

# **Assessing the Sexual Risks and Reproductive Health Needs of Orphans and Vulnerable Youth in Zimbabwe**

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**February 2006**



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## Acronyms

ABC	Abstinence, Being faithful and Condom use
AIDS	Acquired Immuno-Deficiency Syndrome
CADEC	Catholic Development Commission
CBD	Community-Based Distribution
CRS	Catholic Relief Services
CSO	Central Statistical Office
CSPRO	Census and Survey Processing System
DOMCCP	Diocese of Mutare Community Care Program
EA	Enumeration Area
GOZ	Government of Zimbabwe
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
IR	Intermediate Result
NGO	Non Governmental Organization
OVY	Orphans and vulnerable youth
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RH	Reproductive Health
RUDO	Rural Unity for Development Organization
SPSS	Statistical Package for the Social Sciences
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
STRIVE	Support for Replicable, Innovative, Village/Community Level Efforts for Children Affected by AIDS in Zimbabwe
USAID	United States Agency for International Development
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
ZNFPC	Zimbabwe National Family Planning Council

## **Acknowledgements**

The 2004/05 Zimbabwe OVY assessment was funded by USAID.

Data collection and processing of the 2004/05 OVY Survey were carried out by Target Research, a private consulting firm based in Zimbabwe and active in other countries in Eastern and Southern Africa. Target Research was supported by Family Health International technical expertise and that of two data processing consultants – Rachel Makasi and Julius Majale.

This assessment would not have been successful without the collaboration of the local populations in the areas covered by the survey, the research teams who collected the survey data, the program staff from the four partner organizations (RUDO, Zvimba District Council, Batsiranai and DOMCCP) who assisted the survey teams to access communities for the interviews, and the Zimbabwe Central Statistical Office (CSO) which provided the household sampling frame and the districts/ward/enumeration area maps used during the fieldwork.

## Executive Summary

*Assessing the Sexual Risks and Reproductive Health Needs of Orphans and Vulnerable Youth (OVY) in Zimbabwe* is based on a representative survey of 1,894 male and female youth aged 13-21 years. These young people were identified from a random sample of 3,705 households from rural areas of four districts of Zimbabwe, namely: Zvimba, Gutu, Makoni and Buhera South. Household enumeration and interviewing of youth respondents were carried out in November and December, 2004. The data collection was conducted by Target Research.

The overall goal of the assessment was to determine the extent to which the reproductive and sexual health needs of adolescent OVY in Zimbabwe differ from those of adolescents in general so that these needs can be better addressed by service agencies. The specific objectives of the assessment were: a) to determine the sexual and reproductive health and service needs and experiences among OVY and non-OVY; and b) to identify risk factors that may increase the vulnerability of OVY to unprotected sex, commercial sex, sexual abuse, HIV/AIDS, STDs and unplanned/unwanted pregnancies, compared with non-OVY. The assessment questionnaires were designed to collect information on households' characteristics, their population by age and sex, background data for all women youth aged 13-21 years, as well as their knowledge, attitudes and behaviors with respect to reproductive and sexual health, including HIV/AIDS.

**Prevalence of orphans and vulnerable youth:** An orphan was defined as a household member below 25 years of age who lost either or both parents. Vulnerable youth were household members below age 25 years whose parents were alive but with at least one of them having been chronically sick over the past 12 months. In the four districts, 33 percent of males and females below the age of 25 years were orphans. The percentage of orphans varies little between males and females. It increases steadily from 13 percent in the 0-4 years age group to 28 percent among the 5-9 year olds, then stabilizes around 40-45 percent for the 10-24 years age group. About 10 percent of males and females were vulnerable, and this figure did not change much by age.

**Living arrangements and household wealth:** Only 36 percent of the youth aged 13-21 years lived with both parents, 38 percent lived with neither parents, 21 percent lived with only their mother, and three percent with only their father. About 66% of youth who did not live with both parents were orphans. OVYs were more likely to live in female headed households (48%) than non-OVYs (31%). OVYs were also more likely to live in households headed by a youth (8%) than non-OVYs (4%). A wealth index measured using household possessions revealed that households without OVYs were relatively better off than those with OVYs.

**School attendance:** There were no differences in school attendance rates, by age or grade level, between OVYs and non-OVYs.

**Sexual experience:** Married OVY girls were more likely to report having had premarital sex (19%) compared to married non-OVY girls (10%). OVY girls were less able to

negotiate for safe sex than non-OVY girls. Approximately 85% of OVY girls reported that they were confident they can refuse sex when necessary compared to 92% of non-OVY girls. There were no significant differences between OVY boys (89%) and non-OVY boys (92%). Over the 12 month period preceding the survey, high risk sex was more prevalent among OVY girls (60%) compared to non-OVY girls (36%). No significant differences were observed between OVY boys (94%) and non-OVY boys (100%).

**Marriage and childbearing:** 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%). OVY boys and girls were more likely to report unwanted births. 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.

**Rates of STIs:** Rates of self reported STIs were much higher among OVY boys and girls compared to their non-OVY counterparts. 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 boys and non-OVY girls.

**Conclusion:** Gender (being a girl) is the most important risk factor for adverse reproductive health (RH) outcomes among OVYs in Zimbabwe. Rates of marriage, high-risk sexual behaviors, unwanted childbearing, and STIs are higher among OVY girls compared to other youth. Reproductive health programmes in Zimbabwe should address the plight of OVY girls in the country through well designed targeted interventions.

# 1. Introduction

## 1.1. Background

By the year 2010, at least one fifth of children below the age of 15 years in sub-Saharan Africa will be orphans (Foster, 2002). In 2002, there were an estimated 782,000 orphans (below 15 years of age) in Zimbabwe. This number was projected to rise to 1.1 million in 2005, representing one-third of children in the same age group. It has been shown that HIV/AIDS, which causes about 90 percent of current and future parental deaths, is the major force driving this increasing number of orphaned children (UNAIDS, 2002).

Orphans and other children affected by AIDS suffer a catalogue of deprivations and vulnerabilities, including family dissolution, depression, malnutrition, lack of access to education and health care, homelessness, loss of property, loss of inheritance, stigma, discrimination, abuse, increased risk for HIV and sexually transmitted infections (STIs), unplanned and unwanted pregnancies. Consequently, they generally end up not realizing their full potential (Urassa et al., 2001; Maende, 2002; UNICEF, 2002; Levine, 2001).

There is generally a void when it comes to meeting the needs of adolescents orphaned by HIV/AIDS. Indeed, this sub-population may be particularly vulnerable to HIV infection as they begin to enter their reproductive years with stress of growing up as an orphan and vulnerable youth (OVY). Program interventions are needed to address the unique reproductive health needs of adolescents who are transitioning to adulthood while facing a myriad of of psycho-social and material deprivations (Maende, 2002; Nyambedha et al., 2003).

