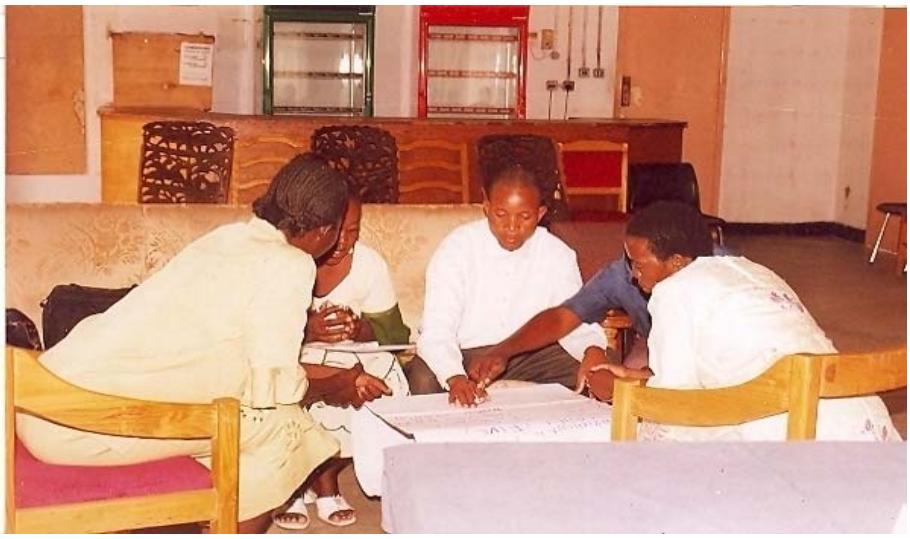
Promoting and protecting the health of orphans and vulnerable children in Monkey Bay, Malawi



A Participatory Reflection and Action (PRA) Project Report

Country Minders for Peoples Development (CMPD) Malawi
with
Training and Research Support Centre
and REACH Trust Malawi

in the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHI in EQUINET. It is part of a growing mentored network of institutions, including community based organisations, PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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Executive summary

This report presents the experiences and learning from participatory action research implemented by Country Minders for Peoples Development (CMPD), (a Malawi non government organization) on the co-ordination of support from service providers and community organisations for protection of sexual and reproductive health of orphans and vulnerable children in Monkey Bay, Malawi. The work was implemented within a Regional Network for Equity in Health in east and southern Africa (EQUINET) programme that aimed to explore, through participatory reflection and action (PRA) methods, dimensions of (and impediments to delivery of) Primary Health Care responses to HIV and AIDS, co-ordinated by Training and Research Support Centre (TARSC) in co-operation with Ifakara Tanzania, REACH Trust Malawi and the Global Network of People Living with HIV and AIDS (GNPP+).

Malawi has had a rising population of orphans and vulnerable children who are reported to lack care, food, educational opportunities and adult role models. Some of the coping strategies used by these children, such as early school dropout and child labour, combined with poor adult support, make them susceptible to risk of early onset of sex and to sexual and reproductive health problems, including HIV infection. This PRA work was implemented in Monkey-Bay in Mangochi district, where HIV prevalence and risk indicators and poverty levels are amongst the highest in Malawi. Local support organizations providing HIV prevention and impact mitigation services for children did so on very limited resources, including from outside sources.

Through baseline and follow up surveys, key informant interviews, focus groups and participatory reflection and action (PRA) meetings the study team led by CMPD

- Identified the health needs and coping strategies of orphans and vulnerable children and their consequent risk of health and SRH problems;
- Mapped the services and resources available for orphans and vulnerable children, and their coverage of and gaps in meeting the identified needs;
- Implemented and assessed the outcomes from actions by local services, CBOs and communities responding to problems prioritized by the community, and
- drew learning from this work on the factors affecting community level support for vulnerable children that would need to be included in comprehensive primary health care responses to AIDS.

A baseline survey was implemented by interview with 89 children, 14 community members and 17 health workers selected from a systematic sample of the 18 villages covered in T Nankumba traditional authority, Monkey Bay. All groups shared the perception that health services poorly addressed the needs of orphans and vulnerable children; and although their needs were seen to be understood by communities, services for these children were not well known to community members. Children generally perceived themselves to be excluded from and poorly supported by communities and health services; with poor communication about their needs.

PRA meetings including health workers, community based organisations (CBOs), community members and children found that vulnerable children and poor people are often segregated from better off people in community, and thus local support. The prioritized health needs of these children shared across groups were identified to be food – rated first by a wide margin - clothing, and education. Limited household and community resources and poor coverage by support services was felt to lead children to expose themselves to health risks such as commercial sex in trying to address these needs. Filling gaps in social protection was thus identified as important.

Resource gaps were identified as the major barrier to more effective support. Mapping of resource flows in the area indicated that while international agencies and government departments are bringing resources in, a small share of these resources flow through the CBOs and community networks that vulnerable children interact with. The bulk of the resources coming to the health sector were for drugs, supplies, facility maintenance, services and administration, and the focus on resourcing points of service delivery means that community level opportunities for care and support are less well resourced, while the low use by vulnerable children of sexual and reproductive health (SRH) and other health services undermines their access to these resources.

Actions identified as feasible with potential impact were implemented to strengthen uptake and link services and community resources to prioritized needs over an initial six month period, including:

- Community farming to support vulnerable children's nutritional needs, and to finance clothing and education support
- Community awareness meetings on health of orphans and vulnerable children, especially young female orphans
- A readmission campaign for the young mothers who dropped out of school
- Training of Health Surveillance Assistants (HSAs) and Community Health Counselors to counsel vulnerable children on SRH issues and protection from abuse
- Introduction of Monthly Health Forums for communities and services to discuss SRH issues and actions and village protection groups to support children.

Progress markers of outcomes to be achieved during that period were set and reviewed. Report was also made of increased reporting by guardians of vulnerable children of cases of child abuse to the police, a reported two fold increase in the number of young female orphans seeking sexual and reproductive health services in public health centers, substantial agricultural harvests from collective community farming activities to be used for children's needs in three of the four areas; reported readmission of 110 young single mothers into schools in the area and report by health workers of improved uptake of health services by first time attender young mothers. The process and action plan was also seen to bring stakeholders working on the health of orphans and vulnerable children together within one framework. The progress markers relating to communication and collaboration were achieved, while those relating to service outcomes and changes in service uptake were not, and demanded more time.

A follow up survey on the same group as the baseline found little change in the understanding of and communication on vulnerable children's needs (already rated relatively high), service accessibility or involvement of children in health service planning, but improvement in co-operation across groups to address children's needs, improved perceived handling of their issues by health services and improved involved of children in CBO planning. It would appear that, at least in the perception of those involved, the ability to act on problems has improved in this process.

This action research suggests that a Primary Health Care approach to AIDS should be embedded within and reinforce a wider social protection strategy that addresses life course needs, such as those of vulnerable children. Strengthening uptake of services and linking services and community resources to prioritized needs suggests that PHC responses need to be decentralized to primary care level, but cannot end at that level. *Significant* attention and resource commitment has to be given to promoting outreach and uptake of services and to the intersectoral actions and CBOs that support this, if resources are to be accessed and used by vulnerable groups like orphans and vulnerable children. This may generate a positive cycle, as increased health action and demand from previously marginalised groups puts pressure on government and funders to increase their support and on health workers to improve their services. Programme attention, skills orientation and investment is also needed in the communication and participatory processes that bring services, CBOs, communities and children into shared and more empowering frameworks for action.

1. Introduction

This report presents the experiences and learning from participatory action research implemented by Country Minders for Peoples Development (CMPD) on the co-ordination of support from service providers and community organisations for protection of sexual and reproductive health of orphans and vulnerable children in Monkey Bay, Malawi.

The work was implemented within a Regional Network for Equity in Health (EQUINET) programme that aimed to explore dimensions of (and impediments to delivery of) Primary Health Care responses to HIV and AIDS. The programme, co-ordinated by Training and Research Support Centre (TARSC) in co-operation with Ifakara Tanzania, REACH Trust Malawi and the Global Network of People Living with HIV and AIDS (GNPP+) provided training on participatory reflection and action (PRA) methods and supported their integration in primary health care and health services at primary care level. It gave focus to a specific community level priority on prevention, treatment and care for HIV and AIDS, and intended to synthesise learning across diverse settings and studies in east and southern Africa on Primary Health Care responses to HIV and AIDS.

