Abstracts & Presentations

MEETING REPORT

26-27 April 2006 Harare, Zimbabwe

OV C Research Workshop:

“From Analysis to Action in Zimbabwe”
Abstracts & Presentations

This is an appendix to the main report of the OVC research workshop “From Analysis to Action in Zimbabwe”, 26-27 April 2006, Harare, Zimbabwe. The Workshop was designed to bring together researchers and programme/policy players to bridge what we know and what we do on behalf of orphans and vulnerable children. It aimed to shine the spotlight on current research, so that key findings could be applied to OVC programming during this crucial phase in the scaling up of the NAP for OVC. Specifically, the Workshop strived to achieve the following outcomes:

1. Specific inputs to the National Action Plan on OVCs and the proposed indicators for monitoring and evaluation of OVC programmes.
2. Guidance for those making funding decisions and those designing and directing programmes for OVC (e.g. PoS).
3. Solid links between researchers and programmers to continue to learn from each other.
4. Updated priorities for OVC research.

In this report the 37 abstracts submitted in preparation of the workshop and the presentations made during the workshop are presented.
The workshop and the proceedings were prepared by a Steering Committee, comprising of members from the Ministry of Public Service Labour and Social Welfare (MoPSLSW), the Biomedical Research and Training Institute (BRTI), the National Institute of Health Research of the Ministry of Health and Child Welfare (NIHR) and UNICEF, in collaboration with the London School of Hygiene and Tropical Medicine (LSHTM). Funding was provided by the Andrew Mellon Foundation, DFID, WK Kellogg Foundation, and UNICEF.

Members of the Workshop Steering Committee:
Isolde Birdthistle (BRTI/LSHTM), Brian Chandiwana (BRTI), Clara Dube (UNICEF), Mrs N Dhlembeu (MoPSLSW), Simon Gregson (BRTI/Imperial College), Auxillia Machingura (BRTI), Charles Mangongera (BRTI), Roeland Monasch (UNICEF), Shungu Munyati (NIHR), Constance Nyamukapa (BRTI)
Abstracts
In order to assure that all relevant research on OVC was included in the workshop a call for abstracts was issued. Researchers were invited to submit a 300 word abstract on their original research in Zimbabwe, addressing one of the following realms of orphans' and vulnerable children's lives: (i) Environmental context; (ii) Economic realities; (iii) Educational status and achievement; (iv) Emotional experiences; (v) Health & survival (including nutrition); (vi) Sexual experiences & sexual health. The workshop steering committee reviewed the 37 abstracts submitted and selected 16 studies which were considered most appropriate for presentation at the workshop (see Part II of this report). Other submissions were presented at a poster session during the first day of the workshop. All abstracts are attached in the section below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Author(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The state of re-integration programmes for children in residential care in Zimbabwe</td>
<td>R Musarandega</td>
</tr>
<tr>
<td>2</td>
<td>Networking, Training and Policy Needs for Improved Care of Children Living with HIV and AIDS in Zimbabwe</td>
<td>G Foster, et al</td>
</tr>
<tr>
<td>3</td>
<td>HIV-associated orphanhood and children's psychosocial distress: theoretical framework tested with data from Zimbabwe</td>
<td>C Nyamukapa, et al</td>
</tr>
<tr>
<td>4</td>
<td>HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe</td>
<td>S Gregson, et al</td>
</tr>
<tr>
<td>5</td>
<td>Rising incidence and prevalence of orphanhood in Manicaland, Zimbabwe, 1998 to 2003</td>
<td>H Watts, et al</td>
</tr>
<tr>
<td>6</td>
<td>Poorer health and nutritional outcomes in orphans and young children not explained by greater exposure to extreme poverty in Zimbabwe</td>
<td>H Watts, et al</td>
</tr>
<tr>
<td>7</td>
<td>The psychosocial well-being of orphans in HIV-afflicted Manicaland</td>
<td>C Nyamukapa, et al</td>
</tr>
<tr>
<td>8</td>
<td>Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe</td>
<td>B Howard, et al</td>
</tr>
<tr>
<td>9</td>
<td>Psychosocial Disadvantage: Preparation, Grieving, Remembrance, and Recovery for Orphans in Eastern Zimbabwe</td>
<td>B Howard, et al</td>
</tr>
<tr>
<td>10</td>
<td>The effect of orphanhood on the health and nutritional status of children in Zimbabwe</td>
<td>H Watts, et al</td>
</tr>
<tr>
<td>11</td>
<td>From Affected to Infected: Understanding the HIV and sexual health risks among adolescent orphans in Zimbabwe</td>
<td>I Birdthistle, et al</td>
</tr>
<tr>
<td>12</td>
<td>Care and Support for Out of School Youths: A Situation Analysis</td>
<td>M Mushunje</td>
</tr>
<tr>
<td>13</td>
<td>Parental Health, School Attendance, and Educational Enrolment of Orphans And Vulnerable Children in Zimbabwe</td>
<td>K Jemison</td>
</tr>
<tr>
<td>14</td>
<td>Orphans and Vulnerable Youth (OVY) on the Brink: Reproductive Health Risks among OVY in Rural Zimbabwe</td>
<td>Pierre Ngom, et al</td>
</tr>
<tr>
<td>15</td>
<td>Interests of NANGO</td>
<td>B Muchabaiwa</td>
</tr>
<tr>
<td>16</td>
<td>Examining environmental context of orphans living in rural Zimbabwe</td>
<td>S Pascoe, et al</td>
</tr>
<tr>
<td>17</td>
<td>Orphans are vulnerable to negative sexual experiences in rural Zimbabwe</td>
<td>O Mutanga, et al</td>
</tr>
<tr>
<td>18</td>
<td>Gender Based Violence Against Girls Desk Study</td>
<td>Girl Child Network</td>
</tr>
<tr>
<td>19</td>
<td>Girls Reproductive Health Research</td>
<td>Girl Child Network</td>
</tr>
<tr>
<td>20</td>
<td>The Impact of Internal Savings and Lending Schemes on OVC: Evaluating experiences with communities in Makoni, Buhera and Gutu</td>
<td>CRS</td>
</tr>
<tr>
<td>21</td>
<td>Assessing the Impact and Cost-effectiveness of Education Assistance to OVCs in Zimbabwe</td>
<td>L Tinarwo, et al</td>
</tr>
<tr>
<td>22</td>
<td>Child Sexual Abuse in Zimbabwe</td>
<td>E Gwiza</td>
</tr>
<tr>
<td>23</td>
<td>Bottlenecks and Drip Feeds - Channelling resources to communities responding to orphans and vulnerable children in southern Africa</td>
<td>G Foster, et al</td>
</tr>
<tr>
<td>24</td>
<td>A Voiceless Community - HIV/AIDS and Zimbabwe's Deaf Youth</td>
<td>L. Foster, et al</td>
</tr>
<tr>
<td>25</td>
<td>SOS Children's Villages</td>
<td>SOS</td>
</tr>
<tr>
<td>26</td>
<td>Orphan Status and Risk among Adolescent Girls in Zimbabwe</td>
<td>Mi-Suk Kang, et al</td>
</tr>
<tr>
<td>27</td>
<td>Combining economic livelihood and behavioral interventions to reduce</td>
<td>M Dunbar, et al</td>
</tr>
<tr>
<td>No.</td>
<td>Title</td>
<td>Author(s)</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>HIV prevalence among young orphans and non-orphans in Chimanimani, District, Zimbabwe</td>
<td>S Munyati, et al</td>
</tr>
<tr>
<td>31</td>
<td>A Situational Analysis of Challenges faced by different types of Orphans in eight districts of Zimbabwe</td>
<td>S Mahati, et al</td>
</tr>
<tr>
<td>32</td>
<td>Levels of Care and Protection Practices for Adolescents</td>
<td>S Moyana, et al</td>
</tr>
<tr>
<td>33</td>
<td>Inheritance issues of orphans aged 15-18 years in two Zimbabwean districts</td>
<td>W Mashange, et al</td>
</tr>
<tr>
<td>34</td>
<td>An assessment of community resources available for OVC</td>
<td>S Buzuzi, et al</td>
</tr>
<tr>
<td>35</td>
<td>Challenges faced by Intervention Agencies in the Provision of Assistance to OVC: A Situational Analysis in eight districts of Zimbabwe</td>
<td>S Gwini, et al</td>
</tr>
<tr>
<td>36</td>
<td>Vulnerability Assessment of Households with Children in Zimbabwe: An Extract from the 2003 OVC Population Census in Bulilimamangwe &amp; Chimanimani Districts</td>
<td>S Rusakaniko, et al</td>
</tr>
<tr>
<td>37</td>
<td>Assessment of the Home environment of Orphans and non-orphans in Chimanimani district</td>
<td>G Nyamundanda, et al</td>
</tr>
</tbody>
</table>
1. The state of re-integration programmes for children in residential care in Zimbabwe.

Renben Musarandega; Child Protection Society, Harare, Zimbabwe.

Concerns grew over the situation of Orphaned and Vulnerable Children (OVC) as the impact of HIV and AIDS intensified from 1997. Commitment to address the problem was intensively mobilised, leading to inception and immediate implementation of the National Plan of Action (NPA) for Orphans and other Vulnerable Children (OVC) in 2005. However, there exist critical sections of OVC, which the nation needs to increase its attention on. One of these is that of institutionalised children. Whilst it is fully recognised that institutionalisation is unhealthy for growth and future of children; their numbers in residential care institutions are increasing while initiatives for re-integration are virtually being abandoned. Child Protection Society (CPS) conducted an operations research survey in 2005 on the state of re-integration programmes in 10 Children’s residential care institutions in Zimbabwe. The study, in its methodology, involved visits to the institutions, and interviews with staff and children, at the same time capturing secondary data from institutions’ records. Wide-ranging information including baselines on state of the children’s education and life-skill development, rate of re-integration, and opportunities and challenges to re-integration was gathered. The survey revealed that the re-integration programme for children in residential care in Zimbabwe is virtually collapsing and that opportunities only lie in reunification of the children with their relatives as opposed to formal foster and adoption. However, the harsh economic environment was observed to be impeding re-integration through re-unifications. It was further realised there is need for resource mobilisation towards this intervention, from both government and other sectors for Zimbabwe to fulfil the right of these children to live in a family environment and at the same time avoid keeping many children in institutions, who will be discharged into destitution in mainstream society.

*Highest HIV prevalence and deaths due to AIDS were reached in 1997 and the level maintained through to 2003 (Ministry of Health and Child Welfare and National AIDS Council, 2004; AIDS Impact Model).*
2.

Networking, Training and Policy Needs for Improved Care of Children Living with HIV and AIDS in Zimbabwe

G Foster†, A Miller‡, K Felsman§, F Bwakura, P Mbetu, B McColgan‡, A Mabonva**, C Chakanyuka

Background

Some 165,000 children are living with HIV/AIDS (CLHA) in Zimbabwe, 2.5% of the child population. As opportunities for ART roll out increase, barriers to care services for all CLHA need to better understood. We present preliminary results of a situation analysis and tentative conclusions.

Method

In 2005-6, a national analysis of community and health facilities caring for CLHA was conducted collaboratively by the National AIDS & TB programme and partners. CLHA and key stakeholders (n=60) in the community, health system and civil society sectors were interviewed using structured quantitative and qualitative tools. Central themes explored included medical and non-medical care provision, awareness of available resources and family-centred care issues.

Results

Data presented will include: Nr. CLHA seen, with confirmed diagnoses, aware of diagnoses, receiving medical, nutritional, psychosocial, palliative, spiritual and family support services; Quality of services for comprehensive care of CLHA; Barriers to obtaining confirmed diagnosis of paediatric HIV infection; Effectiveness of referral within and between medical and non-medical services; Networking, training and policy needs; Understanding of family-centred care.

Conclusions

There is enormous unmet need for training of health workers and communities in CLHA diagnosis, care and treatment issues. Barriers to diagnosis of HIV in children go beyond lack of access to appropriate technologies, and are related to embedded health worker and community perceptions. Holistic care of all CLHA requires establishment of strong community - health system referral networks that are currently poorly established. Efforts must be made to include the many CLHA not accessing basic health systems in care provision especially as ART scale up receives predominant attention. National strategies and policies need to be established to ensure that CLHA are identified receive appropriate services including ART. Complexity in care access issues for children requires that multi-disciplinary stakeholders come together to create supportive policy and systems at an early stage.

‡ Elizabeth Glaser Pediatric AIDS Foundation, Zimbabwe
3. HIV-associated orphanhood and children’s psychosocial distress: theoretical framework tested with data from Zimbabwe

Constance A. Nyamukapa, Simon Gregson, Ben Lopman, Suzue Saito, Helen J. Watts, Roeland Monasch and Matthew C. H. Jukes

Objective

The psychosocial impact of HIV-associated orphanhood is poorly understood. We measured the impact in a sub-Saharan African population and evaluated a new framework for understanding the causes and consequences of psychosocial distress in orphans and vulnerable children (OVC).

Methods

The theoretical framework was developed from literature. Aspects of the framework were evaluated using data from 5,321 children aged 12-17 years interviewed in a cross-sectional national survey in Zimbabwe in 2004. A measure of psychosocial distress was constructed using principle components factor analysis. Ordinary least squares and logistic regression were used to estimate standardised coefficients of psychosocial distress and odds ratios of early sexual activity, respectively.

Results

Compared to non-orphans, orphans had more psychosocial distress (males: Coeff, 0.13; 95% CI, 0.06-0.20; females: Coeff, 0.20; 95% CI, 0.11-0.29). For both sexes, each type of orphan exhibited more severe distress than non-OVC. For boys, but not for girls, non-orphaned vulnerable children suffered more psychosocial distress (Coeff, 0.13; 95% CI, 0.01-0.24). Double, maternal and paternal orphanhood remained associated with psychosocial distress after controlling for differences in more proximate determinants including poverty, sex and age of household head, school enrolment, and support from closest adult and external sources. 0.5% (251/2,398) of males and 8% (181/2,262) of females reported sexual experience. Maternal orphans (AOR, 1.95; 95% CI, 1.34-2.84) and paternal orphans (AOR, 1.29; 95% CI, 1.00-1.67) but not double orphans ($P=1.0$) were more likely than non-OVC to have started sex. These differences reduced somewhat after controlling for psychosocial distress.

Conclusions

Orphaned teenagers in Zimbabwe have greater psychosocial distress, which, in turn, lead to increased likelihood of sexual debut. The impact of strategies to provide psychosocial support should be evaluated scientifically.
4.

**HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe**

*Simon Gregson, Constance A Nyamukapa, Geoffrey P Garnett, Mainford Wambe, James J C Lewis, Peter R Mason, Stephen K Chandiwana, Ray M Anderson*

**Background**

AIDS has increased the number of orphans and vulnerable children (OVCs) in sub-Saharan Africa who could suffer detrimental life experiences. We investigated whether OVCs have heightened risks of adverse reproductive health outcomes including HIV infection.

**Methods**

Data on HIV infection, sexually transmitted infection (STI) symptoms and pregnancy, and common risk factors were collected for OVCs and non-OVCs in a large population survey (n=8202) in eastern Zimbabwe between July 2001 and March 2003. Multivariate logistic regression was used to test for statistical association between OVC status, adverse reproductive health outcomes and suspected risk factors.

**Results**

Amongst women aged 15-18 years, OVCs had higher HIV prevalence than non-OVCs (3.2% versus 0.0%; p=0.002) and more common experience of STI symptoms (5.9% versus 3.3%; adjusted odds ratio, 1.75 [95% CI 0.80-3.80]) and teenage pregnancy (8.3% versus 1.9%; 4.25 [1.58-11.42]). OVCs (overall), maternal orphans and young women with an infected parent were more likely to have received no secondary school education and to have started sex and married, which, in turn, were associated with poor reproductive health. Amongst men aged 17-18 years, OVC status was not associated with HIV infection (0.5% versus 0.0%; p=1.000) or STI symptoms (2.7% versus 1.6%; p=0.529). No association was found between history of medical injections and HIV risk amongst teenage women and men.

**Conclusion**

High proportions of HIV infections, STIs and pregnancies among teenage girls in eastern Zimbabwe can be attributed to maternal orphanhood and parental HIV. Predicted substantial further increases in orphanhood could hamper efforts to slow the acquisition of HIV infection in successive generations of young adults, perpetuating the vicious cycle of poverty and disease.
5. Rising incidence and prevalence of orphanhood in Manicaland, Zimbabwe, 1998 to 2003

Helen Watts, Ben Lopman, Constance Nyamukapa, Simon Gregson

Objective
To quantify and describe orphan incidence in Manicaland, eastern Zimbabwe.

Methods
Statistical analysis of data on 13,740 and 10,308 children, aged 0-14 years, enumerated in household censuses in 4 socio-economic strata, 1998-2000 and 2001-2003, and 10,184 children seen in both censuses (74% follow-up).

Results
Prevalence of all forms of orphanhood increased. The overall rate of losing a parent amongst non-orphans was 27.5 per 1000 person-years (py). Paternal orphan incidence (20.2 per 1000 py) was higher than maternal orphan incidence (9.1 per 1000 py) and maternal orphans lost their fathers at a faster rate than paternal orphans lost their mothers. Paternal and maternal orphan incidence increased with age. Incidence of paternal orphanhood and double orphanhood amongst paternal orphans rose at 20% per annum (incidence rate ratio (IRR) = 1.20; 95% CI 1.06-1.35) and 71% per annum (IRR = 1.71; 95% CI 1.25-2.33), respectively, 1998-2003, but incidence of paternal orphanhood and double orphanhood amongst maternal orphans were unchanged. For 82% of children with a parent who died, the parent was HIV-positive at baseline. More new paternal and double orphans – but not new maternal orphans – than non-orphans had left their baseline household. Mortality was higher in orphans than non-orphans with the highest death rates observed amongst maternal orphans.

Conclusions
Orphan incidence and prevalence are high and increasing due to HIV in eastern Zimbabwe. Orphan incidence patterns differ from orphan prevalence patterns and need to be understood if support programmes are to assist children during periods of high vulnerability.
6.

**Poorer health and nutritional outcomes in orphans and young children not explained by greater exposure to extreme poverty in Zimbabwe**

_Helen Watts, Simon Gregson, Suzue Saito, Ben Lapman, Michael Beasley, Roeland Monasch_

**Objective**

To determine whether differences in exposure to extreme poverty or lack of parental care amongst young orphans and vulnerable children (OVC) explain the greater malnutrition and ill-health seen in OVC.

**Methods**

Development and testing of a theoretical framework to explain the mechanisms through which OVC experience results in increased child ill-health and malnutrition through statistical analysis of data on 31,672 children aged 0-17 years (6,753 aged under 5 years) selected from the Zimbabwe OVC Baseline Survey 2004.

**Results**

28% of children aged 0-4 years at last birthday were either orphans or vulnerable children. OVC were more likely than non-vulnerable children to have suffered recently from diarrhoeal illness (age- and sex-adjusted odds ratio, AOR, 1.27; 95% CI 1.09-1.48) and acute respiratory infection (1.27; 1.01-1.59) and to be stunted (1.24; 1.09-1.41) and underweight (1.18; 1.02-1.36). After further adjustment for exposure to extreme poverty, OVC remained at greater risk of diarrhoeal disease (AOR 1.25; 1.07-1.46) and chronic malnutrition (1.21; 1.07-1.38). In 0-17 year-olds, OVC with acute respiratory infection were more likely not to have received any treatment even after adjusting for poverty (AOR 1.29; 95% CI 1.16-1.43).

**Conclusion**

Differences in exposure to extreme poverty amongst young children by OVC status were relatively small and did not explain the greater malnutrition and ill-health seen in OVC.
7.

The psychosocial well-being of orphans in HIV-afflicted Manicaland
Constance A. Nyamukapa, Simon Gregson, Ben Lopman, Mainford Wambe, Paul Mare, Helen J. Watts and Matthew C. H. Jukes

Objective
To understand the impact of HIV/AIDS-associated orphanhood on children’s psychosocial well-being in Manicaland, eastern Zimbabwe

Methods
1003 children (222 non-orphans, 243 maternal orphans, 255 paternal and 279 double orphans) were selected from a household census and verbal autopsy interviews. Children and their caregivers were interviewed on issues pertaining to extended family (survival status), household socioeconomic status, childcare arrangements, children’s life experiences (work and life style), and the children’s psychological health. STATA v7 was used to analyse the data and - using factor analysis - to derive a psychosocial distress variable from 48 listed items. A theoretical framework designed from literature review is being used to explore the relationship between orphanhood and psychosocial distress, to investigate the influence of potential moderating variables, and to identify causal pathways.

Results
Most orphaned children lose parents around 9-14 years of age. Maternal and double orphans were found disproportionately in grandparent, other relative and non-relative-headed households. Reports from both caregivers (coeff:0.158, p=0.017) and children (coeff:0.185, p=0.001) indicate that girls suffer more psychosocial distress than boys. According to caregiver reports, orphans were less likely suffer from psychosocial distress than non-orphans (co-eff: -0.121, p=0.137) but the opposite was true according to the children’s responses (co-eff: 0.218, p=0.048). Parents were more likely than other caregivers to report children as having psychosocial distress.

Conclusion
Orphaned children report more psychosocial distress than non-orphans in Manicaland. Comparisons of psychosocial well-being in orphans versus non-orphans based on caregivers’ reports may be confounded by differences in the closeness of the relationships of children to their caregivers.
8.

**Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe**

*Brian H Howard, Carl V Phillips, Nelia Matinhure, Karen J Goodman, Sheryl A McCurdy and Cary A Johnson*

**Background**

Africa is in an orphan-care crisis. In Zimbabwe, where one-fourth of adults are HIV positive and one-fifth of children are orphans, AIDS and economic decline are straining society's ability to care for orphans within their extended families. Lack of stable care is putting thousands of children at heightened risk of malnourishment, emotional underdevelopment, illiteracy, poverty, sexual exploitation, and HIV infection, endangering the future health of the society they are expected to sustain.

**Methods**

To explore barriers and possible incentives to orphan care, a quantitative cross-sectional survey in rural eastern Zimbabwe asked 371 adults caring for children, including 212 caring for double orphans, about their well-being, needs, resources, and perceptions and experiences of orphan care.

**Results**

Survey responses indicate that: 1) foster caregivers are disproportionately female, older, poor, and without a spouse; 2) 98% of non-foster caregivers are willing to foster orphans, many from outside their kinship network; 3) poverty is the primary barrier to fostering; 4) financial, physical, and emotional stress levels are high among current and potential fosterers; 5) financial need may be greatest in single-orphan AIDS-impoverished households; and 6) struggling families lack external support.

**Conclusion**

Incentives for sustainable orphan care should focus on financial assistance, starting with free schooling, and development of community mechanisms to identify and support children in need, to evaluate and strengthen families' capacity to provide orphan care, and to initiate and support placement outside the family when necessary.
9.

**Psychosocial Disadvantage: Preparation, Grieving, Remembrance, and Recovery for Orphans in Eastern Zimbabwe**

*Brian Howard, MPH; Nelia Matinhure, MSc; S.A. Sheryl A. McCurdy, PhD; Cary Alan Johnson, MLA*

Few programs for sub-Saharan Africa’s 12.3 million children orphaned by AIDS have focused on these children’s high risk of psychosocial problems. As groundwork for supporting orphans’ healthy development, this study describes the preparation, grief, and memorial experiences and the physical and psychosocial well-being of 144 double orphans and 109 single orphans in rural eastern Zimbabwe. Most received no preparation or orphan-specific support for mourning and emotional recovery. On measures of physical and psychosocial well-being, orphans did more poorly than 87 non-orphaned classmates, perhaps reflecting interaction of economic disadvantage and orphan status. Financial hardship was most severe among single orphans. Double orphans’ responses suggested perceptions of isolation, lack of support, and difference. Distress was greatest among younger orphans (<13 years). Given the importance of emotional health to child and societal development, scaled-up financial assistance should incorporate programs to help children prepare for and recover from the loss of their parents.
10.

