some of the topics are difficult to talk about.

The beneficiary was made aware that he or she would be free to terminate the interview at any point and able to skip any questions to which he or she did not wish to respond.

Compensation

The project team was committed to assuring that study participation was voluntary; therefore, no compensation for participation was given. Respondents were made aware that the interviewer was present only to ask questions and not to provide any gifts or assistance.

3.5 Field Monitoring and Quality Control

To ensure a high quality of data, interviewers were carefully trained, and completed questionnaires were reviewed as part of quality check procedures. Data collectors were trained on data collection methods and provided with translated questionnaires. Guidelines on good data collection practice were provided.

Each completed questionnaire was reviewed first by the research assistant who administered it, then by the supervisor, before submitting it to the researchers for final scrutiny and storage. Questionnaires with inconsistencies were returned to the research assistants the following day for clarification and/or correction. Each day concluded with a review of the day’s work and collective and individual feedback to the research assistants by the supervisor and researcher.

3.6 Data Processing and Cleaning

After the data were collected from all the districts, data processing was carried out in Lusaka. Nine data entry clerks were recruited to enter qualitative and quantitative data. Data entry screens were created in EpiData for quantitative data. To validate data entry of the quantitative data, two teams of data entry clerks entered the same data. Duplicate files were then compared using a double-entry validation process. Inconsistencies were corrected by referring to the questionnaires until a zero-percent error level was reached for the two datasets.

For qualitative data, key informant interview recordings were transcribed. Transcribed texts were read for emerging themes and to generate codes for data categorization. The data were then sorted in Atlas.ti using the codes developed from the interview guide and the data.

3.6.1 Data analysis

As above, the data were first entered in EpiData. The data were then exported to SPSS 18.0 and STATA 9.1 for analyses. Frequency distributions of all study variables by sex and age group were calculated, including chi-square tests of statistical association.

Transcripts were analyzed using qualitative content analysis, which is a process of identifying, coding, and categorizing patterns in data.[11] All transcripts were re-read and recoded several times to improve

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[10] http://www.irb.cornell.edu/documents/SOP%2011%20-%20Children.pdf

inter-rater reliability. Codes were then developed based on identification of key words and sentences. Relationships between coded data were then explored, and clusters of related codes were categorized into sub-categories of data. Sub-categories of data were then compared, re-grouped, and merged under various themes. Codes, sub-categories, and themes were mutually exclusive. Themes were modeled as a web of interconnected issues to conceptualize an overall picture of the findings.

3.7 Research Ethics Approval

Research involving children and adults living with HIV require significant ethical safeguards. Prior to data collection, the final research protocol and survey instruments underwent ethical review and were approved by Health Media Labs, Inc., an institutional review board (IRB) in the United States, and the Biomedical Research Ethics in Zambia.

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[11] Mays N, Pope C. Chapter 9: Quality in Qualitative health research. In Qualitative Research in Health Care. 2nd Edition. Available at: www.bmjpg.com/qrhc/chapter9.html. Accessed 23/10/2010.

4 Findings

4.1 Child beneficiaries

4.1.1 Demographics

A total of 1,869 OVC were interviewed successfully.

Approximately half of children surveyed were girls and half were boys (51.8% vs. 48.2%, N=1,869).

Respondents aged 11 to 17 were included in the analysis. The mean age was 13.8 (median=14). See **Table 4** for age distributions. Analyses are based on programmatically important age groups of 11-12, 13-15, and 16-17. Age was distributed as follows: 29.6% aged 11-12, 49% aged 13-15, and 21.4% aged 16-17. Sex distributions in age groups were relatively even, with slightly more girls in the 11-12 and 13-15 year old age groups, and slightly more boys in the 16-17 year old age group.

Table 4: Respondents' ages

Age	Girls		Boys		Both sexes	
	%	n	%	n	%	n
11 years	11.9%	115	10%	90	11%	205
12 years	18.8%	182	18.4%	166	18.6%	348
13 years	17.8%	172	13.1%	118	15.5%	290
14 years	18.5%	179	17.4%	157	18%	336
15 years	14.7%	142	16.4%	148	15.5%	290
16 years	10.7%	104	14.2%	128	12.4%	232
17 years	7.7%	75	10.3%	93	9%	168

4.1.2 Attendance of formal education

Nearly all children reported that they were currently attending school (95.2%, N=1839), with no differences between boys and girls. Younger children were more likely to report school attendance than older children (98.5% of 11-12 year olds, 96.8% of 13-15 year olds, 94.4% of 16-17 year olds, p=0.000). Children living with a biological parent or aunt/uncle (97.1%) were slightly more likely to report current school attendance than children living with a sister/brother (95.9%) or grandparent (96.9%) (p=0.05). Reasons cited for not attending school included financial constraints (n=42), being too far away from school (n=56), and needing to make money for the family (n=56).

4.1.3 Social Capital and Protection

Two-thirds of children surveyed reported that their primary guardian was a biological mother and/or father (62.8%), 20.9% reported a grandparent, 11.3% reported an aunt or uncle, and 4% reported a sister or brother (N=1868). There were no differences in primary guardianship between boys and girls. Younger children were more likely than older children to report living with their biological mother or father (66% of 11-12 year olds, 63.6% of 13-15 year olds, 56.4% of 16-17 year olds, p=0.000). Older children were more likely to report living with a sister or brother (2.9% of 11-12 year olds, 3.9% of 13-15 year olds, 5.8% of 16-17 year olds, p=0.000) or an aunt/uncle (8.9% of 11-12 year olds, 11.8% of 13-15 year olds, 13.5% of 16-17 year olds, p=0.000). All children were equally likely to report living with a grandparent.

When asked with whom they spend most of their free time, both boys and girls were most likely to respond that they spend most of their free time with friends in their age group, with boys slightly more likely than girls to respond this way (62.6% vs. 50.2%, p=0.000). Other than friends, children reporting spending most of their free time with their biological mother or father (13.5%), with siblings (11.1%), with grandparents (9%), and with other relatives (6.8%). Three% of girls (3.1%) and 2% of boys reported spending most of their free time by themselves. There were no differences by age group.

In response to the question: *if you have a problem, who can you go to for help?,* 45.4% of children responded that they could go to their biological mother; 22.4% responded that they could go to their biological father (boys were twice as likely to report this: 30.1% vs. 15.3%, p=0.000); 10.9% responded that they could go to their biological brother or sister; 20.8% responded that they could go to a biological aunt or uncle; 25.5% responded that they could go to a grandparent; 1.3% responded that they could go to a pastor or other religious leader; 5.9% responded that they could go to a community worker (boys were more likely to report this: 7.7% vs. 4.2%, p=0.001); 9% responded that they could go to a neighbor or friend, and 5.4% reported an 'other' person that they could go to for help (N=1865). Just over three% of children (3.2%) reported that they had no one at all to go to if they needed help. Younger children were more likely than older children to respond that they could go to their biological mother (50.5% of 11-12 year olds, 45.2% of 13-15 year olds, 38.8% of 16-17 year olds) or biological father (26.8% of 11-12 year olds, 22% of 13-15 year olds, 17.3% of 16-17 year olds, p=0.002), but there were no other differences by age group.

In response to the question, *if you were in need of something like money or books or clothes, from whom could you normally request it?,* 48.8% responded that they could request it from their biological mother (girls were more likely to report this: 52.4% vs. 44.9%, p=0.001); 31.3% responded that they could request it from their biological father (boys were more likely to report this: 34.7% vs. 28.2%, p=0.002); 10.7% responded that they could request it from a biological sister or brother; 22.2% responded that they could request it from a biological aunt or uncle; 21% responded that they could request it from a grandparent; 0.6% responded that they could request it from a pastor or religious leader; 6.6% responded that they could request it from a community worker; 1.2% responded that they could request it from a neighbor or friend; 3.9% responded that they could request it from an 'other' person (N=1866). Boys were twice as likely to respond that they had no one that could provide for them (6.4% vs. 3.3%, p=0.002). Younger children were more likely to respond that they could request things from their biological mother (55.5% of 11-12 year olds, 47.5% of 13-15 year olds, 42.5% of 16-17 year olds, p=0.000) or biological father (36.7% of 11-12 year olds, 30.8% of 13-15 year olds, 25% of 16-17 year olds, p=0.001), or grandparent. Older children were more likely to respond that they could request things from their brother or sister (7.4% of 11-12 year olds, 11% of 13-15 year olds, 14.5% of 16-17 year olds, p=0.002), or that they had no one to go to (3.3% of 11-12 year olds, 4.4% of 13-15 year olds, 7.8% of 16-17 year olds, p=0.04).

4.1.4 Working

Just over half of children reported previous work for money (54%, N=1865). Boys were more likely than girls to report previous work (60.9% vs. 47.9%, p=0.000). Older children were more likely to report previous work compared to younger children (47.5% of 11-12 year olds, 54.1% of 13-15 year olds, and 63.5% of 16-17 year olds, p=0.000). There was no relationship among current (or ever) school attendance, guardianship, and previous work. The vast majority of children reporting previous work (92.7%) responded that they worked as laborers, e.g., on a farm or in construction. Six% of children reported fetching water, 2.7% washing clothes, and 2.4% hawking goods. Children reported using the money they earned to pay school fees (20.2%), buy food and clothes (50.9%), buy treats (19.7%), or buy other things (39.7%). Just fewer than eight% of children (7.6%) reported that they gave the money they earned to their guardian. There were no differences in use of money earned between boys and girls. Older children were more likely than younger children to report using money earned to pay for school fees (13.4% of 11-12 year olds, 20.3% of 13-15 year olds, 26.8% of 16-17 year olds, p=0.01). Younger children were more likely than older children to report giving the money they earned to their guardian (10.3% of 11-12 year olds, 7.9% of 13-15 year olds, 4.3% of 16-17 year olds, p=0.04).

Nearly one-quarter of children reported that they had previously been forced to do work that they did not want to do (23.8%, N=1837), with no differences between boys and girls, or among age groups.[12] There was no relationship among current (or ever) school attendance, guardianship, and forced work.

4.1.5 Ownership of assets

A majority of children reported having two or more sets of clothes (88.5%, N=1859), with no differences among age groups. Girls were more likely than boys to report having two or more sets of clothes (90.7% vs. 86.3%, p=0.003). Sixty% of children reporting having bedding (60.1%, N=1860), with no differences between boys and girls, or among age groups. Just under half of children reported having one or more pairs of shoes (45.8%, N=1860), with no differences between boys and girls. Older children were more likely to have shoes than younger children (39.8% vs. 45.6% vs. 54.5% of 11-12 year olds, 13-15 year olds, and 16-17 year olds, respectively, p=0.000).

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[12] This is not an indicator of child labor, but represents the proportion of children who were asked to work or do a chore that they did not want to do.

4.1.6 Physical abuse

Three-quarters of children reported that they had previously been hit or beaten (74.6%, N=1854), with no differences between boys and girls, among age groups, or by guardianship. Half of children reported that they had been hit or beaten in the last six months (49.3%, N=1380), with no differences between boys and girls or among age groups. Children reporting their primary guardian as an aunt or uncle (54.8%), or a brother or sister (51.7%), were more likely to report that they had been hit or beaten in the last six months (p=0.003). One-third of children reporting that they had previously been hit or beaten responded that they had sought help at some point (33.6%), with no differences between boys and girls, or among age groups (N=1336). Of those who sought help, 71.8% reported that they sought help from a family member, 15.1% sought help from a friend, 2.4% sought help from a hospital or clinic, 0.9% sought help from a community organization, 0.9% sought help from a pastor/religious leader, and 16.8% sought help from another source (N=457).

4.1.7 Gender-based violence

When asked whether they agreed or disagreed with the statement *a husband may be justified in hitting or beating his wife*, 10.1% of children strongly agreed, 19.1% of children agreed, 40% of children disagreed, and 30.8% of children strongly disagreed (N=1755), with no differences between boys and girls: see **Table 5**.

Table 5: Attitudes toward gender-based violence

	Strongly agree		Agree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	N
Female	97	10.7%	168	18.6%	354	39.2%	285	31.5%	904
Male	80	9.4%	167	19.6%	348	40.9%	256	30.1%	851
11 to 12	34	6.9%	93	18.8%	214	43.2	154	31.1	495
13 to 15	87	10%	169	19.5%	346	40.0	264	30.5	866
16 to 17	56	14.2%	73	18.5%	142	36.0	123	31.2	394

Sixty-three children surveyed reported a history of forced sex (3.5%, N=1801), with no differences between boys and girls, among age groups, or by type of guardian. Just under half of those reporting a history of forced sex reported forced sex in the six months prior to survey (42.2%, N=45). Nearly two% of boys reported previously forcing someone to have sex with them (1.7%, N=812), with no differences among age groups.

When asked whether they agreed or disagreed with the statement *when a husband wants sex, a wife cannot refuse*, 18.2% of children strongly agreed, 29.1% of children agreed, 33.1% of children disagreed, and 19.6% of children strongly disagreed (N=1491): see **Table 6**. Girls were more likely to disagree/strongly disagree compared to boys (56.4% vs. 48.1%, p=0.026). Older age groups were more likely to strongly agree or strongly disagree (but not agree or disagree); when strongly agree and agree were aggregated, and strongly disagree and disagree where aggregated, there were no differences among age groups.

Table 6: Attitudes toward forced sex

	Strongly agree		Agree		Disagree		Strongly disagree		Total
	n	%	n	%	n	%	n	%	N
Female	133	17.2%	204	26.7%	282	36.5%	154	19.9%	773
Male	126	19.4%	210	32.4%	188	29%	124	19.1%	648
11 to 12	52	13.9%	120	32%	137	36.5%	66	17.6%	375
13 to 15	137	19.1%	206	28.7%	231	32.2%	143	19.9%	717
16 to 17	70	21.3%	88	26.7%	102	31%	69	21%	329

4.1.8 Health

Nearly 80% of children rated their health as good to excellent (78.9%, N=1864), with no differences between boys and girls or across age groups. Just over half of children reported illness in the four weeks prior to survey (53.7%, N=1866). Girls were more likely to report illness than boys (58.5% vs.

48.6%, p=0.000), but there were no differences across age groups. In terms of type of last illness, 36.8% reported malaria, 26.5% reported cough/cold, and 16.5% reported diarrhea. Eighty% of children reported receiving treatment for their last illness (N=1003), with no differences between boys and girls or across age groups.

4.1.9 Food Security

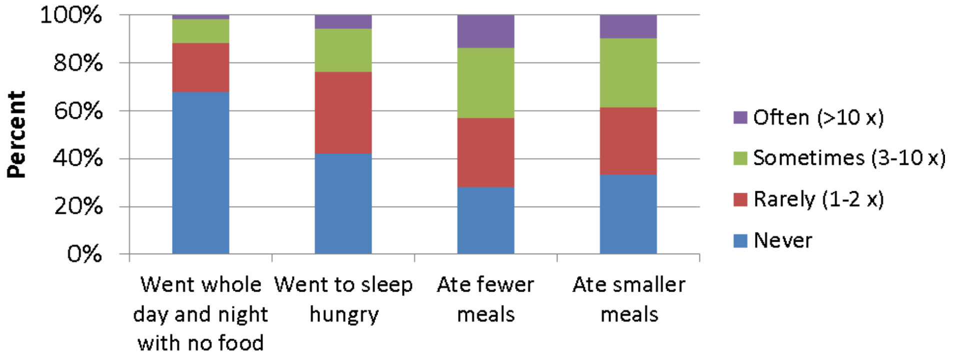
Food security data are presented in **Table 7** and graphically in **Figure 1**.

Table 7: Reported food insecurity in the four weeks prior to survey

In the last four weeks…	No		Yes						N
			Rarely 1-2 times		Sometimes 3-10 times		Often >10 times		
	n	%	n	%	n	%	n	%	
Went a whole day and night without eating	1257	67.4%	386	20.7%	182	9.8%	35	1.9%	1865
Went to bed hungry	783	42%	633	33.9%	338	18.1%	105	5.6%	1866
Ate a smaller meal than needed	606	32.5%	529	28.4%	540	29%	178	9.5%	1865
Ate fewer meals than needed	507	27.2%	543	29.2%	538	28.9%	259	13.9%	1862

Some respondents, who reported food insecurity, did not know how often they experienced this in the last four weeks, and hence figures do not aggregate to 100% exactly.

Figure 1: Percent reporting food insecurity in the four weeks prior to survey



One-third of children reported going a whole day and night without eating in the four weeks prior to survey because there was not enough food in the house (32.6%, N=1865), with no differences between boys and girls, or among age groups. Among those children reporting this, 64% said this happened rarely (one to two times in the past four weeks), 30.2% said this happened sometimes (3 to 10 times in the past four weeks), and 5.8% of children said this happened often (more than 10 times in the past four weeks) (N=605).

Nearly 60% of children reported going to bed hungry in the in the four weeks prior to survey because there was not enough food in the house (58%, N=1866), with no differences between boys and girls or among age groups. Among children reporting this, 58.9% said this happened rarely (one to two times in the past four weeks), 31.4% said this happened sometimes (3 to 10 times in the past four weeks), and 9.7% of children said this happened often (more than 10 times in the past four weeks) (N=1077).

Two-thirds of children reported eating a smaller meal than they felt they needed in the four weeks prior to survey because there was not enough food in the house (67.5%, N=1865), with no differences between boys and girls, or among age groups. Among children reporting this, 42.4% said this happened rarely (one to two times in the past four weeks), 43.3% said this happened sometimes (3 to 10 times in the past four weeks), and 14.3% of children said this happened often (more than 10 times in the past four weeks) (N=1248).

Three-quarters of children reported eating fewer meals in a day in the four weeks prior to survey because there was not enough food in the house (72.8%, N=1862), with no differences between boys and girls, or among age groups. Among children reporting this, 40.6% said this happened rarely (one-two times in the past four weeks), 40.2% said this happened sometimes (three-10 times in the past four weeks), and 19.3% of children said this happened often (more than 10 times in the past four weeks) (N=1344).

4.1.10 Psychosocial Well-being

Included in the OVC questionnaire was the validated Strengths and Difficulties Questionnaire (SDQ). The SDQ uses a three-point scale to assess children's functioning in the following areas:

- emotional well-being
- conduct
- hyperactivity
- peer relationships
- pro-social behavior

The SDQ is administered to the parents or teachers of four to 10 year olds and directly to 11-16 year olds (Goodman, 1997, 1999; Goodman et al, 1998).

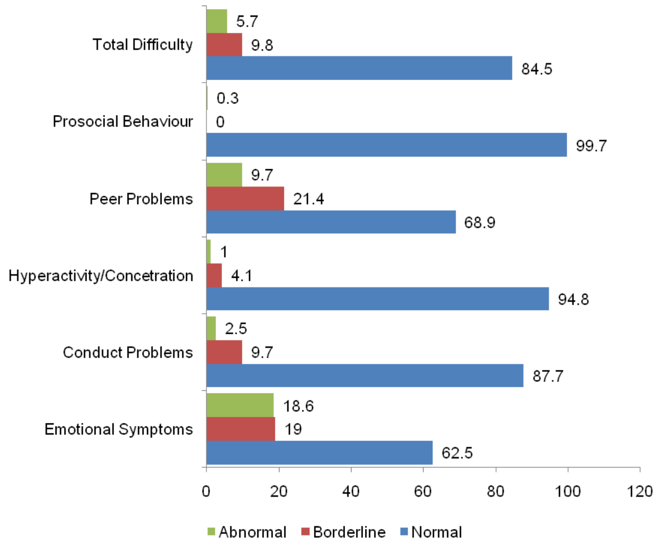
Data are presented in **Table 8** and **Figure 2** below.

Table 8: SDQ Scores

SDQ Scales	Normal		Borderline		Abnormal	
	n	%	n	%	n	%
Emotional well-being	1153	62.5%	350	19%	343	18.6%
Conduct	1630	87.7%	181	9.7%	47	2.5%
Hyperactivity	1762	94.8%	77	4.1%	19	1%
Peer Relationships	1274	68.9%	395	21.4%	179	9.7%
Pro-social Behavior	1852	99.7%	-		6	0.3%
Total Difficulties Score	1609	84.5%	187	9.8%	108	5.7%

Nearly one in five children surveyed showed abnormal emotional well-being (somatic complaints, worries, tearful feelings, nervousness, fear and insecurities), and a further 19% had "borderline" scores. One in ten had peer relationships problems (child prefers to play alone, may be bullied or bullies). A "total difficulties score" was calculated based on the scoring of the subscales of the SDQ. Only 5.7% of children surveyed were in the abnormal band. Importantly, SDQ scores do not confirm the diagnosis or presence of psychological disorder.

Figure 2: Percent of OVC per SDQ Scales



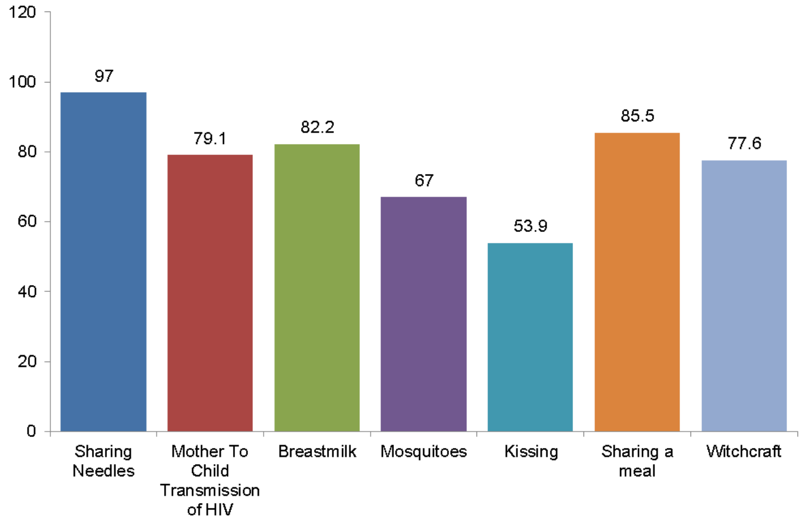
Analysis by key demographics (age group, sex, guardianship) did not yield statistically significant variances.

