SITUATIONAL ANALYSIS OF ORPHANS AND CHILDREN MADE VULNERABLE BY HIV/AIDS IN LIBERIA

A REPORT FOR THE LIBERIAN GOVERNMENT AND UNICEF

JUNE 2005

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KATIE PAINE AND SUBAH-BELLEH ASSOCIATES

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The Situation Analysis of Orphans and Children made Vulnerable by HIV/AIDS is a tool that will be used to provide useful guidance on how problems among the most vulnerable children and families in Liberia can be effectively addressed.

The Situation Analysis indicates that there are approximately 184,000 orphans in Liberia. There is no exact figure on those that have been orphaned by HIV/AIDS. The situation analysis states that 62% of these children are paternal orphans, 26% maternal orphans and 12% with both parents dead. The report indicates that nearly 4% or parents death were caused by malaria .7%, Pneumonia 1.2%, Diarrhea 0.9%, and Tuberculosis 0.2%. On the one hand, circumstances of orphans is seen to depend to a great extent on which parent had died: on the other hand, community members interviewed all agreed that orphans generally have a harder life than non-orphans. Orphans lack care and support as well as the practical things such as food, clothes and healthcare. It is considered that orphans were less likely to be able to make choices in their life as compared to non-orphans.

The OVC Situation Analysis will enable all relevant agencies to properly plan and implement programmes and activities to address the needs of OVC, families and caregivers. Based on this Situation Analysis, a draft "Strategic Plan of Action for Children" has been developed for the protection, care and support of Orphans and Vulnerable Children (OVC) in Liberia. To sustain this Strategic Plan of Action for Children, the following need to be done:

. Develop national policies and guidance on OVC

. Enforce a supportive Legislative Framework by strengthening the existing legislation related to the rights, protection, care and support of OVC

. Strengthen the Birth Registration system

. Support extended families bringing up orphans through community-based programmes.

As a result of this Situation Analysis, we now have a better idea of who an OVC is in the Liberian context, how many there are, the services available and what plans can be put in place to provide better support for them.

Let us not think that the task ahead of us is an easy one. We as a Government are so limited, but with our joint effort (Government, UNICEF, international and national non-governmental organizations and other agencies) and the goodwill towards the Liberian children we can certainly

overcome.

It is our responsibility as Stakeholders to strengthen our collaborative efforts and thereby ensure that all of the basic social services are in place to address the needs of OVC and all children.

Dr. Peter S. Coleman
Minister
Minister of Health and Social Welfare

Angela M. Kearney Representative UNICEF- Liberia

ACKNOWLEDGEMENTS

The consultants wish to express their appreciation to the Government of Liberia and UNICEF for the opportunity to carry out this situational analysis, and hope that the results will be useful in addressing the problems of orphans and children made vulnerable by HIV/AIDS (OVC) in Liberia.

In particular we thank the Ministry of Health and Social Welfare, especially Deputy Minister Vivian J. Cherue, and UNICEF - Liberia, especially Benetta Joko Tarr, Fatuma Hamidali Ibrahim, Keith Wright and Angela Kearney.

We thank the other OVC Task Force members:

- Africare (Esther King-Lincoln)
- CRS (Jessie Duncan)
- LOAF (Betty Mason)
- Lutheran Church of Liberia HIV/AIDS Programme (Rev. Janice Gonoe)
- NACP (Lwopu Bruce)
- SC UK (Faith Outland and Peter Wisseh)
- SOS Children's Villages - Liberia (George Kordahi)
- Union of Orphanages (Rev. Alexander Stem)
- UNHCR (Ika Itek)
- UNICEF (Miatta Abdulai Clark)
- UNMIL (Jean Roger Kuate)

We thank all the other key informants, who included:
CAP: Deroe Weeks
CCF: Wayne Blier
CHAL: Ellen George
Don Bosco Homes: Hoover Denis
ELWA: Pati Chon
FPAL: Sandra Howard Kendor
IRC: Dr. Margaret Itto
LIGHT Association: Saa Howard
Ministry of Gender and Development: Deputy Minister Lwopu Kandakai Minstry of Education: Olivia Marse
Mother Patern College of Health Sciences: Sophie Parwon
NARDA: Rufus Kaine
SC UK: Ina Christensen
Sisters of Charity
UN dispensary: Dr Mohamed Kamara
UNFPA: Dr. Bernice Dahn
UNHCR: Dr Babu Swai
UNICEF: MacArthur Hill, Dr Isabel Simbeye
UNMIL: Colonel Joyce Ng'wane Puta
WFP: Dexter Merchant

WHO: Dr. Musu Duworko
World Vision Liberia: Anne Mesopir
YMCA: Peter Karmeh

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The report would not have been possible without the whole team at Subah-Belleh and Associates led by Pewu Subah, Oliver Subah and Sumo Zeze, and including the efficient survey supervisors: Koboi Kadii, Paul Karmon, Oliver Subah and David Taylor; the hard-working survey

4,..

interviewers: Roger Abim-Karmon, David Daniels, Augustine Fayiah, Edward Fineboy, Robert Johnson, Suwah Karbah, Forkpa Karmon, Cooper Koryor, Rebecca Larblah, William Manow, Steven Marsh, Esther Moore, Willieta Morris, Phelicia Ross, Matthew Sandikie, Marbu Seimuvula, Edwin Sherman, Yanquoi Subah, Miatta Tarnue, Blama Taylor, Bennie Toe, Victor Wallace, Gayl Wulah and Edwin Zaza; focus-group adviser Lancedell Matthews; Programmer Leonard Greene; health adviser Jacqueline Greene; and the data-entry staff Wolobah Bivona, Tenneh Kogie and Olayemi Subah.

In particular we extend our gratitude to the thousands of people who gave their time to be interviewed or to join a focus-group discussion. This report would not exist without their valuable contributions. We only hope that the findings will have some positive impact in terms of improving the lives of orphans and other vulnerable children in Liberia.

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Situational Analysis of Children Orphaned

AIDS and Children

Vulnerable by HIV/AIDS in Liberia 2005

EXECUTIVE SUMMARY Background

In 2003 an estimated 43 million children in sub-Saharan Africa had lost one or both of their parents, meaning that 12.3% of all children in the region were orphans. Countries with the highest percentages of children orphaned are those with high HIV prevalence levels and those that have recently been involved in armed conflict.

Of these 43 million orphans, an estimated 12.3 million have been orphaned by AIDS. The social consequences of the AIDS pandemic have been far-reaching, and the effects on the rights and well-being of children have been devastating. Not only have all these millions of children lost their parents, but others have been made vulnerable because they live in a household with sick family members, or a poor household that has taken in AIDS orphans, or because they have HIV themselves. Other groups of disadvantaged children include disabled children, those living in a household headed by an elderly person or a child, and those living in households where adults are terminally sick. Children growing up in vulnerable circumstances

may be affected by poor nutrition, inadequate access to education, lack of emotional support, poor health and exploitation or abuse

Liberia has an estimated total population of 3,239,000, 53% of whom are children. As one of the least developed countries in the world it has been estimated that 80% of the population lives below the poverty line. The recent civil war (1989-2003) has affected every aspect of daily life: many adults and children died, abuses of all kinds were rampant, much of the population was displaced, and of course the economy collapsed.

Children in Liberia live precarious lives. Liberia has some of the highest mortality rates in the world, life expectancy in 2002 was estimated at 41.5, and immunisation coverage for children is 28%. The combined gross enrolment ratio for primary, secondary and tertiary schools in 2001/2 was 61 %. An estimated 78% of the population is illiterate. Malnutrition is widespread with 39% of children less than five years of age stunted and 26% underweight.

Estimates of the numbers of orphans and AIDS orphans are made for the 'Children on the Brink' report: the figures quoted for Liberia in 2004 are a total of 1.8 million children of whom 230,000 are orphans (13%), and 36,000 are AIDS orphans (15% of all orphans). One of the consequences of the war has been the separation of families and there are severe economic pressures which can make it difficult for extended families to adopt orphans.

Data available on HIV prevalence in Liberia is scanty; an estimate from 2003 is 2.7-12.4%. These figures would suggest that there are at least 75,000 people living with HIV in Liberia, the vast majority of whom have not been diagnosed.

In response to the global concern about the issues around orphanhood, especially children affected by HIV/AIDS, Liberia set up a National OVC Task Force in June 2004. The Task Force is spearheading this situational analysis whose results will be used in the development of a strategic plan of action for OVC and put in place a national planning process for OVCs.

Aim of the Situational Analysis

To provide useful guidance on how problems among the most vulnerable children and families can be addressed effectively, by

. producing information needed for geographic targeting and identifying key interventions that can be implemented to produce sustainable results,

. identifying geographic areas where families and communities are having the most difficulty in protecting and providing for the these children,

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. identifying cost-effective responses to the most critical needs of OVC and their families, and

.identifyingl providing reliable survey information on orphaning and adult mortality (from AIDS), and identifying a system for ongoing monitoring and evaluation of the impact of AIDS on children and their families.

Review Of International Literature

The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) describe the standards to which those responsible for the upbringing of children should aim: care and protection in a family environment. The Declaration

of Commitment from the UN General Assembly Special Session on HIV/AIDS in 2001 (UNGASS) identifies children orphaned and affected by HIV/AIDS as needing special assistance.

The joint report from USAID, UNAIDS and UNICEF in 2004, 'Children on the Brink', describes the devastating consequences of the HIV epidemic for children: AIDS is undermining the rights and well-being of children and threatens child survival and development. A large number of international agencies, including UNICEF, UNAIDS, The World Bank, Family Health International and International HIV/AIDS Alliance, have published policy documents on avc describing the problems faced by vulnerable children, the causes of these problems and the good practices that can be followed to mitigate the problems.

In 2004 a consortium of international agencies (including UNICEF, UNAIDS, DFID, FHI, Global Fund, SC UK, USAID and WHO) published 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS'. This emphasises that the children who are actually orphaned by AIDS are only a fraction of those whose lives have been radically altered by the impact of HIV/AIDS. The framework proposes strategies which include strengthening the capacity of extended families, supporting communitybased responses, ensuring access for OVC to services, improving policies and legislation and raising awareness of the consequences of HIV on children.

To conclude, the international literature emphasizes the scale of the problem of orphans and vulnerable children, seen largely as a consequence of HIV/AIDS. As such it is seen to threaten both individual child development and national development. The responses needed vary among communities and countries, as the impact depends on many local factors. For interventions to be effective it is essential to understand these factors, and for the organizations involved to work collaboratively.

Review Of Liberian Literature On Children

The National Plan of Action for Children Framework (2000-2015) makes the situation clear: the devastation of the war has seriously affected schools, health services and other infrastructure, resulting in poor health and education indicators. The reconstruction agenda has been described as a 'Herculean task': challenges include high levels of malnutrition, the very poor condition of many health facilities, major weakness in the educational system.

Throughout the years of civil war and especially the 2003 war, thousands of Liberian children have been victims of killings, rape and sexual assault, abduction, torture, forced labour, forced

recruitment into fighting forces, displacement and other violations. Most of the former CAFF have been reunited with their families. In Monrovia a survey of street-children was carried out in 2003, and most were there just to meet their daily needs, and would prefer to be going to school.

A large number of children can be found in orphanages, many of whom are thought to be there because of economic hardship, and not only because of the death of a parent. In 2004 there were an estimated 117 orphanages in Liberia with a total of 8,167 children. An assessment of some of these institutions found that many of them were sub-standard.

Review of Existing Liberian Policies and Laws Regarding Children

The CRC/NPA process (1998-2000) gave an opportunity for the country to think about policies and laws affecting children through a broad-based and participatory process. In 1999 a National Reference Group on Children was formed, and a National Policy Conference was held to review the CRC report and finalise the draft NPA Framework. The National Plan of Action for Children Framework (2000-2015) incorporates four themes: health and survival, education and development, identity and protection, and participation.

In the National Multi-Sectoral Strategic Plan for the Prevention and Control of STI/HIV/AIDS 2004 - 2007 specific focus is placed on the growing numbers of PLWHA and orphans, realising that the population is still at the stage of denial regarding HIV/AIDS.

Methodology

A situation analysis of children orphaned or made vulnerable by HIV/AIDS has not been carried out in Liberia before. Three methods were chosen for the collection of relevant information:

1. a nationally representative survey of households using structured questionnaires; in a total of 117 Enumeration Areas 25 structures were selected and a householQ listing exercise carried out, and within selected households all orphans and disabled children, and five non-orphans were interviewed
2. focus group discussions with members of the communities, including orphans and widows; topics explored included what happens when a parent dies, what are the consequences for the children who have been orphaned, perceptions of the situation of orphans, coping strategies for orphaned children, problems faced by such children, perceptions of interventions and opportunities available, and a profile of community thoughts on whom they consider are vulnerable children and on solutions to the avc issue in their localities in Liberia
3. Interviews with stakeholders and other key informants; to assess the availability and accessibility of existing services including education, health and social services for avc.

Results

Household listina

A total of 3,561 households were included in the household listing. A total population of 24,250 was enumerated in the 117 EAs; 12,863 (53.0%) were under the age of 18 years. A total of 1,381 children under the age of 18 years (10.7% of all children) were listed as orphans, having lost either one or both biological parents. Most of the orphans listed had lost only a father, 861 out of 1,381 (62.3%) compared to those who had lost only a mother, 352, (25.5%) and those who had lost both parents, 168 (12.2%). Three hundred and thirty-six (2.6%) of 12,863 children under 18 years had some form of disability. The vast majority of these children were living in . Montserrado County (7.1 % of children in this county were reported as disabled).

Household Head Interview Results

A total of 1,148 interviews were held with household heads about the conditions in the household and knowledge and attitudes about HIV/AIDS. When asked about the distance to local facilities, it was reported by 41.1 % that the health facility was within 15 minutes walking distance, the nearest elementary school was within this distance for 72.5%, and the source of drinking water was within this distance for 85.3%. When asked whether there were children with disability in their household, 9.3% of household heads reported that this was the case.

It was reported that in 14% of the households a child would get sick every week, in 46.8% every two weeks, in 31.1 % rarely, and in 7.8% never. The main sicknesses were reported to be malaria (51.9% off households), fever (14.6%) and diarrhoea (13.2%). As with the healthseeking behaviour of the household head when sick, the majority of these children were reported to be taken to the health facility (68.4% of all households), or treated at home (23.3%).

Of the household heads interviewed, 77.3% (n=887) said that they had heard of AIDS and 22.7% (n=261) said that they had not. In general knowledge and attitudes were poor.

Household Questionnaires for Children 0-17 Years

In each EA 15 households were selected for choosing respondents for the household questionnaires, and all orphans and disabled children, plus five non-orphans were interviewed. For those under the age of 12 a caretaker was interviewed, and those aged 12 -17 were interviewed directly. A total of 1,701 interviews was carried out, comprising 1,143 caretakers and 558 older children. Of this group 1,168 were orphans, 442 non-orphans and 91 were disabled children.

The Kpelle were the most numerous of the respondents (13.7% of the total), and also provided the largest numbers of orphan interviews (14.4%). The proportion of orphans in each ethnic group was also very similar, giving no suggestion that there are particular groups of people who are more likely to have died, leaving their children orphans. Most of those interviewed were Liberians (97.8%), and 84.4% were Christian.

Orphans seen in the survey were being raised by relatives and not by non-relatives. Many of them had only lost one parent so were living with the surviving parent; thus almost half of them were in a household where the remaining parent was household head. The next most common relationship with the household head was to be the child of another relative (27.7% of orphans).

Overall 62.9% of respondents were currently attending a normal school. Orphans and disabled children were as likely as non-orphans to be attending school. Girls and boys were equally likely to be attending school, and schools in the public sector and in the private sector were equally popular. The major reason given for not attending school was lack of money or support.

Respondents were asked how often the child did not have enough to eat, and orphans were significantly more likely to report having insufficient food.

Most children, whether orphans or not, had always lived in the households where they were found during the interview. Among orphans 52.2% had always lived in the household compared to 75.3% of non-orphans.

The mothers of 70.8% of the orphans were alive, and the fathers of 30.1 % were alive, whilst 11.8% had lost both parents. In total 81.7% of all orphans interviewed had lost a male parent and 41.0% had lost a female parent. Most of those who had lost their parents said they had died less than five

years ago. The most common cause of death for both mothers and fathers was the war.

Questions on sexual relationships were only administered to children aged 12 to 17 years. Almost a quarter said that someone had, at least on one occasion, tried to touch their private.

parts, and more than half of respondents reported that they had had sex. There were no significant differences in reported sexual behaviour between orphans and non-orphans. Condom usage was poor: 69.1 % reported that they never use condoms. Knowledge and awareness about STI and HIV/AIDS were poor.

For most of the children (28.7%) their monthly income was less that $200 (Liberian) and there were no marked differences between orphans and non-orphans.

Focus Group Discussions

A total of 17 FGDs were analysed, seven with adult community members, two with widows, six with orphans, one with AIDS orphans and one with PLWHA.

Community members remarked that the war had played a major part in creating the present-day problems for children and families. Children may have lost their parents in the war or been separated from them. The economic impact of the conflict makes it hard now for many families to afford to bring up children. Some children learnt what are perceived as 'bad habits' having been involved with the fighting forces.

Community members all agreed that orphans generally have a harder life than non-orphans: they lack care and support as well as the practical things such as food, clothes and healthcare. It was thought that orphans were less likely to be able to make choices in their life. Some community members were not sympathetic to orphans.

The circumstances of orphans was seen to depend to a great extent on which parent had died. Relationships with stepparents were seen as potentially difficult. But in spite of all the difficulties of bringing up orphans, it was felt that in some situations foster parents did indeed do their best to treat them kindly and fairly.

Some orphans related how they could not go to school and were obliged to work to survive. The emotional consequences of orphanhood were reported to be partly due to the day-to-day difficulties they experienced as well as lack of support from people around them.

One comment from the group of PLWHA summarized the findings of many the groups, by talking about how a child loses the practical support of parents when they die, how the child may not be well taken care of after that and therefore the child may start to behave differently which leads to problems for them.

Most of the community members concentrated on the practical difficulties of bringing up orphans in addition to their own children: lack of food, clothes, shelter and access to healthcare. Many needy children were not thought of as well behaved or disciplined, and therefore difficult to take care of.

While a widow may be able to provide good care for her children in many ways, they are also likely to encounter many problems because of lack of financial resources. Access to education was brought out as one of the most pressing needs for orphans. Many of the widows commented that educating their children was their biggest difficulty. Similarly for PLWHA the economic problems were their highest priority, and clearly lack of money to buy food will have a grave impact on children.

It is clear that many orphans are obliged to work to sustain themselves, or else to engage in other activities to acquire food or money. In general there is great willingness from extended families and the wider community to offer support to orphans, however there are many constraints in people's lives which make it hard for them to care adequately for orphans. The belief in some communities seemed to be that orphanages were one of the first places to seek help for orphans.

While in most groups the respondents had correctly understood some of the basic facts about HIV, there were also a number of incorrect beliefs and stigmatising attitudes. There seemed to be little awareness of the impact of H IV/AI DS around them by almost all participants. Where the respondents talked about AIDS orphans the tone was negative.

Stakeholder/Kev Informant Interviews

A total of 33 agencies were visited, some of whom are working directly with children or orphans, and others with people affected by HIV. But the majority are providing services to the general population or to children in general. The interviews held with these agencies aimed to discover the way in which they perceived the issue of OVC, the services they were providing and their strategic priorities.

Government agencies include the Ministry of Health and Social Welfare, which includes the National AIDS Control Programme, the Ministry of Education and the Ministry of Gender and Development.

A number of UN agencies are carrying out work related to children and to HIV, including UNICEF, UNFPA, UNHCR, WHO, the UN dispensary, WFP and UNMIL.

The healthcare system incorporates both government-run facilities and those of NGOs. Very few have the capacity for HIV counselling and testing.

There are considerable number of NGOs who prioritise children in their work, but have not todate concentrated on orphans or children affected by AIDS. Their programmes may indeed have an impact on OVCs by offering services to children generally, but they are not designed with OVCs in mind. Several of these organisations are carrying out HIV prevention activities. These include CCF, World Vision, CRS, YMCA, IRC, CAP and SCUK.

While there appears to be a proliferation of small orphanages, many of these are not accredited and the Government has a major task to ensure that they are providing a high standard of care to children who truly do not have a family to take care of them. The largest organisation providing residential services for orphans in Liberia is the SOS Children's Villages.

Relatively few NGOs are working directly with those affected by HIV/AIDS. The Lutheran Church HIV/AIDS Programme has carried out substantial training in HIV counselling, and provide a VCT centre in Monrovia, Phebe and Kakata. The LIGHT Association is a support group for PLWHA. The Liberian Orphans and AIDS Foundation was set up in 2001, in response to children losing their parents from AIDS and needing support. They place orphans in family homes, and provide nutritional support, funding for schooling and counselling. LOAF has 279 registered orphans, or vulnerable children, who are actively being supported, but many others drop in. The Missionaries of Charity provide what is basically an AIDS hospice (known in the community as Black Gate), for 55 adults and 30 children. Don Bosco Homes works with the children staying at the Missionaries of Charity by providing recreational activities and linking them to community groups.

Limitations of the ove Situation Analysis

. Paucity of information about coping mechanisms and other community-based responses to assist those caring for orphans.

. Stigma around HIV/AIDS: some respondents have been hesitant to disclose sensitive

information regarding OVC because of stigma.

. HIV/AIDS prevalence: the potential increase in numbers of OVC in Liberia is difficult to estimate due to the lack of accurate data on HIV/AIDS prevalence.

.Street children: little new information was collected, yet there are clearly considerable numbers of street children and they are more likely to be orphans and are particularly vulnerable.
Household heads were asked about distance to schools, health facilities and water sources, but the functionality of the facilities and the safety of the water were not assessed, limiting the value of this information for programming.
Some children who were interviewed as 'non-orphans' described that in *fact* they had lost one or both of their biological parents. This means that the national estimate for the prevalence of orphanhood derived from this household listing exercise has some element of uncertainty.

..Discussion and Conclusions

This situational analysis of orphans and other vulnerable children in Liberia is the first attempt of its kind to identify the scale of the problem, the issues involved and assess the existing services provided. It is hoped that these baseline findings will be useful for comparison purposes at a later date if the situation appears to change. The results will also be used for planning improved and co-ordinated interventions for avc, and for the development of policy and legal reforms.

The results of the survey allow an estimate of the numbers of orphans in Liberia: 184,000. Most of these orphans have lost only their father (114,632), while 46,920 have lost their mother, and 22,448 have lost both parents.

The data available on HIV/AIDS in Liberia are insufficient to determine how many children become orphans because of AIDS-related deaths. . It has been estimated that there are 36,000 AIDS orphans in Liberia (Children on the Brink 2004). The data collected for this report do not add any further precision to this estimate. The vast majority of these orphans would have no idea that their parent(s) had died of AIDS. The problem of stigma around HIV has led to significant gaps in the information available about AIDS orphans.

