

Assessing the Reproductive Health Needs of Adolescent Orphans and Vulnerable Children in Kenya

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Executive Summary

INTRODUCTION

Many children orphaned by HIV/AIDS are now adolescents and are being taken care of by relatives in communities already impoverished by the epidemic. Other adolescent orphans and vulnerable children (OVCs) are caretakers for younger siblings, responsible for food and shelter. They may become the victims of economic and sexual abuse and may be at increased risk for unplanned pregnancy or sexually transmitted infections (STIs).

An estimated 1.3 million orphans younger than 18 years of age live in Kenya. Anecdotal evidence from Kenyan nongovernmental organizations suggests that OVCs as young as 13 resort to commercial sex work in order to support their siblings; others rely on stealing. It is believed that OVCs have a high dropout rate from school and are at increased risk for rape and STI infection. However, little concrete information is available about the impact of the HIV/AIDS epidemic on adolescent OVCs. Therefore, in collaboration with two nongovernmental organizations in Western Province, Rural Education and Economic Program (REEP) and Widows and Orphans Welfare Society of Kenya (WOWESOK), Family Health International (FHI) conducted a formative assessment to document the needs of OVCs and to provide the information needed to develop appropriate interventions.

For the purposes of this assessment, an OVC was defined as a boy or girl who had lost both mother and father, with at least one of the deaths resulting from HIV infection. Data were collected from multiple sources: in-depth interviews with OVCs ages 16-23 years, guardians of OVCs, and community key informants, as well as a survey of OVCs ages 13 to 23. Finally, a data interpretation workshop was held with local stakeholders to obtain their views on the validity of the results.

The assessment was carried out in two communities in Western Province: Busia, an urban center, and Butula, a rural town within Busia district. Data were collected between 5 July and 27 August 2004. Before beginning data collection, researchers conducted a series of meetings to sensitize key provincial and district leaders.

Special attention was paid to ethical considerations for this sensitive research topic. All research staff received ethics training, with particular emphasis on research with vulnerable adolescents. A social worker was part of the interview team and was available for referrals if a study participant became distressed during interviews. Systems were also in place so that interviewers could make appropriate referrals if they were told of instances of rape or abuse. Other steps to ensure the rights of the study participants included but were not limited to informed consent of all study participants, an emphasis on privacy and confidentiality, and approval by ethical review boards in both Kenya and the United States.

RESULTS

Sociodemographic and household characteristics

A total of 131 adolescent OVCs were surveyed. They were evenly divided between urban and rural participants, but 60 percent were male and 40 percent female. Overall, the median age of the survey participants was 15 years old. Nearly all of the survey participants were not heads of household and were cared for by other relatives (80 percent) or siblings (19 percent). Nearly all had siblings; 80 percent had at least one sibling younger than 18, and over half had four or more siblings.

OVCs who participated in in-depth interviews were older and more likely to be the head of household than were survey participants. The average age of those interviewed in depth was 19 in the urban site and 17.4 in the rural site. Half the rural respondents and one-third of the urban ones identified themselves as head of household.

Most of the survey respondents were still attending schools, though the percent was somewhat higher in the rural area (86 percent) than in the urban area (79 percent). More than half of OVC in-depth interview respondents had left school after their parents died.

Both the survey and in-depth interviews highlighted how OVCs struggle to meet their basic needs, particularly for food and health care. The majority of survey respondents (71 percent) reported that they do not have enough food to eat every day. Approximately one-third in both urban and rural areas said they were often hungry, while another 50 percent said they were hungry once in a while. The survey results also illustrate the need for better access to health care. Overall, 57 percent said they had been sick in the past six months. Most said they had needed to see a doctor, but more than half did not go, mainly because they did not have the money for treatment.

Reproductive health knowledge and practices

Overall, reproductive health knowledge was fairly low. Knowledge was generally higher among those older than 16 years of age compared to those who were younger, and among those who live in the urban rather than rural site. Only 12 survey respondents knew the time during the menstrual cycle when a woman is most likely to get pregnant.

Knowledge of family planning methods was somewhat better, and 59 percent of survey respondents reported that they knew how a woman could prevent pregnancy. Of those, 94 percent could name at least one method of pregnancy prevention. Most mentioned condoms (78 percent), followed by pills (51 percent) and abstinence (35 percent).

Knowledge about STIs was also fairly low, but knowledge specifically about HIV/AIDS was much higher. All survey respondents had heard of HIV/AIDS. Most (93 percent) knew you could get HIV/AIDS by having sex with an infected person, and most knew that HIV cannot be cured. Two out of three said you could avoid HIV by abstaining from sex, and half cited use of condoms.

Only 16- to 23-year-olds were asked about their sexual experiences and practices. The results indicated a fairly low level of sexual activity among this age group. Overall, 31 percent of these older survey respondents said that they had ever had sex, though this

percentage was higher among rural residents and boys. Few, however, reported having sex in the past six months. Of the 19 survey respondents who had ever had sex, eight reported ever using a condom; no one had used any other method of family planning. Almost all reported that their last sex was with a boyfriend or girlfriend, and only six reported using a condom at last sex.

More of the OVCs who participated in in-depth interview reported sexual activity. Overall, 19 of the 43 respondents (44 percent) said they had ever had sex. In this group, more urban residents reported sexual experience than did rural ones. Only three respondents reported having had more than one sexual partner in a week. Only two OVCs from the urban site and three from the rural site reported having had sex during the last three months. Very few in-depth participants reported ever receiving gifts or money in exchange for sex. Two young women in the urban site reported that they had been forced to have sex.

While the results from the survey and in-depth interviews with OVCs do not demonstrate high levels of risky sexual behavior, key informants talked about the pressing reproductive health threats facing OVCs, including sexual abuse, commercial sex work, early pregnancy, and STIs. Poverty was cited as the underlying cause of these behaviors, coupled with a lack of guidance.

Community assistance and support

Knowledge and use of community services was largely dependent on whether the respondent lived in the urban site or the rural one. In general, rural respondents were more likely to know of services available to them and to have used them. Nearly half of the rural survey respondents knew of a place that helps OVCs; REEP was mentioned most. Sixteen rural respondents had gone there for help. In contrast, only four urban survey respondents knew of a place that helps OVCs, and no one had ever gone to one.

Nearly all OVC survey respondents said there is a need for services. The three main services needed were provision of food, schools fees, and clothing. Key informants agreed that these are the three main needs of OVCs. They also mentioned the importance of providing reproductive health information and income-generating activities.

Stakeholders' workshop

Based on their experiences, stakeholders were surprised by a number of findings. First, they did not agree with the finding that a higher number of boys were sexually active than girls. Most stakeholders thought that girls were more likely than boys to be sexually active. They also believed that the level of sexual activity was actually higher than what was reported. The feeling was that most youth ages 15 to 24 are sexually active and that this activity begins at a young age. Stakeholders also expected to see higher levels of risky behaviors. They suggested that the OVC participants may not have been sincere in their responses or that they were too shy to discuss these topics with interviewers.

Finally, most stakeholders believed that more services were available in the urban centers than in rural ones, contrary to the findings. Some pointed out, however, that the urban services target the wrong people and are not well known.

CONCLUSIONS AND RECOMMENDATIONS

- Adolescent OVCs identify lack of food, school fees, and clothes as their primary needs.
- Reproductive health knowledge is fairly low, as is the level of sexual activity. For those who are sexually active, condom use is sporadic.
- The assessment does not show a high degree of risk-taking behaviors.
- These findings are contradicted by the responses of key informants and stakeholders who believe that the reproductive health needs of adolescent OVCs are a pressing issue.
- This discrepancy may be the result of a methodological weakness that omitted high risk OVCs from the sample. Additional data collection is needed to resolve this issue.

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community-based organization
COPHIA	Community-based HIV/AIDS Core, Support and Prevention Program
FHI	Family Health International
FP	Family planning
HIV	Human Immunodeficiency Disease
KNERC	Kenyatta National Hospital Ethics and Research Committee
MSF	Médécin sans Frontière
NGO	Nongovernmental organization
OVC	Orphans and Vulnerable Children
PHSC	Protection of Human Subjects Committee
REEP	Rural Education and Economic Enhancement Program
RH	Reproductive Health
ROK	Republic of Kenya
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WOWESOK	Widows and Orphans Welfare Society of Kenya

I. INTRODUCTION

More than 13 million children under 15 years of age have lost one or both parents to AIDS globally, 11 million of them being from sub-Saharan Africa. Several studies have been conducted showing that orphans whose parents have died of HIV/AIDS face a grim future and are affected by numerous problems. These children are already made vulnerable during the early stage when they have to see their parents die slowly, painfully and progressively (Republic of Kenya (ROK), 2003a). Thereafter, the death of a parent or both parents causes drastic changes in family structure, taking a heavy toll on them socially, mentally, and economically (Maende, 2002). Given the rapidly increasing number of orphans, reduced number of caregivers, and weakened families, the extended family may no longer be the safety net that it once was, although it remains the predominant source of care for orphans.

Many individuals and governments have difficulty grasping the reality of these high prevalence levels of orphans. According to Stanecki (2002), the current burden of disease, death, and orphanhood will be a significant problem in many sub-Saharan African countries for the foreseeable future. Although there have been several efforts to respond to the needs of orphans and vulnerable children (OVCs), these have focussed mainly on OVCs aged five years or less. Many organisations prefer to work with this age group since “these evoke a more compelling emotional response that facilitates fundraising” (Levine, 2001; FHI; 2001; FHI, 2000; Oyombe, 2000; Shaw and Aggleton, 2002).