4.1.11 HIV and AIDS Knowledge and Attitudes

Basic knowledge

A majority of children reported having heard of HIV and AIDS (83.8%, N=1,860), with no differences between boys and girls. Older children were more likely than younger children to report having heard of HIV and AIDS (71.9% of 11-12 year olds, 87.4% of 13-15 year olds, 92.2% of 16-17 year olds, p=0.000). Among those who had heard of HIV and AIDS, 97% agreed that HIV can be transmitted by shared needles (N=1545), with no differences between boys and girls or among age groups. Four-fifths of those who had heard of HIV and AIDS agreed that a mother can transmit to their child in pregnancy (79.1%, N=1432), with no differences between boys and girls or among age groups. Over 90% agreed that abstinence reduces HIV risk (91.3%, N=1538), with no differences between boys and girls or among age groups. Nearly the same proportion agreed that condom use can reduce HIV risk (87.5%, N=1486), with no differences between boys and girls or among age groups. Correct HIV transmission knowledge is presented graphically in **Figure 3**.

Figure 3: Percent reporting correct HIV transmission knowledge



Rejection of major misconceptions

A majority of those who had heard of HIV and AIDS agreed that HIV cannot be transmitted by sharing a meal with PLHIV (85.5%, N=1527), with no differences between girls and boys. Older children were most likely to respond correctly (79.1% of 11-12 year olds, 88.8% of 13-15 year olds, 89.1% of 16-17 year olds, p=0.000). Just over three-quarters of those that had heard of HIV and AIDS agreed that HIV cannot be transmitted via witchcraft (77.6%, N=1556). Boys were slightly more likely to respond correctly (80.7% vs. 74.9%, p=0.005), and older children were more likely to respond correctly (70.5% of 11-12 year olds, 78.4% of 13-15 year olds, 84% of 16-17 year olds, p=0.000). Two-thirds of those who had heard of HIV and AIDS agreed that mosquitoes cannot transmit HIV (67%, N=1498), with no differences between boys and girls. Older children were most likely to respond correctly (62.5% of 11-12 year old, 66.6% of 13-15 year olds, 72.4% of 16-17 year olds, p=0.004). Half of children who had heard of HIV and AIDS agreed that HIV cannot be transmitted by kissing (53.9%, N=1557), with no differences between boys and girls. Children aged 13-15 were most likely to respond correctly (47.6% of 11-12 year olds, 56.9% of 13-15 year olds, 54.4% of 16-17 year olds, p=0.04). A majority of children agreed that HIV cannot be cured by herbs (85.5%, N=1556), with no differences between boys and girls or among age groups. Nearly four-fifths agreed a healthy-looking person can be HIV-positive (78.3%, N=1499), with no differences between boys and girls. Older children were most likely to respond correctly (69.8% of 11-12 year olds, 80.3% of 13-15 year olds, 83% of 16-17 year olds, p=0.000).

Attitudes

Children reported relatively accepting attitudes toward people living with HIV and AIDS. Approximately 80% reported a belief that if a pupil has HIV and is not sick, they should be allowed to continue attending school (78.4%, N=1557), with no differences between boys and girls. Older children were more likely to hold accepting attitudes than younger children (71.7% of 11-12 year olds, 81.5% of 13-15 year olds, 86.3% of 16-17 year olds, p=0.000). Similarly, 80.6% of boys and girls reported a belief that if a teacher is HIV-positive but not sick, they should be allowed to continue teaching (N=1539). Older children were more likely to hold accepting attitudes than younger children (73.7% of 11-12 year olds, 84.3% of 13-15 year olds, 87.2% of 16-17 year olds, p=0.000).

Just over one-quarter of children believe that families with HIV-positive individuals are treated unkindly by other students (25.9%, N=1555), and that children who receive free services are treated unkindly by community (27.7%, N=1558), with no differences between boys and girls or among age groups. Approximately 15% of children believe families with HIV-infected individuals are treated unkindly by teachers (15.4%, N=1557), with no differences between boys and girls or among age groups.

4.1.12 HIV and AIDS Risk Behavior

Sexual debut

Just over one-fifth of children aged 13-17 reported previous sex (21.9%, N=1315). Boys were twice as likely to report previous sex than girls (30.2% vs. 14%, p=0.000), and children aged 16-17 were more likely than those aged 13-15 to report previous sex (32.7% vs. 17.3%, p=0.000). The age of sexual debut ranged from five to 17 years (N=277). The mean age of sexual debut was 12.8 years among boys and 14 years among girls. Nearly half of those reporting previous sex said that “love” was the reason they had sex the first time (44.8%, N=286). Three and a half% (3.5%) reported being forced to have sex their first time, and 5.2% reported that they had sex the first time because they needed money (N=286). One third of respondents reporting previous sex stated that they talked to their sexual partner about HIV before having sex (32.7%, N=284), with no differences between boys and girls or among age groups.

Age of first sexual partner

Approximately one-third of children reporting previous sex said that their first sexual partner was about the same age as them (35.5%), one-third reported that they were younger than them (29.3%), and one-third reported that they were older than them (35.1%, N=242). Boys were more likely to report that their first sexual partner was younger than them (40.2% vs. 6.4%, p=0.000), and girls were more likely to report that their first sexual partner was older than them (70.5% vs. 18.3%, p=0.000). Five% of girls (5.1%) and 2.9% of boys reported that their first sexual partner was more than five years older than them.

Number of sexual partners to date

Over half of children reporting having had previous sex reported one sexual partner (54.6%: 74.4% of girls vs. 45.3% of boys) in their life, and a further 22% (22.2% of girls vs. 21.9% of boys) reported two sexual partners (n=282) in their life. Just over 20% of children who have had previous sex (20.2%: 2.2% of girls vs. 28.6% of boys) reported between three and five sexual partners in their life, and 3.2% (one girl vs. 4.2% of boys) of children reported more than five sexual partners in their life. Girls were more likely to report fewer sexual partners than boys (p=0.000) in their life. There were no differences by age group.

Sex in the last 12 months

Two-thirds of those reporting previous sex, reported sex in the last 12 months (62.8%), with no differences between girls and boys or among age groups (n=285). Among those reporting sex in the 12 months prior to survey, three-quarters reported one sexual partner in the last 12 months (75.8%), and 17.91% reported two sexual partners in the last 12 months (N=190). Less than ten% of boys (9.4%) and no girls reported sex with three or more partners in the last 12 months. Girls were more likely to report only one partner in the last 12 months than boys (91.9% vs. 68%, p=0.013). There were no differences in numbers of partners among age groups.

Condom knowledge

A majority of 13-17 year olds reported that they had heard of condoms (87.3%, N=1315). Boys were more likely than girls to report condom knowledge (90.8% vs. 83.9%, p=0.000), and older children were more likely than younger children to report condom knowledge (84.3% of 13-15 year olds, 94.1% of 16-17 year olds, p=0.000). Half of children reported that they were “confident” or “somewhat confident” that they could obtain a condom (N=1292), with boys being more likely to report confidence than girls (59% vs. 42.4%, p=0.000), and older children more likely to report confidence than younger children (45.6% of 13-15 year olds, 62.4% of 16-17 year olds, p=0.000). When asked where they could obtain condoms, 50.2% said the supermarket, 6.7% said the pharmacy, 62.8% said the clinic or hospital, 3.5% said a friend, 0.5% said a relative, 1.9% said a community organization, 3.5% said a community caregiver, and 17.6% said “other” (N=1300).

Condom use

Among those reporting previous sex, 40.3% reported ever using a condom during sex (N=310), with no differences between boys and girls. Older children were more likely to report condom use compared to younger children (29.5% of 13-15 year olds, 53.5% of 16-17 year olds, p=0.000). Just under one-third (27%, n=84) of those reporting previous sex reported using a condom at first sex, with no differences among age groups. Girls were twice as likely to report condom use at first sex compared to boys (43% vs. 19.2%, p=0.000). Just over one-third (36.7%, n=114) of those reporting previous sex reported using a condom at last sex, with no differences between boys and girls. Older children were more likely to report condom use at last sex (27.4% of 13-15 year olds, 46.5% of 16-17 year olds, p=0.003).

Pregnancy

Among girls reporting previous sex, just under 12% reported a previous pregnancy (11.8%, N=110).

Alcohol and drug use

Almost 100% of children reported no prior drug consumption (99%, N=1234), and 98.2% reported that they had not consumed any alcohol in the four weeks preceding the survey.

HIV risk discussions

Just over 40% of children reported that they have discussed their HIV risk with someone (42.4%, N=1297), with no differences between boys and girls. Older children were more likely to report having discussed their HIV risk with someone than younger children (9.1% of 11-12 year olds, 37.5% of 13-15 year olds, 54.8% of 16-17 year olds) (p=0.000). Children reporting previous sex were more likely to report ever discussing their HIV risk with someone (59.5% vs. 37.8%, p=0.000). When asked who they discussed their HIV risk with, 8.9% said a parent, 7.7% said a sibling, 9.1% said another relative (not parent, not sibling), 67.3% said friends (same age group), 11.1% said their boyfriend/girlfriend, 1.8% said a religious leader, 10% said a community worker, 4.4% said a healthcare provider, and 23.2% said “other” (N=548).

HIV testing

Nearly three-quarters of children reported that they know a place where one can receive an HIV test (73.1%, N=1288), with no differences between boys and girls. Older children were more likely to know a place where one can receive an HIV test (68.7% of 13-15 year olds vs. 83.5% of 16-17 year olds, p=0.000). One-quarter of children reported that they had discussed with someone whether or not they should take an HIV test (26.8%, N=1285), with no differences between boys and girls. Older children were more likely to report having discussed HIV testing than younger children (21.3% of 13-15 year olds vs. 39.9% of 16-17 year olds, p=0.000). There is a significant correlation between whether children have discussed their HIV risk and HIV testing (r=0.46, p=0.000). When asked who they discussed HIV testing with, 11.5% said a parent, 8.8% said a sibling, 11.8% said another relative (not parent, not sibling), 61.8% said friends (same age group), 15% said their boyfriend/girlfriend, 6.5% said a community worker, 9.7% said a healthcare worker, and 8.8% said “other” (N=340).

One-fifth of children reported a previous HIV test (20.7%, N=1300), with no differences between boys and girls. Children aged 16-17 were twice more likely to have had an HIV test than children aged 13-15 (32% vs. 15.5%, p=0.000). Children who reported having discussed their HIV risk with someone were much more likely to report previous testing (67.2% vs. 32.8%, p=0.000).

4.1.13 Access to HIV Prevention, Care and Support

Children were asked about receipt of a number of services, and whether they (still) needed these services: see **Table 9**.

One in five children reported having ever received family planning advice, with girls slightly more likely to report receipt of advice (p=0.017) and older children were more likely to report receipt of advice (p=0.000). Of those who reported ever receiving family planning advice, approximately 40% reported receiving advice in the six months prior to survey. Sixty% of children reported that they needed family planning advice, with girls slightly more likely to report needing services (p=0.031), and older age groups much more likely to report needing services (p=0.000). The high demand for family planning advice among younger age groups and boys is notable.

Table 9: Receipt of family planning advice

Family planning advice	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	386	20.8%	1856	146	38.6%	378	1046	60%	1742
Female	221	23%	962	95	43.6%	218	561	61.6%	911
Male	165	18.5%	894	51	31.9%	160	485	58.4%	831
11-12	51	9.3%	550	19	38%	50	251	50.8%	494
13-15	210	23.1%	910	73	35.6%	205	533	61.6%	865
16-17	125	31.6%	396	54	43.9%	123	262	68.4%	383

"Don't know" omitted from analysis

Just over ten% of children (11.4%) reported ever receiving long-term contraceptives, with girls slightly more likely to report this (p=0.014) and older age groups more likely to report this (p=0.000): see **Table 10**. Of those who reported ever receiving long-term contraceptives, approximately 40% reported receiving them in the six months prior to survey. Half of children surveyed reported a need for long-term contraceptives, with girls and older age groups more likely to report need for services (p=0.000). The high demand for long-term contraceptives among younger age groups and boys is notable. It is unclear what boys meant when they responded positively to receiving long-term contraceptives, or needing long-term contraceptives; perhaps they were referring to information or services received by a sexual partner. Care needs to be taken in interpreting this data.

Table 10: Receipt of long-term contraceptives

Long-term contraceptives: pills or injectable contraceptives	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	209	11.4%	1826	82	39.8%	206	830	48.3%	1718
Female	128	13.5%	946	56	44%	127	471	52.7%	893
Male	81	9.2%	880	26	32.9%	79	359	43.5%	825
11-12	26	5%	523	10	40%	25*	199	40.1%	496
13-15	119	13.2%	899	44	37.6%	117	432	50.9%	848
16-17	64	16.3%	392	28	43.8%	64	199	53.2%	374

"Don't know" omitted from analysis

Two-thirds of children reported ever receiving condoms, with boys and older age groups more likely to report this (p=0.000): see **Table 11**. Of those that reported receipt of condoms, half reported receiving condoms in the six months prior to survey. Just over half of all children surveyed reported that they needed condoms, with boys and older age groups more likely to report this (p=0.000). The high demand for long-term contraceptives among younger age groups is notable.

Table 11: Receipt of condoms

Condoms	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	661	35.8%	1845	322	50.5%	638	946	54.2%	1745
Female	293	30.7%	955	139	50.2%	277	449	49.3%	910
Male	368	41.3%	890	183	50.7%	361	497	59.5%	835
11-12	131	24.1%	543	58	45.7%	127	223	43.7%	510

Condoms	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
13-15	342	37.7%	906	151	46.2%	327	481	56.1%	858
16-17	188	47.5%	396	113	61.4%	184	242	64.2%	377

“Don’t know” omitted from analysis

One in five children reported having ever been treated for sores, bumps or ulcers on their mouth or genitals, with no differences between boys and girls: see **Table 12**. Older age groups were more likely to report having ever been treated than younger age groups (p=0.008). Of those reporting receipt of treatment, two-fifths received treatment in the six months prior to survey. Sixty% of children reported needing treatment for a sore, bump, or ulcer on their mouth or genitals, with boys (p=0.012) and older age groups more likely to report this (p=0.000). This service area was listed in the survey as a proxy for STI treatment, but it seems unlikely that such large numbers of beneficiaries would have been treated for STIs or would need treatment for STIs. Care should be taken in interpreting data.

Table 12: Receipt of treatment of sexually transmitted infection symptoms

Treatment of sores, bumps or ulcers on mouth or genitals	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	395	21.6%	1831	155	40.5%	383	1039	60%	1731
Female	201	21.2%	949	85	43.8%	194	511	56.8%	899
Male	194	22%	882	70	37%	189	528	63.5%	832
11-12	102	18.9%	539	41	41%	100	253	51.2%	494
13-15	194	21.6%	899	72	38.7%	186	531	61.8%	859
16-17	99	25.2%	393	42	43.3%	97	255	67.5%	378

“Don’t know” omitted from analysis

More than two-thirds of children reported having ever receiving information on HIV prevention, with no differences between boys and girls: see **Table 13**. Older age groups were more likely to report that they had received HIV prevention information (p=0.000). Of those that received information, over half received information in the six months prior to the survey. A vast majority of children reported a need for HIV prevention information, with no differences between boys and girls. Older children were more likely to report a need for HIV prevention information than younger children (p=0.000). Although high proportions of children surveyed reported receiving information on HIV prevention, nearly 20% of 16-17 year olds and nearly half of children aged 11-12 reported having never received information on HIV and AIDS, which is concerning.

Table 13: Receipt of HIV prevention information

HIV prevention information	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	1254	68.2%	1840	703	58.2%	1207	1436	84.7%	1695
Female	630	66.2%	952	367	60.9%	603	740	83.6%	885
Male	624	70.3%	888	335	55.5%	604	696	85.9%	810
11-12	291	53.8%	541	150	53.6%	280	392	79%	496
13-15	644	71.3%	903	356	57.4%	620	713	85.4%	835
16-17	319	80.6%	396	197	64.2%	307	331	90%	364

“Don’t know” omitted from analysis

Approximately 30% of children reported that they had received some support in developing their livelihood from an organization, with girls slightly more likely to report this than boys (p=0.008) and older age groups more likely to report this than younger age groups (p=0.024): see **Table 14**. Of children who received support, half received support in the six months prior to survey. A majority of children reported that they needed support in developing their livelihood, with no differences between girls and boys. Older age groups were more likely to report a need for livelihood development support than younger age groups (p=0.000).

Table 14: Receipt of support in developing livelihoods

Support in developing livelihood from an organization, such as training	Ever received?			If yes, received in last 6 months?			Needed?		
	Yes	%	N	Yes	%	N	Yes	%	N
All	543	29.5%	1840	266	52.2%	510	1472	87.4%	1684
Female	309	32.4%	953	151	51.4%	294	766	80.8%	874
Male	234	26.4%	887	115	53.2%	216	706	87.2%	810
11-12	133	24.4%	544	59	48%	123	409	83%	493
13-15	285	31.6%	902	142	53%	268	726	87.9%	826
16-17	125	31.7%	394	65	54.6%	119	337	92.3%	365

"Don't know" omitted from analysis

4.1.14 Malaria-related Knowledge and Behavior

Respondents were asked to spontaneously name malaria prevention methods. Two-thirds (64%) named bed nets as a prevention method; 9.3% named indoor residual spraying as a prevention method; 5.2% suggested staying inside at dawn/dusk to prevent bites; and 5.5% suggested wearing long sleeves and pants to prevent bites (N=1884).

Just under half of respondents reported that their household had a mosquito net (47%, N=1843), and 78.1% of those reporting a household net reported that someone slept under the net the night before the survey. Of those reporting a household net, 20% of children reported that no one in the household slept under a net the night before the survey, despite reporting that the household had a net. Sixty% of children reported sleeping under a net the night before the survey (59.6%, N=879), with no differences between boys and girls or among age groups.

4.1.15 Circumcision

Just under one-third of boys reported being circumcised (29.3%, N=884), with no differences among age groups. Just over one-third of boys who were not circumcised reported that they wanted to become circumcised (37.6%, N=529), with no differences among age groups. Among those reporting a desire to become circumcised, 70.9% stated HIV/STI prevention as the main reason, and 13.8% stated hygiene as the main reason.

4.2 BCS beneficiaries

4.2.1 Demographics

A total of 358 adult respondents were interviewed.

Two-thirds of BCS beneficiaries sampled were female (69.4%, N=240). BCS beneficiaries were aged between 18 and 78 years (mean=43, median=41, N=349). Ninety% of respondents reported ever attending formal school, with no difference between men and women (N=352). However, respondents reported low education levels. Just 8.3% reported completing secondary school (with 16.5% reporting at least some secondary school education), and 28.5% reported completing junior secondary school (N=316). Males were twice as likely to report some secondary school education compared to females (20.8% vs. 11.9%, p=0.03). Just under half of respondents reported that their main language was Bemba (43.2%), 17.9% reported Lozi as their primary language, and eight% spoke Kaonde most regularly (N=352). Other primary languages spoken included: Nyanja (5.1%), Luvale (1.1%), Lunda (5.1%), Tonga (2.6%), and other (16.8%). Just under half of participants reported that they were married and living monogamously (46.3%), 27% were widowed, 14.8% were divorced or separated, 9.4% were single, 2.3% were in married polygamous relationships, and 0.3% were co-habiting (N=352). Male respondents were much more likely than female respondents to report being married and living monogamously (74.3% vs. 33.5%). Females were more likely to report being widowed (34.3% vs. 11.4%), divorced, or separated (16.9% vs. 9.5%), and single (12.7% vs. 2.9%) (p=0.000).

Total household membership ranged between one (respondent only) and 18 members, with the majority of respondents living in households with between four and seven members (including the respondent) (N=350). One in ten BCS beneficiaries surveyed reported that they were the only adult in their household (10.5%), one-third reported that there was one other adult in their household (33%), 21.9% reported that there were two other adults in their household, 17.3% reported that there were three other adults in their household, and 17.3% reported that there were four or more other adults living in their household (range: 4 to 15) (N=352). There were no differences between men and women respondents in the reported number of adults living in the household. Less than eight% of BCS beneficiaries surveyed reported that there are no children living in their household (7.7%), 11.1% reported that there was only one child in their household, and 17.9% reported that there were two children in their household (N=352). Just under half reported that there were three to five children living in their household (47.7%), and 15.6% reported that more than six children lived in their household (range=6 to 14). A majority of respondents reported that some of the children living in their households were not their biological children. Among those reporting children in their household, 14.8% said that none of these were their biological children (N=324). One-third of respondents reported that they had biological children that were living, but not in their household (32.9%, N=348), with no differences between men and women respondents. When asked where these biological children are living, one-quarter said they were living with their biological mother or father (23.3%), just over half said they were living with another relative (56.3%), and a further quarter said they were living by themselves (24.1%) (N=116).

4.2.2 Self-rated Quality of Life

Respondents were asked questions from the CDC HRQOL-14 Index, including the Healthy Days Core Module and the Healthy Days Symptoms Module. When asked how they would rate their health in general, 11.1% rated their health “excellent” or “very good,” 30.7% rated their health “good,” 34.4% rated their health “fair,” and 23.9% rated their health “poor” (N=352), with no differences between men and women. Respondents were then asked to report how many days in the 30 days before the survey their well-being had been compromised. Responses are summarized in **Table 15** below.

Table 15: Self-rated quality of life measures

	None	Between 1-7 days	Between 1-4 weeks (>1 but <4 weeks)	Every day
Physical health was bad (N=343)	33.8%	37.6%	16.9%	11.7%
Mental health was bad (N=339)	39.2%	31.9%	17.1%	11.8%
Physical or mental health issues prevented normal activity (N=294)	32.3%	35.4%	20%	12.2%
Pain prevented normal activity (N=340)	34.2%	36.2%	17.9%	10%
Felt sad or depressed (N=340)	40.3%	28.5%	21.5%	9.7%
Felt anxious or tense (N=336)	38.7%	31.8%	19.6%	9.8%
Did not get enough rest/sleep (N=340)	33.8%	39.4%	17.4%	9.4%
Felt very healthy and full of energy (N=340)	19.7%	24.7%	37.9%	17.6%

Generally, about one-third of respondents expressed high quality of life for any of the questions (no “unhealthy” days), another third of respondents reported up to a week of poor health, and a further third reported poor health for more than one week in the last four weeks. Approximately 10% of respondents reported feeling in poor health every day in the last 30 days.

4.2.3 Economic Well-being

Just over one-third (36.6%) of respondents reported that they were in gainful employment at the time of survey (N=350), with no differences between men and women. Over half of respondents (58.6%) reported farming as their main source of income, and the remainder reported another primary source of income including hawking, fishing, and professional employment (N=343). The mean annual income among all respondents was 1,361,255 Kwacha (median= 500,000, range: 0-4,620,000). Less than four (3.7%) of respondents reported no annual income at all, 12.5% reported an annual income between 5000 and 99,999 Kwacha; 17.7% reported an annual income between 100,000 and 249,000 Kwacha; 13.1% reported an annual income between 250,000 and 499,000 Kwacha; 19.3% reported an annual income between 500,000 and 999,999 Kwacha, and 33.6% reported an annual income of one million Kwacha or more (N=327).