Currently the majority of children are orphaned most likely for reasons other than HIV, as already mentioned. But given the number of children who have lost at least one parent Liberia has a considerable problem regarding orphans and vulnerable children, which will be seriously exacerbated as the adults currently infected with HIV die and leave behind their children.

Traditionally the extended family takes the major role in caring for an orphan, and this is considered an obligation. The situation of those orphaned through AIDS has many similarities to that of other orphans: even where it is likely that a child's parent or parents died of AIDS, with its associated stigma, children are still being taken by members of the extended family. It was reported that generally families were happy to take care of orphans, although the realities of their economic situation made it very difficult for some of them. Most of the difficulties encountered with coping with orphans are economic. Families are already struggling with their own children, and an addition to the family stretches their meagre resources still further. Sending children to school, with all its associated costs, is reported to be a major headache for many.

The survey found that orphans and non-orphans were equally likely to be attending school, but in the FGDs the difficulties of financing education for all children were discussed.

The survey data showed that non-orphans were significantly more likely to be adequately *fed* and never to be short of *food* than orphans. Many orphans are obliged to work to sustain themselves, or else to engage in other activities to acquire *food* or money. In the FGDs community members all agreed that orphans generally have a harder life than non-orphans: they lack care and support as well as the practical things such as *food,* clothes and healthcare.

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Some of the findings from both the survey and from the qualitative data point to the *fact* that orphans have a greater number of hurdles to overcome in their lives than children living with both of their parents. But what has been clear from all the information collected is that the war has created an extremely harsh environment for all those bringing up children. The economic situation makes it hard to *feed,* clothe and school children adequately, and this seems to apply to all parts of the country.

Some of those living in institutions (such as orphanages) appear to be well cared for, but there is also plenty of evidence to suggest that many orphanages should be closed or at least regulated more closely. This should be an urgent priority.

Many organisations in Liberia have been concentrating on working with ex-combatants, and the needs of other children have come second to this imperative. The work with ex-combatants was an urgent priority once the ceasefire was achieved, but now it is time to move on. There are many other vulnerable children whose development is impoverished by their circumstances who should now be targeted by interventions, and these include orphans and those living in extreme poverty.

Some of the results presented in this situational analysis show how children who have been affected by HIV/AIDS may be particularly vulnerable. Organisations such as LOAF are providing services that are appreciated by this group, such as assisting with schooling and supplying *food.* The needs of these children are not so very different to those of other children living in difficult circumstances.

The extended family is the major coping mechanism for supporting vulnerable children in Liberia. The success of the extended family in looking after orphaned children is seriously jeopardised by the extent of poverty, especially in rural areas. There was little information collected about the coping strategies of these families and how the community provides support to those raising orphans.

In terms of the response to the problems *faced* by OVC there are some existing services, but often not co-ordinated, and generally insufficient, given the scale of the problems being experienced.

There is an awareness that OVC issues need to be reflected in national programming. However it has to be said that the response has to date been ad hoc and the incorporation of these concerns into national policies and strategies has not been prioritised. Individual AIDS orphans have been dealt with by the agencies to which they present with compassion, but in the absence of any national guidelines. Support for these activities has been piecemeal. It would be useful for the HIV sector to formalise a policy on OVC.

This report has shown that many children are vulnerable in Liberia. Children who have been orphaned by AIDS may be discriminated against and deprived of basic human rights to education and health. But children who have been orphaned by other causes are no less vulnerable, and this is particularly relevant when looking at the needs of avc in Liberia where relatively *few* AIDS orphans have been identified to date. Children who are not orphans may also be vulnerable for other reasons, and where economic conditions are difficult this has ramifications for their education, health, well-being and safety.

Recommendations

1. Convene a national planning workshop to develop a short-term Plan of Action for the protection, care and support of Orphans and Children Made Vulnerable by HIV/AIDS (OVC) in Liberia.

2. Develop National Policies and Guidelines on OVC.

3. Develop a longer-term Strategic Plan of Action for avc.

4. Use the data and evidence from the forthcoming *National HIV Prevalence Survey* and the *KAP study on Youth* to guide advocacy, policy development, and programme planning for orphans and vulnerable children.

5. Enforce a supportive Legislative Framework by strengthening the existing legislation related to the rights, protection, care and support of children in Liberia.

6. Strengthen the systems for Birth Registration in Liberia.

7. Implement information/education/communication (IEC) strategies to increase awareness and to decrease stigma and discrimination around HIV/AIDS.

8. Organize advocacy by all stakeholders to keep orphans and vulnerable children high on the nation's agenda and to reduce the widespread stigma and silence surrounding HIV/AIDS that continues to hamper the response at all levels.

9. Commission research into coping strategies at the family and community level, in order to plan interventions.

10. Support community-based and faith-based organizations in their efforts to assist OVC.

11. Strengthen extended families bringing up orphans through community-based programmes.

12. Support educational and healthcare expenses of orphans.

13. Work with those orphanages providing a high standard of care; enforce controls for those that are not.

14. Develop programmes to address the needs of street children.

TABLE OF CONTENTS

ABBREVIATIONS USED

ACRWC AIDS CCF CEDAW

CHAL CRC CRS EA ELWA FGD FPAL HH
HIV ICC IDP ILO IRC
LOAF MDG NACP NARDA NGO OVC PLWHA PTCT SCUK SSA UN UNFPA UNHCR UNICEF
UNMIL VCT WFP WHO YMCA

African Charter on the Rights and Welfare of the Child Acquired Immunodeficiency Syndrome
Christian Children's Fund
Convention on the Elimination of All Forms of Discrimination Aga Women
Christian Health Association of Liberia
Convention on the Rights of the Child
Catholic Relief Services
Enumeration Area
Eternal Love Winning Africa
Focus Group Discussion
Family Planning Association of Liberia
Household Head
Human Immunodeficiency Virus
Interim Care Centre
Internally Displaced Persons
International Labour Organisation
International Rescue Committee
Liberian Orphans of AIDS Foundation
Millennium Development Goals
National AIDS Control Programme
New African Research and Development Agency Non-governmental Organisation
Orphans and Children made Vulnerable by HIV/AIDS
People living with HIV/AIDS
Parent-to-Child Transmission (of HIV)
Save the Children United Kingdom
Sub-Saharan Africa
United Nations
United Nations Population Fund
United Nations High Commission for Refugees
United Nations Children's Fund
United Nations Mission in Liberia
Voluntary Counselling and Testing
World Food Programme
World Health Organisation
Young Men's Christian Association

BACKGROUND

Why are we concerned about orphans and vulnerable children?

In 2003 an estimated 43 million children in sub-Saharan Africa had lost one or both of their parents, meaning that 12.3% of all children in the region were orphans. This is an increase of more than one-third since 1990. Countries with the highest percentages of children orphaned are those with high HIV prevalence levels and those that have recently been involved in armed conflict (Children on the Brink 2004).

Of these 43 million orphans, an estimated 12.3 million have been orphaned by AIDS. The survival and development of children affected by AIDS is threatened. Those most commonly infected with HIV are economically-active young adults, and the consequences are devastating for families, communities and nations. The subsequent opportunities available to children who lose one or both parents must inevitably be affected. It is often said that young people are the future of a country, and it is clear that a childhood with limited opportunities will restrict the development of the individual. This has repercussions for their community and their country.

The social consequences of the AIDS pandemic have been far-reaching, and the effects on the rights and well-being of children have been devastating. Not only have all these millions of children lost their parents, but others have been made vulnerable because they live in a household with sick family members, or a poor household that has taken in AIDS orphans, or because they have HIV themselves.

Orphans may be particularly vulnerable, but there are also other groups of children who may be disadvantaged that could suffer in a similar way. These include disabled children, those living in a household headed by an elderly person or a child, and those living in households where adults are terminally sick. Another group of children that need support are those living on the streets, who may have left their family home as a consequence of losing a parent. Children growing up in vulnerable circumstances may be affected by poor nutrition, inadequate access to education, lack of emotional support, poor health and exploitation or abuse (see Fig 1).

Since 1979 there has been a recognition that children are born with basic human rights. As a result there has been an increasing amount of work undertaken to ensure that all children enjoy these rights: the rights to survival, to health and education, to play and culture, to family life, to protection from exploitation and abuse of all kinds, to non-discrimination and to having his or her voice heard and opinions taken into account on significant issues. However some children are less likely to enjoy these rights, in particular those children who are orphaned.

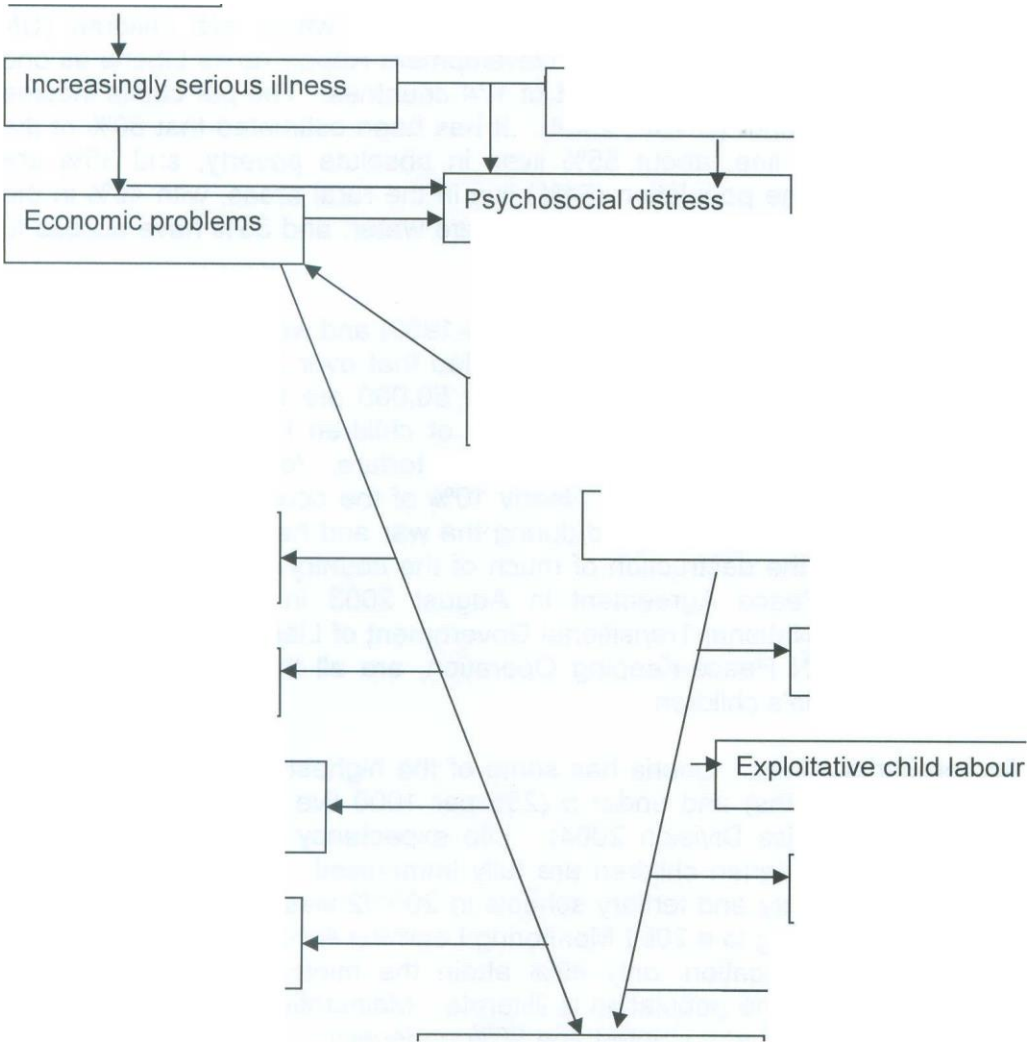
Situational Analysis of

Fig 1:

Orphaned
by AI DS

Children made Vulnerable by HIVIAIDS in Liberia 2005

Problems among children and families affected by HIV/AIDS (from Williamson, 2000)



[HIV infection

Children withdraw from school

Inadequate food

Problems with shelter & material needs

Reduced access to health services

Children may become caregivers

Deaths of parents and young children

Problems with inheritance

Children without adequate adult care

Discrimination

Sexual exploitation

Life on the street

Increased vulnerability to HIV infection

Children in Liberia

Liberia has an estimated total population of 3,239,000, 53% of whom are children (UN Population Division, 2003). The UNDP 2004 Human Development Report ranks Liberia as one of the least developed countries of the world: 161 out of 174 countries. The per capita income has been estimated at $169 per annum (UNDP, 2004). It has been estimated that 80% of the population lives below the poverty line, about 55% lives in absolute poverty, and 35% are undernourished. Just over half of the population (54%) live in the rural areas, with 46% in the urban areas. Only 25% of the population have access to safe water, and 36% have access to good sanitation facilities.

The recent history of Liberia is largely one of civil strife (1980-1989) and war (1989-2003), which has affected every aspect of daily life. It has been estimated that over 250,000 people were killed, most of them in their productive years, and another 50,000 are thought to have died through lack of food, shelter and healthcare. Thousands of children have been victims of killings, rape, sexual abuse and exploitation, abduction, torture, forced labour, forced recruitment into fighting forces and displacement. Nearly 10% of the country's population has been internally displaced. The economy collapsed during the war and has not yet returned to previous levels, partly because of the destruction of much of the country's infrastructure. The signing of the Comprehensive Peace Agreement in August 2003 in Accra, Ghana, the inauguration of the power-sharing National Transitional Government of Liberia in October 2003, and the deployment of a large UN Peace-Keeping Operation, are all thought to be positive developments for Liberia and Liberia's children.

Children in Liberia live precarious lives. Liberia has some of the highest mortality rates in the world: infant (157 per 1000 live births) and under 5 (235 per 1000 live births) (UNICEF, UN Population Division and UN Statistics Division 2004). Life expectancy at birth in 2002 was estimated at 41.5. Only 28% of Liberian children are fully immunised. The combined gross enrolment ratio for primary, secondary and tertiary schools in 2001/2 was 61% (UNDP Human Development Report 2003). According to a 2001 Monitoring Learning Achievement report, even if children do complete primary education, only 42% attain the minimal levels of learning achievement. An estimated 78% of the population is illiterate. Malnutrition is widespread with 39% of children less than five years of age stunted and 26% underweight. Vitamin and mineral deficiencies are common among children and women. Iron deficiency in children aged 6-35 months is 87% (DHS, WHO and UNICEF, 2003). The major childhood illnesses are malaria (accounting for 42% of all illnesses), diahorrea (21 %) and acute respiratory infections (12%).

Estimates of the numbers of orphans and AIDS orphans are made for the 'Children on the Brink' report: the figures quoted for Liberia in 2004 are a total of 1.8 million children of whom 230,000 are orphans (13%), and 36,000 are AIDS orphans (15% of all orphans) (UNAIDS/ UNICEF/ USAID 2003). With the advent of HIV the number of children likely to lose one, or in due course, both of their parents is predicted to increase. The prevalence of orphans and AIDS orphans estimated for Liberia is higher than in many neighbouring countries in West Africa, because of the impact of the war, but does not reach the levels seen in Southern Africa for example.

In a traditional setting in Liberia the extended family provides a mechanism for coping with children who lose one or both of their parents. However one of the consequences of the war has been the separation of extended families and there are also severe economic pressures which can make it difficult for extended families to adopt orphans when they may not have enough resources to care for additional children.

HIV in Liberia

In 2001 the Ministry of Health and Social Welfare reported that the HIV prevalence rate had risen from 4% in 1998 to 8.2%, with more women infected than men (Otti, 2001). By the end of 2003 prevalence was estimated at 11-12% based on the testing of pregnant women in Monrovia (NACP). Prevalence was also estimated for ages 15-49 in 2003 at 5.9% but with confidence intervals of 2.7-12.4%, showing that the data available is poor (UNDP Human Development Report 2003). One of the major sources of information is blood donors (prevalence 5%) amongst whom trends show an increase, as do the number of people presenting with AIDS. These figures would suggest that there are at least 75,000 people living with HIV in Liberia, the vast majority of whom have not been diagnosed. Since the first reported case in 1986, 532 cases have been reported but this is known to be a gross under-estimate due to reporting difficulties. The predominant mode of transmission is heterosexual, but most of those under the age of 15 have been infected through vertical transmission (mother.:to-child) (Otti, 2001). The study on socio-cultural barriers to HIV/AIDS prevention initiatives in Monrovia (Otti, 2001) and the Situation Analysis of the National Response to HIV/AIDS in Liberia (Bropleh & Taylor, 2000) describe the enormous hurdles that need to be overcome at both the community level and the health facility level.

National response

In response to the global concern about the issues around orphans and children made vulnerable by HIV/AIDS, Liberia set up a National OVC Task Force in June 2004. This group prepared the country paper for Liberia's participation in the Regional OVC workshop for West and Central Africa Region held in Dakar, Senegal in early July 2004. One of the key recommendations to come out of this workshop was that each country in the Region should conduct a national OVC situational analysis to ascertain the magnitude, nature and dimensions of the OVC phenomenon in the respective countries. This was taken as a priority activity for the Liberian team in their follow-up action plan. The OVC Task Force comprises Government Ministries, the National AIDS Control Programme, UN Agencies, International and National NGOs and Welfare Institutions.

A growing number of institutions and organisations are carrying out services for people living with AIDS or affected by AIDS. Some of these institutions offer voluntary testing and counselling, drugs and some material support. There are also a few institutions that cater for children that are orphaned by AIDS or made vulnerable by HIV/AIDS.

Although much is being done on HIV/AIDS, there has been no formal, comprehensive and cohesive report or documentation to describe work that is being done, geographic location, services and service providers, categories of persons being catered to (sex, age, and economic status) and the impact that is being made.

It is envisioned that conducting a situation analysis will give confirmed information about OVCs, describe the interventions and the basic social services being provided, and identify gaps and problems that families and communities encounter in their daily lives. Results from the survey will be used to ensure a rights-based programme planning that will address the child's rights to survival, development, protection and participation.

AIM AND OBJECTIVES OF THE SITUATIONAL ANALYSIS

The Aim of the Situational Analysis is to:

1. provide useful guidance on how problems among the most vulnerable children and families can be addressed effectively,
2. produce information needed for geographic targeting and identify key interventions that can be implemented to produce sustainable results,
3. identify geographic areas where families and communities are having the most difficulty protecting and providing for the these children, 4. identify cost-effective responses to the most critical needs of avc and their families, 5. identify/provide reliable survey information on orphaning and adult mortality (from AIDS),
and
6. identify/state a system for ongoing monitoring and evaluation of the impact of AIDS on children and their families.

The Specific Objectives are to:

1. 2.

estimate the scale of the avc situation and conditions for an increase in prevalence. identify the ways that children, child-headed households, families and communities are being affected by the HIV/AIDS endemic;

a. problems that they are facing
b. the ways that they are coping with these problems
c. factors that influence these problems or coping (positively or negatively)

identify service providers and types of services being provided (relevance of the services, adequacy of the services, and the impact of these services)
assess and analyse the policy, legal and programme environment for orphans assess the models of care, identify success, best practice and areas of further development
assess the level of social stigma against OVC
find out the accessibility of the available basic social services
generate a national consultative debate on avc
make recommendations on appropriate strategies and actions for addressing the problems of OVC to the Government, the Task Force on OVCs, NGOs that are working with avcs, the families and communities.

3.

4. 5.

6. 7. 8. 9.

DEFINITIONS

Orphan

The internationally accepted definition of an orphan is as follows:
A child under 18 who has lost one or both biological parents

While this may be contested by some as a modern way of viewing the situation, it is clear that the loss of a mother or a father can have a great impact on the life of a child.

Vulnerable children

Vulnerable children are children who are at increased risk of not enjoying their basic human rights: the rights to survival, health and education, play and culture, to protection from exploitation and abuse of all kinds, and to have his or her voice heard and opinions taken into account on significant issues. Those living without the protection of their parents are clearly potentially vulnerable, but many children may be vulnerable for other reasons, such as disability

or adverse circumstances (for example extreme poverty or illness of economically-active adults) in the household.

The working definition for ove is as follows:

An ove is a person below the age of 18:
i) who has lost one or both parents, or
ii) whose parent(s) is (are) terminally ill, or
iii) who is terminally ill, or
iv) who lives in a household where at least one parent or guardian died, or
v) lives in a household where at least one parent or guardian was seriously ill for at least three consecutive months in the last 12 months, or
who lives in a child-headed household (where the head of household is below 18 years old), or
who lives in a household with only elderly adults (Le. the household contains only children below 18 years old and adults older than 59), or
viii) who lives outside family care (Le. lives in an institution or on the street)

vi)

vii)

Parents
All reference to parents (including the terms mother or father) means the biological parents (mother or father).

Household
The basic unit of analysis for the quantitative data is the household. In Liberia this is a unit of people who prepare food and eat together. They may sleep in separate buildings. Typically a husband, his wife or wives and children will form a household, but there may also be older relatives or non-relatives as part of the household. Individuals living alone can also be identified as a household.

Severe disability
For the purposes of the survey severe disability was defined as any condition that was permanent, and significantly affected the daily life of a child, by restricting activities. These included:

- blindness
- significant speaking difficulty (this would include those who are totally deaf)
- physical disability (restricting activities)
- mentally challenged

REVIEW OF INTERNATIONAL LITERATURE

The Convention on the Rights of the Child (CRC) and the African Charter on the Rights and Welfare of the Child (ACRWC) describe the standards to which those responsible for the upbringing of children should aim. Children are entitled to special care and protection, and 'should grow up in a family environment, in an atmosphere of happiness, love and understanding'. Actions affecting children should always take the best interests of the child first; there should be no discrimination between children; special protection to the most vulnerable or needy must be provided, as all children have the right to survival and development; and the child has the right to have views considered and to participate in decisions affecting them, according to age and maturity. It is recognized 'that, in all countries in the world, there are children living in especially difficult circumstances and that such children need special consideration'. The State is expected to provide special protection for children who are deprived of a family environment.

International concern about the condition of children living in 'especially difficult circumstances' has been rising sharply in the last two decades. This appears to be the result of the awareness in many countries of the devastating social consequences of HIV/AIDS. Increasing numbers of children are living in households where adults are sick or dying, children are losing their mothers and their fathers more frequently than before, and some children are growing up without adequate adult care and supervision.

The Declaration of Commitment from the UN General Assembly Special Session on HIV/AIDS in 2001 (UNGASS) identifies children orphaned and affected by HIV/AIDS as needing special assistance. There is a commitment to strengthen the capacity of governments, communities and families to support such children, including provision of 'counseling and psycho-social support, ensuring their enrolment in school and access to shelter, good nutrition, health and social services on an equal basis with other children; and to protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance' .

The UN held a General Assembly Special Session on Children in 2002 which resulted in 'A World Fit for Children', a document which sets out the goals and strategies which member countries should incorporate in National Plans of Action for Children. These goals and strategies are derived from the CRC and the Millennium Development Goals (MDGs). The MDGs cover the following: eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability, and developing a global partnership for development.

