Unlocking the potential of the child: Improving social support and health care of orphans and vulnerable children through increased child participation in Victoria Falls, Zimbabwe

A Participatory Reflection and Action (PRA) Project Report

Holistic Child Support Initiative, Zimbabwe
with the
Training and Research Support Centre
in the

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Cover photograph by D Masuku and M Chigama HOCSI, Victoria Falls 2009

Executive summary

Even though HIV prevalence is on the decline in Zimbabwe, having dropped from 25.7% in 2002 to 16.1% in 2009, the impact of this epidemic over the last decade has been devastating. This is especially true of children. In a country with over 41% of the population under the age of 15 years, the AIDS epidemic has resulted in over 1 million AIDS orphans and many other vulnerable children. Most of these children remain in their communities, either in child-headed households or looked after by their extended family or members of the community. Due to early school dropout, child labour, economic insecurity and poor adult support, many of these children are susceptible to early onset of sexual activity and thereby to HIV infection. While there has been a massive response from local community groups, government, civic and international organisations to the plight of these children, many of these policies and programmes have been designed in a top-down manner, without taking into consideration the views of the children themselves. This lack of child participation in the planning, implementation and evaluation of programmes weakens their potential impact and undermines the inherent capacity, experience and skills of the children themselves.

The focus of this study is on increasing the participation of orphans and vulnerable children in primary health care (PHC) in Victoria Falls, a town in the north-western part of Zimbabwe, situated on the border with Zambia. Like many border and tourist towns in the southern African region, Victoria Falls has a higher than average HIV prevalence rate of 26.4% and a correspondingly high number of vulnerable children. The study was undertaken by the Holistic Child Support Initiative (HOCSI), a non-governmental organisation based in Victoria Falls, using participatory reflection and action (PRA) methods. It aimed to explore and address barriers to child participation in health services and uptake, including access to anti-retroviral (ARV) treatment, as well as strengthen cooperation between Primary Health Care (PHC) service providers, children and the wider community. The work was implemented within a programme of the Regional Network for Equity in Health in east and southern Africa (EQUINET) that aimed to build capacities in PRA research to explore dimensions of (and impediments to delivery of) PHC responses to HIV and AIDS. The programme was co-ordinated by Training and Research Support Centre (TARSC) in co-operation with Ifakara Health Institute Tanzania, REACH Trust Malawi and the Global Network of People Living with HIV and AIDS (GNPP+).

The study used a mix of quantitative assessment and participatory action research methods (PRA). The quantitative methods included pre- and post-intervention questionnaires. PRA methods were used to generate discussion on the health needs of vulnerable youth, to develop priority areas of action and to reflect on the whole process. An initial baseline survey included 92 orphans and vulnerable children, fifteen community members and ten health workers. The respondents were drawn from nine wards in the two high-density areas of Victoria Falls, namely Chinotimba and Mukhosana. The children were between the ages of 10 and 17 years and were enrolled in primary or secondary school. The survey identified key areas where child participation could be improved in the planning, delivery and use of health services for vulnerable children. It also examined the orientation and uptake of services, communication between

health personnel and children, child participation in planning and budgeting of health services, and overall coordination and networking around the needs of vulnerable children.

The PRA meeting included children, community representatives and health workers. It aimed at identifying current practices with regard to child participation in PHC services, to increase uptake of PHC services, including uptake of anti-retroviral therapy, to prioritise the heath needs of vulnerable children and to find ways of responding to these needs in a more coordinated manner. Participants identified three priority health problems faced by these children. These were, in order of priority:

- poor access to ART;
- child abuse; and
- poor housing.

For each problem, the group discussed its underlying causes and possible solutions. Structural constraints, such as poverty and weakened health and community services, were seen as the primary underlying causes, resulting in difficulties obtaining anti-retrovirals, inadequate counselling at the clinics, delays in reporting and taking action on cases of abuse, poor living conditions at home and poor waste management. Also, according to participants, social and personal issues contributed to inadequate participation of children in finding solutions to their problems. Low levels of participation by other social groups (such as men) in the prevention of mother-to-child transmission (PMTCT) programme was also associated with superstition and denial.

The children, community representatives and health workers proposed a number of solutions, many of which focused on creating greater awareness at community level (for example, about anti-retroviral therapy and child abuse) and were targeted at various social groups, including the children themselves, health workers, teachers and traditional healers. Solutions also included greater involvement of other stakeholders in supporting the health needs of vulnerable children, strengthening existing services and relations to cater to the needs of children, and improved collaboration between stakeholders. Participants also suggested a number of activities to improve children's participation, including establishing child friendly desks in all health institutions, strengthening AIDS Clubs in the schools, establishing Kids Health Action Clubs, and creating children's forums that work with local authorities and other partners.

The action plan was implemented over a period of four months. In this short time frame, the researchers did not expect to address all the issues raised during the PRA research, given that many are structural and need longer term processes. However, community organisations involved in this research did attempt to mainstream psychosocial support activities into all planned actions, undertook a number of awareness campaigns, initiated and participated in child protection committees and started to meet monthly to strengthen coordination.

Progress markers and a follow-up survey showed improvements in some areas, although not all. The findings confirm that there is still a need to improve understanding of the health needs of vulnerable children among health workers, community leaders and adults. However, children noted an improvement in the quality and use of health services, backed up by better interactions and cooperation between themselves, the health workers and the community. On the negative side, the intervention had no or negative impacts on respondents' perception of the referral system, the role of Social Welfare, and the role of children in the budgeting process. As found in other PRA studies implemented in this programme, this could be explained by a rise in knowledge and expectations due to the participatory work undertaken, leading respondents' to be less satisfied with the current situation.

This action research suggests that child involvement is an important component in a PHC approach to meeting the health needs of children. There are various strategies for doing this. At a minimum, these include creation of an enabling social environment that encourages child involvement in decision-making processes, the support of vulnerable children through structured platforms for the exchange of information and experiences, provision of child friendly services, and promotion of effective communication between health workers, community members and children to support effective coverage of services.

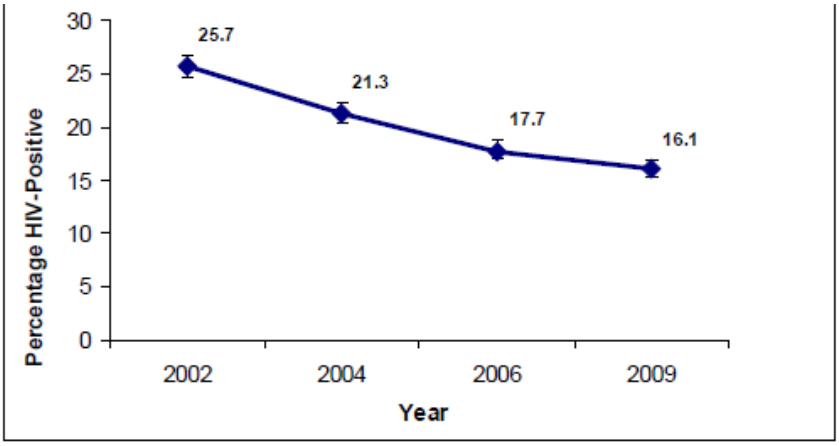
1. Introduction

After Zimbabwe's independence in 1980, there were impressive improvements in the health of the population, following government's commitment to primary health care (PHC) and to provide health care according to need. This commitment to social justice and equitable distribution of resources led to positive health outcomes, including in terms of contraceptive use, child mortality, nutrition and education (Tumwine, 1992). It supported community participation in health at district level and increased coverage of primary health care (PHC), including free access to health and the expansion of rural infrastructures. Unfortunately, these successes were reversed in the 1990s and 2000s, due to shifts in policy and political and resource support fir PHC, to economic decline and to the devastating impact of AIDS. By 2002, the Ministry of Health and Child Welfare (MoHCW) estimated that there were 1.8 million HIV-positive people in Zimbabwe, with a 25.7% prevalence among women aged 15–49 years attending ante-natal clinics (MoHCW, 2002). As a result of HIV-related illness, the burden of disease increased up to sevenfold, increasing demand for health services, displacing other health needs and doubling hospital bed occupancy rates (Ray and Kureya, 2003). Households were forced to take on the burden of caring for ill people at a time of declining real household income.