### *1.1.1. Government of Zimbabwe's and USAID's Responses*

The Government of Zimbabwe (GOZ) has responded to the orphan and vulnerable children (OVC) problem through two policies developed and enacted in 1999, the National Orphan Care Policy, the National HIV/AIDS Policy, and 2004 National Plan of Action for OVC. In these two policies the government outlines its strategy for addressing the orphan problem. The key areas covered include, support for education, access to health care services including counseling, prevention of child abuse and stigma. Although these policies exist, their implementation has been difficult due to the prevailing political and economic situation in the country.

USAID has provided a mechanism for responding to the orphan's problem through its strategic objective "HIV/AIDS Crisis Mitigated," and more specifically through the Intermediate Result "IR3, Increased care and support for OVC and others infected with HIV." USAID/Zimbabwe identified a need for OVC programs that provide access to information about growing up, sexuality, and how to negotiate sexual encounters. This is especially important given that OVC typically have lost the traditional guidance and preparation for adult life that youth learn from their parents, and are increasingly vulnerable to sexual abuse and promiscuity. In response to this programmatic need, Advance Africa with funding from USAID, worked with CRS/STRIVE - Catholic Relief

Services' Support to Replicable Innovative Village/Community Level Efforts – and their partners in four districts in Zimbabwe to provide OVY with reproductive health information and support through both community- and school-based programs. This study is intended to provide baseline data on the reproductive health needs of OVY in order to inform related program development in Zimbabwe.

### *1.1.2. The CRS/STRIVE Project*

Following a Situation Analysis on the impact of HIV/AIDS on children in Zimbabwe, the USAID Mission included support for community responses to children affected by HIV/AIDS in its programming. A grant was awarded to the Catholic Relief Secretariat and resulted in the STRIVE project. CRS/STRIVE works through a network of sub-grantees to implement programs aimed at achieving its goal in Zimbabwe which is to enhance capacity at regional and local levels to support community responses to assist children affected by HIV and AIDS in the country. Sub-grantees are local community and faith-based organizations that implement different OVC intervention packages.

The CRS/STRIVE project is presently being implemented in 16 districts by eight partners. Their work targets OVC below the age of 18 years. The districts are well distributed all over the country and were selected due to the relatively high HIV prevalence in comparison to other districts in the country. The project sites cover both urban and rural settings within the districts.

Currently the STRIVE project interventions revolve around psycho-social support, food security, education support with an emphasis on girls' access to education, economic strengthening of households, community safety nets for orphans and other children made vulnerable by the HIV/AIDS epidemic, and capacity building. The combination of these interventions varies from area to area. As of the end of June 2003, the CRS/STRIVE project had reached a total of 73,907 children through its various interventions. Of these, nearly one-half (32,825) had been reached through focused direct interventions while the rest were indirect beneficiaries. Although the CRS/STRIVE project is making an important contribution, its coverage is still below the estimated 782,000 orphans in the country.

Both CRS/STRIVE and Advance Africa have been funded by USAID to develop and implement programs for OVY including reproductive health services. In addition, Advance Africa implemented its programs through the same partners that CRS/STRIVE is using to implement many of the components of their programs. Because of the common funding, USAID would like these two programs to have a common baseline and strategy for monitoring and evaluation.

### *1.1.3. The Advance Africa Project*

At the time of the implementation of this study, Advance Africa's primary activity in Zimbabwe was to work with the Zimbabwe National Family Planning Council (ZNFPC) to strengthen the country's community-based distribution (CBD) program. More

specifically, Advance Africa was supporting the USAID/Zimbabwe strategic objective to mitigate the spread of HIV/AIDS through the integration of HIV services into the national CBD program. Advance Africa also worked with local NGOs to strengthen adolescent reproductive health services for youth and AIDS orphans by targeting all adolescents aged 10-24 years.

#### *1.1.4. Local Implementing Organizations*

Organizations implementing CRS/STRIVE's and Advance Africa's programs within the four districts<sup>1</sup> covered by the present study are Batsiranai, RUDO, and DOMCCP.

Batsiranai focuses on the care and support of OVC in Buhera South district. The program started in 1997 and currently operates in nine wards with an estimated coverage area of 54 square kilometres.

RUDO's program focus has shifted recently from drought relief to community development and sustainable interventions in the three Provinces of Masvingo (Gutu, Chivi, Masvingo, Bikita and Zaka), Midlands (Zvishavane) and Manicaland (Buhera). It has successfully spearheaded the enhancement of food, economic and health security of the communities through four key strategies involving craft enterprise development, skills development, food production and HIV/AIDS orphan care programs.

DOMCCP works with rural communities in Gowakowa (Makoni District) and covers 129 villages. DOMCCP programs provide material support with school fees and other necessities for orphans. It also implements three income-generating projects that include carpentry, dressmaking and a saving/lending scheme.

## 1.2. Study Justification

The impact of the HIV/AIDS epidemic on orphans and vulnerable adolescents has been difficult to quantify and has been even harder to put on the agenda of policy makers and political leaders. Many individuals and governments have difficulty grasping the reality of sexuality and its consequences among adolescents in general, and being an orphan or vulnerable adolescent complicates the matter further. This may explain why there have been several efforts to respond to the needs of OVY. However, the vast majority of these programs have focused on OVY aged 15 years or less. The few programs that address needs of OVY have focused mainly on education, food security, income generating activities and the provision of psycho-social support. However, once these OVY reach adolescence, they are seldom supported when it comes to sexual and reproductive health needs that accompany their physical and mental changes during this transition period.

CRS/STRIVE and their implementing partners have indicated that they need reliable baseline data that reflect the reproductive health situation of OVY and non-OVY in the

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<sup>1</sup> Zimbabwe is subdivided into 10 provinces and 58 districts. Each district comprises a number of wards, with each ward subdivided in a number of enumeration areas.

areas where they are active. This information will enable them to develop appropriate and targeted programs for OVY that can be justified and do not duplicate efforts already addressing issues common to both OVY and non-OVY.

Therefore, there is an urgent need to determine the reproductive health experiences and service needs of OVY in order to inform the development of programs to help them deal with these difficult periods of transition to adulthood in the absence of their mothers and fathers. This study provides information that is relevant to programs that seek to address the reproductive health needs of OVY in Zimbabwe.

### 1.3. Study goal and objectives

The goal of the research is to determine the extent to which the reproductive and sexual health needs of adolescent OVY in Zimbabwe differ from those of adolescents in general so that these needs can be better addressed by service agencies.

The specific objectives of the current study are:

1. To determine the sexual and reproductive health and service needs and experiences among OVY and non-OVY;
2. To identify risk factors that may increase the vulnerability of OVY to unprotected sex, commercial sex, sexual abuse, HIV/AIDS, STDs and unplanned/unwanted pregnancies, compared with non-OVY.