The effect of orphanhood on the health and nutritional status of children in Zimbabwe
Helen Watts, Simon Gregson, Constance Nyamukapa, Ben Lapman and Michael Beasley

Objective
To investigate the effect of orphanhood on the health and nutritional status of children living in Manicaland, Eastern Zimbabwe

Methods
A longitudinal child cohort study (n=1,003) was established in July 2001 to collect data sets on the experiences of orphans relative to non-orphans. Children were recruited into the study (222 non-orphans, 255 paternal orphans, 243 maternal orphans and 279 double orphans) from a household census and verbal autopsy interviews. A theoretical framework was developed from the literature to explain the mechanisms through which orphanhood might lead to increased malnutrition and ill health during childhood. Statistical analysis of the data set was carried out using Stata v8.0.

Results
The prevalence of malnutrition (<-2 z-scores) amongst 0-18 year olds in Manicaland was 37%; 27% (n=274) being stunted, 25% (n=263) underweight and 5% (n=53) wasted. The prevalence of stunting and underweight is distributed evenly by age. However, wasting is significantly more common amongst children aged 0-8 years, compared to those at older ages. Paternal orphans were more likely to be stunted compared to non-orphans (AOR 1.45; p-value = 0.08). However, there were no other detrimental associations found between orphanhood and malnutrition. Paternal orphans under 7 years of age are more likely to have suffered from diarrhoea in the last 2 weeks (AOR 3.64; p-value=0.08).

Conclusion
The results to date show little association between detrimental health and nutritional outcomes and orphan status. Further investigation is needed to determine the causal pathways between orphanhood and adverse outcomes that are outlined in the theoretical framework.
11.

From Affected to Infected: Understanding the HIV and sexual health risks among adolescent orphans in Zimbabwe

Isolde Birdthistle, Sian Floyd, Auxillia Machingura, Judith Glynn, Stacie Greby, Mike St Louis, Simon Gregson

Objectives

An estimated 15 million children have lost one or both of their parents to AIDS. More than half of these orphans are adolescents. A study was conducted to determine whether and through what mechanisms adolescent orphans may be at increased risk of HIV, HSV-2 and pregnancy.

Method

Data were drawn from a community-based sero-epidemiological survey in Highfield in 2004. All 15-19 year old females within randomly selected enumeration areas of Highfield were invited to an interview and health screening and asked to provide a blood or saliva specimen for HIV and HSV-2 testing. Sexual health outcomes and experiences were assessed by type and timing of orphanhood, and multivariate analyses were used to explore the causal pathways by which orphaned adolescents may be at heightened sexual risk.

Results

(A) The relationship between sexual health outcomes and orphan status

Half of the participants in the Highfield study had lost one or both of their parents. Higher rates of HIV, HSV-2 and pregnancy were seen among orphans compared to non-orphans. Married adolescents experienced higher rates of HSV-2 (42%) and HIV (18%) than never-married girls (6% HSV2+; 6% HIV), however, associations with orphanhood were stronger among non-married participants (n=743). Among never-married adolescents, the highest rates of HIV, HSV2 and pregnancy were seen among maternal (age-adjusted OR=3.3 for any adverse sexual outcome), followed by double (aOR=2.3) and paternal orphans (aOR=1.5), compared to their peers with both parents alive. Maternal orphans were at heightened risk whether they had lost their mother as a child (before age 12) or as an adolescent (age 12 or older). Paternal orphans were at higher sexual risk than non-orphans if they lost their father as a child (aOR=2.5), but, at no significant risk if their father died during their adolescent years (aOR=0.9).

(B) Proximate and distal determinants of orphan risk

Non-married girls who had lost a mother or both parents were more likely than non-orphans to have had sex (aOR=1.7), and to have had two or more sexual partners in their lifetime (aOR=6.0). Girls who had lost their mother only were more likely to have been forced to have sex (aOR=1.7), and to have initiated sex earlier. Possible pathways of sexual risk include:

- **Educational** disadvantage contributes to the higher sexual risk seen among maternal and double orphans. Among older girls (18-20), early school-drop out explained 33% of the effect of orphanhood on sexual risk; among younger girls (14-17), being out of school explained 15% of the higher risk among orphans.

- **Environmental** context: Having two or more important caregivers (other than a parent) explains 6% of the effect of orphanhood; infrequent church attendance also explains 6% of the higher risk among orphans.
**Economic**  Orphaned teens in Highfield appear to be at a financial disadvantage compared to their non-orphaned peers, particularly those who lost their father or both parents. However, such girls’ families receive assistance more than others’, usually from neighbours or their extended family. In multivariate analyses, economic factors did not alter the association between sexual risk and maternal orphan status, but, the girl’s unemployment and a female head of household together explained 23% of the higher risk among girls who lost their father only before 12 years of age.

**Conclusions**

The heightened sexual risk seen among maternal and double orphans is due in part to having a series of different caregivers and dropping out of school early, while paternal orphans appear to be at risk for economic reasons. These factors do not explain all of the effect of orphanhood on sexual risk; a strong significant relationship remained. We will continue to explore causal pathways in more detail with this data as well as nationally representative data from the Young Adult Survey.
12.

Care and Support for Out of School Youths: A Situation Analysis

Mildred T. Mushunje, Senior Manager for Child Protection and Gender
Catholic Relief Services - STRIVE

Objectives
A general gap analysis was carried-out across the CRS/ZW STRIVE partners revealed that the majority of OVC interventions are focused on children at the level of primary school. While some important youth programming is being accomplished, the needs of out-of-school youth (OSY) are seriously neglected. At present, Zimbabwe’s current unemployment rate and family factors of chronic poverty for many OSY, few pathways to a sustainable livelihood are available. At the same time, this population is at increased vulnerability to HIV infection. In the face of these general findings, CRS conducted a more focused, in-depth situation analysis on OSY across Zimbabwe.

Methods
A qualitative approach included a thorough review of current literature. A focus group approach based on a semi-structured interview were carried-out with 120 out-of-school youth who were interviewed in groups of 20, and over six sites across the country, both urban and rural. In addition, a range of key informants were included, gatekeepers who are working with or are in regular contact with OSY. Community perceptions of OSY were also gathered.

Results

1) OSY are a diverse population: across age, gender, education, social class, and rural or urban context. Programming efforts must reflect this reality and a “one fits all” approach with interventions should be avoided.

2) OSY rely on a range of coping strategies. Income sources are primarily from the informal sector. Reliance of drugs and alcohol are prevalent along with increased risk for HIV infection.

3) Youth vulnerability is tied to the poor socio-economic conditions in the majority of OSY families and communities. Intervention strategies must go beyond traditional “training” efforts, relying on genuine youth participation, provision of adequate resources and follow-up over time.

4) OVC have very limited access to organized skill training programs and a block grant approach should be considered with well-respected programs.
Parental Health, School Attendance, and Educational Enrollment of Orphans and Vulnerable Children in Zimbabwe

Kyle Jemison PhD. Principal Investigator (former Head of Operations Research catholic Relief Services-Zimbabwe, STRIVE Project)

Using data from a 2004 household-based survey of children and caregivers, we examine the impact of orphaning and parental illness on education in the context of Zimbabwe. After controlling for other factors, we find that orphans in Zimbabwe are less likely to be enrolled in school than their non-orphaned counterparts. Previous work has not addressed the effect of orphan status on another measure of attendance – the frequency of attendance. We find that, similar to school enrollment, orphans are less likely than non-orphans to attend school on a regular basis. We next investigate the extent to which household economic status affects the likelihood that an orphan will attend school. We find that orphans in better-off households are particularly disadvantaged in comparison to non-orphans. In contrast, orphans in worse-off households have similar probabilities of school attendance in comparison to non-orphans. Finally, we examine the impact of parental illness on children’s education. We find that girls in households with an ill parent are less likely to attend school than boys in similar households and are less likely to attend than girls in households without.
Orphans and Vulnerable Youth (OVY) on the Brink: Reproductive Health Risks among OVY in Rural Zimbabwe

Pierre Ngom, Hazel MB Dube, Rose Wilcher, Ndugga Magwya – Family Health International, P.O. Box 38835, Nairobi, Kenya, pngom@fhi.or.ke

In 2004, Family Health International carried out a study to determine whether orphans and vulnerable youth (OVY) are at higher risk of adverse reproductive health outcomes compared to non-OVY. Data were collected via a random sample survey in three provinces in rural Zimbabwe. Field interviews covered 3,705 households, and 1,894 boys and girls age 13-21 years. An orphan or vulnerable youth was defined as a household member age 13-21 who lost either or both parents, or whose parents were alive but with at least one of them having been chronically sick over the past 12 months.

Married OVY girls were more likely to report having had premarital sex (19%) compared to married non-OVY girls (10%). High risk sex was also more prevalent among OVY girls (60%) compared to non-OVY girls (36%), but no significant differences were observed between OVY boys (94%) and non-OVY boys (100%). OVY girls (42%) were more likely to be in marital unions than non-OVY girls (27%). No differences were observed between OVY boys (5%) and non-OVY boys (4%). About 57% of OVY girls and 75% of OVY boys reported that they wanted their first child later or not at all, compared to 31% and 59% of non-OVY girls and non-OVY boys, respectively. About 4% of OVY girls and 6% of OVY boys reported having had an STI over the 12-month period preceding the survey, while the corresponding figure was nil among non-OVY girls and boys.

Overall, gender (being a girl) was found to be the most important risk factor for adverse reproductive health outcomes among OVY in Zimbabwe. Priority should be given to multisectoral programmes that address the educational, socio-economic, and reproductive health needs of OVY in the Africa region.
15.

Interests of NANGO

Bob Muchabaiwa, Membership Development Manager, NANGO

NANGO is interested in the research aspect of the NPA for OVC. One of the critical aspects which we may want to consider for future research, though it is the position of NANGO that this area is indeed a priority area, is "The level and impact of local and national budgetary allocations to OVC". A mosaic of questions abound that we have to frankly and critically discuss: How much resources are being allocated to OVC? What proportion of the total budget? On what are the budgeted resources used? What has been the impact? Any gaps in resource allocation and utilization? Are the resources reaching the intended beneficiaries - OVC?

Through this research we should be able to interrogate the efficacy of the resources channeled towards OVC? If the NPA for OVC is to be sustainable, lets face it, local and national budgets, should reflect that indeed OVC is a priority area. External aid is good to strengthen the overall response but we also need to find out what we are and can do in the current context to mobilize and coordinate efficient utilization of local resources.
16.

Examining environmental context of orphans living in rural Zimbabwe
Sophie Pascoe, Lisa Langhaug, Webster Manyonga, Oliver Gore, Bothwell Manyonga, Memory Musiwa, Oliver Mutanga, Robert Power, Frances Cowan

Objective
To examine the environmental context of orphaning in rural Zimbabwe.

Methods
A multi-method community-based survey of students from 82 rural secondary schools, collected quantitative and qualitative data and dried blood spots. In-depth interviews (n=60; 50% male, 50% HIV+) and focus group discussions explored issues deriving from the survey.

Results
6791 Form 2 pupils (87% of eligible) were recruited from 30 rural communities; median age 15 years (range 12-21); 35% orphaned. Orphans were 3.4 times more likely to be HIV positive than non-orphans. 5.6% of cohort (n=378) were maternal orphans, 19.9% (n=1352) paternal orphans; 9.5% (n=645) dual orphans. Orphans were more likely to live with extended family or no family than non-orphans (37.1% vs. 2.4%); only 41% of non-orphans lived with both parents. 90.7% (n=1,226) of paternal orphans vs. 71.2% (n=269) of maternal orphans live with their remaining parent. Male maternal orphans more likely to live with extended family than female maternal orphans (27.3% vs. 21.7%). Age was not associated with who a participant lived with.

Qualitative data suggest that orphans:
• living with extended family move frequently, resulting in disruption to their social support and schooling.
• report greater anxiety about their future.
• are discriminated against: given more household chores, receive less food and less likely to be given new clothes.
• are stigmatized and addressed in debasing language that often equates them to non-human objects.
• living with a stepmother are abused, with little or no support from their father.
• are appointed a family guardian without their consultation.
• of younger age are looked after by the maternal side and adolescent/older orphans are looked after by the paternal side, resulting in a shift in traditional patterns.

Conclusion
Being an orphan in rural Zimbabwe leads to wide personal, familial, economic, social and environmental consequences that are largely detrimental to the individual.
17.

**Orphans are vulnerable to negative sexual experiences in rural Zimbabwe**

*Oliver Mutanga, Memory Musiwa, Webster Mavhu, Bothwell Manyonga, Oliver Gore, Lisa Langhang, Sophie Pascoe, Robert Power, Frances Cowan*

**Objective**

To examine the context of sexual experience among young people in rural Zimbabwe.

**Methods**

In a community based survey of 6791 Form 2 pupils, self completed questionnaires and dried blood spot samples were collected. In depth interviews were conducted with 60 randomly selected cohort members (50% male, 50% HIV+). Focus group discussions were also held with young people to explore this issue.

**Results**

Overall 35% were orphans. Orphans are significantly more likely to report having had sex (8.5% vs 7.0% p=0.028).

Although more orphans were sexually active, orphans did not report more risky sex than non-orphans (forced sex, sex while drunk, sex without condoms or more partners). Age at sexual debut was not significantly different between orphans and non-orphans (median age of sexual debut for orphans and for non-orphans = 13 years). Orphans and non-orphans had similar levels of reproductive health knowledge.

Qualitative data did however suggest that orphans were at increased risk for several reasons. Some orphans use sex as a means of ensuring adequate food supply ‘When you are failing to get food, you try to source money using your body’. Secondly some men seek out orphaned girls to have sex with, as the penalties for impregnating them are unlikely to be enforced (marriage, payment of damages). Thirdly, orphans reporting abuse are less likely to be believed. ‘If the orphan reports it, the abuser would then say, ‘don’t you know that that is the same reason why she was chased from where she used to stay, she is a great liar.’

**Conclusions**

Orphans have higher rates of HIV than non-orphans and are more likely to be sexually active. Qualitative data suggest that orphans are at increased risk of sexual exploitation and thereby potentially at increased risk of HIV.
18.

**Gender Based Violence Against Girls Desk Study**  
*Girl Child Network*

**Objectives**
- Reflect on history of activism around violence against girls with a view to come up with real and root causes of violence against girls and devise more effective strategies to curb the menace
- Identify and analyze the most prevalent forms of violence against girls, their social, economic, political and religious manifestations based on data GCN has so far collected on the ground
- Assess impact of Girl Child Empowerment Programs in minimizing violence against girls and long term impact of the strategies currently being implemented by GCN
- Recommend way forward on curbing violence against girls to government, GCN, funding partners, parents and guardians, other women’s and children’s organisations, the media and other stakeholders

**Methods**
- Client and data base
- Diary of Betty Makoni, Director and Founder of Girl Child
- Girl Child Network program activities reports
- Video taped raw footage on club activities and girls’ testimonials
- Unpublished girls’ stories, songs and poems.
- Daily reported cases of rape from the newspapers
- Rape survivors’ evaluation forms upon discharge from Empowerment Villages where they come to seek for temporary shelter from violence especially if it happens in the home
- Input from stakeholders’ workshops
- Club members’ registration forms.
- Official figures from police and courts
- Project Monitoring and spot check reports from the Director and Administration team
- Group and mobile van counseling reports
- Field and home visits reports. We also conducted a number of field home spot-check visit.

**Summary of Results and Conclusions**
- 20 000 cases of Child Sexual Abuse including rape (10 000), incest (2930), early/forced marriages (70), virginity testing (7 000), child prostitution and genital mutilation.
- Survivors are in the 3-13 age group and perpetrators believe virgins cure HIV/AIDS.

**Most present forms of child sexual abuse and perpetrators.**
- Fathers and close relatives have contributed to much of rape statistics.
- Oldest perpetrator was an 83-year-old grandfather.
- Domestic virginity testing has contributed to sexual abuse as fathers end up raping their daughters.
- Gangster and public Sexual violence syndicates have perpetrated violence against girls in secluded places, public entertainment places and the streets.
Organized religious child sexual abuse syndicates in the form of forced marriages within apostolic sects.
Organized cultural/traditional Child Sexual syndicates involving genital mutilation and virginity testing.
Organized Commercial Sex Syndicates including child prostitution and sex trafficking. Victims are mostly from poverty stricken families and child headed households aged 15 and below.
School child sexual abuse syndicates involving school authorities or taking place within school environments.

Major causes of violence against girls
- Cultural beliefs and practices- involve virginity testing and genital mutilation, sex invitation ceremonies.
- Religious beliefs and forced marriages- within apostolic sects involving girls below 16 years.
- Poverty- girls end up engaging in early sexual activities with married men and engage in child prostitution to make out a living.
- HIV/AIDS pandemic- Rise of girl child headed households and high rate of school drop outs.

Fact about Child Sexual Abuse
- 13-16 years of age group the most vulnerable age group.
- Rapist to child transmission of HIV on the increase – 2 000 out of 20 000 confirmed to have contracted HIV.
- Youngest rape survivor aged two weeks from Shamva.
- Youngest married girl aged 11 from Rusape.
- Rural to urban sex trafficking of girls as domestic workers later on sexually abused on the increase.
- Brothels disguised as lodges.

Recommendations and best practices as undertaken by GCN
- Collective stakeholders action to eradicate violence against girls.
- Advocacy and Lobbying a strictly Child Offences Act.
- Review of polices that are geared towards addressing the problem of the girl child.
- Outreach or awareness campaigns and information dissemination.
- Community development and empowerment on the girl child.
- Setting up a Woman As Role Models programme.
- Government to ensure the Legal and Judiciary mechanisms implement the Children’s Protection and Adoption Act.
- Girls Empowerment Villages which are critical in the development of the of the girl child because girls get the spine to grow and prosper. They give a sense of hope to survivors of abuse in the rural areas.
19.

Girls Reproductive Health Research
Girl Child Network

Objectives
The aim of the research was to establish the effects of shortage of sanitary towels on the reproductive health development and education of girls and find out the alternatives being used.

The Objectives were:
1. To find out whether the girls are readily getting sanitary towels and if not, what alternatives are they using?
2. To find out how the shortage is affecting them in relation to their normal lives, growth and development.
3. To specifically find out how menstruation affects education and how this is compounded by lack of sanitary towels.
4. To find out if there are health problems resulting from the shortage and if there are any hygienic related problems deriving there from

Methods
10 Clubs were sampled targeting 20 girls for Secondary Schools and 10 girls for Primary Schools. A structured interview was used to collect data. Individual interviewer administered and self-administered questionnaires and a different structured interview schedule for key informant were used. Data analysis was done manually.

Summary of Results and Conclusions
- Most of the 139 respondents were from very low income families living well below the poverty datum line hence poverty was a remarkable characteristic of the respondents
- 41% (57) had lost either one parent or all, 59% (82) had both parents alive. 14% of the 57 orphaned had lost both parents while 85% had lost only a father and 9% lost a mother. 16% of those with all parents alive and 9% of the total respondent had their parents separated. The respondent’s situation and living conditions resembled those of orphaned children and most of them were living in extremely difficult circumstances.
- 96% (134) of the respondents knew what menstruation is while 4% (5) were not aware although they were already on their cycles.
- 136 out of 139 know machira (rags) as a type of sanitary towel.
- 122 girls (88%) of the total sample know cotton wool, 23% acknowledged knowing pads and tampons
- 113 out of 139 used machira (rags) for three months preceding the study.
- 33 respondents used cotton wool at one point while 6 used Nina famina
- Other types of sanitary ware used were, tissue paper, newspaper, raw cotton, tree leaves, yam leaves, grass, old exercise books, human hair and bamboo tree bucks posing reproductive health dangers such as cancer, infertility, rash and blisters. 109 used tissue paper, 82 used tree leaves at one point, 3 girls used the human hair. Most were from poor and disadvantaged households
- Some of the respondents stated they do not come to school during their cycles, as they have nowhere to wash their socked rags.
Most, if not, all rural based schools are not user-friendly environment for girls of menstruation ages.

37 out of 139 respondents’ school attendance was not affected, while 38 were often affected. 90% fail come to school, as they do not have panties to hold the cotton wool, 85% are afraid of spoiling their uniforms or being laughed at.

90 out of 139 are affected academically, 49 girls not affected.

Class performance is affected due to uneasiness, anxiety, uncomfortably resulting from fear of spoiling uniforms, rags falling off and producing offensive smell.

Recommendations and Needs of the girls

- **Schools:**
  Should provide sanitary towels, buckets and soap for girls to wash their rags, build bathrooms at school.

- **Government:**
  Make cotton wool available at cheap prices of sanitary ware and panties. Make reproductive heath as part of the school curriculum.

- **GCN and others:**
  Donate buckets and soaps, provide cotton wool, panties and soap, and produce reading on natural on reproductive health, educate community on menstruation, lobby government for panties, cotton wool to be available, provide OVC with panties.

- **Community:**
  Should talk to girls about menstruation and growing up, help them draw period calendar, provide sanitary ware and panties.
The Impact of Internal Savings and Lending Schemes on OVC: Evaluating experiences with communities in Makoni, Buhera and Gutu Districts

Objectives

a) To examine the socio-economic effects of IS&L activities in the community, household and OVC using available baseline data
b) To assess the extent to which the IS&L interventions can help mitigate the negative impact of HIV and AIDS on OVC

Methods

A baseline survey for the IS&L intervention was conducted as a benchmark in October 2003. Information was collected on asset accumulation, sources of income, children in school, nutritional status and social capital. Interviews were held with 16 key informants from community leaders and school heads. In-depth interviews were held with 155 IS&L members, out of a total of 2400 members (300 groups). These were also conducted with 20 OVC individuals and 2 OVC IS&L groups. Semi-structured interview guides were used with 24 focused group discussions with IS&L members, totalling 149 participants.

Results

♦ Program impact at OVC level achieved indirectly through increases in household assets, incomes, expenditures and empowerment of parents and guardians.
♦ Assets like pots, plates and cups increased by 66%, 78% and 70% respectively in the three communities.
♦ The top 3 uses of income were school expenses, food purchases and farming inputs.
♦ Households having three meals a day increased by 75% in Makoni, 57% in Gutu and 17% in Buhera.
♦ 25% of the respondents from the 3 sites had looked after someone with a terminal illness in their household during the prior six months.

Conclusions

* IS&L intervention is inexpensive, community owned and managed.
* OVC support from IS&L activity is largely indirect but significant.
* The IS&L methodology can be adapted as an economic strengthening strategy with youth, linked to building life skills, and youth micro-enterprise.
Assessing the Impact and Cost-effectiveness of Education Assistance to OVCs in Zimbabwe

Lovemore Tinarwo, Tendai Gatsi and Samuel Kudhlande††

Despite a decline in the HIV and AIDS prevalence rates from 24.6 to 20.1, Zimbabwe still has the world's fourth highest rate of HIV infection. At least 650 children die every week from AIDS related illnesses. Over the years the number of orphans has steadily risen due to HIV and AIDS. In 2002, it was estimated that there were 761 000 orphans due to HIV and AIDS compared to an estimated 1.3 million with child headed households increasing from 50 000 to 318 000 in 2005‡‡.

CRS/ZW piloted a program called Support To Innovative Replicable Village/Community Level Efforts for orphans and vulnerable children (STRIVE) aimed at improving care and support to OVC, having noted the increase in orphan hood. STRIVE’s main objective was improved care and support to OVC.

The program’s impact was to be tracked using operations research with the following objectives:

- To assess the impact of the education support to OVCs.
- To assess the cost-effectiveness of the models of education support to OVCs.

Data using STRIVE specific tools were collected from 16 STRIVE partners who were implementing direct education assistance (paying school fees, paying for uniforms, stationery) and the block grant education assistance. Special studies, Quarterly reports and surveys were used to collect data over three years. The results showed that the block grant education assistance model was able to retain more children in school compared to direct education assistance in a hyperinflationary environment. Using the same amount of resources, the number of direct and indirect beneficiaries increased by 30% and 132% respectively. It is concluded that the block grant model can retain more children in school than the direct assistance model as well as reducing stigma. It is recommended that further operations research be done to address challenges of block grant negotiations, time periods and financing day-to-day running of the school.