1.1 Vulnerability due to AIDS

As with many other sub-Saharan African countries, Malawi has been severely affected by HIV and AIDS. The first case was reported in 1985 and to-date, despite a national response that has been undertaken over many years, the epidemic persists and the responses do not yet match needs in relation to prevention, treatment and care. The national adult HIV prevalence rate in the reproductive age group of 15-49 years has declined slightly from 14.4 percent in 2003 to 12.0 percent in 2007 (Ministry of Health, 2008). Approximately 930 000 people were estimated in 2005 to be are living with HIV in Malawi, including 70, 000 children under the age of fifteen living with HIV (Government of Malawi 2006). According to the Malawi Demographic Health Survey (NSO Malawi and OCR Macro 2005), 30-35% of all pregnant women aged between 15-49 years were HIV positive and 640 000 people had died of AIDS, with 86 000–100 000 deaths annually. These statistics point to the potential vulnerability in the population arising from this morbidity and mortality. One group with particular vulnerability is the population of young children who have lost one or both parents.

In 2004, 60% of Malawi's total population of 12.3 million were estimated to be under the age of twenty years (NSO 2005; GoM 2006). According to the 2004-5 Integrated Household Survey, 52.4% of Malawi's population lives below the poverty line. This translates into about 6.3 million Malawians who are poor, with the poorest communities in the southern region of the country. Rural areas are poorer than urban, and over half of poor people in Malawi are children. The Malawi Growth and Development Strategy (MGDS) (GoM 2006) identifies that poverty has increased susceptibility to HIV infection and that inadequate supplies of Anti-Retroviral (ARV) drugs, poor access to healthy diets, low levels of education; limited institutional capacities; deep-rooted harmful socio-cultural values, social practices, beliefs and traditions and poor coordination among the service providers are major constraints to effective coverage of communities with prevention and treatment services (GoM 2006).

Reviews of the demographic, social, health and economic impacts of AIDS have found:

- Increased deaths, fewer births, reduced fertility and falling population, with a rise in the orphan population and increased dependency;
- Increased demand for public health care services, and increasing spending on health care;
- School drop out, teacher illness and reduced enrolment and access to quality education;
- Falling labour quality and quantity, more frequent and longer periods of absenteeism, losses in skills and experience, and shifts towards a younger, less experienced workforce;

- Losses in household income, and
- Reduced food availability, access and security, through falling production, loss of family labour, land and other resources; loss of livestock assets and implements and shifts to less labour intensive production (Loewenson and Whiteside 2001; Loewenson 2007).

Such effects have also been documented in Malawi. A review of evidence on community responses to AIDS in Malawi found that AIDS had negative impacts on family members in terms of capacity to generate income and produce adequate food, reduced yields of food crops and income, time and resources diversion to provision of care; closure of small scale businesses and shifts from working in one's own enterprise to casual employment (Munthali 2002). A 2006 study found that the main impact of AIDS related mortality and morbidity at the household level was to induce diversification of income sources, with women reallocating their time from labour intensive work (typically farming and heavy chores) to tasks that would generate cash. Men's time allocation was found to be unresponsive to the same shocks. This reallocation of time was observed to reduce agricultural output (Anglewicz et al 2006). With food consumption the dominant category of household expenditure and the majority of food consumed coming from home production, this research points to negative impacts of AIDS on household food security (Anglewicz et al 2006). These findings point to associations between HIV and AIDS and poverty. Further, if women switch to more immediate cash generating activities to meet costs, there is a risk that this includes commercial sex work, increasing their risk of adverse reproductive health outcomes.

One of the impacts of AIDS is a rising population of orphans and vulnerable children. Out of Malawi's 1.4 million orphans, 500 000 are estimated to have lost one or both of their parents to AIDS. A fifth of all households in Malawi take care of one or more orphans; 49% of these headed by women (UN, WFP 2009; NSO Malawi and ORC Macro 2005). The Malawi Government defines an orphan as a child below 16 years of age that has lost one or more of her parents. Vulnerable children in Malawi are defined as those children with or without parents and who are disadvantaged, who lack the basic support they need and or who may be vulnerable to other harms or deprivation due to their condition (MOGCCS) (2005)

These vulnerable children are reported to lack care, food, educational opportunities and adult role models. While some are taken in by extended families or community members, there is also report of these children being subjected to child labour and various forms of abuse, putting them at risk of HIV infection (UN, WFP 2009). Over 95% of children aged between 0-6 years old live in rural areas and do not have access to opportunities for early childhood development, already weakening their performance when they start primary education. For orphans who lack the parental support and nurturing needed to take advantage of education, many fail to perform well and may drop out of school (Actionaid 2008). School-aged orphans are also reported to have lower enrollment because guardians cannot afford the costs of schooling, because the children are needed to generate income or because the guardians have less interest in the welfare of these children (UN, WFP2009). Those orphans and vulnerable children who finish primary education are reported to have poor transition to secondary school due to lack of cash for school fees or learning materials, and lack of family support and even for those in school absenteeism rates are reported to be high (NAC 2006b).

Various coping strategies have been found from international reviews to deal with these burdens (Loewenson 2007, 2007b). Older children may be expected to take up paid employment and care for younger siblings. Children have been withdrawn from school if there are inadequate household resources or public support. While the larger share of orphans in Africa have been found to be absorbed into and fostered within households, some are not caught within these extended family safety nets and become child-headed households (Foster 2002). Such children have been found to take on adult roles, doing work and caring to support the family. Many quit school and jeopardize

their own health and developmental needs to take on roles as parents, nurse and provider (Lyons 1998; Im-em and Suwannarat 2002).

Early school dropout, child labour, and poor adult support can make children very susceptible to risk of early onset of sex and to HIV infection. Yet this negative situation is not inevitable and there is a window of hope; only 2% of children in Malawi aged 5 -14 are infected with HIV, and most children can remain negative if they are given access to the services they need as children– education, nutrition, healthcare and emotional support (Actionaid 2008).

1.2 AIDS, orphans and vulnerable children in Monkey Bay Malawi

With this context, we explored further in Monkey-Bay, Malawi the particular risks facing orphans and vulnerable children, their coping strategies, and the support mechanisms available to prevent them being exposed to risk environments for HIV and other negative reproductive health outcomes. Monkey Bay is a township found in the Southern Region of Malawi, in the southern part of Mangochi district (See Figure 1 below).

Figure 1: Map of Mangochi district and Monkey Bay, Malawi

Source: Nations Online Project at .www.nationsonline.org/oneworld/map/malawi_map.htm
(permission for use for educational purposes)

Monkey-Bay is in a district that has the second highest HIV prevalence rate in Malawi, after Blantyre rural. While national HIV adult prevalence is 15%, in Southern Region it is 18% (NSO Malawi and ORC Macro 2006).

A data triangulation by National AIDS Commission notes of Mangochi district that

- high female HIV prevalence (22.2%)
- high male HIV prevalence (19.5%)
- high male sex with no condom protection, (13.2%)
- high commercial sex worker (CSW) contact for men in the past year (12.1%)

- high unprotected last contact with a CSW in men (7.4%)
- highest ever had sex for all ages for men (92.6%)
- high ever had sex for women age 15 to 19 years (69.0%) – and rising
- lowest share of males who had heard HIV/AIDS through a radio spot (70.0%) (NAC 2006c).

At the same time HIV prevalence was noted to be falling in Mangochi for all ages and awareness of transmission was noted to be high, but perceived risk low overall, higher among those with recent sexually transmitted infection (NAC 2006c). With a high HIV prevalence rate, the area has a large number of orphans and other vulnerable children, and the Malawi Poverty and Vulnerability Assessment (MPVA) Report observes that Mangochi district has the second highest poverty levels in Malawi, pegged at 60.7% (GoM, World Bank 2006).

The district selected for this work is thus one with high burdens of illness and weak household resources to deal with it. The literature review suggests that in a district of relatively higher risk and vulnerability compared to Malawi generally, orphans and vulnerable children are a particularly vulnerable group, and an important focus therefore for work to assess and reduce risks to their health, including their sexual and reproductive health (SRH).

Eight Community based organizations (CBOs) in Monkey Bay were interviewed to identify the actions that they are taking for orphans and vulnerable children (see Section 2). They had 6005 orphans and vulnerable children registered in 2007 and 10 822 in 2008, but only half of these were recorded to be actually receiving support.