Prior to the introduction of treatment for the prevention of mother-to-child transmission (PMTCT) and anti-retroviral treatment (ART) programmes in Zimbabwe, AIDS-related mortality was high – estimated at 500 deaths per day in 2002 (Ray and Kureya, 2003). This led Zimbabwe to have one of the lowest life expectancies in the world (UNDP, 2008). Despite the fact that that ART has accelerated in the last few years, there are gaps in coverage of treatment for those in need (MoHCW, 2009).

Since 2002, HIV prevalence in Zimbabwe has been on the decline. As shown in *Figure 1*, HIV prevalence is now 16.1% of pregnant women, a considerable drop from the 25.7% seven years earlier (MoHCW, 2009). The reasons for this decline are thought to be in a reduction in high risk sexual behaviour (resulting in a decline in HIV incidence), coupled with an increase in adult mortality. Nevertheless, by 2008 one in seven Zimbabweans were still infected with HIV, and treatment delivery and access was challenged by severe weaknesses in the health system (ZADHR, 2008).

Figure 1: Percentage of HIV-positive women aged 15-49 at antenatal care facilities, 2002–2009



Source: MoHCW, 2009

The epidemic has had a severe impact on children, especially since Zimbabwe is a country with over 41% of the population under the age of 15 years (CSO, 2008). It has left over one million children as orphans at the end of 2008 (Government of Zimbabwe, 1999). In Zimbabwe, the definition of an orphan is a child below the age of eighteen who has lost one or both parents. Most of these children remain in their communities, either in child-headed households or looked after by their extended family or members

of the community. There are also many vulnerable children in the country, who are defined as those children with or without parents who are disadvantaged economically or socially, in other words, lacking the support they need to ensure their rights to food, shelter, education and other basic needs (ibid). Various coping strategies to deal with these burdens have been identified in regional reviews (Foster, 2005). 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 with households, some become child-headed (Foster, 2002). Such children have been found to take on adult roles, doing work and caring to support the family. Many quit school and jeopardise their own health and development needs to take on roles as parents, nurses and providers (Im-em and Suwannarat, 2002).

Early school dropout, child labour and poor adult support can make children highly susceptible to early onset of sexual activity and to HIV infection. These challenges call for a specific and clearly defined response from health and other social institutions to ensure children's needs are met. There has been wide response from local community groups, government, civil society organisations and international institutions, such as for support of school fees and other material support, psychosocial support and access to health services, including providing ARVs for HIV-positive children. Government has passed a number of acts to support the rights of children in difficult circumstances, such as the Children's Protection and Adoption Act [Chapter 5:06] and is also a signatory to a number of international conventions, such as the United Nations Convention on the Rights of the Child. While many of these policies and/or programmes have had some positive effect on the lives of vulnerable children, most have been designed in a top-down manner, and the views and voice of the children themselves are not generally incorporated in their design. Lack of child participation in the planning, implementation and evaluation of programmes that directly affect them weakens the potential impact of these programmes and undermines the inherent capacity, experience and skills of the children themselves (Faulker et al, 2002; Johnson, 1998).

This study thus aimed to increase participation by orphans and vulnerable children in developing programmes for their social support and improved access to health care. It took place in Victoria Falls, a town situated in the northwestern part of Zimbabwe on the border with Zambia. Victoria Falls had a population of approximately 32 000 people in 2002 (CSO, 2004), and the Victoria Falls Municipality estimates that this number has possibly doubled since then (personal communication, Victoria Falls Municipality Department of Social Services, 2008). The town’s main source of income has been tourism but this has been badly affected by the political and economic situation in the country in the last decade. Unemployment and poverty is high.

Like many border and tourist towns in the southern African region, Victoria Falls has a higher HIV prevalence rate than the national average, mainly due to cross-border activities and tourism, as well as high levels of spousal separation, multiple sexual partners and commercial sex work. Chinotimba Clinic serves a predominantly urban population in Victoria Falls and is one of the ante-natal care (ANC) sentinel surveillance sites for the MoHCW National HIV and AIDS surveys. During the last ANC survey (2009), Chinotimba Clinic with an HIV prevalence of 26.4% had the highest national HIV prevalence in ANC attendees aged 15–49, compared to a national average of 16.1%. Although high, it was lower than in previous years; for example, in 2003, prevalence was 33%. This high HIV prevalence has resulted in a similarly high number of orphans, estimated at 2,500 in the town (personal communication, Victoria Falls Municipality Department of Social Services, 2008) A large number of these orphans live in Mukhosana and Chinotimba townships and come from vulnerable family backgrounds.

There are a number of key institutions working in Victoria Falls that are supporting the needs of these children. These include the Zimbabwe Red Cross Society, Lubancho House, Hwange AIDS Project, Churches and Environment Africa, as well as the Holistic Child Support Initiative. These organisations meet at least quarterly to monitor their work and map the way forward.

The Holistic Child Support Initiative (HOCSI) is a non-governmental organisation that was established in 2005 to meet the specific needs of OVC in the Victoria Falls municipal area. To date, HOCSI has been involved in a number of activities such as school support for OVC, counselling for both OVC and their care givers, HIV-prevention programmes, psychosocial support training for orphans and vulnerable children and their care givers, income-generation projects and supplementary feeding programmes. During our interaction with children and organisations in Victoria Falls, HOCSI came to recognise that there are a number of issues that need to be addressed:

- Children's health and social needs were not being adequately met because they did not participate in identifying their own needs and were not included in the planning and implementation of social and health programmes directed at them.
- PHC services did not fully cater to the health needs of children in difficult circumstances due to lack of child participation.
- There was inadequate collaboration between health service providers and organisations assisting the children.

In early 2008, the programme manager at HOCSI attended a training course on participatory action research (PRA) methods for people-centred health systems, which was convened by the Regional Network for Equity in Health in east and southern Africa (EQUINET), through the Training and Research Support Centre (TARSC) and Ifakara Tanzania. The course was aimed at building capacity in PRA research to explore dimensions of – and impediments to the delivery of – PHC responses to HIV and AIDS. It stressed that PRA is designed to raise the community's voice and strengthen collective forms of community analysis and organisation so that people become more empowered to take up ownership of and further their own interests in their own health services. HOCSI realised that PRA approaches would prove invaluable in exploring ways to include children in defining their own health needs. As a result, the HOCSI participatory research programme was planned and implemented as a follow-up to the EQUINET/TARSC/Ifakara regional workshop in February 2008.

