

What's New in Research?



A review of recent research in the field of Orphans and Vulnerable Children

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PEPFAR and USAID have partnered with AIDSTAR-Two and Human Sciences Research Council (HSRC), South Africa to produce *What's New in Research?* - a monthly digest that will alert readers to new scientific publications. The newsletter focuses on relevant, evidence-based applied science about children affected by HIV and AIDS, policy research, tests of effectiveness, rigorous program evaluation, and cost analysis. *What's New in Research?* is an effort to make existing research more visible and accessible, and to encourage further research activities in the field of OVC.

Reviewed in this edition of *What's New in Research?*

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The definition of true orphan prevalence: Trends, contexts and implications for policies and programs

Belsey, M.A. & Sherr, L. (2011). *Vulnerable Children and Youth Studies*, 6, 185-200

Abstract: *This study utilizes Demographic and Health Surveys (DHS) or Multiple Indicator Cluster Surveys (MICS) data to explore paternal, maternal and double orphaning in 38 sub-Saharan African countries. The analysis allows for inclusion of older adolescents (15–17-year-olds) and also looks at predictors of double orphaning. The data suggest a population rate of double orphans of 2.1% in sub-Saharan Africa. This is five- to ten-fold greater than in other regions. It also shows an increase over time, whereas other regions are reporting stabilization or decreasing rates. In the 38 sub-Saharan African countries, 26.8 million children (7.8%) were paternal orphans (3.5% in Niger to 16.7% in Lesotho) and more than 25.3 million (7.4%) were maternal orphans (2.6 in Guinea to 21.7% in Namibia). More than one in 50 children (2.1%) in these countries have lost both parents by 2010, with double orphans accounting for 12.4% (range 4.0–26.4%) of all children who had lost one or both parents. In multiple regressions,*

human immunodeficiency virus (HIV) prevalence rates nine years earlier were the biggest predictor of subsequent double orphan rates. These figures clarify the size and diversity of the problem and also point to the imperative to define parental death accurately by recording maternal, paternal and parental death clearly and separately, and focus research and interventions appropriately. They also point out that in order to monitor the impact of HIV/acquired immune deficiency syndrome (AIDS) interventions on orphanhood there is a need for follow-up surveys which should take into account such confounding factors as differences in urban/rural sample design and “hidden” maternal orphans.

Availability: *Subscription or pay for access.*

Comment: This very important study, emanates from Mark Belsey’s seminal 2005 work for the United Nations Department of Social and Economic Affairs - *AIDS and the Family: Policy Options for a Crisis in Family Capital* (see <http://www.un.org/esa/socdev/family/Publications/aidsandthefamily.pdf>) – and extends analyses Dr Belsey conducted for Learning Group 1 (Strengthening Families) for the *Joint Learning Initiative on Children and AIDS* (JLICA) (see <http://www.tandfonline.com/action/doSearch?type=simple&filter=multiple&stemming=yes&searchText=Joint+Learning+Initiative+on+Children+and+AIDS&publication=40000071&x=13&y=11>) for free access to published articles from JLICA.

The authors use data from 31 nationally representative Demographic and Health Surveys (DHS) conducted between 1995 and 2009 and 11 reports from UNICEFs Multi-Indicator Cluster Surveys (MICS) between 2000-2006 to generate models of the numbers of maternal, paternal and double (“true”) orphans. The study looks at orphans due to all causes, not only AIDS in 38 countries in sub-Saharan Africa, and it includes also children 15-17 years and accommodates increases in urbanization over time. Older children (15-17 years) had not been included in earlier analyses because children were defined in HIV and AIDS datasets as 0-15 years. HIV prevalence rates are used to project orphaning 9 years ahead, roughly the period from untreated infection to death – up to 2016. Despite these adjustments, some difficulties with estimates remain, including the fact that “foster” parents may “misreport” themselves as natural parents.