When asked how they manage to make ends meet, 22.2% of respondents reported help from other household members, 26.2% reported help from relatives, and 15.6% reported help from the community and/or community organizations (N=347, multiple responses possible). Less than 20% (19.1%) reported not being able to make ends meet (N=346). When asked what sort of support they received from relatives, if any, 24% reported financial assistance for the household, 24.9% reported food assistance for the family, 3.7% reported school fees for children, 2.6% reported help with medical expenses, and 5.4% reported other support, including basic material items and psychosocial support (N=350). Just over half (53.7%) of respondents reported receiving no financial/material support from relatives. When asked what sort of support they received from organizations, if any, 2.9% reported financial assistance for the household, 22.7% reported food assistance for the family, 4% reported school fees for children, 7.5% reported help with medical expenses, 1.7% reported livelihood training for self or a household member, and 9.5% reported other support – mainly basic material items (N=348). Just fewer than 60% (59.5%) of respondents reported receiving no financial/material support from organizations. In total, 9% of respondents reported that their income, combined with support received from relatives and organizations, was sufficient to meet their needs (N=342), with no differences between men and women.

One in five respondents (19.3%) reported having ever received support in developing their livelihood from an organization (N=342), with no differences between men and women. There was no relationship between receipt of livelihood development support and reported income sufficiency. Among those who reported receiving livelihood development support, 8.8% received a small loan to develop their business, 28.8% received training, and 65.2% received materials or commodities (N=66, multiple responses possible). When asked who helped to initiate livelihood development support for them, 68.7% said a community caregiver, 7.6% said a pastor or other religious leader, 10.6% said a community leader, and the reminder cited other sources (N=66).

Respondents were asked about asset ownership. Three-quarters (75.4%) reported owning land, 78% reported owning a house, 60% reported owning a bed, 84.3% reported owning bedding, 94.3% reported owning at least two sets of clothes, 30% reported owning a radio, 9.7% reported owning a TV, 4% reported owning a VCR, 4.4% reported owning a DVD player, 1.1% reported owning a stove, 1.7% reported owning a refrigerator, 2.3% reported owning a sewing machine, 0.9% reported owning a car, 24.1% reported owning a bicycle, 2.3% reported owning gold and/or silver jewelry, 33% reported owning a mobile phone, and 7.4% reported owning a wheelbarrow. Men were more likely than women to report owning land (83.8% vs. 71.8%, p=0.017), a bed (67.6% vs. 56%, p=0.044), a radio (40% vs. 24.8%, p=0.005), and a bicycle (33.3% vs. 20%, p=0.008). There were no other differences in asset ownership by sex.

4.2.4 Food Security

Respondents were asked how many meals they eat in a typical day. Just under 20% (17.7%) reported eating only one meal per day, 63.7% reported eating two meals per day, and 18.6% reported eating three or more meals per day (N=350). Food security data are presented in **Table 16** and graphically in **Figure 4**. There were no differences between men and women across any of the food security variables.

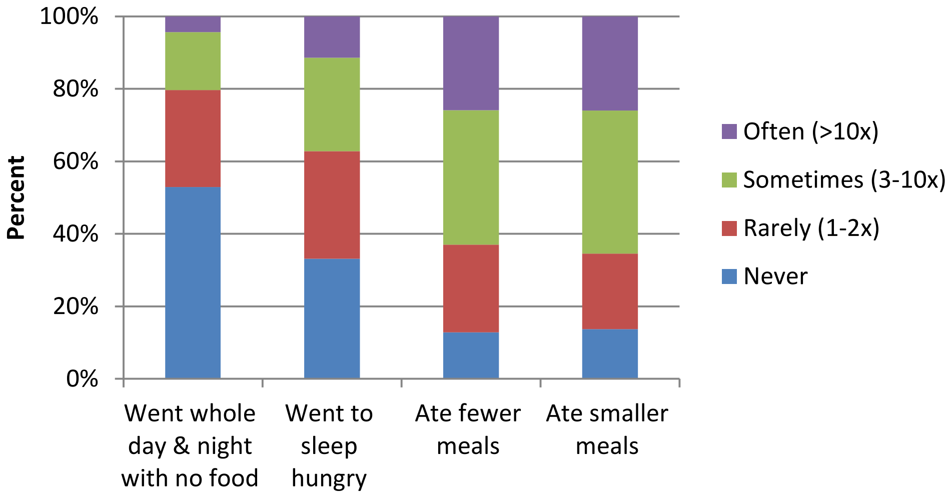
Table 16: Reported food insecurity in the four weeks prior to survey

In the last four weeks…	No		Yes						N
			Rarely 1-2 times		Sometimes 3-10 times)		Often >10 times		
	n	%	n	%	n	%	n	%	
Worried that HH did not have enough food	49	14%	69	19.8%	119	34.1%	107	31.8%	349
Self or HH member had to eat a limited variety of foods	39	11.2%	69	19.8%	142	41.5%	96	27.8%	348
Self or HH member had to eat smaller meals than needed	47	13.5%	71	20.7%	135	39.4%	89	26.1%	348
Self or HH member had to eat fewer meals than needed	44	12.6%	83	23.9%	127	36.8%	89	26.1%	348
There was no food at all in HH	120	34.5%	87	25%	95	27.6%	41	12.4%	348

In the last four weeks…	No		Yes						N
			Rarely 1-2 times		Sometimes 3-10 times)		Often >10 times		
	n	%	n	%	n	%	n	%	
Self or HH member went to bed hungry	113	32.5%	101	29.3%	88	26.1%	39	11.8%	348
Self or HH member went a whole day and night without food	182	52.6%	92	26.4%	55	16.4%	15	4.6%	348

Some respondents who reported food insecurity did not know how often they experienced this in the last four weeks; therefore,%ages do not quite total 100%.

Figure 4: Percent reporting food insecurity in the four weeks prior to survey: Self or household member



A majority of respondents (86%) reported worrying in the four weeks prior to the survey that the household did not have enough food (N=349). Among those worried about food shortages in their household in the four weeks prior to survey, 23.1% said they worried only one to two times in the past four weeks, 39.8% said they worried three to ten times in the past four weeks, and 37.1% said they worried more than 10 times in the past four weeks (N=299).

A majority of respondents (88.8%) reported that they or another household member had to eat a limited variety of foods in the four weeks prior to the survey due to a lack of resources (N=349). Among those reporting this, 22.2% said this happened only one to two times in the past four weeks, 46.6% said this happened three to 10 times in the past four weeks, and 31.2% said this happened more than 10 times in the past four weeks (N=311).

A majority of respondents (86.5%) reported that they or another household member had to eat a smaller meal than needed in the four weeks prior to the survey due to a lack of resources (N=348). Among those reporting this, 24% said this happened only one to two times in the past four weeks, 45.7% said this happened three to 10 times in the past four weeks, and 30.3% said this happened more than 10 times in the past four weeks (N=300).

A majority of respondents (87.4%) reported that they or another household member had to eat fewer meals than needed in the four weeks prior to the survey due to a lack of resources (N=348). Among those reporting this, 27.5% said this happened only one to two times in the past four weeks, 42.4% said this happened three to 10 times in the past four weeks, and 30.1% said this happened more than 10 times in the past four weeks (N=302).

Two-thirds of respondents (65.5%) reported that at some point during the four weeks prior to survey, there was no food of any kind in the household due to a lack of resources (N=348). Among those reporting this, 38.5% said this happened one to two times in the past four weeks, 42.5% said this happened three to 10 times in the past four weeks, and 19% said this happened more than 10 times in the past four weeks (N=226).

Just over two-thirds of respondents (67.5%) reported that at some point during the four weeks prior to survey, they or another household member went to bed hungry due to a lack of food in the household (N=348). Among those reporting this, 43.6% said this happened one to two times in the past four weeks, 38.9% said this happened three to 10 times in the past four weeks, and 17.5% said this happened more than 10 times in the past four weeks (N=234).

Just under half of respondents (47.4%) reported that they or another household member went a whole day and night without eating at some point during the four weeks prior to survey due to a lack of food in the house (N=348). Among those reporting this, 55.8% said this happened one to two times in the past four weeks, 34.5% said this happened three to 10 times in the past four weeks, and 9.7% said this happened more than 10 times in the past four weeks (N=165).

4.2.5 HIV Treatment and Adherence

Less than 4% of respondents (3.6%) reported having their first HIV test less than 12 months before the survey, 12.9% reported that they had their first test one year ago, 60% reported testing for the first time two to five years ago, 20.2% reported testing for the first time six to10 years ago, and 3.3% reported taking their first HIV test more than 10 years ago (N=332), with no differences between male and female respondents. Nearly two-thirds (64%) of respondents reported that they first tested due to persistent illness (N=347). Only 21.9% reported testing just to know their status; 5.8% were tested as part of an antenatal check-up, 2.6% tested because their spouse tested positive, and 2.3% tested because their spouse died of suspected AIDS. There were no differences in reasons for testing between men and women.

Just over half of respondents reported that a household member was also HIV-positive. One-quarter of respondents reported that only their spouse was HIV-positive (24.5%), and one-quarter reported that their spouse and at least one other household member was HIV-positive (23.8%, N=323). Half of respondents reported that another household member had died of AIDS (47.6%, N=332). Of those who reported that a household member died of AIDS, 61.4% reported that a brother and/or sister died, 15.8% that a spouse died (only), 13.3% that a child died (only), and 6.3% that a spouse and at least one child died, and 3.2% said that a father and/or mother died (N=158).

Nearly all respondents (97.1%) had heard of medications to treat HIV (ARVs) (N=344), with no difference between men and women. In addition, 6.1% reported taking herbal or traditional medicine to treat HIV (N=342), with no difference between men and women. Nearly 90% (86.1%) of respondents reported currently taking ARVs (N=345), with no difference between men and women. When asked how they learned about ARVs, 88.6% said a health worker, 17.1% said a peer support group for people living with HIV and AIDS, 10.4% said a friend, 8.7% said a family member, 3% said a church group, 9.1% said TV or radio, 2% said newspapers or magazines, 0.3% said posters or leaflets, and 1.7% said a traditional healer (N=298, multiple responses possible).

Two-thirds of respondents taking ARVs reported that they had never missed a dose (65.9%), 13.2% said that they had not missed a dose in more than three months, 7.1% reported that they had missed a dose in the last one to three months, 6.1% reported missing at least one dose in the last month (but not the last week), and 7.8% reported missing at least one dose in the last week (N=296). When asked why they missed a dose, 58.3% said they forgot, 25.2% said they ran out of medication, 4.9% said it was due to side effects, 11.7% said that they were busy and did not have their medication with them at the time they were supposed to take it, and 5.8% reported another reason (N=103, multiple responses possible). When asked how strictly they adhered to their schedule over the past week, 89.2% reported strict adherence (no missed doses, mediation taken at right time), 8.8% reported some mistakes (missed doses and/or medications taken at wrong times), and 2% reported taking their medication when they remembered (frequently off schedule) (N=296). When asked the last time they missed a full day of medication, 81% reporting never missing their medication for a full day, 7.9% reported that they had not missed a full day of medication in over three months, 3.1% said they had missed a full day of mediations in the last two-three months, 3.8% reported missing a full day of medication in the last month (but not the last week), and 4.1% reported missing a full day of medication in the last week (N=290). Just under 10% (7.8%) reported ever stopping treatment for a week or more since starting treatment initially (N=295). When asked how they remind themselves to take their medication, 28.6% use an alarm, 21.7% said their family/friends help remind them, 10.8% said they take their medication at meal times, 5.4% said they take their medication during specific television or radio programs (N=295, multiple responses possible). There were no differences between men and women in any adherence indicator.

All respondents taking ARVs reported getting them from the health clinic, except one who reported receiving them from his caregiver (N=296). Only 3.1% of respondents reported paying for ARVs (N=293) with the rest receiving ARVs free of charge. Over 80% of respondents (83.8%) reported that they have someone that they can count on to accompany them to the hospital if needed (N=333), with no difference between men and women. Nearly 60% (58%) of respondents reported no HIV care related travel expenses, 10.2% reported spending 5000 Kwacha or less (approximately $1USD) per month on HIV care related travel expenses, 17.3% reported spending between 6000 to 20,000 Kwacha per month, and 14.6% reported spending more than 20,000 Kwacha per month (N=226).

4.2.6 HIV and AIDS Knowledge

Respondents were asked a series of true / false questions regarding HIV and AIDS. Over 70% of respondents (71.6%) correctly responded that a person cannot get HIV from mosquito bites (N=342). Less than half of respondents (47.7%) responded correctly that HIV cannot be transmitted by kissing (N=342). The majority of respondents (95.9%) reported that people can protect themselves from HIV by abstaining from sexual intercourse (N=343). A similar proportion (93.9%) responded correctly that a person can protect themselves from HIV by using a condom correctly every time they have vaginal sex (N=344). Fewer respondents (81.7%) replied correctly that a person can protect themselves from HIV by using a condom correctly every time they have anal sex (N=344). The majority of respondents understood correctly that a person cannot acquire HIV by sharing a meal with someone who is HIV-positive (95.6%, N=343). A similarly high proportion (97.1%) responded that a person can acquire HIV through an injection with a needle already used by someone who is HIV-positive (N=343). Only 83.4% responded correctly that a pregnant woman with HIV and AIDS can transmit HIV to her unborn child during childbirth, and slightly higher proportion (88.7%) understood that a woman who has HIV and AIDS can transmit HIV to her child while breastfeeding (N=344). Almost all respondents (96.5%) responded correctly that a healthy-looking person may be HIV-positive (N=344). Women were more likely than men to respond that a healthy-looking person may be HIV-positive (98.3% vs. 92.1%, p=0.000). There were no difference between men and women on any other knowledge variable.

4.2.7 HIV-related Risk Behavior

Half of respondents (47.4%) reported sex in the last six months (N=342). Men were much more likely than women to report sex in the last six months (65% vs. 40%, p=0.000).

Just over half of respondents (51.6%) reported a regular sex partner (N=335). Again, men were much more likely to report a regular sex partner than women (69.4% vs. 43.8%, p=0.000). Of those reporting a regular sex partner, 94.1% reported only one regular sex partner, with 4.1% reporting two regular sex partners, and two individuals reporting three regular sex partners (N=168). Just over 60% (61.1%) of those reporting a regular sex partner, said that their partner was HIV-positive, 25.1% said their partner was HIV-negative, and 13.8% said that they did not know the HIV status of their regular partner (N=167). There were no differences between men and women.

The vast majority of respondents (92.9%) reported that they had disclosed their HIV status to their regular partner/s (N=170), with no difference between men and women. Knowledge about partners' HIV status is reciprocal; rates of disclosure of own status were much lower (68.2%) among those reporting that they did not know their partners HIV status.

Among those reporting a regular partner, a majority (84.9%) reported sex with their regular partner in the last six months (N=172), with no difference between men and women. Three-quarters of respondents (76.9%) reporting sex with their regular partner in the last six months, reported using a condom at last sex (N=147), with no difference between men and women.

Condom use was related to HIV status of the regular sexual partner. Over 90% (91.4%) of those with an HIV-negative regular sexual partner reported condom use at last sex, compared to 74.4% of those with an HIV-positive regular sexual partner, and 57.1% of those reporting that they did not know the status of their regular sexual partner (N=142, p=0.012). The few participants not reporting condom use with their regular sexual partner at last sex were asked why they did not use a condom. Seven people reported that their partner does not like condoms, six people said that they did not have a condom with them, five people reported that their partner was HIV-positive (and thus condoms were felt to be unnecessary), five people felt that if they suggested condoms their partner would be suspicious that they were HIV-positive, two people said that condoms reduce sexual pleasure, and two people said that they find condoms difficult to put on (N=32, multiple responses possible). Nearly two-thirds (61.9%) of respondents reported consistent condom use with their regular sexual partner over the last six months, 16.3% reported never using condoms, 14.3% reported using condoms less than half the time, and 7.5% reported using condoms more than half the time, but not always (N=147). Respondents with HIV-negative partners were more likely to report consistent condom use than respondent with HIV-positive partners or partners of unknown status (74.3% vs. 61.2%, vs. 42.9%, N=141, p=0.010). There was no difference in reported consistent condom use between men and women.

Less than five% (4.7%, n=16) of respondents reported sex with a casual partner in the last six months (N=338), with no difference between men and women. Numbers were too small for further analysis. Seven men and three women reported giving a woman money or another item of value in exchange for sex in the last six months (N=261). Two women and one man reported giving a man money or another item of value in exchange for sex in the last six months (N=168). Eleven women respondents (5%) reported receiving money or another item of value in exchange for sex in the last six months (N=218). No men reported this.

Eight respondents report ever using marijuana, and one respondent reported a history of petrol, cocaine, and heroin use (N=328). No respondents reported a history of injecting drug use.

4.2.8 Perceived Stigma and Discrimination

The majority of respondents (88%) reported that they had disclosed their HIV status to at least one person (N=341), with no difference between men and women. When asked to whom they disclosed, 46.2% said their spouse, 41.5% said a sibling, 53.2% said another relative (aunt, uncle, or grandparent), 31.8% said friends, 7.7% said a pastor or other religious leader, 2.3% said a sexual partner other than a spouse, and 1.3% said their employer (N=299, multiple responses possible). Nearly 80% of respondents (79.2%) said that they are careful about to whom they disclose their HIV status (N=337). Over 40% of respondents (42.3%) felt that people are afraid of them when they find out that they are HIV-positive (N=326). Two-thirds of respondents (66.1%) have told those close to them to keep their HIV status a secret (N=336). One-third of respondents (32.7%) reported that people have called them names such as “living shadow” or “walking death” (N=336). Just under half of respondents expressed that they never feel the need to hide their HIV status (N=335). One-quarter of respondents (24.3%) reported that they have lost friends because of their HIV status (N=334). Nearly 30% (29.6%) reported feeling that they are not a good person because they have HIV/ AIDS (N=338). Nearly 60% (58.3%) of respondents agreed that they work hard to keep their HIV status a secret (N=338). Just under half of respondents (44.7%) agreed with the statement that people living with HIV and AIDS are treated as outcasts (N=338). Men were much more likely than women to report taking care in deciding to whom to disclose their HIV status (91.8% vs. 73.3%, p=0.000) and to report working hard to keep their HIV status a secret (70% vs. 53.1%, p=0.004). There were no other differences between men and women.

4.2.9 Gender-based Violence

One-third of respondents (32.6%) reported ever being hit or beaten by their spouse or another sexual partner (N=334), with no difference between men and women.[13] Two-fifths (37.8%) of female respondents reported that they had sought help following a beating at least once, generally from a family member (N=37). Nearly 20% (18.9%) of women respondents reported that they had ever been forced to have sex by their husband or someone else (N=227). Of women reporting a history of forced sex, one-third (32.8%) reported forced sex by their husband or someone else in the last 12 months (N=64).

More than one-third of respondents (36.7%) agreed or strongly agreed with the statement that a husband is justified to hit or beat his wife (N=332), with no difference between men and women. Half of all respondents (48.6%) agreed or strongly agreed with the statement that if a husband wants to have sex, is wife is not supposed to refuse (N=333), with no difference between men and women.

4.2.10 Circumcision

Fifteen percent (15.3%) of male respondents reported being circumcised (N=98). Among those not circumcised, one-third (32.9%) desired to be circumcised (N=82). The main reason cited for wanted to be circumcised was to reduce the risk of HIV and other STIs (n=22). When asked about the benefits

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[13] Male respondents were asked if they had ever hit or beaten their spouse or sexual partner

of circumcision, 56.6% reported reduced HIV risk, 22.7% said better hygiene, and 9.4% said circumcision was more culturally appropriate (N=99, multiple responses possible).

4.2.11 Malaria

Respondents were asked about methods to prevent malaria. One-third of respondents (33.1%) cited sleeping under an insecticide-treated bed net, and a further third (32.3%) cited sleeping under a bed net. One in five respondents (21.1%) cited spraying the house with repellent, 9.7% said wearing long sleeves and trousers, 6.7% said avoiding going outside at dawn and dusk, and 22.6% of respondents mentioned other methods of prevention such as avoiding stagnant water and taking antimalarial (N=341, multiple responses possible).

Sixty% of respondents (59.2%) reported that they had a mosquito net in their household (N=338). Among those reporting at least one bed net in their household, 85.4% reported sleeping under a net the night prior to survey (N=198), with no differences between men and women. When asked what they do when they suspect they have malaria, 94.5% responded that they go to a health center (N=329).

4.2.12 Access to Services

Respondents were asked about receipt of a number of services, and whether they (still) needed these services. Data are presented in **Table 17** below.

Table 17: Clients who have received and who need services

	Ever received?			*If ever received*, received in last 6 months?				Needed?		
				A[14]		*B*[15]				
	n	% N	N	Y	% n	n	% N	n	%N	N
HIV testing and counseling	334	98.5%	339	183	56%	327	54%	242	82%	295
Females	226	98.7%	229	123	55.4%	222	53.7%	166	83.8%	198
Males	97	98%	99	54	56.8%	95	54.5%	67	77%	87
HIV treatment medication	298	87.9%	339	231	78.6%	294	68.1%	254	86.1%	295
Females	202	88.2%	229	151	75.5%	200	65.9%	170	86.3%	197
Males	88	88.9%	99	73	84.9%	86	73.7%	76	86.4%	88
HIV treatment medication adherence counseling	306	90.3%	338	224	74.2%	302	66.3%	251	85.1%	295
Females	208	90.8%	229	147	71.4%	206	64.2%	167	84.3%	198
Males	89	89.9%	99	69	79.3%	87	69.7%	76	86.4%	88
Pain assessment	230	68%	338	147	64.8%	227	43.5%	228	77%	296
Females	162	71.1%	228	97	60.6%	160	42.5%	151	76.6%	197
Males	63	63.6%	99	46	74.2%	62	46.5%	69	76.7%	90
Pain medication	235	69.5%	338	159	68.2%	233	47%	220	75.9%	290
Females	158	69.3%	228	101	64.3%	157	44.3%	144	74.6%	193
Males	69	69.7%	99	51	75%	68	51.5%	69	78.4%	88
Treatment for nausea / vomiting	133	39.6%	336	66	51.6%	128	19.6%	179	57.7%	310
Females	96	42.3%	226	47	50.5%	93	20.8%	116	56%	207

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[14] %ages in this column reflect respondents who responded affirmatively. The denominator used excludes those who responded “I don’t know” or did not provide a response.