Adolescent OVCs

Significant numbers of children orphaned by HIV/AIDS are now adolescents and are being taken care of by relatives in communities already impoverished due to AIDS (NAS COP, 2001). In many cases, the children themselves become responsible for the daily struggle to survive, and provide themselves sufficient food and shelter. These circumstances often do not provide the adolescents with the coping mechanisms required to go through adolescence. Children orphaned by AIDS, suffer a catalogue of deprivations and vulnerabilities, including: loss of family, depression, malnutrition, lack of access to education and health care, homelessness, loss of property, loss of inheritance, stigma and discrimination (Maende, 2002; UNICEF, 2002, Levine, 2001). In addition, adolescent OVCs in particular may end up being caregivers for younger siblings, the victims of economic and sexual abuse, and at increased risk of unplanned pregnancy or infection with sexually transmitted diseases including HIV.

Adolescent girls whose parents have died of AIDS are particularly at risk of getting infected with HIV because when economic situations are difficult, some seek the favors of a ‘sugar daddy’ (an older man who offers compensation in exchange for sexual favours), others engage in transactional sex for money or goods, and some may enter sex work (willingly or forced) to pay for school fees, or to support themselves and other members of the surviving families (UNICEF, 2002; Legarde et al., 2001). Women, and especially teenagers, find it difficult to ask men to use condoms because men are sometimes drunk and sexual matters are seldom discussed within relationships. The high age differential between these men and their adolescent female partners makes it even

more difficult to negotiate condom use. Therefore, desperate adolescent orphan girls are unlikely to successfully negotiate for safe sexual practices, placing them at great risk of infection (APHRC, 2002).

The vulnerability of adolescents who are orphaned by HIV/AIDS creates unique circumstances with far reaching consequences. Although several studies have been conducted to assess the situation of orphans and children in vulnerable circumstances especially due to HIV/AIDS, this 'lost generation' of young people have been marginalized and excluded in interventions that have been aimed at mitigating the extent of the pandemic in the community.

In March 2003, Kenya developed guidelines on orphans and other children made vulnerable by HIV/AIDS (ROK, 2003a). This marks a commitment on the part of the government of Kenya to recognize the plight of OVCs and to take steps to improve the conditions of their lives.

OVCs in Kenya

HIV started to spread in Kenya in the late 1970s or early 80s. It has since been rising to an estimated level of 15% in rural areas and as high as 35% in some urban areas. To date, the estimated number of AIDS cases in Kenya is 2 million including; 1.5 million Kenyans who have already died of AIDS, leaving behind about 1.3 million orphans under 18 years of age (NASCOP, 2001). This figure is projected to reach 1.8 million by 2005 (ROK, 2003b). Given that an estimated 700 people die daily from HIV/AIDS related complications, children are being rendered orphans at an alarming rate (ROK2003b; ROK, 2003a).

According to two Kenyan nongovernmental organizations (NGOs) working with OVCs, there is anecdotal evidence to suggest that OVCs as early as 13 get into commercial sex work in order to fend for their siblings. Others, both boys and girls, resort to early marriages so that their spouses can help bring up their siblings. OVCs have a high rate of school drop-outs and many resort to alcoholism and drug abuse to cope with their lives. Some resort to stealing in order to get the basic necessities. Rape and sexually transmitted infection (STI) infection are prevalent.

Furthermore, the NGOs report that community attitudes toward OVCs are mixed. There may be sympathy immediately after death but then they are discriminated against. Guardians often do not like it if OVCs perform better than their biological children and may kick them out so they end up having a series of guardians. Some guardians mistreat the OVCs and some see them as a source of labour. Some community members think of them as beasts of burden. Poverty contributes to these attitudes and has made community members apathetic to the plight of OVCs. Some sympathize but feel they cannot help. Without the resources to adequately take care of their own children, they do not feel that they can take care of another person's child.

At this stage very little concrete information exists as to the exact nature and impact HIV/AIDS has had on adolescents in Kenya. While there is a good deal of anecdotal

information from small studies about children affected by HIV/AIDS, there are no studies on the circumstances that adolescents who were orphaned by HIV/AIDS have to go through as they deal with the social and biological changes associated with adolescence. Therefore, there is an urgent need to determine their reproductive health needs and develop programs to help them deal with these difficult periods in the absence of their mothers and fathers.

COPHIA Project

USAID/Kenya is currently funding Pathfinder International to conduct HIV/AIDS prevention, care and support activities through its Community-based HIV/AIDS Care, Support and Prevention (COPHIA) program. Some of the activities COPHIA is involved in include: paying school fees for OVCs in formal and informal schools, providing text books and school uniforms, training older orphans in income generating activities, and holding sensitisation seminars for local leaders to solicit support for OVC. Other implementing agencies working with COPHIA use their own resources to mobilize communities for food donations which are shared among OVCs; to organise placement of OVC in “foster homes” within their local communities; and to negotiate for bursaries for OVCs with school management boards and other government facilities. Thus far, 1,900 children have benefited from this type of support.

COPHIA has home-based care as one of its core areas of activities in Western Province. Western Province has one of the highest prevalence rates of HIV in the country (in 2000, Busia stood at 28.5%, Mbale at 16% and Kakamega at 12%) (NASCOP, 2001). In Western Province COPHIA works with the Rural Education and Economic Enhancement Program (REEP) and the Widows and Orphans Welfare Society of Kenya (WOWESOK).

i) REEP

REEP is a community-based organisation (CBO) in Butula – a fairly rural town within Busia district. Their focus is on HIV/AIDS related activities. REEP has large community participation and it addresses issues such as wife inheritance, economic empowerment and support of orphaned children due to HIV/AIDS. Specific activities include educating OVCs, food distribution, vocational training and assistance to OVCs in setting up their own businesses, health care and rehabilitation, purchasing dairy animals for guardians and families willing to care for OVCs, and outreach and health education. In addition, they collaborate with the Butula Mission Hospital to run a Volunteer Counseling and Testing centre and train counselors. REEP estimates that there are 12,000 orphans in Butula Division.

ii) WOWESOK

WOWESOK is a CBO that deals with issues facing widows and orphans. WOWESOK's main activities include providing legal services, rehabilitation, home-based health care, agricultural empowerment, microeconomic training and microcredit. Their headquarters is in Nairobi but one of its district branches is in Western Province in Busia town, an urban district. In Busia, WOWESOK supports orphans using group leaders in the community and also supports primary, secondary and tertiary education of the OVCs.

Funding was provided by USAID/Kenya to conduct an assessment to provide information for developing appropriate interventions and strategies for addressing adolescent orphans' reproductive health needs. Family Health International collaborated with COPHIA and the affiliated NGOS, REEP and WOWESOK, to conduct this assessment. The information obtained will help the Ministry of Health and the COPHIA Project to include reproductive health issues faced by orphans in their OVC programming.

Study Objectives:

The overall objective was to provide information on the reproductive health (RH) needs of adolescents whose parents died of HIV/AIDS in order to inform the development of strategies to improve the reproductive health of adolescent orphans.

Sub-objectives include:

1. To assess RH outcomes among OVCs.
2. To identify and better understand determinants of these health outcomes including: RH knowledge and attitudes toward sexual and RH issues; access and barriers to RH services; and social, economic and cultural factors motivating risky sexual behavior.
3. To identify community responses to help adolescent orphans cope with RH challenges.
4. To use the information obtained to identify the gaps in these responses and to develop policies and strategies for responding to the reproductive health needs of orphaned adolescents.

II. METHODOLOGY

This assessment worked with two local CBOs, REEP and WOWESOK, who were already providing services to OVCs in Western Kenya. The CBOs helped identify OVCs and other key informants. The assessment made use of rapid assessment techniques and data were collected through a survey with OVCs; in-depth interviews with OVCs, and in-depth interviews with key informants. After the data were collected they were analysed and the results presented back to community leaders and other stakeholders who participated in a data interpretation workshop. This triangulation of methods 1) increases the validity and reliability of findings; 2) deepens our understanding of the social and behavioural dynamics of reproductive health among adolescents who have been orphaned by HIV/AIDS; and 3) lays groundwork for subsequent intervention development and evaluation.

1. Target Population

The target population was individuals who could provide information to help understand the RH needs of OVCs and the services available to them. For the purposes of this assessment, an orphan was defined as someone who has lost both their mother and father with at least one of the deaths resulting from HIV/AIDS infection. OVCs, both girls and boys, between the ages of 13-23 were included in different components of the

assessment. OVCs interviewed included those who are heads of households and those who currently have a caretaker or guardian. Key informants included guardians, teachers, religious leaders, CBO staff, service providers and others as identified. The assessment took place in Western Province, in Butula, a rural town within Busia district, and in Busia town, which is urban.

2. Study Methods

The assessment was composed of four main components which are described below:

Survey: A household survey was carried out among households with adolescents whose parent(s) died due to HIV/AIDS. OVCs between the ages of 13-23 were included. This was not a population-based random household survey, but rather, identification of houses was made through REEP and WOWESOK. If more than one OVC was living in the household, the individual to be interviewed was selected randomly.

In-depth interviews with OVCs: In-depth interviews were conducted with older OVCs between the ages of 16 and 23. OVCs in this age group living in households selected for the household survey but not selected for the survey itself were asked if they would like to participate in an in-depth interview at a later time.

In-depth interviews with key informants: In-depth interviews were carried out with adult key informants such as guardians in households selected for the survey, teachers, individuals working with OVCs through community-based organizations, village elders, religious leaders and service providers.

Data interpretation workshop: A data interpretation workshop was conducted on April 19, 2005 in western Kenya to present the results back to the community. The workshop was used as an opportunity to get feedback from stakeholders and community leaders as to whether the findings seemed logical. The participants were able to provide additional insights and to make comments and suggestions. The results of this workshop are integrated into the discussion section.

3. Sample size

A summary of the targeted and actual sample sizes are found in the table below:

Method	Targeted Sample	Number per subgroup	Total	Actual numbers
Survey	Boys and girls Urban and rural	30	120	131
OVC in-depth interviews	Boys and girls Urban and rural Head of HH or with guardian	5	40	43
Key informants interviews	Service providers, teachers & other interested adults Urban and rural	10	40	40
	Guardians urban and rural	15	30	30

4. Data Collection

Prior to the initiation of data collection, a series of meetings were conducted to sensitize key leaders in the province and district. The entry point to the community was first through the medical provincial head in charge of health matters within Western Province. Thereafter, the research team met with the district health officer and administrative officials within Busia district. After these visits, there were visits to community leaders in Busia and Butula including to chiefs and village elders.