### 1.4. Methodology

#### *1.4.1. Study Design and sample size*

The present study consists of a population-based household survey conducted in rural areas of four districts of Zimbabwe, namely: Makoni and Buhera (Manicaland Province), Zvimba (Mashonaland Province), and Gutu (Zvimba Province). The survey covered areas with or without OVY programs.

The samples of households and youth (age 13-21 years) were selected using multi-stage stratified clustered sampling procedures. At the first stage, wards were stratified by district and type of OVY programs operating in the district using the preliminary 2002 Zimbabwe Census data. For each of the sample ward, a sampling frame consisting of enumeration areas (EAs) was compiled. The EA frame includes updated counts of households and population. The number of households from each of the sample enumeration areas were counted and listed. From the list of households for each sample EA, the average number of sample households to select was obtained using systematic sampling procedures. For each sample household, a complete census of its members was carried out. The census captured the age of household members, their sex, education, relation to the household head, whether the member slept in the household in the night preceding the enumeration day and whether the household member was an orphan or not.

All age-eligible orphans and one third of all age-eligible non-orphans were asked to participate in individual interviews.

The OVY survey sample sizes and response rates are presented in Table 1. When calculating the individual response rates, we excluded from the denominator youth who were registered as usual members of the household but were absent from it for an extended period of time, mainly for schooling purposes. Response rates for household and youth interviews were 96 percent.

Table 1. 2004 OVY Survey response rates.

Target Populations	ALL areas
<b>Households</b>	
Sampled	4,225
Occupied	3,849
Interviewed	3,705
Household response rates (%)	96.3
<b>OVY 13-21 years</b>	
Eligible	2,089
Present*	1,527
Interviewed	1,470
Eligible OVY response rate (%)	96.3
<b>Non-OVY 13-21 years+</b>	
Eligible	598
Present*	440
Interviewed	424
Eligible non-OVY response rate (%)	96.4

\* Present = number of youth registered as usual household member minus those who were absent from the household for an extended period of time (mainly because they are in boarding school or temporarily resident elsewhere).

+ Only one third of non-OVYs were eligible for interview.

#### 1.4.2. Fieldwork instruments

Three questionnaires were developed for the data collection phase. A household questionnaire was used to carry out a census of all members of each sampled household, and also to collect information on selected household assets and characteristics. The household questionnaire helped identify eligible OVY and non-OVY (age 13-21 years) for the individual interview. An individual questionnaire was administered to all eligible male and female youth – irrespective of their OVY status - who consented to and were available for the one-on-one interview. Such a questionnaire covered information on respondent's background characteristics, AIDS/STIs knowledge and health seeking behavior, RH/contraceptive knowledge and attitudes, reproductive, and marriage. Both the household and the individual questionnaires were translated into Shona, the local language spoken in the four selected districts.

### *1.4.3. Recruitment and Training*

Family Health International sub-contracted Target Research, a local research firm, to carry out the data collection phase. Target Research recruited, trained, and dispatched to the field a team of 32 fieldworkers and eight supervisors. When recruiting the field staff, priority was given to those with the highest education levels, who have experience on reproductive health research, were able to adapt to various socio-economic environments, and were proficient in local languages. Two experienced data entry clerks were also recruited to process all survey questionnaires.

Training and pre-testing of survey questionnaires were carried over the period November 5-12, 2004. The first phase of the training focused on Research Ethics. Project staff were then trained on interviewing techniques and on the content of the questionnaires. A series of mock interviews in Shona were conducted at the end of the training. The questionnaires were field tested in Domboshowa, Seke Rural and Goromonzi. Finally, the two data entry clerks of the project were trained on data entry using the CSPro program during the period November 17-18, 2005.

### *1.4.4. Data Collection*

The field staff was divided into eight teams. Each team comprised of a team leader/supervisor and four Research Assistants. Identification of EAs and related boundaries were done using updated maps from the Zimbabwe Statistical Office. Each team leader prepared his/her team's fieldwork itinerary. All field teams left Harare on November 16, 2004 for their respective fieldwork districts. Fieldwork started on November 17, 2005 and ended on December 22, 2004.

### *1.4.5. Data Processing and Analysis*

Questionnaires were checked and edited in the field, and those requiring field corrections were sent back to the data collectors. As fieldwork progressed, completed questionnaires were sent back to Target Research offices in Harare for data entry. Data entry started on February 5, 2005 and ended on March 15, 2005. The CSPro software was used for data entry, while data analysis was done in STATA and SPSS.

## 2. Household and individual Characteristics

### 2.1. Housing characteristics

During the household census which was part of the 2004 OVY survey, respondents were asked to provide information on sources of drinking water, cooking fuel, sanitation facilities, and durable goods owned by their households. The survey data collectors were to complement this by gathering information on the type of flooring and roofing materials for the household's dwelling unit.

Table 2 presents housing characteristics in the four districts covered by the survey. Most houses in the survey areas have their floor made in cement (68%) and their roof in grass/thatch (46%) or Asbestos sheets (42%). Almost all households (97%) rely on firewood/straw for cooking fuel, and less than 15 percent have access to electricity. Covered wells and boreholes top the list of drinking water sources. Sanitation facilities are mostly ventilated pit/Blair toilets which were reported by 43 percent of the households, while about half of them (48%) reported no sanitation facilities. Only 25 percent of the households reported owning a radio. Bicycle possession was reported by only 20 percent of the households. The ownership of television, telephone, and car was rare as expected of rural areas.

The patterns of housing characteristics and household possessions shown in Table 2 suggest that households in Zvimba and Makoni are slightly better off than those in Gutu and Buhera. As shown in Tables 2, this is corroborated by the household wealth index, a summary measure of household possessions and housing characteristics using principal component analysis. Households in Zvimba and Makoni are skewed towards the top third and fourth better off quartiles, while those in Gutu and Buhera are more concentrated in the bottom and second poorest quartiles. These differences are confirmed by the variations in the overall wealth scores which is highest in Zvimba (0.54) and Makoni (-0.03) and lowest in Gutu (-0.36) and Buhera (-0.27).