Table 1 CBO data on registered orphans and vulnerable children and resources mobilized, 2007 and 2008

For 2007				**For 2008**		
CBO	**Number of OVC**	**Resources mobilized and used (Malawi Kwacha)**	**Source of funds**	**Number of OVC**	**Resources mobilized and used (Malawi Kwacha)**	**Source of funds**
Chiwalo	1 750	570, 000 (U$4071)	Local fundraising initiatives	2 300	240, 000 (U$1714)	Local fundraising initiatives
Mwalembe	980	175, 000 (U$1250)	Local fundraising initiatives	1 240	340, 000 (U$2429)	Local fundraising initiatives
Sangadzi	420	230, 000 (U$1643)	Local fundraising initiatives	780	180, 000 (U$1286)	Local fundraising initiatives
Mwanyama	1 340	80, 000 (U$571)	Local fundraising initiatives	1 620	165, 000 (U$1179)	Local fundraising
Chembe	520	840, 000 (U$6000)	Local fundraising, gifts from tourists	740	1, 240, 000 (U$8857)	Local fundraising, gifts from tourists, small grant
Nsumbi	470	75, 000 (U$536)	Local fundraising initiatives	540	120, 000 (U$857)	Local fundraising gifts
Chantulo	173	428, 000 (U$3057)	Local fundraising initiatives	230	540, 000 (U$3857)	Local fundraising and small grant
Malembo	352	340, 000 (U$2429)	Local fundraising initiatives	3 372	490, 000 (U$3500)	Fundraising locally

Source: Information provided by CBOs interviewed to the research team

Ninety percent of the CBOs in Monkey-Bay have never received substantial funding since their establishment. Their funding levels relative to the number of orphans they cover in 2007 and 2008 indicate the inadequacy of the resources made available through these organisations for

care and support of vulnerable children. In 2007, these CBOs had a total of $19 557, or a total of $3.26 per child registered. In 2008 they had a total of $23 679, or $2.19 per child registered annually. While it is possible that children may be registered by more than one CBO and while there are other CBOs in Monkey Bay, the information indicates the extremely low level of funding available to CBOs to provide support to the children they register. It appears that these local support organizations providing HIV prevention and impact mitigation services obtain very limited funds from outside sources. These children thus depend on other sources of support in the community, including from households headed by elderly and widowed people or other children.

While child vulnerability to AIDS is thus a public health concern, given exposure of these children to risk environments for AIDS and other health problems, this background evidence suggests that the health and social needs of vulnerable children are still poorly addressed, with the organizations at community level that provide this support poorly funded relative to the needs they seek to address.

Country Minders for Peoples Development (CMPD) is one of the CBOs in Monkey Bay. It was formed in Malawi in 2003 to advocate for economic and social justice advocacy and to empower communities to engage on and achieve their rights, including to health. The organization takes these goals forward through research, analysis, information sharing, training, community empowerment, advocacy, and networking. The CMPD Secretariat is in Lilongwe the capital city of Malawi and in Malawi the organization is a member of the Civil Society Coalition for Quality Basic Education (CSQBE), Malawi Health Equity Network (MHEN), Malawi Human Rights Youth Network (MHRYN), National Youth Council of Malawi (NYCOM) and Malawi Network for Conflict Transformation (MANECOT). CMPD works in two main areas; Traditional Authority (T/A) Njewa, Lilongwe district in the Central Region of Malawi and T/A Nankumba (Monkey-Bay), Mangochi district in the Southern Region.

Given its focus and the concerns around children and AIDS, CMPD sought to use participatory reflection and action (PRA) methods to

- identify the health needs and coping strategies of orphans and vulnerable children, particularly young female orphan children, and the extent to which coping strategies increases their risk of health problems, including SRH problems.
- map the services and resources available for orphans and vulnerable children, the extent to which they address their identified needs and the implications of gaps in services.

On the basis of the problems prioritized by and within the community, we sought to implement and assess the outcomes from an action process to strengthen communication and co-ordination across community based organizations, services to better protect the health of orphans and vulnerable children and to address identified gaps. We sought to draw learning from this work on the factors affecting community level support for vulnerable children that would need to be addressed as part of building comprehensive primary health care responses to AIDS.

As an action research programme we aimed to achieve some ‘change’ outcomes in Monkey Bay, including:

- improved communication, shared understanding and co-operation across organizations relevant to children and the community of the health needs and coping strategies of orphans and vulnerable children, especially female children; and
- increased uptake of health and SRH services by orphans and vulnerable children.

Through this we aimed to strengthen the capacities and mechanisms for planning, implementing, and monitoring the responses to orphans and vulnerable children in the area. We also aimed to build our own capabilities to implement participatory action research and to integrate PRA approaches in our work.

While there are many sources of child vulnerability in Monkey Bay, we chose to focus on children below the age of 16 years who had either lost one or both parents or who had parents and were disadvantaged by the death of an adult family member due to AIDS. We gave particular attention to female children.

This work followed training by EQUINET through TARSC and Ifakara Health Institute and was intended to provide mentored support to the team to build capacities to integrate PRA approaches to strengthen community level roles in health. We reflect at the end of the report on the experience and the lessons on this.

2. Methods

CMPD identified four facilitators for this work, including the lead author who was trained in PRA methods by EQUINET. This team selected twenty people with the support of Area Development Committee (ADC) and Monkey-bay Community Development Office from the various stakeholders working on orphans and vulnerable children's health in Monkey-Bay and this group formed a steering committee for the work. the committee included eight CBOs, traditional/community leaders, health service providers, members of the Area Development Committee and village development committees, government representatives from the Monkey-Bay Community Development Office and Social Welfare ministries and community members from women caring for orphans in community based care centers and home based care support groups. Orphans themselves were not part of the steering committee due to the nature of the work required, but were involved in the participatory processes. The group provided leadership and guidance for the implementation of the work and the community action plan. It was also set up from the beginning as a local mechanism to sustain the initiative. The inclusion of diverse members aimed to promote collaboration and communication between different stakeholders working on orphans and vulnerable children's health in Monkey-Bay. Meetings were held with the committee to orient them to the processes, build a team with capacities to support the PRA work, share responsibilities and input to planning for the process. The authorities and communities involved through this community gave authority to implement the work, input and consent to the design.

The action research process involved a number of stages

i. A baseline survey through questionnaire interview to assess the current coping strategies, responses and services and perceptions of communication and co-operation across organizations providing support and services.
ii. Workshops using PRA methods to identify needs, priorities, proposed health actions and goals. The workshops also aimed to enhance communication across actors involved in the responses
iii. Focus group discussions and key informant interviews to deepen information gathered from the PRA processes
iv. An intervention phase to implement actions, with review meetings using PRA approaches to assess programmes on identified progress markers
v. A follow up survey using the same indicators as the baseline survey to assess change on the perceptions of responses and services and of communication and co-operation across organizations providing support and services.

The tools used were pre-tested and training provided to all the facilitators in using PRA methods prior to the activity commencing. These stages are briefly outlined below. The work was carried out between May 2008 and February 2009.

2.1 Baseline and follow up survey

A baseline survey was administered before the process began through a structured interviewer administered questionnaire to orphans and vulnerable children, community members, health workers and CBOs in 18 villages in T/A Nankumba, Monkey Bay. The baseline and follow up surveys included health workers, orphans and vulnerable children, community members and CBO workers selected on a quota sample, and with systematic sample using a random starting point for the community interviews, from each of the eight communities in Monkey-Bay.

Table 2: Composition of the sample in the baseline and follow up survey

Category of respondent	Total number
Children	89
Adult community members	14
Health workers	17
CBO representatives	8
TOTAL	128

The baseline and follow up survey assessed parameters that related to the areas of intended outcomes, ie

- Understanding of the needs of orphans and vulnerable children by community members, CBOs and health workers;
- Communication about children's needs between community members, health workers, CBOs and children, including on planning for child support;
- The extent to which community members, health workers, health services, CBOs are relevant to and cooperate in addressing children's health needs, and
- The accessibility and uptake of health services to orphans and vulnerable children.

All questionnaires administered to local people were administered in the local Chichewa language. Responses were recorded on a likert scale of 1-5 and captured respondents perceptions of the issues included in the questionnaire.

2.2 Focus group discussions and key informant interviews

Focus group discussions and key informant interviews were conducted with health workers, Area Development Committee (ADC) members, directors of CBOs and directors of Community Based Care Centers (CBCCs). Eight focus group discussions were facilitated, one in each of the eight target communities in Monkey-Bay and involving these personnel in each area. Five facilitators facilitated and recorded the focus group discussions, two from CMPD, one community member, one from a CBO, and one government representative. The choice of facilitator did not appear to affect the responses to the questions.

2.3 Participatory Reflection and Action (PRA) meetings

Two workshops were conducted in July and September 2008 in Monkey-Bay by the team, facilitated by the PRA facilitator team (see earlier) using participatory methods. The first workshop aimed to identify and agree on the main needs of the orphans and vulnerable children, the available services and resources for their health and the impact of such services and resources on their health, including the SRH of young female orphans and vulnerable children in Monkey-Bay.