1.1 Objectives of this study

This study aimed to bring about a number of changes, namely improved participation of vulnerable children in identifying their health priority needs and expanding the response by health services to these needs through:

- better or enhanced provision of and access to PHC services, including access to ART; and
- strengthened cooperation between PHC service providers and the community.

The study aimed to:

- compare the different perceptions of health workers and community members and discuss how to include children's perceptions in health planning through PRA approaches, which will help to identify vulnerable children's priority health needs and responses;
- use PRA approaches to organise PHC services, including ART, so that they meet the needs of OVC better, which includes the reviewing of regular services with health workers, community and children, as well as identifying and overcoming barriers in services and staff approaches;
- identify actions and mechanisms to improve networking and joint work between health services and other services that support vulnerable children's health and community responses; and
- set up an action plan and to implement and monitor progress on this action plan and review progress and lessons learned.

By meeting the aims given above, the following outcomes are expected:

- increased participation of vulnerable children in the community in identifying their health needs and potential responses to these needs;
- explicit programming of responses to vulnerable children's health needs, including ART in PHC services, and orientation of health staff to address these needs in a child-friendly manner;
- increased uptake of PHC services by orphans and vulnerable children's;
- increased referral of eligible vulnerable children for ART; and

- increased networking and joint work between health services, other services that support vulnerable children's health and community needs.

This paper describes the extent to which the programme of work we initiated in Victoria Falls managed to meet these expectations. It documents the methodology, findings and actions taken during implementation, and also reflects at the end of the report on our experiences and lessons learnt.

2. Methodology

After completion of the EQUINET/TARSC/Ifakara training on participatory approaches, the HOCSI-trained facilitator developed a protocol for implementation of the programme in Victoria Falls Town. This was done with technical input and guidance from TARSC. The project was launched in July 2008, but in the challenging situation facing Zimbabwe throughout 2008, the work only commenced operationally in June 2009.

Before the project was launched, the following schedule was put together:
- introducing and discussing the work with relevant stakeholders in Victoria Falls (vulnerable children, PHC service providers and organisations supporting vulnerable children);
- formulating data collection instruments and PRA tools;
- conducting the initial baseline survey;
- setting up and orienting the PRA team;
- running a workshop with orphans and vulnerable children, community representatives and health workers on setting priorities and identifying responses to health needs and other needs of vulnerable children;
- reviewing meeting with vulnerable children, health workers, community representatives and organisations supporting vulnerable children;
- implementing an action plan developed during the workshops with stakeholders;
- conducting a post-baseline survey at the end of the project;
- reviewing progress and determining the way forward (stakeholder workshop); and
- presenting a final report with lessons learnt, knowledge gained and recommendations.

The study used a mix of quantitative assessment and PRA methods. The quantitative methods included a pre- and post-intervention questionnaire. Participatory methods were used to generate discussion on the health needs of vulnerable youth, in developing priority areas of action and reflection on the whole process. We used a range of participatory methods, including the ranking and scoring, spider diagrams, stakeholder mapping, Johari's Window and Stepping Stones.

The programme began with a series of introductory meetings with stakeholders in our coverage area. During these meetings, stakeholders helped to select the PRA team and to identify the catchment area for the research. The PRA team was then trained by the lead facilitator to improve their competencies in the use of participatory approaches. The project team consisted of four people: the District AIDS Coordinator (NAC), a social welfare officer, a teacher from Chamabondo Primary School and the programme manager for HOCSI. This group was chosen based on their skills and availability. The team then revised and finalised the protocol for the implementation of the PRA project. The team decided to implement the programme in two high-density suburbs of Victoria Falls, namely Mukhosana and Chinotimba, which have the greatest concentration of vulnerable children due to the high prevalence of HIV and AIDS, as well as poverty and overcrowding. The study drew its participants from among health workers, community representatives, and representatives of organisations considered relevant to the improvement of the quality of life for children in difficult circumstances.

A structured interviewer-administered questionnaire was used to collect information during the baseline survey. It was administered before the first PRA workshop and was targeted at 92 children, fifteen community members and ten health workers, drawn from nine wards in the two high-density areas. The

children were between the ages of 10 to 17, and the gender breakdown was equal (50% boys, 50% girls). Of those interviewed, 60% were orphans and vulnerable children. All the children were either enrolled in primary or secondary school. The same questionnaire was administered post-intervention and used the same group of respondents of 87 children, thirteen community members and ten health workers. The number was lower than for the pre-intervention questionnaire because some of the initial respondents could not be located.

The questionnaire addressed the following topics:

- the respondent's views on orphanhood and vulnerability of children in the community;
- community awareness of the health needs of orphans and vulnerable children;
- discrimination against vulnerable children;
- aspects of consultation and participation;
- child-friendly budgeting;
- accessibility of PHC services;
- the quality of service delivery;
- the current nature of assistance towards vulnerable children; and
- communication between stakeholders (community, health workers and children).

The questionnaire was pretested and then reworded to ensure the questions were fully understood. The interviewer used both English and the local languages (Shona, Ndebele and Nambia) when asking the questions. Interviewees then recorded their answers on the questionnaire.

After the initial baseline survey, the priority setting workshop was held using PRA approaches. Participants were drawn from the group who took part in the survey. The workshop was held in November 2008 and was attended by a total of 30 participants, including five from five community-based organisations (one from each), two school representatives, fifteen school children, five community representatives and three health workers. This workshop aimed to identify current practices with regard to child participation in PHC services, as well as prioritise the heath needs of vulnerable children and ways of responding to these needs. Specifically, the objectives of the workshop were:

- to identify the priority health needs of orphans and vulnerable children in Victoria Falls and to explore their underlying causes;
- to identify existing responses to the needs of vulnerable children;
- to identify existing organisations and social groups assisting vulnerable children at community level;
- to assess the barriers and ways of overcoming these barriers in the provision of health services to vulnerable children, including child/health worker communication; and
- to explore how children, community groups and health workers can work together to meet the health needs of vulnerable children.

A variety of participatory tools were used to meet these objectives and to promote participation. These included ranking and scoring, spider diagrams, stakeholder mapping, Johari's Window and Stepping Stones. These tools were adapted to suit the local environment, such as by using local materials and role playing in place of more complex tools. The findings are presented in the next section of this report.

The PRA workshop concluded with an action plan that was implemented over the following four months. During the implementation phase, community representatives, school representatives, health workers, police, representatives of organisations supporting children and children met on three separate occasions. Children were also engaged in two focus group discussions and one focus group discussion with community members to discuss various issues related to child participation in strengthening PHC services for vulnerable children. Participatory methods were used to promote debate and participation. The importance of building partnerships among all players in the support of vulnerable children was discussed. The final stakeholder workshop then reviewed the actions against agreed progress markers and discussed lessons learnt and the way forward.

With regard to consent and issues of confidentiality, local authorities were informed about the survey objectives and gave consent for the survey to be administered within their jurisdiction. Prior to implementation of the baseline survey, parents and guardians were informed orally of the purpose and nature of the study. The parents and guardians consented on behalf of the children and themselves.