Table 2. Housing Characteristics

Percentage distribution of households by housing characteristics and by district, 2004					
Housing Characteristics	Districts				
	Zvimba	Gutu	Makoni	Buhera South	All
<b>Flooring material</b>					
Earth/sand/mud/dung	24.5	40.8	30.0	32.6	32.0
Wood planks	0.0	0.1	0.0	0.0	0.0
Parquet/polished wood	0.0	0.0	0.0	0.1	0.0
Ceramic tiles	0.1	0.1	0.2	0.0	0.1
Cement	74.7	59.0	69.3	67.0	67.6
Carpet	0.6	0.0	0.5	0.3	0.3
Other	0.1	0.0	0.0	0.0	0.0
<b>Roofing material</b>					
Grass/thatch	44.0	51.4	31.8	52.8	45.8
Tin cans	0.0	0.0	0.0	0.0	0.0
Corrugated iron/Marata	12.4	6.6	18.4	11.1	12.1
Asbestos sheets	43.0	42.0	49.8	36.1	42.0
Tiles	0.6	0.0	0.0	0.0	0.1
<b>Electricity</b>					
Has electricity/solar	28.2	7.4	10.9	9.8	13.5
<b>Cooking fuel</b>					
Electricity	9.9	0.1	1.5	0.1	2.5
Firewood/straw	90.1	99.8	98.5	99.2	97.2
Dung	0.0	0.1	0.0	0.7	0.3
<b>Source of drinking water</b>					
Piped water	14.9	0.2	9.7	3.4	6.7
Open well/Borehole	28.1	43.9	10.8	21.9	25.4
Covered well/borehole	46.6	51.6	75.8	68.0	61.6
Surface water	10.2	4.3	3.3	6.7	6.2
Other	0.2	0.0	0.4	0.0	0.1
<b>Sanitation facilities</b>					
Flush toilet	8.8	0.0	0.0	0.0	1.9
Traditional pit	9.0	12.0	4.1	4.6	7.0
Ventilated improved pit (VIP)/Blair	48.7	30.9	61.0	34.0	42.6
Bucket toilet	0.4	0.1	0.7	0.2	0.3
No facility/bush/field other	32.9	57.0	34.2	61.2	48.2
other	0.2	0.0	0.0	0.0	0.0
<b>Durable goods</b>					
Radio	36.8	19.4	24.9	20.2	24.7
Television	18.4	2.9	5.7	5.2	7.7
Telephone/mobile	4.5	0.3	0.4	0.2	1.2
Refrigerator	4.9	0.2	1.7	0.4	1.6
Bicycle	31.5	12.0	19.0	19.1	20.2
Ox/Donkey cart	31.4	23.1	26.8	22.5	25.5
Motorcycle/scooter	0.8	0.2	0.3	0.0	0.3
car	6.4	0.3	0.5	0.4	1.7
<b>Wealth quartiles</b>					
Bottom 25% (poorest)	11.1	37.8	18.5	30.1	25.0
Second 25%	21.0	26.6	18.8	30.5	25.0
Third 25%	20.2	24.1	36.7	21.4	25.2
Top 25% (richest)	47.7	11.6	26.0	18.0	24.8
<b>Overall wealth score</b>					
	0.54	-0.36	-0.03	-0.27	-0.06
n	825	952	879	1,049	3,705

## 2.2. Prevalence of orphans and OVYs

Questions on orphanhood and vulnerability were asked for all household members aged below 25 years. The household respondent (Head of household) was asked whether each eligible household member had father/mother alive, and whether those parents who were alive had been chronically sick in the past 12 months. Chronic sickness was defined by being too sick to work or do normal activities around the house for at least 3 months over the past 12 months. An orphan was defined any age-eligible household member (i.e. below 25 years of age) who lost either or both parents. Vulnerable youth were all age-eligible household members whose parents were alive but with at least one of them who has been chronically sick over the past 12 months. Orphans or vulnerable youth (OVY) were household members aged below 25 years of age who were orphans or vulnerable according to the above definitions.

Overall, 33 percent of males and females below the age of 25 years were orphans. The percentage of orphans varies little between males and females. It increases steadily from 13 percent in the 0-4 years age group to 28 percent among the 5-9 year olds, then stabilizes around 40-45 percent thereafter. About one in ten boys and girls below age 25 years are vulnerable (Table 3).

Table 3. Prevalence of orphans and vulnerable boys and girls below age 25 years

Percentage who orphans and percentage who are OVYs, by age groups, Zvimba, Gutu, Makoni, Buhera South, 2004						
Current age (in completed years)	<b>Orphans</b>					
	Females		Males		All	
	%	n	%	n	%	n
0-4	13.4	1,254	13.3	1,284	13.3	2,538
5-9	28.3	1,391	28.5	1,397	28.4	2,788
10-14	41.1	1,389	38.6	1,440	40.0	2,829
15-19	41.0	1,168	45.1	1,317	43.1	2,485
19-24	41.4	878	45.0	819	43.1	1,697
All (0-24)	32.6	6,080	33.0	6,257	32.8	12,337
	<b>Orphans or Vulnerable</b>					
	Females		Males		All	
	%	n	%	n	%	n
0-4	24.0	1,182	26.3	1,205	25.2	2,397
5-9	41.4	1,322	42.7	1,323	42.0	2,645
10-14	52.5	1,344	49.8	1,390	51.1	2,734
15-19	49.8	1,120	54.1	1,277	52.1	2,397
19-24	54.7	838	54.4	791	54.6	1,629
All (0-24)	44.1	5,806	44.7	5,986	44.4	11,792

### 2.3. Parental survival, youth living arrangements and household Composition

In addition to the information on the survival of parents, the household survey also collected data on co-residence with parents for youth aged 13-21 years. Only 36 percent of the youth aged 13-21 years live with both parents, 38 percent live with neither parents, 21 percent live with only their mother, and three percent with only their father. The majority of youth 13-21 (64%) do not live with both parents, and 66% of such youth have lost at least one parent (Table 4). Patterns of youth/parents co-residence are similar between boys and girls, except that a larger percentage of girls with both parents alive (16%) were not living with such parents compared to their male counterparts (10%). Higher marriage rates in the 13-21 age group among girls compared to boys may partly explain these differentials.

Table 4. Orphanhood and youth living arrangements

Percent distribution of female and male youth age 13-21 (household de jure population) by living arrangements and survival status of parents, Zvimba, Gutu, Makoni, Buhera South, 2004			
Household living arrangements	Female Youth	Male youth	ALL
Living with both parents	34.0	37.1	35.6
Living with mother but not father			
Father alive	8.0	8.6	8.3
Father dead	11.3	13.9	12.7
Living with father but not mother			
Mother alive	1.0	1.0	1.0
Mother dead	1.6	3.1	2.4
Not living with either parent			
Both parents alive	15.7	8.9	12.2
Only father alive	4.7	2.9	3.8
Only mother alive	8.4	7.0	7.7
Both parents dead	13.7	14.8	14.2
Missing information	1.6	2.7	2.1
Total	100.0	100.0	100.0
Number of youth	2,224	2,039	4,263

Death or incapacitation of parents increase young people's vulnerability partly because of the social and economic consequences these events have on the household. OVYs are faced not only with changing living arrangements, but also with significant modifications of the composition and the well-being of their households. As shown in Table 5, being an OVY is associated with living in a household headed by a female and/or a youth aged 13-24 years, and/or in a household that is worse off than average. The fact that mortality and disability rates among the elderly are higher for males compared to females explains in part the higher female headship rates among households with OVYs compared to those where no OVYs live. The deaths of adult or elderly household heads increase the likelihood that the households with OVYs are headed by an adolescent.