The second workshop aimed to provide a mutual platform for the stakeholders involved to review the level of collaboration between actors and organisations working on the health of orphans and

vulnerable children, how this affected care and support services and the response to orphans and vulnerable children's health needs in Monkey-Bay. This was used to provide a planning platform for stakeholders to plan actions to address the identified gaps and improve responses to health needs of orphans and vulnerable children in Monkey-Bay.

A number of participatory methods and tools were used in the process, including social mapping, ranking and scoring, stakeholder mapping, and tools to systematise organization of experience in the participants on needs, determinants and actions, such as spider diagrams and wheel charts. This is further elaborated as the results are presented.

2.4 Actions and progress review

The actions planned at the PRA meetings were implemented between September 2008 and April 2009. Two participatory monitoring and evaluation meetings were held involving the stakeholders involved in the programme and the PRA team to review the actions against progress markers set of what communities sought to achieve in the period. These meetings aimed to monitor and review progress and develop strategies to address implementation challenges and gaps,

3. Implementation and results

3.1 The baseline survey, interviews and focus group discussions

The findings of the baseline survey are shown in Table 3 below. (The follow-up survey findings are reported at the end of the section on findings).

Generally, all three groups had a shared perception that

- Health services poorly address and are not relevant to the needs of orphans and vulnerable children;
- Community members do not know the services available for orphans and vulnerable children; and
- Orphans and vulnerable children needs are reasonably well understood by communities.

In other areas the perceptions differ. Children themselves generally perceived that

- They are relatively excluded from and poorly supported by communities and health services; and
- There is poor communication between community members, health services and children about their needs.

Communities generally have the most favourable perception of the situation, particularly in relation to co-ordination, communication and co-operation around children's needs, the involvement of children in planning and the likelihood of female children to use services for STIs.
Health workers in contrast had a poorer perception, both of the relevance and use of health services, and of the involvement of and communication between community members and children. Their perception was more favourable in respect of service access, but the relevance and quality of these services and their uptake was less favourably perceived.

The baseline suggests significant scope for improvement in

- Orientation and uptake of services to meet children's needs
- Communication between services, community members and children;
- Involvement of children in planning responses to their needs; and
- Inadequate knowledge of services available for children's needs.

Table 3: Results of the baseline survey

("Agreeing" refers to those giving "strongly agreeing / agreeing" as the response to the question)

QUESTION	% Children agreeing N=89	% Community members agreeing N=14	% Health workers agreeing N=17
Orphan and vulnerable children needs are understood by community members	62	79	76
Male and female orphan and vulnerable children needs are the same	52	43	65
Orphan and vulnerable children needs are understood by CBOs	56	57	65
Orphan and vulnerable children needs are understood by Health workers	56	50	59
Community members and CBOs communicate well about orphan and vulnerable children needs	58	57	47
Community members and health workers communicate well about orphan and vulnerable children needs	44	50	59
Orphan and vulnerable children and community members communicate well about orphan and vulnerable children needs	52	43	47
Community members and CBOs cooperate well in supporting orphan and vulnerable children	57	57	59
Community members and health workers cooperate well in addressing orphan and vulnerable children health needs	49	71	12
Health services addresses the needs of orphan and vulnerable children	37	64	35
Health services are accessible to male orphan and vulnerable children	33	43	53
Health services are accessible to female orphan and vulnerable children	48	43	53
Health services are relevant to male orphan and vulnerable children needs	47	71	47
Health services are relevant to female orphan and vulnerable children needs	47	50	47
Health workers and orphan and vulnerable children communicate well	55	79	47
Male orphan and vulnerable children are likely to go to a health service for a SRH problem like a sexually transmitted infection (STI)	61	57	53
Female orphan and vulnerable children are likely to go to a health service for a SRH problem like an STI	48	71	53
Community members are involved in planning CBO support for orphans and vulnerable children	52	29	53
Orphans and vulnerable children are involved in planning CBO support for them	61	93	29
Community members know the services available for orphan and vulnerable children support	54	36	35
Orphan and vulnerable children know the services available for their support	65	57	35
Orphans and vulnerable children are involved in planning health services for them	48	57	59
Community leaders (religious, chiefs) give strong support for orphans and vulnerable children	49	64	65

Staff at the three health centres in Monkey-Bay reported children being born to mothers below the age of sixteen years, with birth complications and maternal deaths. The community members interviewed felt that a large share of pregnant women and girls did not go to public health centres to deliver, citing problems such as long distances, poor treatment from health workers, lack of drugs and cultural beliefs. This led them to seek treatment from traditional healers, sometimes with negative SRH outcomes.

The focus group discussions and interviews reported weak collaboration between health workers, community members and CBOs in addressing vulnerable children's needs in Monkey-Bay. Even though CBOs exist, and CBCCs were established by government through the district assemblies to mitigate the impact of AIDS in communities, these organisations were reported to obtain no financial and technical support from Mangochi District Assembly or National AIDS Commission (NAC) and to raise their resources through local fundraising initiatives including gardening, small scale businesses and support appeals to community members. They also reported receiving donations from tourists, the Member of Parliament (MP) of the area and from international non government organisations (NGOs) from outside the district.

One CBO director said for example during one of the focus group discussions, *"we do not have enough to give the orphans here and out of sympathy, because these are our own daughters, we go from house to house sometimes to get assistance for these orphans. With the road being constructed {in reference to Monkey-Bay Golomoti road} many of these orphans engage into sex for money with these road workers. We have seen many of them being impregnated and ignored. Some of them are dying of AIDS. But what else can we do".*

The baseline interviews and discussions suggest that while there have been interventions in the community, they have not adequately involved the community in their design and planning. While they provide charity they fail to adequately empower affected households and community support organizations and structures to sustainably respond to household and community needs. According to the interviews, other factors also affect this: the interventions fail to address the root causes of HIV spread in the area; there are no long term interventions that build competencies in households and community support groups to address needs and there is poor collaboration between various stakeholders working on the issue.

3.2 Participatory reflection and action on needs, resources and actions

Through the series of two workshops, described in the methods section, we facilitated dialogue within and across community, children, health workers and CBO representatives to identify priority health needs of orphans and vulnerable children, available services and their adequacy and uptake, and to develop intervention plans around improved responses to health needs.

Participants described their community through a social mapping exercise, using a community map. Participants were divided into two groups with children in one group to give them the opportunity to talk more easily. The two groups identified a shared understanding of the social groups within their communities and then drew a social map of their community showing important social features and locating the places where orphans and vulnerable groups are found and supported (See Figure 2).

The maps were then presented and discussed and the similarities and differences of the maps identified to prepare a composite understanding of the key social features for orphans and vulnerable children in the community. The maps showed water sources (lake and river), mosques and churches, health facilities, schools, roads, gardens, houses as well as forests, trees and graveyards. The participants identified on the maps that

- Orphans and vulnerable children are found in many community sites, but notably in female and child headed households and in orphanages.
- Vulnerable children and poor people are somewhat segregated from better off people within areas of the community and this is also reflected in the community structures and organisation.

Figure 2: A sample of a community map

"It is important to draw such maps because they are able to show the differences within different social groups within the same community."
Male participant

Participants identified the main health needs off orphans and vulnerable children in the area as clothing, food and nutrition, education support, sexual and reproductive health counseling and parental guidance. Using a ranking and scoring methods, with each participant allocating ranks, the three top needs were perceived to be

- Food – rated first by a wide margin
- Clothing, and
- Education support.

The "but why" method used to explore some of the deeper determinants of children's health risks commonly identified limited resources within households in the community and poor coverage by support services, as this led children to seek survival strategies that expose them to health risks. The weak coverage of support services was felt to be a product of both under-funding and poor collaboration between stakeholders working with vulnerable children's health in Monkey-Bay.

Participants then divided into three groups, with each exploring further one of the identified three priority health needs. Each group identified, using spider diagrams and colour labels the actions that address these needs, pooling their knowledge to identify a shared understanding of those already underway, and those not yet in place. Groups were then brought together to review and discuss each others work and add further inputs.

