
A Study on Children Affected by AIDS in Zimbabwe

Background and Purpose of Study

The Situation Assessment and Analysis of Children and Women in Zimbabwe (1998) revealed that at community level, people are concerned about all categories of children and adolescents at risk. While statistics are scant in this area, the CEDC study (1997) estimated disabled children at about 150 000, children in institutions at 5 000, abused children at 3 500 and street children at 1 000. The Inter-Censal data of 1997 found working children between 10 and 14 years, and the number of orphaned children at 600 000.

While there are various responses to each of the categories of children and adolescents at risk, it is generally noted that such responses do not cater for the greater number of children and are often fragmented. As a consequence, children are faced with reduced protection, are more vulnerable to neglect, abuse and being exploited, can expect reduced opportunities for education and increased risk of HIV infection.

The negative impact of HIV/AIDS and the general decline in economic performance has severely strained the capacity of the family - the primary caregiver - to cater for the material, emotional and psycho-social well-being of the child.

A large number of Zimbabwe's economically productive population is dying at an early age from the AIDS epidemic, leaving an increasing number of their dying offspring in need of care. According to UNAIDS (1998), Zimbabwe ranks very high in the world among the countries hardest hit by the AIDS epidemic. UNAIDS (1998) estimated that 25.8% of the Zimbabwean population has the HIV virus since the condition was first reported in Zimbabwe in 1985. Presently, it is estimated that 1 200 people die every week due to HIV/AIDS-related illness. Sentinel site surveillance data indicates that about 46% of pregnant women receiving antenatal care are HIV positive. It is estimated that 9% of newborn babies are infected with the virus. By 1997, 500 000 children had lost one or both parents to AIDS and it was estimated that by the year 2 000, there would be more than 800 000 orphans.

Orphans generally face problems related to stigmatisation of HIV/AIDS. Another challenge is that orphans have to fend for themselves or contribute more than is normally expected, to their own up-keep. This is very clear in child-headed households. Some child-headed households are "broken down" when the children are "parcelled" out to relatives for "better" care. In such situations, the extreme is that children lose contact with each other as siblings, signalling the real loss of their own family. In the care of relatives, orphans face the danger of being abused. There is anecdotal evidence to the fact that some relatives take in orphaned children for the sake of getting extra labour to work in their fields or for domestic chores (UNICEF 2000).

There are many actors assisting communities to cope with the crisis of children and adolescents at risk. However, this diverse number has resulted in uncoordinated and fragmented voluntary efforts and poor sharing of information. District authorities, well situated to take leadership in this area, are also unclear about their role/authority in basic service provision. The complexity of the problem associated with children and adolescents at risk, largely due to their interconnectedness, necessitate the need to consolidate available information, analyse the causes of the problem and validate study findings. This should be the first step towards the formalisation of a comprehensive strategic direction aimed at evaluating the extent of coverage provided by largely voluntary mechanisms and the effectiveness of safety nets in assuring the basic survival and protection of vulnerable children. It is hoped the outcome will provide a strong basis for advocacy for the development of a longer-term plan and result in the adoption of appropriate strategies.

The overall objective of the study was to compile, consolidate and validate available information on children affected by AIDS, in order to facilitate the development of a long-term national strategy aimed at promoting, protecting and fulfilling the rights of these vulnerable children. This study was initiated to look at children affected by AIDS in Zimbabwe, analyse their situation in the perspective of role and capacity and bring out the gaps. These gaps will be critically analysed, looking at causality factors that result in children affected by AIDS losing their privilege as rights' holders and assuming new roles as duty-bearers amongst other issues.

Assessment of Problems Faced by Children Affected by HIV/AIDS

Communities with severe HIV/AIDS epidemics are seeing a rapid increase in the number of children affected by AIDS. The UNAIDS report on the global HIV/AIDS epidemic released in June 2000 estimates that as of 1999, 34.3 million people were living with HIV/AIDS. Of these, 1.3 million were children under 15 years of age. Since the beginning of the epidemic world-wide, about 500 000 children have died due to AIDS. It is estimated that 13.2 million children under the age of 15 have lost one or both parents to the pandemic. Sub-Saharan Africa has experienced the worst epidemic, with 24.5 million people living with HIV/AIDS. Of the children orphaned by AIDS throughout the world, 95% are in Africa.

In Zimbabwe, it is estimated that 23.7% of all children under 15 years of age are orphans. This brings the total number of orphans to about 1 066 702. These figures are expected to rise to 1 244 286 and 1 264 047 by year 2005 and 2012, respectively. The National Orphan and CEDC Enumeration Report (December 1999) put the combined proportion of children who had lost one or both parents at 73.1 %. The sample size was 96 235 children. According to the report, the ratio of children who have lost one parent to orphans varied significantly between sampled districts. On a province-by-province basis, it varied from a low of 11 for every 10 orphans in Matebeleland South to a high of 27 for every 10 orphans in Bulawayo. The implied national ratio is that for every 10 orphans there are 16 other children who have lost a parent. Findings also imply that about half of the children are cared for by someone in the age range in which 1 in 4 are estimated to be HIV/AIDS positive. These children face a high risk of losing the current caregiver. The mortality and morbidity rates of premature adults resulting from HIV/AIDS have been known to have devastating impacts on children. Issues such as loss of income when breadwinners lose the capacity to work, loss of labour for subsistence production, increased expenditure on modern and traditional health care, loss of assets and inheritance etc, have been reported to have a great impact on children.