[15] %ages in this column reflect respondents who responded affirmatively. The denominator used includes all respondents who ever received services. This column makes the assumption that those who responded “I don’t know” or did provide a response did not receive any services in the last six months, and therefore may provide a more accurate estimate of%age of respondents who received services in the last six months.

Males	32	32.3%	99	16	53.3%	30	16.2%	58	62.4%	93
Treatment for skin rash / itching	147	43.8%	336	66	46.2%	143	19.6%	176	56.1%	314
Females	103	45.4%	227	43	42.6%	101	18.9%	113	53.6%	211
Males	40	40.8%	98	20	52.6%	38	20.4%	57	61.3%	93
Treatment of diarrhea	210	62.9%	334	110	54.2%	203	32.9%	175	58.7%	298
Females	143	63.8%	224	73	52.5%	139	32.6%	115	58.4%	197
Males	61	61.6%	99	34	57.6%	59	34.3%	55	60.4%	91
Treatment of sores, bumps or ulcers in mouth, genitals	128	38%	337	62	50%	124	18.4%	172	55.3%	311
Females	97*	42.7%	227	46	48.9%	94	20.3%	113	54.6%	207
Males	29*	29.3%	99	15	53.6%	28	15.2%	56	59.6%	94
Treatment for malaria	307	90.6%	339	196	65.6%	299	57.8%	209	72.3%	289
Females	212	92.6%	229	129	62%	208	56.3%	140	72.5%	193
Males	85	85.9%	99	58	70.7%	82	58.6%	64	73.6%	87
Testing for TB	193	57.4%	336	80	42.6%	188	23.8%	188	61.6%	305
Females	130	57.3%	227	53	41.4%	128	23.3%	127	61.4%	207
Males	60	61.2%	98	25	43.9%	57	25.5%	57	64.8%	88
Treatment of TB	158	46.7%	338	67	43.5%	154	19.8%	139	45.1%	308
Females	107	46.9%	228	43	41%	105	18.9%	97	46.2%	210
Males	48	48.5%	99	22	47.8%	46	22.2%	40	45.5%	88
Adherence counseling for TB medication	159	48.5%	328	69	44.5%	155	21%	148	49.2%	301
Females	105	47.7%	220	45	43.7%	103	20.5%	103	50.7%	203
Males	50	51.5%	97	21	43.8%	48	21.6%	43	48.9%	88
Nutritional advice	288	85.7%	336	169	60.1%	281	50.3%	268	90.2%	297
Females	197*	86.8%	227	112	58.3%	192	49.3%	182	92.4%	197
Males	84*	84.8%	99	53	64.6%	82	53.5%	76	84.4%	90
Food or vitamins	242	72.2%	335	143	60.1%	238	42.7%	268	89.3%	300
Females	171	75.7%	226	94*	55.6%	169	41.6%	177	89.4%	198
Males	66	66.7%	99	45*	70.3%	64	45.5%	81	88%	92
Bed net to protect against mosquitos	240	71.6%	335	89	37.9%	235	55.2%	271	89.1%	304
Females	170	75.2%	226	60	35.9%	167	26.5%	183	89.7%	204
Males	65	65.7%	99	27	42.9%	63	27.3%	79	87.8%	90
Physiotherapy	90	26.9%	331	33	37.9%	87	10%	222	68.9%	322
Females	63	27.9%	226	20	33.3%	60	8.8%	153	70.2%	218
Males	25	25.3%	99	12	48%	25	12.1%	62	66%	94
Treatment for anxiety or depression	98	29.6%	331	39	43.3%	90	11.8%	200	64.9%	308
Females	74*	33.2%	223	28	41.8%	67	12.6%	138	67%	206
Males	22*	22.4%	98	10	n/a	21	10.2%	55	59.8%	92
Referral to a support group for PLHIV or their families	238	70.8%	336	126	54.1%	233	37.5%	243	81.5%	298
Females	163	71.8%	227	86	53.8%	160	37.9%	159	80.3%	198
Males	69	69.7%	99	35	52.2%	67	35.4%	75	83.3%	90

Birth spacing or FP advice	244	72.6%	336	107	45.1%	237	31.8%	177	59%	300
Females	170	74.9%	227	74	44.8%	165	32.6%	116	58%	200
Males	67	67.7%	99	29	44.6%	65	29.3%	56	61.5%	91
Long-term contraceptives: pills, injectables	187	55.7%	336	83	45.9%	181	24.7%	166	54.4%	305
Females	139*	61.2%	227	56	41.5%	135	24.7%	114	56.4%	202
Males	43*	43.4%	99	24	58.5%	41	24.2%	47	50%	94
Condoms	280	83.3%	336	176	64.5%	273	52.4%	214	71.8%	298
Females	183*	80.6%	227	105*	58.7%	179	46.3%	132**	66%	200
Males	89*	89.9%	99	64*	74.4%	86	64.6%	74**	83.1%	89
Information on how to prevent HIV transmission	325	98.2%	331	214	67.9%	315	64.6%	250	88.3%	283
Females	219	98.6%	222	142	67%	212	64%	165	88.2%	187
Males	96	97%	99	64	68.8%	93	64.6%	76	87.4%	87
Information on preventing infection with new strain of HIV	286	85.6%	334	180	65.5%	275	53.9%	254	88.8%	286
Females	193	85.8%	225	117	63.6%	184	52%	167	87.9%	190
Males	85	85.9%	99	56	67.5%	83	56.6%	79	89.8%	88
Free legal services	56	16.7%	335	21	37.5%	56	6.3%	235	72.5%	324
Females	38	16.8%	226	14	36.8%	38	6.2%	155	71.4%	217
Males	18	18.2%	99	7	n/a	18	7.1%	73	75.3%	97
Small loan from a community organization	54	16.2%	334	11	20.8%	53	3.3%	283	87.1%	325
Females	41	18.2%	225	11*	27.5%	40	4.9%	191	87.6%	218
Males	13	13.1%	99	0*	n/a	13	0	83	85.6%	97

*p≤0.05, **p=0.003

Irrespective of need, reported (ever) receipt of services in the following areas was over 75%: HIV counseling and testing, HIV treatment, HIV treatment adherence counseling, malaria treatment, nutritional advice, condoms, information about how to prevent HIV infection, and information on how to prevent infection with a new strain of HIV[16]. More than half but less than 75% of respondents also reported ever receiving the following: testing for TB, treatment for diarrhea, pain assessment and pain mediation, food or vitamins, bed nets, referral to a support group for PLHIV and their families, birth spacing or family planning advice, and long-term contraceptives. Less than half but more than a quarter of respondents reported ever receiving the following: treatment for depression or anxiety, physiotherapy, adherence counseling for TB medication, TB treatment, treatment of sores, bumps or ulcers in the mouth or genitals, and treatment for a skin rash or itching. Ever receipt of the following services was below 25%: free legal services, a small loan from a community organization. There were few differences between men and women. Men were more likely to report having received condoms (and to report needing condoms), and women were more likely to report having ever received long-term contraceptives. Women were more likely to report having ever received treatment for depression or anxiety.

Respondents were asked if any of their household members had received services. Findings are summarized in **Table 18** below.

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[16] With respect to services "needed," it is surprising how many HBC beneficiaries reported that they needed HIV counseling and testing. This may indicate a problem with the questionnaire. Uniformly, reported need was higher than reported receipt of services, possibly indicating unmet need.

Table 18: Proportion of household members of clients who have received, and who need services

	Ever received?			*If ever received*, received in last 6 months?				Needed?		
	n	% N	N	Y	% n	n	% N	Yes	%N	N
HIV testing and counseling	194	58.1%	335	111	59%	188	33.1%	221	74.2%	298
HIV treatment medication	125	37.5%	333	88	72.1%	122	26.4%	157	51.5%	305
HIV treatment medication adherence counseling	130	39.3%	331	92	72.4%	127	27.8%	160	52.6%	304
Pain assessment	104	31.3%	332	57	56.4%	101	17.2%	162	53.8%	301
Pain medication	116	35%	331	76	68.5%	111	23%	162	54.5%	297
Treatment for nausea / vomiting	61	18.5%	329	31	52.5%	59	9.4%	146	46.6%	313
Treatment for skin rash / itching	65	19.6%	332	30	48.4%	62	9%	138	44.1%	313
Treatment of diarrhea	111	33.9%	327	73	67%	109	22.3%	141	47.2%	299
Treatment of sores, bumps or ulcers in mouth or genitals	68	20.7%	328	35	53.8%	65	10.7%	139	44.7%	311
Treatment for malaria	207	62.3%	332	143	71.1%	201	43.1%	191	64.7%	295
Testing for TB	93	28.1%	331	44	48.4%	91	13.3%	146	46.9%	311
Treatment of TB	69	20.9%	330	30	44.8%	67	9.1%	119	37.8%	315
Nutritional advice	144	44%	327	87	62.1%	140	26.6%	216	73%	296
Food or vitamin supplements	114	35%	326	66	59.5%	111	20.2%	233	75.9%	307
Bed net to protect against mosquitos	112	34.3%	327	52	48.1%	108	15.9%	253	82.1%	308
Physiotherapy	40	12.5%	319	19	47.5%	40	6%	161	50.9%	316
Treatment for anxiety or depression	49	15.4%	318	23	46.9%	49	7.2%	151	48.7%	310
Referral to a support group for PLHIV or their families	74	22.8%	324	41	56.2%	73	12.7%	166	53.4%	311
Birth spacing or family planning advice	127	38.8%	327	78	61.9%	126	23.9%	181	59.3%	305
Long-term contraceptives such as pills or injectable contraceptives	112	34.3%	327	69	62.7%	110	21.1%	176	57%	309
Condoms	168	51.5%	326	120	73.2%	165	36.8%	206	68.2%	302
Information on how to prevent HIV transmission	195	60.9%	320	140	72.2%	194	43.8%	222	77.1%	288
Information on how to prevent infection with a new strain HIV	146	45.2%	323	93	66%	141	28.8%	209	71.8%	291
Free legal services	31	9.6%	324	11	37.9%	29	3.4%	203	63.4%	320
Small loan from a community organization (not an individual)	27	8.3%	324	6	23.1%	26	1.9%	248	77.5%	320

Irrespective of need, more than half of family members reported that at least one household member had ever received HIV counseling and testing, treatment for malaria, condoms, and information on how to prevent HIV transmission (with or without program support). Approximately one-third of all respondents reported that at least one household member had ever received the following services: HIV treatment, HIV treatment adherence counseling, pain assessment, pain medication, diarrhea treatment, nutritional advice, food or vitamin supplements, a bed net, birth spacing or family planning advice, long-term contraceptives, and information on how to prevent infection with a new strain of HIV (with or without program support). Less than one in three respondents reported that a household member had received any of the following services: treatment for nausea/vomiting, treatment for skin rash/itching, treatment for sores, bumps or ulcers on the mouth or genitals, testing for TB, treatment for TB, physiotherapy, treatment for depression or anxiety, referral to a support group for PLHIV and their families. Less than one in ten respondents reported that a household member had ever received free legal services and a small loan from a community organization.

Overall there appears to be high demand among household members across service areas, i.e., the proportion needing a service is higher than the proportion reporting receipt of services. Of note are the discrepancies in receipt of services and need in key service areas such as HIV counseling and testing and HIV treatment. The gap could represent additional household members that have not had access to services or could represent a lack of understanding of the service by the respondent, poor questionnaire design, or a combination.

4.3 Community Caregivers

4.3.1 Demographics

A total of 406 community caregivers were interviewed.

Sixty% of respondents were female (60.7%, N=392). The mean age of community caregivers surveyed was 45.1 years (median=44, range=22 to 80, N=401). The majority of caregivers surveyed reported that they had attended school at some point (99.3%, N=405), with no differences between men and women. One-third of caregivers who attended school reported completing secondary school (34.4%), one-third reported completing junior secondary school (32.7%), 27.9% reported completing primary school, and 3.9% reported completing university or vocational training (N=401).

Two-thirds of caregivers surveyed reported being married (68.6%), 7.7% reported being single, 7.2% reported being divorced or separated, and 16.6% reporting being widowed (N=404). The majority of caregivers surveyed reporting having children of their own (98%, N=402). More than half of caregivers indicated that they had more than three biological children (55.2%), and 30.1% reported having one or two biological children (N=402). Nearly 80% of caregivers surveyed reported that they had three or more children under 18 years old living with them (78.4%, N=403). Only 4.7% of caregivers surveyed reporting having no dependents younger than 18 years in their household.

Caregivers were asked their monthly income, which was coded in ranges (making mean and median income difficult to calculate). Less than one% of caregivers reported no income at all (0.8%); one-quarter (25.3%) reported a monthly income between 5000 to 99,999 Kwacha; 17.3% reported a monthly income between 100,000 to 149,000 Kwacha; 8.5% reported a monthly income between 150,000 to 199,999 Kwacha; 14.5% reported a monthly income between 200,000 to 299,000 Kwacha; 14% reported a monthly income between 300,000 to 499,000 Kwacha; 13.8% reported a monthly income between 500,000 to 1,000,000 Kwacha, and 5.8% reported a monthly income over one million Kwacha (N=399).

4.3.2 Community Caregiver Role

Role

A majority of caregivers surveyed reported that they have been community caregivers for more than one year, with no differences between men and women (93.8% N=403). Ninety-nine% of respondents reported that they were aware of their job roles and responsibilities as caregivers (N=401), with no differences between men and women or length of time spent working as a community caregiver.

Home visiting

Over half of respondents reported visiting 10 or more households in their community caregiver role (51.1%), 15.9% of respondents reported visiting between seven and nine households, 24.3% reported visiting between four and six households, and 8.7% reported visiting between one and three households (N=403). The mean number of households visited was 12.5 (median=10).

Caregivers were asked how often they visited their clients. Nearly half of caregivers surveyed reported that they visited their clients weekly (47.3%), 27.4% reported visiting clients monthly, and 15.9% reported visiting clients more than once per week (N=402). There was no relationship among frequency of visits, sex and length of time working as a community caregiver. However, awareness of job role and responsibilities was correlated to reported frequency of household visits (p=0.000).

Caregivers were asked how many different households they visited in an average week. Overall, 38.8% of caregivers sampled indicated that they visited five or more different client households in an average week, with 30.8% and 29.6% indicating that they visited three to four different households and one to two different households, respectively, and less than one% reporting that they visit no households in an average week (range: 0-30, N=399).

Caregivers were asked how many different households they visited in the week prior to survey. Overall, 28.7% of caregivers sampled reported visiting five or more different client households the week prior to survey, with 27.7% and 33.2% indicating that they visited three to four different households, and one to two different households, respectively, and 10.5% reporting that they did not visit any household the week prior to survey (range: 0-30, N=401).

The majority of caregivers surveyed (84.6%) reported that they travel between client households on foot, with 15.1% reporting traveling by bicycle (N=390). Men were far more likely to report traveling by bicycle than women (24.2% vs. 9.3%, p=0.000). Overall, 40.2% of caregivers surveyed reported owning a bicycle (N=403). More men reported owning a bicycle than women (46.4% vs. 35.4%, p=0.031).

Caregivers were asked about the number of hours they spent visiting their clients each week. The majority of the respondents (43.6%) reported spending one to three hours per week visiting their clients; 26.4% reported spending three to six hours per week visiting clients; 11.5% reported spending six to 10 hours per week visiting their clients; and 5% of respondents reported spending more than 10 hours per week visiting clients (N=401). Over 13% (13.5%) reported spending less than one hour per week visiting clients.

Caregivers were asked if they had their clients' phone numbers and if they communicated with some of their clients by phone. Only 16.2% reported that they communicated by phone (N=402). Of these, 7.2% said that they had all of their clients' numbers, and 87% said that they had some of their clients' numbers (N=65).

4.3.3 Services Provided and Training

Caregivers were asked whether they provided a range of health services to their clients. They were also asked whether they had received training to provide these services, whether such training was received in the six months prior to survey, and if they felt that they needed training in any of these service areas. Results are presented in **Table 19** below.

Table 19: Services provided by Community Caregivers

Service	Provide service	Ever received training		Received training (among those providing service)		Received training in last 6 months		Need training	
	N=403	%	N	%	N	%	N	%	N
Child health assessments	72.7%	56.9%	398	73.6%	292	23.5%	226	98.4%	387
Child nutritional assessments (MUAC)	49.1%	37.7%	382	67.9%	196	26.1%	142	97.9%	388
Psychosocial counseling for children	74.1%	59.5%	398	77.3%	299	26.3%	232	97.4%	385
Child protection monitoring	75.4%	52.4%	395	68.3%	300	22.8%	202	97.4%	385
Household HIV counseling and testing	30.8%	32.7%	394	80.6%	124	25.4%	126	98.2%	389
HIV post-exposure prophylaxis	30%	23.5%	391	66.9%	121	22.2%	90	99.5%	397
Health assessments for PLHIV	74.3%	58.3%	396	75.5%	298	23.5%	221	97.2%	387
HIV treatment adherence counseling	62.7%	55.7%	397	83%	253	25.8%	213	96.7%	391
Pain assessment for PLHIV	61.2%	47.8%	391	73.1%	242	21%	181	98.2%	389
Psychosocial counseling for adults	65.8%	52.6%	392	76.2%	261	20.9%	196	97.9%	390
Nutritional assessments for PLHIV	68.1%	53.1%	399	72.8%	276	26%	204	96.9%	391

The types of services provided by caregivers varied (but not by caregiver sex). Three-quarters of caregivers reported providing child health assessments and psycho-social counseling for children, but less than one-third reported providing household HIV counseling and testing and HIV post-exposure prophylaxis (referral). In all cases, caregivers reporting providing a service were more likely to report having received training in that service area (p=0.000). Still, significant training gaps appear, with up to one-third of caregivers providing services not having received training to provide that service. On average, one-quarter of caregivers reporting ever having received training in a particular service area, reported receiving training in the six months prior to survey (at STEPS OVC start-up). An overwhelming majority of caregivers reported needing training in all service areas, regardless of whether or not they had received training in the last six months.

Caregivers were also asked whether they provided information in a number of areas; results are presented in **Table 20** below.

Table 20: Information provided by Community Caregivers

Information area	Provide information	Ever received training		Received training (among those providing information)		Received training in last 6 months		Need training	
	N=399	%	N	%	N	%	N	%	N
HIV counseling and testing	71.2%	57.7%	397	78.1%	283	23.5%	221	96.6%	384
ART drug interactions	57.8%	44.5%	389	71.7%	230	19.4%	170	99%	386
Opportunistic infections	67.2%	53.4%	393	75.5%	269	23.3%	206	97.9%	386
Prevention of TB and early warning signs	70.6%	53.1%	390	72.6%	281	19.4%	201	96.3%	380
PMTCT	73.2%	56.9%	383	73.2%	287	28.8%	212	97.3%	377
HIV post-exposure prophylaxis	41.2%	30.9%	385	67.5%	163	25.9%	112	98.2%	389
Injection safety	53.2%	41.2%	379	71.7%	212	28.4%	155	97.2%	386
Sexual prevention of HIV	91.2%	70%	390	75.7%	358	30.4%	263	94.9%	372
Prevention with positives	80.1%	64.8%	392	77.7%	319	24.4%	246	96.8%	379
STIs	87.3%*	68%	394	76.6%	346	24.5%	257	96.3%	380
Child nutrition	78.7%*	61.2%	389	75.6%	308	23.2%	228	96.3%	375
Nutrition for PLHIV	78.4%	59.7%	395	74%	312	25.2%	230	97.1%	382
Child immunizations	65.2%	44.2%	391	66.7%	258	25.1%	167	98.7%	382
Malaria prevention and control	85%	62.8%	395	72%	336	27.3%	242	97.1%	379
Birth spacing and family planning	70.8%	48.8%	389	64.5%	279	29.9%	187	97.4%	384

*Males were slightly more likely than females to report providing information on STIs to clients (91.4% vs. 84.4%, p=0.042); females were slightly more likely than males to report providing information on child nutrition to clients (83.5% vs. 71.5%, p=0.005)

The types of information provided by caregivers varied. Nearly all caregivers reported providing information on sexual prevention of HIV (91.2%); on the other hand, only 41.2% reported providing information on HIV post-exposure prophylaxis to clients. Generally, between two-thirds and three-quarters of all those providing information had received training in this area previously. Caregivers reporting providing information in a given area were more likely to report having received training in that service area (p=0.000). Approximately one-quarter of all those who reported previous training, reported training in the six months prior to survey. Still, significant training gaps appear, especially around child immunizations, birth spacing/family planning, and HIV post-exposure prophylaxis. Nearly all caregivers surveyed reported needing training in all information areas, regardless of whether or not they had received training in the last six months.

Caregivers were asked whether they had received training specifically on how to monitor a client's progress. Half of caregivers surveyed reported that they had received training in client monitoring (48.6%, N=403), with no differences between men and women. Nearly three-quarters of caregivers indicated that they had received this training more than a year prior to survey (as expected due to the start-up of STEPS OVC) (72.5%, N=192). Nearly ten% (9.8%) reported receiving training in the three months prior to survey, and a further 17.1% reported receiving training three to 12 months prior to survey.

Caregivers were asked whether they had ever heard of the Child Status Index (CSI). One in five caregivers had heard of the CSI (21.1%, N=389), with no difference between men and women. Caregivers who reported receiving training on monitoring clients' progress were nearly twice as likely to report having heard of the CSI (26.7% vs. 16%, p=0.009). Nearly half of those reporting having heard of the CSI had received training in using the CSI (43%, N=86), with no difference between men and women. A majority of those who had heard of the CSI wished for more training (regardless of previous training) (95.2%, N=83).

A majority of caregivers reported that they use the information they gather during household visits to make caregiving decisions (82.7%, N=388), with no difference between men and women.

4.3.4 Confidence in Role as Caregiver

The vast majority of community caregivers (94.9%, N=395) reported that they were comfortable discussing sexual prevention of HIV with adult beneficiaries, with no difference between men and women, caregivers with different education levels or marital status. A similarly high proportion of community caregivers (93.5%, N=397) reported that they were comfortable discussing sexual prevention of HIV with beneficiaries under 18 years old, with no difference between men and women, caregivers with different education levels, or marital status.

Most community caregivers (92.7%, N=386) also reported comfort in discussing birth spacing and family planning with beneficiaries. Interestingly, men community caregivers were slightly more likely to report comfort in discussing birth spacing and family planning than women caregivers (94.6% vs. 91.1%, p=0.045). Widowers, married, and divorced caregivers were slightly more comfortable discussing birth spacing and family planning than single caregivers (95.1%, 92.5%, 100% vs. 83.3%, p=0.007). There were no differences among caregivers with different education levels.