There are wide variations in orphaning rates between countries in the region, largely attributable to differences in the staging of the epidemic and the time of introduction and comprehensiveness of antiretroviral (ARV) treatment, as well as other causes of orphaning, principally violence and conflict. In sum though, approximately 2.1% of children are double (“true”) orphans, having lost both their mother and father. In addition, some 7.9% of children have lost a mother, and 7.5% of children have lost a father. That is, 14% of children have lost one parent. Double orphans comprise 12% of all children who have lost one or both parents. The largest proportion of double, or “true”, orphans (35%) are in the 15-17-year-old age range.

Implications for Policy and Practice: The rates of double orphaning in sub-Saharan African are 5-10 times higher than in regions of the world that have not experienced such virulent HIV epidemics, with some 7.36 million children being “true” orphans. Nonetheless, double orphans

comprise a small proportion of all children. Some 88% of children currently being called orphans (by the definition of having lost one or both parents) have a surviving parent – either a mother or a father. Given the high likelihood of co-infection between men and women living together, children in these households are highly vulnerable to become “true” orphans. This means that every effort should be made to reach such families, to ensure that the surviving parent is tested for HIV and treated if needed, and that they are given whatever support they most need to be able to continue to care for their children. Misreporting maternity – in the case of a woman reporting that she is the mother of a child, when the biological mother has died or is missing for another reason – is a problem for demographic estimates. This happens more often with respect to younger than older children. Programmatically, however, this is less of a problem, and is likely an asset on which support can be built. If a woman thinks of herself as a mother, then she is likely to act like a mother with respect to a child’s care, and she will benefit from recognition and reinforcement of this role in respect of the child.

The corresponding problem occurs when men are reported to be deceased when they are missing. The father might have had so little to do with the family that, to all intents with regards the care of the child, he is dead. Again, this might be a problem for demographic estimates, but it is a fairly accurate portrayal of the care and support available to a child from the father.

Demographic and Health Surveys

Demographic and Health Surveys (DHS) are nationally representative surveys to collect standard information on population issues, health and nutrition. MEASURE DHS is supported by USAID through Macro in the USA and conducted in collaboration with country partners who collect data. Interviewees, usually women aged 15-49 years (but more recently also men) are randomly selected from all households in the country to give a cross-section of the population. Random selection means that each person in the population in the specified age range has as much chance, as any other person, of being selected to be interviewed. This ensures that the information collected is representative of all people and not only of a sub-group, such as those people who live in cities, people who work etc. The information collected thus applies to everyone and to the whole country. DHS began in 1984 and, since then, 260 surveys have been conducted in 90 countries. The sample sizes are large, usually between 6 000 and 30 000 depending on the population of the country and country DHS are usually repeated every 5 years. The questions are standardised to enable comparison between rounds of DHS in a country and between DHS in different countries. However, countries can add additional questions depending on the context. The surveys also use similar methods to select participants, training, and pre-testing. The process of a DHS, from start to finish, is very carefully quality controlled. MEASURE DHS makes the data from surveys freely available and can be found at <http://www.measuredhs.com/Data/>.

The definition of true orphan prevalence: Trends, contexts and implications for policies and programs

Wadsworth, M., DeCarlo Santiago, C., Einhorn, L., Etter, E., Rienks, S. & Markman, H. (2010). *American Journal of Community Psychology*, 48, 257-171.