Who are the Children Affected by HIV and AIDS?

According to the UN Convention on the Rights of the Child Part 1, Article 1, and African Charter on the Rights and Welfare of the Child Article 11, a child is defined as “... every human being below the age of 18 years...”. This definition of a child shall be used consistently in this review. However, it is more difficult to arrive at a clear-cut definition of a child affected by HIV/AIDS, as the impact is felt at different levels.

HIV/AIDS has affected children in many different ways, exposing them to different levels of vulnerability. The impact of AIDS is felt most by children when they have to adopt new roles and responsibilities in families. Children are affected by HIV/AIDS when:

- they have to care for sick parents and younger siblings;
- they have to care for sick parents and younger siblings;
- the quality of life is reduced due to transfer of money to other relatives living with AIDS;
- they live with elderly grandparents, usually grandmothers, who is usually over 60 years of age and is already looking after two or three more families;
- some children head households and look after younger siblings, some of whom may be sickly;
- mother is absent from home caring for a family member in another household;
- access to finance is reduced as breadwinner becomes ill, medical costs are high, or when breadwinner dies and little capital that is left is expended on funeral costs; and
- their standard of living deteriorates due to economic constraints as they accommodate cousins into the family after the death of an aunt/uncle.

It is estimated that in Zimbabwe 25% of all children are living in a family with at least one HIV positive parent. Such children are affected by AIDS and are vulnerable to economic and psychological insecurity.

Another distinct category of children affected by AIDS is that of children who are orphans. The National Aids Co-ordination Programme (NACP) projected that there would be more than 800 000 orphans by the year 2000, peaking to 1.1 million by 2005. Other estimates by Hunter and Williamson put the number of orphans at 1.3 million by 2010. Estimates on orphans highlight the extent of the problem after the death of a parent(s). This tends to underestimate the number of children affected by AIDS since there are a considerable number who are not orphans but under the care of parents who are HIV positive.

“The problem of children affected by HIV/AIDS begins long before their parents die and extend beyond their individual household to affect relatives, neighbours, and whole communities. Intervention therefore must target communities and must include all children affected by HIV/AIDS not just those whose parents have been infected with HIV or have died from AIDS” (Hunter and Williamson 1996).

Analysis of Causal Factors

Manifestations of Children Affected by HIV/AIDS (CABA)

The most imminent manifestation of children affected by AIDS is orphanhood. These are usually identified in communities as children who are malnourished, assuming adult responsibilities, overworked and are usually out of school. These immediate manifestations tend to influence interventions as programmes are designed to meet the physical needs of orphans. Studies in Uganda by Segendo and Nambi 1997, revealed that children affected by AIDS have more psychological needs that tend to be more internalised than externalised. The internalised behaviour i.e. depression, anxiety, low self-esteem etc., comes as a result of feeling hopeless when parents become sick, scared when parents die, angry when they have to stay with grandparents, head households or stay with relatives. Internalised behaviour change is less likely to be noticed than externalised reactions. Most orphans in Zimbabwe are more likely to be stigmatised on the basis of their orphan status or poverty rather than because of the possible death of a parent from AIDS (Foster et al 1997b). There is need to understand how families and communities identify children affected by AIDS and how they design programmes for intervention. Most literature identified the following as the most prominent manifestations of children affected by AIDS (CABA).

Characteristics of Orphans

One of the immediate impact of AIDS on children is the drop out rate from school, when children have to care for an ill parent/sibling or have no money to continue with education. The National Orphan and CEDC Enumeration Report in Zimbabwe (December 1999) also shows that there are more orphaned children out of school than other categories of children in especially difficult circumstances (as shown in Table 1 below).

Table 1:- Orphans among Out of School Children

Age Category	Orphans	Other	CEDC	Total
Under 5 yrs	2683 (20.6%)	10365	13048	
5-6 yrs	1747 (25.0%)	5230	6977	
7-12 yrs	1559 (30.8%)	3496	5055	
13-16 yrs	2390 (20.6%)	5421	7811	
17-18 yrs	969 (30.1%)	2254	3223	
Age not known/stated	64 (20.0%)	250	314	
All out of school children	9412 (25.8%)		27016	36428

It has also been found out that school performance is poorer among the children orphaned by AIDS (Williamson J 1999). Studies have noted that education and school attendance is disrupted when parents become sick. Those children living in a household headed by an adolescent and grandparent may be more vulnerable to school drop-out. There is need to assess the composition of those children who might have dropped out of school or who experience disruptions in school attendance.

Two hundred and thirty-two children were recorded to no longer be in school, 24 of these are aged 10 years and below, 77 aged between 11-15, 89 aged between 16-18 and 42 above 19 years.

Limited Access/Performance of CABA in Education

The Department of Social Welfare used to pay school fees for those children in especially difficult circumstances. This department no longer honours this obligation as much as they used to. As a result, the vast majority of children drop out of school due to lack of school fees.