†† CRS/ZW Operations Research, Monitoring and Evaluation Department.
‡‡ UNAIDS report 2005
22.

Child Sexual Abuse (CSA) in Zimbabwe

*Dr Gwiza, Family Support Clinic (FST) Harare*

**Background**
A multi-disciplinary CSA clinic was opened at Harare Hospital (HH) in 1995 in response to the inadequate care offered to children presenting to the public health service. FST was formed in 1998 as a Government/NGO partnership to source funding and integrate activities with the Victim Friendly Courts Initiative. Family Support Clinics have opened in Chitungwiza and Mutare and training undertaken country-wide and regionally. Outreach services are undertaken to high density suburbs, raising awareness and facilitating identification/referral of cases.

**Activities / statistics (2005)**
- 5,023 visits (65% to FSC HH).
- 1,916 new patients.
- 3,118 review visits (51% for a second/subsequent visit).
- 9% boys.
- 27% aged 0-5 years, 31% 6-11 years, 42% 12-16 years.
- 12% presented <72 hours after the event, ie inside the time that post-exposure prophylactic (PEP) anti-retroviral drug use may be effective.
- 1,455 gave a story of a perpetrator: 24% relatives, 71% known to the child (not a relative), 5% strangers.
- 57% rape, 22% ‘statutory’ rape, 5% sodomy (anal abuse of a boy), 5% ‘indecent assault’ (mostly anal abuse of a girl).
- 1,776 children medically examined: 46% findings of penetration; 9% ‘highly suggestive’, 8% ‘suggestive’, 6% ‘inconclusive’, 31% no visible injury (not excluding sexual abuse).

Figures will be presented concerning numbers of CSA who are:
- Orphans Harare-233 for 2005
- Out of school (>6 years) – 502 for all 3 clinics
- On PEP- 20 for Harare only
- Numbers of cases taken to court - 821

**Discussion/Conclusion**
These children have succeeded in finding adult assistance to visit the clinic and therefore represent the ‘tip of the iceberg’ of CSA. Orphans and children in other forms of difficult circumstances are disproportionately represented. This work is challenging, specialised, demanding multi-sectoral training/integration of medical/nursing/psychological/social work/legal/court/police and educational services. FST’s work with nearly 15,000 abused children over 10 years is unique in the region, proving it can be done. In collaboration with MoHCW, FST intends to expand training within all sectors/provinces so that near-universal national coverage can be achieved.
Bottlenecks and Drip Feeds - Channelling resources to communities responding to orphans and vulnerable children in southern Africa

**Geoff Foster**1 and **Rose Tindwa**2

1 Ministry of Health, Zimbabwe
2 TARSC, Harare

**Background**

A considerable challenge is how to support growing numbers of Vulnerable children within their own communities. Small groups of committed Community members care for children, but are in urgent need of external assistance. International funding for HIV/AIDS programmes has increased dramatically in recent years. Many blockages exist that prevent resources from reaching communities. The priority question for governments and international agencies is how to ensure that resources can best be disbursed in order to build the capacity of affected communities and households and directly benefit vulnerable children.

**Methods**

Save the Children commissioned a study to identify policy and advocacy issues that, once addressed, would increase the flow of resources to CBOs. Literature was reviewed and data collected from 80 CBOs and national organizations in Mozambique, South Africa, Swaziland and Zimbabwe. Data will be presented from Zimbabwe.

**Key findings**

The study found few examples of effective mechanisms for channelling resources to CBOs responding to the needs of vulnerable children. The research identified 'bottlenecks' that are stopping the smooth flow of funds to support community initiatives. Providing resources to communities is not taken seriously. Current mechanisms do not allow for resource 'flows' that reach CBOs. Donors and governments are not held accountable for spending to support community initiatives.

**Recommendations**

Current aid allocations are unable to find their way through to community groups, and it is unlikely that simply increasing aid flows will result in sufficient resources reaching community level. CBOs need long-term funding that is 'drip-fed' - continuous, steady, small amounts of resources to ensure that communities can sustain their responses and improve the quality of life for African children. Greater investment should be made at different levels of the funding systems. Technical support should be increased at all levels and HIV/AIDS funding tracked to determine how much reaches communities.
A Voiceless Community - HIV/AIDS and Zimbabwe's Deaf Youth

*Foster L1, Flackson D1, Foster G2.*

1. NZEVE Deaf Children’s Centre, Mutare;
2. Mutare Provincial Hospital

**Background**

Although deaf people are more vulnerable to HIV/AIDS than hearing people, they have been largely excluded from education and awareness campaigns. When the deaf have been included little attempt has been made to ensure suitable methods and materials are used. Research on the effectiveness of HIV prevention activities amongst the deaf in developing countries is non-existent. [NL]

**Methods**

Research investigated the Knowledge, Attitude, Behaviour and Practice (KABP) related to HIV/AIDS of young deaf adults in Zimbabwe. An initial literature review highlighted the lack of data and limited study material surrounding many key concerns relating to HIV/AIDS among deaf people. The sample of 34 Zimbabwean deaf youth, completed answer sheets to sign language-interpreted questions supplemented by picture cards, and attended informal confidential voting interviews (pocket chart voting) and focus group discussions. 11 of the sample had attended HIV/AIDS participatory education activities. [PARA]

Results: Deaf youth attendees of HIV/AIDS sessions, compared to non-attenders were more likely to: believe deaf people can get HIV/AIDS (92% vs 35%); believe HIV can spread through unprotected sex (73% vs 26%); believe HIV can spread from mother-to-child (82% vs 48%); have greater personal HIV/AIDS risk perception (64% vs 48%); choose to use a condom (64% vs 35%). Only 55% of attenders and 44% of non-attenders knew someone who had died from AIDS whilst both groups had misconceptions, believing HIV could spread through using a toilet (82% and 46%); mosquito bites (44% and 46%); and kissing (48% and 39%). [NL]

**Conclusion**

Obtaining information concerning HIV/AIDS from the deaf presents several challenges. Education is successful in increasing deaf people's knowledge and personal risk assessments though it is unclear whether it leads to positive persistent changes in sex behaviour. Greater investments in education, particularly using participatory techniques, and better understanding of HIV prevention of deaf people are needed.
25.

**SOS Children’s Villages**

**Study Justification**

SOS Children’s Villages in Zimbabwe launched an orphan outreach programme in an endeavour to support the orphaned children in Harare, Bindura and Bulawayo. It has been realised that assistance is only possible to efficiently and sustainably support the children if they express the problems they face in relation to their livelihood and suggest type of support options. The study therefore intends to provide SOS with the true picture of the livelihood of households taking care of orphaned children. This information will guide and give direction to the proposed Orphan Outreach programme in Glen View.

**2.0 Main Aim**

The study aims to gather information that will form the basis and foundation for planning, implementing and managing of the proposed Community – based – Orphan Outreach Programme in the areas of operation

**2.1 Specific Objectives**

- Identify problems faced by the guardians and orphaned children.
- Identify the coping mechanisms employed by such households.
- Find out the level of access to social services by such households (education, health, accommodation etc)
- Identify institutional support available and level of authority in the community.
- Find out beneficiaries’ expected assistance package and their participation in project management.
- Establish the preferred project management structures
- Establish capacity and opportunities for partnership with the community i.e. their envisaged role in the programme.

**2.2 Methodology**

The study mainly depended on tools of analysis used in the Household Economy Assessment (HEA) Methodology. HEA is a methodology for investigating the sum of ways in which the household gets its food, cash income and assets and its expenditure on food and non-food items. The methodology helps in understanding what the households are vulnerable to and how they cope with their situations. The household’s capacity to cope with identified problems is then analysed basing on the information collected. The study largely used the wealth group breakdown, which was identified by the Famine Early Warning Systems Network (FEWS-Net) in collaboration with the Consumer Council of Zimbabwe (CCZ) in their Harare Urban Vulnerability Assessment of 2001. The 2001 study offers baseline information of the livelihoods of households in Harare urban. Primary data was collected from adults and children separately to allow verification of information. Children were put into homogenous groups to allow maximum participation of all children in the group.

**3.0 Environmental Context (home and community)**

The programmes operate in high density areas of Glen Norah and Glen View – Harare, Makokoba and Mzilikazi – Bulawayo and Chipadze, Chiwaridzo in Bindura. Many of the residents are of foreign origin. (Malawi, Mozambique and Zambia.) Old people who have since retired from the industries therefore own most of the houses. Majority of the household heads are now widowed and are staying at their matrimonial homes. Being of foreign origin, the community does not have rural homes to turn back to when times are hard. They have very few blood relatives in Zimbabwe, they have since been out of touch with relatives back home or are in touch but the transport fares are so prohibitive that they cannot visit each other. Grandparent headed households are therefore a common feature in the programme areas. The cosmopolitan nature of urban communities leaves the children to the sole support and care of their guardian. If the guardian is no more, the children fend for themselves and no one around them notices.

**4.0 Economic realities**

**4.1 Sources of income**

Participants indicated that their sources of income are mainly informal. A few households (5-10%) have at least one member employed in the formal sector (usually low level to casual jobs). The informal activities that bring some income in the household include small scale vegetable and fruit vending, selling drinks and freezits, peanut butter, manure, and commodities which are currently scarce on the market (e.g. mealie-meal and cooking oil), traditional healing, and casual jobs such as doing domestic work for others, crocheting, sewing and hairdressing.

**4.1.1 Renting out rooms**

Renting out some of the rooms in their houses to lodgers is a common source of income in most high-density suburbs and in these particular families.
4.1.2 Casual Work
The casual work done includes domestic work for other families in the locality, such as laundry, and cleaning the house. Some revealed that they work in other people’s fields. This is very seasonal and it impoverishes them as they spend a lot of time in other people’s field without attending to their own. Making wool and crochet items for cross boarder traders are also another source of income. However the payments in most casual work are in kind e.g in exchange for clothes and kitchen utensils.

4.2 Children’s contribution to the household’s income
Both boys and girls who participated in this study indicated that they help in the households to bring income. About two thirds of the children (41%) indicated that they help by selling freezits, vegetables and fruits after school and during weekends. Some boys (about 5% of the boys) of secondary school age indicated that they do odd jobs at the informal sector industry in the community. They offload trucks of fertilizers and cement and get some money. Girls of the same age plait people’s hair. The money they get from selling freezits, vegetables and fruits is normally taken by their guardians who use it for all the household needs. However guardians did not take the money the children got from doing odd jobs by the guardians so the children bought T-shirts, slippers and school stationery with it. Boys of secondary school age indicated that they were sometimes forced by circumstances to con people to get money. They are sometimes asked by adults to run errands for them for example going to buy beer from a bar and get paid.

4.3 Expenditure Patterns
As an urban community where most items are procured through purchasing, the expenditure had quite a long list of items to meet the basic needs. This has forced a lot of them to adjust their living standard.

4.3.1 Rent, water and electricity bills
House rentals, water and electricity bills are the first three expenses that worry urban communities. Some households that are taking care of orphaned children have had their water and electricity supply cut due to non-payment of bills.

4.3.2 Food and non-food household items
Food and non-food household items are also a priority. Household supplies are bought as they get finished or when money is available. There is a vast deficit between the income and expenditure for these families. This exposes the level of vulnerability, food insecurity and the level of the children’s standard of living.

5.0 Educational status and achievement
Access to education could be denied to an orphaned child due to the costs involved especially if there are a lot of children in the household and the guardian has no proper source of income. Children indicated that they are sent away from school for some weeks until their fees are paid. This disturbs their education and their results reflect so. Some children can spend the whole year out of school then they would have to redo the same grade the following year in order to catch up with other children. Orphaned children’s concentration in school is disturbed by hunger as some of them do not eat anything before they go to school or eat only a little and only eat in the evening with the rest of the household members. The children also expressed that they spend 3-4 years with one uniform (an over/small size donated) and a pair of shoes such that they are ashamed of their dressing. This has serious psychological effects on the children’s performance in school and in their interaction with other children and teachers. Some of the children indicated that they do not have school bags to put their books. By so doing, they either ask friends who have bags to carry the books for them (and the orphan will have to carry the bag all the time) or just carry the books in their hands expediting the wear and tear of the books. The children do not have anyone to help them with homework when they get home because most of the guardians, especially grand parents are illiterate and some have no interest in the children’s education. They would rather send them to do some domestic chores and leave them with very little time and energy to study. In houses that had electricity cut, they cannot do their homework or study at night. Verbal abuse from teachers and schoolmates also limits the level of interaction. This also emotionally traumatises the children. None of the orphans in the preschool age group attend due to the shortage of resources and low priority accorded to preschool education. The children just start off in grade one. This deprives children of their right to early childhood education. Guardians expressed concern that some of the orphaned children do not have birth certificates and cannot be registered in school. Non-availability of birth and death certificates makes it difficult for children to qualify.

6.0 Health and survival (including nutrition)

6.1 Health
Access to health services is hindered by the high cost of clinic and drug fees. Guardians looking after orphaned children cannot afford the drugs required for the opportunistic infections some of them are suffering from. Children and adults eventually die prematurely due to non-availability of medication.

6.2 Food
Most families are only managing to have at most two meals per day. Some children go to school without eating. They only have something to eat after school, during supper.

6.2.1 Sources of Food
6.2.1.1 Purchasing
Sources of food mentioned by the respondents included purchasing, exchange with cross-border traders, and gifts. Urban communities mainly depend on purchasing to access food. When they cannot find basic food in the shops they buy from private traders who sell them at exorbitant prices. Purchasing as a source of food also is greatly affected by the availability of income.

6.2.1.2 Urban agriculture and Remittances from rural homes
Urban agriculture normally allows the urban households to access small fields where they grow maize, sweet potatoes and other crops. A few households received support from communal areas since most of them are from neighbouring countries and have no rural home.

6.3 Accommodation
Most of the guardians own the houses they are living in. The large household sizes (8-13 people per household) and the fact that rooms are rented out to lodgers, accommodation ends up being a problem with an average of 6-8 people (both adults and children) sharing a room. The participants indicated that they use kitchens and dining rooms as bedrooms at night. Those sharing a room share 2 blankets on a plastic or sack mattress. This compromises privacy and exposes the children to sexual abuse when a mixed group of adults and children share a small space to sleep.

6.4 Clothing and blankets
Due to the large household sizes and the complex problems faced by the guardians, the children indicated that it was not easy for them to update their wardrobes resulting in them wearing over or undersized worn out clothes. This exposes them to lots of stigma and discrimination. Children indicated that they are suffering from cold at night due to inadequate blankets.

7.0 Emotional Experiences
Orphaned children face a lot of challenges in their day to day lives. The challenges start during the illness, through to death and after the death of their parents. Some of the problems include trauma and grief, neglect and loss of parental love, separation from siblings and loss of property, stigma and discrimination and general loss of livelihood opportunities. Sexual abuse is a wide spread problem, particularly for girls in many communities with orphaned children. They are often at a higher risk. Children who are sexually abused have no one to report to and they also fall easy prey to perpetrators because of the poverty level and general lack of adult support. More often, sexual abuse is not reported or publicly acknowledged because of the shame it brings on the family and the girl. This is worse when it happens to orphans by people they live with. The additional burden that comes with taking in more children (into a resource strapped family) sometimes triggers ill feelings among the guardians and children. The guardians will vent out their anger to the children by physically abusing them.

7.1 Children experience trauma and grief during illness and death of parents

7.2 Lack of parental love care and attention leads to developmental problems
The children expressed that they were discriminated against, that was why they “misbehaved” so as to survive in the difficult situation.

7.3 Children do not like to be separated from their siblings after the death of their parents
The children expressed that they felt like a double loss if they are separated from their siblings. The young ones felt lost and took long to adjust, while the older ones were worried about the welfare of their younger siblings living elsewhere.

7.4 Children find it difficult to adjust to the life at the guardians’ home
Sometimes the new family scorned them and blamed them for anything that went wrong in the household. This traumatised them, as it took long to develop coping mechanisms to adjust to the situation.

7.5 Children worry about how their parent’s estate is shared
Children indicated that everything in their house belonged to the family because each one had contributed to the acquisition of the property in one way or the other. The children felt that it was their right to inherit everything.

7.6 Stigma and discrimination is common among children who have lost parents
Children who have lost their parents to HIV/AIDS are discriminated against in their community particularly those children with compromised health.

7.7 After the death of parents children are neglected
Significant proportion is withdrawn from school to do household chores and they are the first ones to miss school if something goes wrong at the home or if resources are inadequate. Most orphans do not have birth certificates, some of them when they fall ill they are not taken for medical attention. Their general outlook makes it easy to tell an orphan from one who is not. Other relatives do not support in looking after the orphans after they discovered that they could not inherit the estate left by their deceased relative.
7.8 Children's life becomes uncertain when their parents are deceased
They felt that the new families they joined might have their own goals and objectives different from those initially set in the original family. They are not sure if the new family will support them to the end.

7.9 The Girl Child
There were problems that were very peculiar to girls only. Girls who reach puberty face the problem of not getting someone to prepare them for issues such stages. The girls further indicated that they have problems getting sanitary ware to use during their monthly periods. One girl indicated that she does not have appropriate dressing and materials to use, so she stays away from school until her monthly period is over. Domestic work in certain households is all left for the orphaned girl to do. The girls who have parents or guardians who are sick indicated that they do most of the care for the sick. In instances where the household head is the brother, the girls indicated that sometimes the “guardian” uses money on himself and does not provide for the sister’s basic needs or even household needs particularly non-food items. Some girls in this situation (taking care of the male “guardians”) are still in primary school. The worn out uniforms and old clothing are more embarrassing to older girls than the young ones as they compare themselves to their peers who wear appropriate clothes.

7.10 The Boy Child
Although the boys are excused from most domestic work, they also have problems that affect them as boys. One boy indicated that his guardian verbally abuses him by saying his mother was a prostitute. Manual work at the home is all theirs. The boys also indicated that relatives who want to get the houses, which the children are staying in, harass them (especially the eldest boy). Some of these relatives just come to harass the lodgers so that they move out by so doing making it difficult for the orphans.

PART 2

The findings presented above are from-orphaned children in Bindura, Bulawayo and Harare. Vulnerability varies with age as indicated under education where orphaned preschool age children are not supported due to non-prioritising by guardians, access to food for the younger ones is even more difficult since they may not have friends to visit and share meals.

Urgent needs /interventions of children in the various areas

Economic realities
- Support guardians with skills training and start up capital for income generation.
- Support post O and A level children with tertiary/vocational training

Educational status and achievement
- Support with payment of fees and provision of uniforms including basic stationery in some instances
- Solicit for parental/guardians support in children's education
- Support children’s study circles to ensure they get better passes

Emotional experiences
- Children need to resolve grief
- There is need for life skills training to deal with psychological and physical challenges
- Psychosocial support is required to facilitate acceptance of situation

Health and survival
- Provision of supplementary food, blankets and clothes (as per need)
- Facilitate access to treatment of opportunistic infections and relevant drugs (ARV?)
26.

**Orphan Status and Risk among Adolescent Girls in Zimbabwe**

Mi-Suk J. Kang, Megan Dunbar, Nancy Padian, Sue Laver

**Objectives**

According to UNICEF, 1 in 5 children in Zimbabwe is orphaned. We examined the impact of loss of a parent on risk behaviours, pregnancy, HSV-2 and HIV prevalence in adolescent girls.

**Methods**

A convenience sample of 196 adolescent girls aged 16 to 19 was recruited from two peri-urban communities near Harare Zimbabwe. Information on demographics, sexual and romantic partnerships, sexual risk behaviours, alcohol and drug use, and reproductive health was collected through Audio Assisted Computerized Self Interview, and health history information was collected through a face-to-face interview. Participants were then tested for HIV, HSV-2 and pregnancy.

**Results**

Of participants, 29% had lost a father, 7% had lost a mother, and 20% had lost both parents. Participants who had lost a parent were more likely to be sexually active (40% vs 24%) and to be in a current sexual relationship (44% vs 19% of sexually active). Though not statistically significant, 12% who had lost a parent had drunk alcohol vs. 8% of those with both parents and 6% vs 1% had tried a drug. Participants who had lost a mother were at highest risk for both HIV (15% vs 3% with both parents and 4% for those who had lost a father, p< 0.01) and HIV-2 (15% vs 6% with both parents and 5% for those who had lost a father, p=0.03). Participants who had lost either parent were more likely to ever have been pregnant: 23% with no parents, 15% who had lost a mother and 9% who had lost a father, compared to 5% who had not lost either parent (p=0.10).

**Conclusions**

Adolescent girls who have lost a parent are at increased risk for STIs/HIV and pregnancy. Interventions should be developed to target these girls and young women, particularly those that have lost a mother.
Combining economic livelihood and behavioral interventions to reduce HIV/STI risk among adolescent female orphans

Megan S. Dunbar, Mi-Suk J. Kang, Catherine Maternowksa, Imelda Mudekunye, Definate Nhamo, Julie Roley, Hibest Assefa, Nancy S. Padian, Sue Laver

Objective
HIV/STI behavioural interventions are not sufficient to achieve sustained safe-sex behaviour among adolescents. We tested the feasibility of a combined economic livelihood and behavioural intervention to increase relationship power/control and thus reduce risk among female orphans in Zimbabwe.

Methods
A sample of 50 orphans (having lost at least one parent) aged 16-19 was recruited from Chitungwiza and Epworth. Using ACASI and face-to-face interviews, we collected information on demographics, knowledge, behaviour, reproductive health, and relationship power/control, and tested for HIV, HSV-2 and pregnancy. The 6-month-long intervention combined micro-credit (business training, loans, mentorship, and peer groups) with sessions on HIV/reproductive health and relationship negotiation. Measures were repeated at 3 and 6 months; qualitative and quantitative data were collected on intervention delivery.

Results
At baseline, 43% had ever had sex and 57% had ever used a male condom. Prevalence was 8% for HIV, 16% for HSV-2 and 20% for pregnancy. Training attendance averaged 79% and 80% received a loan. At six months, more participants had their own income (44% from 6%, p<.01), and could answer all HIV knowledge questions correctly (38% from 16%, p<.01). Although not statistically significant, relationship power scores were related to condom use (80% in highest vs 40% in lowest tertile), and relationship power scores increased in sexual (50% from 11%) and non-sexual (38% from 5%) relationships. Only 5% repaid loans. Participants cited Zimbabwe’s economy, insufficient training, lack of family support and vulnerability to theft/coercion as barriers to economic success.

Conclusions
Although this feasibility study was not powered to detect differences in outcomes between baseline and follow-up, results suggest that a combined intervention has potential to reduce risk, but that micro-credit alone may not be the best livelihood option within this context.
28.

**HIV prevalence among young orphans and non-orphans in Chimanimani, District, Zimbabwe**

*Shungu Munyati, Exnevia Gomo, Simba Rasakaniko, Brian Chandiwana, Junior Mutsvangwa & Wilson Mashange*

**Objective**

There is a paucity of information on HIV infection rates in children, especially those 2-11 years old. This study was to determine the extent and magnitude of HIV infection among children in this group.

**Methods**

752 children aged 2-11 years of age with the permission of their guardians were systematically randomly selected in Chimanimani District. Dried blood spots (DBS) were collected for HIV testing and structured questionnaires administered to the guardians to collect data on demographics.

**Results**

Prevalence of orphanhood was 15.7% with 63.9% being paternal. The majority of orphans were <6 years old when they lost one or both parents. Overall HIV prevalence was 3.3% with highest rate, 5.8% (95% CI: 2.9-10.2), among children aged 6-8 years compared to 2.7% (95% CI: 1.3-5.1) and 1.3% (95% CI: 0.4-5.1) in the 2-5 and 9-11 year olds, respectively. HIV prevalence among orphans and non-orphans was 5.6% (95% CI: 2.1-11.7) and 2.9% (95% CI: 1.6,4.6) respectively, and twice as high among those who had lost a mother compared to paternal or double orphans.

