

Factors Related to the Placement into and Reintegration of Children from Catholic-affiliated Residential Care Facilities in Zambia



All photos by John Healey for CRS.

© 2016 Catholic Relief Services. All rights reserved. This material may not be reproduced, displayed, modified or distributed without the express prior written permission of the copyright holder. For permission, contact pqpublications@crs.org.

Catholic Relief Services
228 West Lexington Street
Baltimore, MD 21201-3443

Factors Related to the Placement into and Reintegration of Children from Catholic-affiliated Residential Care Facilities in Zambia

Authors: Katie Januario, John Hembling, Ashley Rytter Kline and Jini Roby

Acknowledgements

This research was made possible by the generous support from the GHR Foundation.

Special thanks to the Ministry of Community Development and Social Welfare; the Zambia Association of Sisterhoods; and the Children in Families partners including UNICEF, Save the Children, CMMB, and Bethany Christian Services for their active collaboration and support.

Thank you also to the research team who supported research design, tool development, data analysis, feedback and review – Caroline Bishop, CRS Sr. Technical Advisor for Vulnerable Children; RuralNet Associates Limited; especially Stephen Tembo, Maxwell Bweupe, Kelvin Munjile, John Kunda and Twaambo Munaumba; and consultants Earnest Kasuta, Dr. Joseph Zulu, and Kelley Bunkers.

We are especially grateful to members of the CRS team – Patience Vilinga, Caroline Bishop, Michele Gilfillan, Shannon Senefeld, Paul Perrin, Shannon Cornelius, David Leege, Exhilda Siakanomba, Ana Maria Ferraz De Campos, Carrie Miller, Lucy Steinitz, Danielle Nestadt, Wendy-Ann Rowe, Severine Chevrel, and Denise Struckenbruck.

CRS would also like to express sincere appreciation to the Catholic-affiliated residential care facilities and the many community members, families, caregivers, and young people who participated in this research. Your contributions and insights were invaluable.

Acronyms

CIF: Children in Families (GHR Initiative)

CMMB: Catholic Medical Mission Board (previously known as)

CRS: Catholic Relief Services

DSWO: District Social Welfare Office

MCDSW: The Zambian Ministry of Community Development and Social Welfare

SILC: Savings and Internal Lendings Communities

TFH: The Faithful House

UNICEF: United Nations International Children's Emergency Fund

ZAS: The Zambia Association of Sisterhoods

ZEC: Zambian Episcopal Conference

Contents

Abstract	1
Introduction	3
Methodology	5
Sample	5
Research Design	5
Research Instruments and Protocols	6
Study Limitations	7
What does Catholic-affiliated residential care for children look like?	9
Facility Characteristics	9
Financial and in-kind support	11
Relationship with the government and local community	12
Services provided by the facilities	12
Health Services	14
Social Services	15
Number of children in care	15
Characteristics of the children who live in Catholic-affiliated residential care facilities ...	17
Age and Sex	17
Where children are from	17
Disability and chronic illness	19
Reason for placement	19
Death of a parent	21
Behavior	21
Disability or illness of a child	22
Abuse, maltreatment and neglect	22
Family and household background	22
Visitation	24
Leaving Care	25
Alternative family based care	27
Perceptions of alternative family based care options	27
Reintegration	28
Care Leavers	31
Transition to independent living	31
Support: What was received and what did they need	32
Life on the outside	32
Challenges of leaving care	33
Relationships	34
Advice for others	34
Discussion and Recommendations	35
References	38
Appendix 1: Sampling	39



Abstract

BACKGROUND

To support recent child care reform efforts in Zambia, Catholic Relief Services, in collaboration with the Government of the Republic of Zambia, Ministry of Community Development and Social Welfare and in partnership with the Zambia Association of Sisterhoods (ZAS), conducted formative research to better understand and document the factors related to children's placement in Catholic-affiliated residential care facilities in Zambia, as well as perceptions around reintegration and leaving care. This study was part of the GHR Foundation's *Children in Families* (CIF) strategy.

METHODS

The research consisted of an in-depth review of 39¹ of 40 Catholic-affiliated residential care facilities² in Zambia. Quantitative and qualitative data were gathered from community leaders, facility directors, caregivers, parents, and youth which offered insight into Catholic-affiliated residential care facilities in Zambia and surrounding communities. The findings from this study will be used to inform future programming by CRS and others, including the Government of Zambia, Catholic partners, and key stakeholders aimed at preventing placement of children into facilities, strengthening families, and reintegrating children back into family-based care. This study will also be used to influence national policy implementation.

KEY RESULTS

The study found that the top reasons for placing children in Catholic-affiliated residential care facilities were: 1) poverty (primarily resulting in the inability to afford school fees and/or food insecurity); 2) death of a parent; 3) disability or chronic illness of the child in care; 4) abuse, maltreatment, or neglect; 5) disability or chronic illness of a household member; and 6) caregivers' inability to cope with rebellious behaviors displayed by children and youth.

The most common needs cited by caregivers with children in residential care were economic and educational support. Caregivers who did not place children in care were more likely to feel that lack of school support would contribute to placement. Community leaders also stated that economic support was essential.

When a child enters care, a family's connectedness through visitation is extremely important for a successful reintegration process. According to the child survey, most children (63.7%) had family visit them in care at least once since they entered the facility. More than half (53.7%) of the children had family visit in the past 12 months.

Qualitative data indicated that reintegration planning was not standard practice at the residential care facilities with few caregivers stating that they had discussed reintegration plans with facility staff. Care leavers also did not appear to have formal reintegration preparation, with almost half stating that the decision to live on their own was agreed upon (e.g., they would leave after completing Grade 12). Despite this lack of consistent reintegration planning, 137 children were

¹One of the 40 identified Catholic-affiliated residential care facilities choose not to participate in the research study.

²Residential care in this case is understood as a group-living arrangement in a specially designed or designated facility where salaried staff or volunteers are mandated or called to ensure care [on a shift basis] for children who cannot be looked after by their family due to the latter's inability or unwillingness to do so.

reported by facilities as leaving the facility in the previous year. Across all 39 facilities, the most common ways that a child left a facility were through placement with family or kin (which may include reunification with biological parent/s) or by aging out of facility.

RECOMMENDATIONS

The research findings add to the body of knowledge that influence the acceleration of childcare reform in Zambia. Notably, the research serves as the basis for shaping the involvement of Catholic-affiliated residential care facilities in particular with advancing the government's strategy. CRS recommends that there is a purposeful process of change and consensus-building among residential care facilities and stakeholders with regards to buy-in to the alternative care movement in Zambia.

- At national level, CRS recommends continued partnership with the Zambia Association of Sisterhoods (ZAS) and the Zambia Episcopal Conference (ZEC) to develop their capacity to be change agents who can advocate for a shift in knowledge and attitudes with regards to prevention and response to family separation across Catholic structures and congregations.
- The findings indicate more comprehensive and interdisciplinary support is needed to help families care for their children at home. Over the years, CRS has invested in a number of interventions to support family strengthening within orphans and vulnerable children and other development programs. This has included the implementation of approaches such as CRS' The Faithful House³(TFH) curriculum, parenting education and economic strengthening activities such as social cash transfers, Savings and Internal Lending Communities (SILC) and agriculture initiatives. CRS recommends that any future work is applied through a similar lens that takes into consideration the interdisciplinary needs of the family unit.
- CRS recommends creating a targeted communication strategy through partnership with ZAS and ZEC to lead the national dialogue around alternative care, reintegration and family strengthening. ZEC is the entry point to working with Dioceses throughout Zambia which oversee all Catholic churches, Catholic schools, Catholic-affiliated facilities as well as the general Catholic community, while ZAS is the entry point to working with sister-led Catholic-affiliated residential care facilities.
- By working through a collaborative partnership with ZAS, CRS recommends designing focused programs to build the capacity of Catholic sisters through education and development to fill a much needed gap within the social service workforce.
- Structural changes that improve availability and accessibility of community services for vulnerable households are needed (e.g., care for the disabled (including parents or caregivers who suffer from a mental illness or disability), child and youth recreation facilities), complemented by adjustments in government programming (e.g., better regulation of school fees, improved quality of education, expansion of economic safety net programs such as social cash transfer), could prevent child separation from the family.⁴
- CRS recommends working with facilities to better prepare young people for independent life as well as working with communities to help develop a social support structure that supports care leavers.

³The Faithful House (TFH) is a culturally sensitive, faith and values-based skills-building curriculum designed to strengthen relationships for cohabitating couples. TFH curriculum, currently implemented in 14 African countries and benefiting over 110,400 beneficiaries, has been proven effective in strengthening household governance, improving household economic empowerment, and challenging harmful cultural and gender norms.

⁴During the National Consultation on Child Care Reform meeting, a number of gaps in both capacity and coordination were identified at both ministerial and sectorial levels, and a national 'Call to Action' was delivered at the close of the meeting which reinforced the Government's commitment to care reform and addressing the gaps.



Introduction

There is increasing global concern over the number of children who live outside of parental care or are in jeopardy of being separated from their family. Evidence indicates that a child who is separated from their family has a much greater risk to suffer exploitation and harm by living on the street or within institutional care.¹ Global estimates show that approximately 80-90% of children in residential care have at least one living parent.² A growing body of evidence demonstrates that poverty, not loss of parents, is often the primary reason for placement in residential care.^{3,4,5,6,7} Other reasons include disability^{8,9}, lack of access to social services such as day care and education, family breakdown, and single parenthood.^{10,11}

This research effort aims to understand the Zambian context of residential care in the overall national scheme of care reform policy. The Zambian Ministry of Community Development and Social Welfare (MCDSW) reports that there are 8,335 children (4,504 boys and 3,831 girls) living in child care facilities in Zambia¹². In the past three years, support from the GHR Foundation and UNICEF has enabled the Ministry to evolve the national policy context rapidly with regards to alternative care for children. The government recently launched *Minimum Standards of Care for Child Care Facilities, Regulations and Procedures* (2014) and is in the process of finalizing guidelines for kinship care, foster care, and adoption as well as planning for formalizing care management protocols. The MCDSW collected baseline data in all residential care facilities throughout the country to support the national child protection policies and practices. From a government policy standpoint, institutionalization is increasingly seen as an option of last resort.

The government estimates that 190 residential care facilities for children exist in Zambia, with 40 being Catholic-affiliated. With its extensive global network of social support services, the Catholic Church has a long history of supporting vulnerable children through the establishment and operation of residential childcare facilities. This study fills an important gap related to residential care in general and Catholic-affiliated residential care specifically, in Zambia. Researchers gathered critical information from or about key decision makers, service providers, community members, caregivers, children, and youth. This is the first study that has been conducted on this topic in Catholic-affiliated facilities.

As part of the GHR Foundation's Children in Families (CIF) strategy, Catholic Relief Services, UNICEF, Save the Children, CMMB, and Bethany Christian Services in Zambia, work in partnership to support reintegration and family strengthening efforts throughout Zambia. In January 2014, CRS received funding from the GHR Foundation to conduct formative research to explore the factors related to children's placement in Catholic-affiliated residential care facilities. In partnership with the MCDSW and ZAS, CRS conducted research with 39 facilities and in 10 surrounding communities. Other partner agencies are currently conducting additional research, such as UNICEF's assessment on behalf of MCDSW of all known residential care facilities throughout Zambia and Save the Children's mixed methods study on kinship care. Work in reintegration, foster care and other family strengthening efforts are also part of the CIF initiative in Zambia.

This research was part of an effort to collaborate with government line ministries, faith organizations and other key stakeholders on implementing the Zambian national policy. The study's findings support the government's baseline by providing facility and community level data, and they provide information on the key characteristics of children living in Catholic-affiliated residential care facilities,



Children and caregivers play with blocks at a residential care facility in Zambia.

including information about their families, children's length of stay in facilities, drivers of placement of children in Catholic-affiliated residential care and services provided by facilities both on-site and in nearby communities.

These findings will be used to design evidence-based programming through a participatory process with key stakeholders to reduce the number of children entering care, support family strengthening and reintegration, and develop a model for transitioning facilities to provide alternative types of services for children and families in the community.