Some school authorities identified children affected by AIDS as children who are always sleepy in class; this is because of the dual roles that these children play, as carers of sick parents and siblings, as well as trying to cope with school demands. Some children were reported to come to school late as they first prepare food for other children and leave school early, to go and prepare meals for their sick parents. These children lack concentration and their performance in school is generally poor.

Lack of Birth Certificates

The issue of national documents was highlighted as a major problem. Some of the children affected by AIDS do not have birth certificates. This presents a problem, as some are not enrolled in schools unless they acquire such certificates, and they are not allowed to write public examinations either. For those children with no extended family members willing to help, they will not be able to acquire such documents. The National Orphan and CEDC Enumeration exercise found out that among the children in the sample of 96 235, 38.8% did not have birth certificates. The proportion of children without birth certificates stood at 40.7% among orphans and 38.1% for the rest of the sample.

According to children...

- My school attendance is very erratic. I have to go home early to cook for my mother. She has to take her medication with food, and there is no one else to cook the food for her.
- "Looking after my 5 year old sister is very difficult. I leave her with neighbours when I go to school", said a 14 year old girl.
- We go to school later and have no time to study.
- Our uncle says it is pointless to educate girls because they will get married.

Some relatives were known to take the death certificates. Because of this, children could not show the registration offices any proof of the death of parents; hence no assistance could be received. Many people in the rural and resettlement areas highlighted the fact that they do not acquire these documents because the registration centres were too far away and inaccessible.

Poor Health and Nutrition

It might be expected that the health of orphans, especially those in the care of elderly and adolescent caregivers would be worse than would other children. Substitute caregivers may be uninformed about good nutrition, oral rehydration and treatment for diarrhoea and recognition of serious illness (Foster G 1998). The current health system tends to invest more education in mothers as primary health care-deliverers, hence adolescents and elderly caregivers may tend to be uninformed about health issues and may have poor access to health delivery services. This violates the children's rights to health (CRC, Article 24, African Charter, Article XIV).

Children Heading Households

Child-headed households were mainly found in farming and mining sectors. This is mainly due to migration, as families were isolated from relatives and the extended family when they moved from the rural areas to mining or farming areas. These families rarely, or never, visited the extended family mainly due to economic reasons.

Table 2. School Levels of Children Heading Households

Primary (Grade)	Secondary (Form)	Tertiary	Not Attending School
4	25	2	18

Children start assuming additional responsibilities before the parents are terminally ill, or are bed-ridden. Most children indicated that they started caring for their siblings when the parents were still strong. The parents would leave the younger children in the care of older siblings whilst they went to work. When the parents are occasionally ill, the older siblings continue with the responsibilities until the parents are bed-ridden or die.

In rural areas, there were relatively limited numbers of children heading households. This was mainly because the people in the rural areas are, to some extent, still practising traditional ways of caring for children and the sick. For example in Buhera, wife inheritance is widely practised and accepted, thereby protecting children. (One man inherited 3 wives and is looking after 25 children as his own. About 15 of these children are under the age of 12). The National Orphan and CEDC Study found 27 male and 77 female caregivers aged 15 years and less. A further 181 males and 165 females were aged between 16 and 18 years inclusively. Field validation will confirm the roles and capacity of the extended family and communities to care for children affected by AIDS. There is need to understand new phenomenon of children or adolescents and elderly grandparents heading households. For some children, heading households may be the best option when faced with a limited number of bad options; e.g. children may lose their property to stepparents after inheritance by relatives. It might be necessary to allow a family of children headed by a sibling to remain intact while taking steps to enable this household to cope eco-

nomically and socially. The head of the household will remain rights holder, and the extended family and community, the duty-bearers with a role to socialise the children. The distribution of children and dismembering the family by dispersing siblings can be a certain route to greater psychological distress and emotional disturbance. The prevalence of child-headed households may not necessarily indicate the failure of the extended family coping mechanism. Most child-headed household studies in Zimbabwe indicate that there were some members of the extended family who would have taken care of the children but were not willing to do so for various reasons. In as much as child-headed households can be seen as a coping mechanism, it can also be taken as a sign of abandonment of the children. Child-headed households were also identified in Rakai District of Uganda, in Zimbabwe and Tanzania with prevalence of 30/1000, 4/1000, and 0.3/1000, respectively. (*Foster et al 1997, Nalugoda et al 1997, Urrasa et al 1997*).

Inadequate/Poor Accommodation

Inadequate/poor accommodation was a major problem in almost all households visited. In one of the households, three boys and three girls slept in one room. The boys slept on the bed and the girls under the bed. This was of concern especially with regard to sexual abuse and incest. Another household had the elder sister (17 years old with her own two children) taking care of siblings, living in a one-roomed house. Eight children were living in a two-roomed house with a mentally retarded man. The children were caring for him. Children affected by AIDS have major problems with accommodation. Women who were members of PWA support groups identified the same problem. They live in one or two-roomed houses with their children, both boys and girls. When the mother is sick with TB, she fears passing on the infection to the children. Some PWAs lived in a shack with their children, after they were chased away by relatives. Sometimes, when they are ill with diarrhoea or vomiting, infection control is very difficult with children in the same room. One woman reported that she was living in a two-roomed house with her seven children. Another woman was living in one room with her two children and their stepfather. This puts the children at high risk of sexual abuse. In another family, the 26 year-old sister caring for siblings sleeps in one room with a 19 year-old young man. This affects children both physically and psychologically.