**Conclusion**

This is the first study in Zimbabwe to provide HIV prevalence data for this age group using a large sample. The information generated is important in prioritisation, design, and implementation of programmes to support HIV-infected children and other vulnerable children. Although sub-sample sizes were too small for meaningful statistical comparisons, the most affected are the 6-8 year olds where prevalence was more than twice as high as those 2-5 and 9-11 years, suggesting that a significant proportion of HIV-infected children are living beyond five years of age but not much further than 8 years. The difference in prevalence between orphans and non-orphans is expected considering that the majority of orphans are children orphaned due to HIV/AIDS. While the government is moving as quickly as possible in making ARVs available to the vulnerable, this should also be supported by strong advocacy for immediate introduction of ART for children as well.
Exnevia Gomo, Shungu Munyati, Simba Rasakaniko, Brian Chandiwana, Junior Mutsangava & Wilson Mashange

Objective
The age group 15-24 years, represents youth and is thus a pool of sexually maturing yet inexperienced young men and women. The study describes general risk behaviours and associations with HIV prevalence in an attempt to forge a better understanding of the transmission dynamics of the epidemic in Chimanimani district.

Methods
Specific questionnaires on demographics and HIV related behavioural aspects were administered to 756 OVC aged 15-24 years. Dried blood spots (DBS) were collected for HIV testing. Data were analysed using STATA Intercooler Version 7.0.

Results
HIV prevalence was 9.3% (95% CI, 7.2-11.6%) and higher among the 19-24 year olds (12.1%) than the 15-18 year olds (5.6%). It did not differ by gender in the 15-18 age group, but in the older, 19-24 age group was higher in females (16.1%; 95%CI: 11.8-21.3) than males (5.6%; 95%CI 2.4-10.7).

Fifty one percent reported ever having sex with a mean age of sexual debut of 17.9 years in both sexes. 31.1% reported ever having used a condom, although no association with HIV found. Of those who reported ever using a condom, 13.1% selectively used condoms with some sexual partners and not with others. Condom use during the last sexual encounter was reported by 53.2% with the main reason for its use being prevention of pregnancy (69.5%). Only 44.9% said it was to prevent STIs.

Orphanhood status was assessed in the 15-18 age-group only. The prevalence of orphanhood was 36.9% and mostly paternal. Although statistically not significant and to be interpreted with caution due to the small numbers, HIV prevalence by orphanhood status nevertheless showed a slightly higher prevalence among orphans than non-orphans (12.8%, 10.6% and 10.8% for maternal, paternal and double orphans, respectively) compared to 8% HIV prevalence when both parents were alive.

Conclusion
Figures, including gender differences support national statistics and the evidence of the role of intergenerational sex in transmission of HIV among young girls and women is apparent. Gender mainstreaming should therefore be considered when designing intervention programmes.

Early sexual debut is apparent in both girls and boys and the non-use or inconsistent use of the condom is prevalent with a large gap in the role of condoms for prevention of HIV transmission.
30.

**A Survey of Psychosocial Situation & Experiences of OVC in Zimbabwe: A Case of Chimanimani & Bulilimamangwe Districts of Zimbabwe**


**Objective**
To characterize the psychosocial experiences of OVC in the two districts to inform the development and implementation of appropriate intervention programmes.

**Methods**
A cross-sectional study design was used targeting 1500 children from randomly selected wards in the districts. In each selected household one child would be randomly selected from each of the targeted age groups.

**Results**
There were about 3% of child-headed households in Chimanimani while Bulilimamangwe had only 1%. 75% of the OVC aged 6-14 years had moved into another household, with more boys being displaced from their parent’s original homes. For the 15-18 years group, 50% had been displaced and 33% had been separated from their siblings, and 50% were looked after by their mothers or grandmothers. 5% of the 6-14 years old OVC reported that they had been sexually abused by their guardians. 25% of OVC in all the age group had feelings of unhappiness, worry, frustrations, anger, fear of new situations, scary dreams, trouble falling asleep or preferred being alone. 5% of OVC in Chimanimani and 33.3% in Bulilimamangwe were still bothered by their parents’ death at the time of the survey. 11% of children in households with orphans were reported to treat the orphans badly while this was 10% among the guardians. 98% of OVC were free to talk to their guardians when feeling sick or just down, while 77% said they were encouraged by their guardians to live without fear.

**Conclusions**
There is need to provide psychosocial support services and counseling to OVC since a sizeable number of the OVC reported having scary dreams/nightmares or had trouble falling asleep. Service providers should consider increasing their educational assistance to OVC since quite a number of OVC were not attending school, which further stigmatizes the OVC among their peers and within the community.
A Situational Analysis of Challenges faced by different types of Orphans in eight districts of Zimbabwe


Objective

To compare challenges that different types of orphans, i.e. maternal, paternal and double orphans, confront at home and in the community.

Methods

Focus group discussions, case studies, in-depth interviews and secondary data, used to collect information from orphans (18 years of age and below) in 8 districts of Chimanimani, Mutare Urban, Mutes, Nguva, Bulilimangwe, Geri Urban, Simba and Bandera.

Results

Challenges that were similar across orphan-type were lack of food, clothing, money for school fees and school uniforms (school drop outs), absence of dual parental guidance, street kids and early marriages. Worst affected were the double orphans especially the young and school-going age who reported lack of parental care and love; no one to offer guidance on good morals of child upbringing. Some reported being subjected to child labour (e.g. housemaids, herding cattle, weeding fields) with deterioration in standard of living, as no one would offer material support. Some experienced stigma and discrimination as people assumed that their parents died as a result of HIV and AIDS.

In terms of psychological/emotional experiences paternal orphans seemed to face less challenges as the mother was there although some mothers would abandon the children due to strained relationships with in-laws, whilst the girl child could be sexually abused by half-brothers or step father. Loss of possessions to fathers’ relatives especially if mother re-married was another challenge.

Maternal orphans appeared to be better in terms of material support. Challenges to a large extent arose from the ill treatment by stepmothers whilst the older girl child had to assume motherly role at an early age. Sexual abuse of the girl child by father was also sited.

Conclusion

Organisational or community support should take cognizance of the challenges being faced by different types of orphans and factor these in their interventions.
Levels of Care and Protection Practices for Adolescents

Objective
To establish the levels of protection received by children aged 12-14 years.

Methods
A cross-sectional study was done in Chimanimani. Questionnaires were administered to children aged 12-14 years.

Results
The study recruited 601 children and 54.4%, 9.7% and 1.7% were being looked after by their mothers, grandmothers and fathers respectively, when they were at home. More than 40% of the carers were always present/nearby when the child was at home. About two thirds of the children were required by their care-takers to say where they were going at all times, especially at night (77.6%).

The majority of the children reported never being left in the care of a male non-family member (91.7%) or female non-family member (82.0%), sent out of the home yard without adult supervision (65.7%). There were no differences between orphans and non-orphans.

Almost three quarters (74%) of the children reported that their teachers always attended classes. More than a third (38.2%) reported that their teachers ensured that no unauthorised persons entered the school, 23.2% watched the children as they left school while 46.1% watched them when coming to school.

About a quarter (27.6%) had discussed sexual abuse issues with their parent(s)/guardians while 46.6% had discussed with their teachers. Overall, 16.0% had learnt about sexual abuse from their mothers and 7.5% from their fathers. More females (21.4% vs 10.8%, p=0.001) discussed with their mothers and more males (10.5% vs 4.4%; p=0.018) discussed with their fathers.

Conclusions
• Most guardians were reportedly not exposing children to practices that increased vulnerability to abuse.
• Mothers play a major role in protecting children.
• Teachers impart more knowledge on sexual abuse to children than guardians.
• Mothers educate girls on sexual abuse while fathers educate boys.
Inheritance issues of orphans aged 15-18 years in two Zimbabwean districts

Objective
To identify problems that are faced by orphans pertaining inheritance issues.

Methods
A cross sectional study was conducted in randomly selected wards in Chimanimani and Bulilimamangwe districts.

Results
A total of 447 OVC were interviewed and the prevalence of orphanhood was 232 (51.9%), with 19.8% maternal, 53.9% paternal, and 26.3% double orphans. The mean age for the orphans was 16.5 (SD = 1.1) years with an almost equal number of boys and girls 121 (52.2%) and 111 (47.8%) respectively.

Regarding wills, 3.9% knew that their parents had written/left a will for them and 50.7% mentioned that their parents had not left any written will, while 19.1% did not know. The majority (77.8%) of the orphans whose parents had written wills said the wills were adhered to.

About a tenth (8.2%) of the orphans mentioned that their parents had made plans for them before they had died while 13.0% did not know whether any plans were made for them or not. For those who had plans made for them, 57.9% said the plans were adhered to.

More than half (54.1%) of the orphans were consulted on the distribution of the family assets.

Less than a third (30.5%) of the orphans whose parents who owned a house, indicated that they had inherited their parents’ house together with their siblings whilst 43.5% did not inherit their parents’ houses.

Conclusion
- Most parents/guardians were not making any plans or writing wills for their children/dependants before they die resulting in the dispossession of property from the orphans.
- Plans and wills that were made, though few, were adhered to in most cases showing that relatives were respecting the wishes of the dead.
An assessment of community resources available for OVC


Objective
To investigate the availability of community resources to help OVC.

Methods
The study was conducted in January in eight districts in Zimbabwe. Data collection was done using qualitative research techniques. Their responses were content analysed.

Results
Most key informants reported that there were few community initiatives, though fragmented, to assist OVC. These included gardening, poultry, baking of buns, oil production and peanut butter. Other communities were assisting with fetching firewood, food, weeding/ploughing and rehabilitation of houses. The key resource that communities have was the human resources: care givers and volunteers.

Zunde ramambo was reported to be in existence in most communities, but ineffective due to droughts and community members are not cooperative. Some caregivers noted that proceeds from it were inadequate. Churches helped with food, school fees, counselling and mobilisation of resources such as clothes from well wishers but most of them assisted their members only.

Due to inadequacy of community resources some OVC reported that they were resorting to casual jobs such as herding cattle, weeding, fencing gardens to earn money to pay for school fees and buy basic necessities.

Major challenges for OVC community initiated projects were:
- Poverty
- High cost of inputs
- Absence of incentives
- Harsh economic environment
- Lack of IGP management skills

The above mentioned challenges were making the sustainability of community initiated projects difficult.

Conclusion
There were community projects which operated at a low scale and were not well coordinated. There are a number of factors which militated against the sustainability of projects of which poverty was the major one.
Challenges faced by Intervention Agencies in the Provision of Assistance to OVC: A Situational Analysis in eight districts of Zimbabwe


Objective

Various Intervention Agencies, such as government ministries, NGOs, CBOs, FBOs and the community at large, are making tremendous efforts in caring for OVC. However, the efforts of these agencies are being hampered by various challenges they come across as they carry out their work. The study sought to determine the challenges faced by these agencies.

Methods

A situational analysis was conducted out in the 8 Districts of Chimanimani, Mutare Urban, Mutasa, Nyanga, Bulilimamangwe, Gweru Urban, Zvimba and Bindura. Qualitative methods of data collection, i.e. focus group discussions (FGD), case studies, in-depth interviews and secondary data were used to collect information from the children as well as the caregivers, traditional leaders, government representatives, FBOs, CBOs and NGOs.

Results

Though various issues were cited as challenges faced by the Intervention Agencies, the major outcry was lack of coordination of activities between the organizations and stakeholders resulting in duplication of activities. This resulted in duplication of services especially food handouts, where some OVC households receive double benefits.

Further, the harsh macro-economic environment leading to massive price changes vis a vis static budgets, meant resources were inadequate for them to implement their interventions compounded by the apparent increase in the number of orphans due to the HIV/AIDS pandemic which was overwhelming. Manpower problems due to high staff turnover was also sited as major challenge as it also affected monitoring of activities adversely whilst nepotism and corruption in the selection of beneficiaries seemed to be on the increase.

Conclusion

There is need for the government to come up with a body to coordinate the activities of Intervention Agencies if efforts to utilize the meager resources are to be maximized and to put in place effective monitoring systems that ensure that the available support is directed at the deserving children and their households.
Vulnerability Assessment of Households with Children in Zimbabwe: An Extract from the 2003 OVC Population Census in Bulilimangwe & Chimanimani Districts

Objective
To access the degree of vulnerability among households with children in Chimanimani & Bulilimangwe districts and develop a new simple way of assessing household vulnerability & poverty.

Methods
A Total Vulnerability Indicator Score (TVIS) was developed to measure vulnerability of households and the indicators were access to food, education, health, shelter, protection and other basic child needs as enshrined in the 1989 United Nations Convention on the Rights of the Child.

Results
35% of the households in Bulilimangwe had one meal a day, whilst this was 10% in Chimanimani. 61.4% of households in Bulilimangwe and 66.3% in Chimanimani went for some days without food. 69.9% of households in Bulilimangwe had inadequate clothing whilst this was 87.5% in Chimanimani. 55.5% Bulilimangwe and 61.6% of in Chimanimani had inadequate school uniforms. About 51% of households in Bulilimangwe were not able to pay medical fees if their children fall sick. This was 42.4% Chimanimani. The prevalence was 5% in Bulilimangwe and 3.2% in Chimanimani. Of these children in child-headed households 55.5% and 46.9% in Bulilimangwe & Chimanimani respectively had no caregivers, further more 29.7% (Bulilimangwe) and 36.6% (Chimanimani) had no one to discuss problems with. Using the TVIS incorporating household scores on all the vulnerability indicators, Bulilimangwe had 34.3% vulnerable households whilst Chimanimani had 21.4%.

Conclusions
In both sites a significant proportion of households are vulnerable as evidenced by the lack of basics such as food, clothing and poor access to health & education. Whilst it’s a new measure, the TVIS proved to be a simple, reliable and robust methodology to assess household vulnerability & poverty.
37.

Assessment of the Home environment of Orphans and non-orphans in Chimanimani district.

Objective
To compare the home environment of orphans and non orphans.

Method
A cross sectional study on the home environment of orphans and non-orphans aged 2 – 11 years.

Results
A total of 689 guardians were interviewed. Nearly a fifth (16.2%) were caring for orphans and the predominant carers were mothers (79.7%) followed by grandmothers (13.8%). The carers of orphans were older than those of non orphans (44.9 SD=20.2 vs 36.6 SD=16.6 years, p<0.001).

The majority of children had someone to take care of them all the time. A quarter of the guardians sometimes left children alone at home whilst 40.8% reported leaving them under the care of a person who was under 15 years in the previous week before the study. The proportion of orphans who were left at home alone was slightly higher than that of non-orphans (5.56% vs 4.47%, P=0.874).

Most children shared a room or bed with someone. More orphans (57.4%) than non-orphans (48.5%) slept in shared bed compared to although there was no significant difference.

Some guardians (6.5%) operated a business at home amongst these were shebeens.

Nearly a third of the guardians consumed alcohol, while 10% used recreational drugs. There were twice as many guardians of orphans than non-orphans (11.1% vs 5.4%, p=0.025) who consumed alcohol.

Conclusion
- Most children always had someone to look after them although a quarter were exposed to risks as they were sometimes left alone or under the care of a minor.
- Orphans were generally under care of older guardians than non orphans.
- Small proportion of children live in homes where businesses are run
- Proportion of guardians of orphans who consume alcohol, which was small, was more than twice that of guardians of non orphans.
Part II - Handouts of Plenary Presentations

In the main report, key findings for programming and further research are summarized and key issues are highlighted for the different presentations. In the remainder of this annex, all presentations are presented as handouts.

1. Workshop Objectives - Shungu Munyati
2. Trends in the HIV Epidemic in Zimbabwe - Simon Gregson
3. Overview of the orphan situation in Zimbabwe - Roeland Monasch
4. National response so far - N Dhlembeu
5. Rising incidence and prevalence of orphanhood in Manicaland, Zimbabwe, 1998 to 2003 - Helen Watts and Constance Nyamukapa
7. Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe - Brian Howard
8. The impact of Internal Savings and Lending schemes on OVC: Evaluating experiences with communities in Makoni, Bulwer and Gutu - Washington Masikati and Mildred T. Mushunje
10. Bottlenecks and Drip Feeds - Channelling resources to communities responding to orphans and vulnerable children in southern Africa - Geoff Foster
12. Enrolment, attendance & attainment among orphans & non-orphans (drawn from UNICEF & Manicaland studies) - Charles Mangongera and Constance Nyamukapa
13. The psychosocial well-being of orphans in HIV-affected Manicaland - Constance Nyamukapa
15. HIV prevalence among young orphans and non-orphans in Chimanimani District, Zimbabwe - S. Munyati, Exnevia Gomo, Simba Rusakaniko, Brian Chandiwana, Junior Mutsvangwa and Wilson Mashange
16. Networking, training and policy needs for improved care of children living with HIV and AIDS in Zimbabwe - Geoff Foster

---

Copies of the full presentations in PPT can be requested from Susan Mapira (smapira@nicef.org) or Roeland Monasch (rmonasch@unicef.org).
17. The effect of orphanhood on the health and nutritional status of children in Zimbabwe - Helen Watts and Simon Gregson

18. HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe - Simon Gregson and Isolde Birdthistle


20. From Affected to Infected: Understanding the HIV and sexual health risks among adolescent orphans in Zimbabwe - I Birdthistle, S Floyd, A Machingura, N Mudziwapasi, J Glynn, and S Gregson
Handouts of Plenary presentations

1. **Workshop Objectives** - Shungu Munyati
2. **Trends in the HIV Epidemic in Zimbabwe** - Simon Gregson
3. **Overview of the orphan situation in Zimbabwe** - Roeland Monasch
4. **National response so far** - N. Dhlembeu
5. **Rising incidence and prevalence of orphanhood in Manicaland, Zimbabwe, 1998 to 2003** - Helen Watts & Constance Nyamukapa, BRTI Zimbabwe and Imperial College UK
7. **Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe** - Brian Howard
8. **The impact of Internal Savings and Lending schemes on OVC: Evaluating experiences with communities in Makoni, Bubera and Gutu** - Washington Masikati and Mildred T. Mushunje
10. **Bottlenecks and Drip Feeds - Channelling resources to communities responding to orphans and vulnerable children in southern Africa** - Geoff Foster
12. **Enrolment, attendance & attainment among orphans & non-orphans (drawn from UNICEF & Manicaland studies)** - Charles Mangongera and Constance Nyamukapa
13. **The psychosocial well-being of orphans in HIV-afflicted Manicaland** - Constance Nyamukapa
15. **HIV prevalence among young orphans and non-orphans in Chimanimani District, Zimbabwe** - S. Munyati, Exnevia Gomo, Simba Rusakaniko, Brian Chandiwana, Junior Mutsvangwa and Wilson Mashange
16. **Networking, training and policy needs for improved care of children living with HIV and AIDS in Zimbabwe** - Geoff Foster
18. **HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe** - Simon Gregson and Isolde Birdthistle
WORKSHOP OBJECTIVES

OVC Research: From Analysis to Action*

Shungu Munyati, Acting Director, National Institute of Health Research
Harare Holiday Inn, 26-27 May 2006

INTRODUCTION

• Growing attention and resources are being devoted to orphans and vulnerable children

• Researchers are accelerating efforts to understand specific and most urgent needs of these children, the causes and consequences of these needs

• Agencies are increasing investments in OVC programmes

SO

Time is right to consolidate existing knowledge with programming on OVC

How do we intend to do this?

WE WILL

► Review the 'state of the situation' with regard to orphan prevalence and incidence, and the contribution of the HIV/AIDS epidemic.

► Showcase the most recent OVC research findings to capture the 'state of the science' in Zimbabwe.

► Invite responses to the research by members of organizations and ministries active in the response to the plight of OVCs.

( and thereby get guidance from those making funding decisions and designing and directing programmes for OVC)

► Compare what we know and what we are doing, to identify gaps in research and programmes (update priorities for OVC research)

At the End of the Two Days we hope that we will have been able to

• Bring together researchers and programme/policy players to bridge analysis with action in Zimbabwe in terms of the plight of Orphans and Vulnerable Children and thereby contribute to the mounting response within the broader framework of the NAP of OVC (e.g. Issues of funding priorities; policy formulation and evidence-based action)

• Develop solid links between researchers and programmers to continue to learn from each other

THANK -YOU
EVIDENCE FOR HIV DECLINE IN ZIMBABWE
A COMPREHENSIVE REVIEW OF THE EPIDEMIOLOGICAL DATA

Simon Gregson – for the Zimbabwe Ministry of Health & Child Welfare, UNAIDS & CDC

Evidence for stabilisation or decline in HIV prevalence?
Mortality increase or decline in HIV incidence?
Behaviour change or natural dynamics?