Published Abstract: *This article reports prepost intervention results from a randomized controlled trial evaluating the initial efficacy of a couples-based intervention aimed at teaching skills for coping with stress and improving relationship skills in a sample of 173 ethnically diverse low-income co-resident mothers and fathers who were raising at least one child together. Couples were randomly assigned to one of three interventions or to an assessment-only control condition. The Fatherhood, Relationship, and Marriage Education (FRAME) intervention is a 14-h psycho-education intervention developed specifically to strengthen the ability of low-income mothers and fathers to reduce conflict, cope with stress, and co-parent effectively. Three versions of FRAME were assessed: a men-only group, a women-only group, and a couple's group. The pre-post intervention analyses revealed reductions in financial stress, disengagement coping, and involuntary disengagement responses, as well as improvements in problem solving. These pre-post changes on stress and coping variables were both statistically significant and reliable as assessed by the Reliable Change Index (Jacobson and Truax 1991). Results were particularly strong for the couples' and women's groups. In addition, positive pre-post changes on stress and coping variables were associated with pre-post reductions on symptoms of depression for participants assigned to an intervention. The results demonstrate that participants in FRAME acquire some of the key skills taught in the intervention, and skills acquisition appears to translate into symptom reduction. In addition, this study highlights the value of an intervention aiming to improve the capacity of parents with economic hardship to cope effectively with stress. Availability: Subscription or pay for access.*

Comment: This US-based study illustrates a scientific evaluation over the short-term of an intervention aimed at helping families cope with chronic economic stress, a problem faced also by many families affected by HIV and AIDS. The intervention, Fatherhood Relationship and Marriage Education (FRAME) is derived from the Family Stress Model. Across the world, poverty is associated with poor physical and mental health. In turn, this affects family relationships and effective parenting, both of which can lead to negative outcomes for children. Chronic stress also disturbs the general ability to cope with problems, leading to reliance on ineffective, and sometimes damaging 'disengagement' (avoidance, denial, escape, rumination and wishful thinking). FRAME is a father-inclusive, father-friendly psycho-education intervention with three components: relationship education, coping skill training, and child-centered parent training.

Implications for Policy and Practice: Everywhere there is greater appreciation for the importance of including men in sexual, reproductive, relationship and parenting interventions, including with respect to HIV and AIDS. In this study, the couples and women's groups were more effective than the men's group and the control. The authors speculate that having a woman leader may have reduced the effectiveness of the intervention in the men's group. Importantly, though, non-attending men whose partners participated in the women's group

showed deterioration on several measures, even more than did control men. The authors conclude it is insufficient to gear relationship and parenting services to women only and that the results give support to calls for father- and men-inclusive parenting and relationship services. As has been found in many low- and middle-income countries, depression among both men (15%) and women (30%) experiencing economic stress was high, and this decreased across all groups following the intervention. In fact, all groups improved on several of the measures, leading to the speculation that the \$200 paid to participants for completing the baseline, as well as the support received with babysitting and child care to enable couples to participate may have had systematic positive effects in themselves. This finding reinforces the importance of including a control group in order to be sure that benefits can be attributed to interventions, specifically.

Randomised Control Trials (RCT)

A randomised controlled trial (RCT) is a study based on a particularly strong scientific design, regarded as the “gold standard” for providing evidence of the efficacy and effectiveness of an intervention. Efficacy is proof that an intervention works under ideal conditions; effectiveness that it works under real-world conditions. The key feature of an RCT is that participants are randomly assigned to one or other treatment group or a control BEFORE the intervention begins. It’s like tossing a coin to decide who gets what intervention. The effect of this is that all historical and contemporary personal and social characteristics of the participants – which may influence the results – are likely to be evenly distributed across the groups. The sort of personal and social characteristics that can influence the results of an intervention include, for example, motivational differences between parents who enroll into an intervention and attend regularly and those that don’t. Parents who are motivated to help their children will be doing a lot of other things that benefit their children, any and all of which may result in the effects measured at the end of the intervention.

When HIV-positive children grow up: A critical analysis of the transition literature in developed countries

Persson, A. & Newman, C. (2012). Qualitative Health Research, published online, DOI: 10.1177/1049732311431445.