Table 4: Actions identified to address the prioritized needs of orphans and vulnerable children in Monkey Bay

Actions identified as needed and already underway	Actions identified as needed but not underway
TO ADDRESS NUTRITIONAL NEEDS	
• Collection of foodstuffs from households that have enough stocks to support vulnerable children in the area • Providing school feeding programmes targeting vulnerable children as an incentive to ensure school attendance and reduce absenteeism and drop out in vulnerable children	• Distribution of adequate food to child headed households to address hunger and avoid children dropping out of school to search for food • Education of community members, especially children, women and the elderly, on nutrition issues and problems and on options for nutritional support. • Provision of seeds, farm inputs, implements and technical support to children/female headed households affected by AIDS to boost their food production; • Collective community farming to harvest food and cash crops to distribute to vulnerable children and households affected by AIDS to support nutritional needs
TO ADDRESS CLOTHING (and other basic) NEEDS	
• Mobilization of money and clothing from households to distribute to vulnerable children in the area - taking place, but at a low level.	• Support for life skills, production skills, resources to vulnerable children and affected individuals and establishment of income generating activities through CBOs to organise resources for food, clothing and education needs of vulnerable children
TO ADDRESS EDUCATION NEEDS	
	• Conduct awareness campaigns on the need to send children to school and ensure that they remain in school • Provision of clothing (school uniforms), school learning/writing materials and payment of school fees for vulnerable children • Campaign against violence against girls in schools (eg through rape, teacher/pupil sexual relationships, forcing girls out of school to marry) • Support of care for ill parents so children do not drop out of school to provide care
OTHER	
	• To provide sexual and reproductive health (SRH) services and resources to communities especially young female orphans and women

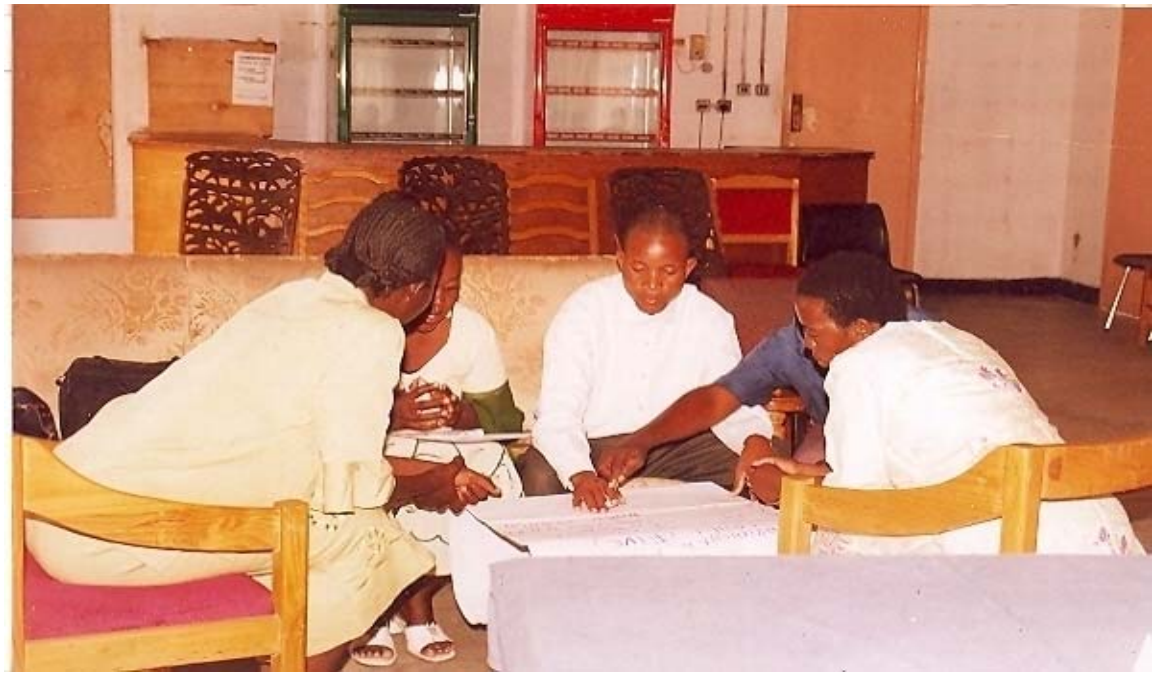
The predominance of activities *not taking place* was felt by participants to demonstrate the underlying problem of the inadequacy of interventions to address the spectrum of needs of orphans and vulnerable children.

"I believe this (lack of adequate interventions) is due to lack of resources for the community based organizations and not lack of willingness or interest to help orphans."
Community participant

The resource gap was felt to leave orphans and vulnerable children poorly protected and exposed to survival strategies that predispose them to commercial sex and SRH problems. Filling the gap in social protection would be important to address health needs and reduce such risks.

The biggest challenge facing CBO work in Monkey-Bay was felt to be the gap in resources to support vulnerable children. The resources mobilized had not matched the growing demand generated by the rising number of vulnerable children due to the illness and death from AIDS in the area. Community support was seen to be dwindling because most households have their own vulnerable children to look after from their extended families making it very difficult for them to support other households, and community support groups lack of adequate resources. It was also felt that the resources mobilised had not been distributed effectively to various district constituents by the Mangochi District Assembly and support institutions, leaving some children not covered. Equally it was felt that communities and support institutions had weak capacities to advocate for resources and services for dealing with HIV and AIDS. This was observed to leave children very vulnerable. Young female orphans were noted to be left with newborn siblings to look after, yet these babies needed informed care and breastfeeding.

Figure 3: Community discussions in the PRA meeting



Source: CMPD 2008

To explore the follow up actions, participants mapped the relevant stakeholders in Monkey-Bay working with orphans and vulnerable children and their current work from amongst the CBOs, health service providers; NGOs, faith based organizations, and families. The actions identified (on cards) in the previous round were allocated to a specific stakeholder identified in the community. This generated heated debate sometimes as participants could not agree on roles and responsibilities for different actions. This generated discussion on the roles of each stakeholder in relation to orphans and vulnerable children according to guidelines for OVC Care and Support produced by the Ministry of Gender, Child Welfare and Community Services ((MOGCCS, 2005) At the end of the exercise it was evident that following these guidelines meant that CBOs have the biggest responsibility in addressing the identified needs of orphans and vulnerable children at local level, followed by NGOs.

Table 5: Allocation of actions to address the prioritized needs of orphans and vulnerable children to stakeholders in Monkey Bay

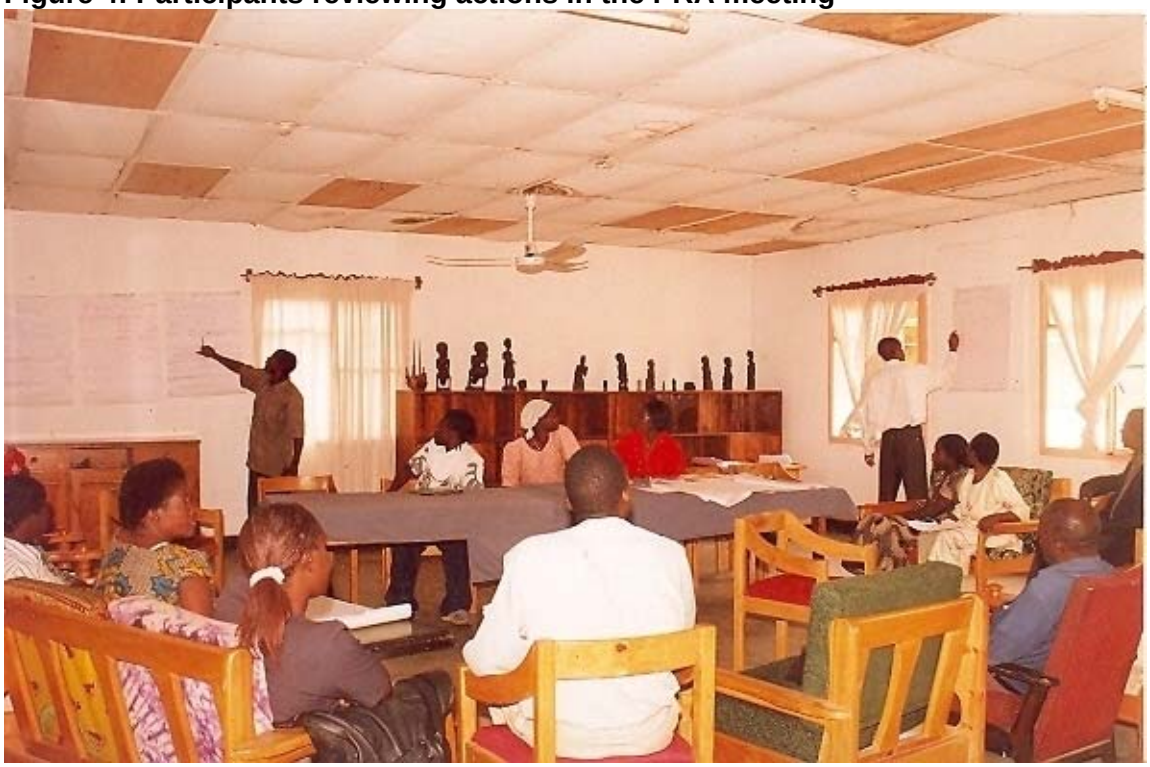
Role players for actions identified as needed and already underway	Role players for actions identified as needed but not underway
TO ADDRESS NUTRITIONAL NEEDS	
• Collection of foodstuffs from households that have enough stocks to support vulnerable children in the area - **implemented by CBOs** • Providing school feeding programmes targeting vulnerable children as an incentive to ensure school attendance and reduce absenteeism and drop out in vulnerable children - **done by NGOs**	• Distribution of adequate food to child headed households to address hunger and avoid children dropping out of school to search for food- **to be implemented by NGOs and CBOs** • Education of community members, especially children, women and the elderly, on nutrition issues and problems and on options for nutritional support.- **to be implemented by health service providers**. • Provision of seeds, farm inputs, implements and technical support to children/female headed households affected by AIDS to boost their food production; - **to be implemented by NGOs and CBOs** • Collective community farming to harvest food and cash crops to distribute to vulnerable children and households affected by AIDS to support nutritional needs- **to be implemented by community members and CBOs**
TO ADDRESS CLOTHING (and other basic) NEEDS	
• Mobilization of money and clothing from households to distribute to vulnerable children in the area - taking place, but at a low level.- **implemented by CBOs**	• Support for life skills, production skills, resources to vulnerable children and affected individuals - **to be implemented by CBOs and NGOs** • Support for establishment of income generating activities through CBOs to organise resources for food, clothing and education needs of vulnerable children - **to be implemented by CBOs**
TO ADDRESS EDUCATION NEEDS	
	• Conduct awareness campaigns on the need to send children to school and ensure that they remain in school - **to be implemented by CBOs and NGOs** • Provision of clothing (school uniforms), school learning/writing materials and payment of school fees for vulnerable children- **to be implemented by CBOs** • Campaign against violence against girls in schools (eg through rape, teacher/pupil sexual relationships, forcing girls out of school to marry)- **to be implemented by CBOs** • Support of care for ill parents so children do not drop out of school to provide care
OTHER	
	• To provide sexual and reproductive health (SRH) services and resources to communities especially young female orphans and women **to be implemented by health service providers**.