Table 5. Household composition

Percentage distribution of households by gender and age of household head, and household wealth score, Zvimba, Gutu, Makoni, Buhera South, 2004			
Household composition	Households with OVYs	Households without OVYs	All
<b>Gender of household</b>			
Male	51.9	68.6	63.0
Female	48.1	31.5	37.0
<b>Age of head of household</b>			
13-24 years	7.8	4.0	5.3
25 years or above	82.8	96.0	84.7
n	1,241	2,464	3,705

#### 2.4. Individual background characteristics

Selected individual background characteristics of the male and female youth interviewed during this study fieldwork are presented in Table 6. More than half of male youth were concentrated in the 16-21 year age group. A similar age structure was observed for female youth, although this group was slightly younger than the males. There were no significant differences between the age structures of OVYs and non-OVYs.

Table 6. Respondents' background characteristics

Percentage distribution of respondents by background characteristics and OVY status, Zvimba, Gutu, Makoni, Buhera, 2004.						
Background Characteristics	Male Youth			Female Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
<b>Age</b>						
13-15	29.8	36.0	34.7	39.7	40.9	40.6
16-21	70.2	64.0	65.3	60.3	59.1	59.4
<b>Childhood place of residence</b>						
City	3.4	4.2	4.0	4.4	3.5	3.7
Town	4.7	5.2	5.1	2.9	4.2	3.9
Commercial farm	28.4	30.3	29.9	22.8	22.3	22.5
Communal area	63.5	60.3	61.0	69.9	70.0	70.0
<b>Religion</b>						
Traditional	3.8	1.9	2.3	2.0	2.9	2.7
Christian	86.4	83.6	84.2	96.7	94.1	94.8
Muslim	0.3	0.5	0.4	0.2	0.1	0.1
None	9.5	13.7	12.8	1.1	2.9	2.5
Other	0.0	0.3	0.3	0.0	0.0	0.0
<b>Education level attained</b>						
None	2.8	0.0	0.6	0.0	0.2	0.2
Primary	28.7	33.5	32.5	36.1	40.2	39.2
Secondary	67.2	66.5	66.6	63.9	59.5	60.6
Higher	1.3	0.0	0.3	0.0	0.1	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0
n	195	773	968	217	689	906

Respondents were asked to indicate the place where they lived up to the time they were 12 years old. Because the areas covered by the survey were all rural, the majority of the respondents reported that they grew up in either in a commercial farm or a communal area. Less than 10 percent of the male and female youth mentioned an urban area as their childhood place of residence. These patterns of childhood residence were the same for female and male youth and for OVYs and non-OVYs.

Christianity is the dominant religion practiced by 84% and 95% male and female youth, respectively. The male youth seem to be less religious than the female youth as suggested by the higher percentage of boys (13%) reporting having no religion compared to girls (2%). Religious affiliation did not vary between OVYs and non-OVYs.

Almost all male and female youth had ever been to school, and more than half of them have reached secondary school levels. Educational levels beyond secondary school were rare among both male and female youth. Educational attainment is slightly higher for boys compared to girls. There was, however, no substantial educational differences between OVYs and non-OVYs.

### 3. Reproductive Health

#### 3.1. Marriage and childbearing

The percentage of currently married youth aged 16-21 years is presented in Table 7, for OVYs and non-OVYs separately. As expected, female youth are much more likely to be married (38%) compared to male youth (5%). Findings shown in Table 7 indicate that marriage rates are much higher among OVY girls (42%) compared to non-OVY girls (27%), while no differences are observed between OVY boys (5%) and non-OVY boys (4%).

Table 7. Marital status

Percentage distribution of youth by current marital status and OVY status, Zvimba, Gutu, Makoni, Buhera South 2004.						
Marital status	Male Youth			Female Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
Never married	94.1	94.5	94.4	70.0	52.0	56.7
Married	4.1	5.3	5.1	27.4	41.7	38.0
Widowed	1.8	0.2	0.5	0.8	0.3	0.4
Divorced/separated	0.0	0.0	0.0	1.8	6.0	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
N	195	773	968	217	689	906

An immediate consequence of the higher marriage rates among female OVYs compared to those among non-OVYs is that girls who are OVYs are more likely to be mothers than their non-OVY counterparts. Table 8 shows that about 39 percent of OVY girls reported that they had already given birth compared to 23 percent among non-OVY girls. No differences were observed among boys (1% for both OVYs and non-OVYs). The high marriage and childbearing rates among OVY are worsened by high rates of unwanted childbearing. While 31 percent of non-OVY girls indicated that their first pregnancy was unwanted, the corresponding figure was 57 percent among OVYs (Table 8.)

Table 8. Childbearing and unwanted pregnancies

Percentage who are mothers/fathers and percentage who wanted their first pregnancy later or not at all, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004						
RH indicators	FEMALE					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
% mothers	22.9	126	38.7	406	34.6	532
% wanted their first pregnancy later or not at all	30.9	33	56.9	154	52.5	187
RH indicators	MALE					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
% fathers	1.1	131	1.2	517	1.2	648
% wanted their first child later or not at all*	59.4	3	75.4	9	72.0	12

\* The number of observations is too small to warrant any statistical significance.

### 3.2. Reproductive health knowledge and attitudes

Male and female youth were asked when they thought a woman was more likely to get pregnant during her inter-menstrual cycle. Only about one in ten male and female youth knew that the highest risks of pregnancy occur half-way between periods. The majority of male and female youth either gave inaccurate responses or said they did not know what the answer was (Table 9). There were no differences between OVY and non-OVY with respect to knowledge of the fertile period.

Most male and female youth knew ways to avoid a pregnancy (Table 9). Almost all of them have ever heard of contraceptive methods and the vast majority was able to mention at least one contraceptive method. It must be noted, however, that only 13 percent of male youth and 41 percent of female youth mentioned abstinence as a way of avoiding a pregnancy. Again, there were no significant differences between OVYs and non-OVYs regarding these indicators of reproductive health knowledge.

The above findings strongly suggest that most male and female youth, irrespective of whether they are OVYs or not, lack the required reproductive knowledge to help them make appropriate decisions and avoid unwanted pregnancies. Although such youth have high knowledge of contraceptive methods, they certainly do not know when to use them since they have inaccurate knowledge of their fertile period.