Field work took place from 5th July 2004 to 27th August 2004. The study team worked closely with the collaborating NGOs to identify field workers to carry out the assessment activities. Two supervisors were identified to oversee day to day operations. There were two teams, one for the urban site and one for the rural site. Each team had 4 field workers (2 men and 2 women) aged between 21 and 34 years.

Experts in the data collection techniques trained the field workers for five days. The training took place between 28th June 2004 to 2nd July 2004. Aside from administration of the survey and in-depth interview instruments, training emphasized ethical issues and included completion of the FHI ethics curriculum. Specific areas covered in the training were administration of informed consent, understanding of social adverse events and how to report them, and administration of referrals to trained counselors (more details on these issues can be found in the section on ethical considerations). The survey and in-depth interviews with OVCs were pretested during the training.

In addition, a trained social worker participated in the training to ensure that interviewers respond appropriately to responses that may occur as a result of the questions, in particular during the OVC in-depth information. The social worker also reviewed transcripts during the pretest and between interview sessions to give feedback to interviewers. Interviewers were also given a chance to discuss their own feelings about what they heard in the interviews. This was done to provide emotional support to the interviewers and to make sure their feelings were not affecting the quality of the interviews. The social worker was also available during data collection to assist with any OVC participant who might become traumatized during the interviews.

5. Data entry and analysis

Quantitative data was entered using EpiInfo version 6.0 software. The data entry screens were pretested to make sure that the error checks were functioning properly. In addition, to minimize the possibility of data entry errors, a subset of records was entered a second time to check for data entry accuracy. SPSS software package was used for analysis. Analysis was primarily descriptive. Although the subgroups were small, the data was analysed separately to look at differences in boys and girls and urban and rural sites. Results are presented as percents except in cases with small sample sizes. When the sample size is less than 20, only real numbers are presented.

Qualitative data was transcribed, translated, and typed in MSWord. Coding and analysis was carried out in NUDIST on the translated text. Codes were developed with the

analysis team. Summaries of coded data were prepared by data analysis staff in a narrative format, organized according to the topic areas of inquiry.

6. Ethical considerations and informed consent

This study was reviewed and approved by the Protection of Human Subjects Committee (PHSC) at Family Health International (FHI) protection of human subjects and the Kenyatta National Hospital Ethics and Research Committee (KNERC).

Informed Consent

Informed consent was administered to all study participants. Because not all of the OVCs knew that their parents died of AIDS, the informed consent did not make reference to the fact that this assessment is to develop interventions specifically for children whose parents died of AIDS. Instead it was stated in a more generic way that the purpose of the assessment was to collect information from children whose parents have died in order to improve their health care service delivery. Written consent was requested, however, because of the stigma associated with being an OVC, codes were used in place of signatures. For OVCs under age 16, parental consent was obtained from adult guardians or a head of household over the age of 21. If, however, the head of household was less than 21 years old, a child advocate was available as part of the survey team to advise on the suitability of enrolling the child into the study.

Social Adverse Risks

It was expected that some OVCs would become upset or cry during the interview or become traumatized in remembering or discussing events that occurred during their parents' illness until their death or with respect to their current living situation. A social worker was identified at each of the study sites, Butula Mission Hospital and Busia District Hospital for Butula and Busia respectively, who the OVCs could be referred to for counseling and support. Furthermore, a social worker was nearby during the in-depth interviews to be able to step in if necessary during the interview. The interviewers also learned the signs to look for during an interview that might signify that counselor intervention is necessary. The FHI study staff worked closely with the NGOs and the field workers to report immediately any Social Risk Event. Six social risk event forms were submitted to FHI's PHSC. In all cases, study OVCs cried during the interviews as a result of the questions; all were referred as appropriate.

Other ethical issues

Throughout this assessment, an emphasis was placed in privacy and confidentiality. All data was collected in a private setting. Participants were assigned a research number that was used in lieu of their names as an identifier for their materials. Participants were not identified by name on any study documentation sent to FHI. All research material are maintained in a locked cabinet with access only by study staff, on an as needed basis.

No compensation was provided for survey participants since the interviews took place in or nearby their houses. However, a transport allowance of Ksh 100 was given to key informants and others participating in the in-depth interviews. Finally, fieldworkers had information on services available to OVCs that they could give to the participants.

Fieldworkers did not provide counseling to OVCs on issues that arose during the interviews, such as family planning information or legal advice. But they had information on available services that the OVCs and their guardians could use.

7. Problems/challenges encountered:

The three main challenges to conducting the fieldwork were as follows:

- Some orphans whose names appeared in the household lists were not within households during the times when the fieldworkers visited the households. Often the field workers found that they had moved to other places, mainly to stay with relatives.
- A few guardians felt that it was not necessary for the study team to interview OVCs under their care because they thought that the OVCs did not have any problems.
- Butula division (the rural site of the study) is too vast. Fieldworkers had to travel long distances in order to get to locations where some of the households with orphans had been listed.

III. RESULTS

The results are divided into four sections. The first section examines the sociodemographic and household characteristics of the assessment participants. It then looks in more detail at specific characteristics of OVC participants including education, food status, health care needs and job status. The second section concentrates on the reproductive health knowledge and practices of OVCs, including their sexual activity and access to reproductive health services and support. This is followed by an assessment of the impact of OVCs on family life including on the guardians who are taking care of them. It also examines the needs of OVCs, community assistance available to OVCs and guardians and an assessment of the future. The final section summarizes the discussions of the stakeholder data interpretation workshop. It discusses assessment as they related to stakeholders' opinions and experiences.

1. Sociodemographic and Household Characteristics

Sociodemographic Characteristics-survey respondents

Table 1 shows that the survey population is more or less evenly split between urban and rural residents in accordance with the study design. In terms of age, the population is evenly split between younger (13-15) and older (16-23) age groups. It should be noted, however, that most respondents within the 16-23 year old age group were at the younger end of the age range, and the median age for this group was 17.0. The median age for the entire survey population is 15.0. In the urban areas, the population is also evenly split between males and females though in the rural area there are twice as many males as females.

Table 1. Sociodemographic characteristics of OVC survey respondents			
Characteristics	Urban	Rural	Total
	(N=66)	(N=65)	(N=131)
	%	%	%
Age			
13 – 15	55	52	53
16 – 23	45	48	47
Median: 13 – 15	15.0	14.0	14.0
Median: 16 – 23	17.0	16.0	17.0
Median: Overall	15.0	15.0	15.0
Sex			
Male	52	68	60
Female	48	32	40
Marital status-single	100	100	100
Religion			
Catholic	52	40	46
Protestant	45	57	51
Other/ no response	4	4	4
Average number of siblings	4.0	3.2	3.6
One or more siblings under 18 years of age	76	85	80
Siblings living in this household	21	15	24
Of the siblings not living in this household, where are they living ?	(N=47)	(N=44)	(N=91)
In Own Household	0	12	6
With other relative	26	15	30
With other friend	2	2	2
In different places	62	57	59

None of the respondents were married. Nearly all of the survey respondents are either Catholic or Protestant. There are, however, slightly more Catholics in the urban sites and more Protestants in the rural ones.

Most of the respondents have siblings and 80% have at least one sibling who is aged 18 or younger. The average number of siblings is 4.0 in the urban site and 3.2 in the rural one. However, only one-fourth have siblings living in the same household as the survey respondent. Of those not in the same household, the majority (59%) report that their siblings are in different places while 30% report they are with other relatives.

Household Status

Only two respondents reported that they are the head of their house hold (Table 2). For 80%, a relative was the head of household whereas most of the rest named a sibling as the head. Even if they are not head of household, 28% provide some care for their siblings though more rural respondents reported that they provide care than urban ones. Care was given mostly by providing or washing clothes or in helping provide and prepare food.

Table 2. Household status of OVC survey respondents						
Characteristics	Urban (N=66)		Rural (N=65)		Total (N=131)	
	N	%	N	%	N	%
Head of household						
Self	2	3	0	0	2	2
Sibling	14	21	11	17	25	19
Other Relative	50	78	53	82	103	80
Other	0	0	1	2	1	1
Provide care for siblings	8	12	29	45	37	28
Type of care provided (of those providing care) <i>(more than one response per participant is possible)</i>	(N=8)		(N=29)		(N=37)	
Prepare/Provide food	6		16	55	22	60
Provide/Wash clothes	5		23	79	28	76
Take care of educational needs	2		8	28	10	27
Giving advice/Guidance	1		8	28	9	24
Number of households lived in since parents died						
0	0	0	2	3	2	2
1	18	27	37	57	55	42
More than 1	48	73	26	40	74	56

Other ways they helped was by taking care of educational needs or by giving advice/guidance. Only two respondents did not move to another household after their parents died. Urban residents more often moved to more than one household after their parents died. Rural residents more often moved to just one household though 40% moved to more than one.