With the resource gap identified as a major barrier to more effective coverage of support for orphans and vulnerable children, a resource pockets method was used to explore further the resources available in the district and where they are allocated (see Loewenson et al 2007 for information on the tool). Through this exercise it was discovered that the larger share of resources for vulnerable children's health in Monkey-bay was being sourced and allocated through government health facilities and international development organizations and partners. A significantly smaller share was perceived to be flowing from and through CBOs and within the communities. There seemed to be little direct transfer of resources across stakeholders, such as from health sector to CBOs.

"This exercise has opened up our eyes to see that as CBOs, we are not doing enough in mobilizing resources for OVC health."
Mwalembe CBO Director

Further the bulk of the resources coming to the health sector were in the form of drugs, or were used for supplies, facility maintenance, services and administrative purposes that are not specifically accessible to or geared towards care and support of orphans and vulnerable children. International agency resources for dealing with AIDS were identified as going to Voluntary Counselling and Testing (VCT) Services and care of people living with HIV and AIDS (PLWHA). As these resources tend to be focused on points of service delivery, the community level needs children have for their care and support may be less visible.

Figure 4: Participants reviewing actions in the PRA meeting



Source: CMPD 2008

It was apparent that an allocation of resources that had been more supply than needs driven had left the community level needs of vulnerable children somewhat marginalized, given their low visibility at services. The participatory process and opportunity for organised community and children's input was however felt by both health workers and local leaders to have raised attention to the need for more careful needs based planning in the allocation of scarce resources.

"This exercise is an eye opener. I hope this exercise will assist all of us to identify areas that need much attention but are neglected and strategize how we can together take necessary actions to ensure that they are attended to adequately. Previously we did not have skills to map out how resources on health are flowing to different social groups in our areas; it was difficult to trace important areas that were being neglected."
Female health worker at Monkey-Bay Health Centre.

"We should be doing this exercise annually as an evaluation exercise to see if there are any important areas that are being ignored as well as whether there have been improvements. This will also help us to advocate for changes in allocations of health resources from areas that are not needed most to areas that are needed most."
Chief Chembe.

3.3 Development of an action plan

On the basis of the actions identified, the participants to the process set up an action plan to identify actions that were feasible with potential impact on the identified needs area. It was proposed that the actions would be implemented over a six month period. Identified progress markers of outcomes were set and reviewed during that period to assess outcomes and review the strategies. The plans and progress markers are shown below:

Table 6: Action plan to address the prioritized needs of orphans and vulnerable children

Planned action	Responsible	Period	Intended outcomes
Community farming to support vulnerable children's nutritional needs, and resources for clothing and education support, viz: • identification of land • land preparation • planting, weeding and harvesting • construction of food banks • identification of beneficiaries and distribution of resources	Community members in 18 villages with the support of CBOs in their respective villages	September 2008-March / April 2009	To harvest at least 300 bags of maize, 100 bags of Soya beans, 100 bags of groundnuts in each village and able to support through this 50 vulnerable children especially female children with food and provide resources for clothing and education support for a year.
To conduct community awareness meetings on health of orphans and vulnerable children, especially young female orphans, and on what needs to be done to address the problems	Overall PRA team together with Community based Organizations in each of the 18 villages.	October 2008	Community members sensitized on the challenges experienced by orphans and vulnerable children, especially young female orphans and actions to address the identified health problems.
Readmission campaign for the young mothers who dropped out of school	Community Based Organizations and the Overall PRA team	October 2008 onwards	80% of young female mothers who dropped out of school due to pregnancy and other SRH issues are back in school by December 2009.
Training of Health Surveillance Assistants (HSAs) and Community Health Counselors to counsel orphans and vulnerable children, especially young female orphans regarding SRH issues and protection from abuse	Health service providers	October 2008-December 2008	Orphans and vulnerable children, especially female orphans, have received information on SRH and are able to make informed decisions to reduces SRH risks. At least 30 community counselors, 18 HSAs and 5, 000 orphans and vulnerable children counseled on SRH by May 2009.

Introduction of Monthly Health Forums in which communities will discuss SRH issues and review progress made and develop further actions to address identified gaps.	Overall PRA team and health service providers	From September 2008 onwards	Monthly health forums held Increased awareness in communities of SRH Increased collaboration and communication between communities and health service providers responding to SRH issues.
Facilitation of village PRA training and establishment of Child protection groups	The Overall PRA team with the support of CBOs and CMPD facilitators	October 2008	Communities trained in the use of participatory approaches in responding to orphans and vulnerable children's health needs. Village Child Protection groups established and looking into the welfare and protection of orphans, especially young female orphans.

The community members and the PRA team also set progress markers to assess how far they were achieving goals, and these included

i. Increased collaboration between various stakeholders in responding to orphan and vulnerable children's needs in Monkey-Bay (including on SRH issues) by December 2008.

ii. Increased resources for and service provision for orphan and vulnerable children, especially young female orphans by June 2009, including
   - 30 community counselors, 18 HSAs and 5 000 orphans and vulnerable children counseled on SRH.
   - Orphans and vulnerable children, especially female orphans, have received information on SRH and are able to make informed decisions to reduces SRH risks.

iii. Improved communication between community members and the health service providers in OVC Sexual and Reproductive Health issue as well as other health related issues

iv. Increased SRH seeking behaviors and uptake of public health centers among orphans and vulnerable children in Monkey-Bay by December 2009

v. Increased community participation in governance and management of HIV and AIDS programmes for orphans and vulnerable children by December 2009, including
   - Village Child Protection groups established and looking into the welfare and protection of orphans, especially young female orphans.

vi. Increased awareness and involvement of communities through PRA skills and approaches in community programmes by December 2009, including .
   - 300 bags of maize, 100 bags of Soya beans, 100 bags of groundnuts harvested in each village to support vulnerable children
   - Community members sensitized on the health challenges experienced by orphans and vulnerable children and Increased awareness in communities of SRH
   - Communities trained in the use of participatory approaches in responding to orphans and vulnerable children's health needs.

vii. An increase in the number of orphans and other vulnerable children who enroll in school and a reduction in absenteeism, drop out and year repeat among vulnerable children in Monkey-Bay by December 2009, including
   - 80% of young female mothers who dropped out of school due to pregnancy and other SRH issues back in school by December 2009.

viii. A reduction of community behaviors and practices associated with SRH abuses in orphans and vulnerable children, such as early forced marriages, rape, forced school drop out, forced initiation and harmful cultural practices, forced child labour, especially in young female orphans by December 2009.

