Zimbabwe 2017 VACS Data File

SUMMARY

The Zimbabwe Ministry of Health and Child Care led all aspects of the 2017 Zimbabwe Young Adult Survey, a Violence Against Children Survey (VACS). The Zimbabwe National Statistical Agency (ZimStat) advised on survey design, provided the survey sample, and supported data weighting. Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)–Zimbabwe provided technical assistance and coordinated the field implementation of the survey. The U.S. Centers for Disease Control and Prevention (CDC) provided technical assistance. CDC contributors supported weighting and data analysis for this report. The authors consulted with partners and the government of Zimbabwe on evidence-based strategies to prevent violence against children and youth.

The purpose of the Zimbabwe VACS was to estimate, among adolescents (ages 13–17) and young adults (ages 18–24), (1) the national prevalence of childhood violence, defined as violence occurring before 18 years of age, and (2) the national prevalence of violence in the 12 months prior to the survey. In addition, the Zimbabwe 2017 VACS sought to measure the prevalence of HIV in the study population and its association with violence, as well as estimate HIV incidence through recency testing.

The Zimbabwe 2017 VACS is a nationally representative household study that identified female and male participants ages 13–24 using a three-stage, cluster-randomized design. The participant questionnaire covered demographics; parental relationships; education; general connectedness to family, friends, and community; gender beliefs; safety; sexual history and risk-taking behaviour; experiences of physical, sexual, and emotional violence; violence perpetration; pregnancy; health outcomes and risky behaviours; and violence disclosure, service-seeking, and utilization of services. Additionally, the survey contained questions about HIV testing knowledge, utilization, and *most recent* test result.

The 2012 Zimbabwe National Census served as the basis of the sampling frame for the Zimbabwe 2017 Violence Against Children Survey (VACS). The primary sampling units were the enumeration areas (EAs) from that census. The sample size for females was determined from a standard cluster sample formula, whereby an estimated prevalence of sexual violence of 11 percent for males and 11–24 percent for females was assumed based on the prevalence of sexual violence in previous surveys, with a relative standard error (RSE) of 8 percent. Additionally, the sample size took into account the expected number of males and females who would complete an HIV test. To calculate separate male and female prevalence estimates for having experienced violence, the study used a split-sample approach. This means that each EA was assigned as a location to survey either females or males. The split-sample approach, consistent with World Health Organization (WHO) guidelines, served to protect the confidentiality of participants and eliminate the chance that a perpetrator of sexual violence and a victim of the opposite sex in the same community would both be interviewed.

The survey used a three-stage cluster-sampling survey design. In the first stage of selection, 1,000 female EAs and 118 male EAs were randomly selected out of 29,365 EAs with a probability proportional to the size of the EAs in terms of households present. In the second stage of selection, the survey data collection teams conducted a mapping and listing of all structures and households in each of the selected EAs. The survey teams then input the total number of eligible households in the EA into a Microsoft Access programme developed specifically for VACS household selection. The programme randomly selected 30 households in the EA to whom to administer the survey. In stage three of selection, one eligible participant (female or male, depending on the EA) was randomly selected by a computer programme built using CSPro from the list of all eligible participants ages 13-24 years in each household and the selected participants were then interviewed.

The study oversampled females in districts with a higher expected prevalence of HIV among 16- to 24-year-olds (i.e., districts in the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe, or DREAMS, programme). The female sample consisted of seven strata: national, DREAMS Area 1 (Bulawayo), DREAMS Area 2 (Chipinge), DREAMS Area 3 (Gweru), DREAMS Area 4 (Makoni), DREAMS Area 5 (Mazowe), and DREAMS Area 6 (Mutare).

Furthermore, the sample size was adjusted for expected nonresponse among selected households. Last, the study was designed to produce reliable estimates, defined as having an RSE of less than 30 percent. In the male sample, 3,445 households were surveyed in 118 randomly selected EAs. A total of 803 males completed the individual questionnaire. In the female sample, 29,635 households in 1,000 EAs were surveyed. A total of 7,912 females completed the individual questionnaire. The overall response rates for males and females were 66 percent and 72 percent, respectively. HIV status was obtained from 496 males and 5,288 females 16–24 years old through either HIV testing or self-reports.

Due to the complex sample design, clustering, stratification and sample weights should be taken into account in the data analysis in order to obtain proper point estimates and variances. Users of the Zimbabwe 2017 VACS Data Files should use statistical software packages such as SAS, SPSS, SUDAAN, or Stata that have specific analytic procedures for complex survey designs. The cluster, stratification, and sample weight variable are GeoCode, District1, and finalwt, respectively.