Review approach aimed to be:
Comprehensive - examine all potentially relevant sources
Consensus - consult local & international stakeholders

Identified 30 potential different data sources

National ANC surveillance
Young Adult Survey
DHIS 1988, 1994, 1999
GOZ/UNICEF survey 2004
PMFCT records
VCT records (PSI/MOH CW)
NBTS data
Military applicants*
Vital registration
ZVITAMBO study
ZICHIRE study
Regal Drive Shiri project
UZ-UCSF*
ZAPP
ZIMPACT study
Manicaland study
PSG / Horizons
Sugar estates
JSI survey data
IOM records*
IOM 855 surveys

Formal request letters sent by MOHCW & UNAIDS
E-mail requests & meetings to identify & obtain relevant data
Data synthesis & analysis
International stakeholders - UNAIDS Reference Group
Local stakeholders' meeting - Government, researchers, donors

Organisations represented at Stakeholders' meeting

MOHCW (3)
ZCISO
NBTS (2)
CDC (Dr Hader)
USAID (Dr Halpert)
DRD (Mr Whymms)
UNAIDS (Dr Behne)
UNFPA
UNICEF (Mr Monasch)
IOM
PSI
PACT
ZVITAMBO
BRTI
ZICHIRE
Imperial College
LSHTM
HIV/AIDS epidemiological review process overview & status

- Identified 30 potential different data sources
- Formal request letters sent by MOHCW & UNAIDS
- Email requests & meetings to identify & obtain relevant data
- Data synthesis & analysis
- International stakeholders - UNAIDS Reference Group
- Local stakeholders’ meeting - Government, researchers, donors
- Report

EVIDENCE FOR DECLINE IN HIV PREVALENCE

Epidemiological profile HIV prevalence trends
National: ANC attendees (Genscreen)

Source: MOHCW National ANC Surveillance

Epidemiological profile HIV prevalence trends
Harare: Trend in pregnant & post-natal women

Source: ZVITAMBO

Epidemiological profile HIV prevalence trends
Manicaland: ANC vs. women in the general population

Source: Manicaland Study

Epidemiological profile HIV prevalence trends
Manicaland: Men & women in the general population

Source: Manicaland Study
COMPONENTS OF HIV PREVALENCE DECLINE

Components of HIV prevalence decline: HIV incidence trends

- Harare: Post-natal women (●) & male factory workers (★)
- ZVITAMBO
- BRTI

Components of HIV prevalence decline: Mortality trends

- Harare - Registered deaths
- Harare - Census
- Bulawayo - Registered deaths
- Bulawayo - Census

Components of HIV prevalence decline: Mortality trends

- Manicaland study sites

Source: Manicaland Study
CONTRIBUTION OF BEHAVIOUR CHANGE

Contribution of behaviour change
Age at first sex, 15-24 year-olds

<table>
<thead>
<tr>
<th>Year</th>
<th>DHS</th>
<th>PSI</th>
<th>Manicaland</th>
<th>YAS</th>
<th>UNICEF</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Median age at first sex

Contribution of behaviour change
Non-regular partnerships, 15-29 year-olds

Males

- 0%
- 20%
- 40%
- 60%
- 80%
- 100%

Year

Non-regular partner in past 12m

Females

- 0%
- 20%
- 40%
- 60%
- 80%
- 100%

Year

Non-regular partner in past 12m

Contribution of behaviour change
Condom use – last non-regular partnership
15-29 year-olds

Males

- 0%
- 20%
- 40%
- 60%
- 80%
- 100%

Year

Condom use: last non-regular partner (12m)

Females

- 0%
- 20%
- 40%
- 60%
- 80%
- 100%

Year

Condom use: last non-regular partner (12m)

Trends in condom distribution

<table>
<thead>
<tr>
<th>Year</th>
<th>Commercial</th>
<th>Social Market</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>1994</td>
<td>12%</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>1995</td>
<td>14%</td>
<td>21%</td>
<td>34%</td>
</tr>
<tr>
<td>1996</td>
<td>16%</td>
<td>23%</td>
<td>36%</td>
</tr>
<tr>
<td>1997</td>
<td>18%</td>
<td>25%</td>
<td>38%</td>
</tr>
<tr>
<td>1998</td>
<td>20%</td>
<td>27%</td>
<td>40%</td>
</tr>
<tr>
<td>1999</td>
<td>22%</td>
<td>29%</td>
<td>42%</td>
</tr>
</tbody>
</table>

Source: UNFPA

Contribution of behaviour change
Manicaland: summary

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Started sex (m: 17-24; f: 15-24)</td>
<td>27%</td>
<td>27%</td>
</tr>
<tr>
<td>New partners in past year (a)</td>
<td>0.57</td>
<td>1.13</td>
</tr>
<tr>
<td>Partners in past month (b)</td>
<td>0.75</td>
<td>0.77</td>
</tr>
<tr>
<td>Current partners (c)</td>
<td>0.84</td>
<td>1.15</td>
</tr>
<tr>
<td>Casual sex in past month (d)</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>Unprotected sex with recent casual partner (e)</td>
<td>58%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Source: UNFPA

OVC Research Workshop Report – “From Analysis to Action in Zimbabwe”
Handouts of plenary presentations

Page 5 of 78
CONCLUSIONS
AS AGREED AT STAKEHOLDERS MEETING

- HIV prevalence declined in Zimbabwe over the period 2000-2004:
  the first such decline in southern Africa

- Decline due to falling HIV incidence & high mortality
- Sexual behaviour change contributed to the declines in HIV
  prevalence & incidence

- DHS+ 2005 data will help to confirm these trends

- 1-in-5 adults still infected - much still to be done
Overview of the Orphan Situation in Zimbabwe

Roeland Monasch, UNICEF
OVC Research Workshop
"From Analysis to Action in Zimbabwe"
26-27 April 2006
Harare

Outline
- Number & Percentage of Orphans
  - Epidemiological model
  - Household survey data
- Maternal/Paternal/Double Orphans
- Vulnerable Children
- Geographical distribution of OVC

Epidemiological Models

Based on latest MoHCW estimates there are 1,050,000 orphans due to HIV/AIDS
(Age: 0-14 years)

MoHCW, UNAIDS, WHO, CDC

Zimbabwe - Epidemiological Models
Epidemic curves, HIV, AIDS & orphans

The number of orphans will rise even after the number of adults infected stagnates or declines

Household Surveys/Census

Census 1992 & Census 2002
PASS II

Zimbabwe - Household Surveys
Percent children who are orphaned in rural Zimbabwe, 1990-2005

Probably 1.6 Million children lost one or both parents
One in Five orphans lost a parent in last 12 months
Percent orphans (0-17) by length of orphanhood

Age of Orphans & OVC

Over 90 per cent of orphaned children with extended family
Relationship of double orphans with head of household they live in, Zimbabwe

Increasing proportion is Maternal/Double Orphan

Orphans & Vulnerable Children

Orphans & other children made vulnerable by HIV/AIDS
Geographical distribution
OVC in Zimbabwe, 2004/5

Districts with more than 40% of Households Projected to be Food Insecure in Jan-Mar 2006

Districts with 10%+ of Children (0-17 years) who are Maternal or Double Orphans

Source: Survey on Orphans and Other Vulnerable Children in Rural & Urban High Density Zimbabwe, 2004-2005
ZimVAC, 2005 Census, 2003

OVC Research Workshop Report – “From Analysis to Action in Zimbabwe”
Handouts of plenary presentations
Zimbabwe NPA for OVC: Vision and Goal

- **Vision:** Reach out to all OVC in Zimbabwe with basic services that positively impact on their lives
- **Goal:** Develop a national institutional capacity to identify all OVC and to reach out with service provision to at least 25% of the neediest OVC
- **Time frame:** Adopted by SSACC in August 2004. Initial period of 3 years and continuous. Was launched on 08 Sept. 2005 HICC
- **Premised on the UNGASS goal 65, 66 and 67.**

Objectives of the NPA for OVC

- Strengthen the existing coordination structures for OVC programmes and increase resources mobilization,
- Education (increase enrolment and retention of OVC,
- Increase access to food, health services and water and sanitation (for all OVC - ongoing),
- Increase education on nutrition, health, and hygiene for all OVC,
- Increase the percentage of children with birth certificates,
- Healthy family environment and protection from abuse
- Increase child participation.

Focus of the NPA for OVC

- Seeks to intensify the implementation of national legislation and policies pertinent to children
- Policy puts in place a mechanism for coordination, which is the overall responsibility of government to provide minimum standards and guidelines for civil society, the community and all other development partners to monitor and respond to the situation of children

Policies, Legislation and Programmes

- **Policies**
  - Zimbabwe has three (3) key national policies supporting children:-
    - Zimbabwe National Orphan Care Policy- 1999
    - National AIDS Policy- 1999
    - National Plan of Action for Orphans and other Vulnerable Children (NPA for OVC)- Aug. 2004

Zimbabwe National Orphan Care Policy- 1999

- Developed by stakeholders promoting the community and based on:-
  - The six tier safety net system for children
    - Biological/nuclear family
    - Extended family
    - Community care
    - Formal foster care (through court)
    - Adoption where appropriate
    - Institutional care (last option)

Emphasis is on strengthening and capacitating communities to monitor and provide for the welfare of ‘their’ OVC
Legislation

- Legislation pertinent to children include:
  - Children’s Protection and Adoption Act
  - Guardianship of Minors Act
  - Maintenance Act
  - Child Abduction Act
  - Sexual Offences Act
  - Education Act

Programmes

- National Strategy on CDC: a govt social protection programme
- BEAM
- Public Assistance (allowances, health, pauper burial etc)
- Victim- Friendly Initiative
- National Programme of Action for Children (1992)
- Many programmes by partners

NPA for OVC institutional structure

Cabinet Of Zimbabwe
  - Cabinet Committee on Poverty Eradication and Social Services Delivery (PESSA)
    - Working Party of Officials
      - Provincial Child Protection Committees
        - District Child Protection Committees
          - Community Level Child Protection Committees

Child Protection Committees

- Membership drawn from:-
  - Govt. line ministries and NAC.
  - Rural and Urban Councils, the private sector, donor agencies
  - Representatives from religious groupings
  - PVOs, CBOs, FBOs working at all levels
  - Village, chief, ward representatives
  - Local and govt extension workers including teachers, village community workers, ward coordinators, Agritex officers, councilors, churches, elected persons from the community
  - All are welcome

Role of the Child Protection Committees

- Monitoring: the situation of children at all levels and responding to their plight
- Advocacy: for the rights of children, lobby policy makers, mobilise and raise awareness
- Networking: offer an opportune platform for networking, cooperation and sharing information
- Research and Training: update information and prepare relevant training material
- Resource mobilization: mobilise and rationalize scarce resources

Community Involvement

- NPA for OVC adopts a facilitating and flexible learning process approach to the provision of assistance targeting OVC by all players.
- Community Capacity- Centered Development (CCCD) approach.
- Ensure meaningful child participation recognising the potential they have and what they can share about their unmet needs
The Challenges

The pressing challenges include:
- Unfavourable socio-economic environment exacerbated by unpredictable weather patterns
- HIV and AIDS pandemic whose greatest impact is on the economically active and reproductive age group.
- Lack of information and researched data as well as accurate statistics on OVC – including no. reached per intervention.

A Call for Commitment!!

OUR CHILDREN, OUR FUTURE
OUR
Collective responsibility
United we Stand!!!!!!!!!!!!
Rising incidence & prevalence of orphanhood in Manicaland, 1998-2003, & temporal changes in living arrangements

Helen Watts & Constance Nyamukapa

Background & Aims of the Study

Epidemiology definitions

- Orphan prevalence - level of existing orphans
- Orphan incidence - rate of new orphans
- Incidence is important:
  - to assess whether the number of newly orphaned children is going up or coming down
  - to identify the early & acute impacts of orphanhood
  - to identify where newly orphaned children originate from

Background

The number of children under 18 years of age orphaned in Zimbabwe increased from 570,000 (9% of all children) in 1995 to 1.3 million (19%) in 2003

Extensive data have been collected on levels & correlates of orphan prevalence but few studies have investigated orphan incidence, this is unfortunate since incidence data could be used to distinguish present trends in orphanhood from the effects of the past.

Aims

1. To measure & compare orphan incidence in 4 different socio-economic strata in Manicaland, eastern Zimbabwe
2. To describe recent trends in orphan incidence
3. To quantify the contribution of HIV-associated mortality to orphan incidence
4. To compare & contrast patterns of orphan incidence & prevalence

The Manicaland HIV/STD Prevention Project

Ongoing cohort study located in eastern Zimbabwe

33,740 and 10,308 children, aged 0-14 years, enumerated in household censuses in 4 socio-economic strata, 1998-2000 & 2001-2003, & 10,184 children seen in both censuses (74% follow-up)
Results

Orphan incidence & prevalence

- The overall prevalence of orphanhood among 0-14 year olds increased from 12.2% (1998-2000) to 17.2% (2001-2003)
- Paternal orphan incidence (2.02%) was significantly higher than maternal orphan incidence (0.91%)
- Paternal & maternal incidence were significantly higher when a parent had been HIV positive:
  - IRR 7.3 (paternal)
  - IRR 8.3 (maternal)

HIV prevalence rates for Manicaland

- HIV prevalence rates for adults between 17-44 years old between 1998-2000 in Manicaland

Maternal & paternal orphan prevalence by age of child
OVC Research Workshop Report – “From Analysis to Action in Zimbabwe”
Handouts of plenary presentations

Double orphan prevalence by age of child

Incidence rates (per 1000py) by HIV status of parent & orphan type

Socio-demographic & economic correlates of orphanhood


Socio-demographic & economic correlates of orphanhood
**Socio-demographic & economic correlates of orphanhood**

**MATERNAL**
- Most likely to originate & remain with female household heads
- Start with household heads of mixed ages but move to child-or elderly-headed households
- Start with caregivers of mixed education but move to less educated household heads
- More likely to originate in a household with a radio but this advantage disappears with time

**Mortality**
- 83% of children’s fathers & 82% of children’s mothers who died in the inter-survey period had been HIV-positive at baseline
- At follow-up, 110 children were reported to have died since baseline
- The age-standardised mortality ratio (SMR) for orphans compared to non-orphans was 2.7
- For maternal & paternal orphans, the SMR was 6.1 & 1.7

**Rising orphan incidence rates**
- High HIV-associated mortality & rising orphan incidence are placing increasing strain on the capacity of families to cope with additional children
- Maternal orphan incidence - which has been steadily increasing in recent years - may soon exceed paternal orphan incidence

**Future assistance**
- Data on orphan incidence can be used to inform support programmes on when & where assistance may need to be initiated

---

![Children in a field](image)
Examining the environmental context of orphans living in rural Zimbabwe

Sophie Pascoe, Lisa Langhaug, Webster Mavhu, Oliver Gore, Bothwell Manyonga, Memory Musiwa, Oliver Mutanga, Robert Power, Frances Cowan

Collaborating organisations

- University of Zimbabwe
- University College London
- London School of Hygiene & Tropical Medicine

- Funded by US National Institutes of Mental Health
- Feasibility study funded by Wellcome Trust

www.uz-rds.co.zw

Goal of the project

- To see if an HIV prevention programme in young people can reduce rates of HIV, STD, unintended pregnancy and reported unsafe sexual behaviour in rural Zimbabwe

Objective

- To examine the environmental context of orphaning in rural Zimbabwe

Data being presented today

- RDS baseline survey that was conducted in 2003
- 60 in-depth interviews that were conducted 2004-5 (50% ♂ 50% HIV+)
- FGD with young people and adults in rural communities

Trial design

Baseline survey 2003
Start intervention
Interim survey 2005
Final survey 2007

Baseline survey

- List all young people who are eligible
- Obtain parental consent (94%)
- Obtain young person’s assent (91%)
- Deliver questionnaire (87%)
- Collect finger prick blood sample for HIV and HSV-2 antibody
- Collect urine for pregnancy testing (girls only)
Baseline Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of participants</td>
<td>3521 (52%)</td>
<td>3270 (48%)</td>
</tr>
<tr>
<td>Age range (yrs)</td>
<td>12-21</td>
<td>12-20</td>
</tr>
<tr>
<td>Mean age (yrs)</td>
<td>15.5</td>
<td>14.9</td>
</tr>
<tr>
<td>HIV +ve</td>
<td>20 (0.6%)</td>
<td>31 (1.0%)</td>
</tr>
<tr>
<td>95% CI</td>
<td>[0.3-1.0]</td>
<td>[0.6-1.6]</td>
</tr>
<tr>
<td>Pregnant</td>
<td>-</td>
<td>4 (0.1%)</td>
</tr>
</tbody>
</table>

Other baseline characteristics

- 35% (95% CI: 33.9 to 36.2%) are orphans
- 9.5% of participants both parents had died (29% father dead; 15% mother dead)
- 85% live with mother, father or both parents some or all of time
- Orphans are more likely to be HIV positive than non orphans (age sex adjusted Odds Ratio 3.4 (95% CI: 1.9-6.1))
- 65% of HIV positives in cohort are orphans

Who do orphans live with?

- Orphans were more likely to live with extended family or no family than non-orphans (37.1% vs. 2.4%);
- Only 41% of non-orphans lived with both parents.
- 90.7% (n=1,226) of paternal orphans vs. 71.2% (n=269) of maternal orphans live with their remaining parent.
- Male maternal orphans more likely to live with extended family than female maternal orphans (27.3% vs. 21.7%).

Orphans living with extended family move frequently

- She has moved several times. After her mother’s death, the 3 siblings were split up.
- Anna went to stay with her grandmother. Anna’s grandmother promised to send her to school but instead decided to marry her to a friend. Anna’s prospective husband was much older than her.
- Anna’s aunt instructed her to go to Harare and live with her mother’s young sister.
- She later moved from Harare to Zaka to live with her father and his fourth wife (and their child).

Have decisions made for them without their consultation

- After her mother’s death, her maternal relatives convened a meeting where they discussed Abigail’s future.
- One of her uncles who works in Bulawayo offered to take her so that she could continue with her education.
- Her eldest uncle blocked the move arguing that, ‘this child should go and live with her father.’
- It took the uncles and father a year to make the decision where she should live. She missed a year of school.

Orphans are discriminated against

When there are inadequate school fees in a household, orphans are forced to drop out of school first. They then spend most of their time at home, doing household chores such as watering the garden and herding cattle. – FGD

“...This orphan is made to herd cattle whilst his stepmother’s children go to school … he is only able to go to school twice a week” – FGD participant
Orphans report difficult relationships with their stepmothers

The treatment that I received was ordinary. She (stepmother) didn’t deny me food .... but there were marked differences for example when it came to the provision of new clothes. She would just buy me cheap quality clothes that were quite different from the ones that she bought for her own children

Abigail – she complained that she is denied food. She is always accused of having done bad things even if those things were done in her absence.

Orphans are stigmatized

It was mentioned that chi- and ka- are debasing forms of language that equate orphans with non-human objects. When they are used on people, they imply derision. FGD

I would be scolded. These prefixes are used to refer to bad things or other things that are not human beings.

Tendai (orphan – in-depth interview)

It’s worse if there is no-one looking out for you

‘Orphans from these resettlement villages are often discriminated against and do not benefit from certain programmes. No one represents them, especially when it comes to food. The food will end up being distributed to other kids whose parents are alive and orphans will not get anything. No one helps them’

Community member FGD

Summary

• 35% of Form 2 school pupils were orphans in 2003
• Orphans appear to move frequently which adds to their sense of disruption
• Orphans report that they are rarely consulted on their future
• Qualitative data suggests that orphans are often discriminated against and stigmatized by family and the wider community

“knowing that you are alone in the world, and no one really cares about you indicates that you are grown up”

Chipo in-depth interview
Barriers and Incentives to Orphan Care in a Time of AIDS and Economic Crisis
A Survey of Caregivers in Rural Zimbabwe

Brian Howard, MPH
brianhoward58@hotmail.com

Structure of presentation
- Background
- Methods
- Results
  1) Characteristics of caregivers of double orphans
  2) Physical and emotional well-being of caregivers
  3) Attitudes towards fostering, barriers to fostering
  4) Perceptions that might inhibit fostering
- Conclusions – key findings, interventions to consider

Methods 1
- Part of project initiated by the aid organization Africare
- 3 groups of children:
  Group A – double orphans (n=212)
  Group B – children cared for by a parent, other children in household are all siblings, household severely affected by AIDS (as assessed by Africare) – around 2/3 single paternal orphans (n=85)
  Group C – children cared for by a parent, other children in household are all siblings, household not severely affected by AIDS (n=74)

Methods 2
- Groups A and B – selected at random, from children attending primary or secondary school
- Group C – matched on grade level and sex to children selected into Groups A and B. "Control" group – potential to foster orphans
- For each selected child, primary caregiver invited to participate
- Definition of primary caregiver – “person child would turn to first if needed food, clothes, a personal item, affection, comfort, or guidance”
- Caregiver identified by child, confirmed by caregiver
- 92% interviewed. Interviews in household, interview conducted in Shona

1) Characteristics of caregivers of double orphans
- Group A
  - 85% female (similar among children cared for by a parent)
  - 53% grandmothers, 22% aunts, 14% siblings
  - 34% age 60+
  - 5% age <20
- 48% without spouse (37% widows)
- Poor:
  - 54% subsistence farming
  - 20% household head a skilled or general wage employee, vs. 38% of control group
  - 20% household head had no regular income, vs. 12% of control group
2) Physical and emotional well-being

<table>
<thead>
<tr>
<th>A: Foster parents (%)</th>
<th>B: Africare parents (%)</th>
<th>C: Control parents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.aggregate stats (n=363).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All 3 groups struggling. Only 2% mentioned government, local leaders, or NGOs as someone could turn to for help.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Groups A and C similar except for % always get enough to eat, and % with no one to ask for help.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priorities for assistance were financial: school fees (84%), food (70%), help with income generation (50%).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3) Attitudes toward fostering

Almost all, in all 3 groups, said they were willing to foster a child, even if already fostering.

4) Perceptions that might inhibit fostering

Above factors might limit willingness to step forward for fostering, especially for a child from outside the family.

Conclusions

- Overwhelming willingness to foster orphans from the extended family, motivated by family. Further investigation is needed.
- No reservoir of financially secure households that must simply be persuaded to take in orphans.
- Few caregivers receiving external support.
- For around 30% financial resources were the primary barrier to fostering.

Possible interventions:
- Financial assistance in the form of foster stipends, including free schooling. School fees subsidised for all children in need.
- Non-fostering parents target for outreach, emphasizing non-material rewards of fostering, reduction of AIDS stigma, and removing financial disincentives e.g. guaranteeing payment of school fees.
- Community mechanisms to facilitate fostering outside the family when necessary.
Presented by Washington Masikati and Mildred T. Mushunje

Objectives of the evaluation

- To examine the socio-economic effects of IS&L activities in the households, community and OVC using available baseline data
- To assess the extent to which the IS&L interventions can help mitigate the negative impacts of HIV and AIDS on OVC

Methodology

- Interviews held with 16 key informants from community leaders and school heads
- In-depth interviews held with 155 IS&L members, 20 OVC, 2 OVC IS&L groups
- Semi-structured interview guides used for 24 (149 participants) FGDs

Background to the IS&L intervention

- Baseline survey conducted in 2003
- Survey collected information on asset accumulation, sources of income, children in schools, nutritional status and social capital
- Communities trained in IS&L processes
- Currently have 300 groups (2400 members)
- Groups (6-10 members/group) meet monthly as a cluster to make contributions, to repay loans with interest and to borrow

Results

- Impact at OVC achieved indirectly through increase in household assets, incomes and expenditures
- Assets like pots, plates and cups increased by 66%, 78% and 70% respectively
- Top 3 uses of income were school expenses, food purchases and farming inputs
- Households having 3 meals a day increased by an average 50%
Ownership of household utensils before and after IS&L

Ownership of Livestock

Uses of income as percentage of total income

Uses of loans from IS&L

Opportunities for Out of School Youths
- Young people are an untapped resource within the country with community perceptions of them largely being negative.
- Youth vulnerability, particularly those out of school, is widespread in the country and is tied up to the poor social and economic status of their parents, communities and the nation. This vulnerability is further compounded by the widespread of the HIV/AIDS pandemic.

Continued...
- A sense of helplessness and powerlessness is pervasive amongst out of school youth.
- There is an appreciation that out of school youth should be assisted and communities and youth alike are willing to commit themselves to improving their own socio-economic status.
- Programs dealing with youth development are widespread in the country but it is difficult to measure the full impact of these due to wide fragmentation. As much as these are widespread, there’s limited interventions that focus specifically on Out of School youth because this target group is generally difficult to access and organise, and is highly mobile.
Conclusions

- IS&L intervention is inexpensive, community owned and managed
- OVC support from IS&L activity is indirect but significant
- The methodology can be adapted with youth through life skills and IGAs
- The activity, through asset based savings, provides cushion against inflation
SHAZ! Girls Mean Business Too
Shaping the Health of Adolescents in Zimbabwe

M. Dunbar, M. C. Maternowska, M. Kang, I. Mahaka, J. Roley, H. Assefa, N. Padian
Presented by Dr. S. Laver (PI Zimbabwe)
Women’s Global Health Imperative UCSF
UZ-UCSF Women’s Health Programme

Major Funding from:
National Institutes of Health and the Tides Foundation
The First United Methodist Church of Pennington
Amigo de los ninos de California

In this presentation

• Phase I: Problem Identification
  Formative assessment

• Phase II: Pilot intervention
  Cross sectional study
  Findings
  Implications for Main intervention

• Phase III: Main intervention
  Progress to date

What is SHAZ?

SHAZ means:
“Shaping the Health of Adolescents in Zimbabwe”
SHAZ is a research project to identify individual, social and environmental factors that impact HIV transmission in young, vulnerable girls and develop an intervention to address them

Where is our Research Site?

Phase I
Problem Identification
Formative Assessment:

Key findings:
• Social and economic breakdown leads to loss of support, vulnerability to abuse and risky strategies – such as transactional sex
• Aspirations for career development apparent, but ability to achieve difficult (drop out, no money for school)
• Perception of STI/HIV and unintended pregnancy risk high, yet application of “correct” behavior problematic
• Power within relationships circumscribed by type of relationship (eg boyfriend, sugar daddy, family)
• Knowledge is necessary but not sufficient to effect sustained results

Phase Two
Cross-sectional Survey

Study design
• Cross sectional survey
• Convenience sample, 200 young women ages 16 - 19
• In-and out-of-school orphaned girls
• Living in Epworth or Chitungwiza
• ACASI interviews, face to face health history,
• Lab testing for HIV, HSV-2 and pregnancy
Phase Two
Cross Sectional Survey

Main findings:
Orphan girls are:
• More likely to be sexually active (40% vs. 23%)
• Have a higher prevalence of HIV, HSV2 and pregnancy (at least 2 times higher)

Phase Two
Pilot Intervention

Study design:
• Sub-set of 50 orphans of the 200 girls in cross-sectional survey invited to join pilot
• Followed up at 3 and six months

Phase Two
Pilot Intervention Results

Sexual activity
• Nearly half of all participants were sexually active
• 90% of sexually active girls were “in love” or wanting a marriage partner
• 43 - 67% reported being either physically forced, tricked or coerced into sex
• 10% reported needing food, money or school fees

Phase Two
Pilot Intervention Further findings

Intervention Components
• Life Skills training: well received
• Business Training: attendance averaged 80%; of these 80% created business plans
• Mentoring: “western concept”, tended to be exploitative or not useful; few mentors/peers developed meaningful bonds; guardian and family support proved more meaningful than “outsiders”
• Microcredit loans:
  – Competing needs took priority:
  – At 6 months 20% had repaid first installment; only 5% had repaid their loans in full
  – Lack of financial skills combined with poor economic conditions limited business opportunities

Example Results: Micro-credit Program

<table>
<thead>
<tr>
<th>Business</th>
<th>Loan Amount</th>
<th>Business</th>
<th>Net Profit</th>
<th>Loan Status</th>
<th>Reason for success</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Chipo”</td>
<td>$ZW400,000</td>
<td>Interiors</td>
<td>$ZW2 million</td>
<td>Repaid</td>
<td>Support from mother</td>
</tr>
<tr>
<td>“Beauty”</td>
<td>$ZW 300,000</td>
<td>Buy/sell food stuffs</td>
<td>$ZW 250,000</td>
<td>Nothing paid</td>
<td>Transportation, roadblocks, safe space $/cash</td>
</tr>
</tbody>
</table>

What did we learn from the Pilot Intervention?