Below is a summary of causal factors analysed in three different categories. Immediate causes are factors which lead directly to the manifestations demonstrated by children affected by AIDS. These are factors that are seen at face value. They are also the causes that are easily identified by communities when asked why children affected by AIDS are experiencing certain problems.

The second level of causal factors is the underlying causes. These are hidden causes that contribute tremendously to the immediate causes. Most people will identify these underlying causes with a lot of probing, and looking deeper into causal analysis of problems experienced by children affected by AIDS.

The last level is that of basic causes. These are few, but lie at the base of all the identified causal factors.

Stigmatisation

Many children heading households reported feelings of stigmatisation from the local community and from relatives. When probed to find out how the stigma was manifested, the children reported the following:

- They are laughed at because of their poverty. Some of the children said they could not go and play with others because they will laugh at their tattered clothes. One boy said he had no friends at school because they all said he wanted their food. During break-time and lunch hour, other children share their food, but because he has nothing to share, other children shun him.
- Other children take away a younger orphan's money that was saved up for lunch. "They gang up and take the money by force," said a 9 year old girl whilst she sobbed.
- Other children were stigmatised by relatives and community members who said their families are cursed because there are so many deaths. Others will openly say, "Your mother died of AIDS and your father will be dying soon too"; and thus they do not want to be associated with such children. One child witnessed a terrible incident when her mother asked for water from a certain household. Soon after drinking the water, the mother at that household broke the cup saying no one else should use it in case they would also be infected.
- At school these children are stigmatised by other children. The older girls reported that community members no longer treated them as children, even though they treated other girls of the same age with parents as

children. The community now saw these girls as “mothers” and expected them to work hard to care for their siblings. As a result, the girls had no friends except those who were in similar circumstances.

Abuse

Respondents from focus groups discussions, individual and group interviews, identified child abuse as prominent in communities. Some community opinion leaders however indicated that, where there is a community care of orphans programme, child abuse significantly goes down as few cases are reported due to the monitoring that takes place. However, the most noted form of child abuse was verbal, and stepmothers were referred to party primarily responsible for the abuse. Some reported the abuse from grandparents, whom they said were not used to living with so many young children. Children also reported being beaten up by grandparents and stepparents. In one city, a 17 year old boy was stabbed in the eye by a neighbor during a scuffle. The incident was reported to the police but nothing was done. It is typically the girls who report sexual abuse. Their fears included men who come and knock at their door during the night. Others reported that elderly men who promised to marry them as second wives raped them, and never fulfilled their promise. Another girl reported that when she was raped by an elderly man, she reported the incident to church leaders (*Vapostori*) who took the man and prayed for him. They then released him, saying he was now cleansed.

A 9 year-old orphan was falsely accused of raping a 2 year old, but was proved not guilty after medical checks. The children were reported to lack training in self-help projects. As a result, they may be tempted to sell their bodies for quick money when they are in a desperate situation. Some children end up involved in early marriages as they seek security and protection. Most of the children reported that they work in other people’s fields to raise money for food. However, some of the people do not give them the money as promised, but give them food instead.

Table 3. Causal Analysis

Manifestations	Immediate Causes	Underlying Causes	Basic Causes
Withdrawn and Sad	<ul style="list-style-type: none"> • Lack of parental love and attention • Labelling and discrimination • Child abuse • Dismembered from family • Psychological distress 	<ul style="list-style-type: none"> • Insecurity • Stigma • Family breakdown • Lack of community protection • Vulnerable because they are alone 	<ul style="list-style-type: none"> • Parental illness and/or death • HIV/AIDS • Poverty • Death
Child Headed Household	<ul style="list-style-type: none"> • Lack of extended family support • Lack of implementation on government policy on child protection 	<ul style="list-style-type: none"> • Strained family relationships • Migration, e.g. to mining, farming and resettlement areas • Long illness • Breakdown of cultural beliefs and practices • Lac of national commitment to execute policies • Overworked government departments • Poor understanding of extent of problems of CABA 	<ul style="list-style-type: none"> • Poverty • Long illness • HIV/AIDS • Poor prioritisation of state funds
Elderly/Grandparent Headed Household	<ul style="list-style-type: none"> • Strained family safety networks 	<ul style="list-style-type: none"> • Multiple deaths of family members • Weak social support network 	<ul style="list-style-type: none"> • HIV/AIDS
Large Number of Children Living in One Household	<ul style="list-style-type: none"> • Polygamy • Divorce and remarriages 	<ul style="list-style-type: none"> • Wife inheritance • Cultural beliefs • Long illness • Infidelity 	<ul style="list-style-type: none"> • Deaths • HIV/AIDS

Economic Causal Factors

Extended illness causes problems such as lack of finance, lack of caregivers for the sick person, quarrels and fights in the home, no one to work in the field hence lower yields, children dropping out of school, etc. During interviews and focus group discussions, economic issues were always the first to be mentioned by respondents as key casual factors. Most children affected by AIDS are easily identified in communities because of their poor economic status. It is worthwhile to note that these children start to be affected by the harsh economic environment when

their parents are very sick and leave employment. The majority of the respondents confirmed that the children actually assume adult responsibilities way before the parents are seriously ill. Most children are seen involved in several economic activities to supplement the income in the household. In the rural areas, the issue of going to plough in other people's farms to raise money known as "*maricho*" in Shona was a widely accepted practice of supplementing income in the home. It is thus difficult to have a clean cut-off point as to when children start to feel the burden of caring for the family economically. These children seem to continue with the same tasks they used to do when the parents were still able to fend for the family. The marked difference was in financial management, as the children would now have to manage the home budget on their own without assistance from the parents. The second marked difference was when parents started to sell household goods to raise money for medication. By the time the parent(s) die, the children have no resources to use as a base to raise more funds.