Methodology

The study sought to answer three main research questions:

1. What characterizes Catholic-affiliated residential care for children?
2. What are the main factors that promote family preservation, family reintegration, alternative family-based care, adoption and residential care for vulnerable children?
3. What happens to children who leave the care of a Catholic-affiliated residential facility (care leavers)?

SAMPLE

Data collection took place from November 2015 to April 2016 in multiple sites throughout Zambia from respondents in Catholic-affiliated residential childcare facilities and surrounding areas. This sample for this study included several key groups including the administration, caregiving staff, and youth in Catholic-affiliated facilities, parents and caregivers who had children in facilities as well as those who did not, community leaders, and care leavers. Catholic-affiliated facilities were identified through a mapping process and included institutions that are part of the Cheshire Home Society of Zambia³, a Zambian NGO that cares specifically for children with disabilities. A purposive sample of 15 facility directors were selected to capture experiences and perspectives from a variety of contexts, including geographic location, urban/rural, type of resident (e.g., disability, street children, boys only, girls only), and facility size. The community-based data collection activities purposively selected up to four community leaders in 10 communities. The locations were selected to capture information from a diverse set of facilities, as described previously. In the same communities, primary caregivers who (a) had placed a child in residential care, (b) were at elevated risk of placing a child in residential care, and (c) had reintegrated a child back into family-based care were selected. Facility directors, local community leaders, and government social workers identified these caregivers and invited them to participate in the interviews. Care leaver participants were identified from recommendations of facility directors and staff, community leaders, and other care leavers. The facility director, community member, or other adult were requested to contact the care leaver on behalf of the study to grant initial verbal permission to reach out to the care leaver. For more information on sampling for this study, see Appendix 1.

RESEARCH DESIGN

This study was designed to seek both quantitative and qualitative data at the individual, family, and community levels. Quantitative data collection focused on obtaining information about facilities; including their staffing, operating structures and the services they provided children in care, to learn more about their families, ages, reasons for placement, etc. A series of qualitative interviews was conducted among a range of individuals in ten communities.⁶ Qualitative approaches sought to generate in-depth information about the lived experiences, perceptions and attitudes of a wide range of stakeholders, including youth currently in care facilities; caregivers who currently had children in care facilities and those who did not; care leavers;

⁵Cheshire Home Society of Zambia is an independent NGO located in Zambia. The care facilities that are affiliated with the NGO in Zambia are also operated by Catholic organizations such as Sister congregations and lay professionals.

⁶Criteria for the selection of communities included location (urban versus rural); a Catholic-facility within the area; the size of the facility within the area; the main operator of facility within the area (sister or brother operated, lay ministry, etc.); the type of children in care at the facility (boy or girl only, OVC general population, disability focused, etc.)

and community leaders which included district social welfare officers, police officers, teachers, social workers, faith leaders and village headmen. Interviews with primary caregivers who have reintegrated with children into their household and caregivers who have not placed a child in care despite similar challenges with those that have were interviewed for this study.

RESEARCH INSTRUMENTS AND PROTOCOLS:

CRS developed the instruments utilizing information from the *Minimum Standards of Care for Child Care Facilities, Regulations and Procedures* (draft version) as well as consultation with key stakeholders and experts in the field of reintegration and child care reform. Local research consultants completed a review for cultural and facial validity. The instruments were piloted in conjunction with the enumerator training with a small number of participants from non-Catholic residential care facilities prior to data collection. The research protocol, all tools, informed consent forms and assent forms for youth⁷ went through a thorough ethical review process and were approved by an independent institutional review board (IRB), ERES Converge IRB.⁸

DATA COLLECTION PROCEDURES

Facility profile: All facility directors were invited to complete a facility profile. The profile consisted of a structured questionnaire to collect basic information about the facility itself. Facility directors or their designees provided information regarding their backgrounds; the facility background and record keeping systems; the services provided by the facility and to whom they are provided; staffing at the facility; a basic description of the children in care, including arrivals and exits; and a review of children with disabilities.

Semi-structured interviews with facility directors: Fifteen facility directors were purposively selected to complete a semi-structured interview. The interview covered factors related to the placement of children into residential care, attitudes towards alternative care options, the types of services needed to prevent separation, and attitudes towards the transition of facilities to a family-promotive model of care.

Structured questionnaire with caregivers about children and youth: A random sample of 268 children and youth in residential care facilities aged 0-25 was selected based on facility lists. Only children and youth who live at the facility year-round were included in the sample frame. Children and youth were not interviewed directly. A residential care facility staff member who provided care for the sampled children, including facility caregivers, facility directors, and social workers, were interviewed about the selected child using a structured questionnaire. Caregivers were able to use the child's file to find information if they were not able to answer the questions on their own. Over half (53.4%) of caregivers referred to the child's file for information. One facility chose not to participate in the child sample because the administration felt it was against their child protection policy, resulting in a total sample size of 268 children from 38 facilities.

⁷All tools, consent forms and assent forms for youth were translated in five local languages and approved by the IRB, ERES Converge.

⁸ERES Converge, IRB No. 00005948; FWA No. 00011697 and project approval reference No. 2015-Oct-006

Semi-structured interviews with community members: Interviews were conducted with community leaders (n=48), primary caregivers who have placed children in residential care (n=30), primary caregivers whose children are at heightened risk of family separation but had not placed a child in residential care (n=29), and primary caregivers who had reintegrated a child back into family-based care from a residential care facility (n=30).

Semi-structured interviews with youth: Interviews with youth between 16-25 years of age currently living in a facility (n=34) were asked questions including the causes of child placement into facilities, their experience living in facility care and their perceptions and attitudes towards alternative care options.

Semi-structured interviews with care leavers: Interviews with young adults aged 18 to 30 years (n=40) who lived in a facility⁹ for at least one year and left care within the past five years were asked questions on a range of topics, including their experience living in residential care, their perceptions and attitudes towards alternative care options, and their perceptions and attitudes towards independent living and aspirations for the future.

DATA ANALYSIS

Quantitative data were collected through the facility profile and the structured questionnaire which were used with facility staff to collect information about a sample of facility residents (0-25 years old). Descriptive statistics, including frequencies, means, and proportions were calculated using Stata SE statistical software.

Using Nvivo qualitative data analysis software, qualitative data were sorted and categorized by thematic threads occurring in the responses. In conducting the interviews, researchers had seen that there were frequently recurring responses for each of the key questions, often reaching saturation points within approximately ten to fifteen interviews. Since most of the surveys were administered to 30 or more respondents, we felt with a high level of confidence that most respondents shared common perceptions and experiences. When we sorted and organized the responses our initial impressions were confirmed. Following initial coding, some categories were split or combined to produce a more holistic and succinct report. The use of the ecological framework was useful in organizing responses to some questions into various system levels.

STUDY LIMITATIONS

The results of this study should be interpreted in light of its limitations. The sample size for the child survey that was applied to facility caregivers was designed to calculate basic descriptive statistics to characterize children living in Catholic-affiliated residential care facilities. This sample design limited our ability to look very closely at sub-groups of children.

While 39 facilities participated in the facility profile, some facility directors or their representatives had incomplete knowledge of some topic areas, resulting in varied sample sizes for certain items. This limitation was also apparent for certain areas of inquiry in the child survey, including composition of the family of origin and experiences of abuse. To mitigate the effects of non-response, the sample size calculation inflated the sample size by 20 percent. Although the

⁹The care leavers who participated in this study were former residents of residential care facilities in Zambia, not necessarily Catholic-affiliated facilities.

facility caregivers could access the children's records during the interview, for certain questions respondents did not know the information for up to 30% of the sampled children. Any systematic differences in completeness may have resulted in a recall bias. Additionally, one large facility participated in the facility profile, but declined to participate in the child survey, potentially explaining any discrepancies in the results between these two data collection activities.

Given the sensitive nature of the topic, social desirability bias, or the tendency to tell the interviewers what is socially acceptable, may have influenced the results of this study. In particular, it may have impacted the semi-structured interviews with caregivers who placed their children into residential care facilities, youth in care, and care leavers. To limit the impact of this type of bias, informed consent was obtained, enumerators repeatedly reminded the respondents that all information collected would be kept confidential, and names were not collected during data collection.



What does Catholic-affiliated residential care¹⁰ for children look like?

FACILITY CHARACTERISTICS

STAFF AND STRUCTURE

According to the facility profile, the majority of Catholic-affiliated facilities were operated by Catholic Sister congregations¹¹ (28 out of 39 facilities). Lay missionaries were the second largest affiliated group operating 6 out of the 39 facilities. Other facilities were operated by a Catholic priest or brother congregation/order.

Of those respondents who participated in the facility profile, 29 identified themselves as a facility director, Catholic Sister-in-charge, or founder, and of these respondents, the mean number of years spent as a director of a facility was 7. Two thirds (66.7%) of respondents were Zambian and one third (33.3%) were from another country. The average number of staff working in the facilities was 23, with an average of 12 staff being from the nearby community. Volunteer support was relatively low within the facilities (n=39) with an average of 2.3 volunteer workers per facility.

The facility profile also included a review of each facility's record keeping system. Most facilities (21 out of 38) reported that they used a paper-only records system. Less than half (16 out of 38) facilities used a combination of paper and electronic records. All (100%) of the facilities (n=37) reported that each child had a file at the facility. Over one-third (37.1%) of facilities (n=35) reported that the child had access to his/her file.

Nearly all (94.6%) facilities (n=37) had an admissions form for children. Among the facilities with an admissions form (n=35), 90% included a field for the child's facility admission date and 86.7% included a field for the name of person or agency placing the child. The majority (76.7%) included a field for the reason for admission; 86.7% included a field for the name of person or agency placing the child; and 76.7% included a space for contact information for person or agency placing the child. A smaller percentage of facilities (n=35) included information on the child's siblings (sibling names were included on 46.7% of forms and contact details were included on 34.5%).

The importance of obtaining family information when a child enters residential care is paramount in order to conduct family tracing and reintegration efforts. Under the Government of Zambia's Juveniles Act Cap 53 Section 22, child care facilities not only have the responsibility to support

¹⁰The researchers have decided to use the terms "residential care" and "residential care facility" as per UNICEF Guidelines on Alternative Care (2009). Common terms used in the Zambian context include, among others, "child care institution," "children's home," "Cheshire homes," and "transit homes."

¹¹In the Roman Catholic Church, the term "congregation" refers to a community of men or women that have taken religious vows and follow a specific charisma or faith practice. In Zambia, there are approximately 47 Catholic Sister congregations.



and maintain children in their care, but the facilities must also assist with reintegration efforts and provide permanency planning for a child to return to family care. As highlighted in Figure 1, admission forms did not consistently gather names and contact details for all family members, however the vast majority of facilities did include fields for parent’s name and contact information. Almost all (90%) facilities included a field for the mother’s name (80% included a contact information for the mother) and 86.7% included a field for the father’s name (80% included a contact information field for the father). See Figure 1 for a full description of the percentage of facilities that included select information about the child’s family on their admissions form (n=35).