In addition to obtaining verbal consent, respondents were given a guarantee that the data collected would not be used in a manner that would identify individual respondents. Interviewers signed a document protecting confidentiality of individual responses and respondents were told not to record their names.

3. Results

3.1 Analysis of initial baseline data

Information that we collected during the baseline survey (the pre-intervention questionnaire) was analysed to assess levels of information available to respondents and their understanding of orphanhood in the community of Victoria Falls. The groups interviewed included children, health workers and community representatives. In this section, we will discuss the baseline data in the following order:

- the situation of vulnerable children in the community;
- services for vulnerable children in the community;
- the interaction between health services and the community/children; and
- mechanisms for communication and change.

In analysing the baseline data, we focused on the number of respondents who answered either 'strongly agree' or 'agree' to each of the 20 statements in the questionnaire. (The 20 statements are provided in *Tables 1* to *4*). This approach allowed for an easier analysis of the findings. We have not included the percentage who answered either 'don't know' or 'disagree/strongly disagree', unless these answers give further insight into the respondents' answers.

The first five statements in the questionnaire dealt with the situation of vulnerable children in the community. In this section of the baseline analysis, we sought to find out respondents' perceptions of the extent of orphanhood and child vulnerability in their community, their views on the differences in understanding of adults, community leaders and health workers with regard to the health needs of vulnerable children, and how they perceived the level of discrimination against children living with HIV (See *Table 1*).

There was general agreement between all groups (children, health workers and community representatives) that there are many children in Mukhosana and Chinotimba Townships who are either orphans or vulnerable children. Community members, who are the custodians of the children, were 100% in agreement that there is a high prevalence of orphanhood and vulnerability in their communities. The children also viewed this problem as being prevalent (79%). At 55%, health workers were less committal about the seriousness of the problem, possibly as clinic staff had been able to do little outreach over the previous few years and may have lost touch with the seriousness of the problem at community level.

Table 1: Situation of vulnerable children in the community

Statements in questionnaire	% children agreeing/strongly agreeing (N = 92)	% health workers agreeing/strongly agreeing (N = 10)	% community members agreeing/strongly agreeing (N = 15)
1. Most children in my community are vulnerable children.	79	55	100
2. Adults in the community know well the health needs of vulnerable children in my community.	39	36	67
3. Community leaders know well the health needs of vulnerable children in my community.	42	45	35
4. Health workers in the community know well the health needs of vulnerable children in my community.	48	55	47
5. People in our community discriminate against children living with HIV.	40	45	100

All respondents recognised that adults, community leaders and health workers had only a partial understanding of the health needs of vulnerable children. The children generally felt that health workers had the best understanding, but most vulnerable children were not satisfied that their health needs were understood by the wider community.

Statement 5 sought to analyse the level of discrimination against children living with HIV. Except for the community members who unanimously agreed (100%) that the levels of discrimination are high, both the health workers and vulnerable children were divided on whether discrimination against HIV positive children existed. Of significance is the number of vulnerable children who answered 'don't know' to this question (23%), which may be interpreted as children not wanting to commit themselves on this sensitive issue. Statements 6 to 11 of the questionnaire sought to determine the ability of vulnerable children to access PHC services, especially in relation to treatment of HIV and AIDS, as well as the quality of these services and the referral system related to use of these services (see *Table 2*).

Table 2: Services supporting vulnerable children's health needs at community level

Statements in questionnaire	**% children agreeing/strongly agreeing (N = 92)**	**% health workers agreeing/strongly agreeing (N = 10)**	**% community members agreeing/ strongly agreeing (N = 15)**
6. Vulnerable children in my community can easily access treatment services at clinics for their health needs.	37	36	13
7. Vulnerable children in my community use health centres/clinics when they need to.	27	64	20
8. Local health care centres provide satisfactory quality services for vulnerable children.	36	45	60
9. Vulnerable children in my community find it easy to access treatment for AIDS.	55	82	60
10. Vulnerable children with HIV are generally referred to health services for treatment by other institutions in the community.	53	82	87
11. Vulnerable children are assisted by the Social Welfare Department to access health services.	52	36	67

The baseline data indicates that most vulnerable children feel that health services poorly address their needs, as the majority stated that it is not easy to access treatment services, that only a minority use the health services and that the quality of services is low. Vulnerable children are slightly more positive about access to treatment specifically in relation to HIV and AIDS. The children also agreed that HIV positive children were being referred to the health centres by institutions such as the schools, although health workers and community members were more positive about this. In relation to the role of the Social Welfare Dept in assisting vulnerable children to access health services, the children and community members had a more favourable perception of the situation – health workers less so. The baseline, and follow up focus group discussion, indicates that there was confusion among the health workers regarding the welfare office of the Municipality of Victoria Falls and the Department of Social Welfare, which is based in another town (Hwange).

The focus group discussion with the children triangulated the findings from the baseline questionnaire. Generally, the children stated that they were not happy with the services being offered by health institutions. They cautioned each other not to expect too much from the health workers and to recognise the pressure the health workers work under, particularly during these difficult times. As one child remarked: 'You are not the only person who needs to be attended to. There are elders who are in a more critical condition.' Children felt that there was limited assistance coming from both the community and health workers. Health institutions tended to demand payment and disregarded referral letters from institutions like schools. Health personnel also insisted that an adult accompany a child to the clinic, regardless of the child's age or their capacity to express themselves and their needs. Even though requirement is stipulated by clinic policy, the children still felt this was harsh, especially if the child was in pain and in need of immediate assistance. They felt that service providers were not giving them an opportunity to say how they feel because the accompanying adult would be giving all the information. As one child said during a focus group discussion: 'At least they should ask me how I feel'.

Statements 12 to 18 of the questionnaire dealt with issues pertaining to interaction between the health services and the community/children. *Table 3* indicates that children are not satisfied with the level of interaction between themselves and the community – over 50%, and sometimes as many as 80%, maintain that they are not involved in identifying their health needs or follow-up actions, that they have little say in health budgeting, and that community and child communication with health workers is poor. During the focus group discussion, children highlighted the health workers' tendency to talk directly to the parent or guardian, ignoring what the child had to say. Nevertheless, 64% of children did say they thought the health workers were supportive and friendly to them, as compared to 100% of health workers who felt the same. Generally, the community representatives and health workers were more inclined to think favourably about the level of communication between the health system and users.

During the focus group discussion, the children emphasised their concern with the lack of consultation between themselves and health providers. They insisted that if they were consulted, health service delivery would be more effective. They expressed concern at the lack of child-friendly centres and recreation facilities and indicated that the junior council could be a vehicle to capture children's views during budget formulation. Vulnerable children have expectations, and they want to be involved or consulted. As one child said: 'If it's for us, then we must be consulted'.

The final two statements in the questionnaire dealt with mechanisms for communication and change. These statements sought to find out if there were working mechanisms for community members, vulnerable children and health workers to discuss issues, and whether or not organisations were working well together to assist vulnerable children (see *Table 4*).