• Need to identify and work with culturally and institutionally appropriate partners
• Appropriate support (social and career) is essential, along with phased process leading to improved livelihoods
• Combined livelihoods and life skills approach has potential; girls wanted to succeed, but structural forces dictated otherwise
What did we do as a result of what we learned?  
Phase Three

**Adapted findings from pilot phase for the new intervention:**
- Reviewed the pilot intervention- successes and challenges
- Adapted intervention to political and economic situation in Zimbabwe
- Expanded life skills education based on participant input and pilot results
- Shifted from a livelihood component to a vocational training component
- Identified existing local institutions to provide vocational training options
- Expanded social support component to maximise guardian involvement, career counseling, peer networking/ safe spaces for adolescents

Where are we now?  
Phase III – Main intervention

**Study aim:** To evaluate if a combined healthcare and vocational training, integrated social support (guidance counseling and parent/guardian involvement) and HIV prevention education significantly reduces economic vulnerability and HIV transmission as compared to Life Skills education alone.

**Setting:** Chitungwiza

**Participants:** 300 participants -150 participants randomly assigned to the intervention and 150 participants to the control arm.

**Inclusion criteria:** Female, orphaned, 16-19 years, living in Chitungwiza, HIV and HSV11 negative, not pregnant/intending pregnancy; OOS

**Intervention components:**
- Life skills plus Red Cross basic training
- Vocational training (choices include Advanced Red Cross)
- Strong Integrated Social support component

Main Intervention Progress to Date

**Screened 251**
- Enrolled 157
- Of the total screened, 33 excluded
  - HSV2 positive: 15
  - HIV positive: 11
  - HIV and HSV-2 positive: 3
  - Pregnant: 7
  - Dropped out: 2

Acknowledgements

- Study participants
- Epworth and Chitungwiza Community Advisory Boards
- UZ-UCSF Study Team
- Women’s Global Health Imperative: Dr. Nancy Padian, Megan Dunbar, Dr. Catherine Maternowska, Julie Roley, Mi-Suk Kang
- Funded by: National Institutes of Health, The Tides Foundation
1. Description of Studies

STUDY 1: Literature review of community safety nets for OVC in sub-Saharan Africa

STUDY 2: 4-country data collection and literature review of mechanisms to channel resources to community-level organisations supporting OVC in southern Africa

References:
- Bottlenecks and Drip Feeds: Channeling resources to communities responding to orphan and vulnerable children in southern Africa. G Foster. Save the Children (UK). London, 2005

2. Context

Most support to households affected by HIV/AIDS comes from kin and communities

- World Bank study of households affected by HIV/AIDS in Kagera, Tanzania found that 90% of their financial support came from relatives and community groups
- Only 10% of their support came from NGOs and, to a lesser extent, from government

World Bank, 1997

Model of family and community safety net functioning

- Components of community safety nets
- The ideal: Strong extended family & community safety nets
- The protection: Weak family, strong community safety nets
- The fear: Weak extended family & community safety nets

“Under the Radar” Foster, 2006
Proliferation of Community-Level Organisation Responses

3. Cost of services delivered to support vulnerable children

Increased HIV/AIDS and OVC Funding

Local NGO costs are low

CBO costs are less than NGO’s

International NGO costs are higher and they deliver fewer services

In Uganda, the average cost / child supported in larger NGO programs was 170 per cent higher than smaller CBO programmes

In Zimbabwe, the Bethany Project mobilised 656 volunteers supporting 8,004 OVC at around $2.50 / child

FACT mobilised 7 community groups involving 142 volunteers supporting 6,500 OVC at around $4 / child

(Phiri et al, 2001)
International NGOs are less cost-effective

‘Community and faith-based organizations appear to have a comparative advantage over international NGOs in delivering services to the most beneficiaries in the most cost effective manner.’

STRIVE (CRS Zimbabwe) 2004

"Ballpark" figure for international OVC programs

PEPFAR-funded OVC programmes:
$100 per child assisted

Ref: Personal observation

Development Aid Economics 101

If international donors estimate the cost of OVC projects delivered by international organisations is $100 per vulnerable child
And the cost of services delivered by community-level organisations is estimated (conservatively) as $10 per vulnerable child …
Then what happens to the other $90?

US Overseas Foreign Aid

"At least 60 percent of U.S. foreign aid funding never leaves the U.S., but instead is spent on office overheads, travel, procurement of American-made cars, computers ... as well as salary and benefit packages."

Paper for the U.S. Congress on foreign aid spending by Curt Tarnoff and Larry Nowels (specialists in foreign affairs).

4. What is “community-based”?

Non-Governmental Organisations

1. Direct implementers
2. Indirect implementers
3. Intermediary NGOs (often international)
4. Umbrella-body NGOs

Most not “community-based” but some “community-oriented”
Community-Based Organisations

1. Implementers of NGO program
2. Supported by NGOs
3. Unsupported by NGOs

Community Initiatives ("Voluntary Associations")

1. Savings Associations
2. Burial Societies
3. Agricultural and Business Cooperatives
4. Grain-Loan Schemes
5. Mutual Assistance Organisations
6. Support Groups for PLHA
7. Community Home-Based Care Initiatives
   proliferating in response to impact of AIDS

Faith-Based Organisations

1. Congregations (over 2 million in SSA)
2. Religious Coordinating Bodies

Funding Community-Level Organisations

1. Congregations
2. CB0s
3. "Small" NGOs

5. Study Findings

<table>
<thead>
<tr>
<th>Respondents (n = 75)</th>
<th>National level</th>
<th>Field level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Government</td>
<td>International organisations</td>
</tr>
<tr>
<td>Mozambique</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>South Africa</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Swaziland</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>TOTALS</td>
<td>7</td>
<td>21</td>
</tr>
</tbody>
</table>
Major Findings of Study

- Very few examples of effective mechanisms for channelling resources to community-level organisations responding to the needs of vulnerable children
- Consternation and frustration of community-level organisations about the difficulty in accessing external funding and the lack of significant funding reaching the base

Why do Funds not Reach the Base?

- Why donors and intermediary NGOs do not provide more resources to community groups responding to OVC (N=20)

Congregations have good governance & finance systems but lack external support

- A 30-point Capacity Assessment was administered to 192 Congregations, 34 CBOs and a sample of 7 NGOs and 7 RCBs.

6. Strategies for Overcoming Funding Bottlenecks
Internationally funded “projects” - $ rarely reach “Ground Zero” – the community

Donor
International NGO
National NGO
National NGO
Local NGO

Technical support
Financial resources

Deficiencies of externally-initiated projects

- Frequently involve few community-level organisations (CLOs)
- Technical assistance but usually few grants to CLOs
- Strengthens NGOs but maintains dependency of CLOs on NGOs
- May not meet the needs of communities

Intermediary Organisations as Grantmakers

- Concern about the costs of international NGOs
- Local “intermediary” NGOs, umbrella network NGOs and religious coordinating bodies have potential but few provide technical support or make grants to related organisations
- “Dripfeeding” demands commitment to capacity building by organisations

Local NGOs as Intermediary Grantmakers

- Many local NGOs provide Technical Assistance (TA) to CBOs and some provide one-off grants
- Few local NGOs provide TA or grants to other NGOs
- A few Community Foundations focus on grantmaking and also provide TA

Umbrella Body NGOs as Intermediary Grantmakers

- Some have extensive coverage (e.g. Red Cross; National NGO Networks)
- Others have involvement in HIV/AIDS (e.g. Church Hospital Associations, PLHA or ASO Networks, ZOE Network with 500 church members responding to OVC)
- Most have limited technical support and minimal grantmaking experience
- Potential for favouritism and inducing competition
- Some do not reach community-level groups

Religious Coordinating Bodies as Grantmakers

- Considerable potential because of involvement by member congregations in OVC support
- Few have technical support capacity and hardly any grantmaking capability
- Extensive coverage and “multiplier” advantage of RCBs cf. to NGOs
“Multiplier” and Coverage Potential of Religious Networks in Kenya

<table>
<thead>
<tr>
<th>Religious Grouping</th>
<th>Nr of congregations</th>
<th>Nr of adherents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>800</td>
<td>6,800,000</td>
</tr>
<tr>
<td>Church of the Province of Kenya</td>
<td>3,600</td>
<td>2,700,000</td>
</tr>
<tr>
<td>Africa Inland Church</td>
<td>5,435</td>
<td>2,100,000</td>
</tr>
<tr>
<td>Presbyterian</td>
<td>1,020</td>
<td>1,600,000</td>
</tr>
<tr>
<td>Pentecostal Assemblies</td>
<td>4,023</td>
<td>700,000</td>
</tr>
<tr>
<td>Seventh-day Adventist</td>
<td>2,135</td>
<td>700,000</td>
</tr>
<tr>
<td>Assemblies of God</td>
<td>1,400</td>
<td>600,000</td>
</tr>
<tr>
<td>African Orthodox</td>
<td>540</td>
<td>580,000</td>
</tr>
<tr>
<td>African Independent Pentecostal</td>
<td>456</td>
<td>570,000</td>
</tr>
<tr>
<td>Baptist Convention</td>
<td>2,610</td>
<td>415,480</td>
</tr>
<tr>
<td>Full Gospel</td>
<td>2,714</td>
<td>380,000</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>1,800</td>
<td>346,000</td>
</tr>
<tr>
<td>Methodist</td>
<td>2,000</td>
<td>230,000</td>
</tr>
</tbody>
</table>

Concluding Remarks

“The trail of donor money is as clear as mud,” said Annabel Kanabus, director of UK AIDS charity Avert.

…”governments seemed content to let the poor help the poor, rather than assuming responsibility for children whose families had been decimated by HIV/AIDS. Churches and community groups pooled meager resources to help children apply for school-fee waivers, monitor school attendance, and do home visits to ensure that sickness in the family was not interfering with access to education. They survived on shoestring budgets despite the availability of significant international resources”

Letting them Fail: Government Neglect and the Right to Education for Children Affected by AIDS. Human Rights Watch, October, 2005.
STRIVE Support to Replicable, Innovative, Village/Community Level Efforts for Children Affected by AIDS in Zimbabwe

OVC Workshop: From Analysis to Action
Assessing the Impact and cost-effectiveness of Education Assistance to OVC in Zimbabwe.

Presented by L. Tinarwo, T. Gatsi and S. Kundhlande (CRS/ZW ORMED)

Structure of the Presentation
- Background
  - Overview of OVC and HIV/AIDS
  - STRIVE Overview
  - Policy perspectives
- Objectives
- Methodology
- Findings
- Conclusions
- Recommendations

Overview of OVC and HIV/AIDS
- HIV/AIDS orphans increased from 1 million to 11 million in Sub-Saharan Africa
- In Zimbabwe, HIV/AIDS orphans have increased from 761,000 in 2002 to 1.3 million in 2005.
- Child headed households increased from 50,000 in 2002 to 318,000 in 2005 (IFSW, 2006).
- Despite the decline in HIV/AIDS prevalence rates from 24.6% to 20.1% (IFSW), the no. of orphans continue to increase.

STRIVE Overview
- Increased care and support for Orphans, Vulnerable Children
  - Education Assistance
  - Food Security
  - Psychosocial Support
  - Economic Strengthening
  - Health Assistance
- It has benefited over 230,000 children since 2001.
- STRIVE works through 16 partners working in all provinces of Zimbabwe.
- Funding partners are USAID, Sida, UNICEF and CRS

Objectives of the Study
- To assess the impact of education support to OVC
- To assess the cost-effectiveness of the models of education support to OVC.

Policy perspective
- Pre-Independence
  - Limited access to education
- Post-Independence pre-ESAP
  - Increased expenditure on education by GoZ.
  - Free universal primary and secondary education
- Post-Independence post-ESAP
  - Reduced gvt expenditure in social sectors
  - Re-introduction of user fees
  - Worsening HIV/AIDS crisis
  - BEAM introduced to cater for disadvantaged children

Page 35 of 78
Why Education Assistance?

• Provides sense of continuity and predictability in child’s everyday life
• Provides a social development through peer relationships and a potentially caring adult (teachers, etc)
• In Zimbabwe, other forms of support are often linked to the school environment.
• STRIVE baseline noted that education was the number one need for children followed by food

Definitions

• Cost-effectiveness
  – Cost effectiveness is defined as the dollar spent per child supported and the lower the cost per child the more effective the intervention.
• Orphan
  – The term orphan refers to a child below the age of 18 who has lost one or both parents.
• Vulnerable Children include children who are destitute from other causes other than HIV and AIDS.
• Block grant
  – lump sum payment given to a school, which can then use the money to purchase materials, refurbish classrooms, strengthen infrastructure, etc

Methodology

• Operations Research process that involves the collection and analysis of quantitative and qualitative data
• Partners’ monitoring and reporting systems
• Special studies
• Surveys

Findings

• Typology of Education Assistance
  – Direct Fees
  – Block grants support - targeted
  – Block grants support - not targeted
  – Free universal primary education
  – Self-financing

Increased number of beneficiaries

When STRIVE intensified the block grant approach the no. of children increased dramatically. There was a sharp increase in the no. of indirect beneficiaries compared to direct beneficiaries.

Effect of block grant on no. of beneficiaries

• Dramatic increase in no. of beneficiaries after initiation of block grant
• This was mainly a result of a sharp increase in no. of beneficiaries.
STRIVE Support to Replicable, Innovative, Village/Community Level Efforts for Children Affected by AIDS in Zimbabwe

Cost per child

- The cost per child decreased from US$16.46 to US$8.52
- Decrease was a result of the increase in the number of indirect beneficiaries after the increase in the no. of partners conducting block grants.

Trend in no. of partners conducting block grants

- As the inflation rate increased, the % of partners implementing block grants increased.
- Was after a realization that continuing with direct school fees assistance would lead to less OVC being retained in school

Conclusions

- The block grant retains more OVC in school compared to the traditional direct assistance.
- Free universal primary education remains more favorable to retain more OVC and children in general.
- Time value of money
- It reduces stigma
- Minimizes transaction costs

Recommendations

- More research on the block grant negotiations
- Period of block grants
- Number of beneficiaries to be negotiated for.
- Organizations are encouraged to adopt the block grant in a hyperinflationary environment.
School Enrolment, Attendance & Attainment in Orphans & Vulnerable Children in Zimbabwe

Charles Mangongera & Constance Nyamukapa

Imperial College
London

Trends in school enrolment

Net enrolment - Primary (6-12 yrs) & Secondary (13-16 yrs) ages

Source: EMIS Statistical Report 2004

Trends in school enrolment

Males, 17-18 years & Females, 15-18 years

Source: Manicaland Study

Trends in school enrolment

Transition rate from Form 4 to Form 5

Source: EMIS Statistical Report 2004

Percentages of children out of school by sex & age

Source: Zimbabwe OVC Baseline Survey 2004/05

Page 38 of 78

<table>
<thead>
<tr>
<th>Age-group</th>
<th>Students</th>
<th>Out-of-School</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td></td>
</tr>
<tr>
<td>15-16</td>
<td>0.0</td>
<td>1.3</td>
<td>0.74</td>
</tr>
<tr>
<td>17-18</td>
<td>0.4</td>
<td>1.4</td>
<td>0.8</td>
</tr>
<tr>
<td>15-18</td>
<td>0.2</td>
<td>1.4</td>
<td>0.8</td>
</tr>
</tbody>
</table>
|           |          | Source: Manicaland Study

Educational Support

Educational support: 6-17 year-olds

- 7.8% of those in school (4% BEAM)
- 7.9% of boys
- 7.5% of girls
  
  OR = 0.34, p=0.34

- 7.3% of those in primary school
- 9.6% of those in secondary school
  
  OR = 1.41, p=0.06

More boys in primary supported 8% vs. 7% [p=0.02]
More girls in secondary supported 11% vs. 9% [p=0.02]

Absence from school: 6-17 year-olds

16% overall (M: 17%, F: 15%) - missed 2 weeks

Male orphans more likely than female orphans to miss primary school (OR, 1.16; p=0.05);
no difference at secondary level

Educational assistance

<table>
<thead>
<tr>
<th>Educational assistance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>OVC status</td>
<td>Double</td>
<td>Maternal</td>
</tr>
<tr>
<td>Non-OVCs</td>
<td>3.9</td>
<td>4.6</td>
</tr>
<tr>
<td>VCs</td>
<td>4.4</td>
<td>4.6</td>
</tr>
</tbody>
</table>

School Attendance
Educational Attainment

### Factors that improve children's chances of having completed primary school:
- Being older or female
- Living in:
  - Rural village
  - Better-off household
  - Female-headed household with a more educated household head
  - With a close relative

### Results: Determinants of primary school completion

<table>
<thead>
<tr>
<th>Factor</th>
<th>OR</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental loss</td>
<td>1.69</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Time since father died (years)</td>
<td>1.09</td>
<td>0.013</td>
</tr>
<tr>
<td>Time since mother died (years)</td>
<td>0.90</td>
<td>0.013</td>
</tr>
<tr>
<td>Socio-economic location</td>
<td>0.86</td>
<td>0.357</td>
</tr>
<tr>
<td>Town</td>
<td>0.86</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Estate</td>
<td>0.85</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Roadside trading centre</td>
<td>0.48</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Subsistence farming area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socio-economic status of household</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td>1.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Finished floor</td>
<td>1.63</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Household head characteristics</td>
<td>1.23</td>
<td>0.056</td>
</tr>
<tr>
<td>Female</td>
<td>1.22</td>
<td>0.056</td>
</tr>
<tr>
<td>School education</td>
<td>1.66</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Relationship to head of household</td>
<td>1.68</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Parent</td>
<td>1.69</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Greenwichan</td>
<td>1.54</td>
<td>0.001</td>
</tr>
<tr>
<td>Other relatives or not related</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Child's sex</td>
<td>1.27</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age</td>
<td>1.26</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Sex (female)</td>
<td>1.26</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

N = 2.402

### Summary

- School enrolment is high by African standards
- Boys are more likely to be out of school than girls especially at primary school level
- Insufficient funds is the most common cause of school drop-out
- Orphans – especially male orphans - are more likely to have dropped out of school
- School completion depends on duration of orphanhood
- Children receiving assistance are less likely to miss school
- Maternal orphans are the least likely to be receiving support but most likely to be missing school & - in Manicaland – more likely to drop out of school
- For girls, being out of school is a risk factor for HIV infection – secondary schooling has a protective effect

School enrolment is high by African standards
- Secondary school enrolment is much lower but continued to increase up to the early 2000s
- Boys are more likely to be out of school than girls especially at primary school level
- Insufficient funds is the most common cause of school drop-out
- Orphans – especially male orphans - are more likely to have dropped out of school
- School completion depends on duration of orphanhood
- Children receiving assistance are less likely to miss school
- Maternal orphans are the least likely to be receiving support but most likely to be missing school & - in Manicaland – more likely to drop out of school
- For girls, being out of school is a risk factor for HIV infection – secondary schooling has a protective effect
Psychosocial Disorders in Orphans & Vulnerable Children in Zimbabwe

Constance Nyamukapa

Impact of HIV/AIDS Epidemic on Children’s Psychosocial Well-Being

HIV/AIDS is affecting all aspects of human life – most vulnerable are children

- Basic needs: shelter, food, access to healthcare, education, clothing etc.
- Economic needs: productive skills – vocational education, income generating/farm/productive outputs
- Legal needs: enforcement of property inheritance rights
- Psychosocial needs: loving & caring environment, psychosocial support, socialisation

Study Objectives

- Develop theoretical framework for understanding relationships between orphan experience, unmet psychosocial needs & adult life chances
- Compare & contrast psychosocial well-being by orphan status in Zimbabwe to establish unmet needs in children
- Evaluate the effectiveness of extended family systems in meeting children’s psychosocial needs
- Evaluate methods of collecting sensitive data from children without upsetting them emotionally
- Describe & evaluate some forms of external assistance for appropriateness in meeting children’s unmet psychosocial needs
- Assess cumulative & life course impact of orphaned children’s unmet psychosocial needs

Theoretical Framework

National Data

Zimbabwe OVC Baseline Survey 2004

- National survey – 21 districts
- Data collected November to December 2004
- 5,321 children aged 12-17 yrs interviewed

Do orphans have more psychosocial disorders?

- Males: Double orphans, Maternal orphans, Paternal orphans, Other vulnerabilities, Non-OVCs
- Females: Double orphans, Maternal orphans, Paternal orphans, Other vulnerabilities, Non-OVCs

Why do orphans have more psychosocial disorders?

- Conditions that can increase psychosocial disorders:
  - Poverty
  - Town or estate
  - Not related to household head
  - Out of school
  - Male-headed household
  - Not related to closest adult
  - Lack of support from closest adult

- Most common in:
  - Double & paternal orphans
  - Maternal orphans
  - Double & maternal orphans
  - All orphans
  - Maternal orphans
  - All orphans
  - Double orphans

Why are psychosocial disorders a problem?

- AOR
  - MORE STARTED
  - FEWER STARTED

Locations:
- Urban
- Commercial farms
- Planned household
- Other household

Household head:
- Female
- Male

School attended:
- No
- Yes

Psychosocial disorders:
- Zero
- Index
Findings from Manicaland Study

Study Design

- Manicaland HIV/STD Prevention Project used as sampling frame, household census & verbal autopsy
- Closed child cohort sample purposively selected after a pilot study in 2002
- 1,430 children aged 0-18 yrs selected for study:
  - VAs - all newly orphaned children
  - HH census – 1/3 paternal orphans, all maternal & double orphans & 1/5 non-orphans
  - 348 paternal, 370 maternal, 434 double & 278 non-orphans
- After 1 year, 1,003 (70%) selected children & their caregivers interviewed – 254 (73%) paternal orphans, 248 (67%) maternal orphans, 279 (64%) double orphans & 222 non-orphans (80%)
- Data collected from December 2002 to March 2004

Data Collection

- Children & caregivers interviewed on: extended family survival status, household socio-economic status, social capital, child care arrangements, child life experiences, general child health & psychological health issues, work & lifestyle, education enrolment, forms of family support
- Psychosocial well-being questions:
  - Children age ≥12
  - Caregiver for all children (0-18 yrs)
  - Risky behaviour questions (≥15 only)
- Childhood disorders & other mental health checklists adapted to measure psychosocial well-being of affected children using variables on depression, anxiety, physiological issues, conduct behaviour, self-esteem, social integration etc.
- Family (genogram) tree drawn with help of child, caregiver & other family members to identify possible sources of support

Manicaland Child Cohort Study

Do boys or girls have more psychosocial disorders?