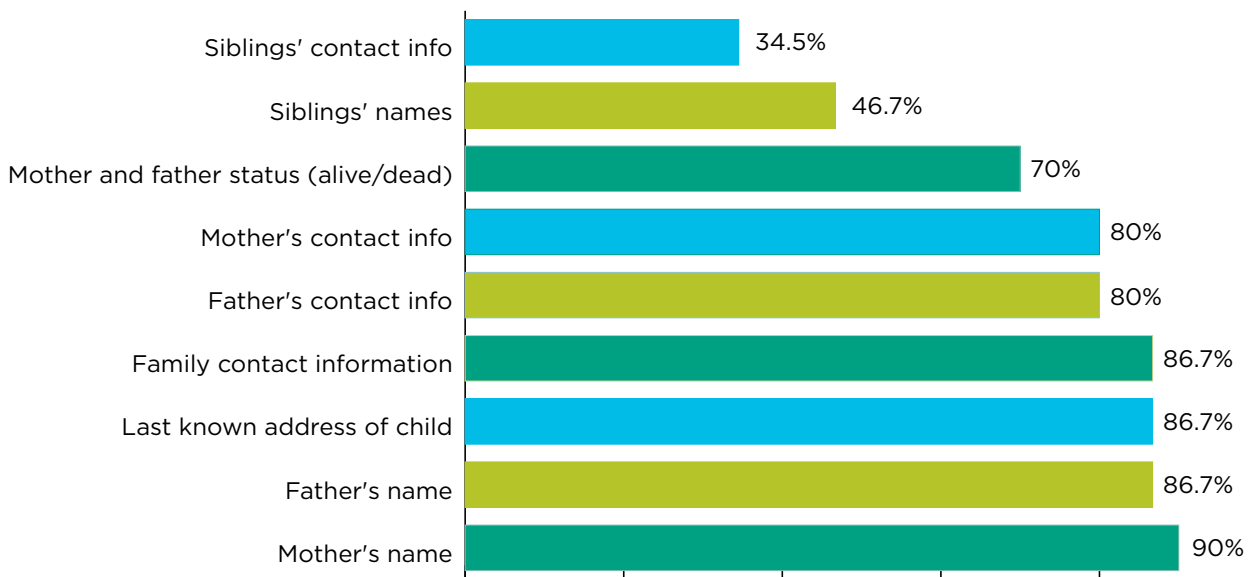


Figure 1: Percentage of facilities with an admissions form that captures select information

According to the facility profile, 90% of facilities (n=37) had child protection policies in place, 71% of facilities had staff sign the protection policy (of the 35 facilities with a policy), and 58% of facilities (n=31) had volunteers sign the protection policy.

FINANCIAL AND IN-KIND SUPPORT

The facility profile collected information about the financial support received from various sources over the previous year (see Figure 2). The main sources of support that the facilities received were from the Catholic dioceses and/or Sister congregations (64.1%); national or international NGOs (46.2%); or individual or family donations (38.5%).

Facilities were also asked about whether they had children in their care who were sponsored by an outside donor over the past year. Almost half (48.7%) of facilities (n=39) reported that they sponsored children. The mean number of sponsored children from the past year was 14 children from reporting facilities (n=17).

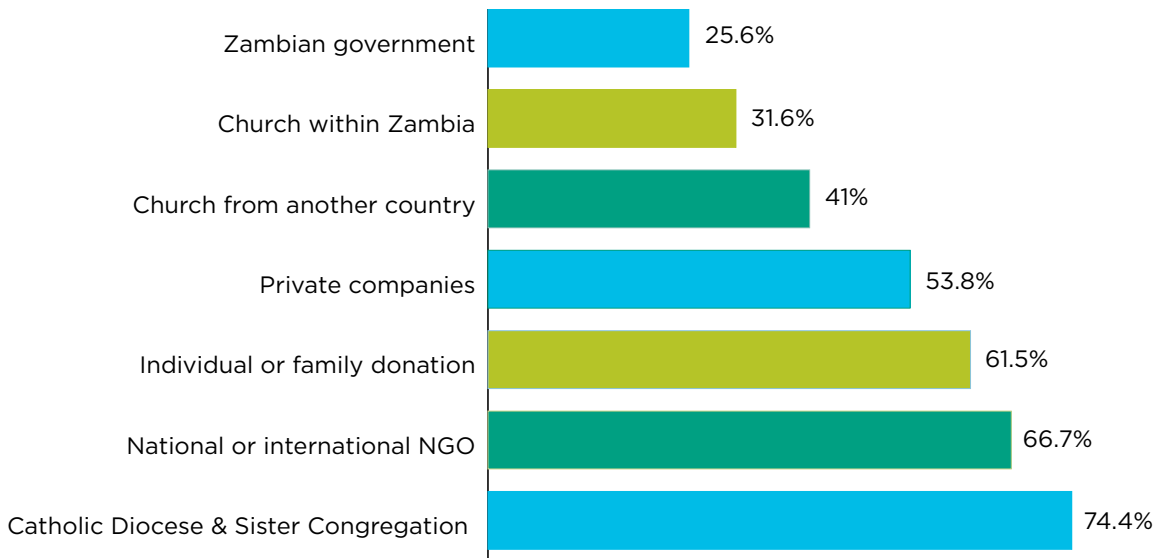


Figure 2: Percentage of facilities that received funding from select sources

The most common sources of in-kind support, or non-financial support in the form of material goods or services, were individual or family donations (64.1%); private companies (56.4%); and Catholic dioceses and Sister congregation (53.9%).

RELATIONSHIP WITH THE GOVERNMENT AND LOCAL COMMUNITY

According to the facility profile, most (77%) facilities participated in the development of government child protection policies, such as the *Minimum Standards of Care for Child Care Facilities*. Nearly all (95%) of the facilities described their relationship with the district social welfare office (DSWO) as good or very good. During a results validation meeting with the facilities, participants indicated that while the facilities did not have a poor relationship with the DWSO, they did not have a collaborative relationship either. They emphasized that coordination could be improved by both parties.

The majority (92.3%) of facilities (n=39) described their relationship with the surrounding community as very good or good. More than half of facilities (56.8%) reported that a community leader participated on their governing boards. The majority (71.0%) of facilities (n=38) also responded that a facility representative participated in a community committee, such as a child protection committee.

SERVICES PROVIDED BY THE FACILITIES

Results from the facility profile showed a variety of educational, health and social services were provided by facilities to both residents and to people within the community. .

EDUCATIONAL SERVICES

Facilities provided formal educational services to both their residents and the surrounding community, including on-site schools, computer classes, and life skills education. They also provided trainings on various topics, including agriculture, parenting skills and income generating activities. Figure 3 below indicates the percentage of facilities (n=39) that offered formal

educational services. Figure 4 shows the percentage of facilities (n=39) that offered other types of educational services. Both figures depict to whom the service was offered - to residents only, the community only, both residents and the community, or not offered by the facility at all.

Formal educational services were predominately provided to residents only, with preschool and early childhood education (ECD) being offered most frequently (20.5% of facilities, n=39). Lower primary school was the second most frequently offered education level with 12.8% of facilities providing for their residents only. Across all school levels, upper secondary level education was least frequently offered by facilities to their residents or the community (0% for residents only, 2.6% for community only and 7.7% for residents and community).

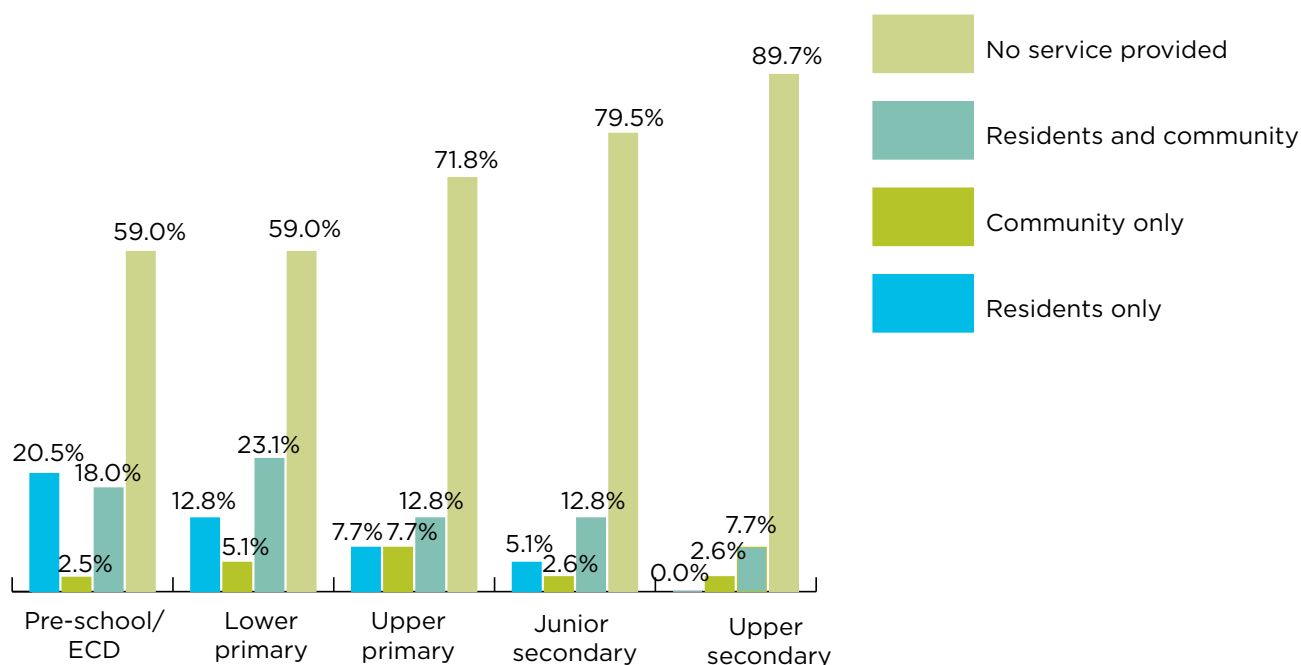


Figure 3: Percentage of facilities that offered select educational services

According to the child sample, 75.4% of children (n=268) attended school, while 58.2% attended a school that was affiliated with the facility. Out of the 202 children that attended school, 78.1% had their school fees paid for by the facility, while 6.5% had fees paid for by either a parent or parent contribution. The majority of children also had their school material fees (e.g., uniforms, books) paid for by the facility (88%).

Facilities (n=39) offered a breadth of skills trainings and opportunities for young people to learn, see Figure 4 below. The highest percentage of facilities offered life skills training to either their residents only (35.9%) or to both residents and other members of the community (30.8%). Income generating activities (28.2%), agriculture (15.4%) and parenting skills (12.8%) trainings were also offered to both residents and community by facilities. While several (30.8%) facilities provided a library to residents only, some (20.5%) facilities still provided the service for residents and community members.

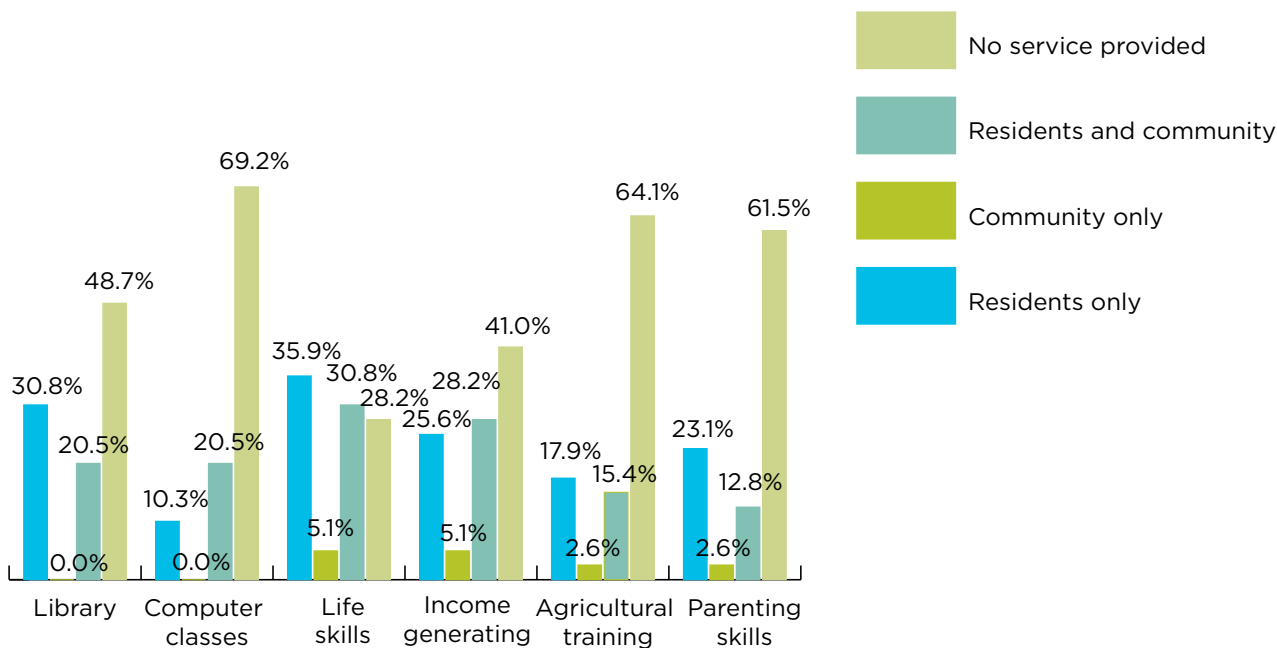


Figure 4: Percentage of facilities that offered other types of educational services

HEALTH SERVICES

Facilities provided health services to their residents and the community (Figure 5). Over one-fifth (20.5%) of facilities offered clinical services to residents and other community members. Only 5.1% of facilities provided these services to residents only. Health aid materials, such as wheelchairs and glasses were provided by 20.5% of facilities to both residents and community. Over a quarter of facilities (25.6%) paid health fees for residents and community members. Ten of the 39 facilities responded that they provide specific services for people with disabilities or chronic illness.