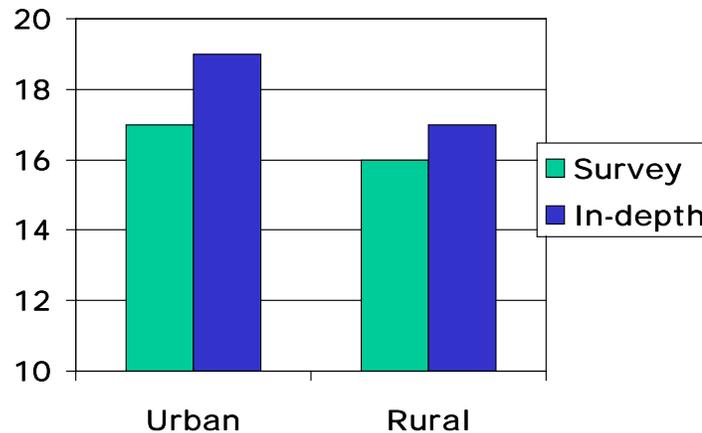
Sociodemographic Characteristics-in-depth interview participants

Table 3 shows basic characteristics about the participants in the in-depth interviews; OVCs aged 16-23, key informants and guardians. Altogether, 20 female and 23 male OVCs participated in these interviews. Only one male in the urban site, and one male and one female in the rural site were married. Nearly all the in-depth participants had siblings, with a range of from 1 to 7. The average was 4.1 siblings in the urban site and 3.0 in the rural site. In the urban site, more than one-third identified themselves as the guardian or head of household (sometimes in combination with another relative) while the rest identified a sibling or other relative as the head. In the rural site, half the respondents were head of household.

Table 3 Sociodemographic characteristics of in-depth interview participants		
Characteristics	Urban	Rural
OVC's	(N=21)	(N=22)
Sex		
Male	11	12
Female	10	10
Marital status		
Married	1	2
Not Married	20	20
Average number of siblings	4.1	3.0
Is head of household	8	11
Average age	19.0	17.4
Key Informants	(N=20)	(N=20)
Sex		
Male	8	15
Female	12	2
Age		
25 – 39	12	6
40 – 57	8	14
Marital status		
Married	17	16
Not Married/Single/no response	3	4
Profession		
NGO/CBO	5	5
Teacher	7	8
Health Care worker	7	6
Other	1	1
Guardians	(N=7)	(N=13)
Sex		
Male	1	6
Female	6	7
Age		
20 – 29	1	0
30 – 49	3	5
50 and over	3	8
Marital Status		
Married	5	6
Not Married/Single	1	0
Widow	1	7
Average number children cared for	9.3	8.8
Average number biological children	3.6	4.9
Average number OVC's	5.7	3.8

The age range was between 16 to 23 with an average age of 19.0 years in the urban site and 17.4 years in the rural one. While the in-depth OVCs are the same age range as the older survey group, the groups are not exactly comparable. Figure 1 shows that both the in-depth urban and rural participants have a higher median age than the equivalent survey rural and urban groups.

Figure 1: Median age of 16-23 year old survey participants and in-depth respondents by urban/rural status



The key informants were a group of professional men and women in the communities of Busia and Butula who worked with OVCs or who had knowledge of OVC issues. They ranged in age from 25 to 57 and most were married. The overwhelming majority were teachers, health care providers or administrators in nongovernmental organizations (NGOs)/community-based organizations (CBOs).

The guardians who participated in in-depth interviews in the urban site were nearly all females while those interviewed in the rural site were about half female and half male. The age range of the guardians was from 21 to approximately 80 though more than half were over age 50. Only one guardian was single and the rest were married or widowed. More guardians in the rural site were widowed and aged 50 or over compared to guardians in the urban site. The number of total children in these households ranged from 4 to 20; with an average of 9.3 children in the urban households and 8.8 children in the rural households. Guardians took care of between one to 16 orphans. All of the orphaned children came to these households from the families of relatives; none were from friends' families. Nearly all of the guardians had biological children in addition to orphaned children in their households.

Education

Most of the survey respondents were still attending school, with the percent somewhat higher in the rural area (86%) compared to the urban site (79%) (Table 4). While these percents are high, they may be at least partly explained by the fact that the median age of the group is so low, i.e. 15.0. In both the urban and rural sites, a higher percentage of

boys were currently attending than girls (85% vs. 72% urban and 91% vs. 76% rural; data not shown). The majority are in primary school though the urban site has more respondents who have gone on to secondary school; 14 compared to 4 in the rural site. Sixteen respondents; nine girls and seven boys, reported that they stopped their schooling before completion with the main reason being that they lacked school fees. Nearly all the respondents believe it is important to complete their education. The three main reasons why they felt this is in order to get a job for the future (66%), help other family members (48%) and to be able to be independent (38%). While a high percent of the respondents themselves were still in school, fewer of their siblings under the age of 18 were still in school. This may be the result of having older siblings under the age of 18 who are head of household and not able to continue with their education. Overall, 67% reported that all of their siblings under age 18 were still in school while the rest reported that they had some siblings or no siblings under age 18 still in school. Respondents in the rural site more often reported that all their siblings were still in school compared to the urban respondents.

Table 4: Education status of OVC survey respondents						
Characteristics	Urban (N=66)		Rural (N=65)		Total (N=131)	
	N	%	N	%	N	%
Currently Attending School	52	79	56	86	108	82
Highest level of education						
None	2	3	0	0	2	2
Primary	50	76	61	94	111	85
Secondary	14	21	4	6	18	14
Education status (of those currently not in school)	(N=14)		(N=9)		(N=23)	
Completed	4		1		5	22
Stopped before completion	8		8		16	26
No response	2		0		2	8
Why did you stop before completing your education?						
Nobody was interested in seeing me go to school	2		0		2	9
Lack of school fees	7		7		14	61
Lack of books/School uniform	1		1		2	9
Do you think it is important to complete your education?	64	97	64	98	128	98
Why do you think it is important to complete your education? (more than one response per participant is possible)						
Get a job in the future	41	62	45	69	86	66
Help other family members	34	52	29	45	63	48
Be able to be independent	22	33	18	28	40	31
Of your siblings under 18, how many are in school?	(N=50)		(N=55)		(N=105)	
All siblings under 18 are still in school	30	60	40	73	70	67
Some siblings under 18 are still in school	3	6	4	7	7	7
No siblings under 18 are still in school	17	34	10	18	27	26
Don't know	0	0	1	2	1	1

In contrast, for OVCs in the urban sites who participated in the in-depth interviews, the death of the parents had profound implications for the participants' ability to remain in school. More than half said they had to stop when their parents died and only three said their deaths did not impact their education. The difference with the survey respondents should not be surprising since the in-depth participants were on average older than the survey respondents and more likely to be head of household and taking care of younger siblings.

In contrast, most of their siblings were able to continue in school and only two participants reported they had siblings who had to stop their education. As noted by one female participant, *"If my parents were alive I would not have been this way. Because in primary I passed very well and was supposed to go to a provincial school. But now I ended up in a district school. And then even after my form four, I would be doing something, but now due to lack of fees..."* (Busia, female, 20). A young man explained how caring for his siblings meant that he could not go to school. *"It has really changed... the work I am doing is very hard. When my mother was there, I wasn't doing this work. I was going to school. If there was someone who could take care of these children, I would go back to school."* (Busia, male, 22)

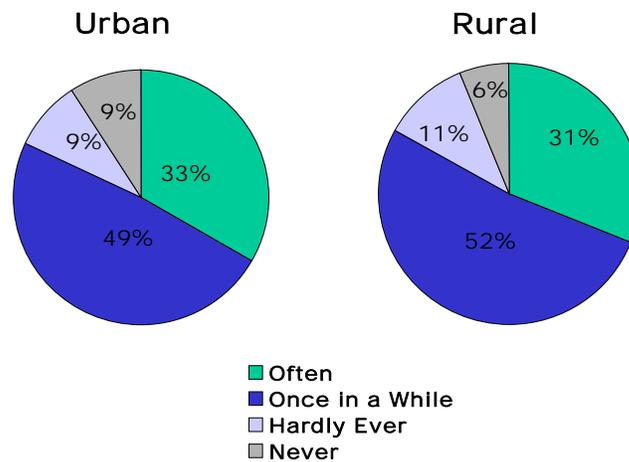
The situation was somewhat different in the rural site where half of the participants were either in school or able to return to school because of assistance from REEP. Only a few stopped and were not able to go back. Similarly, most of their siblings were able to remain in school.

While not borne out from the data from the sample in this assessment, one of the key informants who is a teacher suggested that boy OVCs are more likely to be able to continue their education compared to girls. *"...you will find guardians would like to educate more of the boys than girls. So they feel once an orphan girl has reached class eight, that is the end of education but the boy can continue because he knows the girl will get married and then the boy will say with him."* (Butula, male, teacher) A social worker agreed that girl OVCs are less likely to be educated. *"Girls are treated very differently from boys. First of all, even relatives would rather support a boy by taking him to school while they make the girl work at home to fend for the boy who is in school..."* (Butula, female, social worker/NGO administrator)

Food and Health Care

Both the survey and in-depth interviews highlighted the struggles that OVCs have to meet their basic needs, e.g. as food and health care. The majority (71%) of survey respondents reported that they do not have enough food to eat everyday with this problem somewhat more acute in the rural site (75%) than the urban one (67%) (Figure 2). Approximately one-third in both sites say they are hungry often with another 50% reporting they are hungry once in a while.

Figure 2: How Often Are You Hungry?
OVC survey respondents, age 13-23 years



Nearly all of the OVC in-depth participants said there were times when they did not have enough to eat. In order to get food most either worked or relied on assistance from others, in the case of the rural participants many went to REEP. This is often a time that makes the participants think of their parents since they feel that if their parents were alive there would be enough food. Many said that this situation makes them feel “*bad*” or “*sad*.” Yet many still maintain a positive attitude and stated how they still persevere or how the lack of food gives them strength to work harder at a job or in school. In the words of a 17 year old young man, “*that is what makes me think a lot. I start asking myself, why did my mother give birth to me to have struggles in this world.*” (Busia, male, 17) Another young man talked about the impact of a lack of food on his younger siblings, “*There is no food and the children need to eat. They just cry... because they are small children... I feel bad, so I go to get food on credit for them. I bring it for them and then they eat.*” (Busia, male, 22)

The survey also illustrates the need for better access to health care for OVCs (Table 5). Overall 57% said they had been sick in the past six months. Most felt they needed to see a doctor but more than half did not go, mainly because they did not have the money for treatment. More respondents in the rural reported this problem than in the urban site.