Four-fifths of caregivers (81.9%) reported that they felt equipped to support clients in adhering to their HIV treatment (N=393). Men were more likely than women to report feeling equipped for adherence support (86.6% vs. 78.3%, p=0.000). There were no differences among caregivers with different educational attainments.

A majority of caregivers (92.8%) reported that they knew where to refer a client living with HIV for medication (N=389). Men caregivers were slightly more likely to report comfort in referring a client for medication than women (95.3% vs. 91.2%, p=0.022). There were no differences by educational status.

Nearly 85% (84.4%) of community caregivers reported that they felt comfortable supporting clients and their families prepare for death (N=391). Women were more likely to report feeling comfortable in supporting clients in this way compared to men (84.8% vs. 62.8%, p=0.016). There were no differences among caregivers by educational status.

4.3.5 HIV and AIDS Knowledge

More than four-fifths community caregivers (82.5%) reported ever having had an HIV test (N=400), with no difference between men and women or educational attainment. Ninety-nine% of those reporting a prior HIV test received the results of their test.

Respondents were asked a series of true / false questions regarding HIV and AIDS. A majority of respondents (88.5%) correctly responded that a person cannot get HIV from mosquito bites (N=400). Two-thirds of respondents (67.4%) responded correctly that HIV cannot be transmitted by kissing (N=399). A majority (93%) reported that people can protect themselves from HIV by abstaining from sexual intercourse (N=399). A similar proportion (91.8%) responded correctly that a person can protect themselves from HIV by using a condom correctly every time they have vaginal sex (N=400). Three-quarters of caregivers (77.4%) responded correctly that a person can protect themselves from HIV by using a condom correctly every time they have anal sex (N=399), with males more likely than females to agree (82.2% vs. 74%, p=0.006). Fewer than nine in ten respondents (88.9%) agreed that a person can protect themselves from HIV by using a female condom correctly every time they have sex (N=398).

The majority of respondents understood correctly that a person cannot acquire HIV by sharing a meal with someone that is HIV-positive (96.2%, N=397). A similarly high proportion (98%) responded that a person can acquire HIV through an injection with a needle already used by someone who is HIV-positive (N=399). Ninety% of caregivers (90.2%) responded correctly that a pregnant woman with HIV and AIDS can transmit HIV to her unborn child during childbirth, and slightly higher proportion (93%)

understood that a woman who has HIV and AIDS can transmit HIV to her child while breastfeeding (N=398). Over ninety% (90.2%) of caregivers agreed that HIV cannot be transmitted through witchcraft (N=399).

Almost all respondents (97%) responded correctly that a healthy-looking person may be HIV-positive (N=397). Ninety-five% of caregivers responded correctly that herbs cannot cure HIV (N=398). Only 85.5% of caregivers agreed that there was a difference between HIV infection and AIDS (N=393), and only 46.1% of caregivers understood correctly that not all people living with HIV need to be on anti-retroviral treatment (N=395).

Community caregivers were asked when they thought that people living with HIV were most infective. One-third said “always” (32.7%), one-third said when they have AIDS (34.3%), 18.9% said when someone is first infected, and the rest suggested another time (N=397). Caregivers were asked when they thought people living with HIV should start ART. One in five (19.8%) said “immediately following infection,” 6.5% said “when they get sick or get AIDS,” 45.5% said “when their CD4 count drops below 350 cells/mm^3, and 27.3% said that it depends on CD4 count and disease progression (N=400).

Community caregivers were asked to name as many minor side effects of ART as they could. One-third (33.1%) said nausea/vomiting, 5.5% said insomnia, 25.6% said loss of appetite, 36.6% said headache, 12.5% said dry mouth, 39.6% said diarrhea, 12% said hair loss, 16.5% said tingling in hands or feet, 6.3% said short-terms sadness or worry, and 48.6% reported other side effects including skin rashes, cough, dizziness, fever, nightmares and swelling of limbs (N=399). Community caregivers were asked to name as many major side effects of ART as possible. One-third (37.8%) said persistent diarrhea, 13.5% said blurry vision, 12.5% said spots on the tongue, 6.3% said trouble swallowing, 40.9% said skin infections, 8.5% said blood in stool, 14% said persistent and worsening fatigue, 23.6% said swollen feet, 22.6% said persistent dizziness, 12.8% said sudden difficulty walking due to pain, 15.5% said vomiting blood, 8.3% said persistent insomnia, 10.8% said inability to eat / malnutrition, 9.5% said depression or persistent anxiety, and 26.6% of caregivers reported other major side effects including persistent cough (N=399). Of note, a large number of caregivers mistakenly noted malaria or persistent malaria, as well as symptoms of sexually transmitted infections as major or minor side effects of ART.

When asked why it is important for clients to take their HIV medications on strict schedule, 44.7% said to avoid drug resistance, and 48.7% said that ART is only effective if taken on schedule, as prescribed (N=394). Of these, 10.9% replied that adherence is important to both avoid drug resistance and to ensure effectiveness.

4.3.6 Attitudes and Values

As expected, community caregivers generally had very accepting attitudes towards people living with HIV and AIDS. The vast majority of caregivers reported a belief that if a pupil has HIV and is not sick, they should be allowed to continue attending school (96.7%, N=398). Similarly, 97% of caregivers reported a belief that if a teacher has HIV and is not sick, they should be allowed to continue teaching (N=398). Just over one-quarter of caregivers (29.6%) reported a belief that people living in households where one or more household members is living with HIV, are treated unkindly by the community, and that households who receive free services are treated unkindly by community (25.1%, N=398). There were no differences between men and women among attitude variables.

Nine in ten community caregivers (90.7%) reported a belief that children ages 15 to 18 should be taught how to use condoms correctly to protect themselves from HIV. Only 58% of community caregivers reported a belief that children aged 10-14 should be taught to use condoms correctly N=398). There were no differences between male and female caregivers.

4.3.7 Referrals

Findings on referrals of clients and household members of clients are presented in **Table 21**. For nearly all issues, reported knowledge of where to refer clients was high. More than nine in 10 respondents reported knowledge of where to refer clients for HIV testing, ART, PMTCT, STI treatment, TB testing or treatment, family planning, condoms, and spiritual/pastoral care. (Just less than 90% of respondents reported referral knowledge for IPT for pregnant women and long lasting insecticide nets (LLINs).) Fewer than 50% of respondents knew where to refer clients for livelihood support, vocational training, and Kids’ Clubs. (Only half of respondents reported referral knowledge for legal aid.)

Reported referral rates for clients were surprisingly high among caregivers who reported referral knowledge. More than half of caregivers with referral knowledge reported referring clients for HIV testing, ART, psychosocial counseling, PLHIV support groups, LLINs, family planning, condoms, and spiritual/pastoral care in the last six months.

Reported referral rates for household members of clients were also high. More than one-third of caregivers with referral knowledge reported referring household members of clients for HIV testing, IPT (pregnant women), LLINs, indoor residual spraying, Kids' Clubs, youth peer education, women's groups, family planning, condoms, and spiritual/pastoral care in the last six months.

Table 21: Knowledge of referrals and reported referrals of registered clients and household members

	Knows where to refer client			Has referred client in last 6 months				Has referred household member in last 6 months			
	n	% N	N	Y	% n	n	% N	Y	% n	n	% N
HIV testing	383	96%	399	197	51.7%	381	49.4%	145	38.6%	376	36.3%
ART	371	93%	399	193	52.7%	366	48.4%	110	30.4%	362	27.6%
PMTCT	362	90.7%	399	143	40.3%	355	35.8%	99	27.9%	355	24.8%
Treatment of OIs	343	86.2%	398	137	40.7%	337	34.4%	89	26.7%	333	22.4%
STI treatment	368	92.5%	398	144	39.7%	363	36.2%	98	27.3%	359	24.6%
Post-rape care	295	74.5%	396	63	21.6%	292	15.9%	41	14.2%	289	10.4%
PEP	250	63.3%	395	48	19.4%	248	12.2%	26	10.6%	246	6.6%
Psychosocial counseling	347	87.4%	397	177	51.8%	342	44.6%	103	30.4%	339	25.9%
TB testing or treatment	361	90.7%	398	161	45.2%	356	40.5%	93	26.4%	352	23.4%
Nutritional support/feeding	309	77.8%	397	133	44%	302	33.5%	86	28.6%	301	21.7%
Livelihood support, e.g., cash transfer	189	48.3%	391	59	31.6%	187	15.1%	40	21.2%	189	10.2%
Vocational training	181	45.6%	397	55	30.4%	181	13.9%	38	21.2%	179	9.6%
Legal aid, e.g., will writing	206	52.2%	395	44	21.4%	206	11.1%	40	19.5%	205	10.1%
Support group for PLHIV and families	335	84.2%	398	170	51.2%	332	42.7%	102	31.2%	327	25.6%
Immunizations	345	86.7%	398	162	47.4%	342	40.7%	110	32.3%	341	27.6%
IPT for pregnant women	355	89.6%	396	164	46.7%	351	41.4%	117	33.4%	350	29.5%
LLINs	357	89.9%	397	185	52.6%	352	46.6%	129	36.9%	350	32.5%
Indoor residual spraying	317	79.6%	398	137	43.5%	315	34.4%	105	33.8%	311	26.4%
Kids' Club	145	36.5%	397	63	43.2%	146	15.9%	51	35.2%	145	12.8%
Youth peer education	260	66.2%	393	118	45.4%	260	30%	93	36%	258	23.7%
Women's group	288	72.7%	396	136	47.9%	284	34.3%	95	34.1%	279	24%
Family planning	371	93.7%	396	189	51.4%	368	47.7%	142	39%	364	35.9%
Condoms	380	95.7%	397	249	65.9%	378	62.7%	194	51.7%	375	48.9%
Spiritual/pastoral care	358	91.3%	392	207	57.8%	358	52.8%	153	43.3%	353	39%
Child abuse	339	86.3%	393	100	29.8%	336	25.4%	69	20.6%	335	17.6%
Gender-based violence	322	81.9%	393	88	27.4%	321	22.4%	69	21.6%	319	17.6%

4.3.8 Caregiver Well-being

All caregivers were asked whether they could handle all of their caregiving responsibilities comfortably in the time they had. The vast majority (92.3%) of respondents strongly agreed that they were able to handle their responsibilities in the available time (N=396), with no difference between men and women.

Just over half (56.6%) of community caregivers surveyed reported that they felt adequately supported to carry out their job responsibilities (N=387), with no difference between men and women.

Nearly all (96.7%) community caregivers surveyed agreed or strongly agreed that even with their caregiving responsibilities, they still had adequate time for themselves (N=396), with no difference between men and women.

All but one respondent reported enjoying their caregiving responsibilities (N=397), and all but four respondents agreed that they were good at their job as community caregiver (N=388).

4.3.9 Information Technology

Caregivers were asked whether they owned a functioning mobile phone. Overall, 67.4% of caregivers owned a functional mobile phone (N=392), with no difference between men and women.

The majority of caregivers reported that they did not know how to use a computer (89.6%, N=393), with no difference between men and women. Caregivers reporting more years of schooling were more likely to report knowing how to use a computer (p=0.000). Eighteen caregivers reporting knowing how to use Excel.

4.4 Key informant interviews

Data were collected from 17 key informants. Respondent identities are kept anonymous. Due to the limited demographic range of respondents, comparison of results across key demographics was factored into interpretations where possible, but is limited.

Table 22: Distribution of Key Informant Respondents

	Western	Northern	North-western	Central	Unknown
Government	1	5	2	2	1
Non-Government	1	2	1	1	1

Interview findings convey best practices and lessons learned from previous OVC/HIV programs – RAPIDS and SUCCESS – two programs that STEPS OVC builds from. Respondents also provided their perspectives on current strengths and weaknesses of STEPS OVC. Interviewees were also asked about sustainability and the transition of STEPS to local ownership.

4.4.1 Best Practices and Lessons Learned in OVC Programs

Respondents were asked about their knowledge of previous OVC/HIV programs, namely RAPIDS[17] and SUCCESS[18], implemented by a consortium led by World Vision Zambia and Catholic Relief Services respectively as illustrated in the figure below. Those respondents familiar with either or both programs were asked a series of questions about the programs' successes and weaknesses.

4.4.1.1 Human Resources

Respondents felt one of the lasting and valuable marks of previous OVC programs was caregiver mobilization and training (n=5). When describing a previous program's success, two respondents

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[17] Reaching HIV and AIDS Affected People with Integrated Development and Support (RAPIDS) program was a $57 million program from 2004-2010. RAPIDS had four main goals: improving the quality of life for OVC as well as their households; improving the quality of life for PLHIV; improving the livelihoods of vulnerable youth; and strengthening the resilience of households made vulnerable by HIV and AIDS. RAPIDS was present in all nine Zambian provinces and in 52 of the 72 districts and reached 258,812 OVC.

[18] Scaling Up Community Care to Enhance Social Safety Nets (SUCCESS) provided high-quality care to chronically ill people through home-based care providers and hospices. Under this model, skilled nurses took key leadership roles to help implement projects, working with a force of trained local volunteer caregivers. SUCCESS focused on rural provinces where demand outpaces available health services.

provided examples of effective caregiving by describing how caregivers continued to work after the program closed out. One respondent said:

> *"The example of capacity building of caregivers, to me that was a success and they were able to efficiently provide the service that was needed in a community."*

Another respondent supported this by saying:

> *"I think knowledge transfer, and even personal attitude, because despite that the program phased out, the caregivers that we had continued rendering their skills, very well rendered."*

However, one respondent explicitly expressed the opposite opinion, saying that one of the main challenges from previous programs was "[Lack of] capacity in terms of the technical skills [among staff]."

Several respondents (n=6) also commented about human resource incentive structures. General concern for lack of incentives/compensation for both caregivers and government staff was apparent across respondents.

> *"If they have volunteers, they should not be calling them volunteers but they should be people that can be motivated in monitoring their programs, and they do not pay them the way they are supposed to be paid. So I would think that if they need to succeed in terms of volunteering, then they should improve the way they treat them."*
>
> *"[One challenge is] apathy with government staff and the issue of allowances…[there are] no provisions for allowances for government staff as projects partner with the government."*

However, one non-government respondent contributed that a previous incentive program, where community caregivers received gifts in kind, yielded high retention rates:

> *"[The program] would be able to provide…meaningful incentives that came to the caregivers on the project, so we didn't experience much of drop out in terms of caregivers."*

Additionally, multiple respondents expressed concern that providing allowances to government staff leads to an unmotivated and competitive culture in which staff favor events hosted by donors that provide higher allowances.

> *"Government officers are accustomed to allowances to attend workshops or facilitate. It becomes difficult, then: when allowances are not available, government officers don't attend. Similarly, rates of donors are different, so government officers go to the events sponsored by the donor with the highest allowance."*

4.4.1.2 Service Delivery

Multiple respondents (n=4) agreed that previous programs had successfully established a foundational base for STEPS OVC to build off of and expand upon.

> *"[Previous program] activities were well integrated into other programs, for example District AIDS Task Force (DATF). Also well accepted by community due to good public relations."*
>
> *"There are organizations that [STEPS OVC is] able to cooperate with that are already on the ground, already operating, and also there is the willingness: a baseline has already been done."*
>
> *"[Previous program] success is due in part to the program making use of existing structures at the community level."*

Somewhat contrary to this, a few issues were identified as key challenges to service delivery in previous OVC/HIV programs. Various interviewees (n=4) suggested previous programs' erratic support of households contributed to poor service delivery, client dropouts, and mistrust in communities. Dependence on donor funds for services was identified as a confounding factor that contributed to unpredictable service delivery and beneficiary dissatisfaction. One respondent suggested that this had effectively tarnished the reputation of OVC service providers in some communities.

> *"Support was not constant [with previous program]. Sometimes you would pay school fees, then another day, support hasn't come: this resulted in poor reporting [duplication] and drop-outs."*
>
> *"Dependency of support from donors [exists], leading to clients losing confidence in local organizations as they provide erratic service due to bureaucracy."*

There was also concern about the sustainability of previous programs. One respondent described this based on experience with previous programs, saying:

> *"I think the [previous] program last time we were talking about providing caregivers with sustainable solutions, the people were putting up efforts by farming so that they can continue sustaining the program and can overcome its weaknesses. Challenges are those organizations that are providing just short-term solutions: you know we have this meal for OVC given to them for six months, then we created dependency on those people, then after that you leave - what next? "*

Along similar lines, respondents expressed concerns that clients were overly dependent on donors, and a culture of "hand-outs" prevailed in some areas, a result of program approaches that poorly address comprehensive household needs (n=6).

> *"But there are certain organizations where they don't focus on sustainability; they just want to give handouts. For a project that wants to empower people to do things for themselves, and then you have other players within the same community that just want to give handouts"*
>
> *"While food supplement was good I still feel that in its own way it might have provided a lot of dependency in terms of the clients wanting to receive food all time...so now looking back, people still think they will receive food supplement."*
>
> *"They go visiting they had not been able to provide the needs, sustain the people's needs or wants, education requirement for children and I think it is not only STEPS OVC but also other organizations – that component of sustainability is not there."*

4.4.1.3 Infrastructure

Respondents also expressed concern over a lack of supplies, transportation and infrastructure to support previous programs (n=3), resulting in an inability to communicate effectively and difficulty providing services, particularly in hard-to-reach areas.

> *"Under [previous program], the challenges, sometimes there is a shortage of stationery. Then apart from that, communication I think was also a challenge; the issue of internet. You know when you are in an urban area [it's easier], but when you are here [rural areas], you know the headquarters will want reports, but there's no internet."*
>
> *"I think the main challenge is transportation. If STEPS OVC can put something that would be very helpful to community and the district at large."*
>
> *"Challenge of transport to islands (fuel costs more) Kilwa and Chisenga Island which most NGOs do not reach…some areas are too far."*

4.4.2 Strengths and Weaknesses of STEPS OVC

Participants were asked about the strengths, weakness, and opportunities of the STEPS OVC program specifically. Responses mostly focused on the perceived weaknesses of STEPS, although in some cases it is clear that respondents were not speaking solely about STEPS OVC but rather describing a collective representation of past and current OVC/HIV programs.

4.4.2.1 Targeting

Multiple respondents (n=5) expressed concern regarding how clients are currently targeted, resulting in most-in-need populations not receiving services and/or a large degree of existing unmet need among beneficiaries.

> *"I think the problem is target identification...in terms of selecting the actual beneficiaries of the project you find that there is very little or almost no coordination in terms of the selection criteria…each organization will come in, use their own selection criteria, and at the end of the day you find they have selected the same people. So you find that you are leaving out certain key populations."*
>
> *"Some orphans benefitting are not real orphans. Most beneficiaries are not supposed to be on the program. The people that select beneficiaries are not transparent and put in wrong people at expense of deserving ones."*

4.4.2.2 Duplication of Services

Duplication of service efforts and double counting of program beneficiaries were chief current concerns among interviewees (n=6); a result of uncoordinated efforts across a large number of service providers.

> *"Maybe another challenge I can name is reconciliation of efforts because there are so many partners that are coming on board and there may be duplication of work, which to me would be interpreted as wastage of resource material, financial and human."*
>
> *"When it comes to resources maybe for OVCs mitigation programs, you find there is double capturing …the same people benefiting and probably others being left out. So there is need for that coordination."*

4.4.2.3 Service Delivery

Respondents provided feedback on STEPS OVC service delivery. Some responses may reflect STEPS OVC specifically, a previous program, or a combination of both; however, there were commonalities of key challenges across respondents.

Respondents expressed concerns about current **coverage** of OVC programs.

> *"Some organizations are actually doing activities in various areas...but rural areas are less covered."*
>
> *"You find that there is congestion of NGOs in one particular area as compared to spreading the activities around the districts and also maybe the country."*
>
> *"Geographical coverage, because it is limited to operating to a radius of five square meters, so it's a very small area which is being covered... And maybe the other challenge would be, even these other* organizations that we mentioned, when it comes to catchment areas, you find that you are confined."

There is also concern that STEPS will be overburdened due to unwieldy demand for services and limited local resources to support scale-up.

> *"Challenge is that you know the workload is a lot and I think in organization usually have their limits of helping the children that is a big challenge but I know that they cannot manage everything…we are not saying the coming in of STEPS OVC will cure our problems because the situation is big. They can't do everything, but I am sure they can do something."*
>
> *"I think the demand for the services will be too much for them so probably they need to come up with the strategies that can address certain issues within the problems faced by the OVC, so I think it is overwhelming demand for support--I am sure there will be a lot of people when they see the program is here."*

4.4.2.4 Financial Support

While two respondents believed one of STEP OVC'S strengths is financial support and PEPFAR resources, two other respondents perceive there are not enough resources to meet demand.

> *"It's all about how we are going to assist OVC in terms of giving them educational materials, even school fees and stuff. That is a big challenge because when you go in communities you will find a lot of OVC that need to go to school but then their guardians are not working or do anything and they may not be able to afford it. What is going on now with STEPS OVC I think it's a big challenge for us because money is a problem."*
>
> *"We do not generate resources as Zambians; we entirely depend on aid from outside, so that is a big challenge. What if the aid stops today, what happens next? We need to have sustainable solutions and that is what we are lacking."*

4.4.2.5 Partnerships and Coordination

Respondents also noted one of the primary weakness of OVC programs, including STEPS OVC, is poor coordination and partnerships across stakeholders (n=7).

> *"[STEPS OVC] is supposed to network and be able to make linkages, but you find that some organizations are not prepared to partner. Either they keep their sources of funding a secret, or they wouldn't even tell you where they are working. This is a big hurdle to forming partnerships."*

> *"The consultation is not very well done so that at the end of the day, you find a lot of people with a lot of question marks with dissatisfied minds… most of our partners feel they are self-sufficient and they do not usually consult [with government]."*

> *"Implementation of programs is not well coordinated and unsystematic due to a top-down approach in implementation. HQ dictates what activities to do and they do not flow."*

4.4.2.6 Human Resources

Despite respondents' feedback that previous programs succeeded in human resource capacity building efforts, there were concerns about the burden of caregiver responsibility and number of qualified staff available to support STEPS' implementation and operations (n=7).