The joint report from USAID, UNAIDS and UNICEF in 2004, 'Children on the Brink', describes the devastating consequences of the HIV epidemic for children: from a total of 43 million orphans in sub-Saharan Africa, an estimated 12.3 million children have been orphaned by AIDS. This means that 12.3% of all children in sub-Saharan Africa are orphaned, significantly higher than other regions of the world. HIV/AIDS is destroying years of improvements in economic and social development. The impact on children is enormous: their safety, health and survival are at risk. They are more likely to drop out of school, to be abused, to contract HIV themselves or suffer from poverty. Family coping mechanisms have been stretched to the limits of their capacity in some countries, and malnutrition has been frequently reported in these circumstances. The report concludes that AIDS is undermining the rights and well-being of children and threatens child

survival and development.

From a wide range of studies UNICEF has concluded that the consequences of orphanhood include: psychosocial distress, economic hardship, withdrawal from school, malnutrition and illness, loss of inheritance, fear and isolation and increased abuse and risk of HIV. 'Institutionalized care for the majority of children is not a preferred option. Resources are more effectively used in strengthening the abilities of extended families and communities to care for orphans and other children left behind'. UNICEF suggests that a response should be based on partnership at all levels (UNICEF 2002).

UNAIDS has produced Principles to Guide Programming for Orphans and other Children affected by HIV/AIDS, which is a consensus on these issues, based on a human-rights approach for programming:

1. Strengthen the protection and care of orphans and other vulnerable children within their extended families and communities 2. Strengthen the economic coping capacities of families and communities 3. Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children and their caregivers
4. Link HIV/AIDS prevention activities, care and support for people living with HIV/AIDS and efforts to support orphans and vulnerable children
5. Focus on the most vulnerable children and communities, not only those orphaned by AIDS
6. Give particular attention to the roles of boys and girls, men and women, and address gender discrimination
7. Ensure the full involvement of young people as part of the solution
8. Strengthen schools and ensure access to education
9. Reduce stigma and discrimination
10. Accelerate learning and information exchange
11. Strengthen partners and partnerships at all levels and build coalitions among key stakeholders
12. Ensure that _xternal support strengthens and does not undermine community initiative and motivation

The World Bank has also identified the rise in numbers of 'at-risk children' (the consequence of AIDS, warfare and migration) as a major threat to social development. 'Such children face heightened risk of malnutrition, mortality, morbidity and psychosocial damage. The extent of a child's vulnerability depends on a number of factors: whether they have been infected themselves with HIV, whether they have relatives willing to care for them, whether they are allowed to go to school, how they are treated within the community, what degree of psychosocial trauma they have suffered from their parents' death, what responsibilities they are left with (Le. younger siblings) and so forth'. Good practices recommended include: informal fostering, education and health subsidies (to promote fostering), family tracing and reunification, and institutional care (as a last resort). 'Interventions need to be carefully chosen to: a) address the specific risks faced by orphans in a given country environment, and b) strengthen rather than supplant existing community coping strategies'. The World Bank has produced a Child Needs Assessment Tool Kit that gives information on the scale of the problem, magnitude of the needs and coverage of current programmes.

Family Health International describes how there is no easy solution to consequences of HIV/AIDS on families, but feel that lessons can be learnt from past experiences. These include: 1. Appropriate government policies are essential to protect OVC
2. evc need access to appropriate healthcare
3. evc need socioeconomic and psychological support
4. Education is vitally important in offering evc a chance for their future

5. A human rights-based approach is essential

6. Community-based programmes are most appropriate (essential to strengthen their care and coping capacity; more effective than institutional care for orphans)
7. Involve children and youth as part of the solution not part of the problem
8. Build broad collaboration between key stakeholders
9. Use a long-term perspective
10. Integrate with other services
11. Link care and prevention

The International HIV/AIDS Alliance campaigns persuasively for children to be cared for in families and communities, rather than institutions. They have looked at ways of expanding community-based support for OVC, and conclude that responsibility lies in the hands of multiple stakeholders. If there is an enabling environment, then CBO/NGO support can be used to support the community-level responses (International HIV/AIDS Alliance, 2002)

An analysis of national surveys in sub-Saharan Africa which cover orphanhood and childcare patterns finds that on average one in six households is caring for orphans, with the extended family taking care of over 90% double orphans (Monasch, 2004). Orphans more frequently live in households that are female-headed, larger and have a less favorable dependency ratio. Orphans are approximately 13% less likely to be attending school than non-orphans. There is no consistent evidence that the extended family and other community coping-mechanisms are not absorbing the increase in numbers of orphans. But there is some evidence that orphans as a group are especially vulnerable, as they live in households with less favorable demographic characteristics and have lower school attendance.

In 2004 a consortium of international agencies (including UNICEF, UNAIDS, DFID, FHI, Global Fund, SCFUK, USAID and WHO) published 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV and AIDS'. This report emphasizes that the children who are actually orphaned by AIDS are only a fraction of those whose lives have been radically altered by the impact of HIV/AIDS. The reaction of families and communities is applauded as compassionate and resilient, but it is felt that they are struggling under the strain, and few resources have been made available to assist their response. The framework proposes strategies based on lessons learnt over the years, taking families and communities as the foundation of the response. Interventions should be targeted to communities with these vulnerable children and integrated into programmes to promote child welfare and reduce poverty. These five strategies are:

1. Strengthen the capacity of families to protect and care for OVC by prolonging the lives of parents and providing economic, psychosocial and other support; 2. Mobilize and support community-based responses; 3. Ensure access for OVC to essential services, including education, healthcare, birth registration and others;
4. Ensure that governments protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities;
5. Raise awareness at all levels through advocacy and social mobilization to create a supportive environment for children and families affected by HIV/AIDS.

To conclude, the international literature emphasizes the scale of the problem of orphans and vulnerable children, seen largely as a consequence of HIV/AIDS. As such it is seen to threaten both individual child development and national development. The responses needed vary among communities and countries, as the impact depends on many local factors. For interventions to be effective it is essential to understand these factors, and for the organizations involved to work collaboratively. They need a shared understanding of the problems they are facing and the most appropriate response. It is for this reason that many countries have commissioned a situation

analysis concerning orphans and vulnerable children.

REVIEW OF LIBERIAN LITERATURE ON CHILDREN

The introduction to the National Plan of Action for Children Framework (2000-2015) makes the situation very clear: 'Liberian children lost more than a decade, due to the devastation of the war. This is reflected in the disruption of school, health services and infrastructures' (p.4). This document describes the high levels of infant, child and maternal mortality, the preventable causes of child-death (neo-natal tetanus is the leading cause), the high prevalence of anaemia, low levels of immunisation and high rates of malnutrition. Access to safe drinking water and sanitation is poor. Both the health and education delivery system are plagued with structural problems, including a dire lack of personnel.

There are 11,780 demobilized former CAFF (children associated with fighting forces) who have been processed through the Interim Care Centers (ICC); 11,673 of whom have been disarmed, demobilised and reunified with their families. The small number remaining are largely foreign nationals. Since 2003 Save the Children UK has been working with children separated from their families due to the war. This work is ongoing.

The Government of Liberia, the Eminent Person's Group on Advocacy for Children and UNICEF commissioned a situation analysis in 1999, entitled 'Challenges and Opportunities for Fulfilling the Rights of Children in War-Torn Liberia'. This report describes the reconstruction agenda as a 'Herculean task'. And from the children and women perspectives, the prospects for rapid amelioration of their conditions are bleak. The situation is complicated by its own magnitude and severity, as well as the basic lack of national capacity' (p.31). Having described the structural weaknesses and lack of skilled human resources, the report looks forward and finds windows of opportunity for policy advocacy and community action for the wellbeing of children. The section on health describes the poor health indicators of children, and the lack of health facilities and personnel, and concludes that the challenges are in the area of availability, utilisation and quality of health care services. The recommendations are to decentralise health services, to emphasise preventive and primary care, retrain health workers and empower local communities to get involved. The chapter on education describes how primary education has been free and compulsory for children aged 6-16 since 1912, but this has never been implemented. The New Education Law of 1973 extends free education to junior high, and limits fees in secondary school to charges for registration. The total number of school facilities in 1999 was 3,385, of which 519 are pre-school, 2,405 primary and 461 secondary. Of the estimated 1,629,726 children aged 3-18 in the country, the Ministry of Education statistics show 42% are in school, with the vast majority in primary school. One of the reported reasons for children not attending school is that their families need them to work, and may not be able to pay the costs associated with schooling. Lack of qualified teachers is also a major constraint, and where they have been recruited the non-payment of salaries is a serious disincentive. The chapter concludes that 'education in Liberia is one of the greatest post-conflict challenges that the country has to meet' (p.68).

A large number of children can be found in orphanages, many of whom are thought to be there because of economic hardship, and not only because of the death of a parent. The situational analysis describes how there are reported to be 80 recognised orphanages in Liberia with a total of 4,788 orphans, of whom 56.6% are female, and 43.4% male. Many of the orphanages are in Montserrado County (61.3% of the total). It is believed that parents may send a child to an orphanage in the belief that this will give the child a better chance to obtain quality and free education. The institution-based strategy for caring for orphans is criticised in the report, and a major policy shift is called for. In December 2004 one orphanage in Monrovia was closed down and the 102 children were relocated to another orphanage. 52 of the total of 102 children have been reunified (32 of these children had come from one community). Economic difficulties are

thought to have led to an increase in the number of working children, especially girls, and also street children.

In 2002 the situation analysis was updated through a desk review which concentrated on the four thematic areas of the CRC: health and survival, education and development, identity and protection and participation. This report presents data showing the high prevalence of malnutrition, which is reported to be higher in children who are cared for by someone other than their natural mother. The very poor condition of many health facilities is also highlighted. The data presented in the section on education also give further evidence of poor access to education, and the lack of teachers and incentives.

The situation analysis describes how there are reported to be more street children since the war, mostly involved in selling, loading and washing cars and gambling. The report also recognises the difficulties faced by children with disabilities. A street children task-force was formed in 2003 and carried out a survey of 1,746 children in Monrovia. Most of these children found on the streets were boys (71 %) and 84.7% were above the age of 10 but the youngest child interviewed was only 4 years old. The most common activities were selling (47%), hustling (33.3%) and washing dishes (11.2%), with small numbers reporting loading cars, pulling nets, hair braiding and other activities. Many of the children reported that they were on the streets to meet their daily needs (50.1%), because of the war (19.3%), or because of peer pressure (10.7%) or domestic violence (10.0%). Although they were found on the street, many of them would return to a family home at night to sleep (45.5%). When asked what were their most pressing needs, 61.8% answered that they wanted to go school, while others said that they needed skills, business opportunities, food, family environment and shelter.

The National Transitional Government of Liberia and the United Nations/ World Bank Joint Needs Assessment was carried out in 2004 in order to identify the highest priority requirements in the transition period. The sector priority entitled basic services describes how it has been estimated that less that 10% of Liberians have access to any kind of health care, and that little of health infrastructure that existed before the war is functioning; and how Liberia's education system has been among the weakest in Sub-Saharan Africa for the past two decades. HIV/AIDS is considered as a cross-cutting priority issue, and prevention activities as well as care and support are planned. However there is no mention of the impact of the epidemic on children. The transitional framework has 10 goals, many of which are likely to have an impact on the lives of children, such as the reintegration of ex-combatants, the return of displaced persons to their places of origin, the promotion of the rule of law, and increasing access to primary health care, community water and sanitation, and education for all.

As part of the preparation for this Needs Assessment, UNICEF carried out a Child Protection Sector Report in late 2003. This report describes how the escalation of conflict in 2003 led to a further deterioration of the situation of children. An estimated one-third of the population was displaced in 2003, and over 70% of the country was inaccessible to aid. It was estimated that 465,000 Liberians were displaced within the country, perhaps half of whom were children. Most were living in poor conditions with lack of food, shelter and educational opportunities. Over 350,000 Liberians sought asylum in neighbouring countries. An estimated 15,000 children were recruited to join fighting factions and thousands of others separated from their parents. Family tracing and reunification is a great challenge. The number of children associated with the fighting forces has been estimated as 10,000-20,000. Thousands of girls are thought to have been subjected to sexual violence, abuse and exploitation during the war. The report describes the street children study quoted above and identifies them as another vulnerable group. Child disability has been reported at 10.4%, and the

major cause is polio. It is estimated that at least half of disabled Liberian children are not in school. This report quotes another study which estimated that 23% of Liberian children under the age of 15 do not live with their biological

parents. This same study found that malnutrition was more prevalent in children who were cared for by persons other than their biological mothers.

A report from the Watchlist on Children and Armed Conflict, entitled 'Nothing left to lose: the legacy of armed conflict and Liberia's children' describes the consequences of the civil war on the lives of children. Throughout the years of civil war and especially the 2003 war, thousands of Liberian children have been victims of killings, rape and sexual assault, abduction, torture, forced labour, forced recruitment into fighting forces, displacement and other violations. The report describes the on-going violations of children's security and rights, such as the extent of internal displacement and sexual exploitation, the lack of educational facilities partly because 80% were destroyed in the war, and the extent of preventable and treatable diseases.

In 2004 there were an estimated 117 orphanages in Liberia with a total of 8,167 children. The majority of these institutions were started during the 1990s. Many of the children in these institutions are not orphans but have become separated from their parents by the war. NGOs working with orphanages estimated that 40% of the children in these institutions are orphans, and that insufficient work is being carried out for family reunification. While a child is under the care of an orphanage it is not easy to carry out family tracing and reunification partly because many orphanages refuse to allow the process, but also because there are strong Government polices on family tracing and reunification.

The report of the Bureau of Social Welfare on the 'Assessment of Welfare Institutions in Montserrado and Lower Margibi Counties (2004) describes the activities carried out by the Child Protection Network Task Force in assessing orphanages. The Task force is aiming to improve care guidelines for children and to facilitate the process of de-institutionalisation of children in Liberia. A total of 95 orphanages were assessed in Montserrado and Lower Margibi Counties, with a total of 4,927 children living in them. For the majority of these orphanages their accreditation had expired. The assessment concludes that 36 of these orphanages should be closed, and 18 placed on probation. Problems encountered included the following: many did not provide care to an acceptable standard, girls and boys did not always have separate sleeping facilities, there was often poor access to education and health care, record keeping was poor, many children were not orphans but come from the surrounding communities, few had income-generating activities, and relied on donations. A multi-agency group, the Child Protection Taskforce, led by the Ministry of Health and Social Welfare, is charged with strengthening the existing accreditation process and upgrading the guidelines for orphanages and welfare institutions. Those orphanages that do not meet standards will be closed down. One of the orphanages with 102 children has recently been closed, 52 of these children were immediately returned to their families, and all the other children have been relocated to another orphanage.

REVIEW OF EXISTING LIBERIAN POLICIES AND LAWS REGARDING CHILDREN

The Government of Liberia endorsed the World Summit Goals for Children in 1990, and ratified the UN Convention on the Rights of the Child (CRC) in June 1993. Following this, a draft National Plan of Action for Children was prepared but never finalised for implementation because of the civil war. For the same reason no CRC country report was prepared until 1999 when the Government prioritised the issues of children, and commissioned the situation analysis of children referred to above. The First Country Report of Liberia on the Convention on the Rights of the Child was presented in November 2000. The tone of this report is generally positive. However this had changed somewhat by May 2004, when the Report to the Committee on the CRC describes how the poor situation of children has continued to deteriorate due to internal conflict. Children's rights to survival, protection and development have been seriously impaired. Many have been separated from their parents, other have been injured by

bullets and mortar shells, and yet others traumatised and distressed. The difficulties encountered include: displacement, poverty, malnutrition, and lack of access to water, sanitation, healthcare, and education. The most immediate needs are the provision of basic social requirements, including health and education. The report concludes that many legal reforms are needed, starting with the harmonisation of Liberian laws with the CRC.

The CRC/NPA process (1998-2000) gave an opportunity for the country to think about policies and laws affecting children through a broad-based and participatory process. In 1999 a National Reference Group on Children was formed, and a National Policy Conference was held to review the CRC report and finalise the draft NPA Framework.

The National Plan of Action for Children Framework (2000-2015) incorporates four themes: health and survival, education and development, identity and protection, and participation. Under each of these themes are key recommendations, detailed goals, responsible lead and supporting sectors and the actions required. The recommendations are broad and ambitious, and if achieved would greatly improve the quality of life of all Liberian children. It was envisaged that plans of action at county level would be developed, and Bong County was developed as a pilot project. The NPA was seen as a way of attaining the World Summit Goals for Children and implementing the articles of the CRC. Implementation should involve all Government Ministries and Agencies, as well as all sectors of society. Unfortunately the security situation from 20002003 largely prevented the implementation of these initiatives.

The Government of Liberia also adopted the ILO Convention 182 on the Elimination and Prohibition of the Worst Forms of Child Labour in 1999 and ratified it in 2002. The same year, the Ministry of Labour hosted a conference on the implementation of the convention where a National Plan of Action was developed. In 2004 the Transitional Government signed the CRC Optional Protocols on the involvement of children in armed conflict, and on the sale of children, child prostitution and child pornography. They also signed the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The African Charter on the Rights and Welfare of the Child (ACRWC) has not been signed or ratified.

National Multi-Sectoral Strategic Plan for the Prevention and Control of STI, HIV/AIDS 2004 - 2007

This plan is based on extensive consultations, and aims to mobilise adequate resources for the prevention and control of HIV/AIDS. The overall goals are to reduce the number of new HIV infections (especially among young people) and to reduce the impact of HIV/AIDS on individuals, families and communities. One of the strategies is to 'mainstream' HIV/AIDS.

Specific focus is placed on the growing numbers of PLWHA and orphans, realising that the population is still at the stage of denial regarding HIV/AIDS. Gaps in the programme response for children orphaned by AIDS are identified as follows:

. Inadequate national response to the needs of children orphaned by HIV/AIDS; only one NGO (LOAF) is involved with the care and support for these children . The lack of, or inadequacy of support for families and care-givers of AIDS orphans . A need to carry out an assessment of children orphaned by AIDS

To reduce the rate of HIV transmission, it is planned to increase IEC/BCC activities, particularly among young people. To provide care and support to those affected by the epidemic, it is planned to work with children, families and communities affected by AIDS to improve their wellbeing and decrease the burden of the disease. Key activities identified include:

. Carry out needs assessment of children orphaned by AIDS and other vulnerable children . Develop a national policy and guidelines for responding to the needs of orphans and other vulnerable children

- Advocate for the care and support of orphans and other vulnerable children within the context of the family and the community
- Support community-based initiatives geared towards guiding and caring for orphans and other vulnerable children
- Mobilise and strengthen community-based responses (such as income-generating venture for families) to meet needs of persons affected
- Increase the capacity of children and young people to meet their own needs through access to quality education and protection from exploitation
- Ensure basic legal protection through laws and policies to protect affected persons and decrease stigma, and behaviour change interventions

Bureau of Social Welfare Structure

There are four divisions in the Bureau of Social Welfare: Family Welfare, Community Welfare, Special Education and Training.

The Ministry of Health and Social Welfare works through county health teams, each of which is supposed to have a social welfare component. Many County Health Officers have been newly appointed, and are supposed to work with teams of social workers. However there have been many problems with posting social workers to the counties, and in recruiting and training social workers.

Educational System

Since 1912 there has been a National Policy on Education, which decrees free and compulsory education for all those aged 6-16. This has never been achieved in practice.

Data from 2002 show that 164,397 students were registered in the government primary and secondary schools, with 21,762 teachers. In addition, a substantial number of children attend private schools.

Adoption Laws

The statute on adoption decrees that it should take place through the court system. In practice many children are informally adopted within the extended family.

Inheritance Laws

Traditionally a woman is seen as part of the husband's property. When he dies she might expect to be inherited by his family, which often meant she would marry a brother. If she chose to leave she had no right to any support from the family. A bill was recently passed which means that for customary and civil marriages the widow should now receive one-third of the late husband's property, with the remainder going to the children or the extended family if there are no children. Plans are being made to raise community awareness about this new law so that it can be successfully implemented.

METHODOLOGY

A situation analysis of orphans and vulnerable children has not been carried out in Liberia before. The first step was to carry out a review of the international literature on ave, the Liberian literature on children and existing Liberian policies and laws regarding children. This review allowed for a thorough understanding of the experiences of other countries, as well as the background situation in Liberia. It subsequently provided the basis to develop an appropriate methodology for the research. The sample design was developed with use of locally available data.

The terms of reference for this situation analysis emphasised the need for both quantitative and qualitative research tools. It required the collection of statistical information about the prevalence of orphans and the circumstances under which they live, the perceptions of children and the community about the vulnerability of children, and assessment of models of care and the programmatic environment. In addition, orphans and vulnerable children can be found in a wide range of environments and in many different circumstances, so it was important to use a multiple of research tools. The methods chosen were:

1. a nationally representative survey of households using structured questionnaires; 2. focus group discussions with members of the communities, including children; 3. interview with stakeholders and other key informants.

Household Survey

Background

The last census in Liberia was conducted in 1984. The results of that census have not been published. For this reason, most of the census data available may be too old for describing the present situation in the country. Furthermore, no intensive research has been made exclusively on orphans or children affected by AIDS.

Due to the lack of general information on the entire population, the basis for selecting an adequate and representative sample is outdated. The sampling frame (EA listing) available to be used for sample surveys was constructed during the 1984 census. However, the Ministry of Planning and Economic Affairs is using the EA listing for all their work in the country.

Sampling Design

The sampling strategy had four stages. The first is the stage where the Enumeration Areas (EA) are selected, next the Structure is selected, then the Households are selected and finally the Household members are selected. In the sample size a cluster of 15 households was predetermined. This number was allocated to one enumeration area (EA). The size of EAs are determined by the number of structures (mainly dwelling units).

Sample Size

The expected level of precision (95%), confidence level 7.5%, and the proportion of the population (52.5%) in the age range of the child are the major factors used to determine the sample size. Based on these factors, 1,766 households were estimated to be an adequate sample size for determining the prevalence of ave cases in the population. Using the cluster size (15 households), the sample size (1,766 households) was transformed into 117 EAs to be the number of Primary

Sampling Units (PSU).

Selection Procedure

First Stage: At the primary stage, 117 Enumeration Areas (EAs), the primary sampling units (PSU), were selected by means of systematic sampling procedure from the list of 5,062 EA nationally. The sample EAs were selected before the field data collection began.

Second Stage: On arriving in a selected EA, 25 structures were selected using systematic selection procedure (establishing and following skip pattern). During this exercise, all households within the selected dwelling units were listed to form the frame for the household selection.

Third Stage: From the household listing, 15 households were selected among the households listed on the basis that the household must have at least one child listed, by means of systematic sampling procedure. Within the selected households, all children were tallied in the various categories: non-orphan, orphan and disabled.