Figure 5: The PRA team in Monkey Bay

Source: CMPD 2008

3.4 Implementing the action plan

The action plan was implemented between June 2008 and February 2009. The report outlines the major elements of the actions implemented below.

3.4.1 Improved shared understanding across CBOs/NGOs, services and the community of the health needs and coping strategies

Building on the shared understanding between stakeholders developed at the PRA workshops, community Health Forums were held monthly for community members and health workers to review health needs of orphans and vulnerable children. This brought different stakeholders working on OVC health together in addressing the health needs of OVC in Monkey-Bay. The forums followed the same PRA approaches to discuss SRH and service issues, with a focus on options for improving *communication between health workers and community members. Approximately sixty community members, fifteen health workers, four Area Development Committee (ADC) members and five project facilitators participated in these community health forums.*

Health workers, Community Based organizations, child welfare protection groups and community members also worked together in awareness campaigns against child rights abuse. The PRA team, CBOs, health workers, social welfare/ child protection workers and traditional/community leaders collaborated in the work. They covered issues of forced early marriages, child sexual abuse including rape, commercial sex, inappropriate health seeking behaviors and the sexual and reproductive health (SRH) problems of for orphans and vulnerable children. These sessions were conducted in all the eight target communities.

Figure 6: Community awareness meeting in Sangadzi in Monkey Bay

Source: CMPD 2008

Following the awareness campaigns, community members reported being more open to discuss and report sexual and reproductive health problems and child abuse in their communities. Guardians of vulnerable children reported cases of child abuse, with four cases reported in the six months compared to four cases over the two years previous reported to the Monkey-Bay police unit. Health workers reported a two fold increase in the number of young female orphans seeking sexual and reproductive health services in public health centers between June and December 2008 compared to the previous two years (2006/07). Nevertheless old habits die hard. Some people have been slow to change and the awareness activities need to continue for longer for wider and sustained change.

3.4.2 Improved communication and cooperation between CBOs/NGOs, services and community on support to orphans and vulnerable children

Following the PRA Workshops, agricultural workers, CBOs and community members setup sites for collective community productive farming. On these sites community members are growing maize, beans, soya beans and groundnuts in collaboration with agricultural workers and the PRA team.
These community farming initiatives were piloted in Chiwalo, Mwalembe, and Sangadzi and Chembe villages. Groundnuts, soya beans and maize seeds and fertilizer and other farm tools were provided by CMPD, Icelandic International Development Agency (ICEIDA) and the community members themselves. Community members worked in the community farms from land preparation, ridging, planting, weeding and harvesting. CBOs in these villages and the PRA team provided leadership, supervised and mobilized community members for the work in the fields. The biggest challenge was to mobilize the community members to work in the fields when they also had their own fields. A duty roster for the field work helped to manage these different responsibilities fairly.

Chiwalo and Mwalembe exceeded the 300 bags of maize, 100 bags of Soya beans and 100 bags of groundnuts aimed at, Sangadzi reached the target, but Chembe failed to reach the target due to the dry spell in the area leading to a poor harvest.

Figure 6: Communities working in collective maize gardens in Monkey Bay

Source: CMPD 2008

CBOs, teachers, and the PRA team worked together in re-admission campaigns for the young single mothers who dropped out of school due to early forced marriages, commercial sex and early pregnancies before completing primary school level. The aim was to ensure their readmission back to school, Re-admission campaigns were conducted in all eight communities through meetings with young single mothers in the communities, public sensitization and panel discussions using the local Dzimwe Community Radio. The PRA team, head teachers and CBOs collaborated in this initiative of bringing back these young single mothers to school.

The results are still being monitored but in Chiwalo community, 52 young single mothers visited Nkope School in October of 2008 to inquire of the possibility of being re-admitted back in school. Fifty eight young single mothers have been reported to have been readmitted in school in Chiwalo, twelve in Sangadzi, twenty six in Mwalembe and fourteen in Chantulo.

3.4.3 Increased uptake of health and SRH services for orphans and vulnerable children

A community health forum was facilitated in November 2008 on the barriers to orphans and vulnerable children using public sector health services. In this forum grievances between health workers and community members were raised and discussed, using PRA tools (Joharis Window, Margolis Wheel and the Wheel Chart) Each side was given an opportunity to express their views on the communication and relationship between health workers and communities, and discussions followed on how to address these different grievances and view points using different participatory methods and tools. At Monkey-Bay community health center, for example, use of SRH services rose to 64 cases in the six months June to December 2009, compared to 24 in 2006 and 18 in 2007. Health workers reported that the increase was largely in young mothers who had not visited the health facility before.

A male health worker at Monkey-Bay Community Health Centre showing his appreciation for the exercise said "*We never knew (as health workers) that there were many outstanding issues between us and the community members we serve. It was a wonderful experience here to hear the concerns of the community members regarding how we treat them and the services we provide to them….and we also found an opportunity to express the challenges we face as health workers and we hope there will be mutual understanding between us now..*"

Finally 30 community health counselors and 18 Health Surveillance Assistants were identified for training in counseling on SRH but not yet implemented due to time limitations, given that most people were busy in the fields. It was scheduled for after the harvest.

3.4.4 Improved opportunities, capacities and mechanisms for planning, implementing, and monitoring health promoting activities for orphans and vulnerable children

The PRA process itself opened up dialogue across groups in the area and provided methods for dialogue on problem identification and planning actions on health promoting activities for orphans and vulnerable children. The establishment of Community Health Forums and implementation of joint activities through the developed Monkey-Bay Community Action Plan has also brought stakeholders working on the health of orphans and vulnerable children together within one framework.

Village Child Protection groups were established, or established committees engaged with. Complaints in villages on child rights violations are being reported to these groups who in turn report them either to the Welfare offices or the police for redress. Some of these issues are handled directly by these groups or the local traditional leaders. The groups face a challenge of lack of adequate capacity (knowledge and skills) to handle child rights violations, and lack resources to sensitize community members on issues..

4. Review and evaluation of the process and outcomes

Review of the process and outcomes was implemented through two measures:

i. Participatory review was held through PRA workshops to assess progress and evaluate impact of the planned activities, and to review progress against the set progress markers and outcomes.
ii. A follow up survey was held using the same questionnaire as the baseline survey on the same target group and compared against the baseline survey

These results are discussed here.

4.1 Participatory review and assessment against progress markers

Two participatory monitoring and evaluation (M&E) workshops were held to assess progress and evaluate impact of the planned activities, the set progress markers and set key outcomes. The planned activities were largely implemented, and some of the areas of progress are noted in the prior sections. The final workshop review found that progress markers related to communication and collaboration had been achieved, while those relating to service outcomes and changes in service uptake were still to be achieved, and demanded more time. In the review meetings community members reported feeling greater confidence with using the PRA tools in their organizations, and some had started using them in their area of work.

The community members and PRA team reported gains in skills in using PRA methods and tools. There was evidence of benefit in the community (as discussed in the action section), and also in the increased collaboration between different stakeholders working on vulnerable children's issues in Monkey-Bay. Awareness was perceived to have increased on children's needs with evidence of an increase in both community and service responsiveness to these needs. There is also evidence of improved uptake of services by young people.

4.2 Follow up survey results

The comparison between the baseline and the follow up survey indicates that some areas showed positive change, while others did not, and in some perceptions became more negative.

The repeat survey on the same target groups found little change in relation to

- Understanding of the needs of orphan and vulnerable children by community members, CBOs and health workers (already rated relatively high in the baseline)
- Communication by orphans and vulnerable children and community members about orphan and vulnerable children needs
- Health service accessibility and relevance to male and female orphan and vulnerable children
- Community member involvement in planning CBO support for orphans and vulnerable children
- Orphan and vulnerable children knowledge of the services available for their support and involvement in planning health services.

While it may be expected that some factors are slow to change, like health service access, little change in dimensions such as communication and understanding is more surprising, given the communication that took place in the process. It may be that the process did not reveal new issues but rather improved the co-ordination across groups for identifying priorities and *acting* on them. It has also been found in such processes that as people become more aware of their potential roles or options their expectations increase, affecting their satisfaction with current situations.

Areas were change *was* perceived to have taken place was in relation to

- Community members and CBOs cooperation in supporting orphan and vulnerable children
- Health workers and orphan and vulnerable children communication
- Male and female orphan and vulnerable children likelihood of using health services for a SRH problem like a sexually transmitted infection (STI)
- Orphans and vulnerable children involvement in planning CBO support for them
- Community member knowledge of the services available for orphan and vulnerable children support; and
- Community leaders (religious, chiefs) support for orphans and vulnerable children.