Inheritance

When asked whether certain assets were unfairly distributed after the death of their parents, many children reported a lot of unfairness. Some of the children do not know what happened to the estate after the death of both parents; some reported that their uncles did not give them the parents' death certificates and they could not access the pension benefits. Another group was that of children whose parents' belongings were not distributed at all after the death. Some relatives took all their belongings including blankets, plates, sofas and chairs and left them with nothing. Another family reported that it was not the relatives who took them, but their father's friend (*sahwira*) since they had no relatives in Zimbabwe. Most of the women were bitter about issues of inheritance. One woman said she was accused of infecting her husband with AIDS and was chased away from home during his illness. After his death, she came back to take away the children but was not allowed to. Another father deserted the family because he said their mother was HIV positive. Both the children and the mother do not know where he is.

Some women reported that when a man married two wives, after his death the children of the second wife do not get anything. Other women disclosed that their children were from different fathers, so it was difficult for them to claim inheritance from any of the fathers.

Most of the PWAs reported that they had no resources. They could not afford to hire cattle to strain on their health. They also do not have money to access transport during illness since some services are too far away. Some reported financial problems. When the husband was ill, they borrowed a lot of money to meet medical expenses; now they cannot afford to pay it back. Some cannot afford to pay rent and rates anymore.

According to children...

- It is very difficult to care for sickly siblings; sometimes my 6 year old sister cries and I do not know what to do. I sometimes cook peanuts for her to make her quiet. I have no money to take her to the clinic.
- There is nobody to care for us. Mother and father died at the same time, so it is more difficult to cope. Since the death of my parent, I have to work in people's fields (*maricho*) to raise money for food.
- People do not tell us when the maize is distributed by the community leaders. They also say we have no authority to collect the maize, that we should have an adult who will register us. Sometimes we feel the uncle registers us and takes all the maize using our names.
- We spend many nights without food.
- Most of our property was stolen after the death of our parents. Now we have 3 cattle; Uncle just comes and takes cattle to plough his field without consulting us; we plough our fields last after they have finished theirs.

Poverty

HIV/AIDS is a potent cause of poverty. Households with family members who are living with HIV/AIDS experience high expenditures in seeking medical care, special diet, funeral expenditure, property removal, etc. All these impact on the children as their health, nutrition and physical well being deteriorates. Impoverished care-givers may fail to seek treatment for an ill child because they cannot afford the time away from work, family commitments or meet the costs of transport, consultation or medicines (Foster 1998). The extended family tends to be stressed and fail to cope as indicated by the numbers of children dropping out of school and requiring care, a rise in the number of orphans, street children, adolescents heading household, etc. Some orphans may have to seek work in town, usually as domestic workers, agricultural labourers or are involved in commercial sex work, to generate

income for their households. This is a violation of the children's rights to protection against labor. (African Charter on the Rights of the Child, Article XV; CRC, Article 32).

Children Caring for Sick Parents and Siblings

Most women identified their children as the only people who can care for them when they are sick. In one household, the mother had been sick for the past 19 months and was being cared for by her 16 and 13-year-old daughters. The women reported that their husbands deserted them when they became seriously ill.

Other respondents, especially from the PWA support groups interviewed, raised issues regarding infection control. This was highlighted as a major problem especially when the parent had diarrhoea or was vomiting. This was said to be critical when the family was living in a one-roomed house, or when accommodation was not adequate. The children caring for sick parents may not have the necessary training or knowledge on proper infection control. In a few instances, the children are too young and even when provided with gloves, these are too big for the child to use.

These children found it difficult to care for younger children when they were sick. One girl said she always felt hopeless when her younger sister was ill and crying. In many instances, these children heading households do not realise the extent of the sickness until the illness is at an advanced stage. Health officials refuse to treat unaccompanied children, i.e. children who do not come with an adult. These children are supposed to ask their neighbours to escort them to the clinic, and the neighbours are not always available to do so.