Forth Stage: From the tally sheet, all identified orphans and disabled children, and five nonorphans were interviewed. All households were interviewed in the cases where there were less than the number required for interview. In the cases where orphan households are listed the orphan households must have preference over all other households to be included in the sample. For example, if there are 15 households with orphans, these households must be selected for the sample.

Data Processing

Two software programs were used to do the data processing and tabulation. The data entry was done in Microsoft Access and the tabulation and analysis was done using SPSS.

Training

Since the ove situation analysis is the first of its kind in Liberia, highly experienced enumerators and supervisors were recruited for the implementation. This was aimed at ensuring that experienced field staff would quickly understand the survey instruments and also be able to relate to orphans and vulnerable children with a high degree of professionalism.

Training of enumerators and supervisors lasted for three days. The first phase of the training was aimed at acquainting the field staff with the rationale for the survey, survey methodology in general and the questionnaires to be completed during data collection. This process lasted for three days during which, with the guidance of the consultants, all the questionnaires were reviewed. Questions needing clarification were extensively discussed. To ensure the full participation of all, questions were addressed to participants. Some sessions of the training were dedicated to translation of the questionnaires into Liberian pidgin. This exercise was aimed at ensuring a common understanding and interpretation of the concepts in the questionnaires. Several mock interviews were also conducted which were observed, and comments made on how well the interviews went and improvements recommended.

A day was allocated for the pre-test of the questionnaires. This pre-test was aimed at assessing the quality of the questionnaire and also exposing enumerators and supervisors to its practical administration. The pre-test was conducted in a selected community of Monrovia. Following the pre-test a day's session was held to share experiences of the exercise, assess enumerators and supervisors understanding of the questionnaires and determine the quality of the

questionnaires. During this exercise misconceptions were identified and addressed, and some of the shortcomings of the questionnaires also discussed and remedies identified.

Field Work

To ensure good coordination and ease of mobility, five distinct teams were put together for the data collection. Each team comprised five enumerators and a supervisor, including men and women. Team One was assigned to Monrovia; Team Two was assigned to Monroiva, rural Montserrado, Grand Bassa, Rivercess and Bong; and the other teams covered the rest of the country.

Focus Group Discussions (FGDs)

For the FGDs in the communities the survey team identified the most suitable respondents from the household listings.

Focus group discussions were conducted in two communities within each county with: . orphans, and/or

- widows, and/or
- community members

With the permission of the participants the focus group discussions were taped, and later transcribed into English. During the sessions children were informed that they did not necessarily have to talk about themselves.

Two organisations (LOAF and the LIGHT Association) working with people affected by HIV/AIDS in Monrovia also assisted by gathering groups of participants for focus-group discussions. This made it possible to include the voices of PLWHA and AIDS orphans themselves.

Topics covered included: what happens when a parent dies, what are the consequences for the children who have been orphaned, perceptions of the situation of orphans, coping strategies for orphaned children, problems faced by such children, perceptions of interventions and opportunities available, and a profile of community thoughts on whom they consider are vulnerable children and on solutions to the ove issue in their localities in Liberia.

Key Informants

A total of 33 organisations were visited in order to assess the availability and accessibility of existing services including education, health and social services for ave. Key persons in NGOs, donors, religious and public sector, and Government institutions were interviewed in order to gather an inventory of the various institutions and their efforts related to ove in Liberia, covering services for orphans, vulnerable children of all kinds and people affected by HIV/AIDS. These interviews did not use structured questionnaires but were designed to solicit information on institutional arrangements for orphans and vulnerable children, and for PLWHA.

RESUL TS

Household Listing

As explained in the methodology chapter 117 Enumeration Areas (EAs) were selected for the household interviews, from the total of 5,062 in Liberia. In each EA, 25 dwelling structures were selected on a systematic basis (total 2,925), and all households in these structures were listed. This entailed recording the total number of persons in the household, and for those aged under 18 years, their sex, information about their biological parents' survival status, (alive or dead), and the presence of disability. A total of 3,561 households were included in the household listing.

Table 1: Summary of EA Population Liberia 2004 OVC Study

County	No. of EAs	Total Population	0 to 17 yrs	
			No.	Percent
Bomi	4	842	467	55.5%
Bong	10	2,058	1,210	58.8%
Grand Bassa	6	769	435	56.6%
Grand Cape Mount	5	1,788	735	41.1%
Gbapolu	5	791	399	50.4%
Grand Gedeh	6	933	510	54.7%
Grand Kru	4	534	455	85.2%
Lota	8	1,368	739	54.0%
Margibi	7	1,734	1,205	69.5%
Maryland	5	1,096	581	53.0%
Montserrado	29	6,838	3,373	49.3%
Nimba	15	3,130	1,535	49.0%
Rivercess	4	803	436	54.3%
River Gee	4	822	464	56.4%
Sinoe	5	744	319	42.9%
Total	117	24,250	12,863	53.0%

A total population of 24,250 was enumerated in the 117 EAs; 12,863 (53.0%) were under the age of 18 years (see Table 1). In Grand Cape Mount, Montserrado, Nimba and Sinoe Counties the o to 17 year olds constituted less than half of those surveyed whilst in the rest of the country they constituted over half of those surveyed. The counties with the highest percentage of 0-17 year olds were Grand Kru (85.2%) and Margibi (69.5%).

Orphans

Table 2: Summary of Orphanhood Status according to household listing, Liberia 2004 OVC Study

County	Both Parents Alive (%)	Mother Alive, Father Dead %)	Father Alive, Mother Dead (%)	Both Parents Dead (%	Total Orphans (%)
Bomi Bong					
Grand Bassa Grand Cape Mount Gbapolu					
Grand Gedeh Grand Kru					
	(			)	
	403 (86.3)	39 (8.4)	19 (4.1)	6 (1.3)	64 (13.7)
	1,083 (89.5)	90 (7.4)	33 (2.7)	4 (0.3)	127 (10.5)
	395 (90.8)	27 (6.2)	5 (1.2)	8 (1.8)	40 (9.2)
	606 (82.5)	74 (10.1)	27 (3.7)	28 (3.8)	129 (17.6)
	340 (85.2)	31 (7.8)	18 (4.5)	10 (2.5)	59 (14.8)
	412 (80.8)	69 (13.5)	19 (3.7)	10 (2.0)	98 (19.2)
	399 (87.7)	37 (8.1)	15 (3.3)	4 (0.9)	56 (12.3)
	632 (85.5)	86 (11.6)	17 (2.3)	4 (0.5)	107 (14.5)
	1,135(94.2)	51 (4.2)	8 (0.7)	11 (0.9)	70 (5.8)
	508 (87.4)	47 (8.1)	18 (3.1)	8 (1.4)	73 (12.6)
	3,130(92.8)	104 (3.1)	104 (3.1)	35 (1.0)	243 (7.2)
	1,410(91.9)	96 (6.3)	24 (1.6)	5 (0.3)	125 (8.1)
	384 (88.1)	25 (5.7)	17 (3.9)	10 (2.3)	52 (11.9)
	395 (85.1)	44 (9.5)	12 (2.6)	13 (2.8)	69 (14.9)
	250 (78.4)	41 (12.9)	16 (5.0)	12 (3.8)	69 (21.6)
	11,482(89.3)	**861 (6.7)**	**352 (2.7)**	**168 (1.3)**	**1,381 (10.7)**
Lota Margibi Maryland Montserrado					
Nimba Rivercess					
River Gee Sinoe					
Total					

Total Children

467
1,210 435 735 399 510 455 739

1,205

581 3,373
1,535
436 464 319 12,863

A total of 1,381 children under the age of 18 years (10.7% of all children) were listed as orphans,

having lost either one or both biological parents [1] (see Table 2). Among the children aged 0-17 years surveyed, the highest proportion of orphans was seen in Sinoe, 21.6%, followed by Grand Gedeh, 19.2% and Cape Mount, 17.6%. Margibi had the lowest proportion of orphans, 5.8%, followed by Montserrado, 7.2% (see Table 2). Most of the orphans listed had lost only a father, 861 out of 1,381 (62.3%) compared to those who had lost only a mother, 352, (25.5%) and those who had lost both parents, 168 (12.2%).

Fig 1: Orphanhood Status according to household listing, Liberia 2004 OVC Study

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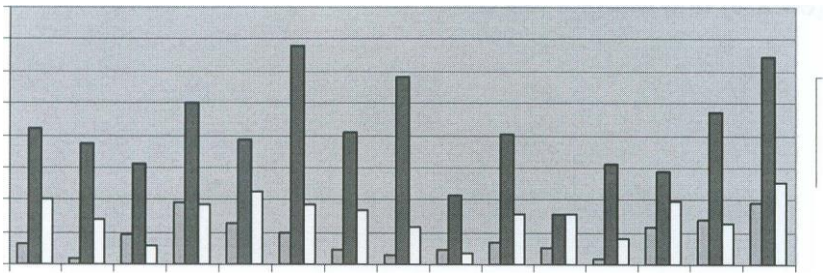

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county

[1] All reference to the terms parent, father and mother used in this report refers to the biological parent, biological father and biological mother.

Fig 1 shows a clear illustration that more fathers than mothers have died and left orphans behind. The difference in all locations is very significant except in Montserrado, Gbapolu and Rivercess, where orphans were equally likely to have lost their mother as well as their father. Overall 6.7% of all children had lost their father but not their mother, 2.7% had lost their mother but not their father, and 1.3% had lost both parents.

Disabilit_

Three hundred and thirty-six (2.6%) of 12,863 children under 18 years had some form of disability. The vast majority of these children were living in Montserrado County, (7.1 % of children in this county were reported as disabled) whereas in other counties prevalence of disability ranged from 0.4% (Nimba) to 1.9% (River Gee).

Household Listing Demographics

A few questions were asked to the household heads about their own situation when the listing exercise was carried out. The majority of household heads were women (55.8%). Most household heads were married (73.5%), with 18.3% single, 6.2% widowed and 2.0% divorced or separated. A large number had not been to school: 45.5% of household heads; 18.4% had had an elementary education, 29.1 % a secondary education, and 6.9% a higher education. As would be expected levels of education were higher among the household heads of Montserrado than in other counties (none 32.2%, elementary 12.2%, secondary 35.6%, and higher 20.1 %). It was more common for household heads in Montserrado, Margibi and Maryland to be in formal employment than in other counties (over 15% of respondents), while self-employment was common in all counties (23.4%), and the remainder reported that they were unemployed (63.4% of all household heads). When asked about their occupation, 45.9% replied that they were farmers, 23.5% housewives, 24.3% professionals, and 6.3% students. Again minor variations could be seen between the counties, with Montserrado providing the lowest proportion of farmers among household heads (18.4%) and the highest numbers of professionals (43.8%).

Household Head Interview Results

A total of 1,148 interviews were held with household heads about the conditions in the household and knowledge and attitudes about HIV/AIDS. The largest number of interviews (323, 28.1 %) was conducted in Montserrado County, and between 29 and 95 interviews were held in each of the other counties (see Table 3).

Table 3: Number of interview of household heads per county, Liberia 2004 OVC Study

County	Frequency	Percent
Bomi	32	2.8
Bong	79	6.9
Grand Bassa	47	4.1
Grand Cape Mount	45	3.9
Gbapolu	69	6.0
Grand Gedeh	90	7.8
Grand Kru	34	3.0
Lofa	69	6.0
Margibi	65	5.7
Maryland	75	6.5
Montserrado	323	28.1
Nimba	96	8.4
Rivercess	35	3.0
River Gee	29	2.5
Sinoe	60	5.2
Total	1,148	100.0

The household heads were asked about their own health over the last three months. Almost a quarter (24.1 %) reported that they had not been sick in this period. The remainder reported that the main sickness they had suffered from was malaria (38.0%), followed by backache (10.2%). The majority of those who had been sick had gone to a health facility (67.7%) while 23.3% reported that they had treated themselves. When asked about the distance to local facilities, it was reported by 41.1 % that the health facility was within 15 minutes walking distance, the nearest elementary school was within this distance for 72.5%, and the source of drinking water was within this distance for 85.3% (see Table 4). For most households (57%) it was reported that the children usually fetched the water.

Table 4: Distance to facilities according to Household Head interview, Liberia 20040VC Study

	Health facility		Elementary school		Source of drinking water	
	No.	Percent	No.	Percent	No.	Percent
Less than 15 minutes walking distance	472	41.1	832	72.5	979	85.3
15-30 minutes walking distance	219	19.1	164	14.3	122	10.6
More than 30 minutes walking distance	288	25.1	103	9.0	39	3.4
Not accessible by walking	168	14.6	48	4.2	8	0.7
Total	1147		1147		1148	

The ethnic group of the household head respondents was reported as in Table 5:

Table 5: Ethnic Group of Household Heads, Liberia 2004 ave Study

Ethnic Group	Frequency	Percent
Americo-Liberian	6	0.5
Bassa	121	10.5
Belle	13	1.1
Dey	6	0.5
Gbandi	27	2.4
Gio	65	5.7
Gola	66	5.7
Grebo	141	12.3
Kissi	25	2.2
Kpelle	198	17.2
Krahn	1119.7	
Kru	89	7.8
Lorma	82	7.1
Mende	10	0.9
Mandingo	38	3.3
Mano	34	3.0
Via	72	6.3
Others	44	3.8
Total	1,148	100.0

When asked whether there were children with disability in their household, 9.3% of household heads reported that this was the case. The most common reported disability was physical (38.1 % of all disability reported), followed by hearing (22.9%), seeing (19.6%), speaking (6.7%), both physical and psychological (6.7%), and psychological (4.8%).

It was reported that in 14% of the households a child would get sick every week, in 46.8% every two weeks, in 31.1 % rarely, and in 7.8% never. The main sicknesses were reported to be malaria (51.9% of all households), fever (14.6%) and diarrhoea (13.2%). As with the healthseeking behaviour of the household head when sick, the majority of these children were reported to be taken to the health facility (68.4% of all households), or treated at home (23.3%).

Household heads were asked whether they had birth certificates for the children in the household, and 21.7% reported that they did have them.

Of the household heads interviewed, 77.3% (n=887) said that they had heard of AIDS and 22.7% (n=261) said that they had not. The remaining questions were only asked to those who had heard of AIDS. The most commonly mentioned mode of transmission was sexual contact (761, 66.3% of all household heads), followed by needles or objects that cut the skin (399, 34.8%), blood contact (175, 15.2%), mother-to-child transmission (48, 4.2%), mosquito contact (29,2.5%), commode seat (19,1.7%) and kissing (13,1.1%). Eighty-nine (7.8%) said they did not know how HIV/AIDS is transmitted. The most commonly mentioned way in which to prevent transmission was avoid multiple sex partners (448, 39.0%) followed by using a condom (446, 38.9%), abstinence (163, 14.2%), avoiding injections (135, 11.8%), safe sex (131, 11.4%), avoiding blood transfusions (127, 11.1 %), and ABC method (31, 2.7%). Only 3.3% of household heads said that they knew someone infected with HIV/AIDS. One hundred and five (9.1%) reported not knowing how HIV/AIDS is prevented.

When they were asked what they would do for a relative or someone in the community with HIV/AIDS, the most common response was to take them to the hospital or health facility. The majority of household heads did not know about any services available for people living with HIV/AIDS, but 19.2% mentioned that health services were available and 10.5% mentioned counselling. When asked if the assistance available from organisations for people living with AIDS is too much or too little, again the majority of respondents did not know. Where an answer was given, the response was mostly that the assistance was inadequate. Similar answers were seen when household heads were asked whether the government is doing too much or too little for the welfare of people living with HIV/AIDS: most could not give an answer, but the most common response was that too little was being done.

Very few of the respondents knew of any person or organisation caring for children with HIV/AIDS (59, 5.1 %). When asked how far this place was, 50 of the 59 respondents answered that it was either more than 30 minutes walking distance away or not accessible by walking. Many of them reported that treatment at this place was free (45, 76.3%).

For those respondents who had heard about HIV/AIDS, most felt that babies who are born HIV positive should be provided with the best care possible (708, 79.4%), but a few thought you should kill the baby (29, 3.3%), or do nothing (17, 1.9%). When asked if they would take a child into their household if the parents had died of AIDS, the majority of respondents replied that they would (512, 57.3%), but some (312,34.9%) said they would not, and a few (41,4.6%) said they would only take them if the child tested negative. The main reason given for refusing to take a child was the fear of getting infected with AIDS and of losing contact with others, but there were also those household heads who said they did not have the means to support such an orphan. Providing foster homes for children whose parents had died of AIDS was thought to be the most important thing that needed to be done for them

There was considerable concern from respondents that if their children were to play or attend school with HIV positive children that they would get infected: of the 895 household heads who answered this question, 215 (24.0%) strongly believed this to be true, 74 (8.3%) somewhat believed it, while 479 (48.3%) did not think that this was the case, and the remainder did not know.

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Household Questionnaires for Children 0-17 Years

From the 3,561 households included in the household listing 1,755 were selected for choosing respondents for the household questionnaires (15 households in each EA). All the orphans and disabled children, and five non-orphans in each EA, systematically selected, were interviewed in these households.

Two questionnaires were used, one administered to caretakers of children 0 to 11 years and the other administered directly to children 12 to 17 years. The two questionnaires were similar in many respects except that the sections on economic activities, knowledge and attitudes to HIV, and sexual relationships and sexual behaviour were used with the 12 to 17 year olds but not with the caretakers of the younger children, as they were not applicable. A total of 1,143 caretakers and 558 older children were interviewed. Where the same question was asked to the caretaker and to the older children, the data were merged to provide an overall picture. For ease of reference in the text this merged group will be referred to as 'the children interviewed', and the total number of interviews carried out was 1,701 (see Table 6).

Demoaraphic Characteristics

Table 6: Distribution of interviews, Liberia 2004 OVC Study

County	Orphans		Total interviewed	
	No.	Percent	No.	Percent
Bomi	34	2.9	47	2.8
Bong	91	7.8	143	8.4
Grand Bassa	32	2.7	64	3.8
Grand Cape Mount	42	3.6	63	3.7
Gbapolu	60	5.1	86	5.1
Grand Gedeh	68	5.8	91	5.3
Grand Kru	35	3.0	53	3.1
Lota	65	5.6	107	6.3
Margibi	72	6.2	99	5.8
Maryland	43	3.7	61	3.6
Montserrado	430	36.8	581	34.2
Nimba	87	7.4	146	8.6
Rivercess	33	2.8	51	3.0
River Gee	26	2.2	46	2.7
Sinoe	50	4.3	63	3.7
Total	1,168	100.0	1,701	100.0

From the household listing exercise all those children identified as orphans or severely disabled were supposed to have been interviewed using structured questionnaires. A total of 1,168 orphans were interviewed (68.7% of the total), and 91 disabled children. In addition five nonorphans were selected in each EA, as it was thought useful to compare some of the characteristics and variables especially between orphans and non-orphans. A total of 442 nonorphans were interviewed.

Table 7: Sex, ethnic distribution and orphanhood status of children interviewed, Liberia 2004 OVC Study

Ethnic Qroup	Male	Female	Orphans (column %)	Total (column %)
Americo-Liberian	9	6	9 (0.9)	15 (0.9)
Bassa	87	89	87 (8.4))	176(10.4)
Belle	7	9	7 (0.7)	16 (0.9)
Dev	19	9	20 (1.9)	28 (1.7)
Gbandi	16	20	19 (1.8)	36 (2.1)
Gio	44	53	43 (4.2)	97 (5.7)
Gola	61	48	71 (6.9)	109 (6.4)
Grebo	95	96	118 (11.5)	191 (11.2)
Kissi	82	92	111 (10.8)	174 (10.2)
Kpelle	119	114	148 (14.4)	233 (13.7)
Krahn	60	64	70 (6.8)	124 (7.3)
Kru	68	57	84 (8.2)	125 (7.4)
Lorma	26	29	34 (3.3)	55 (3.2)
Mende	28	31	36 (3.5)	59 (3.5)
MandinQo	21	16	22 (2.1)	37 (2.2)
Mano	45	59	68 (6.6)	104 (6.1)
Via	65	35	66 (6.4)	100 (5.9)
Others	10	12	17 (1.7)	22 (1.3)
Total	862	839	1,030 (100.0)	1,701 (100.0)

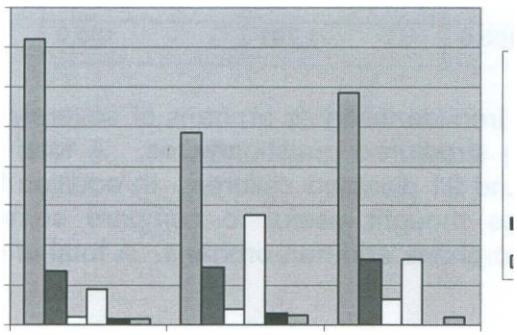
The Kpelle were the most numerous of the respondents (13.7% of the total), and also provided the largest numbers of orphan interviews (14.4%) (see Table 7). The proportions of boys and girls interviewed in each ethnic group were remarkably balanced, with only the Dey and the Via showing a markedly higher number of boys interviewed. The proportion of orphans in each ethnic group was also very similar (see column percentages), giving no suggestion that there are particular groups of people who are more likely to have died, leaving their children orphans.

On nationality, as expected, most were Liberians, 97.8% of all the children interviewed. The majority were Christian, 84.4%, with 14.5% Muslim, 0.5 indigenous religion and 0.6% other religion.

Child's Relationship with Household Head

Fig 2: Child's relationship with household head, Liberia 2004 OVC Study

80% 70%



60%

- 50%

c

B 40%

...
CD
Co 30%

l1li *Sonl* daughter

. Grandchild

0 Sibling

0 Child of another relative

20% 10%

- Child of neighborl friend l1li Spouse

0%

Non-orphan

Orphan

Disabled

Orphans seen in the survey were being raised by relatives and not by non-relatives. As seen in Fig. 2 nearly all orphans were found to be closely related to the household head. Many of the 'orphans' had only lost one parent so were living with the surviving parent; thus almost half of

them were in a household where the remaining parent was household head (48.4%, compared to non-orphans, 71.9% of whom were the child of the household head). The next most common relationship with the household head was to be the child of another relative (9% of non-orphans, 27.7% of orphans, 16.5% disabled). About one in seven were grandchildren of the household head, and this proportion was almost identical for all groups of children. Some children were married at a young age: the youngest who reported that they were the spouse of the household head were 12 years old, and 6.6% of all children aged 12-17 were married to the household head.

Birth Registration

Among orphans 77.1 % reported not having a birth certificate, whilst among the non-orphans 74.9% reported not having a birth certificate. Overall, only 18.8% of children reported that they had a birth certificate.

Education

The questions on schooling sought to establish the child's educational history, type of school, and for those who have dropped out or have never attended, and reasons for this.