Published Abstract: *Young people with perinatally acquired HIV are routinely problematized in the research literature as inadequately equipped to manage transition to adolescent sexuality and adult clinical care without comprehensive interventions, partly because of challenges associated with adolescence itself, and partly because of neurocognitive and psychosocial dysfunctions commonly attributed to these children. However, little is actually known about this population, given their recent emergence in the HIV epidemic. Using critical discourse analysis, we argue that several problematic assumptions operate in this literature, hampering the objective of understanding these young people. Our analysis can contribute to a reframing of future research on HIV-positive adolescents, by encouraging greater attunement to the experiences of the adolescents themselves and to the discursive meanings that underpin research agendas, so that different and more productive questions can be asked and answered.*
Availability: *Subscription or pay for access.*

Comment: As a result of treatment, many children living with HIV in developed countries, and increasingly in high HIV prevalence poor countries, are entering adolescence and adulthood. This paper explores two transitions – the transition into adolescent sexuality and the transition into adult clinical care. The authors analysed 80 relevant articles that were sourced through a thorough search of journal databases. The challenges young people were anticipated to face included living with a difficult to treat chronic disease, multiple physical complications of the disease and medication, lifelong adherence, an uncertain life course and potential early death, impaired neurocognitive development, and high rates of psychosocial and behavioural problems. Also, challenges included family and other contextual factors, not only the disease and its treatment affected behavioural and emotional outcomes. This included secrecy about their own and their parent's HIV status, stigma, parental and/or sibling illness and death, and family backgrounds that are often characterised by disadvantage, minority status and social instability. There are also challenges arising from some children being cloistered and infantilised by their families and attendant medical personnel. Lastly, adolescence itself is portrayed as a challenging period, with dramatic physical, psychological and social changes.

Implications for Policy and Practice: Without wishing to cast doubt on or minimise these challenges, the authors draw attention to oft-repeated, uncritically assumed facts about young people with perinatally acquired HIV infection and the transitions they have to face, and they note that these give rise to predetermined interventions. They contrast this with observations of more positive and resilient adjustment, often derived from interviews with adolescence themselves. These include coping strategies, insight, maturation, responsibility and self-management derived from their experiences of growing up with HIV. Instead of one-sided views, the authors encourage more exploration of the factors that build on young people's strengths and encourage young people's active participation in interventions. The authors also

draw attention to the need for support for health care providers, many of whom are themselves bewildered and uncertain about how to “let go” of their paediatric patients and how best to relate to adolescents and young adults.

Discourse Analysis (DA)

Discourse analysis is a way of analysing language – spoken, written or signed – to determine how its use conveys meaning and comes to dominate the way we think about issues and act on them. DA is not so much a specific method as a way of thinking and, as such, can also be applied to both quantitative and qualitative research approaches, methods and findings. DA can help us to understand the assumptions we make even about the existence of “a problem”, what causes it, and how best to address it. A bit like artists who often look at the spaces between objects as well as at the objects themselves, DA asks, amongst other things: who is saying this, on what basis, who is not getting an opportunity to give their views, what is not being said, and how does this change how we look at the issue?

HIV and AIDS-related stigma and transnational NGO support to orphans and vulnerable children in Zimbabwe

Wagner, A. (2011). *Transnational Social Review – A Social Work Journal*, 1, 73-89.

Published Abstract: *This qualitative study explores HIV and AIDS-related stigma and its interrelations with transnational NGO support for orphans and vulnerable children in Zimbabwe. The findings suggest that the targeting criteria for support of the participating organization have stigmatizing effects, since they enable the identification of children and families affected by the epidemic. However, HIV and AIDS-related stigma seems to be no longer predominantly fuelled by moral prejudice and the fear of infection, but by the fear of additional economic and emotional burdens that may be caused by people affected. Thus, material support can also lessen stigma and contribute to a normalization of the people affected.* Availability: <http://budrich-journals.de/index.php/tsr/article/view/5542/4687>