Below is a summary of economic casual factors:

Table 4: Analysis of Economic Casual Factors

Manifestations	Immediate Causes	Underlying Causes	Basic Causes
Tired and Overworked	<ul style="list-style-type: none"> • Child Labour 	<ul style="list-style-type: none"> • Long illness of bread winner • Abusive guardian • Death of bread winner • Property grabbing 	<ul style="list-style-type: none"> • Poverty • Poor national economic performance • Poor prioritisation of national resources • Death of parents • HIV/AIDS
Prostitution Early pregnancies	<ul style="list-style-type: none"> • Food insecurity • Poor accommodation • Lack of parental guidance and care • Lack of attention and love 		
Children living on the streets	<ul style="list-style-type: none"> • Hunger • Abuse • Lack of parental guidance 	<ul style="list-style-type: none"> • Unemployment • Strained family safety network • Negative peer influence 	
Poor/Inadequate accommodation	<ul style="list-style-type: none"> • High rentals and rates • Sub-letting 	<ul style="list-style-type: none"> • Lack of resources • Unemployment 	
Debts	<ul style="list-style-type: none"> • Insufficient resources 	<ul style="list-style-type: none"> • Long illness • Redundancy 	

Intervention and Responses

Government

The Department of Social Welfare of the Ministry of Public Service, Labor and Social Welfare is the government arm in charge of child protection, mandated by the Children's Protection and Adoption Act, for which the department is the major administrator. Government responses specific to CABA include the following:

- Development of National Orphan Care Policy drafted in 1995. Its main tenets include: care of orphans in the institutions is a last resort and should be temporary; all children, including orphans, should receive education and there should be law and guidelines to enforce this right; property rights' of orphans should be safeguarded by legislation, and their care and protection must comply with the CRC and African Charter on the Rights and Welfare of the Child;
- Development of an HIV/AIDS policy;
- National HIV/AIDS policy;

- Establishment of National Child Welfare Forum as a co-ordinating body for issues related to children and child protection with multi-sectoral representation. CWF has been decentralised to provincial, district ward and village levels in order to facilitate implementation, monitoring and co-ordination of child-related activities in the respective localities;
- Legal review in favour of vulnerable children, including amendment of the Administration of Estates Act (inheritance) and the Customary Marriages Act (prohibiting the pledging of girls and women in marriage);
- Facilitating birth registration through mobile registration units; however this initiative has not reached most in need due to the lack of funds;
- National enumeration of orphans and children in especially difficult circumstances (CEDC) and mapping of services available to these children; and
- Piloting initiation of Community-Based Orphan Care programmes in Masvingo (rural model) and in Bulawayo (urban model).

The major function of the CWF is to facilitate community-based child welfare initiatives, including support to Orphan Care Programmes at local level through:

- awareness raising on child rights
- encouraging the formation of community-based child rights committees
- co-ordinating and monitoring the situation of children
- resource mobilisation at national and community level
- research, networking and advocacy.

Non-Governmental Organisations (NGOs)

The Zimbabwe AIDS Directory 1995 lists a total of 111 organisations involved in HIV/AIDS work. Most implementing organisations are involved in orphan care, home-based care and counselling. The Directory of Children's Services in Zimbabwe 2000 lists 99 organisations that provide child services in Zimbabwe.

The following seem to be the major responses from NGOs to the issue related to CABA.

- *Community Mobilisation and Capacity-Building*
Aiming at enabling communities to act upon children affected by HIV/AIDS, some NGOs provide support and guidance to communities to set up and manage programmes for CABA.
- *Provision of Financial and Material Support*
This can be either the direct provision of cash and kind to the households in need or through assistance to initiate income generation activities to supplement income for these families.
- *Psycho-Social Support for CABA and their Care-givers*
This included pre- and post-bereavement counselling and training of children and their care-givers in life skills. This also addresses the importance of preparation for death of parents and provides guidance for writing wills and ensuring important documents for children to gain access to necessary social services.
- *Development of Complementary Models of Care (Farm Model)*
Adding on to the government initiatives to establish rural and urban models of care, which will be elaborated upon later on. Farm Orphan Support Trust (FOST), an NGO, pioneered the first community response to the situation of orphans in the commercial farming areas. HIV/AIDS is eroding family structures and children of farm workers are particularly vulnerable. This vulnerability is exacerbated by:
 - the absence of traceable families;
 - dislocation of families from familial clan groups;
 - marginalisation from society; and
 - multi-ethnic backgrounds of farm workers and their families.

The absence of strong extended family ties creates the need for appropriate community-based approaches to orphan care, hence FOST aims above all to keep sibling orphans together, within a family of the same culture and

in a familiar background.

The structure of the community-based programme in the commercial farms comprises the:

- *Farmer* — who provides the resources essential to the survival and development of children and adolescents;
- *Workers' Committee* — which maintains a close link with the farmer regarding the welfare of farm workers and their families;
- *Farm Development Committee* — headed by a respected member of the farm community. The committee carries out similar functions to those of the village committees of the rural model. The committee fosters an environment that ensures ongoing care and protection of children and adolescents at risk; and
- *Community-Based Organisation* — whose role is facilitative towards the development of community-based child-care activities.

Approaches to implementing the farm model have proved successful. The pilot programme has been replicated in the other farming communities in Zimbabwe.

Representatives from other countries visit the project sites resulting in Zimbabwe learning and benefiting through sharing experiences and lessons learnt.

FOST has developed an orphan care programme on the commercial farms. If this is not possible, orphans are placed within substitute families. The final option is that small groups of orphans will live together on a farm, looked after by a carefully chosen caregiver. Some of the challenges involved the farm community at every level of the decision-making process and the establishment of a monitoring system that ensures adequate support to orphans and caregivers.

The success of the programme, in the midst of economic hardships, is determined by community motivation, the viability of the farms, the commitment of government, the agricultural industry and the Zimbabwean society to ensure appropriate care and protection of orphans. Like the other models, the coverage is still predominantly limited to two or three provinces. Some of the farms running this farm model have been designated for resettlement leaving the future of the children uncertain.