Table 8: Current educational status for orphans and other children, Liberia 2004 OVC Study

	Non-Orphan (%)	Orphan (%)	Disabled (%)	Total (%)
Normal academics	271 (62.0)	732 (63.4)	53 (59.6)	1056 (62.9)
Islamic school (madrassa)	6 (1.4)	10 (0.9)	1 (1.1)	17 (1.0)
Skill training	0 (0.0)	2 (0.2)	0 (0.0)	2 (0.1)
None	160 (36.6)	410 (35.5)	35 (39.3)	605 (36.0)
Total	**437**	**1,154**	**89**	**1,680**

Overall 62.9% of respondents were currently attending a normal school (see Table 8). Orphans and disabled children were as likely as non-orphans to be attending school. There was no difference in reported school attendance between boys (60.7% in normal school) and girls (63.5%). For those attending school 50.2% were attending a school in public sector, and 49.1 % in private sector. The major reason given for not attending school was lack of money or support, both for those who had been at school in the past and stopped attending (15.3% of all respondents) and for those who had never attended (12.7%).

Feeding

Questions in this section sought to elicit information on the child's eating patterns. Most children (85.3%) eat with everybody else in the household. The main reason given for not eating with everyone else was 'doesn't like eating with others'. Orphans (86.0%) were no less likely to eat with others than non-orphans (85.1 %).

Respondents were asked how often the child did not have enough to eat, why they didn't get enough and what they did to get food. A small number of children (2.6%) had insufficient food every

day, while over a quarter (26.2%) were short of food a few time each week (see Table 9). Non-orphans were significantly more likely to be adequately fed and never to be short of food (58.7%) than orphans (49.0%) (see Table 9).

Table 9: Frequency of children having insufficient food, Liberia 2004 OVC Study

Everyday
A few times/week A few times/month Never
Total

Non-Orphan (%)	Orphan (%)	Disabled (%)	Total (%)
4 (1.0)	36 (3.4)	0 (0.0)	40 (2.6)
96 (24.5)	283 (26.7)	33 (36.7)	401 (26.2)
62 (15.8)	221 (20.9)	20 (22.2)	303 (19.8)
230 (58.7)	518 (49.0)	37 (41.1)	785 (51.3)
392	**1,058**	**90**	**1,529**

The main reason given for a child being short of food was that there was insufficient food for everyone (35.0% of all respondents). Most of the children were reported to stay hungry, beg, work, steal or find food for themselves.

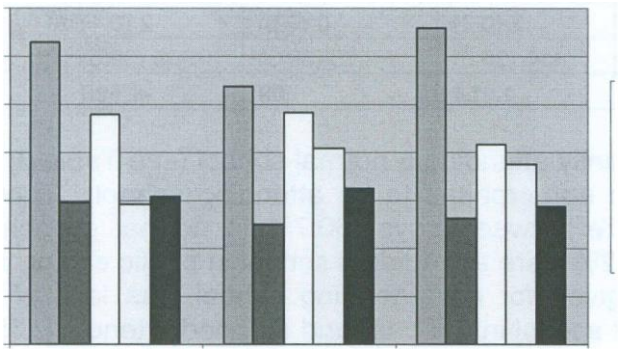
Health Care

Children were asked when they were last sick, what the illness was, what was done to get well and who took the child to get treatment. Just over a quarter of all children reported being sick in the last week (see Fig 5). There were no clear differences between the categories of children.

Fig 3: Time children reported last being sick, Liberia 2004 OVC Study

35.0%

10.0%



Ell Last week

. Last 2 weeks

D Last rronth

D foJbre than a rronth . Rarely sick

30.0%

25.0%

1: 20.0%
QI
u

_ 15.0%
Q,

5.0%

0.0%

Non Orphan

Orphan

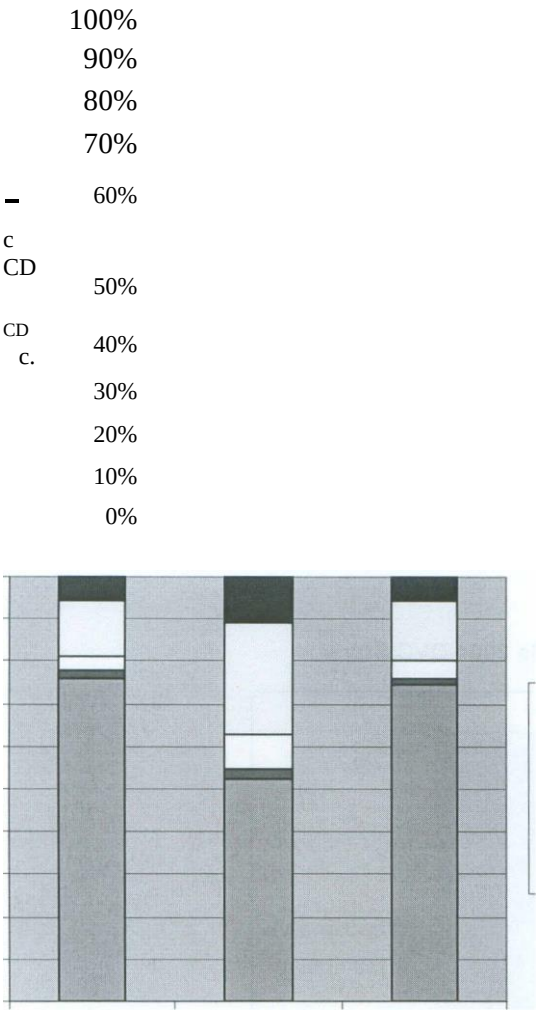
Disabled

Fever/headache and malaria were the health problems most commonly reported by each group of children. When they were sick, 68.5% said that they went to a health facility, 6.3% visited a traditional healer or herbalist, 4.2% took no treatment, 12.1 % were treated by a family member and 7.0% treated themselves. Orphans were most likely to be taken for treatment by the household head or a caretaker, whereas non-orphans and disabled children were more likely to be taken by their parents.

Whereabouts and Well-being of Child's Parents

These questions established the whereabouts and health and well-being of the child's parents and whether the child had always lived in the household or not.

Fig 4: Time children have lived in their current household, Liberia 2004 ave Study



As seen in Fig 4, most children, whether orphans or not, had always lived in the households where they were found during the interview. Among orphans 52.2% had always lived in the household compared to 75.3% of non-orphans and 74.7% of disabled children. For those who had not always lived in the household, 61.5% orphans and 58.9% controls lived with their parents before whilst 31.9% orphans and 41.1 % controls lived with other family members; small numbers lived with non-relatives, on their own or in orphanages (totalling 3.0%).

For orphans the main reason for joining the household was because one or both parents died (62.1%), followed by schooling (14.2%) and lack of support (11.1%) (see Fig 5). Among the non-

orphans the major reason was schooling (41.1 %), followed by lack of support (16.8%). For disabled children they gave schooling (30.4%) and lack of support (30.4%) as equal reasons, and 8.7% also said that sickness was the reason.

Fig 5: Reason children moved to live in their current household, Liberia 2004 ave Study

70.0%

60.0%

50.0%

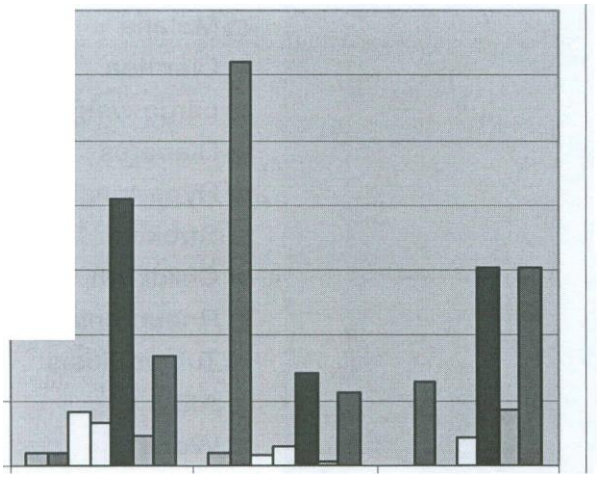
1: 40.0%
CI)
(.)
...
8. 30.0%

20.0%

10.0%

0.0%

Ii;:) One or both parents sick



- One or both parents died

Ii;:) Parents separated!
divorced
Ii;:) Parents tra\lelled

- Schooling

iii Because of sickness

Non-orphan

Orphan

- Lack of support

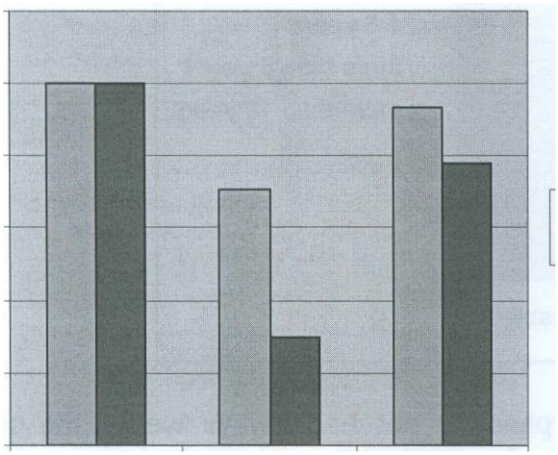
Disabled

45

Fig 6: Survival status of children's parents, Liberia 2004 OVC Study

120%

20%



100%

80%

c:

B 60%

...
OJ
c..

III mother alive . father alive

.....

40%

0%

Non-orphan

Orphan

Disabled

I'-.

The mothers of 70.8% of the orphans were alive, and the fathers of 30.1 % were alive, whilst 11.8% had lost both parents (see Fig. 6). In total 81.7% of all orphans interviewed had lost a male parent and 41.0% had lost a female parent.

-

Most of those who lost their parents said they died less than five years ago, 63.6% and 61.2% for mothers and fathers re spectively; with 7.5% and 10.2% respectively having died within the past

one year.

Fig. 7: Cause of death of parents of orphans, Liberia 2004 OVC Study

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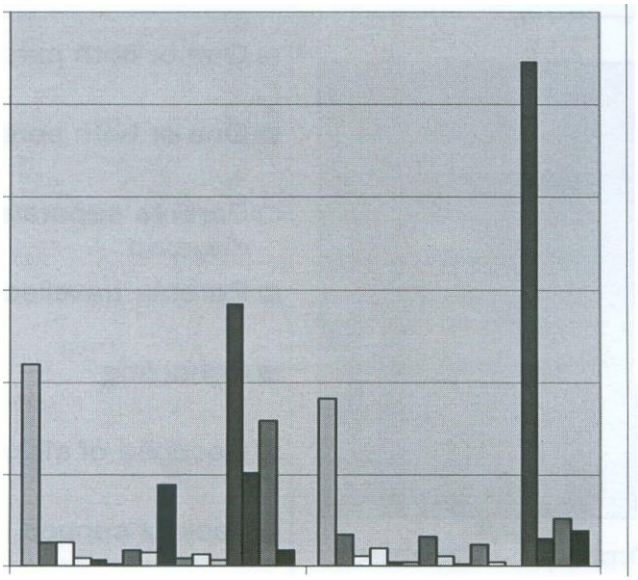
50.0%



[]I Sudden death

. Accident

0 Malaria

0 Diarrhea

. Large weight loss I:!I Diabetes

. Hypertension

0 Stroke

. Childbirth

. Pneumonia

.....

60.0%

40.0%

c
Q)

_ 30.0%

Q)
c..

20.0%

10.0%

0 Tuberculosis I:J AIDS

mother

father

.War

. Don't Know . None

. Non-response

0.0%

The most common cause of death for both mothers and fathers was the war (see Figure 7). Many respondents did not know the cause of death, describing it commonly as a 'sudden

death', 'none' or 'don't know'. The next most common response for cause of mother's death was childbirth. The numbers in the remaining categories are too small to draw any conclusions.

Many of the surviving parents were reported to have been seriously ill in the past year; the most common complaints were malaria (33.7% of parents) and backache (7.5%). Fathers were more likely to be reported to have been seriously ill (84.6%) than mothers (74.3%).

Sexual RelationshiQs and Behaviour

Questions on sexual relationships were only administered to children aged 12 to 17 years. Almost a quarter (23.9%) said that someone had, at least on one occasion, tried to touch their private parts; the proportion of orphans and non-orphans reporting this was almost identical (24.6% and 24.4%), but the proportion of disabled children was significantly lower (14.8%). The majority of children did nothing following this incident (72.0%), and if they informed anyone it was most likely to be their parent or guardian (15.9%).

More than half of respondents reported that they had ever had sex (53.4%). The majority of those who were sexually active reported one partner in the past year (71.1%), with 22.7% reporting two or more. There were no significant differences in reported sexual behaviour between orphans and non-orphans. Condom usage was poor: 69.1 % reported that they never use condoms.

Knowledge and Awareness about STI and HIV/AIDS

Less than half (41.0%) of the 558 respondents aged 12-17 had heard of sexually transmitted infections. Of those who had heard about STIs the majority believed that gonorrhoea was most common (71.2%), followed by HIV/AIDS (52.4%), with few giving the responses of vaginal discharge (5.7%) or painful urination (4.4%).

Many of the respondents (59.7%) had heard of HIV/AIDS. The majority of this group (78.4%) knew that HIV/AIDS is spread through sex, with 51.7% knowing that needles or other objects that cut the skin can transmit the virus, 13.3% mentioning blood contacts, 3.6% mentioning transmission from mother to child at birth, and 5.4% had incorrect knowledge (mosquitoes, kissing commode seats). Means of prevention included condoms (37.8%), avoiding multiple partners (32.4%), abstaining from sex (21.0%), avoid injections (18.9%), safe sex (12.6%), avoiding blood transfusion (12.0%) and the ABC method (2.7%). There were no significant differences between orphans and non-orphans.

Economic Situation

Questions on children's economic situation were asked to those aged 12 to 17 years. Topics included their source of income, the type of work they do, total monthly income and what they do with the money.

Most of the children (63.6%) reported that their major source of income was from their parents. Other sources included selling (12.7%), and boyfriends (6.8%). There were no significant differences between orphans and non-orphans. To earn money, petty trading, domestic work and farming were the most common responses.

For most of the children (28.7%) their monthly income was less that $200 (Liberian) and there were no marked differences between orphans and non-orphans (see Figure 8). However disabled children appeared to be more likely to have a higher income than the non-disabled

children. When asked what they do with the money they were most likely to spend it or take it to the household head.

Fig. 8: Monthly income of children in Liberian dollars, Liberia 2004 ove Study

40 35 30

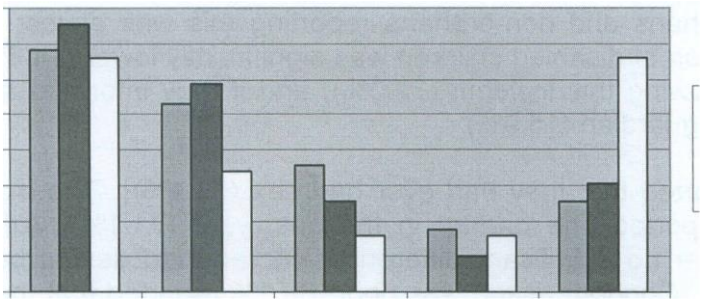
C 25

III

_ 20

__ 15

10 5 0



Less than $200

$200 $500

$1,001 $2,000

$2,001 $20,000

$501 $1,000

income

III Non orphan . Orphan

0 Disabled

48

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Focus Group Discussions

FGD participants

Focus group discussions were held in 11 counties. A total of 17 transcripts from these FGDs were analysed, as follows:

.Seven with adult community members; some groups were mixed-sex, other not. Many of these participants were looking after orphans themselves. They were asked about the way in which their community dealt with orphans, what were the problems and the coping strategies employed, how this situation had changed over recent years, and their awareness of the impact of HIV on their community.

Two with widows. They were asked how they were managing with bringing up their children and the coping strategies they employed.

Six with orphans. The children were asked how they viewed the situation of orphans compared with other children, in the areas of education, food, general care and wellbeing, emotional support, workload and opportunities. For some groups sexes were combined since the questions were felt not to be sensitive, and the facilitators were careful to ensure that all participants expressed their views. One of the groups was held in an IDP camp.

One with AIDS orphans at LOAF. Similar topics were covered as for the other orphan groups.

One with PLWHA at the LIGHT Association. Topics covered included the problems they faced in their daily lives, how they were bringing up their children, where they got support and other coping strategies.

….Causes of vulnerabili_

Community members remarked that the war had played a major part in creating the present-day problems for children and families. It was thought that during the war children were losing their parents more frequently than at present, but that of course the adults who had died in the conflict had left a large group of orphans who are now a burden on the community.

The war had a number of direct consequences on the situation of children. Children may have lost their parents in the war or been separated from them.

Abandoned children are not getting their basic needs met just like orphans (community member)

The economic impact of the conflict makes it hard now for many families to afford to bring up children.

Children both orphans and non-orphans are all suffering because there is no food

(community member)

Some children learnt what are perceived as 'bad habits' as a result of being involved with the fighting forces:

The civil war in Liberia made the children rude because most of *the children fought the war. Some parents abandoned the children and do not care,* so *the children are left with no alternative but to join friends (whether good or bad) to make ends meet and find daily bread* (male community member)

The children at LOAF had a slightly different perspective, many of them having experienced the sickness of their parents:

Some parents are sick, therefore they are not able to meet the children's basic needs; the children have to go out in search of it or go out to do mischief which gives the parents a *bad name.*

Problems faced byQmhans

This topic generated the largest number of comments in all the FGDs: almost all participants had experiences or opinions to share about the difficulties children face when they have lost their biological parents.

Comments from community members

Community members all agreed that orphans generally have a harder life than non-orphans: they lack care and support as well as the practical things such as food, clothes and healthcare.

Children who have lost their parents are vulnerable because of the lack of food, clothes, a *decent place to sleep, and* so *on. And these children cannot decide for themselves what they want, compared to children whose parents are alive whose basic needs are met by their parents no matter what the problems are* (widow)

They cannot be compared to other children, because the care non-orphans receive is much better than orphans (community member)

You get orphans that are not taken care of properly, for example during the Christmas holidays they do not dress the same (male community member)

Economic difficulties were seen to make children increasingly vulnerable:

Situations that make life difficult for these children are their parents are jobless or they are fatherless and their mothers are not doing petty trade to keep the family going or keep up the home (community member)

One of the conditions is low income. The parents have to send these children to sell in order to have their daily bread. In other words there are child laborers as *well* (community member)

There was an awareness that orphans were less likely to be able to make choices in their life:

The needs of a *parentless child are not always met, they cannot make decisions for themselves, they have no choice and they don't have constant support. But* as *for children with parents is the direct opposite* (widow)

The attitude to orphans in the community was not always supportive:

The community just shouts at kids and drives them away (community member)

In this community most of the time I see these children being ill-treated. They are being overlooked. No one really cares sometimes even some of their relatives ill-treat them (community member)

Some ill-treat orphans. A few days ago I saw a *lady knocking an orphan with* a *very large*

stick which was very bad, I really pity that child (community member)

Some orphanages were not considered to be a good source of alternative care, as they were not looking after children well:

Some of the children in the orphan home are badly off as *only medical care is provided: they don't have enough food. They are almost like children on the streets* (widow)

50

If a child had only lost one parent they may be in a better situation to those who have lost both:

Some orphans will have a *single parent dead and will have better care but those who have both parents dead will not receive the parental care* as *compared to the other child* (community member)

The circumstances of orphans was seen to depend to a great extent on which parent had died. It was generally felt that losing a father had different consequences to losing a mother, partly because the father may have been the main breadwinner or the one primarily responsible for discipline:

Most children are afraid of *their father* so *when the father is absent it is difficult to discipline the child or children* (widow)

Losing the mother would also have particular consequences, especially for younger children:

Those who lose their mother face more difficulties because to find a *mother to take care* of

you in the absence of *the father is difficult* (community member)

There were a number of comments about the difficult relationships that children may have with stepparents, for example:

Those living with stepparents are worst off. Most stepmothers and fathers treat these kids very badly and nothing is done it about mainly because people are afraid getting involved in

other people family business (community member)

But there was also an awareness that if the widowed parent remarried the response of the stepparent to the children may vary:

If the father died the mother can remarry and her children will be treated the same as *the man's children by the new husband, but it is difficult for some women to accept other children in their home* (community member)

Sometimes stepmothers under feed the child and his father does nothing, other times step

father abuse their children (mainly daughters) (community member)

In spite of all the difficulties of bringing up orphans, it was felt that in some situations foster parents did indeed do their best to treat them kindly and fairly:

There are some parents who show differences but in other homes there is no distinction or segregation among the children (male community member)

Some orphans are treated the same as *non-orphans if they have caring external relatives that are God-fearing and loving* (male community member)

Some people treat orphans like their own children (community member)

Most people are not willing to take in orphans but some do take good care of *us* (male orphan)

Comments from orphans

The orphans interviewed covered described many of the same difficulties as the community members: economic difficulties, emotional problems, and lack of support from the wider community. Some of them related how they could not go to school and were obliged to work to survive:

I'm *not going to school and I have to sell to get small money to buy clothes and slipper for* me *these are the only remedy to* my *problems* (male orphan)

In some cases it may even be the guardians who are forcing the orphan to work:

At times when you are living with foster parents; you are forced to do *things that make you bad..... forced to* do *hard labor* (orphan)

Foster parents force you to do *things against your will, even* if *you are ill* (orphan)

The emotional consequences of orphanhood were reported to be partly due to the day-to-day difficulties they experienced as well as lack of support from people around them:

People look at us bad. We *are always dirty* (male orphan)

We *don't* have *parents to provide food and clothes, and* we *are overlooked* by *older folks and they take advantage of* us (female orphan)

You see other parents buying for their kids and no *one to* do *so for you and will feel* very *sad* (orphan)

Always being reminded that you are an orphan by *the foster parents* (orphan)

Always accused of being the worst kid by *both foster parents and outsiders* (orphan)

I *see myself as being empty because* I *lost both parents, for those* who *lost single parents life* is *a bit ok, but those children whose parents are alive live a better life. However, some community members treat* us *good while others treat* us *bad* (male orphan)

One orphan described how some of their problems could be overcome:

Orphans should be *sent to good* homes *where they will experience love and that will help them forget their* past. *Always encourage and comfort them that they are the future leaders. Try not to remind them of the past* (orphan)

A comment from one of the children at LOAF brought together many of themes that had been brought out by both community members and other orphans:

Before my parents died I was *a cheerful and happy child having both parents to give all the love and affection a child needs. But* now *that my parents are dead, there's* no *one to give me the same love and affection or make me happy, so as a result some of* us *start to get involved in some bad habits like smoking, stealing, taking drugs;* if *it's a female she may get involved with a lot of men because* no *one* is *there to help.*

Comments *from* members of the LIGHT Association

In the FGD held with PLWHA there were a many similar comments about the difficulties *faced* by orphans, supplemented by awareness of the consequences of stigma around HIV/AIDS on their children. In general they did not talk directly about their own children or their fears for the future, but addressed more general issues. One comment summarized the findings of many the groups, by talking about how a child loses the practical support of parents when they die, how the child may not be well taken care of after that and therefore the child may start to behave differently:

When parents are alive they are able to bear or take responsibility of things that concern you like your schooling, feeding, clothing, shelter and health needs; but with your parents dead other family members will not be *willing to take those responsibilities. All these hurt you as a child and make you* go *astray or behave wrongly which* is *not* good.