<table>
<thead>
<tr>
<th>Orphan status</th>
<th>Caregiver’s responses</th>
<th>Children’s responses</th>
<th>Test for difference</th>
<th>Test for difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-orphans</td>
<td>N: 252</td>
<td>N: 103</td>
<td>-0.158</td>
<td>0.017</td>
</tr>
<tr>
<td>Orphans</td>
<td>764</td>
<td>454</td>
<td>0.210</td>
<td>0.046</td>
</tr>
<tr>
<td>Paternal orphans</td>
<td>243</td>
<td>154</td>
<td>0.336</td>
<td>0.009</td>
</tr>
<tr>
<td>Maternal orphans</td>
<td>217</td>
<td>137</td>
<td>0.150</td>
<td>0.035</td>
</tr>
<tr>
<td>Double orphans</td>
<td>249</td>
<td>173</td>
<td>0.160</td>
<td>0.100</td>
</tr>
</tbody>
</table>

*Adjusted for age and gender

Manicaland Child Cohort Study

Do orphans have more psychosocial disorders?

<table>
<thead>
<tr>
<th>Orphan status</th>
<th>Caregiver’s responses</th>
<th>Children’s responses</th>
<th>Test for difference</th>
<th>Test for difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-orphans</td>
<td>202</td>
<td>100</td>
<td>-0.121</td>
<td>0.137</td>
</tr>
<tr>
<td>Orphans</td>
<td>756</td>
<td>454</td>
<td>0.210</td>
<td>0.046</td>
</tr>
<tr>
<td>Paternal orphans</td>
<td>243</td>
<td>154</td>
<td>0.336</td>
<td>0.009</td>
</tr>
<tr>
<td>Maternal orphans</td>
<td>217</td>
<td>137</td>
<td>0.150</td>
<td>0.035</td>
</tr>
<tr>
<td>Double orphans</td>
<td>249</td>
<td>173</td>
<td>0.160</td>
<td>0.100</td>
</tr>
</tbody>
</table>

*Adjusted for age and gender

Manicaland Child Cohort Study

Orphan caregivers less close to children?

<table>
<thead>
<tr>
<th>Caregiver relationship to child by form of orphanhood</th>
<th>Orphan status</th>
<th>Non-Orphans</th>
<th>Paternal</th>
<th>Maternal</th>
<th>Double</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent</td>
<td>74</td>
<td>65</td>
<td>16</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Father’s new/co-wife</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt/uncle</td>
<td>7</td>
<td>8</td>
<td>22</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Grandparents</td>
<td>15</td>
<td>19</td>
<td>36</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Other relation</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Not related</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figures based on data available
Manicaland Child Cohort Study

Orphan caregivers less close to children?

Children under the care of less closely related caregivers are more likely to exhibit psychosocial well-being imbalance than those in the care of close relatives.

<table>
<thead>
<tr>
<th>Caregiver</th>
<th>Caregivers' responses</th>
<th>Children's responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Test for difference</td>
</tr>
<tr>
<td></td>
<td>Mean</td>
<td>P-value</td>
</tr>
<tr>
<td>Parent</td>
<td>326</td>
<td>0.110</td>
</tr>
<tr>
<td>Grandparent</td>
<td>234</td>
<td>-0.293</td>
</tr>
<tr>
<td>Other</td>
<td>251</td>
<td>-0.311</td>
</tr>
<tr>
<td>Unknown</td>
<td>52</td>
<td>-0.414</td>
</tr>
</tbody>
</table>

*Adjusted for age & sex

Girls are more likely than boys to exhibit psychosocial disorders (caregivers & children’s responses)

Orphans experience more problems than non-orphans according to the children’s responses but not according to caregiver responses

Psychosocial disorders were more common among children living in extreme poverty – but this was only one of the reasons why orphans had more disorders

Maternal orphans are amongst those with the most severe psychosocial disorders – but are missing out on services

Orphans are more likely to engage in risk behaviour partly because of their psychosocial disorders & being out of school
A Survey of Psychosocial Experiences of OVC in Zimbabwe: A Case of Chimanimani & Bulilimamangwe Districts of Zimbabwe

Presented by Brian Chandiwana

Authors: S. Munyati, B. Chandiwana, A. Chingono, S. Rusakaniko, P.F. Mupambireyi, S. Mahati, W. Mashange, S. Buzuzi, T. Moyana, & S. Gwini

Part of Series of OVC Research Studies Commissioned by the HSRC & WK Kellogg Foundation in Southern Africa to Inform in the Development & Implementation of OVC Intervention Programmes in the Region

Objectives

The general objective of the OVC baseline survey is to determine baseline data on experiences of OVC as well as their parents/guardians for evaluating the effectiveness of OVC interventions that were to be implemented in the two Districts.

Methods

• A quantitative cross-sectional study design using questionnaires targeting OVC and parents/guardians
• OVC Situational Analysis in the Districts
• OVC Qualitative Study
• Community Definition of OVC
• OVC households were targeted using OVC Census data from the two districts (Munyati et al, 2006).

Methods 2

• 3 questionnaires were used as follows: 1 for the 6-14 year OVC, 1 for the 15-18 years OVC and another for parents/guardians for OVC.
• Sample sizes were 2 400 respondents in the two districts
  – 1471 Parents/Guardians of OVC in the 0-18 age group
  – 761 OVC aged 6-14 years
  – 447 OVC aged 15-18 years

Vulnerability Indicators

1. Number of meals the household usually had a day.
2. Households which indicated that there were some days they would go without food.
3. Households with children of school going age who were not attending school.
4. Households that were not able to pay medical fees if children were sick/ill.
5. Households with children who did not have adequate clothing.

Vulnerability Indicators

6. Households with a household member who had been ill during the month preceding the census exercise.
7. Households with school going children who had no adequate school uniform.
8. Child headed households that had no caretaker.
9. Child headed households that had no one to discuss problems with.
Vulnerability Indicators

1. Number of meals the household usually had a day.
2. Households which indicated that there were some days they would go without food.
3. Households with children of school going age who were not attending school.
4. Households that were not able to pay medical fees if children were sick/ill.
5. Households with children who did not have adequate clothing.

Vulnerability Assessment by District

<table>
<thead>
<tr>
<th>Household Vulnerability status</th>
<th>Bulilimamangwe N = 29007 n(%)</th>
<th>Chimanimani N = 24495 n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Vulnerable</td>
<td>20,838(69.9)</td>
<td>20,209(82.5)</td>
</tr>
<tr>
<td>Moderately Vulnerable</td>
<td>8,262(27.7)</td>
<td>4,159(17.0)</td>
</tr>
<tr>
<td>Highly Vulnerable</td>
<td>707(2.4)</td>
<td>127(0.5)</td>
</tr>
</tbody>
</table>

Sample Population

- Using the TVIS, a total of 4,283 & 8,972 households in Chimanimani & Bulilimamangwe Districts were categorized as **Moderate-Highly Vulnerable**
- Wards were randomly selected in each district and required sample size from each ward was calculated proportionately

RESULTS

Socio-Demographic Characteristics

**Chimanimani:**
- 6-14 yrs: 329 children & 46% orphans
- 15-18 yrs: 185 children & 51% orphans

**Bulilimamangwe:**
- 6-14 yrs: 432 children & 43% orphans
- 15-18 yrs: 262 children & 53% orphans

- Equal distribution of males and females.
- 3% of the children were heading a household in Chimanimani while Bulilimamangwe had 1%

RESULTS

Displacement of Orphans

**Chimanimani:**
- 27% had moved into another household, 13% of those not moved reported that an adult relative had moved into their household. Slightly more boys (53%) than girls (47%) indicated that they had been moved

**Bulilimamangwe:**
- 28% had moved into another household, 18% of those not moved reported that an adult relative had moved into their household. No difference was noted in the rate of displacement by gender

RESULTS

Emotional Experiences

- On average, about 25% of OVC in all the age groups had feelings of unhappiness, worry, frustrations, anger, fear of new situations, scary dreams, trouble falling asleep or preferred being alone.
- Almost half (46.7%) of the orphans were still bothered by their parents’ death at the time of the survey.
- About 5% sometimes think of committing suicide
EMOTIONAL EXPERIENCES (contd)

• 98% of OVC were happy and were free to talk to their guardians when feeling sick or just down.
• 77% said they were encouraged by their guardians to live without fear.
• 83% were hopeful about their future lives.

RESULTS

EXPERIENCES OF STIGMA

• Among the 6-14 yrs orphans, 11% were treated badly by other children & 10% by their guardians. About 20% reported that community members did not talk to orphans.
• Among the 15-18 yrs orphans, on how guardians treated them, 47% were treated caringly, 9% were treated roughly & 24% were treated differently by their guardians compared to guardian’s own children.

Conclusions

• A number of orphans had been displaced from their households, indicating a certain measure of disintegration of families and/or separation of siblings.
• A high proportion of orphans indicated that children in their current household and community were willing to interact and play with them, signifying that stigma seems not to be a major problem in the community.
• A sizeable number of the OVC were having psychosocial problems since they reported having scary nightmares or had trouble falling asleep. But is situation different from the ordinary child??
Research, Monitoring & Evaluation for the Development of Zimbabwe OVC Interventions Programmes

Project Commissioned by Human Sciences Research Council & Funded by WK Kellogg Foundation

HIV Prevalence among Young Orphans and Non-orphans in Chimanimani District

(An Extract from the Baseline Study: Household Survey of HIV prevalence and Behaviour in Chimanimani District)

Presented at the OVC Research Workshop: From Analysis to Action”

Harare Holiday Inn, 26-27 April 2006

By Shungu Munyati

Co-authors: Exnevia Gomo, Simba Rusakaniko, Brian Chandiwana, Junior Matovunganwa & Wilson Mashange

National Institute of Health Research and Biomedical Research and Training Institute

Overall Project Objectives

To develop, implement and evaluate some existing and/or new OVC intervention programs that address the following issues:

1. Home-based child-centered health, development, education and support
2. Family and household support
3. Strengthening community-support systems
4. Building HIV/AIDS awareness, advocacy and policy to benefit OVC

Project Implementation Phases

1. Qualitative Study/Situational Analysis
2. Detailed audit of OVCs & OVC services (includes OVC census)
3. Baseline Surveys- PSS and BSS-
4. Development of new OVC interventions & refine existing OVC programmes
5. Implementation of new & refined OVC programmes
6. Post intervention surveys/summative evaluations

Project Area and Implementers

• Research Sites are the 2 Kellogg IRDP districts of – Bulilimamangwe, Mat South and Chimanimani in Manicaland

• Grant-maker: FACT (MUTARE)

Focusing on HIV Infection in the 2-11 year olds-

- There is a paucity of information on HIV infection rates in children, especially those 2-11 years old.
- Most data available in Zimbabwe and other countries is on children within the first two years of life.
- It has always been assumed that most infected children die before their second birthday and there are few studies following up children beyond two years.
- HIV infections in older children, some of school going age have been reported elsewhere
Focusing on HIV Infection in the 2-11 year olds-2

- Equally important then is to also understand the environment in which the children live, especially orphans. The latter are particularly vulnerable to infection and the impact of HIV and AIDS.
- The environment denotes the protection practices of the parents or guardians as well as the economic status of the households. In this context the parents/guardians' level of awareness and knowledge about HIV/AIDS becomes important in appreciating both vertical and possible horizontal transmission of HIV to children.

The HIV Prevalence of 2-11 year olds as part of the Behavioral Risk and HIV Sero-status Surveillance Survey (BSS)

- The BSS has proven to be a powerful tool in gathering evidence in understanding the underlying dynamics of the HIV a second-generation behavioural surveillance model that involves combining both biological (HIV testing) and behavioral surveillance surveys in the same study.
- The BSS is useful in monitoring trends in HIV risk behaviour, informing effective programme design/direction and evaluation and explaining HIV.
- Explaining transmission dynamics and variations in prevalence.

Specific objectives of the BSS

1. To quantify the magnitude of HIV and AIDS problem in the district especially among the children.
2. To determine the HIV and AIDS knowledge, attitudes, behaviour and practices (KABP) of the general population.
3. To determine prevention and care programmes and human rights issues concerning HIV and AIDS among the general public.
4. To provide evidence based information to policy makers on HIV and AIDS preventive mitigatory needs.

STUDY DESIGN fro the BSS

1. Cross sectional survey, 13 wards randomly selected from a total of 23 wards of Chimanimani district.
2. In each of the 13 wards individuals in four age strata of 2-11, 12-14, 15-24 and 25+ years randomly selected based on proportional sampling using the total populations of each age group in each ward.
3. Two written consent forms - (assent for those below 18 years), from each respondent for both the interview and the specimen.
4. For the 2–11 years age group, the parent/guardian signed the consent form on behalf of their children. Where guardian consented to the interview but the child refused, the interviewer did not proceed with the interview.
5. Age specific questionnaires on demographic, socio-economic and child care practices and HIV related behavioural aspects were administered.

HIV Testing Methods

- Dried Blood Spots (DBS) - were collected on Whatman No.3 filter paper from participants in all age groups.
- Vironostika Uniform II commercial ELISA kits were used (Biomuriex, Netherlands).

RESULTS-Study Sample

1. Of the 934 respondents approached 732 (78.4%) completed the questionnaire and provided blood samples. The refusal rate was 2.4%.
2. 43 (5.9%) had insufficient samples for HIV testing.
3. Results based on the 689 respondents (complete questionnaires and sufficient samples).
RESULTS-2

Demographic characteristics of the child as reported by their guardians

<table>
<thead>
<tr>
<th>DEMOGRAPHIC VARIABLE</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>340</td>
<td>49.3</td>
</tr>
<tr>
<td>Female</td>
<td>349</td>
<td>50.7</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>331</td>
<td>48.0</td>
</tr>
<tr>
<td>6-8</td>
<td>187</td>
<td>27.2</td>
</tr>
<tr>
<td>9-11</td>
<td>171</td>
<td>24.8</td>
</tr>
<tr>
<td>Orphanhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevalence of orphanhood</td>
<td>108</td>
<td>15.7</td>
</tr>
<tr>
<td>Maternal</td>
<td>19</td>
<td>17.6</td>
</tr>
<tr>
<td>Paternal</td>
<td>69</td>
<td>63.9</td>
</tr>
<tr>
<td>Double</td>
<td>20</td>
<td>18.5</td>
</tr>
<tr>
<td>Age when child lost mother (N=39)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5 years</td>
<td>28</td>
<td>71.8</td>
</tr>
<tr>
<td>6-11 years</td>
<td>9</td>
<td>23.1</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2</td>
<td>5.1</td>
</tr>
<tr>
<td>Age when child lost father (N=89)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤ 5 years</td>
<td>73</td>
<td>82.0</td>
</tr>
<tr>
<td>6-11 years</td>
<td>15</td>
<td>16.9</td>
</tr>
<tr>
<td>Unspecified</td>
<td>1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

RESULTS-3

Overall HIV prevalence by sex, age and locality of child

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>N</th>
<th>HIV POSITIVE</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>340</td>
<td>2.4</td>
<td>1.0</td>
<td>4.6</td>
</tr>
<tr>
<td>Female</td>
<td>349</td>
<td>4.3</td>
<td>2.4</td>
<td>7.0</td>
</tr>
<tr>
<td>p = 0.155*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age GROUP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-5</td>
<td>330</td>
<td>2.7</td>
<td>1.3</td>
<td>5.1</td>
</tr>
<tr>
<td>6-8</td>
<td>189</td>
<td>5.8</td>
<td>2.9</td>
<td>10.2</td>
</tr>
<tr>
<td>9-11</td>
<td>170</td>
<td>1.3</td>
<td>0.4</td>
<td>5.1</td>
</tr>
<tr>
<td>p = 0.093</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESULTS-4

HIV prevalence by orphanhood status

<table>
<thead>
<tr>
<th>ORPHANHOOD STATUS</th>
<th>N</th>
<th>HIV POSITIVE</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal</td>
<td>18</td>
<td>10.5</td>
<td>1.3</td>
<td>33.1</td>
</tr>
<tr>
<td>Paternal</td>
<td>69</td>
<td>4.3</td>
<td>0.9</td>
<td>12.2</td>
</tr>
<tr>
<td>Double</td>
<td>20</td>
<td>5.0</td>
<td>0.1</td>
<td>24.9</td>
</tr>
<tr>
<td>Both parents alive</td>
<td>559</td>
<td>2.9</td>
<td>1.6</td>
<td>4.6</td>
</tr>
<tr>
<td>Not known</td>
<td>23</td>
<td>4.5</td>
<td>0.1</td>
<td>22.8</td>
</tr>
<tr>
<td>p-value = 0.234</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESULTS-5

HIV prevalence of children by hospitalisation records in the past 12 months

<table>
<thead>
<tr>
<th>HOSPITALISATION</th>
<th>N</th>
<th>HIV positive</th>
<th>%</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalised</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Hospitalised</td>
<td>53</td>
<td>2.8</td>
<td>1.0</td>
<td>8.3</td>
</tr>
<tr>
<td>p-value = 0.093</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Summary

- This is the first study in Zimbabwe to provide HIV prevalence data for this age group using a large sample.
- Overall prevalence of 3.3% among children 2-11 years old is less than reported for the age group 2-9 year (6.2%) in South Africa (Nelson Mandela/HSRC study of HIV/AIDS, 2002).
- Low prevalence may be due to prevention of mother to child interventions (PMTCT) since most of HIV infections in children are as a result of mother to child or
- That most of the infected children die early in infancy??.
In Summary

- The most affected are the 6-8 year olds where prevalence was more than twice as high as the age groups 2-5 and 9-11 years.
- Although sub-sample sizes were too small for meaningful statistical comparisons data suggests that a significant proportion of HIV infected children are living beyond five years of age but not much further than 8 years.

- Observed difference in prevalence between orphans and non-orphans
- Could be because the majority of orphans are children orphaned due to HIV/AIDS or
- That apart from other socio-economic impacts, these children re themselves highly vulnerable to HIV infection arising from the potential for early onset of sexual activity, commercial sex and sexual abuse.

2. Morbidity (hospitalisation) was closely associated with HIV infection suggesting that HIV contributes significantly to the morbidity profile in this community.

Recommendation

- While the government is moving as quickly as possible in making ARVs available to the vulnerable adults, this should also be supported by strong advocacy for immediate introduction of ART for children as well.
- Prevention of MTCT should be strengthened through various strategies including meaningful involvement of men and ensuring that ARVs for prevention are available and used.

Acknowledgement

- The team appreciates the support they received from the Chimanimani OVC local liaison team: Mr J. Jaibesi, Mr. B. Muchinapo, Mr. P. Sibanda, Sr. Sifovo, the late Sr. M. Ndhlovu, Ms. Ndima and Mr. Sigauke during the whole exercise.
- HSRC and WK Kellogg for the Funding
CHILDREN LIVING WITH HIV/AIDS IN ZIMBABWE

Preliminary Results of a National Situation Analysis

G Foster1, A Miller2, K Felsman3, F Bwakura1, P Mbetu2, B McColgan2, A Mahomva4, C Chakanyuka4

2 Elizabeth Glaser Pediatric AIDS Foundation, Zimbabwe
3 Catholic Relief Services – Strive, Zimbabwe

Nearly 90% of CLHA* live in Africa

*CLHA: Children living with HIV/AIDS

<table>
<thead>
<tr>
<th>Region</th>
<th>PLHA (millions)</th>
<th>CLHA (millions)</th>
<th>CLHA as % of total PLHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zimbabwe</td>
<td>1.8</td>
<td>165,000</td>
<td>9.2%</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>25</td>
<td>1.9</td>
<td>7.6%</td>
</tr>
<tr>
<td>Globally</td>
<td>38</td>
<td>2.1</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

3% of Zimbabwean children are HIV-infected

STUDY AIMS

1. Understand barriers that need to be overcome to ensure that CLHA receive better care, support and treatment

2. Define sub-groups of infected children and articulate their particular needs by the contexts in which they live

3. Explore issues for the policy phase of the initiative.
Diagnosis of HIV Infection in Children

Nr CLHA seen by service providers

Nr respondents

0 1 - 10 11 - 40 > 40

Nr of CLHA Seen

By non-medical
By medical
Takings ART

Knowledge of children of HIV diagnosis

Nr children that know their HIV diagnosis

By non-medical
Medical

Why children are not diagnosed with HIV

Why children are not diagnosed with HIV

Lack of access to testing facilities for children
Limited resources leads to CLHA not getting basic treatment
Lack of access to competent HWS able to diagnose CLHA

Lack of access to testing facilities for children
Limited resources leads to CLHA not getting basic treatment
Lack of access to competent HWS able to diagnose CLHA
Psychosocial support lack leads to HWS not divulging diagnosis
Reluctance to test as this implies parent HIV+
Difficulty of HIV in diagnosing HIV in children
Why children are not diagnosed with HIV

- Lack of access to testing facilities for children
- Limited resources leads to CLHA not getting basic treatment
- Lack of access to competent HWs able to diagnose CLHA
- Psychosocial support lack leads to HW not divulging diagnosis
- Reluctance to test as this implies parent HIV+
- Difficulty of HW in diagnosing HIV in children
- HIV belief that no point in diagnosing CLHA if no ART
- Reluctance to test - “family cannot cope with knowledge”
- HIV belief families do not want to know diagnosis
- HW uncertainty of testing technology

Services for Children Living with HIV/AIDS

90% Consideration of anti-retroviral treatment and affordability
84% Offer of HIV testing
96% Cotrimoxazole prophylaxis
96% Discussion of possible HIV/AIDS diagnosis with guardian
100% Advice to attend early if CLHA develops illnesses
100% Monitoring of nutrition and nutrition counselling

Services provided by medical care providers

Services non-medical services provided

Nutritional support or counselling
Support to families
Community mobilization of support for CLHA
Spiritual support to CLHA
Palliative care
Psychological support to CLHA

Availability of services for CLHA (1)
Nutritional Support

- 6 organisations distributed food to CLHA
- 2 organisations referred CLHA to other organisations supplying food
- 23/33 responses critical of lack of nutritional support services:
  - Lack of availability of supplementary food
  - Political interference in food supplementation

Palliative Care

- Few organisations provided this
- Few descriptions of the service
- Some hospitals admitted children during terminal illness
- PLHA Support Group visited CLHA at home
- Some referred CLHA to Island Hospice
- 11/27 responses critical of lack of palliative care services
Children’s views on medical services

Positive
• Being cared for by doctors, since nurses are more likely to be harsh
• Some of the treatment is very good
• Clinics are “available” – a review date is given but you can come earlier if you need to
• The food is good and you can watch television (as inpatients

Negative
• Some doctors refuse to treat you if you are not their patient
• The blankets and sheets are dirty for CLHA needing admission.
• CLHA are not asked if they have questions and feel unable to ask about issues not raised by the doctor.
• Lack of basic drug supplies.
• Bad taste of medicines leads to lack of adherence; many children only swallow cotrimazole if they feel ill

Referral systems

<table>
<thead>
<tr>
<th>Category</th>
<th>Problems facing CLHA in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orphaned</td>
<td>Lack of financial resources, especially child-headed households. Discrimination leading to lack of financial support for hospital admissions and transportation to clinics. Changes in caregivers.</td>
</tr>
<tr>
<td>Street</td>
<td>Prone to sexual exploitation. Lack of family support and difficulties in adherence</td>
</tr>
<tr>
<td>Disabled</td>
<td>Prone to sexual abuse. Difficulty accessing health care in view of high dependency on adult caregivers</td>
</tr>
<tr>
<td>Sexually abused</td>
<td>Lack of knowledge of caregivers of services for these children. Hidden nature of problem. Stigma. Late presentation leading to ineffectiveness of post-exposure prophylaxis</td>
</tr>
<tr>
<td>Institutionalized</td>
<td>Less problematic than other categories. Sometimes, advantageous since better access to nutrition, resources etc</td>
</tr>
<tr>
<td>Other groups</td>
<td>Children with mentally ill parents, parents in prison or from destitute families. Infants that are ignored and more likely to die</td>
</tr>
</tbody>
</table>
Advocacy and networking of organisations with activities for CLHA

Policies and Strategies for CLHA in Zimbabwe

Training in the care of CLHA
Conclusions

opportunity for health sector to engage in OVC support through provision of comprehensive care of all children living in communities affected by HIV and AIDS

Conclusions

- Decentralisation of care:
- Lack of testing facilities for children
- Lack of ART for children
- Lack of knowledge of paediatrics by non-paediatricians
- Lack of knowledge of non-medical services by health sector
- Lack of communication between health—to-non-health sector
- Lack of referral systems and COC
- Lack of training, esp for non-medical
- Lack of nutrition services
The effect of orphanhood on the health & nutritional status of children in Zimbabwe (data from OVC Baseline Survey 2004 & Manicaland)
Helen Watts & Simon Gregson

Outline of presentation

- Literature review & theoretical framework
- Zimbabwe OVC baseline survey data analysis
- Manicaland data analysis

Hunger keeps children out of school. Most of them have to help their parents collect roots and wild fruit such as metu. From the metu, they produce a kind of paste, which they produce a kind of paste, which they boil in water before they eat it. The metu paste tends to cause diarrhoea and stomach problems.