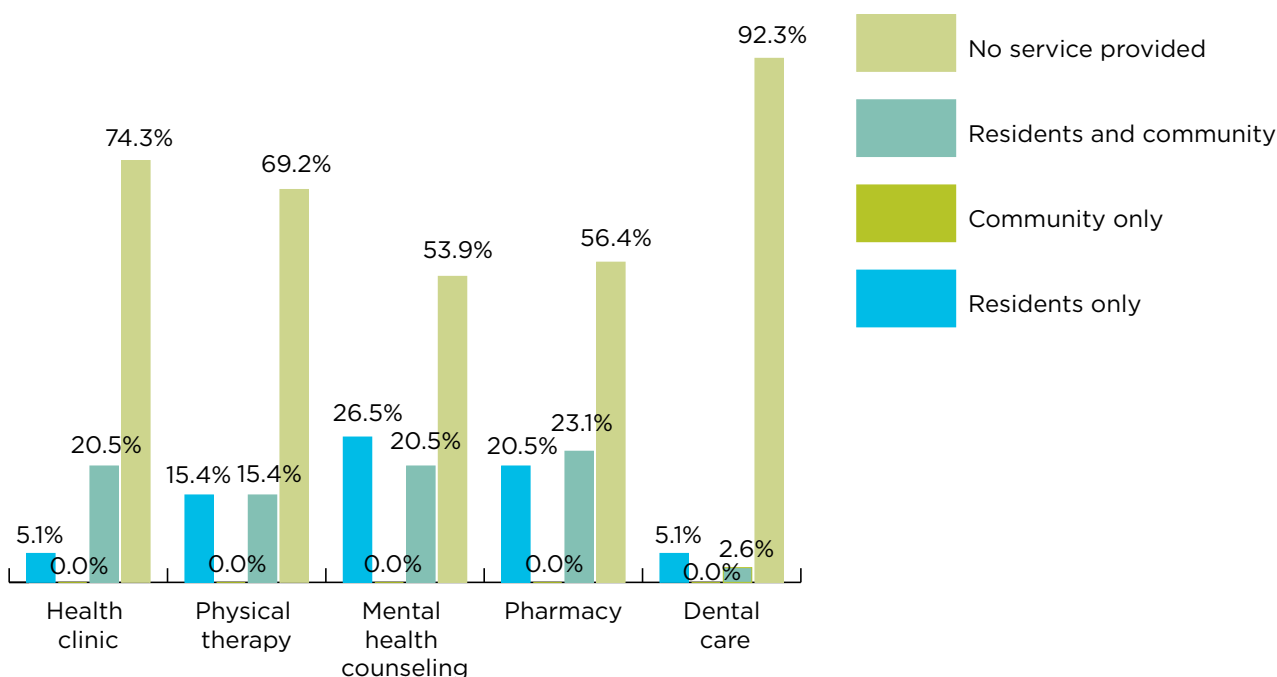


Figure 5: Percentage of facilities that offered select health services

Facilities offered a variety of health services to both residents and community members. One-fifth (20.5%) of the facilities had a clinic on-site and offered services to residents and community members. Similarly, 20% of facilities offered mental health counseling to residents and community members. Twenty-five percent of facilities offered mental health counseling to residents only (see Figure 5). Dental care was the least commonly provided health service, as only one facility out of 39 (2.6%) offered it to both residents and community members.

SOCIAL SERVICES

Facilities provided select social services to the residents, such as clothing and personal items. The majority (64.1%) provided personal items (e.g., toothbrush, soap, diapers, sanitary pads, mosquito net); and clothing and/or shoes (61.5%) to the children in their care. Birth registration services for children at the facility were only offered by a limited number of facilities (5 out of 39 or 12.8%), while food support (not school feeding) was provided by 17 out of 39 (43.6%) facilities to residents and 13 out of 39 (33.3%) of facilities provided this service to both residents and community members.

NUMBER OF CHILDREN IN CARE

At the time of the survey there were 1674 total residents living in residential care facilities (n=38) according to the facility profile. Facilities indicated that 397 children and youth entered in the previous year (n=36).



A caregiver works with girls living in a Catholic-affiliated residential care facility.



3 6 2 5 8
- 5 9 0 9

4 9 0 7 0
- 1 0 9





Characteristics of the children who live in Catholic-affiliated residential care facilities

AGE AND SEX

Results from the child survey provided information about the age of children in care¹². Among children (n=265) from 38 facilities that provided information on the age of residents, most children were school aged, between 11-14 years (23.4%), 15-17 years (19.6%), or 7-10 years (18.1%). Young adults, aged 25 years and above (the oldest reported age was 27 years old) accounted for the smallest age group (2.6%), see Figure 6 below. The mean age of children in care was 12 years. The mean age of children when they entered the facility was 8 years old.

Results from the child survey showed 58.6% of children were male and 41.4% were female (n=268).

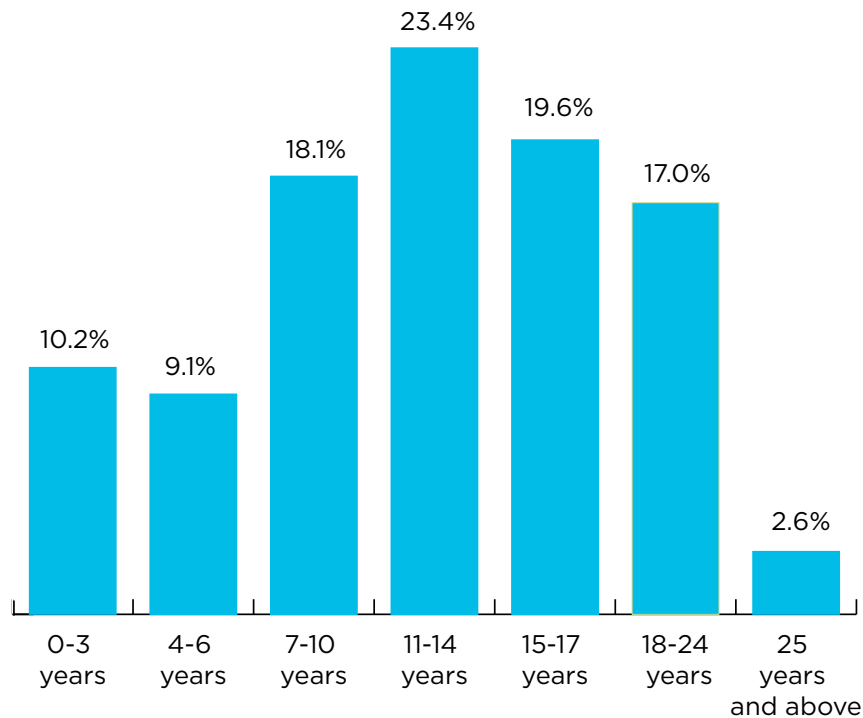


Figure 6: Percentage of children by age group

WHERE CHILDREN ARE FROM

Over two-thirds (66.9%) of the children (n=263) were from the same district as the facility. Over three-fourths of children living in non-disability focused facilities(n=164) and 52.5% of children living in disability-focused facilities (n=99) were from the same district as the facility. Among

¹²One facility declined to participate in this data collection activity citing that it was against their child protection policies.

children who were from a different district as the facility (n=86), 60.5% were from the same province as the facility.

HOW CHILDREN ARE PLACED INTO RESIDENTIAL CARE

According to the facility profile, the most common ways that children were brought or referred to the facility (n=39) was by a hospital, clinic or community health worker (38.5%), a district social welfare officer (also known as social workers) (33.3%), facility outreach (28.2%), or the police (23.1%). The least common ways children entered facilities was through abandonment (12.8%), referral from another facility (12.8%) or through a church or priest (12.8%).

According to the child survey (n=257), when respondents were asked about how the child entered the facility, over a quarter (27.2%) said they were brought by a mother or father (Figure 7). Outreach by facility staff was reported for nearly 15% of the children. According to the Department of Social Welfare, all children placed into a residential care facility should be processed initially through the district social welfare office. In cases where this process is not followed, a committal order should be submitted by the facility within 48 hours of placement. Only 18.7% of children entered the facility by a district social welfare officer. The least common ways that children sampled entered the facility was by arriving on their own (.4%) and through abandonment (.4%).

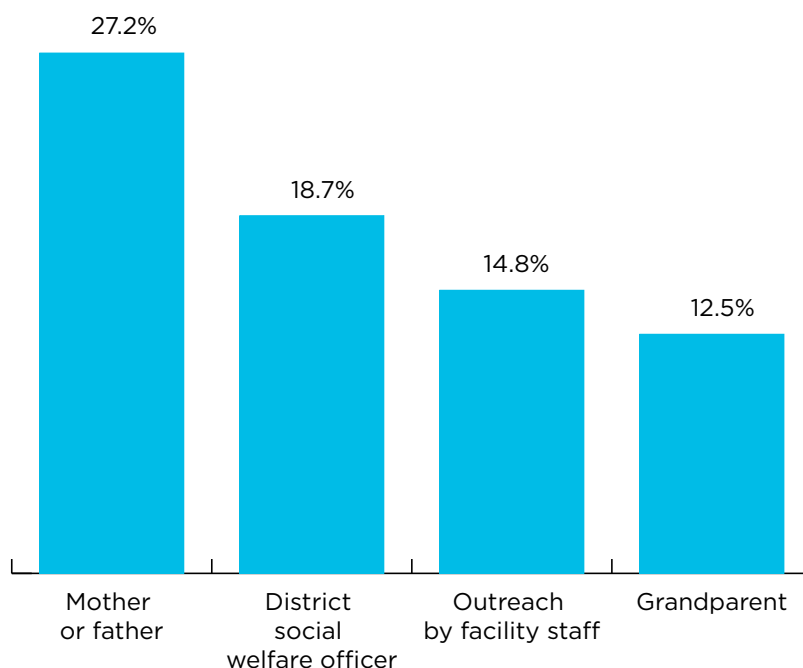


Figure 7: Percentage of children who entered the facility through select means

Also from the child survey, the vast majority of children did not live on the street prior to entering care (90%), suggesting that most children lived in families or in other facilities prior to entering care. Among those children who had previously lived or spent most of their time on the street (n=17), the average number of years living on the street was 2.9 years.

¹³Facilities were categorized as either disability focused (n=12) or non-disability focused (n=27).

DISABILITY AND CHRONIC ILLNESS

According to the facility profile, 603 children in care (36.9%) had a disability. Of these children, 92.5% are currently in a disability-focused facility¹³. The most common disabilities listed were visual impairment, mental retardation, and learning disabilities, (see Figure 8).