Table 3: Interaction between health services and the community/children

Statements in questionnaire		% children agreeing/strongly agreeing (N = 92)	% health workers agreeing/strongly agreeing (N = 10)	% community members agreeing/strongly agreeing (N = 15)
12.	Vulnerable children are involved in identifying their health needs with the authorities in my community.	46	18	20
13.	Vulnerable children in my community are involved in identifying the actions that should be taken to meet their health needs.	35	0	40
14.	The local authority incorporates the views of children when budgeting for health.	24	9	20
15.	The health workers in the local health care centre are supportive and friendly to vulnerable children.	64	100	33
16.	Health workers in our community find it easy to communicate with community members on health issues.	32	91	80
17.	Health workers in our community find it easy to communicate with children on health issues.	39	55	73
18.	People in the community find it easy to talk to health workers.	39	73	60

Table 4: Mechanisms for communication and change

Statements in questionnaire		% children agreeing/strongly agreeing (N = 92)	% health workers agreeing/strongly agreeing (N = 10)	% community members agreeing/strongly agreeing (N = 15)
19.	There are working mechanisms for community members, vulnerable children and health workers to discuss issues.	28	82	40
20.	Organisations in the community are working well together to assist vulnerable children.	59	36	67

According to the data, the children did not think there were any mechanisms to discuss issues related to their health (only 28% agreed or strongly agreed), whereas health workers thought there were (82%). This major difference in perception could be caused by the collapse of outreach services, which once provided an interface between health workers and children/the community. Schools have helped in ensuring that organisations assisting vulnerable children work together and complement each others' effort. This effort has been reinforced by the fact that schools have assigned one focal person to deal with the organisations. There are also community structures that promote networking, such as the District AIDS Action Committee, Ward Child Protection Committees and the Victoria Falls Network for Organisations Supporting Orphans.

In summary, the baseline suggests there are key areas where child participation can be improved in the planning, delivery and use of health services, especially services targeted to meet the health needs of vulnerable children. This is especially true in relation to orientation and uptake of services, communication between health personnel and children, child participation in planning and budgeting of health services, and overall coordination and networking.

3.2 Results from the priority setting/ PRA meetings

3.2.1 Priority health problems facing orphans and vulnerable children

As mentioned in the methodology section, a total of 30 participants attended a two-day workshop, which aimed to identify current practices with regard to child participation in PHC services, increase uptake of PHC services – including ART – prioritise the heath needs of vulnerable children and find ways of responding to these needs in a more coordinated way. By means of a scoring and ranking process, children, health worker and community representatives identified the top three health problems faced by vulnerable children, in order of priority:

- poor access to ART by vulnerable children;
- child abuse; and
- poor housing for vulnerable children.

There was also much discussion on a fourth health problem, namely the exposure of vulnerable children to hazardous waste. We will discuss these four issues in the order given above.

Empowered….a carer compiling the health problems that affect children, during a PRA workshop. Source: D Masuku 2009

Table 5 presents the problems underlying poor ART access, discussion points raised by participants and their proposed solutions to poor access.

Table 5: Underlying problems and proposed solutions to poor access to ART

Underlying problems	Discussion points	Proposed solutions
Poor ARV drug supply	Especially at the hospital or clinic. Private pharmacies usually charge their prescriptions in foreign currency.	Promote child participation: Involve children in activities that promote access to ART for vulnerable children, including identification of those children in need of health care. Improve drug supply: Mobilise resources that will ensure an adequate and affordable supply of drugs to the PHC institutions. Provide greater access to information: Fight stigma, discrimination and denial, and encourage early treatment to those in need by: launching awareness campaigns on HIV and ART to address myths and misconceptions concerning HIV and AIDS, and reinforce early treatment seeking behaviour; launching awareness campaigns targeted at traditional or faith healers; updating health workers on the latest HIV and AIDS treatment and care information; promoting the involvement of other partners/stakeholders in PHC delivery; strengthening AIDS clubs in schools; updating school teachers with current information on HIV treatment; and offering mainstream psychosocial support in all programme activities. Promote participation of men in the PMTCT programme: This can be achieved through awareness campaigns. Encourage men to participate in baby clinics (ante-natal care). Strengthen home-based care: Empower children living with sick parents to become home-based care givers. Provide information, skills and resources, such as gloves and disinfectants. Set up support groups for parents or guardians of HIV+ children and children on ART. Strengthen existing testing and counselling centres to cater for the needs of the children. Promote and provide nutritional support: Establish nutrition support for children in the PMTCT programme especially with infant formula. This will provide an alternative for those who do not want to breast feed their children. Provide nutritional support to children on ART.
Denial	Parents of children suspected to be HIV+ at times go through a process of denial and, instead of seeking treatment from the health institutions, they consult traditional or faith healers.	
Poor participation of men in the PMTCT programme	Very few men are involved in the PMTCT programme. As a result, they lacked key information on the transmission of HIV.	
Delays in offering ART to those in need	Some care givers (parents or guardians) wait until it is too late to put children on ART. In some cases, this is due to neglect.	
Inadequate counselling services	The only institution offering counselling services is the Victoria Falls Government Hospital, which is seriously understaffed and lacks privacy.	
Inadequate nutritional support	Children in the PMTCT programme need more nutritional support as an alternative to breast feeding.	

A child participant presenting on problems faced by vulnerable children during the priority setting workshop Source: D Masuku 2009

During a focus group discussion, children mentioned many forms of child abuse, including physical, emotional and sexual abuse and child labour. A major concern is that these cases often went unreported. *Table 6* presents underlying problems and proposed solutions to child abuse.

Table 6: Underlying problems and proposed solutions to child abuse

Underlying problems	Discussion points	Proposed solutions
Superstition	Sexual offenders believe that when they sleep with children they will be cured of their HIV or STI infections.	Create awareness within the community on child abuse, which will counter superstition and deal with the myths and misconceptions that fuel the HIV epidemic, with children taking a leading role in the campaigns.
Poverty	Children engage in prostitution as a means of survival.	• Empower the children with life skills. • Encourage the formation of income generation projects within their families and for the children. • HIV and AIDS awareness campaigns to be conducted by children.
Delays in dealing with cases of abuse	Regular delays occur in reporting cases of abuse, thus delaying the removal of the abused child to a place of safety.	• Encourage early reporting by children who have been sexually abused to enable them to receive post-exposure treatment and to ensure offenders can be prosecuted. • Children must be educated about types of abuse and how they can assist each other to report such cases.

The poor housing situation was felt to have contributed to an increase in child abuse. One of the participants recounted a situation in Victoria Falls town where there is a place called ‘Esikhwahleni’ (which can be translated as 'single quarters'). Sometimes more than four families share one room divided by curtains. At times children have to sleep underneath the makeshift beds as a result of limited space. This has impacted negatively on the psychological state of children as they witness their parents or guardians engaging in sexual activities. They also sometimes witness their parents or guardians physically fighting with each other. Children need to be given an opportunity to engage with the responsible authority regarding the conditions under which they are living.

Yes I can …. A girl child presenting on behalf of her group during a PRA workshop
Source: D Masuku 2009

In addition to the three top priority issues presented above, participants also discussed the problem of children who are exposed to hazardous material and the impact this has on their health (see *Table 7*).