Other findings from this group which resonated with the analysis from community members and orphans included the following:

Some problems of orphans include: nowhere to live, so they become *street children;* no *support for education, health or their basic needs; being talked to* by *others just* how *they feel like.*

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There is no support for children's education because parents who are diagnosed with HIV are usually not working.

Some people have a *bad attitude towards orphans. They are always reminding them* of *their plight (that they are orphans). They are always picking on them which is unfair in society.*

Some step-motherslfathers treat orphans very bad but nothing is done about it because the other *parent is not always home.*

Some children get frustrated over such tragedy and decide to do things their way and feel they are grown up: they don't listen to advice from older folks anymore.

This group talked at length about stigma and rejection, and this was followed by a comment

about the impact of HIV/AIDS on children:

Children need help - friends at school always laugh at them or avoid them because they don't know their parents have AIDS.

Problems faced bv Carers

Most of the community members concentrated on the practical difficulties of bringing up children in addition to their own: lack of food, clothes, shelter and access to healthcare. One commented:

Orphans are mainly neglected. They need to be taken care of *and counseled* (community

member)

One of the recurring themes was that many needy children were not thought of as well behaved or disciplined, and therefore difficult to take care of.

Children don't have respect and there is no one to control them (community member)

When combined with a lack of support for those looking after orphans, this was seen as a major difficulty:

We *have* so *many children that are very disrespectful, and* we *have taken care* of *other people's children but get no support.* We *have asked for assistance but have had no*

response thus far (male community member)

As has been shown already in this report, the majority of children defined as orphans are being brought up by their mother, after the death of their father. Without the presence of the father one widow remarked on the difficulties of bringing up children alone:

The children will go out for drugs and also follow other bad children; stealing, getting

raped, wanting things that their parents cannot afford (widow)

While a widow may be able to provide good care for her children in many ways, they are also likely to encounter many problems because of lack of financial resources. Many of the widows commented that educating their children was their biggest difficulty:

Tears are in our eyes if the children are not in school; or are not being properly taken care of *because* of *lack* of *funds* (widow)

It is difficult to educate the children without the husband (widow)

Sometimes you put your children first and forget about yourself in terms of *clothes and*

good time, in order to give your children a *good education* (widow)

Similarly for PLWHA the economic problems were their highest priority, and clearly lack of money to

buy food will have a grave impact on children:

Food is a *major concern for PL WHA.*

My *status has made* my *customers stop buying from me. It is hard for* me to *get by* at *this time.*

Access to Education: a high priority

Participants in each category of FGD (community members, orphans, widows, LIGHT Association and LOAF) talked about the problem of paying for education. This was brought out as one of the most pressing needs for orphans.

No, we *are not going* to *school. There are no school fees* (male orphan)

Foster parents refuse to *pay fees, sending you out* to *look for your parents* to *pay it* (orphan)

When orphans were asked what they would most like to change in their life, the answers each time included education.

It is not just the school fees but the associated costs that cause problems for orphans to continue going to school:

Being put out of *school for your materials makes you feel bad* (orphan)

In contrast, health problems and access to healthcare were rarely mentioned as a priority, perhaps because for most children this is not a daily issue whereas schooling is:

The health of *the children varies, but whenever one is sick, he or she has* to *be taken* to a *nearby clinic even if it means spending* a *little* (widow)

Coping strategies

When the FGD respondents were asked about the solutions to the difficulties of dealing with ove their replies fell into three categories: individual coping strategies, community and familylevel support and institutional assistance.

Individual coping strategies

It is clear that many orphans are obliged to work to sustain themselves, or else to engage in other activities to acquire food or money. In most of the FGDs there was reference to children 'cutting contracts' as a survival strategy

They cut contracts, beg, or run after the Pakistanis' wasted food from dump sites (community member)

Children have to *work very hard* to *get their daily bread* (widow)

As for the vulnerable they lack funds to *go* to *school, and because* of *this they have* to *work for people in the community* to *enable them earn some money* to *be able* to *pay their school fees* (community member)

Most kids are working for food. Some others have people they are living with but nothing much is done for them (community member)

Actually these children are too small to *deal with their problems but the bigger ones cut contracts* to *sustain themselves* (community member)

Some of *the orphans go* to *farms* to *help people in order for them* to *find food and buy clothes* (community member)

For girls several groups reported that another option was available:

Girls are mainly involved in sexual activities (community member)

Children at LOAF reported that they could sometimes get support from their extended family *If I have* a *problem I tell my uncle.*

If I have a *problem I tell my grand mother; or others who are willing to listen and help: my relatives and friends.*

Community and family-level

If the family and community can offer support to children in difficult circumstances it can transform their lives. Most of the FGD respondents reported that fundamentally there is great willingness in Liberian society to offer such support:

We share with orphans what ever we *have, talk to them to know they have people who are caring for them by going to them at all times* (community member)

Take time to talk to them so that they cannot run away from the home (widow)

At times we *call them and offer counsel to them. We also offer them food, clothing, health needs and so on* (male community member)

There are strong moral imperatives about child rearing that people would wish to follow:

Bring the children up in the Christian manner; children should be trained how love and fear God (widow)

However, there are many constraints in the lives of those who may wish to help needy children:

People are willing to help the OVCs only if they have the means to do such. It is not easy to do such because things are very hard these days (community member)

The issue of dealing with badly behaved children again came up in this context, and one of the responses to poor behaviour was reported to be to ignore the child:

When the child is not living with you it is not easy to chastise him or her. Just avoid them, because most of them are very rude (male community member)

Respondents at the LIGHT Association identified many of the same problems for the extended families of AIDS orphans:

The families are faced with the problem of support for AIDS orphans - there is no money to send them to school, clothe and feed them.

But there may be an additional reason for these families not to be willing to accept AIDS orphans:

Families taking care of AIDS orphans are afraid of contacting the virus from the orphan since his or her parents died from the virus.

Members of the LIGHT Association generally seemed pessimistic about the assistance that their families would provide to their children:

Family and relatives neglect our children.

Institutional response

Assistance from institutions should not be the first resort, but if it is available it provides a useful backstop in situations where the family and community response is not adequate. One respondent identified the constraints that the most people were under:

It is difficult to find people willing to take responsibility for orphaned children, reason being is most of *these people themselves don't have enough food to eat, but Zuo Mission is taking orphans* (community member)

The belief in some communities seemed to be that orphanages were the one of the first places to seek help for orphans:

Most of *the orphans* we *had around have been taken into orphanages* (community member)

There are other orphans who are neglected. They need to be taken to orphanages as well (community member)

Some assistance has provided by NGOs in terms of food, education and other items:

Sometimes appeals are made to NGOs for help, and through Hope International we *were able to get small food through* a *project called Work For Food* (community member)

Yes, we *have been fortunate to have Save the Children, UK, and they are helping parents with schooling materials, feeding, clothes and medications and money* (widow)

The public school in this community sometimes helps these children and the main assistance given to these children is education (community member)

One respondent remarked that the government also has a role to play:

Absolutely nothing is being done by the government for OVCs in this community (community member)

HIV/AIDS

FGD respondents were willing to display their knowledge about modes of transmission and means of prevention of HIV/AIDS. While in most groups the respondents had correctly understood some of the basic facts about HIV, there were also a number of incorrect beliefs and stigmatizing attitudes, for example:

The way in which they got infected is through prostitution (community member)

By *eating with the same spoon with an AIDS-infected victim one can get AIDS* (male orphan)

There seemed to be little awareness of the impact of HIV/AIDS around them by almost all participants. Where the respondents talked about AIDS orphans the tone was negative:

For me *I cannot take an AIDS orphan in* my *house, if I know I will take them to the doctor* (male community member)

Yes, you can consider taking them because they are children but you have to be careful (male community member)

Stakeholder/Key Informant Interviews

A total of 33 agencies were visited, some of whom were working directly with children or orphans, and others with people affected by HIV. But the majority were providing services to the general population or to children in general. The interviews held with these agencies aimed to discover the way in which they perceived the issue of OVC, the services they were providing and their strategic priorities.

Government Agencies

The Ministry of Health and Social Welfare is the government agency responsible for providing healthcare throughout the country and for the protection of vulnerable children. Much of the infrastructure of the health system was destroyed during the war, but renovations have begun. Recruitment of staff is a major problem, especially at the county level. There is a system of county health teams, who should work with social work teams. Some social workers have recently been trained at Mother Paterno

The Department of Social Welfare is responsible for the accreditation and regulation of orphanages, through a Child Protection Taskforce. The recent assessment of orphanages in Montserrado and Lower Margibi Counties found that many were sub-standard, and that many of the children in these orphanages were not orphans, but come from families that can't afford to feed them or send them to school and feel that the orphanage will give the child a better life. This highlights a fundamental issue in thinking about OVCs in Liberia: many families are struggling just to meet basic day-to-day needs, and if parents fall sick then it multiplies their troubles.

The National AIDS Control Programme was set up by the Ministry of Health in 1987. five areas of work:

- IEC
- Care and support
- Blood safety
- Epidemiological surveillance
- STI management

They have

HIV testing at NACP is free; it is also available at some other centres, almost all in Monrovia:
Mother Patern, Lutheran Church, ELWA, Firestone Hospital, Catholic Hospital, Missionaries of Charity and Phebe Hospital in Bong County. Reporting of the results of HIV testing and of AIDS cases from the facilities to central level is poor. In 2003 15,375 HIV test results from seven counties were reported, with 1198 positive (prevalence of 7.8%). Most of these tests are for blood donors (and unlikely to be representative of the general population), and follow-up care and treatment is not always available. Services available to PLWHA (in Monrovia) include medical care, counselling, food rations, a support group and occasional donations of clothing and bedding for children. Outside Monrovia healthcare designed for PLWHA is scarcely available. Most PLWHA have pressing economic needs, and income-generating activities and micro-finance would be useful. The Global Fund will be providing $7.65 million in 2005-6, which will be used for ARVs, drugs for opportunistic infections, STI management, HIV test kits, CD4 count facilities, training and vehicles. In terms of programming for OVCs, the plan is to support them in the community, not in orphanages, by providing assistance to the extended families.

The Ministry of Education is aiming for free and compulsory education for all children aged 3-10. Yet they report that many children are not in school because their parents are not in a position to send them. Largely because of lack of availability of schooling during the war many students are in school at older ages than would be normal. The private educational sector is popular

among those who can afford their higher fees, as government schools are congested. Fees at government schools range from L$150/semester in kindergarten to L$500/semester. Lack of teachers is a major constraint; in 2002 there were a total of 21,762 teachers at primary and secondary level, and there has been a recent go-ahead to recruit 4000 more teachers. Many schools are able to provide some food for student through WFP donations. UNFPA sponsor Pop/FLE (Population and Family Life Education) and peer education techniques are also used. Access to health-related information is poor outside Monrovia.

The Ministry of Gender is concerned that agencies working with OVCs should co-ordinate their activities. Because society is not open about AIDS PLWHA do not feel free to be open about their status and this makes planning for the future of their children very difficult. To date the Ministry of Gender has not been in a position to support PLWHA or their children.

UN Agencies

A number of UN agencies are carrying out work related to children and to HIV. The national initiative to improve the situation of OVC has to date been led by UNICEF in collaboration with the Government of Liberia. UNICEF's overall programme emphasises a rights-based approach in the fight to improve the situation of children and women, and their programming has a number of elements that potentially impact on OVCs, such as rights promotion and protection, working with the educational sector and strengthening the primary healthcare system.

UNFPA is the major and condom and HIV test kit provider for the country, with distribution organised through NACP. They have two HIV awareness programmes, run by CBOs, and also other programmes on sexual and reproductive health, mainly dealing with adolescents. They identify teenage pregnancy as a major cause for concern and feel that HIV prevention programmes in Liberia still have a great deal of work to do. They believe that people are generally sceptical about HIV/AIDS because they say they need to see PLWHA with their own eyes.

UNHCR is carrying out a wide range of activities in the country, and has more staff on _he ground than other UN agencies. They work with county health teams and NGO implementing partners as well as other UN agencies. They have a special fund for HIV, which is one of their priority areas, and have concentrated on awareness-raising. UNHCR has set up HIV/AIDS committees in each county and provided training and IEC materials. They identify weaknesses in the primary healthcare system that make certain HIV-related activities very difficult to achieve, such as VCT and adequate care and support for PLWHA. Children are another priority area for UNHCR, seen a part of the response to the situation to refugees: much of their work is with agencies that are reuniting separated children, providing repatriation, and providing services in refugee camps.

The WHO reports that there are few services for OVC in Liberia. They chair the Technical Committee for the Global Fund, and the only direct support that will provided to OVC from these monies is to the organisation working with AIDS orphans known as LOAF. There is no National Policy on OVC, and little reference to children in the National HIV/AIDS Policy.

The UN dispensary provides a clinic for UN staff and dependents. They do not treat PLWHA, but refer them to the Catholic Hospital. They offer VCT but it is not popular.

The WFP programme acknowledge that most people in Liberia are food-insecure, but need to work

with priority groups: these include PLWHA and orphans. They supply 26 tonnes of food each month to partner organisations who meet certain criteria and fulfil their reporting requirements. They support 13,000-14,000 children at accredited orphanages, and carry out

visits and assessments of these places. They provide food to in-patients in hospital. They currently work with 13 H IV-related organisations, serving a total of 1,463 people, and hope to increase this to 2,500 in the next year. The regular ration of food supplied per person is 2,000 kcal per month, and this is increased to 2,400 kcal for PLWHA. To access this support an HIVorganisation needs to show evidence of clients who are food-insecure, support groups and counselling; WFP records show that 70% of PLWHA getting food aid are not on ARVs. LOAF has 104 children registered for food rations, and is the only organisation working with children affected by AIDS.

UNMIL has a comprehensive HIV programme in the mission which is designed to be sensitive to all peacekeepers. During induction all UNMIL staff go through a programme which helps them to assess their personal risk, and gives tools for changing their behaviour. UNMIL carries out condom promotion and procurement, and post-exposure prophylaxis is available at the 5 level 2 and 3 hospitals (but has not yet been accessed). They are producing IEC messages for billboards and a radio programme. There is an UNMIL staff member who is public about his HIV status, who is known as the Ambassador of Hope. UNMIL staff give talks about HIV to churches, schools, CBOs and so on. They have trained staff in VCT, and will be opening VCT centres. They have carried out 156 ToTs for peer educators. While they are not mandated to work with children they have identified LOAF as a organisation that needs support, and are carrying out fundraising for them.

Healthcare System

The Christian Health Association of Liberia (CHAL) acts to co-ordinate the church-run health facilities in 12 counties, working closely with government-run facilities. In the facilities they try to take care of opportunistic infections, but some drugs are scarce, and the supply of ARVs is poor. Only a few facilities have the capacity for HIV testing (such as Phebe Hospital in Bong County). CHAL have carried out HIV education for church leaders, and now, for example, pastors in Grand Bassa have an association that goes around doing HIV prevention in the community. In general if children are orphaned they go into the extended family, and are not usually put in orphanages, but it can be a great additional burden, so it is imperative to provide help for the extended family.

Mother Patern is a training college with programmes in nursing, laboratory work, primary health care, women's health and development, HIV and social work. They offer a one-year certificate (30 students a year) and 2Y:z year associate degree (30 students a year). They offer walk-in VCT services and conduct HIV awareness workshops. They note that little work is going on with AIDS orphans, and because the economic situation is bad it can be hard for the extended family to take orphans.

The Family Planning Association of Liberia (FPAL) is the leading NGO in Liberia working in sexual and reproductive health. They are not doing HIV projects as such but see it as a crosscutting issue in their work. HIV is one of IPPF's priority areas, and FPAL include prevention work in all their activities.

NGOs working with Children

There are a number of NGOs who prioritise children in their work, but have not to-date concentrated on orphans or children affected by AIDS. Their programmes may indeed have an impact on avcs by offering services to children generally, but they are not designed with avcs in mind. Several of these organisations are carrying out HIV prevention activities.

CCF has concentrated on working with war-affected children in Liberia, through the provision of basic services (education, food water), and has also carried out training programmes which cover topics such as child protection, rights, HIV/AIOS and gender-based violence awareness.

World Vision operates in four counties carrying out a wide range of programmes not specifically directed at orphans, such as food security, basic healthcare, child protection and so on. However they do support orphanages with non-food items such as clothing. They are aware that the issue of avcs may become a more pressing priority in Liberia in the future. In other countries World Vision have a programme known as the 'Hope Initiative' which provides HIV prevention, care and support to children affected by HIV/AIOS.

In the area of HIV CRS have concentrated on awareness-raising programmes. They have targeted the youth aged 12-24 with community awareness, and have programmes for lifeskills and behaviour change for those from the age of 9. They also provide some support with both food and non-food items for PLWHA.

YMCA has a programme for HIV prevention which targets youth decision-making on sexual behaviour. They believe that fundamental values have been lost and self-esteem damaged and these need to be restored. They prefer to use peer-led mediation, as it is difficult for different ages to talk about sex. They provide funding for generators at video clubs so that they can show short clips about HIV and then a peer educator is available for discussion. They have programmes in lOP camps and high schools

IRC also carry out prevention activities, as they feel that the information available is limited and stigma is high. They try to raise awareness of HIV/AIOS and carry out condom distribution They work with vulnerable children, providing scholarships, counselling and reproductive,realth education. If they find needy orphans they can offer free healthcare.

The Children's Assistance Programme (CAP) is also carrying out HIV-awareness-raising and education in lOP camps and with community youth groups and schools.

Save the Children UK (SCUK) currently works in 6 counties, concentrating on Health, Education, Child Protection and Food Security and Livelihoods. Their work in the health sector aims to build capacity in the health system, mainly in PHC. They support clinics in 6 counties, working with the county health teams. This includes immunisation, drugs, equipment, training and public health education, including HIV/AIOS. SCUK has been involved in identifying children who are separated, and aims to reunify them and provide follow-up. They have been providing support to ensure the protection of children in conflict with the law. Logistical support has been provided to MHSW to monitor orphanages. They commented that NGOs do not know where to find children affected by HIV.

NGOs workinQ with Orphans

While there appears to be a proliferation of small orphanages, many of these are not accredited and the government has a major task to ensure that they are providing a high standard of care to children who truly do not have a family to take of them. There is wide agreement that institutions are generally not the best place for orphans: that they should remain with their extended family who should be supported to care for them. Nevertheless there are some children who do not have any family member able and willing to bring them up, and this is the role of orphanages.

The largest organisation providing residential services for orphans in Liberia is SOS Children's Villages, which was set up in 1981 and operated throughout the civil war. Their mission is to

'help orphaned, abandoned and destitute children regardless of their ethnic background, sex or religion, by giving them a family, a permanent home and a sound basis for an independent life'. They provide a residential facility for children in Monrovia and in Bassa (currently being set up again after serious looting in 2003), and are currently rehabilitating a clinic and social centre in Congo Town, which will operate as a specialist HIV treatment centre. SOS don't have facilities for children infected with HIV, so prefer not to take positive children into the Children's Villages, instead referring them to the Missionaries of Charity. They are keen to work beyond the concept of Children's Villages, by providing services in the community, such as social centres and clinics, which target families in different circumstances offering small business development, microcredit, financial assistance, counselling, educational expenses and so on. SOS is willing to assist all orphanages in Liberia with training and support.

The Union of Orphanages is an umbrella organisation, which has over 100 members, many of whom are from accredited orphanages in Montserrado and Margibi, also Bassa and Nimba. Food supplies are available for these orphanages from Christian Aid and WFP. The coordinator has been running Calvaror Orphanges since 2002, when he and his wife first found children on the street and abandoned. He commented that the orphanages that have failed accreditation procedures are often day-care centres, where the children are not orphans, but go home at night, and these places need upgrading.

NGOs working directlv with those affected bv HIVIAIDS

The Lutheran Church HIV/AIDS Programme has carried out substantial training in HIV counselling, and provide a VCT centre in Monrovia, Phebe and Kakata. They provide on-going counselling and home-visits to those who test positive. They find that is they carry out awareness raising sessions in schools or the market then a lot of people come in for HIV testing. They have been able to provide scholarships for 30 AIDS orphans. They have a care group where they provide care and support to volunteer counsellors.

The LIGHT Association is a support group for PLWHA, established in 2002. They currently have 93 members registered, but new people are coming all the time. Members are mostly diagnosed at Charity Sisters, Mother Patern, the Lutheran Church HIV/AIDS Programme, ELWA, and the Catholic Hospital. They hold weekly meetings with perhaps 40% of members attending regularly. Support is available from UNDP and the Global Fund. They carry out HIV/AIDS education in schools, churches and the community, counselling and advocacy. They receive rations from WFP on a monthly basis for members, but find it is not enough for the month. ARV drugs are available through NACP at ELWA, Catholic Hospital, and Firestone Hospital. They would like to do capacity building for members, such as income generation. Many members are young girls, who need to learn skills in order to sustain themselves. Two children are members of the association, but in

general LOAF is supporting children affected by HIV/AIDS.

The Liberian Orphans and AIDS Foundation was set up in 2001, in response to children losing their parents from AIDS and needing support. They place orphans in family homes, and provide nutritional support, funding for schooling and counselling. LOAF has 140 registered orphans, or vulnerable children, who are actively being supported, but many others (over 70) drop in. They have individual sponsors, no particular donors. They report that the biggest problems for orphans is schooling and nutrition.

The Missionaries of Charity provide what is basically an AIDS hospice (known in the community as Black Gate), for 55 adults and 30 children. The majority of children are suffering from malnutrition or TB, and not HIV, and should return to their families once they are strong again. If children are discharged they try to support them with school fees and food where possible.

They test all new admissions for HIV. They have four HIV-positive children staying presently, and find that families don't always want to have them back. A doctor comes to visit the centre once a week to provide treatment. They also work with the Catholic Hospital, but the problem is that patients there need $20 for testing, after which any medicine is free.

Don Bosco Homes started working with the children staying at the Missionaries of Charity in 2004. They currently see 30 children there, providing packages of recreational items and toys, and linking them to community groups. The children need support for school fees and feeding. Orphans from the extended families are also in the programme. They are planning to help parents with economic empowerment. Don Bosco Homes' overall programme is to empower youth through skills training (such as cooking, tailoring, hairdressing), and they provide shelter for street boys in Monrovia, Buchanan and Bomi.

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DISCUSSION AND CONCLUSIONS

Rationale

This situational analysis of orphans and other vulnerable children in Liberia is the first attempt of its kind to identify the scale of the problem, the issues involved and assess the existing services provided. It is hoped that these baseline findings will be useful for comparison purposes at a later date if the situation appears to change. The results can also be used for planning improved and co-ordinated interventions for avc, and for thinking about policy and legal reforms.