	Urban (N=66)		Rural (N=65)		Total (N=131)	
	N	%	N	%	N	%
Was sick in past 6 months	37	56	38	58	75	57
	(N=37)		(N=38)		(N=75)	
Thought needed to see a doctor	30	81	30	79	60	80
Went to the doctor	19	51	14	37	33	44
Main reasons why did NOT see a doctor	(N=18)		(N=24)		(N=42)	
Did not have money for treatment	9		19	79	28	67
Was given some herbs at home by Grandma	2		1	4	3	7
Was not very sick so found no need to go	2		4	17	6	14

Employment and Job Training

About half of the urban and two-thirds of the rural participants in the in-depth interviews said that they were employed. Most did work such as digging, or other work to help out on farms. Some did boda boda work (taxis using bicycles) and others were in some type of sales work.

About half of the urban participants and one-quarter of the rural ones said that they had been taken advantage of and not paid what they were owed for a particular job. Examples of how OVCs are taken advantage of were described by two of the male indepth participants from Butula. *“I have worked for people who then did not pay me. When I have followed up the money, some have refused to pay me or I disagree with others. Or we can agree on a certain amount of money, and then they pay me much less than the agreed amount. This really hurts me.”* (Butula, male, 23) *“[Sometimes] the money we agree with is what is given though there are times we have to work morning to sunset but when we go for our dues, one says he doesn’t have the money till the following day, but when we go, he comes very harsh even wanting to beat us.”* (Butula, male, 18)

Almost all of the survey and in-depth interview OVC participants said that they would like training for a job or income generating activity. Teaching, mechanic skills and driving skills were the ones mentioned most often by survey participants (Table 6). Some in-depth interview participants reported that they had already taken advantage of training opportunities in either computers or tailoring. Others said there was training available at the polytechnic but they would have to pay for that and they couldn’t. Almost all the in-depth participants said they had a vision of their dream job-- Some just wanted any job that would pay well or any job that they could get . Several had high level aspirations like to be a doctor or lawyer. Others had very practical dreams. Some just wanted to be able to work in the field they had already trained or started to train in-- such as teaching or car repair. Teaching, tailoring and repair work were the jobs that were mentioned most often. Several specifically said they wanted to do something to help those with AIDS or families like themselves.

Table 6: Job training interests of OVC survey respondents			
	Urban (N=66)	Rural (N=65)	Total (N=131)
	%	%	%
Interested in a programme to learn job skills	100	100	100%
What skills would you like to learn <i>(more than one response per participant is possible)</i>			
Lecturer/Teaching	44	37	40
Driving	23	22	22
Mechanic skills	15	32	24
Engineering	5	9	7
Doctor/Medical Practitioner	20	34	27
Tailoring skills	23	15	19
Policeman/Policewoman	14	3	8
Nurse	27	5	16
Computer skills	6	11	8
Other *	51	38	44
*Other includes manager, carpenter, electrician, pilot, sales, accountant, researcher, law, broadcasting, journalism, welding, swimming, music, consultant, soldier, masonry, scientist, secretary, social work, etc.			

2. Reproductive Health Knowledge and Practices

Reproductive Health Knowledge

Overall, reproductive health knowledge was fairly low. Less than two-thirds of survey participants reported they knew how a woman gets pregnant though nearly all these respondents had the correct information (Table 7). Knowledge was somewhat higher in the urban site than the rural one, and more respondents in the older age group than the younger group had the correct knowledge (data not shown). Far fewer knew the time during the menstrual cycle when a woman is most likely to get pregnant. Only 36% overall reported they knew this information though when asked to name the time of the cycle, most had the incorrect response. Only five respondents in the urban area and seven in the rural one had the correct information.

Table 7: Reproductive health knowledge of OVC survey respondents			
	Urban (N=66)	Rural (N=65)	Total (N=131)
	%	%	%
Knows how a woman gets pregnant	68	54	61
How does a woman get pregnant?	(N=45)	(N=35)	(N=80)
Correct response	98	91	95
Correctly knows what time during a woman's cycle she is most likely to get pregnant	11	20	15
Knows how a woman can prevent pregnancy	67	51	59
FP methods named (<i>more than one response possible</i>)	(N=44)	(N=33)	(N=77)
Knows at least one method	93	94	94
Male Condom	84	70	78
Female Condom	23	6	16
Pills	43	61	51
Injectables	11	15	13
Abstinence	25	48	35
Approves of unmarried youth using fp methods (asked of 16-23 year olds only)	(N=30)	(N=31)	(N=61)
	67	48	57
Able to name at least one STI (<i>more than one response per participant is possible</i>)	88	88	88
HIV/AIDS	82	86	84
Syphilis	35	25	30
Gonorrhea	42	26	34
Says can have an STI without having symptoms	55	72	63
What should someone do if they think they have an STI (asked of 16-23 year olds only)	(N=30)	(N=31)	(N=61)
Go to doctor for treatment	90	77	84
Abstain from sex	17	19	18
Go for herbal treatment	3	10	7
Eat nutritious food	20	16	18
Guidance and counseling	13	23	18
Other	7	13	10
Ever heard of HIV/AIDS	100	100	100
How does one get HIV (<i>more than one response per participant is possible</i>)			
Through sex with an infected person	91	95	93
Using unsterilized instruments	50	63	56
Blood contact	36	29	33
Kissing	14	11	12
Breastfeeding/during delivery	17	6	11
Don't know	5	3	4
Believes HIV cannot be cured	98	97	97

Knowledge of family planning methods was similarly low among survey respondents. Fifty-nine percent said they knew how a woman could prevent a pregnancy. Knowledge was greater in the older age group and in the rural area, boys were far more like than girls to say they knew how (data not shown). Of those who said they knew how to prevent pregnancy, 94% could name at least one method of pregnancy prevention. The most frequently mentioned were condoms (78%) followed by pills (51%), abstinence (35%) and natural family planning (26%). There are many (38%) who do not approve of unmarried youth using family planning, though rural youth thought this more often than urban youth (asked only to 16-23 year olds).

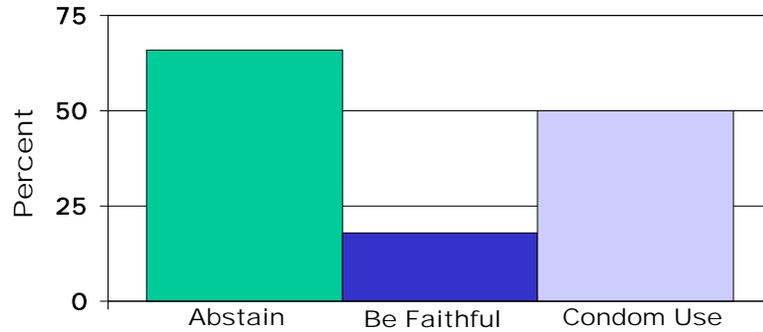
Most of the in-depth interview participants had some knowledge of family planning methods and could name at least one method; condoms were also the method most commonly known. More than half said they knew where they could purchase them with hospitals, chemists, shops and clinics being the most named sites. Only two in-depth participants had negative comments about condoms with one saying they are a sin and the other saying they didn't trust them.

Knowledge about STIs was also fairly low, though knowledge specifically about HIV/AIDS was much better. Most survey respondents were able to name at least one STI. The one named most frequently was HIV/AIDS (84%) followed by gonorrhea (34%) and syphilis (30%). More than half (56%) knew that someone could have an STI without having symptoms though more in the rural site knew this (63%) compared to the urban one (48%). Most respondents (84%) knew that if someone thought they had an STI, that they should go see a doctor for treatment (asked of the 16-23 year olds only).

When asked specifically if they had ever heard of HIV/AIDS, all survey respondents reported that they had; in-depth participants were not asked this question. Virtually all survey respondents knew you could get HIV/AIDS by having sex with an infected person (93%). Other ways to get infected that were named were through use of unsterilized instruments (56%) and blood contact (33%). Respondents also, however, had a number of misconceptions and many incorrect ways to get infected were also named such as through kissing.

Nearly all survey respondents knew that HIV cannot be cured. Knowledge was also good in ways to prevent infection (Figure 3). Two-thirds said that HIV could be prevented by abstaining from sex and half said through the use of condoms. One-fourth said you could avoid HIV infection through sterilized instruments and 18% by being faithful to an uninfected partner. Similarly, most in-depth participants indicated they knew that as least some STIs could be treated and no one said they thought that AIDS could be cured.

Figure 3: Knowing the ABCs:
Preventing HIV Infection
OVC survey respondents, age 13-23 years



Sexual Relations

The results indicate a fairly low level of sexual activity among the 16-23 year olds in both the survey and in-depth OVC participants. One-third of both the urban and rural survey respondents, age 16-23, reported that they had a boyfriend or girlfriend (Table 8). Girls and boys had partners in about equal numbers. Overall, 31% of survey respondents reported that they had ever had sex but more rural than urban residents and more boys than girls (13 boys vs. 6 girls) reported sexual experience.

Table 8: Sexual relations and family planning use among 16-23 year old OVC survey respondents						
Characteristics	Urban (N=30)		Rural (N=31)		Total (N=61)	
	N	%	N	%	N	%
Has a boyfriend/girlfriend	10	33	10	32	20	33
Has ever had sex	5	17	14		19	
	(N=5)		(N=14)		(N=19)	
Had sex in the past 6 months	4		3		7	
Ever used a condom	5		3		8	
Ever used other FP methods	0		0		0	
Last type of partner						
Boyfriend/Girlfriend	5		12		17	
Casual friend	0		2		2	
Condom use at last sex	3		3		6	
Worried about getting pregnant/ making someone pregnant at last sex	3		6		9	
Worried about getting STI/HIV at last sex	2		4		6	
	(N=30)		(N=31)		(N=61)	
Knows where to get FP methods	25	83	17		42	69
Where can FP methods be obtained?(more than one response per participant is possible)	(N=25)		(N=17)		(N=42)	
Public facility	25	100	14		39	93
Private facility	11	44	6		17	40
Chemist	6	24	1		7	17
Other (<i>Herbalist, NGO,shops, friends, schools</i>)	8	32	5		13	31

Few of those survey respondents who had ever had sex reported having sex in the past six months. Of the 19 who have ever had sex, eight reported ever using a condom. No one used any other method of family planning. Almost all reported that their last sex was with a boyfriend or girlfriend and only six reported using a condom at last sex.