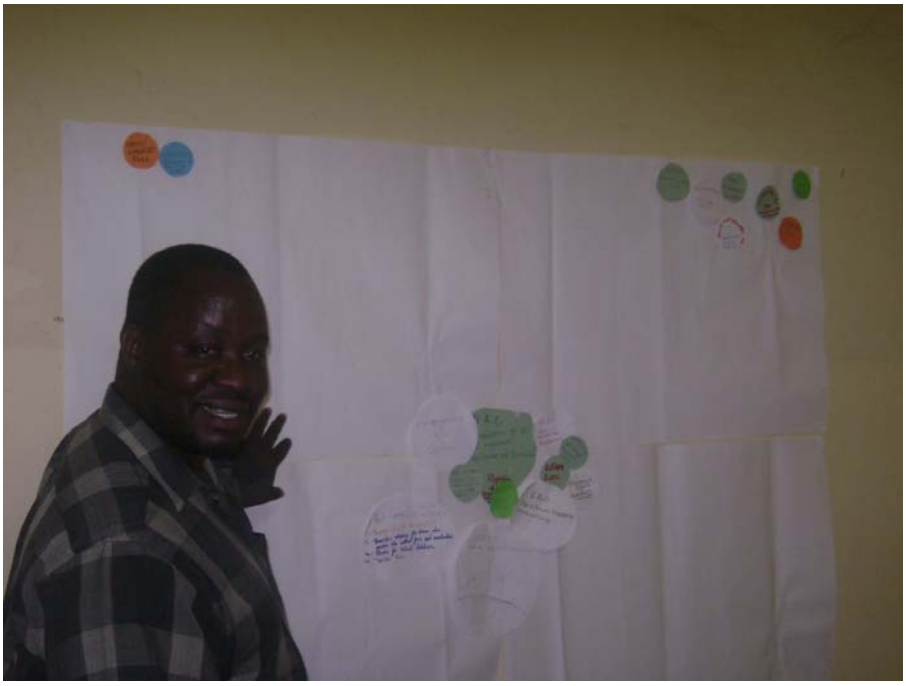
Table 7: Underlying problems and proposed solutions to exposure to hazardous material

Underlying problems	Discussion points	Proposed solutions
Poor waste management	The local authority has failed to collected refuse for months and children have been exposed to the uncollected waste.	• Create children's forums that will work hand-in-hand with the local authority in the area of waste management. • Organise child-led regular cleanup campaigns targeting the removal of waste that may be hazardous to children. • Implement hygiene and environmental education programmes that are targeted at children.
Blocked sewers	Sewage continues to flow unattended, even after the community looked for private plumbers to fix the problem. There is a shortage of disinfectant to rid these sites of infections.	Children can produce information leaflets and posters targeting other children – the main purpose here is to communicate the danger of playing in contaminated areas.
Indiscriminate disposal of used condoms	An increase in the number of night clubs has resulted in people conducting their sexual activities in the bushes and behind buildings. Children have been found to be playing with these used condoms, blowing them up like balloons. This is exposing them to infections.	Children's forums must engage the stakeholders on the consequences of the indiscriminate disposal of used condoms.

In my view…A community member presenting her views on issues affecting vulnerable children during a PRA workshop. Source: D Masuku 2009

3.2.2 Communication between stakeholders supporting vulnerable children, health workers and children

By using a stakeholder mapping exercise, we identified which stakeholders were offering support to OVC in Victoria Falls and assessed the levels of networking and communication between them. The stakeholder exercise identified eighteen stakeholders that were supporting vulnerable children, ranging from non-profit community-based organisations, to non-governmental organisations (NGOs). Of this group, we found that thirteen were networking with each other. The remaining five (mostly well-established NGOs) were working more in isolation.



PRA facilitator leading a stakeholder mapping exercise Source: M Chigama 2009

Several important findings resulted from the stakeholder mapping exercise:

- There are some welfare organisations that tend to work separately and in competition with each other. This has led to a duplication of services instead of services complementing each other. However, most organisations are working in collaboration with each other, which proves to be more in the interests of the child.
- There are capacity gaps within community-based organisations because most their staff have not received formal training in programming for care of vulnerable children.
- Numerous organisations are bypassing the local authority and the National AIDS Council, with some not reporting their activities. Reporting their activities would enable the stakeholders to identify gaps in terms of service provision.

Recommendations included:

- The activities of all welfare organisations should complement each other rather than compete against each other.
- All organisations working to meet the health needs of vulnerable children should meet monthly to share information, collaborate where appropriate and ensure there is no duplication of services.
- The local authority and the National AIDS Council need to ensure that all organisations are registered with their offices and report to them monthly.

At the priority setting meeting, we also explored barriers to communication between health workers and vulnerable children and how these can be overcome, using Johari's Window as a tool to guide the discussion (see *Figure 2*),

Figure 2: Johari's Window

Window A What nobody knows (unknown)	**Window B** What the authorities know (blind)
Window C What the community knows (hidden)	**Window D** What everybody knows (open)

Participants at the meeting identified the following barriers:

- Children are not aware of the difficulties faced by health workers, including the pressures they are under to assist many patients at the same time.
- Children are not fully aware of the health problems facing them.
- Services are not child friendly, which make children afraid to visit health institutions.
- Health workers are not sufficiently committed to their work and to making services more accessible to children.
- There is a lack of communication between the health workers and the children they serve.
- Understanding between health workers and patients is poor due to language barriers. For example, some of the nurses are not able to speak the mother language of the child.

Possible solutions included:

- providing information to children;
- involving children in health issues that affect them;
- conducting awareness campaigns and workshops on children's rights led by the children themselves;
- supporting lessons on HIV and AIDS at school and homes;
- establishing people to provide child friendly support in all health institutions;
- conducting nurses' refresher courses on HIV and AIDS and child-friendly services; and
- establishing health action clubs for children.

The benefits of including children in decision-making processes was highlighted in the meeting by one of the health workers who commented: 'I never knew children knew all this information. In future we will make sure we involve children whenever we are planning.'

4. Developing, implementing and reviewing actions to support vulnerable children

4.1 Pre-intervention meeting

The priority setting meeting developed an action plan to be jointly implemented by all stakeholders (*Table 8*).

Table 8: Action plan to support vulnerable children

Activities and follow-up actions	Objectives	Lead organisations
• Workshop for health workers on ART for infected children • Follow up on the number of vulnerable children enrolled in the ARV programme in homes and schools	• To improve access to ART for infected children • To ensure that children take responsibility over their own medication	Chinotimba Clinic
• Workshop on child friendly services for health workers • Follow up on the establishment of child friendly services at health centres	To improve the quality of service offered to children	Holistic Child Support Initiative
• Conduct network meetings • Community services office to convene monthly network meetings with the full participation of children in the network • Capacity building of welfare organisations supporting vulnerable children	To strengthen networking among stakeholders	Holistic Child Support Initiative
• Conduct awareness campaigns on child abuse • Conduct workshops with both vulnerable children and the guardians/caregivers, community leaders and teachers	To create awareness on child abuse within the community	Save the Children UK
• Stakeholder monthly meetings • The local authority to convene quarterly stakeholders meetings	To strengthen reporting for organisations	Victoria Falls DAAC
• Strengthen School Health Clubs • Train school peer educators in one primary school and secondary school (40 per school)	To strengthen school health clubs	Holistic Child Support Initiative, Intengwe, Save The Children UK