International concern about OVC has largely resulted from the impact of the HIV/AIDS epidemic. However, the numbers of children losing their parents to AIDS has to date not made a major impact in Liberia. Nevertheless this situation analysis shows that there are many children in Liberia who have lost one or both parents and others who are living in vulnerable circumstances and that they are likely to suffer early death, poor health, educational deprivation, abuse, neglect or exploitation. Pre-existing economic constraints combine with their personal circumstances to jeopardise their health, education, well-being and safety.

How many Orphans are there in Liberia?

From the total population of children surveyed aged under 18 years, 10.7% were orphans. In 2003, according to the UN Population Division, there was a total population of children under the age of 18 of 1,717,000. Therefore it may be estimated that 184,000 children in Liberia are orphans. The qualitative data collected for this report showed that many community members feel that as a consequence of the war there are now more children orphaned than was the case in the past. This estimate is slightly lower than that made for the 'Children on the Brink' report (2004) of a total of 230,000 orphans, or 13% of all children, and fits within the pattern seen in West Africa where an estimated 9-14% of all children are orphans.

While this study found that 62.3% of orphans had lost their father, 25.5% their mother and 12.2% were dual orphans, an OVC Situational Analysis in The Gambia found that 73.7% of orphans had lost their mother, 20.0% their father, and 6.3% were dual orphans, and in Nigeria the comparable figures were 60%, 18% and 22%.

Nationally, from the estimate of 184,000 orphans, 114,632 would be estimated to be paternal orphans, 46,920 would be maternal orphans and 22,448 would be double orphans. The practical consequences as well as social significance of losing a parent depends greatly in Liberian society on the sex of parent who has died. For a young child the loss of a mother is more likely to jeopardise their health, both physically and emotionally. A mother plays a critical role in caring for a child, and if she is not there, this situational analysis has shown that the substitute carer may not be able to look after the child in the same way. From the FGDs some felt that losing a mother has the greatest effect, with a mother's love being irreplaceable. However from society's viewpoint the loss of a father is more significant, as the child is part of his lineage. In practical terms the financial contribution of a father to a child's upbringing may be sorely missed in the event of his death.

The causes of death of parents of children have not been tabulated for Liberia. The results of the WHO Burden of Disease Study (2002) for SSA suggest that apart from HIV/AIDS, women die from maternal mortality, injuries, respiratory infections, cardio-vascular disease and tuberculosis, and men from injuries, tuberculosis and cardio-vascular disease. In Liberia considerable numbers of adults also died as a consequence of the war.

AIDS Orphans?

What cannot be determined from this study is how many children become orphans because of AIDS-related deaths. Very few people have been tested for HIV in Liberia except as blood donors, and data available on the prevalence of HIV is weak. It is difficult to state precisely what impact AIDS is having on families and children in Liberia, since the actual numbers of children orphaned through AIDS is unknown. It has been estimated that there are 36,000 AIDS orphans in Liberia (Children on the Brink 2004). The data collected for this report do not add any further precision to this estimate. The vast majority of these orphans would have no idea that their parent(s) had died of AIDS. The problem of stigma around HIV has led to significant gaps in the information available about AIDS orphans.

Currently the majority of children are orphaned most likely for reasons other than HIV, as already mentioned. But given the number of children who have lost at least one parent Liberia has a considerable problem regarding orphans and vulnerable children, which will be seriously exacerbated as the adults currently infected with HIV die and leave behind their children. There is no evidence to suggest that the HIV epidemic is not going to grow exponentially in the years to come, as control measures are currently weak and socio-economic conditions are unfavourable. Of course one of the consequences of such an increase would include a sharp rise in the numbers of AIDS orphans.

Role of Extended Family

Traditionally the extended family takes the major role in caring for an orphan, and this is considered an obligation. The situation of those orphaned through AIDS has many similarities to that of other orphans: even where it is likely that a child's parent or parents died of AIDS, with its associated stigma, children are still being taken by members of the extended family. It was reported that generally families were happy to take care of orphans, although the realities of their economic situation made it very difficult for some of them.

It must be emphasised that many orphaned children are successfully cared for by the extended family. While all orphans are potentially vulnerable, those that are raised in a caring family environment where their needs are met will not necessarily be vulnerable. Data collected for the situational analysis suggest that one of the most effective strategies for the support of OVC would be support to the extended families of orphans, to reduce the burden of the extra mouths to feed.

Nearly all orphans interviewed for the survey were cared for by the extended family system. Over two-thirds of them were closely related to the household head who was either a parent or grandparent or a parent's sibling. Over half of orphans had always lived in the households where they were found. This supports the idea that the extended family structure is playing the lead role in caring for orphans. Those that had moved from another household had often done so because one or both parents died.

Traditionally it is expected that the extended family should take care of children who lose their parents, but this community safety net is often under severe pressure, given the consequences of the war and poverty in the country. This was very clear from the FGD findings for this report: the extended family may be willing to care for orphans but is often not financially able to support the child adequately. Most of the difficulties encountered with coping with orphans are economic. Families are already struggling with their own children, and an addition to the family stretches their meagre resources still further. Sending children to school, with all its associated costs, is reported

to be a major headache for many. In the past, when few children went to school, an addition to the family, particularly of a child who has already passed though the very early years, would likely have been regarded as an asset, providing an extra pair of hands on the farm and around the household. Now, however, with the emphasis on schooling, such an

addition may be a burden to a family. For much of the day the child is not available to help with farming and domestic chores, and then there are the additional costs to be met to ensure the child receives schooling.

Consequences of Orphanhood for the Child

The Government of Liberia has been making great efforts to re-establish a functioning educational system in all parts of the country. In spite of this, however, in the survey over onethird of all children were not attending school, and the main reasons given were lack of money or support. However there was no difference between orphans and non-orphans: they were equally likely to be attending school.

In the focus-groups both adults and children talked of the difficulty of financing education for all children, but especially orphans. A number of orphans reported that they had had to drop out of school as there was no-one to pay their school fees after their parent had died. Access to education was brought out as one of the most pressing needs for orphans, mentioned by a large proportion of them in the FGDs.

The survey data showed that non-orphans were significantly more likely to be adequately fed and never to be short of food than orphans. Many orphans are obliged to work to sustain themselves, or else to engage in other activities to acquire food or money. In the FGDs community members all agreed that orphans generally have a harder life than non-orphans: they lack care and support as well as the practical things such as food, clothes and healthcare.

Who are the most vulnerable children?

Some of the findings from both the survey and from the qualitative data point to the fact that orphans have a greater number of hurdles to overcome in their lives than children living with both of their parents. But what has been clear from all the information collected is that the war has created an extremely harsh environment for all those bringing up children. The economic situation makes it hard to feed, clothe and school children adequately, and this seems ,tp apply to all parts of the country.

Very little information was collected about some parts of the working definition adopted in Liberia: terminal illness of parents or children, child-headed households, elderly-headed households, and those living on the street. It is not therefore possible to say whether these are common situations causing problems for children, or whether they are practical elements of a definition of ave.

Some of those living in institutions (such as orphanages) appear to be well cared for, but there is also plenty of evidence to suggest that many orphanages should be closed or at less regulated more closely. This should be an urgent priority. Attention should also be paid to the risk of child trafficking through orphanages.

Many organisations in Liberia have been concentrating on working with ex-combatants, and the needs of other children have come second to this imperative. The work with ex-combatants was an urgent priority once the ceasefire was achieved, but now it is time to move on. There are many other vulnerable children whose development is impoverished by their circumstances who should now be targeted by interventions, and these include orphans and those living in extreme poverty.

Some of the results presented in this situational analysis show how children who have been affected by HIV/AIDS may be particularly vulnerable. Organisations such as LOAF are providing a useful service for this group. The needs of these children are not so very different to those of other children living in difficult circumstances. The numbers of people currently <
diagnosed with HIV are relatively low, and the facilities available for the adults living with HIV are poor, so that the environment is not conducive to programmes that aim to reach out to large numbers of children affected by HIV/AIDS. There is a great deal of work remaining to be

tackled in improving public knowledge and attitudes about the disease, and especially in improving the services available for testing for HIV and the care and support of those who test positive. Given the patchy coverage of the primary health care system this is a major challenge if it is to be achieved country-wide.

There are so many challenges confronting children in Liberia that is difficult to conclude that the consequence of HIV/AIDS should be seen as the top priority, but there can be no doubt that children are likely to be even more heavily burdened it they lose their parents to AIDS.

Coping mechanisms

Community members considered orphans to be vulnerable, since they do not have their biological parents to support them, and identified that they need support. In theory the mechanism in place for doing this is the extended family, and indeed almost all children who are orphaned in Liberia are taken in by relatives and become absorbed into the wider family, even AIDS orphans.

Both children and adults mentioned that with both parents alive children benefited from the combined efforts of their parents and the pooling of resources, something not possible when a child was orphaned. This affected orphans in the most basic areas, with difficulties arising with the provision of adequate food, health care, clothing and schooling as reported during the focus group discussions.

The success of the extended family in looking after orphaned children is seriously jeopardised by the extent of poverty, especially in rural areas of Liberia. Quite naturally parents will tend to prioritise (even subconsciously) their biological children when resources are scarce.

For the children for whom care within the extended family cannot be found, SOS Children's Village is providing a family-like environment in which they can grow up, well-protected and wellprovided for. Some of the other orphanages may be providing care of a high standard, but all too many are not doing a good job.

During this situational analysis it has been found that the community is not collectively providing support to PLWHA and the orphans, probably because the need has not been generally realised. There was also remarkably little information collected about effective communitybased responses to support families bringing up orphans. Faith-based organisations may be able to provide support to such families, for example. Some respondents commented that the responsibility of caring for an orphan rests solely with the people who take that child in, and the community does not provide support.

Services

In terms of the response to the problems faced by OVC there are some existing services, but often not co-ordinated, and generally insufficient, given the scale of the problems being experienced. It is imperative that organisations involved work collaboratively. They need a shared understanding of the problems they are facing and the most appropriate response. A range of programmes needs to be provided to meet the varying needs of those affected.

There was only one organisation formed specifically to work with AIDS orphans (LOAF). They are able to provide limited support to those children that present themselves to the organisation, and of course this is only in Monrovia, although they do network with other agencies.

National response to HIV/AIDS

There is an awareness that OVC issues need to be reflected in national programming.

However it has to be said that the response has to date been *ad hoc* and the incorporation of these

concerns into national policies and strategies has not been prioritised. Individual AIDS orphans have been dealt with by the agencies to which they present with compassion, but in the absence of any national guidelines. Support for these activities has been piecemeal. It would be useful for the HIV sector to formalise a policy on ove.

Comparison with findings from The Gambia and Sierra Leone

Using a similar survey technique to that adopted in Liberia, the prevalence of orphanhood in The Gambia in 2004 was 9.1 %. As in Liberia children are far more likely to lose their father than their mother. Orphans were more likely than non-orphans to have previously attended school but discontinued. The main reasons for discontinuing for orphans were being unable to pay school fees, and that a parent died, whereas for non-orphans the most common reason was that they failed academically. Orphans were significantly more likely to say that there were occasions when they had insufficient food compared to control children. The major difference that can be noted is that in The Gambia families are almost universally willing to take in children when they are orphaned, and as a result there are very few orphanages. In Liberia the war has damaged the ability of extended families to do this.

Sierra Leone has of course also suffered long years of civil conflict, and is a neighbouring country to Liberia. A survey was not carried out as there was felt to be existing data that answered enough of the quantitative questions. Instead qualitative data was collected through a total of 54 FGDs. It was widely reported that even when taken in by the extended family orphans were commonly neglected and maltreated, and that girls may be forced into marriage. Economic conditions and access to health care have been seriously damaged by the war, with serious consequences for much of society. Difficulties for families taking in children who are not theirs focused mainly on problems with the orphan's behaviour and discipline, and th_ child or the child's family being ungrateful, something that was also found in the data from Liberia. A large number of comments were made regarding the difference in the amount of domestic work orphans have to do compared to non-orphans. It was felt that orphans were more likely to be abused, whether as cheap/free labour or beaten/ raped. One of the strongest findings was the high numbers of street children, their acute vulnerability (including sex work, violence and criminality), and the fact that at least 40% of them in Freetown are orphans.

Limitations

- Paucity of information about coping mechanisms and other community-based responses to assist those caring for orphans.
- Stigma around HIV/AIDS: some respondents may have been hesitant to disclose sensitive information regarding ove because of stigma.
- HIV/AIDS prevalence: the potential increase in numbers of ove in Liberia is difficult to estimate due to the lack of accurate data on HIV/AIDS prevalence.
- Street children: little new information was collected, yet there are clearly considerable numbers of street children and they are more likely to be orphans and are particularly vulnerable.
- Household heads were asked about distance to schools, health facilities and water sources, but the functionality of the facilities and the safety of the water were not assessed, limiting the value of this information for programming.
- Some children who were interviewed as 'non-orphans' described that in fact they had lost one or both of their biological parents. This may have been because the adults caring for them consider them to be their 'own' children, or that it was advantageous to claim them as their biological children for

some reason. Or equally it may mean that the children interviewed felt it was advantageous to claim to be orphans. It does mean that

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the national estimate for the prevalence of orphanhood derived from this household listing exercise has some element of uncertainty.

Conclusions

This report has shown that many children are vulnerable in Liberia. Children who have been orphaned by AIDS may be discriminated against and deprived of basic human rights to education and health. But children who have been orphaned by other causes are no less vulnerable, and this is particularly relevant when looking at the needs of avc in Liberia where relatively few AIDS orphans have been identified to date. Children who are not orphans may also be vulnerable for other reasons, and where economic conditions are difficult this has ramifications for their education, health, well-being and safety.

It is hoped that this document will be a starting point for action to protect and support avcs and their extended families in Liberia. Many agencies have a role to play in this work, from the policy and legislative arena, to the service providers.

RECOMMENDATIONS

1. Convene a national planning workshop to develop a short-term Plan of Action for the protection, care and support of Orphans and Vulnerable Children (OVC) in Liberia.

2. Develop National Policies and Guidance on OVC.

3. Develop a longer-term Strategic Plan of Action for OVC.

4. Use the data and evidence from the forthcoming *National HIV Prevalence Survey* and the *KAP study on Youth* to guide advocacy, policy development, and programme planning for orphans and vulnerable children.

5. Enforce a supportive Legislative Framework by strengthening the existing legislation related to the rights, protection, care and support of children in Liberia.

6. Strengthen the systems for Birth Registration in Liberia.

7. Implement information/education/communication (lEG) strategies to increase awareness and to decrease stigma and discrimination around HIV/AIDS.

8. Organise advocacy by all stakeholders to keep orphans and vulnerable children high on the nation's agenda and to reduce the widespread stigma and silence surrounding HIV/AIDS that continues to hamper the response at all levels.

9. Commission research into coping strategies at the family and community level, in order to plan interventions.

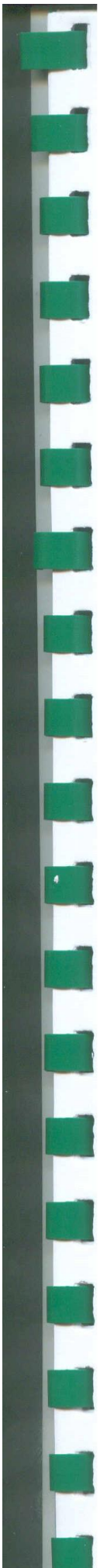
10. Support community-based and faith-based organisations in their efforts to assist OVC.

11. Strengthen extended families bringing up orphans through community-based programmes.

12. Support educational and healthcare expenses of orphans.

13. Work with those orphanages providing a high standard of care; enforce controls for those that are not.

14. Develop programmes to address the needs of street children.



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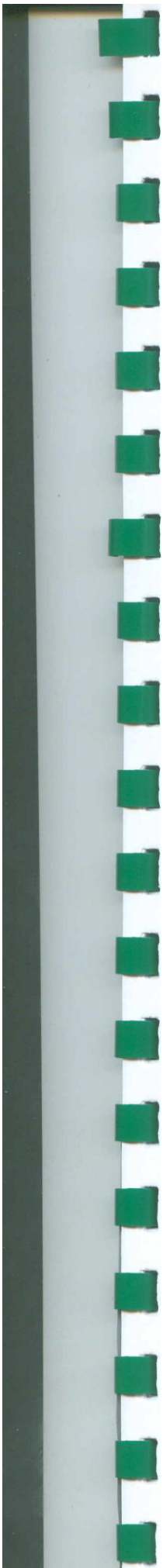

ANNEX 1

Data Collection Tools

1. Household listing sheet
2. Interview for household head
3. Interview for children under age of 12 (administered to caretaker) 4. Interview for children of 12 and above

County

Household Listing Sheet District/Clan

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Head of Household

Marital Status Education

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— CD — Christian=1
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Single =1 Elementary=1 Occupation
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Married=2 Secondary=2 Employment Farming=1
Nationality ,i!_f! i I!
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— Sex Divorced =3 College=3 Employed=1 Housewife=2

Muslim=2 Liberian=1 '0C_, I"_: *i*<, ,_! _

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M=1 Widow = 4 Over college=4 Self-employed=2 Professional=3
Others=3

ther African=2

Name F=2 Age Seperated=5 None =5 Unemployed=3 Student=4 None=4 None African=3

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Enumerator's Name

Supervisor's Name

Enumerator's Signature Date

Supervisor's

Signature
Date

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Questionnaire No.:

SUBAH-BELLEH ASSOCIATES

(management consultants) UNICEF- OVC Situation Analysis *Pre-Tested* **Household** Questionnaire

Line No.:

Introduction: Identify and introduce yourself, establish rapport. Then: explain that the purpose of the survey is to provide information that will guide programs for Orphans and other Vulnerable Children (OVC). Explain further that the study is not meant to publish individual views in isolation of the views of other respondents. Findings of the study will be used to inform the donors and decision-makers about the situation of OVC in the Liberian settings.

Additionally, indicate that responses will be treated with confidentiality. Names taken for respondents will be used only for administrative purpose: to verify and to follow-up in cases of errors in the interview. Those particulars will not be linked to findings of this survey. Give Subah-Selleh contact information if they have any questions.

Identification Items:

Household Serial No. on listing sheet

Name of County:

Name of District/Zone:

Name of Clan/Community:

Name ofTownNiliage/Block:

Structure No:

Structure Location *(Quarter Name):*

Region:

First Name of Respondent:

Date of Interview:

Administrative Items:

Enumerator's Name:

Signature:

Supervisor's Name:

Signature:

1. What main sickness have you encountered in the last three months?

1. Malaria	6. Stroke	11. Backache	16. Impotency
2. Diarrhea	7. Diabetes	12. Broken bone/fracture	17 None (Go to Q.4)
3. Pneumonia	8. Typhoid	13. AIDS	
4. Tuberculosis	9. U.T.I	14. Cancer	
5. Hypertension/Hyper	10. STDs	15. Got Wounded	

2. What was done to treat that sickness? 1. Went to health facility
2. Self-treated

3. Went to herbalist/Spiritualist 4. Did Nothing

3. How far is the nearest health facility from this household? 1. Less than 15 minutes walking distance
2. 15 - 30 minutes walking distance
3. more than 30 minutes walking distance
4. not accessible by walking

4. How far is the nearest elementary school from this household? 1. Less than 15 minutes walking distance
2. 15 - 30 minutes walking distance
3. more than 30 minutes walking distance
4. not accessible by walking

5. How far is the Source of drinking water from this household? 1. Less than 15 minutes walking distance
2. 15 - 30 minutes walking distance
3. more than 30 minutes walking distance
4. not accessible by walking

6. Who fetches water for this household?

1. Purchase water	3. The children
2. Hire labor	4. The Elders

5. All persons 6. Self

7. Which tribe do you belong? (Insert 2 Digits)

1 = Americo-Liberian	7 = Gola
2 = Bassa	8 = Grebo
3 = Belle	9 = Kissi
4 = Dey	10 = Kpelle
5 = Gbandi	11 = Krahn
6 = Gio	12 = Kru

13 = Lorma 14 = Mende 15 = Mandingo 16 = Mano
17 = Via
18 = (Other)

DDDDD0'tknow/refuSed

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Ref (Gen. Health)

8. Is there any child in this household with disability? (if no skip to Q.l0) 1. Yes 2. No

9. What kind of disability does the child have?

1. Seeing
2. Hearing
3. Speaking
4. Physical
5. Psychological
6. Both physical & Psychological
7. Others

10. How often did any child get sick in this household in the past 3 months?
(If never go to Q.12)

1. Every week
2. Every two weeks
3. Rarely
4. Never

11. What was the main sickness

1. Malaria
2. Diarrhea
5. Diabetes
6. Typhoid
9. Backache
10. Got Wounded
13. AIDS
14. Don't Know
17. stomach pain
18. fever

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3. Pneumonia 7. U.T.l
4. Tuberculosis 8. STDs

11. Cancer 15. Sickle cell
12. Broken bone/fracture 16. Epilepsies (Spell)

12. What was done the last time to treat sickness in your household?
1. Self-treated 3. Went to herbalist/spiritualist
2. Went to health facility 4. Did Nothing

13. Do you have birth certificates for your child/children in your household?

1. Yes 2. No 3. Some 4. Don't know

14. Have you heard of HIV/AIDS? **(If No Terminate Interview)** 1. Yes 2. No

15. If **yes,** how do you think people get HIV / AIDS? 1. Through blood contacts

2. Pass from mother at birth

3. Through needles or objects that cuts the skin
4. Sex

16. How can people avoid rUing iN/AIDS?

1. Abstinence
2. Avoid use of injection
3. Avoid blood transfusion
4. ABC Method
5. Protected sex (use of condom)
6. Avoid multiple sex partners
7. Safe sex
8. Don't know

17. Do you know someone infected with HIV/AIDS

1. Yes
2. No

5. Mosquito contacts 6. Kissing
7. Commode seat 8. Don't know

18. What is the first thing you would do for a relative or someone in this community with HIV/AIDS?
    1. Take them to the hospital/Health facility
    2. Provide care for them
    3. Provide information for their assistance
    4. Seek assistance for them 5. Counsel them

6. Avoid them

7. Don't know

19. What kind of assistance/service do you know is given to people living with HIV/AIDS?

1. Counseling
2. Health Services
3. Accommodation
4. Financial
5. None
6. Don't know

20. Do you think people living with HIV/AIDS are receiving too much, too little, or the right amount of assistance from organizations?
(FOLLOW UP: IF TOO MUCH OR TOO LITTLE: Do you think this way strongly?)

1. Too much strongly
2. Too much somewhat
3. Right amount
4. Too little, somewhat
5. Too little strongly
6. (Don't know/refused)

21. Do you think the government is doing too much, too little, about the right amount for the welfare of people living with HIV/AIDS?
(FOLLOW-UP: IF TOO MUCH OR TOO LITTLE: Do you think this way strongly or somewhat?)