More in-depth OVCs reported sexually activity than survey respondents. Overall, 19 of the 43 respondents, 44%, said they had ever had sex. In contrast to the survey, more urban than rural residents reported they had had sex (12 urban vs. 7 rural), though like the survey, a few more boys than girls reported sexual experience (11 boys vs. 8 girls).

Among the in-depth participants, in the urban area, only two had had sex within the last 3 months. The most recent partner was more likely to be a boyfriend or girlfriend, rather than a casual partner. Only one respondent, a young woman, reported that she had ever had more than one partner in a week.

In the rural areas, only three respondents reported sexual activity within the last three months and similar to the urban site, the last partner was more likely to be a boyfriend or girlfriend than a casual partner. One young man and one young woman reported having had more than one sexual partner in a week.

Very few in-depth participants reported ever receiving gifts or money in exchange for sex. A few noted that men had offered them things but that they always refused. Similarly, few reported ever having been pressured to have sex. Two young women in the urban site reported that they had been forced to have sex. Far more reported stories of others that they knew who had been forced or raped. Not all of these stories involved OVCs, but many of them did. Also, some of these stories involved rape, but some of them used force in the sense of a girl being forced by circumstances, not physically forced, to have sex.

Three of the female in-depth respondents stated that they had been pregnant before and an equal number of male respondents said they had gotten a girl pregnant. Of the survey respondents who have had sex, nine of the nineteen say they worried about getting pregnant or making someone pregnant the last time they had sex (Table 8) while ten in-depth respondents expressed similar concerns.

More than half of the in-depth respondents say they worry about getting an STI or HIV while just six of the 19 survey respondents who have had sex say that they worry (Table 8). Two young women who worry explained why. *“Yes, because I have seen so many people dying. I know that even me, I can also get it.”* (Busia, female, 19) *“Yes, I used to fear at times because I had very many partners at one time. So I had fear. You couldn’t know how this people were or where they had been. So many times I used to get worried of getting AIDS or STIs.”* (Busia, female 19) A few who said that they were not worried said it’s because they are practicing safe behaviors, such as abstaining, only having one partner or using condoms. Some of those who said they were worried had never had sex such as this young woman who said, *“No. Because I have learnt to abstain from sex until the right time.”* (Busia, female, 23)

While the results from these survey and in-depth participants do not demonstrate high levels of risky sexual behavior, in-depth interviews with key informants, and to a lesser extent guardians and OVCs, suggest that this is a potential problem among at least a segment of the OVC population.

Nearly all key informants talk about the pressing reproductive health needs of OVCs including sex abuse, commercial sex work, early pregnancy and STIs. Poverty is given as the underlying cause of these behaviors coupled by a lack of guidance. As one guardian put it, these risks occur if a guardian is not *“keen”*

Risky sexual behaviors can be a function of either exploitation or of lack of alternatives. One key informant talked in particular about the hardship on girl OVCS. *“...Thirdly the girl child is used as a beast of burden. Once she is orphaned you will find that someone*

wants to keep her as a house girl, to look after the children or to do farming. The girl child is treated worse. When it comes to the age of onset of sex, we have cases of girls who have had sex as early as age eight.” (Butula, female, social worker/NGO administrator). One OVC also described how circumstances can force girl OVCs into risky relationships. “You will find that many girls who are orphans and who have no choice go looking for sugar daddies. These sugar daddies have sex with them everywhere.” (Busia, female, 17)

Reproductive health services and support

The majority (69%) of survey respondents knew where to get a family planning method, though this was known more by urban survey respondents than rural respondents (Table 8). In both regions, public facilities were named most often followed by private facilities and other places such as shops, friends, herbalists and NGOs.

Many of the in-depth OVC respondents said they were comfortable going to buy condoms, but there were several who said they were too shy or were not comfortable in buying them. A few indicated that while they had not yet used condoms, they might when they were married.

While the OVCs were not asked specifically about access to STI treatment services, one key informant pointed out the difficulties OVCs might face if they need these services. “Another thing is that they may not know even where to turn in case they get STIs. They would have an STI and no finances. These are maybe guardians who are very harsh and therefore approaching this parent who is very harsh to tell them that they have STIs becomes and difficult thing and this child has never been taught how to access hospital services and also when they go to the hospital, the hospital staff are not friendly, you see.” (Busia, female, social worker/nurse)

In terms of personal support, if an OVC wanted someone to talk to about sexual issues, nine of the in-depth participants in the urban area said they had someone, generally a friend. When asked if there were places they could go in the community for help, about half named a place; usually a church, police station or village elders. Fewer rural residents (six) reported they had someone to talk to; these respondents talk to friends or teachers. Half named a place to go to for help, REEP the police, the village chief or hospital.

3. Impact on the Families

The death of parents has an impact both on their children as well as on the guardians and families who become responsible for them. About 80% of the guardians felt that they had no choice but to take their orphaned relatives into their home. This lack of choice was generally related to feeling a sense of responsibility for the children, feeling that there were no other family members who could properly care for them and wanting what’s best for the children.

Almost all of the guardians reported that the addition of orphaned children into their household had an impact on them. Most have difficulties with stretching their income to

meet household needs. The biggest problems cited were paying for food, school fees, health care and clothes. Many did not complain about their difficulties. As some said, they had no choice but to take in the children, these children were their family or they couldn't let the children suffer. As one guardian stated, *"the life is just like that, the way we survive with whatever small we get."* Nonetheless, some did admit that life was *"hard"*, a *"burden"* or a *"struggle."* Three guardians even reported that it led to them having health problems such as being stressed, losing weight, not being able to sleep or increased blood pressure.

In terms of the effect on their biological children, there did not seem to be many reported difficulties in terms of the relationship between the two groups of children. Instead, many reported that the children were all like brothers or sisters. As stated rather poignantly by one guardian, *"I put all of them together and told them that they are their brothers and sisters and they should love each other and they have lived in love and they call each other brothers and sisters."* Rather the problem for the biological children was that the family income was stretched among more people and therefore the biological children had less in terms of food, clothes and/or school options than they would have had without the additional household members. As one guardian reported, *"I had already planned for the family I could take care of. With the addition of these other children, it has become a heavy burden for me."*

Life for the children who are orphaned changes even more dramatically, almost always for the worse. Becoming orphaned affects whether or not siblings get to remain together in the same household, their standard of living and their happiness.

Several OVCs explained how their life changed after their parents died:

"It has changed a lot. When my parents were alive, we were very happy. I never used to cry all the time, because of not having one thing or the other. But nowadays, the children look up to me. Life has really changed. Things are not as they were before..." (Busia, female, 17)

"When our parents were there, we didn't lack food. They ensured we had food. When we were sick they took us to hospital. They also ensured that we had clothing. But right now, when we lack clothing, there is no one to provide. When sick, no one cares. Our parents gave us love." (Busia, female 18)

"We didn't stay as a family. We stay apart. After they died, we had to part. Everyone is on their own. We never meet. We are just apart. I just miss my parents. There are some things I feel like talking about and I wish my parents were there so that I could tell them because they are my parents." (Busia, female, 20)

"...[If my parents hadn't died] I would not have married because I think I am still young." (Butula, male, 23)

Two OVCs described how relatives and neighbors took away their parents' possessions after they died leaving them further impoverished. Two key informants further explain

the impact of poverty on risky behaviors:

“when our parents died our relatives came and took away some of the property like household things and left us with what we have now...” (Busia, male, 18)

“[when my mom dies] there was some confusion. Some people were fighting over my mother’s clothes. You know, my mother had given some people money to plant the garden for her. Now they were fighting over the food which was in the garden. They were fighting over any good thing which was in the house.” (Butula, female 16)

“First of all, it is poverty. In most cases, when parents are sick they sell everything in the home for treatment.... When the parents dies, the children are left totally destitute. The main problem goes to the girl child. The girl is the one who has to look after the other children... She becomes the mother. Without money or food, they become commercial sex workers. This has really happened. Right now, I have OVCs who are 13 and 14 and they are already mothers. When you talk to them, you discover that she became pregnant because of this man who was giving her maize and buying them sugar...” (Butula, female, social worker/ NGO administrator)

“Eeh, as I said before due to poverty many of them after reaching that adolescent stage, they run away to marriage, early marriages, others are being infected. They can’t cope in the community, can’t cope economically, so they need someone to take care [of them economically.] Drop out of school, we have what we call early pregnancies, others are being infected, like with STDs and HIV/AIDS.” (Butula, male, CBO administrator)

Finally, two OVCs explained that the conditions of their life did not get worse after their parents died. In fact for one who had been her mother’s caregiver, she actually felt that her life was now improved.

“Life has changed but not that much. After they died, we just came back to live as a family but without the parents. None of my siblings was taken to live with any relative. We just chose to live alone because my sister said that she was capable of catering for us. And we are at least grown up so we are capable of looking after the younger ones. So we just lived on our own, with assistance from relatives.” (Busia, female 23)

“Actually my life has changed a bit. When my parent (mother) was there, I was the one to take care of her, take her to the hospital if need be because there was nobody else who could do that. After her death, REEP took me back to school and I felt very happy.” (Butula, male, 20)

4. Needs of OVCs

In-depth interviews with OVCs, guardians and key informants highlight the many needs of adolescent OVCs and their families. The problems faced by the OVC participants in both the urban and rural sites are similar. According to the OVCs themselves, the most pervasive are not having enough food and clothes. Other problems included lack of money for school fees, inadequate shelter, lack of home goods such as bedding, and inability to pay for health care or treatment. In addition a few mentioned that there is a

stigma from having parents who died of AIDS. Finally, several mentioned the problem of just feeling lonely and mourning the loss of their parents.