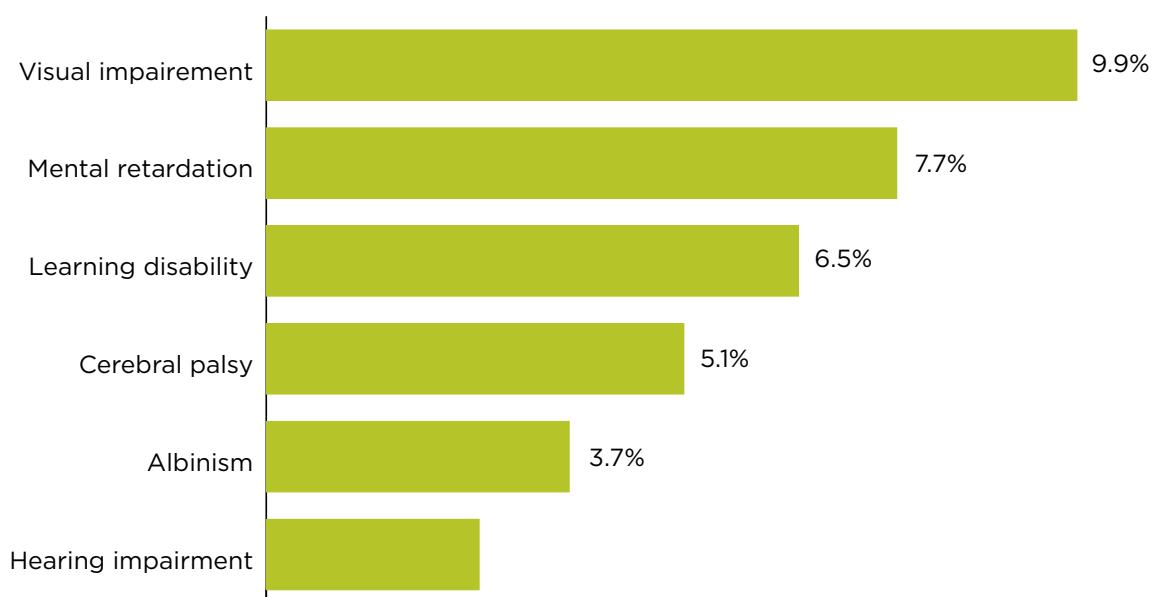


Figure 8: Percentage distribution of residents with a known disability

Additionally, 10.6% of children in the facilities (n=1636) suffered from a chronic illness. Of these children, 78% lived in non-disability focused facilities. The most common illnesses were HIV (9.1%), and Epilepsy (1.5%). The least common illnesses were spina bifida (.03%), autism (.6%), and Down's syndrome (1.1%).

REASON FOR PLACEMENT

The facility profile asked facility directors or a designee to identify the five main factors that led to children being placed in their facility. The primary response from all facilities (n=39) was poverty (84.6%). Not surprisingly, the most common cause of placement for disability-focused facilities was disability or chronic illness of the child (91.7%). The most common reasons for placement in non-disability-focused facilities were poverty (88.9%) and death of a parent (88.9%). Figure 9 shows the main reasons for placement from all 39 responding facilities in total as well as by facility type.

The factors that contribute to placement of a child into a residential care facility were also discussed during the in-depth qualitative interviews. The majority of respondents stated that poverty was the primary reason for placement. Participants repeatedly mentioned two related challenges that families faced in connection to poverty:

the inability to pay the children's school fees

Education is the main factor why families place their children in residential care. Education has become very expensive. We are no longer paying 100 kwachas [local currency]. It is 300 kwacha and above and we cannot afford it! The main reason that children are placed into care

here [community] is to access education. Parents fail to raise money for school uniforms and school fees. (Community Leader)

or insufficient income for food.

Poverty has also left children malnourished due to lack of food in homes. There isn't enough food to feed families found in the community. (Facility Director)

Vulnerable caregivers who had not placed a child in care said the reason they had not placed their child was because they did not know that support services were available, especially educational and food support. During and after the interview, many caregivers inquired about how they could access facility support.

Many young people that were currently living in Catholic-affiliated facilities felt strongly that the high cost of education was the reason for their placement at the facility.

Because I have come here to learn... because of education. (Male Youth)

The reason is that I had stopped going to school. (Male Youth)

Facility directors also discussed the high cost of education, saying that the cost to educate children was a burden on many families and an issue around placement.

Once we trace the parents, they say, "please, please keep that child because we have no resources to educate this child!" (Facility Director)

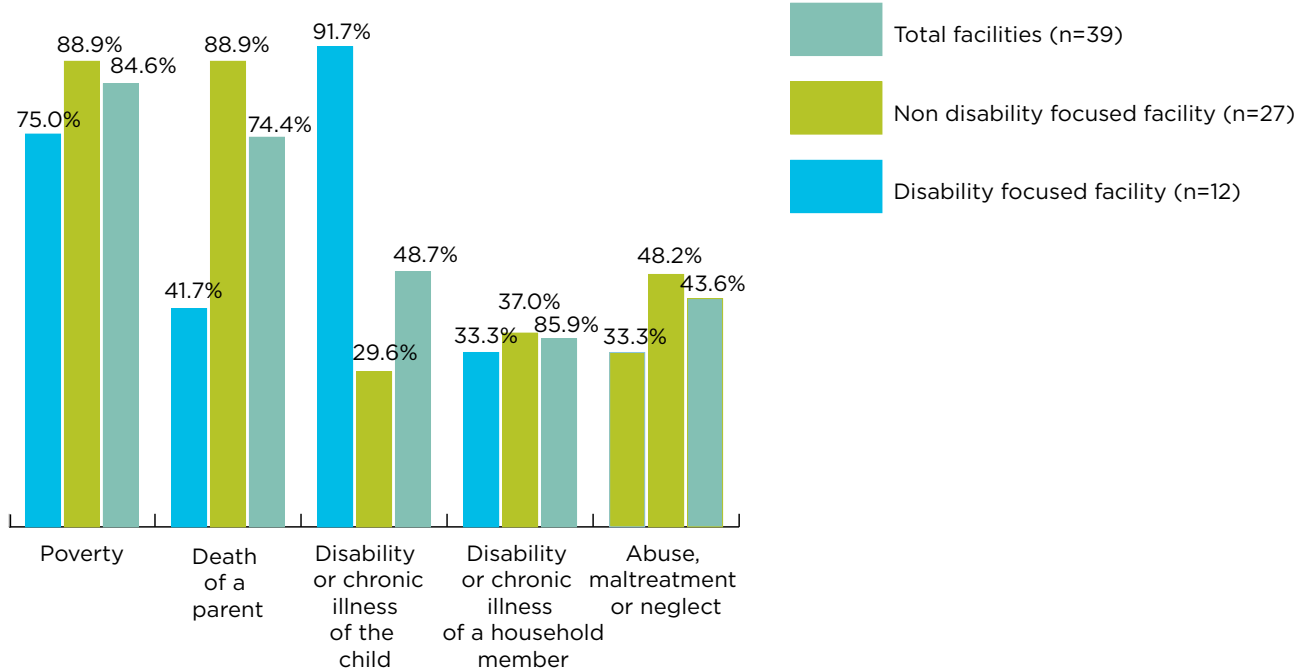


Figure 9: Main factors contributing to placement

DEATH OF A PARENT

Similar to the quantitative results, the death of one or both parents emerged from the qualitative discussions. Almost half of community leaders mentioned death of a parent as a reason for placement. More than half of caregivers that did not place a child and caregivers who had a child reintegrated into their household from facility care mentioned death of a parent as a factor for placement. Interestingly, this was mentioned the least by youth that were currently in care as a reason for their placement.

...when their parents die, the people who are looking after them can't manage, so the family where these children were born minus the parents, can't manage. As a result, they say that these children need to be put in an orphanage. (Community Leader)

[Girl's name]'s parents are both dead. There was nobody after her parents died who was willing to care for her. All the relatives from both my side and her father's side did not show interest in the child's welfare. (Caregiver who had a child reintegrated into their household from facility care)

BEHAVIOR

Poor behavior of a child, often described as acting out, disobeying household rules and substance abuse, was a factor for placement discussed by all types of participants during qualitative interviews, although was not strongly identified as a factor in the quantitative results. Quantitative results captured a facility-based understanding of why children come into their care, however the people that are bringing the child to a district social welfare office or to the facility for placement may not want to disclose poor behavior of the child as the reason for placement.

Some described the causes of poor behavior of the child was the use of substances, such as drinking alcohol and marijuana use.

...what caused our child to go and start living at [facility] in [city] was her bad behavior...We would be thinking she has gone to school, and yet she would just go into the taverns just nearby... (Caregiver who had a child in residential care facility)

Youth in care self-identified that their peers often influenced them to get into trouble or misbehave.

Group influences, because um, there as a time whereby I want to start studying, then one of my friends come and say, "Let's go and play!" So we drink beer or do something else, apart from studying home... (Male Youth)

Another point that was described by a couple of community leaders and facility directors was the lack of recreational facilities within communities. A few community leaders and facility directors indicated that young people turned to inappropriate behaviors, including substance abuse.

...there are no facilities to accommodate children today, just to keep them busy so they are not exposed to different vices where they indulge themselves in bad behavior. (Facility Director)

DISABILITY OR ILLNESS OF A CHILD

Community leaders and caregivers that had a child in care discussed disability or illness as a factor for the child's placement if there was a direct connection to a child with special needs.

... [name of child] having been a disabled child, she can't talk and she can't walk, has had a challenge accessing education facilities... (Caregiver who had a child in care)

Facility directors, primarily those that operated a disability-focused facility, discussed disability as a factor for a child's placement in care.

...we also have children with special needs...about 14 of them. So, these children need special care, special education, physiotherapy and I don't think these children will ever go anywhere... (Facility Director)

ABUSE, MALTREATMENT AND NEGLECT

Abuse or maltreatment of a child, and sexual abuse in particular, was mentioned very infrequently as a cause of placement. Community leaders discussed abuse the most, but mainly in regards to physical abuse, violence within the home, and neglect. One facility representative talked openly about specific abuse cases that they had dealt with including physical and sexual abuse committed by a family member.

Overall, neglect was discussed more frequently by all types of study participants in terms of the family's inability to provide appropriate shelter, food or education. Youth in residential care facilities, however, repeatedly discussed being treated poorly when living with kin or other families. They reported being treated as inferior to biological children in the household, having to do more household work or not being provided the same quality of education as biological children within the home.

It's not good because they [family members] segregate in terms of food, clothing and education. They would rather they did all these things for their biological children, not me. (Female Youth that was previously placed in kinship care)

FAMILY AND HOUSEHOLD BACKGROUND

The child survey captured data on parents and other family members in the child's home of origin. Respondents (facility caregivers) could refer to the child's file if they did not immediately know the information. In 10-30% of the total sample, the respondents did not have sufficient information about the child's family or household. During the validation meeting, facility representatives confirmed that they lacked information about the families of origin, and that it often took years to uncover this information.

Facility caregivers reported that more than half (54.8%) of children had a mother in their household. Less than half (40.8%) had a father living in the household (40.8%). More than one-third (36.8%) of children were reported to have both parents living. Grandmothers were reported to be living in 37.2% of the children's households and grandfathers in 12.9%. Caregivers reported most (80.4%) of the children had siblings. Among the children with siblings (n=172), almost one quarter (22.7%) had siblings residing in the same facility at the time of the interview.



Residents learning together at a residential care facility.

Facility caregivers were also asked questions regarding specific circumstances at the child’s last household of record. Again, many facility caregivers did not have a response or responded that they did not know. Facility caregivers reported that 23.1% of the children had a single mother household and 7.1% came from a single father household. Less than ten percent (7.5%) of the children had parents who had divorced and/or remarried.