> *"STEPS OVC…it has put so much on the caregiver in terms of implementation, in terms of data collection, for making decisions in terms of programming for reporting, it's all done by caregivers."*

> *"Most of our centers (facilities) are understaffed; we have got a problem in that aspect. Then consequently we have people working for long hours."*

> *"Has experienced members of staff, but a weakness is there isn't enough staff to support the program."*

One respondent had a different perspective, saying:

> *"Major strength [of STEPS] is availability of human resources who are able to meet the expectations of communities and organizations they serve."*

4.4.2.7 Monitoring and Evaluation

When asked about weaknesses of the STEPS OVC program, some respondents described the lack of harmonization of data and poor information flow (n=2). Several other respondents also commented that the program is overly focused on reporting and meeting targets (n=3).

Some respondents (n=3) stated that lack of data and information describing the OVC situation and poor targeting contribute to beneficiaries' needs not being met.

> *"There is not so much information or figures (about OVC) and who is helping them. Need to have statistics on situation on the ground."*

> *"Most organization have it wrong. They do not do a proper needs assessment. The opportunities are there that if some proper needs assessment is done, the real issue out there may be understood and the program can position itself appropriately to save the people."*

This is contradicted by one respondent who said one of STEPS OVC's strengths is:

> *"The aspect of monitoring and evaluation and also moving information from community level....sent at the district, then forward to province, which has helped us because we are able to get the correct information from the ground, coming upwards and also to national level."*

Three respondents are concerned that implementing organizations are too focused on meeting donor targets and it is detracting from program quality and effectiveness.

> *"I still see there still is a lot of emphasis on reaching targets and things like that. In my own opinion, I think support should be able to go towards just doing work that will change people's lives. So when we put conditions to say you need to reach so many, implementers might just want to focus on reaching the numbers."*

> *"Sometimes we should not be donor driven, we should be driven by the needs that are on the grounds because these are fellow Zambians and we are the only ones that can help them."*

4.4.3 OVC Program Strategies and Recommendations

4.4.3.1 Prevention

A few responses included information on prevention activities (n=3). One respondent appreciated STEPS OVC's focus and prioritization of prevention interventions, and two other respondents discussed the need for and impact of prevention programs.

> *"Also looking at the people living with HIV and AIDS, a lot has been done in terms of treatment but what still remains is to find out ways in which we can protect those who are not yet infected and try by all means to help those infected from infecting others."*

> *"We need to educate people; people must be sensitized on the HIV prevention the importance of prevention"*

4.4.3.2 Service Delivery

Respondents were asked about the recommended minimum package of care for children and PLHIV. Within the domain of OVC program strategy, in ranking order, respondents prioritized education, nutrition, psychosocial support; basic care, health and income generating activities, and lastly, protection **(see Table 23)**. Two respondents specifically mentioned the need to monitor and improve institutional care.

Table 23: Respondents' ranking of OVC programming priorities

Domain	Count
Education	9
Nutrition	7
PSS	6
Basic Care	5
Health	4
IGA	4
Protection	1

Interestingly, some respondents stated the need for STEPS OVC to shift away from fostering a mentality among the community for providing "handouts" and dependency. Yet other respondents (n=5) believe providing clothes and materials to families should be among the key intervention areas. One respondent noted this juxtaposition,

> *"Children that really don't have enough clothing except the issue of clothing also has a lot of connotation, it might look like handouts."*

4.4.3.3 HIV and AIDS

In addition to providing ART for HIV positive clients, respondents commented on service standards for PLHIV. The majority of respondents prioritized nutrition/food support (n=12) and income generating activities (n=8). Four respondents mentioned the need for counseling, both psychosocial (n=2) and adherence counseling (n=2). Three respondents mentioned the need for scale-up of HIV counseling and testing (HCT), inclusive of pediatric HCT (n=2) and mobile HCT sites (n=1).

4.4.3.4 Stigma and Discrimination

The majority of respondents projected that stigma and discrimination (S&D) toward HIV-positive individuals still exists. While the majority believed S&D is declining in both rural and urban areas, respondents suggested that support groups, awareness building, and altered medical distribution strategies could help mitigate further discrimination.

> *"I think any other support package should be confidential at the hospital, because what is happening now is you will find specific rooms when getting their ARVs, the days that they are given to get their ARVs you will find they have to make a queue so everyone can see them and that does not make sense so they need privacy in terms of to their drugs because others won't stand in that queue."*

Two respondents also commented on "self-stigma," implying the need for support to the individual beyond education of the community at large.

> *"The first one of them sometimes is the self-stigmatization. It comes when someone has been told they are living with HIV, they might want to lock themselves away you know."*

Respondents were asked about S&D of children orphaned or made vulnerable from HIV and AIDS separately from adults living with HIV and AIDS. The majority of respondents believe S&D of children exists (n=13) and is high (n=8) **(see Table 24)**. While six respondents believe S&D of children is declining, one respondent noted it is increasing because households intentionally self-labeled as "OVC households" in order to benefit from social services.

Table 24: Perceptions of Existence and Levels of S&D, by location

S&D OF PLHIV	Exists	Doesn't Exist
Higher in Rural	8	0
Higher in Urban	1	1
No Noticeable Difference	3	1

> *"With realization that there are organizations that help orphans, the stigma has now increased as people want to benefit. Even children who were well supported are now called orphans."*

While the majority of respondents concluded that rural S&D is higher than urban, two respondents contributed that urban discrimination of children is higher than rural because rural orphans are assumed into community care structures, while urban children are at a greater risk to be left without sufficient care **(see Table 24)**.

> *"I think in the rural areas, they are better kept than in the urban areas. You will not find many complaints about children being maltreated in rural areas, because the rural mentality is that your brother's son is your own son, your sister's child is your own child. So my little experience is that in the urban, areas, really, there are complaints about orphans being kept, but in the rural areas you rarely find that."*

Respondents did not provide recommendations to explicitly reduce S&D among children, but rather commented on the overall effectiveness of previous education and awareness programs in reducing S&D at large.

4.4.3.5 Monitoring and Evaluation

Respondents also recommended activities to improve data and information on the situation of children orphaned and made vulnerable by HIV and AIDS (n=4). In general, respondents believe stakeholders and programs could benefit from improved information on unmet needs and service delivery mapping.

> *"I think they will need to do a situation analysis so that they know first who the players are and which of these are doing well, and for those doing well, how do they partner with them so that they supplement whenever where they have short comings, I think that would be very important."*

> *"There is not so much information or figures (about OVC) and who is helping them. Need to have statistics on situation on the ground."*

Respondents also commented on the need to improve information quality and flow at various levels:

> *"So if we can have one reporting format, if you want to collect information, which can be submitted to the district, province and national level and to OVC as they would want to get the information. I think maybe the reporting format of the activities happening on the ground. We need to streamline it in such a way that it doesn't make people produce so many reports at the end of the day."*

> *"The information flow was not well defined and when you have proper structures and clear roles of responsibility of information at different levels that information they get will help them with decision making. If there isn't a proper structure the information won't flow at different levels the information will be made with doubts."*

4.4.3.6 Targeting

Coordinated and standardized identification of children beneficiaries were also recommended by respondents. Opinions of an effective way forward are split, presenting a paradigm of whether or not village leaders/headmen should be involved in the identification decision making process.

One respondent described the politicization of involving village leaders:

> *"There is no way you can avoid them [community leaders] because they are in control and they know the system so well that they manipulate the system to make sure that their immediate families benefit. Communities have also taken advantage of that situation. They say oh, its [Donor] coming, so you find that [Donor] always gives this kind of incentives...So even the answer to anything you will ask, they will give you just to suit the criteria to make sure they get services."*

On the contrary, other respondents (n=3) recommend involvement of village leaders as a primary transition to community lead programs, and therein sustainability. One respondent said:

> *"Family care has broken down and families that are able to help themselves push [to get] support. Others who deserve are left out, an issue that should be addressed by targeting through stakeholders, such as headmen, church, social welfare, and NGOs."*

4.4.3.7 Policy

Respondents were asked about their knowledge and the perceived effectiveness of policies related to HIV and AIDS. Collectively, respondents did not provide many details on policy and policy implementation; however, the most commonly mentioned policy was the HIV and AIDS Workplace Policy (n=4). Effectiveness of this policy is uncertain, with one respondent citing the positive differences and another respondent raising question on the degree of implementation.

> *"The introduction of HIV workplace policy at least it has helped to bring those positive changes and the workers sit weekly, monthly and yearly to talk about HIV and AIDS and what they call Parish AIDS Volunteers [PAVs] who do a lot of education about HIV and AIDS."*

> *"And also, we still find it even in work places, especially, where people don't have a good work HIV policy. You still find that one even in families, where people might not want to really associate with them."*

Four respondents also mentioned policies related to government funding for HIV and AIDS. While some respondents mentioned the need for such a policy, other respondents inferred the policy already existed. Regardless, there was agreement that government funding for HIV and AIDS is not sufficient, and the policy is not being implemented sufficiently.

> *"I may say, somebody needs to awaken a sense of responsibility in the officers at all levels, to allocate at least something to HIV and AIDS instead of always depending on donors when government claims there should be 10% in all allocations going toward HIV and AIDS."*

Very little was mentioned about policies impacting children orphaned or made vulnerable by HIV and AIDS. One respondent suggested policy adoption must be followed by information and education communication (IEC) messages to ensure effective implementation. Another suggested the need for clear operational guidelines for programs that support children orphaned or made vulnerable by HIV and AIDS.

> *"Once that policy is just adopted by the different stake holders and IEC is put in place to educate, because I think changing someone's attitude is not done overnight."*

> *"There is a lot of very good documentation regarding the OVC, but we are not [implementing] most of the recommendations. You know, most of the things are just on paper [and we can overcome challenges by having] clear operational guide lines."*

4.4.4 Sustainability and Transition

Sustainable program impact and continued interventions after STEPS OVC are chief objectives of STEPS OVC's strategy. To this end, respondents were asked about STEPS OVC transition to local ownership and engagement with local government to support continued programs after closeout. Although a number of impediments to sustainability and transition were cited, the majority of respondents believe that STEPS OVC can have a lasting impact through: (1) capacity building interventions; (2) empowering families through income-generating activities; and (3) improving coordination among all stakeholders.

4.4.4.1 Impediments to Sustainability and Transition

Respondents warned of a few impediments to an effective program transition, citing lack of local resources, bureaucracy, and human resources as chief challenges.

> *"There is a little bit of bureaucracy, here and there [in government]. So, even there are times when there could be sources of funding somewhere, but maybe that information is not properly communicated."*

> *"So, the government per say, they are aware, they are doing everything they can, they are committed, but the resources that come through that maybe, are just not enough…government should be aware that there is a strenuous constraint."*

> *"Biggest challenge is resources. Other projects have done similar strategies with low success as locals do not have enough resources."*

> *“So you find that maybe the people that could be of help, either they are not available or not interested, or maybe we could be working with one person here, maybe there is no proper hand over to another person, when another person comes in, there is a totally different picture, you have to start engaging this person again.”*

4.4.5 Capacity Building

When asked about STEPS OVC transitioning to local ownership, the majority of respondents (n=9) suggested capacity building as a fundamental component. However, different types of capacity building interventions were suggested, most of which fit into three categories: caregiver training, government capacity building, and local organizational development.

> *“If we could have more focus on building the capacity of the caregivers to be able to really be meaningful in terms of providing information that we require and also being able to replicate that back to the community even after the STEP-OVC project has gone, the knowledge will be able to remain with the communities so we would have said we succeeded”*

> *“I think that is a strength if you can give a skill, and district empowerment – that is capacity building – will help also.”*

> *“STEPS can capacity build local groups to be self-reliant. First and paramount is capacity building.”*

Some respondents (n= 2) called out a specific need to build local capacity in resource mobilization to help overcome problems with donor dependence.

> *“Most of their [service providers] resources are donor generated, which is unsustainable. Organizations need to come up with plans for generating resources locally.”*

4.4.6 Income Generating Activities (IGA)

STEPS’ impact can be sustained through empowering families and income generating activities (IGA), according to six respondents. Five respondents explicitly referenced IGA, while one respondent took a different approach to household contributions to circumvent donor dependence.

> *“We are supposed to treat capacity such that the once somebody gets better and is able to move up and down, that person should have had the capacity of producing their own food. They should be able to send their own children to school. And also just basically taking care of the family in general. STEPS at the end of the day should be interrelated or linked, they should be forward linkages leading to as in kicking out someone from poverty.”*

> *“They should look more on interventions that require contribution from the beneficiaries. I think beneficiaries should contribute to a certain portion, it can be better that way.”*

4.4.7 Improved Stakeholder Coordination

In general, respondents believe that programs would benefit from improved collaboration to overcome issues of duplication, poor program referrals and linkages, and lack of local ownership. One government respondent summed up the call to collaborate, saying:

> *“We are not talking to each other; there is no communication...once we start talking to each other I think it will be easier at all levels. When we speak as health, they speak as agriculture – if we are talking about the vulnerable, it should seem as if we are talking the about the same objective, same goal.”*

Respondents collectively recommended that improved coordination efforts should be focused within three main stakeholder groups: government, service providers, and community.

Government (n=4)

Four respondents expressed the need for improved coordination between STEPS OVC and government, saying:

> *“One of them is having regular stakeholder meetings and review meeting to keep their activities smart and also part of government, people should have that chance to go and see what they are doing, meaning the people should be allowed to observe in terms of appreciation.”*

> *“STEPS should take advantage of existing government offices, e.g., Social Welfare (OVC) and DATF (BCS).”*

Service Providers (N=10)

The majority of respondents pointed out the vast need for better coordination and collaboration across service providers, saying:

> *“I think what they should do is establish a forum for sharing, so that we sort of harmonize and share experiences and share also the selection criteria.”*
>
> *“I think the best thing is to sit and see what each one of them is doing and probably draw some lines of point of intersection so that if there are certain common elements...they can complement each other.”*
>
> *“We encourage that they [STEPS and partners] meet frequently maybe for stakeholders meetings…and comparing registers so that they are not targeting the same clients.”*
>
> *“First, communication is very vital and transparency, everybody has got to know what everybody else is doing. Then I think universal involvement, although some people do not respond when you call them on board.”*

Community (N=7)

Respondents also emphasized the need for clear community engagement and the fostering of community ownership, saying:

> *“There is need to involve local organizations in planning of activities under STEPS as they know better what their problems are. Avoid top down approach by involving local NGOs in planning (e.g., funder deciding what activities to fund as opposed to beneficiaries).”*
>
> *“I think maybe one suggestion would be, there should a lot of empowerment in terms of skills and resources, so that the community can be able to carry on when STEPS has phased out. So maybe the strategy would be maybe the messages that we carry should always emphasize that this is your project, there is no caregiver who belongs to Africare. You are a community caregiver.”*
>
> *“Let both parties be clear - very, very, very clear - about the terms and also the community are left out in the dark when people are transitioning, they talk to their counterparts and the community is left not knowing what happened but I think we owe it to the community, there must be a courtesy there you know to inform the community that this is really what is happening.”*

5 Discussion and Recommendations

5.1 Child Education

Findings show exemplary levels of school enrolment (95.2%). As children grow older, retention drops slightly (98.5% of 11-12 year olds, 96.8% of 13-15 year olds, 94.4% of 16-17 year olds)[19]. Main reasons cited for not attending school include financial constraints, being too far away from school and needing to make money for the family. Interventions that mitigate school drop-outs such as economic strengthening activities are recommended to improve and maintain primary and secondary school enrolment[20]. Baseline survey results show that among STEPS beneficiaries, boys and girls are equally likely to currently be in school. ZDHS 2007 reported near gender parity of net national school attendance in primary school and a gender disparity in secondary school with males having higher attendance. While baseline survey results show gender parity among STEPS beneficiaries, other national data[21] suggests the need for greater focus on girl enrollment, particularly among secondary age girls.

Key informant interview respondents clearly advocated for prioritization of educational support. The National AIDS Council (NAC 2008) reports high provision of educational support (91.6%) among children reported receiving any support. Coupled with current high enrollment rates among beneficiaries, further exploration into improving performance, quality of education and sustainability of educational support is recommended.

5.2 Child Labor

Over half (54%) of children surveyed have ever worked for money. Boys and older children were more likely than girls and younger children to report previous work. Of those that reported ever working for money, 93% reported working as laborers (farms, construction, etc.)

Children reported using the money they earned to pay school fees (20.2%), buy food and clothes (50.95%), buy treats (19.7%) or buy other things (39.7%). Nearly one-quarter (23.8%) reported that they had previously been forced to do work that they did not want to do.

A guiding principle for OVC programming is that children are to remain in a loving family situation, in which they can maintain stability, care, predictability, and protection. From the findings it is clear that there are instances that threaten this fundamental principle by engaging in work that is not appropriate for their age. Against this background, child protection should be integrated into programming to ensure that children only engage in age-appropriate work.

5.3 Livelihoods

Just over one-third (36.6%) of respondents reported that they were in gainful employment at the time of the survey. The mean annual income among respondents was ZMK 1,361,255 (approximately $255 USD). However, only nine% of respondents reported that their income, combined with support received from relatives and organizations, was sufficient to meet their needs.

Agriculture is the dominant livelihood with over half (58.6%) reporting farming as their main source of income. Other common forms of employment included hawking, fishing and other professional employment. The majority of Zambians, including PLHIV, work in the informal sector[22] where health services and support are not always available. Consequently given the loss of income due to illness, they are often unable to meet their basic needs[23]. Respondents reported some problems providing

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[19] This finding is similar with ZDHZ (2007) that showed that OVC are only slightly disadvantaged with respect to school attendance in comparison to other children at 88% and 91% respectively.

[20] United States Agency for International Development. "PEPFAR OVC Evaluation: How Good at Doing Good?" The Global Health Technical Assistance Project. May 2012.

[21] Human Development Report Office UN Human Development Indices Table, 2008 reports low literacy rates (59.8%) for females aged 15 and above compared to males (76.3%) of the same age range.

[22] The informal sector is part of the 'non-observed economy," which consists of illegal activities, underground activities and the informal sector (Central Statistical Office and Ministry of Labour and Social Security *Labour force Survey Report,* 2005). Of these categories the informal sector and illegal activities such as sex work are targeted by a few implementing organisations for HIV interventions but not to the degree occurring in the formal sector. The majority of workers are not reached.

[23] Zambia National AIDS Strategic Framework (NASF): 2011-2015

basic household needs for their children. While majority of children (88.5%) reported having two more sets of clothes, just under half (45.8%) reported having one or more pairs of shoes.

Zambia has one of the highest incidences of poverty in the world with 68% of people living in extreme poverty[24]. The economic situation of many households is inadequate and/or unstable. Targeted approaches to economic strengthening should respond to the unique characteristics of districts, communities and households.

Interventions should respond to distinct vulnerabilities of families rather than individuals. Destitute families with little-to-no income and assets and severe food insecurity require a specific set of more urgent interventions and longer term assistance to rebuild their basic economic capacity. Families struggling to make ends meet with fluctuating income / assets and moderate food insecurity require programming that focuses on strengthening money management. Other families may be more prepared to grow economically; they may have some assets and less food insecurity, but still live with some degree of income uncertainty and thus require interventions to diversify and grow income.[25]

5.4 Physical, Sexual and Gender-Based Violence

Three-quarters of children reported that they had previously been hit or beaten, with half of children (49.3%) reporting being hit or beaten in the six months prior to the survey. Children reporting their primary guardian as an aunt or uncle (54.8%), or a brother or sister (51.7%) were more likely to report that they had been hit or beaten in the last six months. Less than four% of children reported having ever been forced to have sex (3.5%).

When asked whether they agreed or disagreed with the statement *a husband may be justified in hitting or beating his wife,* the majority of children either disagreed (40%) or strongly disagreed (30.8%).

One-third of adult respondents reported ever being hit or beaten by their spouse or another sexual partner. Nearly 20% of women respondents reported that they had ever been forced to have sex by their husband or someone else. More than one-third of respondents (36.7%) agreed or strongly agreed with the statement that *a husband is justified to hit or beat his wife*.

Perpetrators of violence against women are mainly husbands or live-in partners (67.5%), boyfriends (25.0%), male relatives (5.8%), former husband/boyfriends (2.5%) and strangers (1.7%).

Gender-based violence was identified as a constraint to women accessing HIV counseling and testing services, as well as to obtaining HIV test results in an antenatal clinic. According to ZDHS 2007, 46% of Zambian women who ever experienced physical or sexual violence have ever sought help from any source. Only six% of abused women who ever sought help told someone about the violence and 41% never sought help and never told anyone.

There is a clear need for interventions to support victims of physical, sexual and gender-based violence. Organizations providing high-quality support services should be identified and leveraged to establish local referral networks. Community caregivers should be trained to adequately identify and respond to issues of physical, sexual and gender-based violence. Drafting clear action points on how to address abuse cases should be provided according to cultural norms and local contexts.

5.5 Health and Health Seeking Behavior

Although four in five children (78.9%) rated their own health good to excellent, more than half of children (53.7%) reported illness in the four weeks prior to the survey. The most common illnesses reported were: malaria (36.8%), cough/cold (26.5%) and diarrhea (16.5%). Four in five children reporting illness, reported receiving treatment for their last illness. Girls were more likely to report illness than boys, but there is no difference by sex for treatment reported.

Less than half (41.8%) of adult respondents rated their own health as “good,” “very good,” or “excellent.” A third (34.4%) rated their health as “fair” and 23.9% rated their health as “poor.”

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[24] Zambia Human Development Report, 2007, UNDP

[25] USAID Webinar: Household Economic Strengthening Overview for OVC Implementers. February 23, 2012. http://www.ovcsupport.net/s/index.php?c=168

Household interventions should ensure effective health referrals and services are available and provided. Community caregivers should be trained to facilitate effective health referrals and services (see section 5.11 below). Scale-up of pediatric HIV counseling and testing is also recommended.

5.5.1 Malaria

Malaria accounts for up to 40% of all infant mortality and 20% of all maternal mortality in Zambia (MOH, 2008). Malaria is the leading cause of morbidity and mortality in Zambia, with nearly 4.3 million cases and 50,000 deaths per year. It is responsible for one quarter of childhood deaths and accounts for almost 50% of hospitalizations nationwide.[26]

Access and use of mosquito nets is low among respondents. Less than half of households reported having a mosquito net in their house (47%). Furthermore, of those with nets, only 78.1% reported sleeping under the net the night preceding the survey. Sixty% of children reported sleeping under a net the night before the survey.

These findings are below the national average. MIS 2010 reported 70% of Zambian households have at least one mosquito net and of those with a net, 46.6% reported sleeping under the net the night preceding the survey.