Photo credits: UNICEF/François d'Elbee/2002

Main hypothesis -
Orphans are potentially at increased risk of poor health & nutrition that extend beyond the effects of parent-to-child transmission of HIV infection

Main objective -
To investigate the effect of orphanhood on the health & nutritional status of children living in Manicaland & wider Zimbabwe (Zimbabwe OVC Baseline Survey 2004/5 data)

The HIV/AIDS pandemic has taken its toll in the rural areas, leaving thousands of children orphaned by AIDS. Many of these children, like this little girl, are cared for by elderly grandparents.

Photo credits: UNICEF/François d'Elbee/2002

Orphanhood as a determinant of malnutrition & ill health in children

Nutrition
- Malnutrition is a main cause of early childhood morbidity & mortality in developing countries & is also associated with poor cognitive development
- Orphans suffer from cycles of poverty as a result of the illness & death of their parents. The effects of poverty & hunger are intertwined
- Orphans are therefore especially vulnerable & are at increased risk of malnutrition

Photo Credit: Dédé Kibambi / UNICEF RDC 2003

Child morbidity & mortality

Direct effects:
- HIV infection has increased adult mortality & has also resulted in substantial child mortality & an increase in the number of sick children presenting to health services, due to vertical transmission of HIV

Indirect effects:
- Higher morbidity as sick parents are less able to care for their children
- Poor utilisation of health care services
- Poor diet & lack of care
Literature review

- The impact of orphanhood on the health & nutritional status of children is variable - studies have found contrasting results.
- More detailed research is needed to determine specific effects by age, form of orphanhood & the stage of the epidemic.

Forms of childhood malnutrition

- Growth assessment is a good measure to define the health & nutritional status of children.
- According to anthropometric classification there are 3 forms of malnutrition:
  - Stunting - low height-for-age
  - Wasting - low weight-for-height
  - Underweight - low weight-for-age
- Body Mass Index = weight(kg) / height^2(m) (measures body fatness).

Theoretical framework & hypothesis

- HIV in infant
- Poor diet
- Poor utilisation of health care services
- Orphanhood
- Sick Parent (HIV or Other Illness)
- Individual/ household socio-economic factors
- Differential treatment
- Shorter duration or no breastfeeding
- Community factors & scale of the epidemic
- Child’s immunity
- Malnourishment
- Poor health
- Poorer health & nutritional outcomes in orphans & vulnerable young children not explained by greater exposure to extreme poverty in Zimbabwe - submitted to PIDJ.
In 2004, the Government of Zimbabwe & UNICEF conducted a cross-sectional survey to improve understanding of the situation of OVC in the country. The survey was carried out in 21 districts & covered 12,356 households. 31,672 children aged 0-17 years, of whom, 5,150 were aged 6-59 months were selected from the survey, based on the criteria that complete malnutrition & sickness data were available for each individual.

**Aim**
- **To describe patterns of association between different forms of OVC experience & nutritional & health outcomes in Zimbabwe.**
- **To analyse the determinants of child malnutrition & ill-health & to identify the different mechanisms which contribute to these outcomes in OVC.**

**Methods**
- **Health status indicators:**
  - Acute ARI
  - Diarrhoeal illness
- **Nutritional status indicators:**
  - Stunting, wasting & underweight
- **AORs for experiences of malnutrition & ill-health in OVC compared to non-OVC were calculated using logistic regression.**
- **Causal pathways leading from OVC experience to malnutrition & ill-health (reverse stepwise multiple regression analysis) were investigated.**

**Results - prevalence of ill-health**
- OVC were significantly more likely than non-OVC to suffer from a diarrhoeal disease (sex- & age-adjusted AOR 1.27, p<0.001) or from an ARI (AOR 1.27, p=0.04)
- 19% of OVC compared to 17% of non-OVC were reported to have recently suffered from a diarrhoeal disease. 7% of OVC compared to 6% of non-OVC were reported to have recently suffered from an ARI.
Results – prevalence of malnutrition

Double orphans were more likely than non-OVC to be underweight (AOR 1.84, p=0.01). Maternal orphans had heightened risks of stunting (AOR 1.70, p=0.01) & of being underweight (AOR 1.83, p<0.001). Paternal orphans were at heightened risk of being stunted (AOR 1.23, p=0.04).

Results - determinants of ill-health & malnutrition

- After adjustment for exposure to extreme poverty, OVC remained at greater risk of diarrhoeal disease (AOR 1.25; 1.07-1.46) & chronic malnutrition (1.21; 1.07-1.38).
- Our main finding from this cross-sectional survey is that greater malnutrition & ill-health seen in OVC were not explained by differences in exposure to extreme poverty.
- Further investigation, in the form of longitudinal studies, is needed to understand the complete dynamics of how orphanhood & child vulnerability leads to such adverse outcomes.

Ill-health (1st follow-up)

- Paternal orphans reported more ‘recurring sickness’ in the last few months (from the time of the interview) compared to non-orphans (AOR 1.58 p=0.03).
- Under 7 year-olds also reported more diarrhoea & ARI in the last 2 weeks compared to non-orphans, but this difference is not significant. There was no trend between maternal & double orphans & recent illness, however, the numbers are very small.

Treatment seeking

- In the 1st follow-up, there was no difference in appropriate (hospital, clinic, VCW) treatment seeking behaviour for illness between orphans & non-orphans.
- However, in the 2nd follow-up, maternal orphans were more likely not to receive appropriate treatment for illness compared to non-orphans (AOR 1.50 p=0.05).

Malnutrition by age

- First follow-up
- Second follow-up
Conclusions

- The preliminary findings from the Manicaland data show few significant differences between the health & nutritional indicators for orphans compared to non-orphans, due to small numbers.

- However, the data collected in the Manicaland analysis is more detailed than the OVC Baseline Survey. Therefore, more analyses will be conducted to look further into the causal pathways leading from orphanhood to possible detrimental health & nutritional outcomes.
Orphanhood as a Risk Factor for HIV Infection in Zimbabwe
Simon Gregson & Isolde Birdthistle

Rationale

- HIV prevalence is declining in Zimbabwe
- Increasing evidence that orphanhood can be a risk factor for HIV infection in adolescence (Foster & Williamson 2000)
- Orphanhood levels still rising – so inter alia poses a threat to continued decline in HIV prevalence
- To address problem, need to understand:
  Forms of orphan experience that give rise to HIV risk
  Causal pathways

Aims of presentation

- Bring together evidence for association between orphanhood & HIV risk in Zimbabwe
- Differentiate risk by form of orphan experience
- Case study of rural Manicaland

Recent trends in HIV prevalence, Zimbabwe 2000-2004

Peak in orphanhood may be reached several years after the peak in female adult HIV prevalence


OVC Research Workshop Report – “From Analysis to Action in Zimbabwe”
Handouts of plenary presentations
Projected trends in orphan prevalence (0-14s), Zimbabwe

Orphan prevalence by location, Manicaland, 1998-2000

Orphan prevalence (0-14s) by location, Manicaland, 1998-2000

Evidence for association between orphanhood & HIV risk

HIV prevalence in teenage females by orphan status & location

Data sources

- Rural (general population, 15-18) – Manicaland Study
- Rural (students, 15-19) – Regai Dzive Shiri (Cowan, Pascoe et al.)
- Peri-urban (convenience, 16-19) – UZ-UCSF SHAZ! (Dunbar, Kang et al.)
- Urban (general population, 15-19) – Highfield (Birdthistle et al.)
- National (general population, 15-19) – YAS (ZNFPC, CDC et al.)
**Age-adjusted ORs for HIV infection in teenage females by orphan status relative to non-orphans**

**HIV prevalence in teenage males by orphan status & location**

**Study sites**

**Methods**

- 1,017 (84.6%) of eligible women, 15-18 yrs, interviewed & provided dried blood spot samples for HIV testing
- Data collected on HIV infection, STI symptoms, pregnancy & common behavioural & socio-demographic risk factors
- OVC defined to include orphans, children with an HIV+ or seriously ill parent, or in a household with a recent death
  N.B. HIV & health status of at least one parent known for 56.3% (353/627) of non-orphaned women
  Remaining 274 excluded from primary analyses
- Multivariate logistic regression models used to test for statistical associations between OVC status, adverse reproductive health outcomes & suspected risk factors
HIV prevalence by study location, 2001-2003 vs. 1998-2000

Overall reduction in HIV prevalence
HIV prevalence by study location, 2001-2003 vs. 1998-2000

Evidence of condom use with casual partners, reduced sexual partner change & recent rise in age at first sex

Recent trends in adult mortality, 1998-2003

HIV infection in teenage women by OVC status

STI & teenage pregnancy by OVC status

Risk factors for female adolescent HIV infection

Having an HIV+ parent was associated with increased risk of both STI symptoms & teenage pregnancy (P < 0.05)

Death of mother was associated with greater risk of teenage pregnancy (P = 0.035)
Possible reasons for differences by form of orphanhood

- When father is alive, extended family expect him to meet children’s needs
- Surviving fathers (& their current wives) less committed than surviving mothers to providing for their previous children
- Children whose fathers are still alive typically live in less poor households - so are disproportionately excluded from welfare programmes due to means testing procedures

Summary

- HIV prevalence is falling among young women (& men) in eastern Zimbabwe
- Orphanhood is a risk factor for HIV infection in adolescent women
- Maternal orphans appear to be most vulnerable
- Risk derives largely from early onset of sexual relations
- Early school drop-out is associated with younger age at first sex & increased risk of HIV acquisition ...
- But amongst girls still in school, orphans can also be more vulnerable to HIV
- Further work needed to develop & test explanatory frameworks …
Reported Risk Behaviour and HIV Prevalence in Youth and Orphans & Non-orphans in Chimanimani District

Gomo E³, Rusakaniko S¹, Mashange W³, Mutsvangwa J², Chandiwana B² and Munyati S¹

¹National Institute of Health Research
²Biomedical Research and Training Institute
³Department of Immunology, College of Health Sciences
⁴Department of Community Medicine, College of Health Sciences

OBJECTIVE

• To describe the risk behaviour and HIV prevalence of the youth.
• To compare the risk behaviour and HIV prevalence of 12 to 18 year old orphans and non-orphans.

METHODOLOGY

• Cross sectional study in randomly selected households in 13 wards.
• Questionnaires were administered to gather demographic and HIV related behavioural aspects.
• DBS specimens were collected onto Whatman No. 3 filter paper from all participants.
• DBS were tested using Vironostika Uniform II HIV testing kits (ELISA).

METHODOLOGY (cont’d)

• Enrolment of the participants was on voluntary basis and consent was sought from the parents/guardians of the children and/or the children/youth themselves.
• Data were analysed using STATA Intercooled version 7.0

RESULTS: Part I: 15-24 years

Demographic Characteristics

• Sample size 756
• Age range 15 – 24 years
• Mean age of 19.5 (sd=3.5) years
• 66% single never married, 29% married
• Magnitude of Orphanhood was 37%

Orphanhood status in the 15-18 age group

- 24%
- 9%
- 62%
- 15.4%
HIV Prevalence

- Overall 9.3% (95% CI: 7.2 – 11.6), twice higher in females than males (12.3% vs 5.6%).
- Twice higher in 19-24 (12.1%; 95% CI: 9.1-15.7) compared to 15-18 (5.6%; 95% CI: 3.1-8.5).
- No significant differences by gender in the 15 – 18 age group but in the 19 – 24 group; females (16.1%, 95%CI: 11.8 – 21.3) and males (5.6%, 95%CI: 2.4 – 10.7).
- More than twice higher among married than the single.

Sexual Behaviour

- 51% ever had sex
- Mean age of sexual debut was 18 years for both sexes.
- 31% reported ever having used condom.
  - F – highest in commercial sectors (p=0.006)
  - M – highest in resettlement and LSC (p=0.004)
  - No apparent association of condom use with HIV infection (p=0.781)
  - 13.1% selectively used condoms with some sexual condoms and not with others.
  - 53.3% reported condom use during last encounter, the main reason being prevention of pregnancy (69.5%) & 44.9% wanted to prevent STIs.

Part II

Analysis by Orphanhood Status (12 – 18)

- A total of 902 children age 12-18 were enrolled with 51.4% of them being males.
- Mean age was 14.1 (SD = 1.9).
- 53.8% of the children were from the communal areas.
- Nearly a third (30.9%) of these were orphans and there were more paternal orphans than maternal and double orphans.

HIV Prevalence vs Behaviour

- Overall, HIV prevalence was 3.8% and was one and half times high in non-orphans (4.2%, 95% CI: 1.2 – 5.6) compared to orphans (2.8%, 95% CI: 2.7 – 6.1) though the differences were not statistically significant.
- HIV prevalence was high among those who did not use a condom.
- HIV prevalence was 8.4% among those who had sex whilst it was 3.3% among those who had reported never having had sex and there was a significant difference (p = 0.019).
The majority (88%) of the 15 – 18 years old had one sexual partner and the mean number of sexual partners for those with more than one was 1.2 (SD = 0.5).

Out of the fifteen 12 – 14 adolescents who had sex, only one had sex for the reasons of getting money and both parents of the child were alive.

Alcohol consumption was low (2.2%) among the children and out of these one was HIV positive (non-orphan).

CONCLUSION

Figures, including gender differences support national statistics and the evidence of the role of intergenerational sex in transmission of HIV among young girls and women is apparent.

Early sexual debut is apparent in both girls and boys and the non-use or inconsistent use of the condoms is prevalent with a large gap in the role of condoms for prevention of HIV.

Although it is feared that orphans may be at risk of engaging in transactional sex or just having sex due to the absence of parental guidance or poverty, the study results showed that orphanhood status did not influence condom use, HIV prevalence and the age of sexual debut.

RECOMMENDATIONS

Gender mainstreaming should therefore be considered when designing intervention programmes.

Educational campaigns targeting boys and girls specifically consistent use of condoms.
From affected to infected

Tracing causal pathways of sexual risk among adolescent orphans
I Birdthistle, S Floyd, A Machingura, N Mudziwapasi, J Glynn, S Gregson

Highfield Young Women’s Health Study - 2004

High & Medium Density Suburbs
Low Density Suburbs
Central business district

Highfield Young Women’s Health Study

• Phase 1: Focus group discussions (11)
• Phase 2: Community based, sero-epidemiological survey (n=863)
• Phase 3: In-depth interviews (8)

Recruitment for survey - by Community Volunteers

Visited all households in 80 randomly selected enumeration areas to find 15-19 yr old girls

A central interviewing site: Kuwangira Primary School
Registration, orientation & consent

One-on-one interview (n=863)

68% of those invited

Visit with the nurse (n=861)

Provided biospecimen (n=839)

Thank you pack and referrals

Adolescents Orphaned or Affected by AIDS
Death of mother, father, both parents or primary caregiver
+ Caring for terminally ill parent or guardian

Experiencing a parents’ illness or death

Loss of father, mother or both parents (n=863)

- Double 15%
- Maternal 9%
- Paternal 26%
- Non-orphans 48%

Was parent chronically ill before she died?

-Father died: 101
- Mother died: 106

Don’t Know
No
Yes
Don’t Know
No
Yes

Sexual outcomes
HIV ● HSV-2 ● Unwanted pregnancy

Adolescents living with HIV
Overall... HIV positive: 7.6% (63 / 826)
HSV-2 positive: 11.6% (87 / 750)

By age...

HIV and HSV-2 prevalence
Overall... Stratified by marital status...

Page 74 of 78
Sexual risks by orphan status

- Links with orphan status depend on marital status
- Stronger associations with sexual risk among non-married orphans…

- Married girls were at high risk of HIV and HSV-2 regardless of orphan status

Sexual risks by orphan status

- Associations by type of orphanhood, with any sexual risk

<table>
<thead>
<tr>
<th></th>
<th>HIV</th>
<th>HSV-2</th>
<th>Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father only died</td>
<td>aOR=1.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother only died</td>
<td>aOR=3.3*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both parents died</td>
<td>aOR=2.3*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sexual experiences in the teen years

- Had sex (aOR=1.7 mat+doub) → Sex debut <16 years (aOR=2.3 mat & pat)
- 2+ sexual partners (aOR=6.0 mat+doub) → Ever forced (aOR=1.7 mat)
- Maternal least likely to have a regular sex partner
- Used a condom at 1st sex (aOR=4.3 pat)

No differences: Age of 1st partner; First sex was forced; 1st partner had been drinking

Sexual outcomes

HIV + HSV-2 + Pregnancy

Adolescent Orphans (non-married)

- Death of mother or both parents
- Death of father before age 12

- Economic
  - AIDS-induced poverty
  - Hunger
  - Unemployment

- Educational
  - Early drop-out
  - Delayed level
  - Insufficient funds
  - HIV knowledge

- Environmental
  - Multiple carers
  - Instability
  - Household duties
  - Safety

- Emotional
  - Bereavement
  - Loneliness
  - Hopelessness
  - Stigma

Sexual experiences

- Had sex (aOR=1.7 mat+doub)
- Sex debut <16 years (aOR=2.3 mat & pat)
- 2+ sexual partners (aOR=6.0 mat+doub)
- Ever forced (aOR=1.7 mat)

Sexual outcomes

HIV + HSV-2 + Pregnancy
Adolescent Orphans (non-married)
Death of mother or both parents
Death of father before age 12

**Environmental**
- Raised in Highfield all of life (aOR=1.9)
- Raised in Highfield <1 year (aOR=2.6)
- Maternal head of HH (aOR=3.4)
- Male (aOR=2.0)
- Married (aOR=2.0)
- Parents divorced or separated (aOR=0.6)
- Parents divorced or separated (aOR=2.8)
- Spent most time on homework (aOR=1.8)
- Spent most time on homework (aOR=4.4)
- Spent more time on homework (aOR=1.8)
- Spent more time on homework (aOR=4.4)

**Educational**
- No school (aOR=0.8)
- No secondary schooling (aOR=2.5 and only)
- Completed Form 4 (aOR=1.8)
- Spent most time on school subjects (aOR=3.0)
- Spent most time on school subjects (aOR=6.8)

**Economic**
- Earns only 1-2 per day (aOR=1.3)
- Earns money (aOR=1.5)
- Works at a household (aOR=3.2)
- Completed Form 4 (aOR=2.1 double only)
- Received school fees (aOR=1.5 only)
- Received school fees (aOR=2.0 double only)

**Emotional**
- Feel they were treated differently growing up (aOR=0.09)
- Can’t find work (aOR=1.3)
- Feel they were treated differently growing up (aOR=0.09)
- Works as housemaid (aOR=1.4 double only)
- Received school fees (aOR=1.6 double only)
- Received school fees (aOR=2.0)

What explains the higher sexual risk?
- Clues to the pathways of risk

<table>
<thead>
<tr>
<th>Material &amp; Double</th>
<th>Paternal orphans</th>
<th>Material orphans</th>
<th>Double orphans</th>
<th>Odds Ratio</th>
<th>% change</th>
<th>Odds Ratio</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated (non-married, 18-21 yrs)</td>
<td>2.91 (2.5-3.3)</td>
<td>2.51 (2.0-3.2)</td>
<td>2.15 (1.3-3.5)</td>
<td>2.43 (2.0-2.9)</td>
<td>25%</td>
<td>2.26 (1.4-3.4)</td>
<td>25%</td>
</tr>
<tr>
<td>Female head</td>
<td>2.34 (1.4-3.9)</td>
<td>2.25 (1.3-3.8)</td>
<td>2.04 (1.2-3.5)</td>
<td>2.34 (1.4-3.5)</td>
<td>25%</td>
<td>2.13 (1.3-3.4)</td>
<td>25%</td>
</tr>
<tr>
<td>Regular church attendance</td>
<td>2.10 (1.2-3.9)</td>
<td>1.95 (0.9-4.1)</td>
<td>1.95 (0.9-4.1)</td>
<td>2.10 (1.2-3.9)</td>
<td>25%</td>
<td>2.10 (1.2-3.9)</td>
<td>25%</td>
</tr>
</tbody>
</table>

Findings so far - Summary
- HIV prevention programmes should incorporate the unique needs of paternal, maternal and double orphans, and appreciate the heightened STI risk of married adolescents.
- Education contributes to higher sexual risk, esp maternal & double orphans. Attaining at least Form 4 education offers a strong protective effect. School fees not reaching maternal orphans as well as they reach paternal and double.
- Having a female head of household partially explains higher sexual risk, esp for girls who lost their father at a young age. Economic implications at the household level which we didn’t capture? Support to female household heads.
- Less frequent attendance at church explains a small part of enhanced sexual risk among orphans, especially double. (Though very high attendance in general)
- Adolescent girls need counselling during bereavement, assistance with different guardians.
- Economic vulnerability

<table>
<thead>
<tr>
<th>Non-orphans</th>
<th>Paternal orphans</th>
<th>Material orphans</th>
<th>Double orphans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left school: female reasons</td>
<td>19%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>Completed Form 4 (mat only)</td>
<td>23%</td>
<td>41%</td>
<td>22%</td>
</tr>
<tr>
<td>Works as housemaid (aOR=1.5)</td>
<td>13%</td>
<td>19%</td>
<td>13%</td>
</tr>
<tr>
<td>Worked as a housemaid</td>
<td>5%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>Tied in exchange for money, food or gifts</td>
<td>7%</td>
<td>7%</td>
<td>9%</td>
</tr>
<tr>
<td>Female head (aOR=3.4)</td>
<td>23%</td>
<td>54%</td>
<td>24%</td>
</tr>
<tr>
<td>Completed Form 4 (aOR=2.1)</td>
<td>35%</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>Completed Form 4 (aOR=2.1)</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Completed Form 4 (mat only)</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Maternal head of HH</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Parents divorced or separated (aOR=0.6)</td>
<td>54%</td>
<td>36%</td>
<td>31%</td>
</tr>
<tr>
<td>Parents divorced or separated (aOR=2.8)</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Completed Form 4 (aOR=2.1)</td>
<td>35%</td>
<td>29%</td>
<td>35%</td>
</tr>
<tr>
<td>Completed Form 4 (aOR=2.1)</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Completed Form 4 (mat only)</td>
<td>30%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>Parental household characteristics</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Moving from Analysis to Action...

Shared findings with participants

"You spoke out... We listened... Here's what we learned..."

Girls called for...

- "Teach us how to abstain or delay sex"
- Skills and jobs so we won't depend on rich men and marry early
- A drop-in centre for teens, girls clubs
- Bereavement counselling, support groups
- Assistance caring for sick & domestic duties
- Support for married teens

Pilot test in Highfield

Drop-in Centre offering:
1. Peer HIV/AIDS education training course, modeled on My Future is My Choice, with 2 differences...
   - Adapted to special needs of teen orphans
   - Importance of spiritual, religious life in sexual health
2. Support groups – addressing personal experiences and problems
Also offered one-on-one sessions, but not taken up (not used to professional counselling)

3. Referrals:
   - CPS – for school fees & food aid
   - Family Support Trust – for sexual abuse
   - New Start - for VCT
   - Girl Child Network - for temporary shelter
   - Local clinics - for medical problems
   - Social Welfare office
“It is not a pleasant thing to live without a mother. It really hurts… Being moved around - today you are told to live with this one and the next day with someone else. All I wanted was the love of a mother.”