The action plan was implemented over a period of four months. In this short time frame, we did not expect to address all the issues raised during the PRA research, given that many issues are structural and need long-term processes. However, we did attempt to mainstream psychosocial support activities into all the planned actions due to the fact that the actions involved the social wellbeing of the child. These workshops helped to develop a more common understanding between children and adults with regard to the issues affecting vulnerable children, and also strengthened the capacity of those looking after vulnerable children. Three child protection committee (CPC) meetings were held and a school AIDS club was set up at Chamabondo Primary School. This club aimed to create awareness on HIV and AIDS, as well as promote child participation. The CPC meetings aimed to strengthen the skills and confidence of children to actively involve themselves in issues that affect them, for example during the budgeting

process. The CPC meetings included child representatives. Awareness campaigns on child abuse and the plight of vulnerable children in the community, including children's rights, were organised and conducted during the month of December 2008.These were targeted at the community at large. Three workshops were conducted with members of the community (adults), school children, Zimbabwe Republic Police, teachers, youth organisations, health workers and community-based organisation (CBO) and NGO representatives. Facilitators were drawn from various organisations. The workshops covered a range of issues identified during the priority setting meeting. Topics covered included child abuse, HIV prevention and AIDS, creating a healthy environment for children, and sexual and reproductive health for children and youth. The only challenge we had was a lack of pamphlets, banners and posters to reinforce our campaigns.

The following future actions were decided on:

- Welfare organisations shall work together in strengthening community and child participation in programming.
- Children shall take a lead in identifying their own health needs as well as responses.
- Organisations must organise more psychosocial support training programmes targeted at vulnerable children, their guardians and community leaders.
- Welfare organisations shall work closely with the community services section of the local authority.
- Organisations must work closely with children in every stage of the project.
- Organisations must come up with more activities that will address the priority needs of vulnerable children as identified during the priority setting workshop.
- Organisations shall include activities from the action plan in their plans for 2009.

4.2 Post-intervention meeting

After four months, a second PRA review meeting was held with the same group of vulnerable children, health workers and community representative to review progress undertaken during the implementation phase and to discuss the way forward. Progress was assessed by implementing a post-baseline questionnaire, reviewing the progress markers and holding general discussions. The comparison between the baseline and follow-up survey indicated that, in some cases, there was positive change, while in others there was no or little change or perceptions became more negative.

The repeat survey on the same target group found that, with regard to the perceived situation of vulnerable children in the community, overall awareness of the high number of vulnerable children remained high but no consensus exists between children, health workers and community representatives about who in the community understands the health needs of vulnerable children best. Children stated that adults knew vulnerable children’s health needs best, but health workers and community representatives tended to praise themselves first, before acknowledging the knowledge of others. Discrimination against children living with HIV declined, especially in the eyes of the community, during the implementation phase. Children in the survey perceived a small positive change in the ability of vulnerable children to use health services. They also noted an improvement in the quality of the health services, although it is still low. There was a decline in the way respondents from all three groups viewed the extent to which other institutions referred HIV+ youth to the clinics; there was a similar trend in critiquing the role of Department of Social Welfare in assisting vulnerable children to access health care services.

All groups noted a positive change in vulnerable children’s involvement in identifying their health needs. Child respondents also noted changes for the better in interactions between health workers and children, health workers and the wider community, and in their involvement in identifying actions that need to be taken to meet their health needs. There was a negative change in all groups' perception that the local authority incorporates the views of children when budgeting for health. There was overall consensus that organisations in the community are working better together to assist vulnerable children. The children and community members thought mechanisms for working together had improved, but this was not the case with the health workers.

The pre-intervention and post-intervention questionnaires found little change in relation to: understanding the needs of vulnerable children by both community members and health workers; the quality and accessibility of PHC services to children; vulnerable children awareness and use of services available for their support and care; and vulnerable children's involvement in planning for health services. However, change was perceived to have taken place in some areas, namely: a positive drop in stigma and discrimination against HIV+ children; increased cooperation between organisations supporting vulnerable children; improved communication between health workers and children; increased utilisation of PHC facilities by vulnerable children; and community members becoming more knowledgeable about PHC services available to children.

The findings confirm that there is still a need to improve Health workers, community leaders and adults understanding of the health needs of vulnerable children. However, it appears that children have seen an improvement in the quality and use of health services, backed up by better interactions and cooperation between themselves and the health workers and wider community. It is also pleasing to note that there has been some improvement in the way organisations are working together.

On the negative side, these findings note that the intervention had no impact or a negative impact on respondents' perception of the referral system, the role of Social Welfare, and the role of children in the budgeting process. This can partly be explained by a rise in expectations due to the participatory work done during this study, which negatively affected the respondents' satisfaction with the current situation. *Table 9* compares the results of the pre-intervention and post-intervention questionnaires.

Table 9: Comparison of pre-intervention and post-intervention questionnaires

Statements	**% agreeing/strongly agreeing in the pre-intervention questionnaire**			**% agreeing/strongly agreeing in the post-intervention questionnaire**		
	Children (N = 92)	**Health workers (N = 10)**	**Community members (N = 15)**	**Children (N = 92)**	**Health workers (N = 10)**	**Community members (N = 15)**
OVC situation in the community						
1. Most children in my community are vulnerable children	79	55	100	77	100	100
2. Adults in my community know well the health needs of vulnerable children.	39	36	67	63	60	53
3. Community leaders in my community know well the health needs of vulnerable children	42	45	35	36	40	67
4. Health workers in my community know well the health needs of vulnerable children.	48	55	47	47	100	67
5. People in our community discriminate against children living with HIV.	40	45	100	41	40	33
Services within the community						
6. Vulnerable children in my community can easily access treatment services at clinics for their health needs.	37	36	13	28	40	27
7. Vulnerable children in my community use health centres, clinics whenever they need to.	27	64	20	31	60	33

Statements		% agreeing/strongly agreeing in the pre-intervention questionnaire			% agreeing/strongly agreeing in the post-intervention questionnaire		
		Children (N = 92)	Health workers (N = 10)	Community members (N = 15)	Children (N = 92)	Health workers (N = 10)	Community members (N = 15)
8.	Our local health care centres provide satisfactory quality services for vulnerable children.	36	45	60	45	40	13
9.	Vulnerable children in my community find it easy to access treatment for HIV and AIDS.	55	82	60	60	70	60
10.	Vulnerable children with HIV are generally referred to health services for treatment by other institutions in the community.	53	82	87	44	50	53
11.	Vulnerable children are assisted by the Social Welfare Department to access health care services.	52	36	67	50	20	33
Interaction between health services and community/children							
12.	Vulnerable children are involved in identifying their health needs with the authorities in my community.	46	18	20	51	30	40
13.	Vulnerable children in my community are involved in identifying the actions that should be taken to meet their health needs.	35	0	40	53	30	40
14.	The local authority incorporates the views of children when budgeting for health.	24	9	20	26	0	7
15.	Health workers in the local health care centre are supportive and friendly to vulnerable children.	64	100	33	69	70	47
16.	Health workers in our community find it easy to communicate with community members on health issues.	32	91	80	53	100	20
17.	Health workers in our community find it easy to communicate with children on health issues.	39	55	73	53	100	20
18.	People in the community find it easy to talk to health workers.	39	73	60	53	100	40
Mechanisms for communication and change							
19.	There are working mechanisms for community members, children and health workers to discuss issues.	28	82	40	35	50	60
20.	Organisations in the community are working well together to assist children.	59	36	67	64	60	80

4.3 Reviewing progress markers

In the pre-intervention, participants developed progress markers that were to be used to evaluate progress at the end of the implementation phase and during the post-intervention meeting. Participants worked in four mixed groups, each consisting of a mix of children, community representatives and health workers. These progress markers were divided into what stakeholders felt they *must* achieve during the implementation phase and what they would *love* to achieve. The progress markers were assessed four months later – again in four mixed groups – in the post-intervention meeting. In interpreting the markers, it must be borne in mind that the implementation phase was relatively short and that change is often a slow process, so that lack of progress may also be interpreted as a need for more time for changes to occur. *Table 10* presents the 'must achieve' progress markers.