Comment: This analysis is loosely based on ethnographic conversations with people affected by HIV and AIDS, NGO programme staff and elderly caregivers during home and field visits and community training, as well as perusal of the programme files on 1,971 children and death certificates of 242 parents. Stigmatisation results in internalisation of stigma, with accompanying self-blame, low self-esteem, low hope and retreat from social life. This, in turn, causes people to conceal their HIV status and to avoid support programmes for fear of being identified. The author argues that stigmatization of HIV and AIDS in Zimbabwe has declined with improved knowledge through education campaigns, the introduction of treatment, and the ‘normalization’ of the epidemic that has occurred as a result of the very large numbers of affected people. Nonetheless, the disease is still associated with immoral sexual behaviour,

prostitution and poverty, and stigmatization attaches also to children. Moreover, many people believe that children who are, or are thought to be, living with HIV will die young, and this sometimes occasions neglect. The author discusses how families may withhold children from programmes targeted at orphaned and vulnerable children, despite their need, because of their fear of stigmatisation associated with HIV and AIDS and with poverty. In contrast, some families regard it as a matter of pride to be targeted by a programme, which they take as signalling that the family and child merits support and is thus favoured for attention, including material benefits. This, in turn, can lead to envy and social discord.

Implications for Policy and Practice: How interventions are perceived in communities is important. The paper draws attention to the necessity for programmes to reflect on their goals, targeting, methods and communications to ensure that they continually adjust to changing perceptions and potential stigmatisation. It is imperative to track how targeted children are perceived by family and neighbours, and their peers, especially with respect to being singled out, firstly because of their association with HIV and AIDS and secondly, because they are favoured with material and other assistance while comparably needy children are neglected.

Child and adolescent mental health worldwide: Evidence for action

Kieling, C. Baker-Hennigham, H., Belfer, M., Conti, G., Ertem, I., Omigbodun, O., Rohde, L., Srinath, S., Ulkuer, N. & Rahman, A. (2011). *The Lancet*, 378, 1515-1525.

Published Abstract: *Mental health problems affect 10–20% of children and adolescents worldwide. Despite their relevance as a leading cause of health-related disability in this age group and their long-lasting effects throughout life, the mental health needs of children and adolescents are neglected, especially in low-income and middle-income countries. In this report we review the evidence and the gaps in the published work in terms of prevalence, risk and protective factors, and interventions to prevent and treat childhood and adolescent mental health problems. We also discuss barriers to, and approaches for, the implementation of such strategies in low-resource settings. Action is imperative to reduce the burden of mental health problems in future generations and to allow for the full development of vulnerable children and adolescents worldwide. Availability:*

<http://www.medlive.cn/uploadfile/2011/1018/20111018031042509.pdf>

Comment: This paper is one in a special series in *The Lancet* on mental health. The paper reviews both prevalence and intervention studies with the strong conclusion that more and better research in low and middle income countries (LMICs) is needed. For example, there are some promising interventions for early prevention, as well as both universal and selective interventions for emotional, behavioural and intellectual disorders. Only 58 of a total of 670 randomised controlled trials for child and adolescent mental health problems were from middle-income countries and only one came from a low-income country. In addition, very little is known about risk and protective factors in LMICs.

Implications for Policy and Practice: The authors point to a number of implications for policy and practice. These include, amongst others, the importance of recognising and integrating mental and physical health. For example, infectious diseases and malnutrition affect mental health; similarly maternal depression and lack of psychosocial stimulation affect infant growth and health-seeking behavior. Additionally, child and adolescent mental health services shouldn't be restricted to the health sector, but need to involve also education, social care and criminal justice. The failure of governments to support services has led to a disproportionate reliance on non-governmental organizations to provide services and user fees. It has also inhibited the development of systems care.

Evidence for universal and targeted interventions in early childhood

Based on the comprehensive review conducted for this paper, the authors conclude that benefits to child mental health have been shown from early childhood interventions including: early stimulation interventions; interventions to improve carer sensitivity and responsiveness; integrated nutrition, health and stimulation programmes; attendance at a high quality preschool; and conditional cash transfers to families. These early interventions benefit children exposed to various contextual and biomedical risks including poverty, institutionalisation, low birth weight, stunting, and iron deficiency anaemia (p. 1517)

Social protection in Sub-Saharan Africa: Getting the politics right

Niño-Zarazúa, M., Barrientos, A., Hickey, S. & Hulme, D. (2011). *World Development*, 40, 163-176.