Table 9. Reproductive Health knowledge

Percentage of female and male youth age 13-21 who know about inter-menstrual pregnancy risks, ways of avoiding pregnancy, and who ever heard of contraceptive methods, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004.						
RH knowledge	Female Youth			Male Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
<b>Perceived fertile period</b>						
Just before period begins	6.1	10.9	9.6	19.4	15.9	16.7
During periods	11.6	4.6	6.4	2.5	2.0	2.1
Just after periods end	32.3	34.4	33.9	17.7	19.0	18.7
Half-way between periods	9.8	9.9	9.9	15.3	12.4	13.0
Other	0.0	0.0	0.0	0.0	0.4	0.3
Does not know	40.2	40.2	40.2	45.1	50.3	49.2
<b>Known ways to avoid pregnancy*</b>						
Use contraceptives	61.7	55.7	57.2	90.4	86.3	87.1
Avoid sex	33.9	43.6	41.1	17.4	12.3	13.4
Other	1.3	1.5	1.4	0.4	0.4	0.4
Does not know	12.8	14.7	14.2	4.2	8.2	7.4
<b>Knowledge of contraception*</b>						
Ever heard of any method	96.9	96.9	96.9	98.9	97.8	98.1
Ever heard of any modern method	95.1	96.8	96.4	98.9	97.8	98.1
Able to mention at least one method	77.0	82.0	80.7	91.4	81.3	83.4
Able to mention at least one modern method	74.9	80.0	78.7	90.6	80.9	82.9
n	213	671	884	189	751	940

\* Percentages do not add to 100 because of multiple responses.

About 60 percent of female youth and 57 percent of male youth approved of married couples using contraception (Table 10). Approval of use of contraception was higher among male youth (59%) compared to female youth (36%). Levels of approval of the use of contraception are still low among both OVYs and non-OVYs, girls and boys alike.

Male and female youth were asked whether they thought young people’s knowledge of contraception encourage them to be promiscuous. Over half of the male youth (56%) and 73 percent of the female youth did not think so. It is clear therefore that a large percentage of young girls (27%) and young boys (44%) still associate contraceptive use with promiscuity. Such attitudes towards contraceptives did not vary significantly between OVYs and non-OVYs.

Table 10. Attitudes towards contraception

Percentage of female and male youth age 13-21 by their attitudes towards contraceptive use and by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004.						
RH knowledge	Female Youth			Male Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
Approves of married couples using contraception to avoid pregnancy	53.0	62.3	60.0	48.5	58.8	56.6
Approves of unmarried youth below age 20 using contraception to avoid pregnancy	36.6	35.9	36.0	59.0	59.1	59.1
Does not think that young people’s knowledge of contraception encourage them to be promiscuous	71.9	73.6	73.1	54.7	55.8	55.5
n	213	671	884	189	751	940

### 3.3. Sexual Experiences

A large percentage of youth (age 16-21) reported that they have already had sex, 47 percent among girls and 28 percent among boys (Table 11). These indicators drop significantly to 7 percent for never married girls and remain slightly the same for unmarried boys (23%). When currently married youth were asked about pre-marital sex, about 14 percent and 30 percent of girls and boys respectively indicated that they had sex before marriage. These findings suggest that because of their higher marriage rates, female youth are more likely to be sexually experienced than male youth. The findings also point to higher rates of pre-marital sex among male youth compared to female youth.

When compared to female non-OVYs, OVYs are more likely to have had sex, irrespective of their marital status (Table 11). Female OVYs who were married at the time of the survey were also more likely to report having had pre-marital sex compared to their non-OVY counterparts. These variations were not observed among boys.

Table 11. Sexual experiences

Sexual behavior and attitudes among male and female youth, 16-21, by OVY status, Zvimba, Gutu, Makoni, Buhera, 2004						
	FEMALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
<b>Sexual initiation</b>						
Ever had sex (irrespective of current marital status)	32.4	126	52.1	405	47.0	531
Ever had sex (never married only)	4.6	79	7.9	205	6.9	284
Had first sex before marriage (currently married only)	10.1	36	19.1	179	17.5	215
<b>Relationship with first sexual partner</b>						
Spouse/Live-in partner	64.3	41	40.3	198	44.4	239
Boyfriend/Fiancé	23.5	41	54.5	198	49.3	239
Other friend	2.1	41	0.0	198	0.3	239
Casual acquaintance	0.0	41	0.3	198	0.3	239
Relative	5.6	41	3.7	198	4.0	239
Commercial sex worker	0.0	41	0.0	198	0.0	239
Other	4.5	41	1.2	198	1.7	239
<b>Age of man with whom had first sex</b>						
Younger	0.0	19	0.0	111	0.0	130
About same age	10.4	19	12.3	111	12.1	130
Older	89.6	19	86.1	111	86.5	130
Does not know/can't recall	0.0	19	1.6	111	1.4	130
	MALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
<b>Sexual initiation</b>						
Ever had sex (irrespective of current marital status)	31.1	131	26.9	517	27.9	648
Ever had sex (never married only)	26.8	125	22.1	492	23.2	617
Had first sex before marriage (currently married only)	5.9	6	39.7	21	30.1	27
<b>Relationship with first sexual partner</b>						
Spouse/Live-in partner	0.0	41	6.5	147	4.8	188
Girlfriend/Fiancée	84.6	41	79.2	147	80.6	188
Other friend	10.0	41	8.4	147	8.8	188
Casual acquaintance	3.6	41	3.9	147	3.8	188
Relative	1.8	41	0.0	147	0.5	188
Commercial sex worker	0.0	41	2.0	147	1.5	188
Other	0.0	41	0.0	147	0.0	188
<b>Age of woman with whom had first sex</b>						
Younger	56.6	41	45.9	144	48.7	185
About same age	26.3	41	41.6	144	37.5	185
Older	17.1	41	12.0	144	13.4	185
Does not know/can't recall	0.0	41	0.5	144	0.4	185

Among female youth, 49 percent and 44 percent reported that their first sexual partner was a spouse/live-in partner or boyfriend/fiancé respectively. In contrast, only five percent of male youth, who were much less likely to be married than girls, reported that their first sexual partner was their spouse/live-in-partner, while 81 percent said their first sexual encounter was with their girlfriend/fiancé. Higher marriage rates among girls compared to boys largely explain these patterns of relationship with first sexual partners. Given the fact that OVYs are more likely to be married than non-OVY girls, these findings may also explain why more OVY girls reported that they first had sex with their

boyfriend/fiancé (55%) than with their spouse/live-in partner (40%), while the reverse was true for non-OVY girls. These contrasting relationships at first sex were not observed for boys (Table 11) mainly because of the low and similar marriage rates among male OVY and non-OVY.

The majority of female youth (over 85%) reported that they had their first sex with a partner that was older, while the corresponding figure was less than 20 percent for boys. Perceptions of age difference between partners at first sex was similar between OVY and non-OVYs.

To gauge youth's negotiation skills for safe sex, boys and girls were asked whether they were coerced/tricked at first sex, and whether they were confident they can refuse sex when necessary. A much larger percentage of girls (60%) compared to boys (15%) indicated that they were forced/coerced at first sex. There were however, no differences between the percentage of girls (86%) and boys (89%) who said they were confident they can refuse sex when necessary. OVY girls were less confident (85%) about being able to refuse sex when necessary compared to their non-OVY counterparts (92%), but no differences were observed between these two groups regarding being coerced/forced at first sex – 59 percent and 63 percent, respectively. Self confidence about refusing sex when necessary and exposure to coercion/force at first sex did not seem to vary between OVY and non-OVY boys (Table 11.)