As observed above, it would appear that, at least in the perception of those involved, the ability to act on problems has improved in this process.

Health workers were generally less positive than other groups, although even they perceived positive changes in the areas above (See Table 7). Community member perceptions were generally more positive than those of children. It appears from the follow up that the process had strengthened community level factors in co-operating with and supporting vulnerable children, and that some of the service barriers were felt to have been reduced. However, factors relating to access and quality of services, and the deeper involvement of the children themselves in the processes had yet to be achieved. As the community members noted in their own review, this takes time. It may be that reaching and changing the knowledge and relationships between community members and service providers is an important step to providing a community based support network for vulnerable children. This can only be assessed over a longer term time frame.

Table 7: Results of the baseline and follow up survey

("Agreeing" refers to those giving "strongly agreeing / agreeing" as the response to the question)
CM= Community members HW = Health Workers

	% agreeing in the baseline				% agreeing in the follow up			
QUESTION	**Children N=89**	**CM N=14**	**HW N=17**		**Children N=89**	**CM N=14**	**HW N=17**	
Orphan and vulnerable children needs are understood by community members	62	79	76		62	79	76	
Male and female orphan and vulnerable children needs are the same	52	43	65		44	29	41	
Orphan and vulnerable children needs are understood by CBOs	56	57	65		56	57	41	
Orphan and vulnerable children needs are understood by Health workers	56	50	59		56	50	65	
Community members and CBOs communicate well about orphan and vulnerable children needs	58	57	47		45	36	41	
Community members and health workers communicate well about orphan and vulnerable children needs	44	50	59		36	36	35	
Orphan and vulnerable children and community members communicate well about orphan and vulnerable children needs	52	43	47		52	43	59	
Community members and CBOs cooperate well in supporting orphan and vulnerable children	57	57	59		62	71	47	
Community members and health workers cooperate well in addressing orphan and vulnerable children health needs	49	71	12		58	86	65	
Health services addresses the needs of orphan and vulnerable children	37	64	35		22	21	35	
Health services are accessible to male orphan and vulnerable children	33	43	53		33	43	35	
Health services are accessible to female orphan and vulnerable children	48	43	53		48	43	53	
Health services are relevant to male orphan and vulnerable children needs	47	71	47		47	71	53	
Health services are relevant to female orphan and vulnerable children needs	47	50	47		47	50	47	
Health workers and orphan and vulnerable children communicate well	55	79	47		55	86	71	
Male orphan and vulnerable children are likely to go to a health service for a SRH problem like a sexually transmitted infection (STI)	61	57	53		61	71	71	
Female orphan and vulnerable children are likely to go to a health service for a SRH problem like an STI	48	71	53		56	86	88	
Community members are involved in planning CBO support for orphans and vulnerable children	52	29	53		52	29	53	
Orphans and vulnerable children are involved in planning CBO support for them	61	93	29		71	93	53	
Community members know the services available for orphan and vulnerable children support	54	36	35		65	79	76	
Orphan and vulnerable children know the services available for their support	65	57	35		65	57	35	
Orphans and vulnerable children are involved in planning health services for them	48	57	59		48	57	59	
Community leaders (religious, chiefs) give strong support for orphans and vulnerable children	49	64	65		49	86	71	

5. Reflection on lessons learned

5.1 On Primary Health Care approaches to support of orphans and vulnerable children

The rising population of orphans and vulnerable children who are reported to lack care, food, educational opportunities and adult role models raise social, economic and public health concerns. From a public health perspective, the coping strategies used by these children, such as early school dropout and child labour, combined with poor adult support, make them susceptible to risk of early onset of sex and to sexual and reproductive health problems, including HIV infection. In this study prioritized health needs of these children were identified to be food – rated first by a wide margin - clothing, and education support. Limited resources within households in the community and poor coverage by support services was felt to lead children to expose themselves to health risks such as commercial sex in trying to address these needs. Filling gaps in social protection was thus identified as important. A Primary Health Care approach to AIDS is thus embedded within and reinforces a wider social protection strategy that addresses life course needs, such as those of vulnerable children.

A number of obstacles were found to children accessing the social support they need:

- Although their needs were seen to be understood by communities, the available services for vulnerable children were not well known to community members
- Local CBOs better known to communities and children obtained very limited resources for their interventions, including from outside sources.
- Many resources flow through formal services, including health services, to commodities and activities that demand that children access and use those services, ie at point of care. Yet vulnerable children do not use these services, and perceived themselves to be excluded from and poorly supported by health services; with poor communication about their needs. Community level opportunities for care and support are less visible and less well resourced.

Poor relationships between community members and health workers in Monkey-Bay thus intensified health risk for vulnerable children, and undermined their use of services including the . Voluntary Counseling and Testing (VCT) services needed for prevention and the treatment services for HIV and other sexually transmitted infections. While there is some service provision, de facto the HIV prevention and the mitigation of AIDS impacts are at low levels in this area, closing the potential window of hope for vulnerable children through survival activities like commercial sex.

The lessons learned and the actions that appeared to strengthen uptake of services and link services and community resources to prioritized needs suggest that PHC responses need to be decentralized to primary care level, but cannot end at that level. *Significant* attention and resource commitment has to be given to promoting outreach and uptake of services, if they are to be accessed and used by vulnerable groups like orphans and vulnerable children, especially for female children. The activities that achieve this are not all found within the health sector, and co-operation between and a balance of resource flows to other sectors (agriculture, education, social welfare) and to CBOs for community activities like collective farming can have an impact on health service relevance and uptake.

The increase in the health seeking behaviors and expressed demand on health services by vulnerable children generated by these community led and inter-sectoral processes may put pressure on government and funders to increase resources and support, to cater for the demand. It may also put pressure on health service providers and health workers in Monkey-Bay to improve their services to meet the growing demands. We were not able to test this in the time of the study, but will continue to monitor this.

Bringing stakeholders working on the health of orphans and vulnerable children together within one framework, such as a shared action plan, would seem to be vital. Children themselves can and should be involved in planning these processes, at minimum in identifying priorities and actions with other stakeholders, in ways that do not disempower them. The PRA approaches used in this programme were found to facilitate such involvement in CBO planning, but not in health services. It is possible that more sustained processes and time is needed for changes in health service planning processes.

This also needs to be sustained and supported by national institutions and processes. The National AIDS Commission and development partners have a role in increasing support and funding to the type of interventions described in this report, as part of the inter-sectoral component of PHC responses to AIDS. If the vicious cycle of vulnerability and spread of HIV and AIDS is to be broken for young children, especially female orphans, PHC models for responses to AIDS are needed, with resources allocated to intersectoral, outreach and community level elements and processes that strengthen support to, involvement of and uptake in children.

5.2 On participatory methods as a means to building people centred health systems

Both community members and the PRA team have gained skills and experience in PRA approaches and methods, and perceived benefit from the process. The involvement and ownership they brought provide a basis for activities to be sustained after the study phase. The PRA methods and tools were user-friendly for local communities and provided a means to bridge communication across very different groups (from children to service providers), to build shared perceptions of priorities. They facilitated the raising of grievances among different stakeholders without raising tensions, and enabled discussion of how to address them.

The PRA approaches have provided a means for sharing of information and perspective, and for building the collaboration needed for action across different stakeholders working with vulnerable children in Monkey-Bay. The evidence in this report suggests that there has been an increase in community cohesion and ability to respond to health needs. The team is at the beginning of the process and as PRA approaches take time, it will be important to both support and assess the sustainability of the changes achieved.

5.3 Next steps

The work is ongoing and the CMPD, community, CBOs and services have indicated the intention to sustain the initiatives. Community Health Forums will be used to facilitate discussions regarding health service delivery and resource allocations to the health sector, especially on HIV/AIDS and vulnerable children's health. They will also provide platforms in which community priority health needs will be discussed and identified to which will lead to take forward to District Assembly for consideration, as well as to parliamentarians, national or local health networks, health workers and policy makers.

We realize that we need to deepen the demand for resource allocation to health needs from communities to strengthen PHC, especially regarding HIV and AIDS. This also calls for strengthening the health governance and community involvement in planning, using PRA approaches, to widen and consolidate the gains we observed in this study for other areas of community empowerment for health. This includes strengthening over time the capacities and dialogue with the Area Development/Village Development Committees, Health Centre Committees, CBOs and services to support these processes that raise and identify actions on health needs, and to monitor, track and engage on the resources and services to meet these needs, including for HIV and AIDS.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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