Figure 10 outlines physical, sexual and emotional violence within the home. Almost one quarter (24.4%) of children were reported to have experienced emotional abuse or neglect (23.3%) prior to entering the facility. Physical abuse or maltreatment were reported for 15.8% of children and

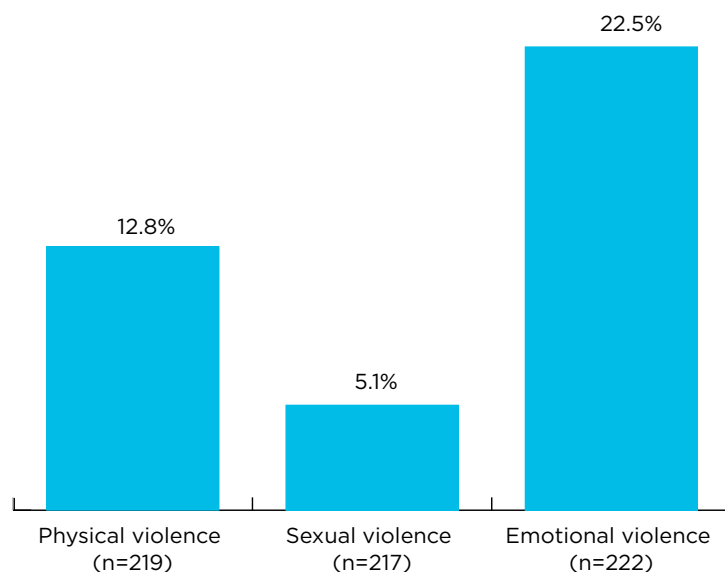


Figure 10: Percentage of children that had experienced violence within the household

abandonment for 13.7%. Sexual abuse or exploitation were reported infrequently (5.8%) as were child trafficking or child labor (3.7%).

During validation, facility directors or their designee reported that neglect and violence, especially that of a sexual nature, was extremely difficult to identify and took years to uncover among children at their facilities.

VISITATION

When a child enters care, a family’s connectedness through visitation is extremely important for a successful reintegration process. According to the child survey, most children (63.7%) had family visit them in care at least once since they entered the facility. More than half (53.7%) of the children had family visit in the past 12 months (Figure 11). Nearly four in ten (41.5%) children who were visited by a family member in the past year (n=135) were visited at least monthly. Figure 11 indicates the percentage of children who were visited by select family members in the previous year (n=137).

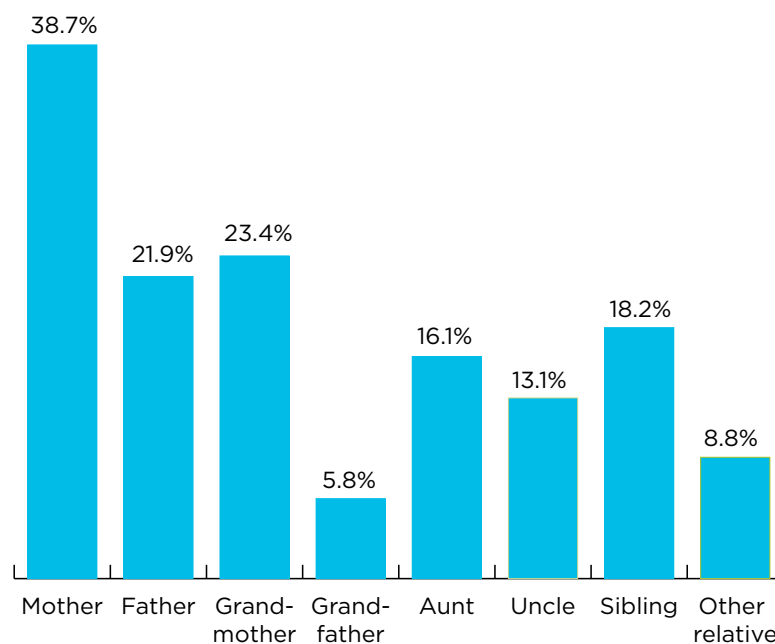


Figure 11: Percentage of children who were visited by select family members in the past year

Children were primarily visited by their mother (38.7%), grandmother (23.4%) and father (21.9%). Children were least visited by a grandfather (5.8%).

From the qualitative interviews, a few caregivers who had placed a child into care expressed their ability and desire to visit their children, however high transport costs impeded visitation.

I have never been to visit from the time she was placed...Why I haven't visited her? I've only just made plans to visit. I'll visit her soon the moment I am able to secure some funds.

No, I don't go there. You think I can go there on foot from home?!

I feel like if I had the money I would go and visit her but there is no money for that. There is nowhere I can get the money from.

Only a couple of caregivers who had placed a child into care described maintaining a connection through phone calls if they were unable to physically visit and a few simply stated that they don't visit, citing that they were too old and the distance to the facility is too far.

LEAVING CARE

As part of the facility profile, facility directors or their designees were asked to identify the three main ways children leave the facility. The majority (76.9%) responded that children were placed with family or kin (not biological parents), aged out of the facility (46.2%), or were reunited with biological parents (33.3%). The death of the child (5.1%) and placement in foster care (5.1%) were the least common ways children left care.

Among children who left during the 12 months prior to the interview (n=137), 41.5% were reunited with biological parents, 22.5% were transferred to another facility and 16.7% were reintegrated with kin (Figure 12). The least reported way for children to leave the facility was through adoption, with 1.4% reporting domestic adoption, and no intercountry adoptions.

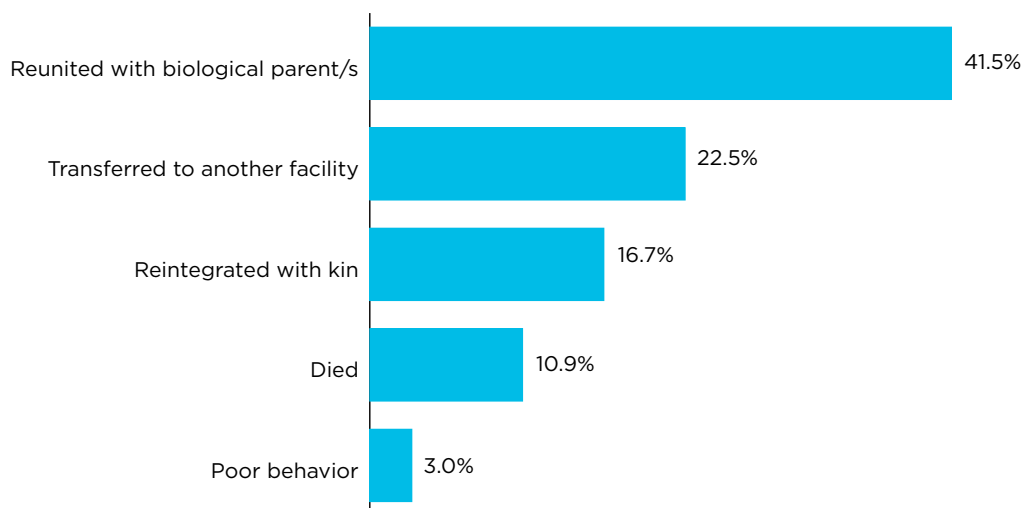


Figure 12: Percent distribution of how residents left facilities in the previous year (n=137)

Note: Two facilities did not report data

The majority of respondents in the youth interviews gave insight into how young people perceived the level of preparation provided by the facility for living on their own. Many youths reported that the facilities were preparing them to be self-reliant, to improve social skills, and to make better overall life choices.

I have been taught how to be responsible and accountable. I have learnt about what is good and bad, and I'm able to make informed decisions. (Female Youth)





Alternative family based care

As part of the facility profile, respondents were asked about the facility’s efforts at arranging kinship care, foster care, and adoption over the previous year. Figure 13 indicates the attempts that were made and by which type of facility (disability and non-disability focused) as well as the total number of facilities participating (n=37). Most facilities, especially the disability focused facilities (74.1%), had worked towards placing children into kinship care over the previous year. From Figure 13, foster care and adoption were less commonly attempted, which during validation with facility representatives was contributed by a lack of available (screened and approved) families for foster care and whether the child was a candidate for adoption.

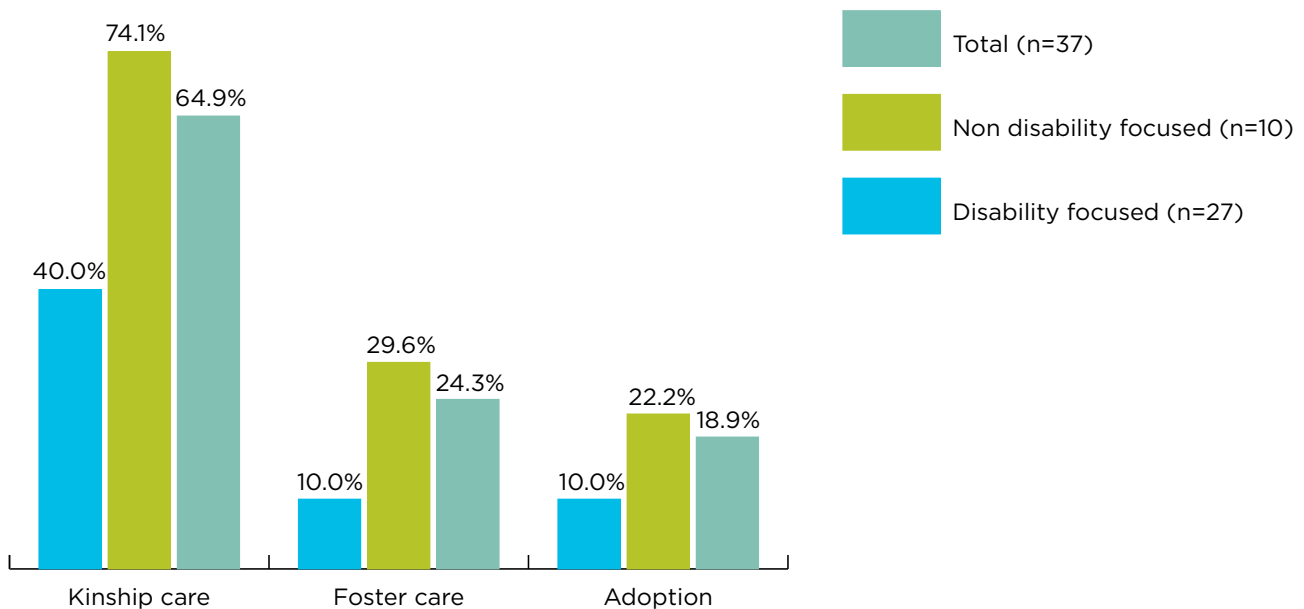


Figure 13: Percentage of facilities that attempted alternative family-based care over the previous year

The child survey also looked at whether any children had been reintegrated with their family or into a family-type setting. Facility caregivers responded that 17.2% of children (n=268) had been placed back with their family prior to reentering the facility and 4.2% of children had been placed into family-like care prior to their reentry into the facility.

Facility caregivers reported that care plans existed for 53.2% of children. Among the 132 children with a care plan, 63.1% of the plans included actions for reintegrating the child into his/her family or into family-like care.

PERCEPTIONS OF ALTERNATIVE FAMILY BASED CARE OPTIONS

The qualitative interviews with facility directors, youth in care and community leaders were a valuable opportunity to discuss experiences and perceptions of kinship care, foster care, and adoption.

Facility directors and community leaders agreed that kinship care was a much needed option in Zambia however, they recognized that issues stemming mostly from poverty limited the care that extended family members are able to provide.

*...we really need to get back to our root. We really need to strengthen kinship care with caution as well. Must be people that are just willingly, voluntarily would want to support a child.
(Community Leader)*

So, I think kinship is a good thing but it's going down. It's dying.... And if they take that child, the treatment is really different. You would find they're treating their own children differently from the other children. (Facility Director)

Also mentioned by respondents, including youth, was the unequal treatment that sometimes occurred by relatives. Youth further described the difficulties of being placed in kinship care after having lived in facility care for a period of time, including being accustomed to facility life.

It [kinship care] can be hard for this child if he or she has been living here [facility] for many years. This is because he or she has to leave a lifestyle and environment he or she is accustomed to and start a new life. (Male Youth)

Foster care and adoption options were discouraged by interviewees, especially among community leaders and facility directors. This stemmed from either the perception that foster care simply is not common in Zambia or skepticism in regards to the intentions of a family that would take on a child that was not their relative.