## 4. HIV/AIDS/STI-Related Knowledge, Attitudes and Behavior

### 4.1. Knowledge of abstinence, being faithful and condom use (ABC)

Abstinence, being faithful and condom use are key program and individual strategies to prevent HIV infection. Knowledge of at least one of these strategies is universal among youth in the four districts covered by the survey (Table 12). Although levels of ABC knowledge do not vary much between OVYs and non-OVYs, it is worth noting that knowledge of condom use as an HIV prevention strategy is relatively low, 67 percent among girls and 80 percent among boys.

Table 12. Knowledge of ABC

Percentage of male and female youth 13-21 who are aware of ABC, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004						
Knowledge of ABC	Female Youth			Male Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
Knows abstinence (A) can reduce HIV transmission	92.2	92.1	92.2	98.8	95.9	96.5
Knows being faithful (B) can reduce HIV transmission	86.1	84.1	84.6	91.5	87.7	88.5
Knows condom (C) can reduce HIV transmission	72.6	64.7	66.6	84.5	79.0	80.2
Knows A, B or C can reduce HIV transmission	99.7	99.3	99.4	100.0	99.9	100.0
n	185	601	786	167	671	838

### 4.2. Knowledge of prevention of mother-to-child transmission (PMTCT)

Knowledge of at least one route through which vertical transmission can occur is also universal among male and female youth (Table 13). All the youth interviewed knew that HIV can be transmitted from mother to child either during pregnancy, delivery or through breastfeeding. Vertical transmission of the HIV virus during delivery was the least known, followed by transmission through breastfeeding, and during pregnancy. Levels of knowledge of these three modes of vertical transmission were similar between OVYs and non-OVYs, except that OVY girls seemed to be more knowledgeable of HIV transmission through breastfeeding compared to non-OVY girls (Table 13).

Table 13. Knowledge of PMTCT

Percentage of male and female youth 13-21 who know that HIV can be transmitted from mother to child and percentage who know that the risk of MTCT can be reduced by a mother taking special drugs during pregnancy, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004						
Knowledge of PMTCT	Female Youth			Male Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
Knows HIV can be transmitted to child during pregnancy	78.3	83.0	81.8	75.5	78.7	78.0
Knows HIV can be transmitted to child during delivery	51.6	55.5	54.5	64.4	58.6	59.7
Knows HIV can be transmitted to child through breastfeeding	58.2	70.3	67.2	72.5	66.6	67.8
Knows at least one of the above	100.0	100.0	100.0	100.0	100.0	100.0
Knows mother can reduce MTCT by taking certain drugs during pregnancy	39.5	43.4	42.4	35.2	38.9	38.2
n	190	568	758	155	665	838

#### 4.3. Attitudes towards people living with HIV/AIDS (PLWHA)

Although more than 90 percent of boys and girls indicated that they were willing to take care of a relative with HIV at home. The other indicators of accepting attitudes toward PLWHA were relatively high (Table 14), among OVYs and non-OVY alike. A little below two third of boys and girls said that they would buy fresh vegetables from a vendor with AIDS, and a similar percentage indicated that they would not want the HIV positive status of a family member to remain secret. Accepting attitudes seems to be lowest towards teachers. Half or less of the youth interviewed believed that a teacher with AIDS should be allowed to teach.

Table 14. Accepting attitudes toward PLWHA

Percentage of female and male youth age 13-21 who have ever heard about AIDS who express accepting attitudes toward people with HIV, by OVY status, Zvimba, Gutu, Makoni, Buhera, 2004.						
Accepting attitudes	Female Youth			Male Youth		
	Non-OVY	OVY	All	Non-OVY	OVY	All
Is willing to take care of a relative with HIV at home	91.2	92.6	92.2	93.6	94.5	94.3
Would buy fresh vegetables from a vendor with AIDS	56.5	60.7	59.6	64.6	63.0	63.4
Believes a teacher with AIDS should be allowed to teach	35.0	47.7	44.5	54.3	50.6	51.4
Would not want an HIV+ status of family member to remain secret	62.4	67.1	65.9	66.7	62.3	63.2
n	213	671	884	189	751	940

#### 4.4. Testing and counseling for HIV

Voluntary counseling and testing (VCT) is an important strategy for controlling the HIV epidemic. All youth interviewed during this study were asked about VCT awareness and HIV testing (Table 15). Levels of awareness of VCT and knowledge of a place where to get VCT services are low among both male and female youth aged 13-21 years. Just a little above 55 percent of boys and girls ever heard of VCT, and only four out of ten of them knew where to go to get tested for HIV. There was no clear association between OVY status and knowledge of VCT and HIV testing services.

Only one out of 10 youth reported having ever been tested for HIV. Even among youth who were ever tested for HIV, only about seven out of 10 received their test results. Intentions to get tested are however high among both male and female youth as about 81 percent of youth who never tested for HIV said that they were willing to go for an HIV test. The findings shown in Table 15 do not indicate any association between experience with or intention for HIV testing and OVY status.

Table 15. HIV testing among youth

Percentage of male and female youth 13-21 by VCT awareness, HIV testing experience, and OVY status, Zvimba, Gutu, Makoni, Buhera, 2004						
	FEMALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
<b>VCT awareness</b>						
Ever heard of VCT	60.2	212	56.6	670	57.5	882
Knows where to go for an HIV test	40.9	188	44.1	577	43.2	765
<b>HIV testing</b>						
Was ever tested for HIV	10.9	212	14.2	670	13.4	882
Got results for last HIV test	88.7	24	71.7	90	75.1	114
Never tested for HIV but is willing to go for a test	77.9	189	81.6	580	80.6	769
	MALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
<b>VCT awareness</b>						
Ever heard of VCT	50.1	188	57.8	751	56.2	939
Knows where to go for an HIV test	47.9	177	39.6	695	41.4	872
<b>HIV testing</b>						
Was ever tested for HIV	7.0	188	10.0	751	9.4	939
Got results for last HIV test	64.5	12	68.1	53	67.5	65
Never tested for HIV but is willing to go for a test	77.7	177	81.3	695	80.5	872

#### 4.5. Knowledge of and attitudes towards condoms

Knowledge of sources of condoms is low among male and female youth aged 13-21 years. Only 43 percent of female youth and 66 percent of male youth knew a place to obtain condoms. Consequently, not many youth think they can get condoms when they want them. Less than half of boys (49%) and only 30 percent of girls were confident that

they could get condoms whenever they want. Both knowledge of condom sources and perceived ability to get condoms when needed did not vary by OVY status.