Key informants agreed that having their basic needs met is the most pressing problem of the OVCs. Other needs named by key informants were that OVCs need reproductive health education and they need guidance. When asked specifically about reproductive health issues, nearly all the key informants felt that these were a pressing need for the OVCs. The majority cited STI and HIV infection and unintended pregnancy and abortion as the most pressing problems. Also mentioned to a lesser extent were rape and sexual abuse and exploitation.

Key informants identified many social problems as a result of being an OVC. The three that were mentioned by the most number of respondents were that they suffer from a lack of parental guidance and love, they become targets for sugar daddies or other types of abuse and they are a bad impact on the community. It was widely felt that the lack of parental guidance leads to risky behaviors and abuse. This is further complicated by the fact that OVCs are largely impoverished which also leads to risky behaviors and abuse. One teacher specifically explained how the lack of basic needs leads to risky behaviors and abuse. *“Mmm, basically in terms of shelter, they don’t have a place to sleep at night or during the day when it is too hot or raining, these gives them a problem, and when you look at the girl child this exposes them to a lot of danger because they have to go out to look for means through which they have to sustain themselves, this opens them up for abuse sexually and commercially because they have to look for funds to sustain themselves and the siblings they take care of among other things.”* (Busia, male, teacher)

Key informants who are health care providers identified reproductive health issues as the most pressing health care issues facing adolescent OVCs. STIs/HIV was the problem most often named, followed by pregnancy and abortion and then other sicknesses. All of the providers said they had treated OVCs in their practice. About half felt they were sufficiently trained and equipped to treat OVCs while the other half felt they were not.

When asked about the education problems facing OVCs, teachers who were key informants felt that the lack of basic needs, e.g. food, shelter and school fees was the main problem. Many also said that OVCs do poorly in school. This was attributed to a variety of reasons including, hunger, overwork and a lack of concentration. All of the teachers have had OVCs in their classes. They feel that most OVCs are known to the class and most report that they are not treated any differently by the teachers or by their peers. For the most part OVCs do not affect the class but their own performance may be affected due to poor health, no food for lunch or a lack of school supplies. Two teachers described how being an OVC can affect their school performance. *“...There are some children who are a bit sickly and they do not get good attention. A child comes from home and the uniform is torn. She doesn’t have a pen. That one makes her not to participate well in the class or carry out class work properly. So when now you do exams, you get such a child does not perform her best like the others.”* (Busia, female, teacher). *“It does in the sense that there are others who go without shoes, come to school not having eaten anything and through lunch break they don’t have any food and this*

definitely affects their performance in class.” (Busia, male, teacher)

More than half the key informants felt that the needs of OVCs were different than adolescents whose parents were still alive. Even many of those who felt their needs were the same, recognized that the OVCs were worse off because they had no parents. The fact that the OVCs had no one to guide them was a recurrent theme in these interviews. Some of these differences were explained by two of the key informants:

“...the problems are the same but when we come to the other children who have parents who are not orphans, you will find that at least their parents do something about it, but the OVC’s basically on their own. So unless teachers or social workers step in, they find it hard to go through this situation.” (Busia, male, teacher)

“... OVCs are poorer than normal children. They have to fend for themselves unlike this normal child who will come and ask mother for food because it is the mother’s or father’s responsibility to get the food. The OVC has nobody to come and ask. It is like growing up without guidance. That is what OVCs say. They are growing up in darkness, they are finding out things for themselves and sometimes they find out too late.” (Butula, female, social worker/NGO administrator)

Guardians largely agreed with the key informants in that nearly all of the guardians felt that adolescent OVCs had special problems compared to non-OVCs. The problem most often mentioned is that life is harder for OVCs since they do not get the things they want or may lack the things they need. Related to this is the idea that OVCs believe that their life would be better if their parents were still alive. Another problem particular to OVCs is that since they are living with guardians they do not feel free to express their likes, dislikes, or problems. Two guardians specifically mentioned that they need special attention or encouragement to get them to open up. Another problem that was mentioned because the guardians are not their parents they do not feel obliged to listen to them and instead do what they want. Some go astray or join bad groups. Some girls may go out with men who give them gifts and some girls may end up in prostitution. Only two guardians replied to a specific question on special reproductive health problems. Both mentioned that pregnancy is common for “*orphan girls.*” One also talked about how the OVCs do not have enough guidance and education about OVCs.

5. Community Assistance and Support

Knowledge and use of community services

Knowledge and use of community services was largely dependent on whether the respondent lived in the urban site or the rural one. In general, rural respondents were more likely to know of services available to them and to have made use of them.

Nearly half of the rural survey respondents knew of a place that helps children whose parents have died (Table 9). REEP is the agency cited by most of the rural respondents, no other agency was cited by more than one respondent. Respondents mainly report that they provide food, medical care, school fees and clothing (data not shown). Sixteen rural

respondents said they have gone there. Most went for food assistance though others went for educational assistance, medical attention and clothing. All of those who went for help found the agency helpful. In terms of medical care specifically, other than REEP, rural residents in the older age group knew of the Butula Mission Hospital. The majority said they had made use of medical services in the past.

Characteristics	Urban (N=66)		Rural (N=65)		Total (N=131)	
	N	%	N	%	N	%
Know of places that help children whose parents have died	4	6	30	46	34	26
Name of places/agencies (<i>more than one response per participant is possible</i>)	(N=4)		(N=30)		(N=34)	
REEP	0		26	87	26	76
Other	6		4	13	10	29
Don't know	0		2	7	2	6
Ever gone to one of these places for assistance	0		16	53	16	47
Reason why went for assistance (<i>more than one response per participant is possible</i>)						
For food	0		10	33	10	29
For medical attention	0		4	13	4	12
Clothing	0		3	10	3	9
Educational needs	0		5	17	5	15
Thinks places/agency was helpful	0		16	53	16	47

While REEP was the predominant agency discussed by in-depth rural respondents, they also mentioned a few other places where OVCs could go for assistance. These included the Nangina project, the AIDS fund, Pathfinder and the Nyanza province orphan school. The type of help that was available from REEP and these other agencies included food, clothes, medicine, education advice, school fees, school supplies, reproductive health education and services including AIDS prevention, condom supply and voluntary counseling and testing (VCT). Over half the rural in-depth respondents had gone someplace for help.

In contrast, only four urban survey respondents knew of a place that helps children whose parents have died and no one reported going to an agency for assistance. The older age group when asked specifically about medical care did know of certain places to go for assistance. The best known were the Busia District Hospital followed by the Tanaka Mission. The majority had made use of the health services.

For urban in-depth OVC respondents, a few reported that they received some assistance

with housing and less than half received assistance with food. However, in most cases, assistance was received from relatives. Only 3 of the urban in-depth participants reported that they went for help to someone who was not a relative.

In-depth urban respondents did know of more places than the survey respondents where they could go for help. Most participants named places like hospitals, churches and health facilities. Only a few named NGOs, and WOWESOK was mentioned by one respondent and Médecin Sans Frontière (MSF) by two. The type of help that was provided at these places of assistance included clothing, food, financial assistance, education and health care.

Knowledge of services among the guardians reflected a similar pattern to the OVCs. Knowledge of local organizations providing assistance in the urban areas was extremely low, with only one guardian reporting knowing that agencies that provided support existed. None of the families in Busia reported having received any type of assistance. In the rural setting, nearly all the guardians knew of organizations that provided support, with most citing REEP. Other agencies that were mentioned included Pathfinder, World Food, RDB and APR. Many of those who knew of agencies providing assistance reported that they had registered when people came around asking which households had OVCs living with them. Yet, even though knowledge was greater only five guardians reported ever receiving assistance. Four cited that they received some food while the fifth said that they had received advice on how to plant vegetables. In addition, four reported that they had tried to get assistance but that they were either turned down or that it never came.

Coping Mechanisms

The two main strategies OVCs use to deal with their problems are to either work hard, or more prevalent, to ask for assistance. In-depth participants reported that they ask for help from a variety of sources including, relatives, friends, teachers, neighbors, and people from church. In the rural site, participants have the advantage of being able to go to REEP for help and many reported that this is what they did. A few participants mentioned that their way of coping is to just persevere, or make do. About half have someone they can go to for help though a few mentioned this person was only helpful at times. Most at least found it helpful to talk to someone, usually a friend or relative. As one OVC reported, *“I realize that having friends is a good thing since they assist me in areas of difficulty.”* (Butula, male, 18) In the rural area, participants would also talk to people from REEP. REEP plays an important role in the lives of many of these OVCs as indicated by these two. *“Life is hard but since REEP is there, I am now able to feel that I am a human being. If REEP was not there, I don’t know where I would be right now.”* (Butula, Male, 16) *“Yes it tries. We have some people who try to help and even give money and food but the most important thing/help comes from REEP.”* (Butula, female, 18) Very few reported they relied on drugs or alcohol to cope though a few said that they used to but stopped. Several said they relied on prayer.

Families supporting OVCs reported very little assistance from others including other

family members or support organizations. Three-fourths said they never received any help from other family members while the remaining guardians said they received assistance at least occasionally.

There were indications in both the urban and rural sites that guardians were unsure how to request assistance or that they felt nervous about doing so. One guardian reported feeling “*fear*” to ask for help while another said they felt “*ashamed*.” Another said they did not know how to approach an organization to request aid while another was under the impression that he needed to give money in order to receive aid. There were also some reports that some guardians expected assistance on the basis that they had registered though it is unknown what was actually said or promised during these visits.