Knowledge of how to prevent malaria is also low. About two-thirds of children and adults correctly reported that sleeping under a bed net can prevent malaria (64% of children, 65.4% of adults). One in five of adult respondents cited spraying the house with repellant and less than one in ten reported wearing long sleeves/trousers (9.7%) and avoiding the outdoors at dawn/dusk (6.7%) as prevention methods.

These findings are also below the national average. MIS 2010 reported 81.7% of women reported that use of mosquito nets could prevent malaria.

Further progress should be made in malaria prevention education and to strengthen interventions. Distribution of insecticide-treated nets (ITNs) should be scaled-up and well-coordinated across service providers. Advocacy for universal bed net access should be prioritized and may benefit from drawing on evidence of improved malaria rates in Luapula province.

5.6 Food Security

Overall, findings show that households do not consistently have sufficient amounts and varieties of food. Two-thirds (65.5%) of adult respondents reported that in the four weeks preceding the survey, there was no food of any kind in the household due to lack of resources. Children also reported inadequate food intake: one-third reported going a whole day or night without eating, 67.5% reported eating a smaller meal than they felt they needed, and 72.8% reported eating fewer meals in a day.

According to the FANTA scale, key results indicate severe household food insecurity, as 32.5% of respondents or any a household member went to bed hungry in the four weeks preceding the survey; 52.6% went a whole day and night without eating in the four weeks preceding the survey; and 65.5% reported that at some point during the four weeks preceding the survey, there was no food of any kind due to lack of resources.

Additional national data supports evidence of significant food insecurity. The National Nutrition Surveillance System (NNSS, 2009) reported approximately 51% of households did not have enough food to meet family's needs in certain months. ZDHS 2007 reported 45% of young children are chronically malnourished (stunted), five% are acutely malnourished (wasted) and 15% of children are underweight.

The current state of food insecurity requires a multi-pronged approach. Households at different levels of food insecurity require specific support that meets their unique needs. In cases of severe food insecurity, more urgent interventions may need to be provided to individuals and households, some of which may require facility-based care. Interventions that respond to the characteristics of mild, moderate and severe food insecurity need to be employed.

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[26] http://www.usaid.gov/zm/population/phn.htm

5.7 Psychosocial Well-being

Nearly one in five children surveyed showed abnormal emotional well-being and a further 19% had "borderline" scores. One in ten had peer relationship problems. The method used to assess psychosocial well-being does not confirm the diagnosis or presence of a psychological disorder. However, results did show concern of abnormal well-being. Interventions to boost children's opportunities to socialize, build positive relationships, identify individuals they can trust, ease fear, reduce worries and nerves and relieve insecurities, are recommended. Furthermore, economic strengthening activities may serve a similar purpose – relieving worries and insecurities of impoverished families, thus improving psychosocial well-being[27].

5.8 HIV and AIDS

5.8.1 HIV Knowledge and Attitudes

The survey findings show respondents have general knowledge of HIV and AIDS, but gaps exist in knowledge of HIV transmission and prevention. These findings are generally consistent with national evidence, which suggests that general knowledge of HIV and AIDS in Zambia is very high at 99%[28]. However, survey results show gaps in comprehensive understanding of HIV transmission and prevention among program beneficiaries. Interventions that include education on HIV transmission and prevention are recommended for both youth and adult beneficiaries. HIV education messages should seek to dispel common misunderstandings identified. Prevention of mother-to-child transmission (PMTCT) messages should be more rigorously integrated into program interventions. Community caregivers' knowledge of HIV transmission and prevention should also be improved (see Section 5.11) to ensure accurate messages are being communicated to beneficiaries.

5.8.2 HIV and AIDS Stigma and Discrimination

Stigma has been identified as the major barrier to universal access and utilization of HIV and AIDS related services (NASF). Survey findings reveal levels of stigma and discrimination are still felt among beneficiaries and influence the decision-making.

Approximately one-quarter of children surveyed expressed concerns of HIV stigma and discrimination. Twenty-six% reported a belief that families with HIV-positive individuals are treated unkindly by other students (25.9%). Nearly 28% (27.7%) of children reported a belief that children who receive free services are treated unkindly by the community.

A greater proportion of adults reported concerns of HIV stigma and discrimination. Just under half of adults (44.7%) agreed with the statement that PLHIV are treated as outcasts. Over 40% of adult respondents felt that people are afraid of them when they find out that they are HIV-positive. Nearly 30% reported feeling that they are not a good person because they have HIV and AIDS.

Concerns of HIV stigma and discrimination impact HIV disclosure; although the majority (88%) of adults reported that they had disclosed their HIV status to at least one person, nearly 60% of respondents agreed that they work hard to keep their HIV status a secret.

The majority of key respondent interviewees reported belief that stigma and discrimination still exists, although it is declining. Respondents suggested that support groups and awareness building could help mitigate further discrimination. Further recommendations were made to improve the confidentiality / privacy of service delivery in order to prevent stigma and discrimination. Facility-based treatment rooms and ARV queues were cited as specific environments that should protect the privacy of clients more. However findings above reported that nearly a quarter of children feel maltreatment from community members, which also calls privacy of community-based services into question.

5.8.3 HIV Prevention and HIV-Related Risk Behaviors

Among youth, findings show early initiation of sex, one or two sexual partners, low condom use and low HIV testing rates. One in five children (21.9%) aged 13 and above reported previous sex. The mean age of sexual debut was 11.8 years for boys and 14 years for girls (range of sexual debut: 5-17

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[27] United States Agency for International Development. "PEPFAR OVC Evaluation: How Good at Doing Good?" The Global Health Technical Assistance Project. May 2012.

[28] Joint Mid Term Review of the National AIDS Strategic Framework 2006 – 2010, January 2009, NAC

years). Just over one-quarter (27%) of those sexually active reported using a condom at first sex, and 40.3% reported ever using a condom during sex. Girls were twice as likely to report condom use at first sex compared to boys.

There is a significant correlation between whether children have discussed their HIV risk and HIV testing. One-quarter of children reported that they had discussed with someone whether or not they should take an HIV test. One-fifth of children reported a previous HIV test (20.7%).

Among adults, nearly half of respondents reported sex in the last six months (47.4%). Similarly, half of respondents reported having a regular sex partner (51.6%). Of those reporting a regular sex partner, 13.8% said that they did not know the HIV status of their regular partner. Condom use was related to HIV status of the regular sexual partner. Over 90% of those with an HIV-negative regular partner reported condom use at last sex, compared to 74.4% of those with an HIV-positive regular sexual partner. Less than five% reported sex with a casual partner in the last six months.

The CDC has found that people who do not know their HIV status are more than twice likely to engage in high-risk sex than those who are aware of their HIV positive status[29]. The study also shows that about 70% of new infections are from people who are not yet diagnosed[30]. ZDHS 2007 reports that young women are slightly more likely than young men to have been tested for HIV and to have received the test results (23% and 13% respectively). Among the adult population age 15-49, 39% of women and 22% of men have been tested for HIV at some point in time.

Youth HIV prevention messages need to be age-appropriate and address HIV risk, HIV prevention, HIV testing and HIV treatment. A safe environment for youth to discuss their HIV risk with an adult should be promoted. Similarly HIV testing should be provided an environment in which youth feel safe. Specific interventions to consider include peer-to-peer education through life skills training, school AIDS clubs, community youth resource centers and ensuring HIV services are ‘youth-friendly’.

Community sensitization on the importance of HIV testing and treatment is also recommended. Adult HIV counseling should include sexual prevention messages, disclosure and treatment. Adult HIV testing should be scaled up. While HIV testing among community caregivers should not be mandatory, community caregivers should be encouraged to know their HIV status in order to set an example for their clients (only 82.5% of community caregivers reported ever having had an HIV test).

5.8.4 HIV Treatment and Adherence

Nearly all respondents (97.1%) had heard of medications to treat HIV (ARVs). Nearly 90% (86.1%) of respondents reported currently taking ARVs. Nearly seven% (6.5%) reported taking herbal or traditional medicine. When asked how strictly they adhered to their treatment schedule over the past week, 89.2% reported strict adherence (no missed doses, medication taken at right time), 8.8% reported some mistakes, and two% reported taking the medication when they remembered (frequently off schedule). Over 80% reported never missing their medication for a full day (81%). Of those who missed a dose, the majority (58.3%) reported that they forgot and 25.5% reported that they ran out of medication.

Only 3.1% of respondents reported paying for ARVs, with the rest receiving ARVs free of charge. Nearly 60% (58%) of respondents reported no HIV care related travel expenses. This supports data from a 2009 NAC report that estimated that as of 2008, 355[31] health facilities were providing ART and that ART services are available in all the nine provinces.[32]

Increasing access to treatment since 2003 has had a major effect on mortality in Zambia, where HIV-related deaths among adults 15-49 years has decreased from 82% in 1996 to 54% in 2007.[33] In 2009, an estimated 927,693 people were living with HIV in Zambia and the number is expected to rise to

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[29] Marks G, et al. Meta-analysis of high risk sexual behaviour in persons aware and unaware they are infected with HIV in the United States: implications for HIV prevention programmes JAIDS, 39(4);446-53, 2005

[30] Marks G, et al. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the HIV virus in the United States. AIDS 20(10):1447-50, 2006

[31] Joint Mid Term Review of the National AIDS Strategic Framework 2006-2010, (July 2009), NAC

[32] National AIDS Council, Technical Report-Joint Mid-Term Review of National AIDS Strategic Framework, 2009

[33] 2009 Epidemiological Estimates report.

1,039,333 by 2015.[34] Many patients have resumed active, productive lives with reduction in the frequency of illnesses that require in-patient care.

Examination of home-based care and support needs for each individual and household is recommended. Interventions to continue to improve adherence is also recommended. One recommendation is to further strengthen the capacity of community caregivers in ART adherence and adherence counseling. Continued awareness building on ineffectual traditional treatment methods should also be employed. It is also recommended to further explore the reasons clients reportedly ran out of medication and help circumvent unavailability of medication.

5.9 Access to HIV Prevention, Care and Support

One in five children reported having ever received family planning advice, and more than two-thirds of children said they had received information on HIV prevention. Sixty% of children communicated a need for family planning advice and the vast majority reported a need for HIV prevention information. Although high proportions of children surveyed cited receiving information on HIV prevention, nearly 20% of 16-17 year olds and nearly half of children aged 11-12 said they had never received information on HIV and AIDS, which is concerning.

Irrespective of need, over 75% of adults reported (ever) receipt of HIV care and support services, HIV counseling and testing, HIV treatment, adherence counseling, malaria treatment, nutritional advice, condoms and HIV infection prevention. Less commonly received (50-75% of respondents reported) were TB testing, diarrhea treatment, pain assessment, pain mediation, food / vitamins, bed nets, referral to support group and family planning. Other areas, such as treatment for depression, physiotherapy, TB adherence counseling, TB treatment, treatment for sores, bumps or ulcers in the mouth or genitals, treatment for skin rash or itching were reported received by between 25 and 50% of respondents. Free legal services and a small loan were received by less than 25% of respondents.

5.10 Male Circumcision

Findings show that circumcision is becoming more common with younger generations. While only 15% of adult respondents reported being circumcised, just over one-third of boy respondents reported being circumcised. Among both adult and youth males, nearly one-third of those not circumcised, reported that they wanted to become circumcised. Results show both need and acceptance of increased circumcision.

National data for Zambia cites HIV prevalence among circumcised men at 10% compared to 12.5% among uncircumcised men.[35] Circumcision should be further promoted as an HIV prevention measure. Awareness building through IEC materials is recommended. Additionally, linkages and referrals between health centers and circumcision centers should be strengthened.

5.11 Community Caregivers

5.11.1 Job Responsibilities

The vast majority of community caregiver respondents (92.3%) strongly agreed that they were able to handle their responsibilities in the available time.

The mean number of households visited was 12.5. Nearly half of caregivers surveyed reported that they visited their clients weekly (47.3%), 27.4% reported visiting clients monthly, and 15.9% reported visiting more than once per week. Awareness of job roles and responsibilities was correlated to reported frequency of household visits.

The majority of caregivers surveyed (84.6%) reported that they travel between client households on foot, with 15.1% traveling by bicycle. Only 16.2% of caregivers reported that they communicated with clients by phone.

Just over half (56.6%) reported that they felt adequately supported to carry out their job responsibilities.

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[34] The 2009 Estimates and Projections Report, Zambia

[35] Demographic and Health Survey (2007),

The caregiver-to-household ratio should be reviewed and a standard household workload should be recommended for all community caregivers. Additionally, supporting increased use of cell phones for caregiver-client communication may also ease their workload. STEPS-OVC currently recommends five households per caregiver. Further exploration into why nearly half of caregivers reported they do not feel supported should be conducted. This should be reassessed and monitored as programs scale-up and revise household-to-caregiver ratios.

5.11.2 Services Provided and Training

Three-quarters of caregivers reported providing child health assessment and psychosocial counseling for children; but less than one-third reported providing household HIV counseling and testing, and HIV post-exposure prophylaxis (referral). One-third of caregivers reported providing services without having received training to provide that service.

Regarding other types of information caregivers reportedly provide to clients (i.e. sexual prevention, post-exposure prophylaxis), between two-thirds and three-quarters of all those providing it had received training in this area. Significant gaps appeared especially in information in child immunizations, family planning and post-exposure prophylaxis.

For nearly all issues, reported knowledge of where to refer clients was high (over 90% for HIV testing, ART, PMTCT, STI treatment, TB testing/treatment, family planning, condoms and spiritual / pastoral care). However, fewer than half knew where to refer clients for livelihood support, vocational training and Kids' Clubs. Only half reported knowing where to refer clients for legal aid support.

Just under half of caregivers reported that they had received training in client monitoring (48.6%). Only one in five caregivers had heard of the CSI (21.1%). Nearly half of those reporting having heard of the CSI had received training in using the CSI (43%).

An overwhelming majority of caregivers reported needing training in all services areas, regardless of whether or not they had received training in the last six months.

Significant caregiver training gaps appear in multiple areas. Caregivers should be trained in all services and information areas, with refresher training and training for newly hired caregivers routinely provided. It is recommended that trainings be provided in partnership with District Health Management Teams (DHMT) to promote sustainability. Caregivers should also be supported with correct and up-to-date information regarding the services they provide. IEC materials are recommended to help caregivers provide information in targeted program areas. Information on available local services – specifically organizations that provide livelihood support, vocational training, Kids' Clubs and legal aid – should be maintained and disseminated.

There is also a gap in monitoring and evaluation (M&E) trainings. Caregivers should be further enabled in their role as primary data collectors through training on M&E, client monitoring, data use and the CSI for outcome monitoring and case management.

5.11.3 Confidence in role as caregiver

The vast majority of caregivers (92 to 95%) reported they were comfortable discussing most issues including sexual prevention, birth spacing and family planning, and ARV referrals. Caregivers reported feeling less confident in their ability to support clients in adhering to their HIV treatment (81.9%), and supporting clients and their families to prepare for death (84.4%).

Support should be provided in areas that caregivers feel less confident through trainings, IEC materials, and supportive supervision.

5.11.4 HIV and AIDS

Overall, knowledge on modes of HIV transmission was relatively high among caregivers. Caregivers generally had very accepting attitudes towards people living with HIV and AIDS (approximately 97% believe HIV+ students and teachers who are not sick should be able to attend/teach). Caregivers reported similar levels compared to beneficiaries of stigma and discrimination (approximately one-quarter of caregivers believe people living in HIV+ households and households who received free services are treated unkindly).

A significant number of caregivers mistakenly noted malaria or persistent malaria, as well as symptoms of sexually transmitted infections, as major side effects of ART. Only 10.9% replied that drug adherence is important to both avoid drug resistance and to ensure effectiveness.

Additional support should be provided to caregivers to improve understanding of HIV transmission, prevention, detection and treatment.

5.12 Program Design, Management, Coordination and Sustainability

Key informant interviews provided additional information regarding program design, management, coordination and sustainability. Multiple respondents (n=4) agreed that previous programs had successfully established a foundational base for OVC/HIV programs to build off of and expand upon. A few issues were identified as key challenges and a few recommendations were suggested to strengthen programs and services.

5.12.1 Service Delivery

Multiple respondents agreed that previous programs had successfully established a foundational base for OVC/HIV programs to build off of and expand upon. Respondents expressed benefits of community caregiver mobilization and generally expressed the belief that previous OVC/HIV programs were of good quality. However, multiple concerns and suggestions for improvement were recorded.

Respondents worried that clients were overly dependent on donors, and a culture of “hand-outs” prevailed in some areas (n=6). Various interviewees (n=4) suggested previous programs’ erratic support to households contributed to poor service delivery, client dropouts, and mistrust in communities. Dependence on donors for services was identified as a confounding factor that contributed to unpredictable service delivery and beneficiary dissatisfaction in some areas.

Multiple respondents (n=5) expressed concern regarding how clients are currently targeted, resulting in most-in-need populations not receiving services and/or a large degree of existing unmet need among beneficiaries. Coordinated and standardized identification strategies were recommended by respondents. Opinions of whether or not village leaders/headmen should be involved in the identification decision-making process were divided among respondents.

5.12.2 Partnerships and Coordination

Respondents noted one of the primary weaknesses of OVC programs, including STEPS OVC, is poor coordination and the absence of partnerships across stakeholders (n=7). Duplication of service efforts and double-counting of program beneficiaries were chief current concerns among interviewees (n=6); a result of uncoordinated efforts across a large number of service providers.

In general, respondents believe that programs would benefit from improved collaboration to overcome issues of duplication, poor program referrals and linkages, and lack of local ownership. Respondents collectively recommended that improved coordination efforts should be focused within three main stakeholder groups: government, service providers, and community.

5.12.3 Monitoring and Evaluation

When asked about weaknesses of the STEPS OVC program, some respondents described the lack of harmonization of data and poor information flow (n=2). Several other respondents also commented that the program is overly focused on reporting and meeting targets (n=3). Still others (n=3) stated that there was a lack of data and information describing the situation of children orphaned and made vulnerable by HIV and AIDS, and that poor targeting contributed to beneficiaries’ needs not being met.

Respondents recommended activities to improve data and information on the situation of children orphaned or made vulnerable by HIV and AIDS (n=4). In general, respondents believe stakeholders and programs could benefit from improved information on unmet needs and service delivery mapping. Respondents also commented on the need to improve information quality and flow at various levels.

5.12.4 Sustainability and Transition

Sustainable program impact and continued interventions after STEPS OVC are chief objectives of STEPS’s strategy. To this end, respondents were asked about STEPS OVC transition to local ownership and engagement with local government to support continued programs after closeout. Although a number of impediments to sustainability and transition were cited, the majority of respondents believe that STEPS OVC can have a lasting impact through: (1) capacity building interventions; (2) empowering families through income-generating activities; and (3) improving coordination among all stakeholders.

6 Study Limitations

6.1 Outdated Sampling Frames

Despite a lot of effort by Futures Group to update the sampling frame following the pre-study visit, the sampling lists still had a lot of people who had dropped out, leading to a high rate of replacement. This was one of the major challenges encountered during data collection.

The child beneficiary list needed to be updated as some of the initial respondents indicated on the sampling list could not be located due to relocation for school, marriage or moving to other areas out of town. In some areas, it was realized that some caregivers had not been to the children's households since December 2009 when RAPIDS project ended. In addition, some children had either shifted or were below the required minimum age. On several occasions the team discovered that some of the sampled children for the survey were below minimum age required to participate in the study, in some cases even below the age of five.

In addition, the definition of BCS clients was quite ambiguous. The BCS list included individuals who were HIV negative even though the questionnaire required that the BCS respondent be HIV positive. The list also included individuals who had already passed away. In some cases, Research Assistants could get in trouble for asking HIV negative individuals, questions that assumed they were positive. As a result, BCS interviews were fewer than planned.

6.2 Timing of the Survey

The survey was carried out in the rainy season which made logistics very difficult. It was difficult and time consuming to follow children in their individual homes and take GPS readings as the research team had improvised meeting them in schools/central locations which were quite far from their homes. If GPS readings were to be done, then each Research Assistant would have done about three to four interviews per day due to logistical limitations.

Being the rainy season also meant that some BCS clients were working out of doors in their fields and could not be found at home.

6.3 Unlinked Caregivers and Child Beneficiaries

It was anticipated that the child beneficiaries would be linked to their caregiver to enable cross-dataset analysis. However, it was not possible to select children whose caregivers had been sampled. This resulted in divorced lists of sampled Caregivers and children, limiting the planned analysis.

6.4 Sensitivity of the questions

Some questions for BCS clients were still quite sensitive even after trying to make them sound better. Although initially, the team planned to use younger and older Research Assistants to interview OVC and BCS clients respectively, it was logistically difficult to implement as sometimes the team would be greeted with more BCS clients than the number of Research Assistants. Given the length of the BCS questionnaire (36 pages), the team could not keep them waiting, resulting in younger Research Assistants interviewing elderly BCS clients on very sensitive and private issues. Younger interviewers asking sex related questions to elderly BCS clients was difficult, not culturally appropriate and could have resulted in some biases.

6.5 Length of questionnaires

The questionnaires were generally long. The four questionnaires ranged, in length, from 16 to 36 pages. Particularly the BCS questionnaire which had 36 pages was too long for the interviewees. Some of the BCS clients complained about the length of this questionnaire, which in most cases took more than one hour to administer.