Table 10: 'Must achieve' progress markers

'Must achieve' progress markers	**Completely achieved it (number of groups)**	**Partially achieved it (number of groups)**	**Not achieved it (number of groups)**
Improved knowledge on ART for children by health workers and the community	1	3	–
Improved child participation in the delivery of PHC services	1	3	–
Improved referral system for children to health institutions by other institutions	–	3	1
Improved communication between health staff and children	–	3	1
Improved communication between health staff and community concerning the health of children	–	2	2

Overall, the 'must achieve' indicators were partially achieved during this period, with a few exceptions on either side of the spectrum. In relation to improving health workers and community knowledge on ART for children, only one group noted that this indicator had been completely achieved, while the others felt there were still knowledge gaps that needed to be filled. It is encouraging to see that all four groups noted an improvement in child participation in the delivery of PHC Services, although they noted there was still room for improvement. One group did not think there had been any improvement in the referral system. They expressed concern over the government regulation that expected all children to be accompanied to a clinic by their guardian or parent. They noted that this was often not possible for orphans or vulnerable children. On improved communication between health staff and children, three groups felt there was partial achievement while one felt there was no achievement. Here, they highlighted the problem of language, where the nurse or doctor may not be conversant with the mother language of the child. Also noted was the tendency by the health workers to speak to the person accompanying them, rather than getting the information directly from the child. Lastly, on improving communication between health workers and the community concerning the health of children, some felt that for a long time health workers had done very little to engage the community on health issues (no outreach programmes). Others were of the view that there was partial achievement in that the "health talks" undertaken, for example at the local clinic, went a long way to fulfill this objective.

The 'love to achieve' progress markers showed a similar trend to the 'must achieve' markers in that most respondents noted only partial achievement (*Table 11*).

Table 11: 'Love to achieve' progress markers

‘Love to achieve’ progress markers	Completely achieved it (number of groups)	Partially achieved it (number of groups)	Not achieved it (number of groups)
Reporting on child health issues	–	2	2
Strengthened networking between organisations	1	3	–
Improved mainstreaming of psychosocial support activities	–	3	1
Functional school health clubs in all the schools	–	1	3
Increased community awareness on child abuse	–	4	–

The progress markers show that there is still room for reporting on child health issues. Respondents felt that there had been some improvement in the way organisations networked, but they noted that there were still some organisations that wanted to work on their own, resulting in many problems related to duplication of services, for example when one child is looked after by several organisations while others get no assistance. The major constraint in trying to mainstream psychosocial support activities related to a lack of institutional capacity to provide such an essential service. Respondents were also of the view that the economic environment in the country over the period of this study made it extremely difficult to implement some of the activities, for example to have school health clubs functional at a time when the schools were struggling to stay open. The progress markers indicate that the study did manage to achieve some of its goals, but there is still much work to be done to meet the objectives of the target group as defined in the PRA workshops. This is a positive outcome – it cannot be expected that all goals would be achieved in so short a time period.

5. Conclusion and recommendations

The issue of child participation remains topical in the community, as the emphasis is on ensuring child involvement in identifying their health needs and developing responses to those health needs. Through the study it was clear that, when children are given an opportunity, they are capable of identifying their own health needs and can prioritise them effectively. Allowing children to input into the planning, implementation and evaluation of PHC services increases the effectiveness of these services. As one child participant said: ‘Never underrate us. We know what affects us, as well as what we need.’

We have also learnt that organisations need to complement each other's efforts rather competing against each other. The study indicates some features of this PHC-oriented approach to child participation:

- providing information about and increasing knowledge of child-friendly PHC through the promotion of child participation and strengthening community involvement in vulnerable children’s support;
- creating an enabling social environment that encourages support of vulnerable children through structured platforms for the exchange of information and sharing of experiences;
- ensuring that PHC centres provide child-friendly services that mainstream counselling services and disability;
- promoting effective communication between health workers, community members and vulnerable children to ensure effective delivery of vulnerable children’s health services; and
- promoting a people-centred health system whose response is to address the health needs of children and the community in general.

The PRA work created a lot of interest in the community. It created a platform to share experiences and knowledge. Initially, the children did not have confidence to work on their own solutions but, as we progressed, their confidence increased. The health workers also had an opportunity to learn during the implementation of this process as one of them commented, ‘I did not think children could say all this

about what affects them, as we used to plan for them without consulting them. PRA tools have enriched us to effectively work with children and ensure their participation.'

The experience from the PRA work undertaken has shown that the communities in which we operate should not be treated as mere recipients of services, but as participants and partners. The views and contributions of the children, health workers and community members have proven to be invaluable during the implementation of the process. The participation of children has been set in motion, and this has added value to vulnerable children's programming and the effectiveness of the work we do. A PRA committee will be setup to deal with other developmental issues including strengthening of community participation in vulnerable children's support.

HOCSI, other CBOs, faith-based organisations and the community we worked in indicated their intention to sustain the initiatives begun during this project. Child protection committees will be used as a vehicle for holding discussions on PHC services and resource mobilisation to support vulnerable children. Efforts will be made to ensure meaningful involvement of children in these committees. Communities will be encouraged to participate to ensure sustainability, as well as strengthening the PHC focus. Our goal is to strengthen the health delivery system and involve communities in planning and implementation of a more people-centred approach to health. Health Centre Committees need to be established and children's representation will not be ignored. Focus will be on identifying children's health needs as well as mobilising resources to respond to these needs.

Health workers proposed that future PRA work should be mainstreamed in all community projects if positive results are to be achieved. The PRA tools make it easier for the community to understand and participate since this was practically involving them. The PRA process adds value to community development.

We suggest that health care services need to be decentralised to PHC level (ward level) to facilitate a PRA approach in providing health services. Community participation and the involvement of other stakeholders are key. Also important is the need for organisations to work together to ensure holistic care for the children. Children also need to be given more information on HIV and AIDS including ART literacy and continued psychosocial support programming. It is expected that more children will develop better health-seeking behaviour as they receive more information on their right to health. This will put more pressure on the limited health resources in Victoria Falls. Greater child participation and community involvement needs to be supported by government departments, such as the Minister of Education, the Minister of Health and Child Welfare and the National AIDS Council to ensure sustainability. Further funding will also be required to implement interventions described in this report.

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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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