- *Research, Information and Networking.*

Various researches have been conducted on HIV/AIDS and its impact on children in Zimbabwe. While findings from these studies can be developed into effective advocacy and planning tools, this has not completely occurred because studies are often carried out in a fragmented manner (e.g. limited to particular geographic location, etc.). CABA statistics have not been reliable and thus a comprehensive picture of the problem has not been possible.

Many NGOs are pursuing partnership with CBOs in order to enhance their capability of addressing the real needs of the communities. Another notable development is that the linkage between home-based care (HBC) and orphans' care, has been strengthened so that would-be orphans and their situations can easily be identified by HBC volunteers even before the children become orphans. However, USAID points out a risk in this approach which is likely to leave out children who are not receiving home care and other categories of vulnerable children.

Community-Based Orphan Care

The first line of response to orphans and vulnerable children has always been the family. Although families usually feel responsible for orphans and vulnerable children (OVC) within their own families, the increase in numbers of OVC, the gradual disintegration of the extended family and the dwindling availability of economic resources, is threatening this natural line of response. It should also be noted that communities do not treat children affected by AIDS (CABA) differently from other categories of vulnerable children.

Communities are assisting orphans through the following:

- provision of material support
- paying school fees
- providing psycho-social and emotional support for children
- providing labour to the families in need, e.g. cleaning their homes, collecting firewood and preparing fields for the children
- initiating Income Generating Activities (IGAs) to support children affected by AIDS
- seeking external assistance through the community under traditional leadership
- other support, e.g. escorting children to the clinic when they are sick

In some cases, such activities are undertaken by Community Based Organisations (CBOs), including church based organisations and support groups. According to USAID there are more than 100 CBOs established in Zimbabwe in response to the situation of CABA. CBOs have the advantage of targeting households with greatest needs, as they make use of volunteers who are living within the communities. Community based volunteers have frequent contacts with vulnerable children and their families in their community and have a neighbourly concern when helping those in greatest need. Empirical studies and past experience have witnessed increasing partnerships between NGOs and CBOs in support of children affected by HIV/AIDS, through strengthening existing community coping mechanisms and structures (e.g. traditional leadership). This approach was proven to be effective and has yielded greater sustainability and sense of community ownership; thus it seems to become mainstream in support and care for CABA.

Community-Based Orphan Care was piloted in two districts of Masvingo and Mwenezi in Masvingo Province. It utilizes traditional roles and responsibilities of traditional leaders, who have the authority to mobilize their people and resources in times of crisis and emergency. Therefore Chief Area Committees, composed of the area sub-chief, advisors and village leaders, were established at ward level. These committees address policy and planning issues coordinate and guide village activities. Local activities are carried out by village committees which are made up of village leaders and five members elected by the community.

The Village Committees report to the Chief Area Committees who in turn report to the District Child Welfare Forum and through whom, as members of the Social Services Sub-Committee, to the District Development Committee provide the linkages of the community-based structures with formal government. This referral system enables the government to understand the needs of the community better and gives communities the ability to influence state policy. The three phases of the process are:

- 1) assessing the situation;
- 2) increasing the awareness of the problems which affect orphans and other vulnerable children; and
- 3) strengthening communities.

The village and ward child committees are trained by the Child Welfare Forum to identify and record all orphans and vulnerable children in their areas, identify their needs and attend to those they can at their level, model is still very while referring other cases to appropriate agencies and higher level committees. The village committees utilise their members, especially the village community worker, to implement child-care initiatives so as to ensure that orphans are properly fed, clothed and housed; and school-aged orphans attend and remain at school. They also carry out household chores to enable orphans to attend school.

Village committees also encourage households to raise money for school fees for orphans and to raise funds for unforeseen emergencies. Donations from each household range between US\$.03 to US\$.10 per month. Villagers pool their resources on behalf of orphans to develop communal gardens and woodlots. The village committees seek external support to sink boreholes, to install grinding mills and to train volunteers on home-based care for orphans and the terminally ill.

In February 1999, the rural model was officially launched in Chief Charumbira's area and all provinces were encouraged to replicate the model in at least one district. Unfortunately government did not in turn commit any

funds for the replication which has moved at a very slow pace. Therefore the percentage of children covered by the model is still very small.

In comparison to some of the early community responses e.g. FACT Mutare or Elim Mission which are faith-based organisations, the government rural model focused on material needs of OVC and only received capacity building in the area of psycho-social support through Masiye Camp in 2000. The organisations use volunteers who visit orphans and vulnerable children within a given radius allocated to them on the basis of their own places of residence. Commitment arises from their moral obligations while those of village community workers, is dependant upon how active the Child Welfare Forum is. In Masvingo, CADEC Masvingo has worked with the Masvingo pilot project and extended its activities to start working with children in affected families before actual orphanhood. small.

Some positive issues which have arisen from the various responses to community-based initiatives include the:

- willingness by all stakeholders to develop a holistic approach to child protection at community level;
- existence, at National Level, of a policy framework which guides the development of community based child care programmes by all stakeholders;
- acknowledgement by stakeholders of the need to effectively utilise available resources and for the urgent need for additional resources which enable service providers to deliver appropriate community based services to all children in need of protection; and
- acknowledgement by stakeholders of the need for documented information to monitor programmatic progress and to determine organisational/community capacities which sustain programme implementation.