1. Too much strongly
2. Too much somewhat
3. Right amount
4. Too little, somewhat
5. Too little strongly
6. (Don't know/refused)

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DDDDD22. Do you know any person or organization caring for children with HIV/AIDS? **(If** no, **skip to Q 25)**

1. Yes
2. No

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23. How far is the place?

1. Less than 15 minutes walking distance
2. More than 15 minutes, under 30 minutes walking distance

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3. More than 30 minutes walking distance 4. Not accessible by walking

24. How much does it cost per visit to get treatment/service there?
    1. Nothing (free) 3. L$ 100 - L$ 300
    2. Up to L$ 100 4. More than L$ 300, under L$ 500

5. More than L$ 500

25. What do you think should happen to babies born HIV positive?
    1. Provide the best care possible 3. Kill the child
    2. Do nothing 4. Don't know

26. Would you take a child into your household whose parents had died of AIDS? (If yes skip to Q.28)
    1. Yes 3. Only if child is tested negative
    2. No 4. Don't know

27. If NO, why?
    1. Fear of getting AIDS
    2. Fear of loosing contacts with others 3. Don't have means of support

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28. What is the first most important thing you think should be done for children whose parents have died of HIV / AIDS?

1. Provide foster homes for them
2. Keep them from mixing with others children
3. Do nothing
4. Don't know/Refused
S. Others specify

29. Do you think that your children playing or attending school with HIV+ children will get infected?
(FOLLOW-UP: do you strongly think this way or somewhat?)

1. Think so strongly
2. Think so somewhat
3. Don't think so somewhat
4. Don't think so strongly

S. Don't know 6. Refuse

Ref: (Child Health)

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Questionnaire No.:

SUBAH-BELLEH ASSOCIATES

(management consultants) UNICEF- OVC Situation Analysis *Pre-Tested*

Care-Taker Questionnaire

Line No.:

Introduction: Identify and introduce yourself, establish rapport. Then: explain that the purpose of the survey is to provide information that will guide programs for Orphans and other Vulnerable Children (OVC). Explain further that the study is not meant to publish individual views in isolation of the views of other respondents. Findings of the study will be used to inform the donors and decision-makers about the situation of OVC in the Liberian settings.

Additionally, indicate that responses will be treated with confidentiality. Names taken for respondents will be used only for administrative purpose: to verify and to follow-up in cases of errors in the interview. Those particulars will not be linked to findings of this survey. Give Subah-Belleh contact information if they have any questions.

Identification Items:

Name of County:

Name of District/Zone:

Name of Clan/Community:

Name of TownMllage/Block:

Structure No:

Structure Location *(Quarter Name):*

Region:

First Name of Caretaker:

Name of Child

Date of Interview:

Type of Respondents:

1. Non-Orphans

Administrative Items:

Enumerator's Name:

Signature:

Supervisor's Name:

Signature:

1. How old is **(child's name)?**

(insert 2 digits)

2. What is the relationship *of* **(name)** to head *of* household?

1. Son/daughter
2. Grandchild
3. Sibling
4. Child *of* another relative
5. Child *of* neighbor/friend

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3. What is the relationship *of* **(name)** to caretaker?

1. Son/daughter
2. Grandchild
3. Sibling
4. Child *of* another relative

S. Child *of* neighbor/friendD

4. Sex *of* **(name)** 1. Male

2. Female

5. Which tribe does **(name)** belong to? **(Insert 2 Digits)**

1 = Americo-Liberian
2 = Bassa
3 = Belle
4 = Gbandi
5 = Gissi
6 = Gio
7 = Gola
8 = Grebo
9 = Kpelle
10 = Krahn
11 = Kru
12 = Lorma

13 = Mande
14 = Mandingo
15 = Mano
16 = Via
17 = (Other)
18 = (Don't know/refused)

6. Child's Religion 1. Christian

3. Indigenous religion

4. Other religion

2. Muslim

7. Child's nationality 1. Liberian

2. Other African national

3. Non-African

8. Does **(name)** have a birth certificate? 1. Yes 2. No

3. Don't know

9. Who issue (name) birth certificate?

1. Mid wife 2. Hospital

3. friends

4. Health ministry

10. What disabilities does **(name)** have?

1. None 4. Hearing
2. Sight S. Mental
3. Speech 6. Physical

DDD

D D

D D

Ref: (Bkgdn)

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11. Which type *of* school is **(name)** presently attending?
    1. Normal academics
    2. Islamic school (Madrassa)
    3. Skills training
    4. None

12. What kind *of* school is **(name)** attending? 1. Public 2. Private

13. What is the last grade *of* schooling **(name)** has completed? **(Insert** a 2 **digit number)**
    (Never Enter School 99)
    (Pre-school insert 00)

DDD14. If **(name)** not currently in school, why **(he/she)** is not in school?

1. Parents stopped (name)
4. Had other obligations
7. Too much work

D2. No money/ no support
5. Did not like school
8. Disability
3. Sick
6. No school facilities
9. Others specify

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15. If (name) never enter school, why did (name) never attend school? 1. Parents stop (name)
4. Did not like school 7. Disability

D2. No money/no support 5. No school facilities 8. Too small

3. Had other obligations 6. War 9. No pre- school facility

Ref: (Schooling)

16. Does (name) eat the same like others in this household? (If Yes skip to Q.18) r---I

1. Yes 2. No 3. Sometimes _

17. If no, why doesn't (name) eat with others?

1. Not here when meals are served 3. Disabled 5. Others specify r---I
2. Sick 4. Doesn't like eating with others _

18. How often in the past month did (name) go without having enough to eat?
(If never skip to Q.21)
1. Everyday
2. A few times/days per week

3. A few times/days per month 4. Never

19. Why didn't (name) get enough food to eat?

1. There was insufficient food for all 4. It wasn't enough to give him/her
2. Not around when food is served 5. He/she was just not given enough
3. (name) never likes the food

20. What does (name) do to get enough food?

1. Beg 3. Steal
2. Work for others 4. Stay hungry

5. Find food for myself

DD D

Ref:(Feeding)

21. When was (name) last sick?

1. Last week
2. Past two weeks
3. Last month
4. More than a month ago
5. Rarely sick

22. What was the illness?

1. Malaria
2. Diarrhea
3. Pneumonia
4. Tuberculosis
5. Body pain
6. Diabetes
7. Typhoid
8. U.T.I
9. STDs
10. Vomiting
11. Fever/Headache
12. Got Wounded

13. Cancer
14. Broken bone/fracture 15. Cough/Chest pain 16. Epilepsies (Spell) 17. Sickle cells
18. AIDS

19. Measles 20. Chicken pox 21. Tooth-ache 22. Asthma
23. Others
24.

23. What was done to get (name) well? (if option 3 skip to Q.23)

1. Go to the Health 'facility
2. Visit traditional healer/herbalist
3. Took no treatment/did nothing
4. Treated by family member

24. Who took (name) for treatment? 1. Household Head
2. Caretaker
3. Parent

4. A friend
5. Health worker 6. Self

7. Neighbor

DDD D

Ref:(Health Care)

25. How long have (name) lived in this household?

1. Since Birth (if 1 skip to Q.28)
2. More than 10 years
3. More than 5 year but less than 10 years
4. One to five years
5. Less than a year

D26. If (name) has not always live here, where else has (name) live before most of the time?

1. With parents
2. With other family
3. In orphanage

Q1

4. On his/her own (Specify)

27. Why did (name) join this household?

1. One or both parents sick
2. One or both parents died
3. Parents separated/divorced
4. Parents traveled
6. Schooling
7. Because of sickness

28. Is (name) mother alive? (If Yes skip to Q. 31)

1. Yes 2. No 3. Don't know

29. If no, when did she die? (Enter 4 Digits)
(Don't know enter 9999)

30. What did she die from?

1. Sudden death
2. Accident
3. Malaria
4. Diarrhea
5. Large weight loss
6. Diabetes
7. Hypertension
8. Stroke

9. Child birth 10. Typhoid 11. Pneumonia 12. Tuberculosis

8. Lack of support

9. Others (specify) D

D

D

13. AIDS

14. War

15. Don't know

16. None

D

31. If mother is alive what serious illness has affected her over the past 12 months?

1. Malaria
2. Diarrhea
3. Pneumonia
6. Typhoid
7. U.T.I
8. ST1s
11. Cancer
12. Broken bone/fracture
13. AIDS
16. None
17. Don't know

D4. Tuberculosis 9. Backache 14. Sickle cell

5. Diabetes 10. Got Wounded 15. Epilepsies (Spell

32. Is (name) father alive? (If Yes skip to Q. 35)

1. Yes 2. No 3. Don't know

33. If no when did he die? (Enter 4 Digits)
(Don't know enter 9999)

34. What did he die from?

1. Sudden death
2. Accident
3. Malaria
4. Diarrhea
5. Large weight loss
6. Diabetes
7. Hypertension
8. Stroke

9. AIDS
10. Typhoid 11. Pneumonia 12. Tuberculosis

DD13. War

14. Don't know

D35. If (name) father is living what serious illness has affected him over the past 12 months?

1. Malaria
2. Diarrhea
3. Pneumonia
4. Tuberculosis
5. Diabetes
6. Typhoid
7. U.T.I
8. STDs
9. Backache
10. Got Wounded
11. Cancer
12. Broken bone/fracture
13. AIDS
14. Sickle cell
15. Epilepsies (Spell)
16. None
17. Don't know

Ref:(Where about/wellbeing of parents)

D

Questionnaire No.:

SUBAH-BELLEH ASSOCIATES

(management consultants) UNICEF- OVC Situation Analysis *Pre-Tested*
Child Questionnaire

Line No.:

Introduction: Identify and introduce yourself, establish rapport. Then: explain that the purpose of the survey is to provide information that will guide programs for Orphans and other Vulnerable Children (OVC). Explain further that the study is not meant to publish individual views in isolation of the views of other respondents. Findings of the study will be used to inform the donors and decision-makers about the situation of OVC in the Liberian settings.

Additionally, indicate that responses will be treated with confidentiality. Names taken for respondents will be used only for administrative purpose: to verify and to follow-up in cases of errors in the interview. Those particulars will not be linked to findings of this survey. Give Subah-Belleh contact information if they have any questions.

Identification Items:

Name of County:

Name of DistrictlZone:

Name of Clan/Community:

Name of TownNillage/Block:

Structure No:

Structure Location *(Quarter Name):*

Region:

First Name of Respondent:

Date of Interview:

Type of Respondents 1 = Non Orphan

2 = Orphan

3 = Disabled

DAdministrative Items:

Enumerator's Name:

Signature:

Supervisor's Name:

Signature:

36. What is your age? **(Insert 2 digits)**

37. Relationship to Household Head
1. Spouse
2. Daughter/son
3. Grand Child
4. Sibling

38. Sex
1. Male

2. Female

39. Which tribe do you belong? **(Insert 2 Digits)**
1 = Americo-Liberian
2 = Bassa
3 = Belle
4 = Dey
5 = Gbandi
6 = Gio
7 = Gola
8 = Grebo
9 = Kissi
10 = Kpelle
11 = Krahn
12 = Kru

13 = Lorma 14 = Mende 15 = Mandingo 16 = Mano
17 = Via
18 = (Other)

40. What is your religion? 1. Christian

2. Muslim

3. Indigenous religion

41. What is your nationality
1. Liberian
2. Other African national

5. Other Relative 6. Non Relative

19= (Don't know/refused)

4 Other religion

3. Non-African

42. Do you have a birth certificate? **(If no skip to Q.9)**
1. Yes
2. No
3. Don't know

43. Who issue you a birth certificate? 1. Mid wife 2. Hospital

3. friends

4. Health ministry

44. Occupational status 1. Student
2. Farmer

3. Petty Trader 4. Sex worker

5. None of these

D D

DDD

D D D

D

Ref: (Bkgdn)

45. What type of school are you attending? **(If none skip to Q.13)**

1. Normal academics
2. Skill training
3. Islamic school Madrassa
4. None

46. What kind of school/institution are you attending? 1. Public 2. Private

47. What is the last grade of schooling you have completed? **(Insert 2 Digits)**
(Never been to school Enter 99)
(Pre-School enter 00)

DD D

48. If not currently in school, why are you not in school? **(If currently in school skip to Q.1S)**

1. Parents stopped me
2. No money/ no support
3. Sick
4. Had other obligations
5. Did not like school
6. No school facilities
7. Too much work
8. Disability
9. Others Specify

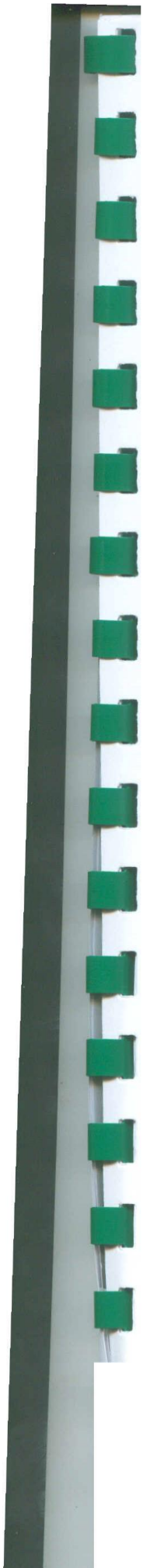
49. If never enter school, why did you never attend school?

1. Parents stopped me
2. No money/ no support
3. Had other obligations
4. Did not like school
5. No school facilities
6. War

7. War
8. Disability

D D

Ref: (Schoolinl l



How often in the past month did you go without having enough to eat? (If never skip *to* Q.21) 1. Everyday
3. A few times/days per month

2. A few times/days per week 4. Never

50.

Do you eat with others in this household? (IF YES SKIP TO 17)
1. Yes 2. No 3. Sometimes

51. If No, why don't you eat with others?
1. Not home when meals are served 3. Disabled 5. Others (Specify)
2. I am sick 4. Don't like to eat with others

52.

Do you usually have enough food? . Yes

3. Sometimes

53.

54. Why didn't you get enough food to eat? 1. There was insufficient food for all
2. It is finish when I get home
3. I never like the food

4. It wasn't enough to give me 5. I was just not given enough

55. What do you do to get enough food?

1. Beg 2. Work for others

3. Steal

4. Stay hungry

56. When were you last sick? 1. Last week
2. Past two weeks

3. Last month
4. More than a month ago

5. Rarely sick

57. What was the illness?

1. Malaria	7. Typhoid
2. Diarrhea	8. U.T.I
3. Pneumonia	9. STDs
4. Tuberculosis	10. Vomiting
5. Body pain	11. Fever/Headache
6. Diabetes	12. Got Wounded

13. Cancer
14. Broken bone/fracture 15. Cough/Chest pain 16. Epilepsies (Spell) 17. Sickle cells
18. AIDS

19. Measles *20.* Chicken pox 21. Don't Know 22. None

58. What did you do to get well?
1. Go to the Health facility
2. Took no treatment/did nothing (if option 2 skip *to* Q.25)

3. Visit traditional healer/herbalist 4. Self treatment

59. Who took you for treatment?

1. Household Head	3. Health worker
2. Parent/Guardian	4. A friend

5. Myself

60.

Do you provide assistance for anyone who is ill?
1. Yes 2. No 3. Don't know/Refuse

(ASK ONLY IF CHILD IS DISABLE)

61.

Do you know *of* any institution catering/providing services to disabled people? . Yes

62. What benefit are you getting from such institution?

D D D

D Ref:{Feeding)

DDD D

D

DCJs

1. Educational support 2. Food

3. Health services 4. Shelter

3. Other

63.

Do you think Disable children/people are receiving too much, too little, or the right amount of assistance from organizations?
(FOLLOW UP: IF TOO MUCH, TOO LITTLE: Do you think this way strongly or somewhat?)

1. Too much strongly
2. Too much somewhat
3. Right amount
4. Too little, somewhat
5. Too little strongly
6. (Don't know/refused)

D

Ref:(Health Care)

64. Have anyone ever tried to touch you in your private part? (If No go to Question 33)

1. Yes 2. No 3. Don't know/Refused D

65. If yes what did you do? (If 'option 4' Skip to 33)

1. Ran from them 3. Report the incident

D 2. Scream for help 4. Did nothing

D

66. Whom did you tell? 1. Parents/guardian
2. A friend

3. Police 4. Relative

5. Nobody

67. If the case was reported what happen?

1. Nothing
2. Discussed it the family way
3. Went to court
4. Jailed person

5. Refused

D D D D D

68.

Have you had sex? (If no skip to Q.36) 1. Yes 2. No

3. Don't know/Refused

69. How many sexual partners have you had in the past 12 months?

1. One person
2. Two persons
3. Three or more
4. None

70.

How often do you and your partner use condom? . All the times

3. Never

71.

Have you heard of Sexually Transmitted Infections/STI's? (If no skip to Q.38) 1. Yes 2. No

72. Which of these STIs you think is the most common? 1. Gonorrhea

§ 4. Vagina discharge c==J 2. Syphilis 5. Painful urination c==J

3. HIV/AID

D 73.

Have you heard of HIV /Infection or AIDS? (If no skip to Q.41) 1. Yes 2. No

D 74.

How do you think one get HIV / AIDS? 1. Through blood contacts
2. Pass from mother at birth
3. Through needles or objects that cuts the skin 4. Sex

5. Mosquito contacts

§6. Kissing

7. Commode seat

75. What can one do to prevent HIV/AIDS? 1. Abstain from sex

2. Avoid use of injection 3. Avoid blood transfusion

5. Protected sex (use condom)

6. Avoid multiple sex partners 7. Safe sex

j ll ,

8f

j

I

J 1 1

4. ABC method

8. Don't know

Ref:{Sexual Behavior)

76.

What is your major source of income?

1. Parents/Relatives
2. Domestic work
3. Business/selling
4. Friend
5. Spouse
6. Refuse
7. Farming
8. Sponsor

9. Other (Specify) 10. Boy friend 11. Girl friend 12. Prostitution

77.

Employment Status

1. Employed 2. Self employed

3. Unpaid worker

4. Unemployed

78. What do you do for money

1. Domestic work
2. Farming
3. Petty trading
4. Gambling

79. How many hours a day do you work?

1. Less than 1 hour
2. One to two hours
3. Three to four hours
4. Four to five hours

5. Begging 6. Prostitution

7. None

5. Five or more hours 6. Don't do work

80. What is your total monthly income in Liberian Dollars?

1= less than $200
2= $200 - $500
3= $501 - $1,000
5= $2,001 - $3,000
6= $3,001 - $5,000
7= $5,001 - $7,500
9= $10,001 - $15,000
10= $15,001 - $20,000
11= over $20,000

4= $1,001 - $2,000 8= $7,501 - 10,000 12=Don't know

81. What do you do with this money?

1. Keep it 2. Take it to Household head

3. Spend it

82. How long have you lived in this household? (if 'option l' skip to Q.50)

1. Since Birth 4. One to five years
2. More than 10 years 5. Less than a year
3. More than 5 year but less than 10 years

83. In which other household have you live before?

1. Parents household 3. Friends household
2. Other family household 4. Orphanage

84. Why did you join this household?

1. One or both parents sick 4. Parents traveled
2. One or both parents died 5. Work
3. Parents separated/divorced 6. Schooling

5.Others (Specify)

7. Because I am sick 8. Others (specify) 9. No support

85.

Is mother alive or dead? (If Alive skip to Q.53) . Alive

86. When did she die? (Enter 4 Digits)
(Don't know enter 9999)

87. What did she die from?

1. Sudden death 5. Large weight loss
2. Accident 6. Diabetes
3. Malaria 7. Hypertension
4. Diarrhea 8. Stroke

DD D

7. Don't know D

13. Refused D

9. Child birth 13. AIDS
10. Typhoid 14. War
11. Pneumonia 15. Others
12. Tuberculosis 16. Don't know

88. If mother is alive what serious illness has affected her over the past 12 month?
1. Malaria 6. Typhoid 11. Cancer 16. Don't know

D Ref:{Employ2)

DD D

DDDq7

2. Diarrhea
3. Pneumonia 4. Tuberculosis 5. Diabetes

17. Others specify

12. Broken bone/fracture 13. AIDS
14. Sickle cell
15. Epilepsies (Spell)

7. U.T.I
8. STIs
9. Backache
10. Got Wounded

89. Is father alive or dead? (If **Alive skip to Q.547)**
1. Alive 2. Dead

90. When did he die?
(Enter 4 Digits)
(Don't know enter 9999)

91. What did he die from? 1. Sudden death
2. Accident
3. Malaria
4. Diarrhea

5. Large weight loss 6. Diabetes
7. Hypertension
8. Stroke

9. War 13. AIDS
10. Typhoid 14. Others
11. Pneumonia 16. None 12. Tuberculosis

D D

D D

92. If father is alive what serious illness has affected him over the past 12 months?

1. Malaria	6. Typhoid	11. Cancer	16. None
2. Diarrhea	7. U.T.I	12. Broken bone/fracture	17. Don't know
3. Pneumonia	8. STDs	13. AIDS	
4. Tuberculosis	9. Backache	14. Sickle cell	
5. Diabetes	10. Got Wounded	15. Epilepsies (Spell)	

Ref:(Where about/wellbeing of parents)

93. What would you do first for a relative or someone in this community with HIV/AIDS?

1. Take him/her to the hospital/Health facility
2. Provide care for him/her
3. Provide information for their assistance
4. Seek assistance for him/her
5. Counsel him/her
6. Avoid him/her
7. Don't know

D

Do you know of any type of assistance/service given to people living with HIV / AIDS?

1. Yes
2. No **(If No skip to 61)**

D

D

94.

95.

What type of assistance? 1. Financial

2. Health services

5. Shelter
6. Don't know

3. Counseling 4. Food

Do you think people living with HIV / AIDS are receiving too much, too little, or the right amount of assistance from organizations?

(FOLLOW UP: IF TOO MUCH, TOO LITTLE: Do you think this way strongly or somewhat?)

1. Too much strongly
2. Too much somewhat
3. Right amount
4. Too little, somewhat
5. Too little strongly
6. (Don't know/refused)

96.

D Do you think the government is doing too much, too little, about the right amount for the welfare of people living with HIV / AIDS?

(FOLLOW-UP: IF TOO MUCH OR TOO LITTLE: Do you think this way strongly or somewhat?)

1. Too much strongly
2. Too much somewhat
3. Right amount
4. Too little, somewhat
5. Too little strongly
6. (Don't know/refused)

97.

98.

Do you know of anybody or organization caring for children with HIV / AIDS?

(If no skip to Q.66)

1. Yes 2. No

99.

How far is the place?

1. Less then 15 minutes walking distance

DDD88

2. More than 15 minutes, under 30 minutes walking distance 3. More than 30 minutes walking distance
4. Not accessible by walking

100. What kind of organization is it?
1. Private 2. Government

D 3. Don,t know

101. Do you think that playing or attending school with HIV+ children will have you infected? (FOllOW-UP: do you strongly think this way or somewhat?)
1. Strongly, think 3. Infected somewhat 5. (Don't know refused)

D 2. Think, somewhat 4. Infected strongly 6. No

Ref:(Problem. faced