Published Abstract: *This paper provides an overview of the recent extension of social protection in sub-Saharan Africa. It identifies two main "models" of social protection in the region: one based on age-based income transfers in the middle income countries in Southern Africa, and another more diverse and incipient group of programs providing a mix of poverty-based transfers in the low income countries in Eastern, Central, and West Africa. It concludes that for an effective institutional framework for social protection to evolve in sub-Saharan Africa, the present focus on the technical design of programs needs to be accompanied by analyses that contribute to also "getting the politics right."* Availability: *Subscription or pay for access.*

Comment: Social protection (SP) is now widely recognised as an effective policy framework to address extreme deprivation in Sub-Saharan Africa. The large number of children and families affected by HIV and AIDS prompted some recent projects; for example, the Orphans and Vulnerable Children Program (TC-OVC) in Kenya and the Mchinji Social Cash Transfer Pilot Scheme in Malawi (see also Webb, 2011). Similarly, concern that poverty could undermine HIV prevention and treatment motivated the development of the UNAIDS Expanded Business Case: Enhancing Social Protection

http://data.unaids.org/pub/BaseDocument/2010/jc1879_social_protection_business_case_en.pdf).

This paper contextualises developments in SP in terms of international aid (shifts from programme and project to direct budgetary support), responses to destitution (from emergency food-aid and humanitarian assistance to regular and reliable SP) and regional and national politics. Regionally, the African Union's Livingston Process manifests support for SP by national governments and nationally SP initiatives (as elsewhere) are linked with political change and electoral politics. The authors outline the differences between social assistance (SA) programmes: a) in some middle-income countries that are largely funded and managed by government and embedded in legislation, in which citizenship rights and entitlements are prominent, and b) short-term SA efforts in some low-income countries which are driven and funded largely by international donors and for which domestic political support is unclear. The former are characterised as policies and the latter as projects.

Implications for Policy and Practice: As programmes of social assistance for children and families expand, it is important that, they do so duly cognisant of the larger debates about SP in the region. Specifically, the authors observe that: "To date, donors have not engaged productively with the politics of social protection in Sub-Saharan Africa where they have more often proposed new initiatives rather than built on existing ones, worked through NGOs and parallel project structures rather than the state, failed to developed good enough baselines on which arguments for scaling up could be based, couched their ideas in terms of welfare rather than growth and failed to identify powerful political actors to work with" (p. 169). Further, that "... unless a political discourse exists within which it is recognised that the poorest are deserving of public action to solve problems of poverty that are not of their own making, and which identify the state as responsible for delivering on this, national-level and government-owned social protection programs are unlikely to emerge and be maintained" (p. 171). And, finally, that "Getting the politics right may be as important, or even more important than getting the initial technical design of programs right" (p. 174).

Social Protection

While there are many definitions of social protection, the authors use that of Conway et al (2000), as "public actions taken in response to levels of vulnerability, risks and deprivation which are deemed socially unacceptable within a given polity or society". The International Labour Organization (ILO) divides these public actions into three categories: a) Social insurance, which includes contributory schemes to protect workers; this has below 10% coverage of the labour force in Sub-Saharan Africa. b) Labour market regulation, such as minimum standards and protection of worker rights; this is also very limited, especially by labour informality; and c) Social assistance, which comprise tax-financed instruments to address poverty and vulnerability. SP in Sub-Saharan Africa has started with social assistance. (Conway, T., de Haan, A. & Norton, A (Eds), Social protection: New directions of donor agencies. London: Department for International Development (<http://www.odi.org.uk/resources/docs/2233.pdf>))