7 Appendices

7.1 Appendix 1: PMP Data Tables

Table 25: PMP+ Indicators among OVC beneficiaries

Indicator	OVC (11-14)						OVC (15-17)					
	Male (531)		Female (648)		All (1,179)		Male (369)		Female (321)		All (690)	
PMP Indicators	%	N	%	N	%	N	%	N	%	N	%	N
% of beneficiaries (aged 13-14, 15-18) who received HCT and their test result[36]	5.8	31	7.1	46	6.5	77	24.4	90	26.2	84	25.2	174
% of beneficiaries who agree: If a pupil has HIV but is not sick, he or she should be allowed to continue attending school	55.9	297	60.6	393	58.5	690	74.0	273	80.1	257	76.8	530
% of beneficiaries who agree: If a teacher has HIV but is not sick, he or she should be allowed to continue teaching at school	59.9	318	60.6	393	60.3	711	74.3	274	79.8*	256	76.8	530
% of beneficiaries who report accurate malaria prevention methods[37]	58.2	309	59.9	388	23.8	281	52.8	195	76.6	246	63.9	441
% of beneficiaries who report sleeping under a ITN the previous night	23.4	124	63.9	202	61.0	326	24.7	91	33.3	107	28.7	198
Attitudes and Values	%	N	%	N	%	N	%	N	%	N	%	N
% of beneficiaries who think PLHIV are treated unkindly in community												
% of beneficiaries who think beneficiaries are treated unkindly in community	20.3	108	20.7	134	20.5	242	29.8	110	24.6	79	27.4	189
% of beneficiaries who think a husband is justified to hit his wife	24.9	132	26.7	173	25.9	305	31.7	117	28.7	92	30.3	209
% of beneficiaries who think a husband is justified to force sex on a wife	35.4	188	31.2	202	33.1	390	40.1	148	42.1*	135	41.0	283
HIV Knowledge (True or False)	% correct	N	% correct	N	% correct	N	% correct	N	% correct	N	% correct	N
A person can get HIV from mosquito bites	47.1	250	48.0	311	47.6	561	63.7	235	64.5	207	64.1	442
People can protect themselves from HIV by abstaining from sex	68.9	366	69.8	452	69.4	818	84.8	313	85.0	273	84.9	586
People can protect themselves from HIV by using a condom correctly every time they have vaginal sex	66.5*	353	62.2	403	64.1	756	78.3	289	79.4	255	78.8	544
People can get HIV by	64.6	343	64.8	420	64.7	763	79.4	293	82.2	264	80.7	557

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[36] % of respondents reporting having received HIV test results among all respondents (i.e., denominator includes those who have NOT been tested)

[37] % of respondents, when asked about how to prevent malaria, mention *at least one* of the following: sleep under a bed net, spray the house with mosquito repellant, wear long-sleeved shirts and long trousers to avoid bites, avoid outdoor activities at dusk and dawn to avoid bites, AND/OR sleep under an insecticide-treated bed net.

Indicator	OVC (11-14)						OVC (15-17)					
	Male (531)		Female (648)		All (1,179)		Male (369)		Female (321)		All (690)	
sharing a meal with someone who is HIV infected												
People can get HIV by getting injections with a needle used by someone who is infected	74.6	396	75.0	486	74.8	882	90.5	334	87.9	282	89.3	616
A pregnant woman with HIV and AIDS can transmit HIV to her unborn child	55.9	297	53.7	348	54.7	645	68.6	253	72.9	234	70.6	487
A woman who has HIV and AIDS can transmit HIV to her child when breastfeeding	57.8	307	60.5	392	59.3	699	68.8	254	77.9*	250	73.0	504
A healthy-looking person can be infected with HIV	55.2	293	57.7*	374	56.6	667	72.1	266	75.1	241	73.5	507

*p≤0.05

Table 26: PMP+ Indicators, 18+ years

Indicator	BCS beneficiaries						Community Caregivers					
	Male (106)		Female (240)		All (346)		Male (155)		Female (238)		All (393)	
PMP Indicators	%	N	%	N	%	N	%	N	%	N	%	N
% of respondents who received HCT and received test results	93.3	99	92.5	222	92.7	321	77.4	120	80.7	192	79.4	312
% of beneficiaries who agree: If a pupil has HIV but is not sick, he or she should be allowed to continue attending school							96.1	149	96.2	229	96.2	378
% of beneficiaries who agree: If a teacher has HIV but is not sick, he or she should be allowed to continue teaching at school							95.5	148	97.1	231	96.4	379
% of respondents who report accurate malaria prevention methods[38]	88.6	94	92	221	91	315						
% of respondents who report sleeping under a ITN the previous night	43.3	46	50	120	47.9	166						
% of caregivers registered at health facilities for referrals							64.5	100	65.5	156	65.1	256
Attitudes and Values	%	N	%	N	%	N	%	N	%	N	%	N
% of respondents who think PLHIV are treated unkindly in community	44.3	47	41.6	100	42.4	147	31.0	48	29.0	69	29.8	117
% of respondents who think beneficiaries are treated unkindly in community							23.9	37	25.6	61	24.9	98
% of respondents who think a husband is justified to hit his wife	33.9	36	35	84	34.6	120						
% of respondents who think a	48.1	51	45	108	45.9	159						

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[38] Percent of respondents, when asked about how to prevent malaria, mention *at least one* of the following: sleep under a bed net, spray the house with mosquito repellant, wear long-sleeved shirts and long trousers to avoid bites, avoid outdoor activities at dusk and dawn to avoid bites, AND/OR sleep under an insecticide-treated bed net.

Indicator	BCS beneficiaries						Community Caregivers					
	Male (106)		Female (240)		All (346)		Male (155)		Female (238)		All (393)	
husband is justified to force sex on a wife												
HIV Knowledge	% correct	N	% correct	N	% correct	N	% correct	N	% correct	N	% correct	N
A person can get HIV from mosquito bites	68.8	73	68.3	164	68.4	237	89.7	139	87.0	207	88.0	346
People can protect themselves from HIV by abstaining from sex	94.3	100	92.5	222	93.1	322	92.3	143	92.4	220	92.4	363
People can protect themselves from HIV by using a condom correctly every time they have vaginal sex	92.5	98	90.4	217	91.0	315	92.3	143	90.8	216	91.3	359
People can get HIV by sharing a meal with someone who is HIV infected	92.5	98	93.3	224	93.1	322	95.5	148	95.8	228	95.7	376
People can get HIV by getting injections with a needle used by someone who is infected	94.3	100	93.8	225	93.9	325	96.1	149	98.7	235	97.7	384
A pregnant woman with HIV and AIDS can transmit HIV to her unborn child	81.1	86	81.3	195	81.2	281	91.0	141	89.5	213	90.1	354
A woman who has HIV and AIDS can transmit HIV to her child when breastfeeding	85.8	91	86.3	207	86.1	298	92.9	144	92.0	219	92.4	363
A healthy-looking person can be infected with HIV	88.7	94	95.8***	230	93.6	324	96.8	150	96.6	230	96.7	380

***P=0.000

Table 27: Well-being indicators, all beneficiaries

Indicators		OVC (11-14)						OVC (15-17)						BCS (18+)					
		Male (531)		Female (648)		All (1,179)		Male (369)		Female (321)		All (690)		Male (106)		Female (240)		All (346)	
		%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
Care	% reporting at least one person to go to for help	93.8	498	94.4	612	94.1	1,110	94.3	348	95.3	306	94.8	654			5.8	14	4.0	14
Health	% who assess own health as *excellent* or *very good*	46.3	246	40.7	264	43.3	510	45.0	166	45.2	145	45.1	311	11.3	12	10.8	26	11.0	38
	Composite healthy days score													Mean (range: 0-30)					
	% sick in past one month	50.5	268	60.5**	392	56.0	660	45.5	168	54.2*	174	49.6	342						
	% receiving treatment for last illness	40.1	213	48.8	316	44.9	529	36.6	135	43.0	138	39.6	273						
Food and Nutrition	In the last four weeks, went a whole day and night without eating because there was no food	33.0	175	33.6	218	33.3	393	33.1	122	29.0	93	31.2	215	42.5	45	48.8	117	46.8	162
	In the last four weeks, went to sleep hungry because there was not enough food	56.9	302	58.5	379	57.8	681	59.3	219	57.0	183	58.3	402	62.3	66	68.3	164	66.5	230

Indicators		OVC (11-14)						OVC (15-17)						BCS (18+)					
		Male (531)		Female (648)		All (1,179)		Male (369)		Female (321)		All (690)		Male (106)		Female (240)		All (346)	
		%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
	In the last four weeks, ate a smaller meal than they felt they needed because there was not enough food	68.9	366	65.1	422	66.8	788	68.0	251	68.5	220	68.3	471	81.1	86	87.1	209	85.3	295
	In the last four weeks, ate fewer meals b/c not enough food	72.5	385	70.8	459	71.6	844	73.4	271	74.8	240	74.1	511	84.9	90	86.7	208	86.1	298
Psychosocial	Emotional symptoms: % normal	64.2	341	61.3	397	62.6	738	63.4	234	56.4	181	60.1	415						
	Conduct problems: % normal	88.7	471	87.8	569	88.2	1,040	87.8	324	82.9	266	85.5	590						
	Hyperactivity: % normal	94.4	501	94.4	612	94.4	1,113	93.8	346	94.4	303	94.1	649						
	Peer problems: % normal	67.8	360	66.7	432	67.2	792	70.2	259	69.5	223	69.9	482						
	Total difficulties score	Mean (range: 0-40)																	
		83.4	443	80.1	519	81.6	962	84.3	311	81.0	260	82.8	571						
	Pro-social behavior: % normal	99.1	526	99.1	642	99.1	1,168	99.2	366	99.1	318	99.1	684						
Protection	% hit in last six months	39.2	208	40.0	259	39.6	467	34.4	127	27.1	87	31.0	214	29.2	31	32.9	79	31.8	110
	% forced/forced someone to have sex in last 6 months (12 months BCS)	0.8	4	0.9	6	0.8	10	0.0		2.2*	7	1.0	7	19.8	21	1.3	3	6.9	24
	% ever worked for money	53.7*	285	46.1	299	49.5	584	70.7***	261	51.4	165	61.7	426						
	% ever forced to work	19.8	105	22.7	147	21.4	252	26.3	97	27.4	88	26.8	185						
Edu.	% currently in school	97.4	517	95.8	621	96.5	1,138	94.0	347	91.9	295	93.0	642						
Econ.	% in gainful employment													37.7	40	35.4	85	36.1	125
	% reporting current income sufficient to meet needs													7.5	8	9.6	23	9.0	31

*p≤0.05, **p=0.002, ***p=0.000

7.2 Appendix 2: Scoring the Self-Report Strengths and Difficulties Questionnaire

The 25 items in the SDQ adapted for this study comprises of five scales of five items each. The total score for all five scales was calculated before working out the total score. The description below provides an illustration of how the scores were calculated.

Calculate Emotional Symptoms Score

This score is generated from the following questions only:

Q503: You get a lot of headaches, stomach-aches or sickness (not true=0, not sure=1, true=2)

Q508: You worry a lot (not true=0, not sure=1, true=2)

Q513: You are often unhappy, depressed or tearful (not true=0, not sure=1, true=2)

Q516: You are nervous in new situations. You easily lose confidence (not true=0, not sure=1, true=2)

Q524: You have many fears, you are easily scared (not true=0, not sure=1, true=2)

Follow these steps:

1. Recode: Some recoding is necessary. Please see recodes next to questions and consultant SDQ analysis form.
2. Run frequency tabs for total score. Minimum score possible is 0. Maximum score possible is 10. Graph distribution of responses. Provide range, mean and median.
3. Recode all respondents scoring 0-5 as “normal.” Recode all respondents scoring 6 as “borderline.” Recode all respondents scoring 7-10 as “abnormal.”
4. Run frequency tabs for “normal,” “borderline” and “abnormal.”
5. Run crosstabs for “normal,” “borderline” and “abnormal” with sex, age group (11-14, 15-18), and district.
6. Run crosstabs for “normal,” “borderline” and “abnormal” with Q109 (caregiver).

Calculate conduct problems score

This score is generated from the following questions only:

Q505: You get very angry and often lose your temper (not true=0, not sure=1, true=2)

Q507: You usually do as you are told (not true=2, not sure=1, true=0)

Q512: You fight a lot. You can make other people do what you want (not true=0, not sure=1, true=2)

Q518: You are often accused of lying or cheating (not true=0, not sure=1, true=2)

Q522: You take things that are not yours from home, school or elsewhere (not true=0, not sure=1, true=2)

Follow these steps:

1. Recode: Some recoding is necessary. Please see recodes next to questions and consultant SDQ analysis form. Recodes are not the same throughout all five SDQ questions, so please take care.
2. Run frequency tabs for total score. Minimum score possible is 0. Maximum score possible is 10. Graph distribution of responses. Provide range, mean and median.
3. Recode all respondents scoring 0-3 as “normal.” Recode all respondents scoring 4 as “borderline.” Recode all respondents scoring 5-10 as “abnormal.”
4. Run frequency tabs for “normal,” “borderline” and “abnormal.”
5. Run crosstabs for “normal,” “borderline” and “abnormal” with sex, age group (11-14, 15-18), and district.
6. Run crosstabs for “normal,” “borderline” and “abnormal” with Q109 (caregiver).
7. Run crosstabs with Q106 (current school attendance)

Calculate hyperactivity score

This score is generated from the following questions only:

Q502: You are restless, you cannot stay still for long (not true=0, not sure=1, true=2)

Q510: You are constantly fidgeting or squirming (not true=0, not sure=1, true=2)

Q515: You are easily distracted, you find it difficult to concentrate (not true=0, not sure=1, true=2)

Q521: You think before you do things (not true=2, not sure=1, true=0)

Q525: You finish the work you are doing. Your attention is good (not true=2, not sure=1, true=0)

Follow these steps:

1. Recode: Some recoding is necessary. Please see recodes next to questions and consultant SDQ analysis form. Recodes are not the same throughout all five SDQ questions, so please take care.
2. Run frequency tabs for total score. Minimum score possible is 0. Maximum score possible is 10. Graph distribution of responses. Provide range, mean and median.
3. Recode all respondents scoring 0-5 as "normal." Recode all respondents scoring 6 as "borderline." Recode all respondents scoring 7-10 as "abnormal."
4. Run frequency tabs for "normal," "borderline" and "abnormal."
5. Run crosstabs for "normal," "borderline" and "abnormal" with sex, age group (11-14, 15-18), and district.
6. Run crosstabs for "normal," "borderline" and "abnormal" with Q109 (caregiver).
7. Run crosstabs with Q106 (current school attendance)

Calculate peer problems score

This score is generated from the following questions only:

Q506: You would rather be alone than with people of your age (not true=0, not sure=1, true=2)

Q511: You have one good friend or more (not true=2, not sure=1, true=0)

Q514: Other people your age generally like you (not true=2, not sure=1, true=0)

Q519: Other children or young people pick on you or bully you (not true=0, not sure=1, true=2)

Q523: You get along better with adults than with people your own age (not true=0, not sure=1, true=2)

Follow these steps:

1. Recode: Some recoding is necessary. Please see recodes next to questions and consultant SDQ analysis form. Recodes are not the same throughout all five SDQ questions, so please take care.
2. Run frequency tabs for total score. Minimum score possible is 0. Maximum score possible is 10. Graph distribution of responses. Provide range, mean and median.
3. Recode all respondents scoring 0-3 as "normal." Recode all respondents scoring 4-5 as "borderline." Recode all respondents scoring 6-10 as "abnormal."
4. Run frequency tabs for "normal," "borderline" and "abnormal."
5. Run crosstabs for "normal," "borderline" and "abnormal" with sex, age group (11-14, 15-18), and district.
6. Run crosstabs for "normal," "borderline" and "abnormal" with Q109 (caregiver).
7. Run crosstabs with Q106 (current school attendance)

Calculate total-difficulties score

Sum scores of the following scales:

- Emotional Symptoms
- Conduct Problems
- Hyperactivity
- Peer Problems

Minimum score possible is 0. Maximum score possible is 40. Graph distribution of responses. Provide range, mean and median.

Calculate pro-social behavior score

Q501: You try to be nice to other people. You care about their feelings (not true=0, not sure=1, true=2)

Q504: You usually share with others, for example games, food (not true=0, not sure=1, true=2)

Q509: You are helpful if someone is hurt, upset or feeling ill (not true=0, not sure=1, true=2)

Q517: You are kind to younger children (not true=0, not sure=1, true=2)

Q520: You often offer to help others (parents, teachers, children) (not true=0, not sure=1, true=2)

Follow these steps:

1. Recode: Some recoding is necessary. Please see recodes next to questions and consultant SDQ analysis form.
2. Run frequency tabs for total score. Minimum score possible is 0. Maximum score possible is 10. Graph distribution of responses. Provide range, mean and median.
3. Recode all respondents scoring 6-10 as “normal.” Recode all respondents scoring 5 as “borderline.” Recode all respondents scoring 0-4 as “abnormal.”
4. Run frequency tabs for “normal,” “borderline” and “abnormal.”
5. Run crosstabs for “normal,” “borderline” and “abnormal” with sex, age group (11-14, 15-18), and district.
6. Run crosstabs for “normal,” “borderline” and “abnormal” with Q109 (caregiver).
7. Run crosstabs with Q106 (current school attendance)

7.3 Appendix 3: Caregiver Validation Meetings

7.3.1 Background

To validate the findings of the caregiver component of the study a series of meetings were held with caregivers. In addition to validating the findings, these meetings were intended to provide caregivers with an opportunity to comment on the findings and as well as provide allow them a platform for which they would make recommendations.

To this end, caregivers from three districts that participated in the baseline were purposively selected

In February of 2012, results of the 2011 study were disseminated centrally to government and other stakeholders at national Level. As one of the program requirements, findings were also to be shared with individuals (at field or community level) that participated during this study; it is for this reason that verification and result sharing events were arranged by PMU in three World Vision Supported Sites/Districts namely, Mongu (Namuso ADP), Kaoma (Luampa ADP) and Mumbwa (Mumbwa ADP).

The field result sharing/verification exercise was led by the Senior M&E Technical Advisor with support from the STEPS OVC M&E Officer- World Vision Zambia and staff from the three participating ADPs.

7.3.2 Objectives

1. This community based sharing whose objectives were to:
2. To share and validate findings of the STEPS OVC baseline survey with Community Caregivers
3. With Community Caregivers, develop program recommendations based on findings

7.3.3 Program/Schedule of Activities

The schedule of activities was a generic one for all the three districts and took the following order:

- Introductions and Workshop Overview (30 minutes)
- Presentation of key findings (1 hour)
- Discussion in small groups of five people on key areas: (45 minutes)
- Services/information provided
- Training (received and needed, priority areas)
- Monitoring clients' progress
- Referrals
- Tea break (provided) (15 minutes)
- Summarize group discussion in plenary (facilitator to bring consensus) (1.5 hours)
- Prioritize group recommendations (30 minutes)

7.3.4 Methodology

The method community based dissemination of findings consisted of flip chart presentations, reading extracts from the report, taking group exercises and conducting discussions.

At the outset, participants were introduced to what was the purpose of the STEPS OVC program baseline, the number of Caregivers and districts that participated.

The facilitator in his presentation used the most basic understanding of statistical presentations using the ratios and proportions illustrating from a whole of '10' and giving practical examples from the Caregivers present.

7.3.5 Summary of Deliberations

This community based dissemination of baseline findings provided information on the picture of STEPS OVC prior to the start of implementation. The presentation was structured in in three (3) main themes of Caregiver under takings namely:

- Profile

- Roles and Workload
- Services and Training

Day I: Monday 13th February 2012 (Mongu)

The dissemination workshop begun with opening remarks from the World Vision Area Development Program (ADP) Manager. He thanked the Caregivers of their continued dedication to due to duty and they are providing to the communities they save. This was followed by introductions (participant name, the zone of operation and what they do). The site visit was supported by the ADP manager and a Community Development worker attached to the STEPS OVC project.

Profile

They were 13 caregivers present of which 60% (two in every three) were women. This was in line with the finding of the baseline study. On school enrolment all the caregivers have attended some school, at different levels; of the 13, 10 said they were in the range of having attended between grades 1 to 12, whereas three have gone beyond grade 12. On marriage, the base line finding was that two in every three caregivers were married. Of the 13 in the workshop, eight were married, representing 62%.

In summary, the profile of a caregiver is that in most cases is a married woman, has some level of education and has children. The average income they earn was ZMK 300,000 with 70% of them likely to be farmers.

Roles, Responsibility and Workload

A majority have been Caregivers for more than a year.

It was found that male caregivers are confident in discussing STI related topics than their female counterparts, whereas the female are more comfortable in discussing nutrition and child health related topics.

Services and Trainings

As in the baseline findings, it was found during the workshop that caregivers were providing services for which they were not trained; of the 13, eight were able to provide CT. of these only two were trained and certified to provide the same service. During discussions, it was established that caregivers are providing more services than they are trained.

During group discussions, training gaps were identified in CT, PEP, Nutrition, Health and Pain assessment. It was also noted that caregivers were making referrals, but they were not documented.

Day II: Tuesday 14th February 2012 (Kaoma)

On day 2, the dissemination was in Kaoma. They were 19 (five male, 14 Female) participants, of which five participated in the baseline study.

Profile

9 of the 19 caregivers present were married of which all the 19 have children. 18 have had some education, as only one participant has never attended school.

Roles, Responsibility and Workload

All the caregivers present reported having been Caregivers for more than a year.

As in Mongu, it was found that male caregivers are confident in discussing STI related topics than their female counterparts, whereas the female are more comfortable in discussing nutrition and child health related topics.

Services and Trainings

As in the baseline findings, it was found during the workshop that caregivers were providing services for which they were not trained.

In the afternoon, two laptops were networked to the STEPS OVC DMIS. The networking was done in order to ease the data entry processes.

Day III: Tuesday 15th February 2012 (Mumbwa)

Day 3 was the last one were 16 (6 male, 10 Female) caregivers attended. In profiling the caregivers all the caregivers had some form of education. This was evident that presentations were done in English with an easy understanding from the all the caregivers.

Services and Trainings

Like in the other two ADPs, caregivers were providing services that were not trained in. For example of the 14 (out of a total of 16) caregivers that were able to provide CT, only seven were partially trained to offer such a service and 10 of the 16 were trained to provide psychosocial counseling.

7.3.6 Summary of Conclusions

In all the three ADPs, they were group presentations and they were as below;

Table 28: Summary of Caregiver Recommendations

Question	ADP Response		
	Namuso (Mongu)	Luampa (Kaoma)	Mumbwa (Mumbwa)
Why are there more female caregivers than male ones?	• Women are more compassionate • Women are more committed to the calling of care giving than males • Women are more closer to families, thus having a caring bond	• Women are more merciful • Men are mostly engaged in income generation, thus spend time on such undertakings. • Women are cooperative, making it easier for them to do voluntary works	• Women have a caring nature • Women are companionate • Women are warm hearted • Empathy among women
How can the Caregiver work be made easier?	• Providing bicycles for easier mobility • Recruiting more caregivers • IGAs and Economic strengthening activities for caregivers	• Providing bicycle spares, bicycles, gum boots and rain coats • Recruiting more caregivers • Provide incentives to caregivers	• Providing bicycles for easier mobility • Having smaller operational areas • Recruiting more caregivers • Allowances to appreciate caregivers • IGAs and Economic strengthening activities for caregivers
How can caregiver workload be reduced?	• Recruiting more male caregivers	• Recruiting more caregivers	• Recruit more caregivers • Personal activities against volunteer work load balance • Work schedule planning • Work self evaluation

7.4 Appendix 4: References

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7.5 Appendix 5: Data Collection Team

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