Community attitudes and support

Overall, OVCs in in-depth interviews indicated that they did not feel that their communities have been very supportive toward them. Most of the respondents in the urban site felt that the community has not been helpful to their needs. In contrast, far more in the rural area felt the community was helping, though some specified it was only REEP that was helping them, not the community as a whole. Their feelings are summed up in the following responses:

“No the community around has not been very supportive. It’s like everybody is concerned with his or her own welfare. Nobody is concerned about you, how you are living, what you are eating, what you are doing, nobody is concerned. So I cannot say they have been of any help to us or to orphans around. Orphans around just struggle on their own.” (Busia, female, 23)

“No. Nowadays people feel that life is hard so they don’t assist. Life is hard, so everybody thinks about his or her own burden.” (Busia, female, 20)

“They should actually try, because without the community we cannot survive along. But now their interests are not with us, so we cannot force them.” (Butula, male, 20)

Key informants discussed the conflicts felt in the communities toward the OVCs. While there is sympathy, there is also a feeling of helplessness since the communities are “*handicapped economically*.” Many view them as a burden or a “*bother*” though some informants felt that this attitude is more pervasive in rural areas than urban ones. But key informants did say many community members do try to help. They also described some communities that have worked together to pitch in and take care of their own OVCs. These conflicts are summed up by one key informant, “*It ranges from pathetic to compassion, you cannot specifically say it is this way or that way but there are a good number of people who are willing to assist but they want to be brought together so that they can tackle the issue collectively.*” (Busia, male, teacher)

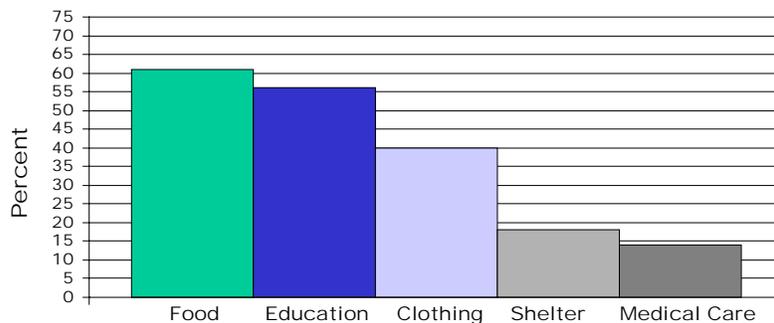
The key informants further explained that many in the communities view the OVCs as having a negative impact on the community as a result of unbecoming behavior, prostitution, drinking or drug abuse, criminal activity such as theft and street children.

While the OVCs may be viewed as a disgrace to the community, community members are also ashamed. One key informant explained it this way, *“Orphans can be a disgrace to the community because there is nobody to take care of their needs and they have the right to survive. As they look for ways on how to survive, they may do this through dubious means, which may not be pleasant to the community.”* (Busia, female, nurse)

Need for services and support

Nearly all the OVC survey respondents said that there are services that they would like to see in their community to provide assistance (Figure 4). The top three types of services cited in both the urban and rural settings were provision of good food, education and clothing. Other services named were free medical facilities, shelter and income generating activities.

Figure 4: Types of Services OVCs Would Like in Community*
OVC survey respondents, age 13-23 years



* More than one response allowed

OVC in-depth respondents further elaborated on how the community could help orphans. They also talked about help with funding education and providing basic needs like food, clothing and shelter. They, however, also discussed more the need for assistance in finding employment or providing job training, and counseling or advice. Education and job training were the areas that in-depth respondents felt were the most important things that were needed. Two OVCs explained the need for job training and education as follows: *“They can help me and other orphans like me get jobs so that we can be able to take care of ourselves.”* (Busia, male, 22) *“They should start projects that involve youth/OVC so that they can teach them skills like carpentry, tailoring which will help them take care of themselves. Also provide school fees or bursaries. This will help the youth.”* (Busia, female, 19)

Guardians’ requests for services were similar to the OVCs. When asked what type of services would be helpful to them as guardians, all but one guardian responded, with most giving more than one response. Between 35%-50% of the guardians said that they would like services that help them (in descending order) with food, school fees, clothing

and business loans/jobs. Other suggestions included help with bedding (e.g. blankets) and health care costs. Similarly, when asked what special services the OVCs themselves need, the main responses were education/school fees, food and clothes.

Finally, key informants had their own ideas as to how to help OVCs. Many of their suggestions on service provision were similar to what OVCs and guardians had said. For instance, they recognized the importance of meeting the basic needs of OVCs and guardians. They also felt it was important to help with income generating activities or other means of alleviating poverty. But they did also have other suggestions such as to provide guidance and counseling to OVCs and to provide reproductive health education. To a lesser extent there were suggestions to provide social activities for OVCs and to build or place OVCs in orphanages. Some specific ideas included: creating youth groups/social clubs, sensitizing the community, establishing a teen resource center so OVCs can gather and share with each other, training for teachers and providing school supplies.

There were also specific suggestions for improving community attitudes and practices. These included educating the community on the rights of orphans, creating awareness and more positive attitudes, decreasing discrimination, addressing issues of economic impact, and reminding communities of African traditions. Two key informants expressed their suggestions this way:

“What can assist these OVCs is through educating the community of the rights of children so that every one gets his/her own right.” (Busia, male, administrator)

“I think people should be more educated through the media and volunteers working in the community should highlight problems faced by orphans.... People should be made to realize that they could also die and leave their children behind. They should be made to understand that this child they think is somebody else’s could also be their child.” (Busia, female, teacher)

Key informants recommended involving churches in these efforts, and educating the community through Barazas and hospitals. Many recommended building community support so that people can work together to help OVCs. There was a recommendation that those that abuse OVCs be punished and a system developed so that OVCs can report abuse. Finally, some recommended that OVCs be placed in orphanages so that they’re the responsibility of the government. It was unclear if this was viewed as a way to help the OVCs or as a way to relieve the burden on the community.

6. Assessment of Future

Despite the challenges in their lives, many of the in-depth respondents still have hope for the future and believe their life will be good or at least better than it is now. Some of these respondents are just genuinely optimistic, though many felt that once they finish school they will have a way to support themselves and their life will be better. Not surprisingly, more of the OVCs in the rural area feel like this since more of them are in school, largely because of REEP. Nearly one-fourth of the respondents do not see their future as being positive and this feeling was more prevalent among the urban

respondents. Many claimed that unless something changes and they receive some type of help or assistance, they do not foresee their life changing for the better.

When asked how they could have a happier future, the answers were almost evenly split between those who felt having job opportunities could help them and those who felt being able to finish/go back to school would be the most beneficial. A few thought they needed some assistance in order to be happy.

IV. DISCUSSION & RECOMMENDATIONS

This assessment highlights many of the issues facing adolescent OVCs. While the focus of the assessment was on reproductive health, the findings indicate that basic needs take precedent in the minds of these adolescents. The results show that for adolescent OVCs who participated in this study, their most basic needs are those that help ensure their day to day survival. Obtaining enough food is the most daunting challenge. Other needs, such as securing clothing, school fees, shelter and money for health care also contribute to the burdens they face.

Nonetheless, there are still indications that reproductive health is an important topic for this group and one that should not be ignored. Interestingly, community key informants and other stakeholders, especially health care providers, were the most likely to feel that reproductive health education and guidance was a compelling need for this group.

While the results did point to the need for more reproductive health education, there was not a clear need for services. The overall level of sexual activity and risky behaviors reported by older adolescent OVCs was relatively low. Most who did report engaging in sexual relations, did so with steady partners. There were few reports of forced sex, or sex in exchange for gifts or money. These findings on sexual activity were unexpected and contrary to the beliefs and experiences of many of the key informants and stakeholders.

According to the stakeholders many believe that the overall level of sexual activity is higher than what was found, especially among girls. Many feel that most youth between the ages of 15 and 24 are sexually active. They also feel that activity generally begins earlier than what was found. The experiences of some also suggest higher levels of risky behaviors. Stakeholders reported that they expected to find higher levels of STIs and pregnancies. Some have seen younger youth already infected with HIV/AIDS/STIs. Younger girls are also seen at antenatal care services.

There are several possible explanations of why the findings do not coincide with stakeholder beliefs. First, it is possible that these findings are valid, and the magnitude of the problem within the communities has been exaggerated. It is also possible that as suggested at the stakeholder meeting, the OVCs either were not honest with the interviewers or did not feel comfortable enough with them to discuss their true behavior. Finally, it is possible that the methodology used in this assessment did not reach OVCs at greatest need such as those who are homeless, doing sex work etc.

In addition to basic needs and reproductive health, other important issues emerge from the data:

- There is a greater burden on older OVC siblings in a family. Younger siblings were more likely to remain in school while older siblings were more likely to have to stop their education. The older siblings, particularly the heads of households, also have the greater responsibilities such as providing food for the family.
- The communities have conflicting attitudes and actions towards OVCs. While they generally have sympathy for them, OVCs are often viewed as having a negative impact on the community. There is also a feeling of helplessness on the part of the communities that there is not much they can do to help. In some communities, however, people have worked together to help OVCs and it would be worthwhile to identify successful programs and replicate them. In addition, stakeholders suggest that capacity building of local communities is needed to address OVC issues.
- Stakeholders were surprised that rural OVCs knew more about services than urban OVCs. Most stakeholders felt that more services exist in the urban areas. Some did note, however, that while the urban areas have more services, they target the wrong people and are not well known. They suggested creating awareness of existing services through posters, public announcements (at churches, *barazas*, and public meetings) and peer educators. They also suggested additional research to find out who is and is not using existing services and why they are not being used.

These results paint a picture of adolescents who are struggling with their daily lives, with many who are put in positions of responsibility for which they are ill-equipped. Fulfilling basic needs is the number one priority and more assistance from communities and organizations are clearly called for. The findings on reproductive health are less clear with the results from the OVCs pointing to a low level of sexual activity and risky behaviors while the stakeholders and key informants believe the levels are much higher. Additional research is needed to resolve this question.

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