Youth awareness of condom sources and their ability to get condoms depends partly on their exposure to information about condoms. Although half of the boys and two thirds of the girls thought that condom advertisements were acceptable on TV, radio and newspapers, less than 25 percent of these youth reported having heard about condoms over the past few months through such media.

Findings shown in Table 16 indicate that more than half of boys and girls do not consider carrying condoms as reputable behavior. Less than half of male and female youth interviewed during the survey thought that a boy/girl who carries condoms in his/her pocket cares about him/herself.

Table 16. Knowledge of and attitudes towards condoms

Percentage of female and male youth age 13-21 by their knowledge/attitudes towards condoms, and by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004.						
RH knowledge/attitudes	Female Youth			Male Youth		
	Non-OVY	OV Y	All	Non-OVY	OVY	All
Knows a place where one can get condoms	42.6	43.7	43.4	65.5	66.7	66.4
Have heard about condoms over the past few months on:						
Radio	27.1	17.5	20.0	24.3	24.1	24.2
TV	13.6	9.6	10.6	10.4	14.2	13.4
Newspapers	19.9	14.0	15.5	13.3	12.9	13.0
Could get a condom if she/he wanted	26.8	31.5	30.3	51.7	48.5	49.1
Thinks it is acceptable to for condoms to be advertised on:						
Radio	54.3	50.8	51.7	71.0	65.8	66.9
TV	50.2	48.3	48.8	71.6	64.2	65.8
Newspapers	52.8	52.3	52.4	72.5	68.5	69.4
Thinks that a boy/girl who carries condoms in his/her pocket cares about him/herself	45.3	44.1	44.4	56.2	44.2	46.7
n	213	671	884	189	751	940

#### 4.6. High-risk sex and condom use

High-risk sex is defined as sex with a non-marital, non-cohabiting partner. High-risk sex is positively correlated with STI/HIV transmission. Table 17 shows the percentage of youth 16-21 who engaged in high-risk first sex and the percentage of youth who used a condom during such a sex encounter. Among sexually experienced boys, almost all first sex acts (95%) were high risk ones, compared to 56 percent among sexually experienced girls. In contrast to these high rates of high-risk first sex, condoms were used at high-risk first sex among only 56 percent of boys and 20 percent of girls. While the prevalence of high-risk first sex was not different between OVY and non-OVY boys, OVY girls were more likely (60%) to engage in high-risk first sex compared to non-OVY girls (36%). However, use of condoms at high-risk first sex did not vary by OVY status (Table 17).

Table 17. High-risk first sex and condom use

Percentage of male and female youth 16-21 who first had sex with non-marital, non-cohabiting partner, and percentage who used condoms at first sex, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004						
	FEMALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
Engaged in high-risk first sex	35.7	41	59.7	198	55.6	239
Used a condom at high-risk first sex	16.3	19	20.0	111	19.6	130
	MALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
Engaged in high-risk first sex	100.0	41	93.5	147	95.2	188
Used a condom at high-risk first sex	55.1	41	55.8	143	55.6	184

#### 4.7. Self-reporting of sexually transmitted infections (STIs)

Boys and girls aged 16-21 who have ever had sex were asked whether they have had any sexually transmitted infection over the 12 months period preceding the survey. Although answers to such a question may reflect respondents' perception of what an STI is, the data may constitute a good marker for differentials in STI prevalence between OVYs and non-OVYs. Table 18 indicates that STIs are more common among OVY boys and girls compared to their non-OVY counterparts.

Table 18. Self-reporting of STIs and related symptoms

Among male and female youth age 16-21, percentage reporting an STI and/or STI symptoms in the last 12 months, by OVY status, Zvimba, Gutu, Makoni, Buhera South, 2004						
Self-reported STIs/symptoms over the last 12 months	FEMALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
Had an STI	0.5	31	4.3	145	3.7	176
Had an abnormal discharge from penis	6.2	51	15.2	221	13.6	272
Had genital sore/ulcer	7.0	50	5.7	221	6.0	271
	MALE YOUTH					
	Non-OVYs		OVYs		All	
	%	n	%	n	%	n
Had an STI	0.0	32	5.7	124	4.2	156
Had an abnormal vaginal discharge	4.9	41	3.2	149	3.7	190
Had genital sore/ulcer	3.8	41	4.5	149	4.3	190

## 5. Conclusion

The 2004/05 OVY survey provides representative information on sexual and reproductive health risks of orphans and vulnerable adolescents age 13-21 years in rural areas of four districts of Zimbabwe. Data from this study are crucial to the implementation and evaluation of OVY programs in Zimbabwe. The data can also serve as baseline information for the monitoring and evaluation of these interventions.

Findings presented in this report suggest that orphans and vulnerable youth live in households that are more affected by poverty than youth who live with healthy parents. Household poverty certainly compounds OVY's reproductive health risks. Traditional programs that provide educational and other material assistance to households with OVYs may contribute partially to breaking the vicious circle of household poverty and ill reproductive health among orphans and vulnerable youth. It is recommended that other programmatic responses like conditional transfer programs which consist of providing target households with OVYs with cash or in-kind subsidies, conditional upon specific desired behaviors such as ensuring that children attend school and receive health care, be added to these traditional approaches.

Almost all OVYs and non-OVYs interviewed during this assessment had ever been to school. Also, educational attainment did not differ between OVYs and non-OVYs in the four study districts. However, high drop-out rates were observed for both groups. These findings point to the need for these programs to shift focus from assisting households to send orphans and vulnerable children to school to ensuring that both OVYs and non-OVYs remain in school throughout the adolescence years.

Compared to female non-OVYs, orphans and vulnerable adolescent girls were more likely to be in a marital union. The average ages at marriage of OVYs and non-OVYs were similar and were both above the age of majority in Zimbabwe (16 years). The higher marriage rate among OVYs compared to non-OVYs is thus more of a reflection of the higher propensity of OVYs to be married, and less of an indication of their earlier entry into marriage. The study did not explore the impact of being married on OVYs' quality of life. Supporting OVYs to stay in school or offering them income generating opportunities will counter the material and emotional needs for them to enter into a marital union, and may enhance their ability to lead better quality lives.

Overall, female OVYs exhibited higher rates of pre-marital sex and high risk sex, and were less able to negotiate for safe sex than non-OVY girls. This was in contrast with the lack of differences in negotiation skills observed between OVY and non-OVY boys. Rates of self reported STIs were much higher among OVY boys and girls compared to their non-OVY counterparts. Given the high HIV/AIDS prevalence rate in Zimbabwe (25%), orphans and vulnerable female adolescents need special protection through programs that empower them with negotiation skills and appropriate information on safer sex.

In summary, multisectoral approaches that address the educational, socio-economic, and reproductive health needs of orphans and vulnerable youth are urgently required in the region. However, as the study results show, even non-OVYs often are in similar circumstances compared to OVYs and hence should not be left out when programming for youth.

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