...mmm...foster care aahm, it's not too common here in Zambia...cause people are so skeptical and then they would be like, how do I give my child to a total stranger who doesn't, I mean who is not my relative? (Community Leader)

Adoption was also described as an arduous and complicated process or that Zambians don't have information on adoption.

Then there is also the procedure for adoption, its...for what I know, for the little knowledge I know about adoption, it is quite complicated here in Zambia...(Facility Director)

...what I know for us Zambians, we don't even know adoption itself. I would say maybe information about adoption is not really there. (Community Leader)

REINTEGRATION

This study explored the factors needed to facilitate successful reintegration of children from facilities into family-based care. Only a few caregivers stated that they had discussed reintegration plans with facility staff, and care leavers also did not appear to have formal reintegration preparation. Not surprisingly, both community leaders and caregivers who placed their children in facilities said that jobs and income were needed to support reintegration as well as assistance with school fees and supplies.

I would tell government to build more schools to support such children. Also give people some loans to help them start some businesses so that they can fend for themselves and their children.

Some caregivers expressed that the child could come home as long as they finished with their schooling.

*If I had the means I would bring them back. I am trying in farming but I do not manage.
(Caregiver who has placed a child in care)*

We have a plan after she gets her education and learns the necessary skills from here [facility], she has to come back home and live with us. And actually what will help is that she would have learnt the necessary skills to sustain her... (Caregiver who has placed a child in care)

Caregivers that had a child in care with a disability expressed that they would need support to take proper care for the special needs of the child within the home.

*Usually the main challenge we have is finding a helper, someone who is able to take care of her. When she is at home, you discover that she remains alone which is not safe. So, we need someone to take care of her, bath and feed her and also we would also need a wheel chair...
(Caregiver who has placed a child in care)*

Some facility directors mentioned that the government needs to be involved in the process and there is a need for support for follow-up with the family and child.

Additionally, a few community leaders and facility directors identified the need for community sensitization to address the environment into which the child would be reintegrated as well as the stigma that the child may face within the community.

*I think the community needs to be talked to, the families in that community ...they should be prepared to receive this person...because that person is also part of that community...
(Community Leader)*

I think, just as I stated before, starting relationships with the families and then making the community aware [reintegration process], maybe through churches, schools and public places. Because you can reintegrate a child in a community, then those that know the boy can start calling him names...(Facility Director)

Interviewers asked caregivers who had a child reintegrated into their household from facility care what made reintegration possible. Most caregivers didn't respond directly to the question but rather described that they had no choice and the child was simply brought back home. Others said that the child had aged out of the facility or that their child had completed secondary school and could return home.





Care Leavers

This study also aimed to describe the experience of care leavers, young adults who had transitioned out of residential care and were currently living independently. Through 40 interviews with young people, male (26) and female (14) participants between the ages of 18-30 years, CRS captured perceptions about care leavers' experiences with the process and preparation for leaving care, the support that they had or needed for independent living and advice for families at risk for separation. The care leavers had lived in residential care facilities throughout Zambia (30 Catholic-affiliated and 10 non-Catholic residential care facilities).

TRANSITION TO INDEPENDENT LIVING

THE DECISION TO LEAVE CARE

The decision to leave care was described by the majority of respondents as a mutual decision between the care leaver and the facility, and some respondents said they were greatly involved in making the decision.

ok, that decision of leaving [facility name], yes it was a decision that I took by myself, because we had a meeting [facility staff]...we had a discussion... (Male Care Leaver)

Many care leavers described very little to no involvement in the decision by their family.

No, this [decision to leave care] was entirely my idea and even here I have been living alone. No family member or community person was involved. (Female Care leaver)

Often the decision was considered the logical next step after residents completed their grade 12 courses. Few care leavers responded that the decision was forced upon them by way of aging out of the facility or that the facility shut down.

PREPARATION

When asked about the preparation that they received by the facility, many care leavers did not mention a formal transition process conducted by the facilities. Instead, they explained that upon completing their schooling, they were given materials to live on their own (e.g., clothing, blankets), and for some, trained in a trade skill. None of the care leavers described any formal counseling offered by the facility, and few mentioned that they discussed coping strategies for living independently, such as dealing with different life situations.

When asked about their feelings about living independently, many care leavers expressed feelings of fear, doubt and worry about the unknown and a new lifestyle that was unfamiliar to them. Others described the fear and worry as ongoing, something that had not been fully resolved.

I was scared because I was alone...But what else could I do, I was all alone. In [name of town], that's where the people who were looking after my dad were. They were my neighbours. They kept him when he started getting sick then he died and then after he died I tried to stay there and look for work to find a way of surviving but things were so difficult. So difficult. (Male Care leaver)

Still, life wasn't good because I don't manage. Eh. I don't manage, things are just bad, so I'm scared all the time because life isn't good for me. Things are difficult. (Male Care leaver)

Care leavers also discussed the challenges of dealing with the stigma associated with growing up in residential care, the difficulties they faced in meeting basic needs and the desire to continue with their education after transition.

at first I was scared because I was- we were labeled. Even when you're passing, and they can see you're from the center, they say 'ah he's a street kid that one'. I could mingle but uhh sometimes I felt like- that I was not part of the society. I belong to those guys on the street, that's how I felt... (Male Care leaver)

When I started living on my own I had a strange feeling because what was in my mind was to upgrade my education until I reach my goals. (Female Care leaver)

I felt bad because things were difficult and I'm still facing difficulties till now. Feeding my kids, paying rentals... (Female Care leaver)

When asked about community level support, none of the care leavers mentioned any type of structured support services. A few participants referred to conversations they had with community members on potential conflict situations and people to avoid in the community.

There were other care leavers that described feelings of excitement to live on their own, most of which had educational opportunities or jobs that they would be transitioning directly into.

I was very excited because I knew was going to have my own business and then live on my own. The money they assisted me with made me feel I was ready to go without much fear... Yes, it was good to leave the facility and start a new life though it was difficult since I didn't know where to go when I reached Lusaka...(Female Care leaver)

SUPPORT: WHAT WAS RECEIVED AND WHAT DID THEY NEED

Many care leavers explained that they did not receive any type of financial support from the facility, however, several were offered assistance with finding employment, either at the facility or elsewhere. Several described the need for additional educational support, some having received it through sponsorship from the facility. Very few described receiving any assistance from the community other than moral support in the form of encouragement to live on one's own or minor food support.

LIFE ON THE OUTSIDE

Some respondents felt that their communities welcomed them after leaving the facilities. A few care leavers mentioned having a better transition if they had previous interaction with the community they transitioned into. Similarly, few added that the presence of their family within the community or that connections to the community facilitated the transition.

They [community] just welcomed me. They welcomed me because I used to come from time when I get my allowance from that facility. (Male Care leaver)

I was welcomed. They were happy to see me. They were very friendly. I mean... because they knew me before and when I came back, we continued the same life that we lived... (Male Care leaver)

The main challenges described by care leavers as they transitioned from facility care to independent living was difficulty in meeting basic needs, such as having enough food and clothing. Others said they had trouble securing a job or sponsorship to continue their education. Respondents also mentioned that they did not feel a sense of belonging once they left care.

...the responsibility part I think. I was used to just having things for free like that. I wasn't worried [when living at the facility], I wouldn't struggle to buy food. I would know I'm under someone's care, I wasn't worried. But there [in community], when I was on my own, I was worried, "What if this happened to me? What am I going to do?" There were a lot of things that worried me... (Male Care leaver)

When asked how they were managing, several care leavers responded that they simply were not able to cope, especially with basic issues such as managing housing and finances. When asked to compare life in the facility and life on their own, the majority responded that life was better now that they were independent.

I am enjoying living on my own with my family and making my own decisions compared to the time someone had to make decisions on my behalf...Yes the time I was in the facility I knew that at this time I have to be eating and at this time I need to be in church and so on, but now all that is up to me. (Male Care leaver)

CHALLENGES OF LEAVING CARE

The main challenges that came from leaving care were often related to the sudden independence that came from being on one's own. This included the expression of feelings around not having the same help that was received at the facility and the reality that the struggles respondents experienced prior to entering care were now again a part of their new independent life.

At [facility name] when I went there, things were okay. At least I was helped in life, but when I went into the community, things became very hard. It's like I went back to stage one, the way I used to suffer with my mother. (Male Care leaver)

Leaving care also meant leaving the family that was created within the facility, causing difficulties to create new relationships and be part of a family that they didn't previously know.

here it was easy because it was a big family... I can say this has been my only ever family. Then when I go there [to the community]... each and every day you are like seeing new members [relatives]. Then you will be told, no this is your family...at first it was difficult trying to enter into that new family because I was used here [facility]. (Female Care leaver)

Equally challenging and connected to newfound independence was not properly understanding finances and how to save money.

I never knew how to budget so money was finishing quickly. Spending money was really the worst... (Male Care leaver)

RELATIONSHIPS

Personal relationships outside of facility care was discussed by most care leavers as a challenge, with a few describing little to no relationship with the young people or staff they knew from the facility.

Others described their relationship with friends from the facility as their family and would even return to the facility to work.

I do communicate with other colleague who are still there [facility] apart from those who are here in Lusaka. All I can say is that we are a family and we want to know what is happening to our friends regardless of where they are...(Male Care leaver)

...we are still in contact with them every week. We usually go there to assist them in working... (Female Care leaver)

ADVICE FOR OTHERS

When care leavers were asked about what advice they might offer to other families or children that are struggling, several said they would encourage others to seek the support of a facility since they provide education and support.

So my advice to the families is to let their children, their grand-children to go to a facility so that they can get helped in that order of ... in form of education and the rest of the things. I would give them the advice that at the orphanage there is a lot of help that can be given. (Male Care leaver)

Others mentioned the importance of staying close to the child in care.

but the only thing I can advise is that make time to visit those children...go and talk to them, because if you...if you just leave them that...in that place just alone with those people... because how do they know that you care for them? (Male Care leaver)

Overall, the interviews with care leavers supported the other findings in regards to the services provided to residents when in care, especially educational support and basic necessities that many vulnerable families were not able to receive from government or community level services. The care leaver interviews described a struggle between feeling a sense of belonging, having opportunities and structure while living within a facility and the challenges of independent living such as sudden responsibility and a lack of structured support, especially with wanting to continue education. Many described their experience in care as good, one that they would recommend to a struggling family or child. It is also noted that almost none of the care leavers reported any mistreatment while living in care.



Discussion and Recommendations

Notwithstanding the limitations, the study contributes to a small but growing literature on residential care facilities and the placement of children in to such facilities in Zambia. The findings in this study support the Government of Zambia's efforts to strengthen the country's child protection policies and practices. Critical information was gathered from community leaders, facility directors, caregivers, parents, and youth which offered insight into the current situation in Catholic-affiliated residential care facilities in Zambia and the surrounding communities. The findings add to the body of knowledge of the factors that influence the Government of Zambia's acceleration of the strategy around childcare reform. As this is the first study to look at these topics in Catholic-affiliated residential care facilities in Zambia, there is much to be learned from the results of this research. Notably, the research serves as the basis for shaping the involvement of the Catholic-affiliated residential care facilities in particular while advancing the government's strategy.

The study found that the five primary reasons children are placed in facilities are poverty, death of a parent, disability or chronic illness of the child in care, abuse maltreatment of neglect, and disability or chronic illness of a household member. Qualitative interviews supported these findings, but also indicated that poverty really had two implications driving parents and primary caregivers to place their children in care: the inability to pay school fees and food insecurity. Children's behavior issues did not come through as a main driver for placement in the quantitative data, but was mentioned in several of the interviews especially among community leaders, primary caregivers and youth living in care. High levels of poverty and a lack of resources to support families with have a caregiver, child, or other household member who have a disability or mental illness are critical issues that need to be addressed.

As uncovered through validation with facility directors, the issue of abuse and neglect is an area that needs further exploration since it takes years to uncover, especially from a primary caregiver or parent of the child and can often be the reason that a child turns to the street or ends up in residential care. The limited qualitative discussion around this topic highlighted the social and cultural practices that often keep this critical information hidden, as well as the importance of continuing to further explore these issues through additional research.

Qualitative data showed that community leaders and caregivers generally hold positive attitudes around facility-based care, believing that residential care facilities can provide opportunity for education, life skills, and values development. Care leavers also had positive feelings about residential care facilities, and many would encourage other vulnerable families to place their children in residential care facilities. This implies that programming to prevent or respond to child separation should also focus on changes in community-level attitudes and beliefs about the benefits of family care versus residential care on children's development.

When asked what would be needed to reintegrate children with their families, the most common needs cited by caregivers with children in care were economic and education support. Community leaders also cited economic support as the primary need. Additionally, several stated that families need training on how to care for the child. Only a few caregivers stated that they had discussed

reintegration plans with facility staff, and care leavers also did not appear to have formal reintegration preparation, with many stating that the decision to live on their own was agreed upon. CRS recommends working with facilities to better prepare young people for independent life as well as working with communities to help develop a social support structure that supports care leavers.

These findings indicate more comprehensive and interdisciplinary support is needed to help families care for their children at home. Over the years, CRS has invested in a number of interventions to support family strengthening within orphans and vulnerable children and other development programs. This has included the implementation of approaches such as the CRS' The Faithful House (TFH) curriculum¹⁴, parenting education and economic strengthening activities such as social cash transfers, Savings and Internal Lending Communities (SILC) and agriculture initiatives. CRS recommends that any future work is applied through a similar lens that takes into consideration the interdisciplinary needs of the family unit. Structural changes that improve availability and accessibility of community services for vulnerable households are needed (e.g., care for the disabled (including parents or caregivers who suffer from a mental illness or disability), child and youth recreation facilities), complemented by adjustments in government programming (e.g., better regulation of school fees, improved quality of education, expansion of economic safety net programs such as social cash transfer), could prevent child separation from the family.¹⁵ A caveat is that the availability of quality services alone may not be a deterrent from placing a child in residential care.

CRS recognizes the faith practice and sincere dedication that the Catholic men and women religious have for the most vulnerable, especially the children within their care. Through sensitization and shared learning, many of the participating facilities have voiced the importance of shifting their current model of care to one that supports family strengthening and reintegration of the children in their care. It is equally understood that many of the Catholic-affiliated residential care facilities that participated in this study provide critical services to their residents and the surrounding communities. Perhaps most importantly, they are meeting needs in communities by providing educational services to families who would otherwise be unable to send their children to school. Disability-focused facilities are providing support for children with various levels of disability that are often overlooked. Helping facilities better understand the importance of a child growing up in a family-based environment while still utilizing the important services the religious community provide is a solution that can bridge an important gap in care reform. This can be done through shifting some of the residential services currently provided today-care or community outreach models. This is especially important for facilities currently providing education services and disability support services.

CRS sees an opportunity for ZAS and ZEC to lead the national dialogue with Catholic-affiliated residential care facilities around alternative care. ZAS is the entry point to working with Sister-led Catholic-affiliated residential care facilities, while ZEC is the entry point to working with other facilities under the Dioceses (e.g., those led by Catholic religious communities, Catholic-affiliated organizations, or Catholic laypersons.) Working through ZAS and ZEC, CRS recommends creating a targeted communication

¹⁴The Faithful House (TFH) is a culturally sensitive, faith and values-based skills-building curriculum designed to strengthen relationships for cohabitating couples. TFH curriculum, currently implemented in 14 African countries and benefiting over 110,400 beneficiaries, has been proven effective in strengthening household governance, improving household economic empowerment, and challenging harmful cultural and gender norms.

¹⁵During the National Consultation on Child Care Reform meeting, a number of gaps in both capacity and coordination were identified at both ministerial and sectorial levels, and a national 'Call to Action' was delivered at the close of the meeting which reinforced the Government's commitment to care reform and addressing the gaps

strategy to accelerate dialogue and encourage positive change in the Catholic-affiliated residential care facilities' knowledge, attitudes and practices with regards to family-based and alternative care models, building on the sensitization initiated as part of the CRS research process. The communication strategy should intend to reach Catholic-affiliated residential care facilities as well as Dioceses and parishes with advocacy messages for protection of the family and promote learning across facilities to stimulate change. The strategy would include awareness and sensitization of CRS' research data, international data and longitudinal studies; government policies and guidelines¹⁶; faith messages related to preservation of the family structure and the "humanism" approach to caring for families¹⁷; and the needs of care leavers.

This research demonstrated that Catholic-affiliated residential care facilities are not homogenous; the facilities have adopted a range of service delivery models, target different populations, and vary in size and scope. They are also at varying levels of operational performance as defined by the national standards. The planning process will take a comprehensive view of the inter-related effects of change, and help facilities anticipate unintended consequences, in recognition that maintaining their current status quo may not be possible in the context of changing national policies and guidelines. Recognizing that there is no one-size-fits-all solution, CRS recommends supporting each facility by facilitating an individual strategic planning process to identify their own unique needs and services they provide to their residents and the community and where they stand from a financial standpoint (any change has repercussions on the facility's ability to secure external funding from donors for continued operations).

Some Catholic-affiliated residential care facilities have already indicated to CRS that they are ready to change their models of care, opening the door to introducing or strengthening approaches to prevention and response to child separation. For each individual facility, moving toward a family-promotive approach can result in significant changes to both short-term and long-term implementation. To facilitate the change process, CRS aims to secure funding to support participating facilities to develop time-bound, results-oriented plans.

CRS looks forward to working with key partners to use the findings from this research to support the Government of Zambia's strategy around child care reform. Shifting Catholic-affiliated residential care facilities to become partners in prevention of family separation is critical to the current child care system in Zambia and this research will serve as the basis for shaping their involvement while advancing the government's strategy for child protection. CRS is uniquely placed for the important work around transforming current Catholic practices of providing care for children through an approach that promotes human development and responds to the most vulnerable. CRS and partners will use these findings to put faith into action to help strengthen families and prevent future separation.

¹⁶This activity is focused on sensitization of the existence and summarized content of the government policies and guidelines. It is not a training on the use of the guidelines.

¹⁷First President of Zambia, Dr. Kenneth Kaunda, included humanism as part of his personal philosophy which carried over into his leadership of economic and social development of post-colonial Zambia (Reference: A Humanist in Africa, by Dr. Kenneth Kaunda, 1966). Humanism centered on a new social order based on the traditional way of life structured on the communal and extended family system and also called on the government to provide social services to all Zambians (including free education, free medical care, etc.). (Reference: Sekwat, A. Beyond African Humanism: Economic Reform in Post-Independent Zambia. International Journal of Organizational Theory and Behavior. 3 (3&4), 521-546 (2000).

References

*Csaky, C. (2009). Keeping Children Out of Harmful Institutions: Why We Should be Investing in Family Based Care. Save the Children: London.

†Williamson, J. & Greenberg A. (2010). Families, Not Orphanages, Better Care Network Working Paper. Available at: <http://bettercarenetwork.org/BCN/details.asp?id=23328&themeID=1003&topicID=1023>

‡The University of Nottingham. (2012). Child Abandonment and its Prevention in Europe. The European Commission's Daphne Programme. Available at: <http://www.bettercarenetwork.org/BCN/details.asp?id=30091&themeID=1001&topicID=1006>

§Ministry of Gender and Family Promotion, Republic of Rwanda (MIGEPROF) and Hope and Homes for Children (2012). National Survey of Institutions for Children in Rwanda; FHI et al (2010). Op cit.

¶UNICEF Malawi (2011). All Children Count: A Baseline Study of Children in Institutional Care in Malawi. Lilongwe, Malawi: UNICEF Malawi

**Ministry of Gender and Family Promotion, Republic of Rwanda (MIGEPROF) and Hope and Homes for Children (2012). Opcit.

††FHI et al (2010). Op cit.

‡‡UNICEF Regional Office for CEE/CIS. (September 2010). At Home or In a Home? Formal Care and Adoption of Children in Eastern Europe and Central Asia. Available at: <http://www.bettercarenetwork.org/BCN/details.asp?id=25427&themeID=1002&topicID=1017>

§§Laumann, L. Household Economic Strengthening in Support of Prevention of Family-Child Separation and Children's Reintegration in Family Care. FHI 360: Washington, D.C., 2015.

¶¶Guidelines for the care and protection of children, draft July 2016, MCDSW

Appendix 1: Sampling

The total number of participants in this study was 697. Table 1 lists each research activity, the number of facilities or communities that will participate, and the total sample per activity.

TABLE 1: SAMPLE SIZES

RESEARCH ACTIVITY	TYPE OF DATA	POPULATION	TOTAL NUMBER OF RESPONDENTS
PHASE I: FACILITY-BASED DATA COLLECTION ACTIVITIES			
Facility profile	Quantitative	Facility Director or designee	39
Cross-sectional survey (structured questionnaire)	Quantitative	Facility staff (administered to staff about sampled residents ages 0-25 years)	268
Semi-structured interviews	Qualitative	Facility Director or appointee	15
Semi-structured interviews	Qualitative	Youth 16-25 years old	34
PHASE II: COMMUNITY-BASED DATA COLLECTION ACTIVITIES			
Semi-structured interviews	Qualitative	Community leaders	48
Semi-structured interviews	Qualitative	Primary caregivers who have placed a child into a residential care facility	30
Semi-structured interviews	Qualitative	Primary caregivers who are at risk for placing a child into a residential care facility	29
Semi-structured interviews	Qualitative	Primary caregivers who have reintegrated a child that was placed in residential care	30
Semi-structured interviews	Qualitative	Care leavers (18-30 years old)	40

4. Qualitative data collection activities

The qualitative activities consisted of semi-structured interviews and were intended to provide in-depth insight into the experiences of a range of respondents. The sample sizes reflected our best estimate of the number of activities that would be needed to reach saturation or the point at which no new themes or issues would be presented, taking into consideration time and budget constraints. The sample sizes were also meant to be logistically and analytically feasible acknowledging the intense effort needed to both conduct and analyze qualitative data.

During Phase I of the study, a purposive sample of 15 facility directors were also selected to capture experiences and perspectives from a variety of contexts, including geographic location, urban/rural, type of resident (e.g., disability, street children, boys only, girls only), and facility size. The community-based data collection activities (Phase II) purposively selected up to four

community leaders in 10 communities. The locations were selected to capture information for a diverse set of facilities, as described previously. In the same communities, primary caregivers who (a) had placed a child in residential care, (b) were at elevated risk of placing a child in residential care, and (c) had reintegrated a child back into family-based care were selected. Facility directors, local community leaders, and government social workers identified these caregivers and invited them to participate in the interviews.

5. Quantitative data collection activities

Quantitative methods will be used during phase I of the study (facility-based data collection). First, all participating facilities (39) were administered the facility profile. However, a random sample of child and youth residents (ages 0-25 years) were also selected. As described previously, a structured questionnaire was applied to appropriate facility staff about the sampled children and youth. Given that the analytical objective of the survey was to describe the children and youth in Catholic-affiliated residential care, the following formula was used to estimate the sample size.

$$\text{Sample Size} = \frac{D[p(1-p) \times Z_{\alpha/2}^2]}{d^2}$$

The children were sampled from 38 out of the 39 facilities. One facility declined to participate in this data collection activity. Lists of children and young people living in all 43 facilities will be elaborated by the facility staff, serving as the sampling frame. Systematic random sampling was used to select the children and young people from the sampling frame. The number selected from each facility was proportional to the total number of eligible children and young people in each facility. A design effect (D) of one was used given this sampling method. An estimated proportion of 50% was used to calculate the most conservative sample size. The desired precision (d) was 6% and the Z score for a 95% confidence level were used in the calculation ($Z_{\alpha/2} = 1.96$). After correcting for size of the population (N=1600) the sample size was 224 children and youth. This sample size was increased by a 20% security or non-response factor, and the total estimated sample size was 280.

The selected children did not serve as the respondents for the structured survey. Upon identifying children and young people at each facility, the data collection team identified the relevant facility staff members who serve as their caretakers. These caretakers completed the informed consent procedures and were interviewed about the selected child or young person.