The major success to the current programme includes the:

- willingness by local chiefs to provide agricultural inputs for orphans, for example, Zunde reMambo;
- establishment of village committees that compromise both men and women;
- maintenance of registers by village committee members;
- willingness by community members to address the immediate needs of orphans and other vulnerable children without the assistance of external organisations; and
- multi-sectoral collaboration among Government, NGOs, CBOs, religious groups and traditional structures.

Challenges faced by this model include determining how the project can benefit fully from the social safety nets for OVC. For example, the DSW was able to return a portion of the funds when some orphan children within the catchment area of the model, were not allowed to go to school due to the non-payment of fees.

The Urban Model

A research study carried out in 1997, with the support of UNICEF and the Child Welfare Forum, initiated the setting up of an orphan care programme in the urban areas. One characteristic feature to the urban set up is that strangers tend to live next door to each other; whereas in the rural areas, relatives live within the same neighbourhood.

Findings from the research revealed that:

- out of the 348 children interviewed, 58% perceived the community as indifferent to their situation and needs;
- the extended family does not exist in the urban set up, and in most instances, the maternal side of the family provides assistance to orphans; and
- community structures comprise Government Departments, NGOs, CBOs and religious organisations.

This model utilises health task forces of the City Health Department as an entry point for mobilisation of the community to respond to orphans and vulnerable children. As these task forces were already working with affected families through home-based care, this facilitated the integration of orphans and vulnerable children into the task forces' activities. The model provided for both thematerial and non-material needs of the children.

The Child Welfare Forum within the urban programme:

- facilitates ongoing identification and monitoring of vulnerable children and their families;
- promotes support mechanisms that increase the coping capacity of urban families;
- encourages increased community support for grandparent headed households and child headed households;
- supports community based programmes which assist orphans and other vulnerable children to maintain their psycho-social well-being, to access health services, to stay at school and to acquire appropriate skills training so that they are able to support themselves;
- builds a collaborative environment at international, regional, national and community levels in order to advocate for issues related to children and adolescents affected by HIV/AIDS.

Compilation of statistical information on the number of children needing assistance is currently ongoing. A review of the pilot programme will be carried out in mid 2001.

Commercial Farms Model

This model is indicative of the fact that Farm Workers are marginalized in terms of government expenditure on development, drought relief, basic services and community development (FOST, 1998). Also, the provision of basic facilities to the farm worker and his family by the farmer is dependent on the viability of the farming enterprise, goodwill and the motivation of the farmer to provide.

The model of care:

- involves the Farm Community at every level of decision making;
- has put in place a monitoring system that ensures adequate support for orphans and care givers;
- ensures that legal requirements to orphan care are met;
- facilitates awareness creation, networking and registration of affected children; and
- operates through the existing Commercial Farmers Union.

The success of the programme in the midst of economic hardships, is determined by community motivation, the viability of the farms and the commitment of Government, the Agricultural Industry and the Zimbabwean Society to ensure appropriate care and protection of orphans and other vulnerable children.

Informal Mining Sector Model

This is being piloted in Zvimba District. A feasibility study carried out by the Zvimba District Child Welfare Forum revealed that very little is known about children and adolescents in the mining sector. The study also indicated that the community needs to be aware of the challenges and problems faced by orphans and other vulnerable children.

Once established, the project intends to:

- set up community structures which provide care to Orphans and Other Vulnerable Children (OVC);
- strengthen existing coping mechanisms;
- encourage the commitment of community members on issues pertaining to OVC; and
- establish an effective information system with the provincial CWF and the community-based child welfare committees.

A major constraint to the pilot programme is that, it does not include communities involved in illegal and informal gold mining. Justification to their exclusion is that these communities are highly mobile, rendering it difficult for the members of the Child Welfare Forum to follow up and monitor the survival, development and protection of OVC.

Emerging Gaps

From the analysis of casual factors, analysis, the following have emerged as intervention gaps in the problem of children affected by HIV/AIDS:

Legislation/Policy Level

- Implementing bodies and co-ordinating bodies lack the mandate to change, where necessary, approaches to project management, e.g. the Child Welfare Forum lacks the legal mandate to institute ombudsman functions.
- Although the Government, supported by donors and UN Agencies, currently disseminates policy information to community level, coverage is not national, resulting in the failure by some service providers and community members to access this information. The Department of Social Welfare also lacks the capacity to effectively co-ordinate and monitor project activities and operationalise child-care policies at local level. This lack of capacity to decentralise, co-ordinate and monitor the replication of pilot projects on orphan-care negatively compromises the universal sustainability of programmes.
- Although support provided to various governments by donors, NGOs and CBOs has improved the quality of life of orphans and other vulnerable children at community level, this support poses some limitations. They include poor organisational management skills by service providers, lack of adequate funding and limited technical support at community level to sustain projects when donors pull out. The results of the field validation exercise and the literature review reinforce the need to set up mechanisms which respond to locally identified determinants in order to decrease the vulnerability of communities to HIV/AIDS. The results of the study also reinforce the need to strengthen community responses, which significantly reduce this vulnerability to HIV/AIDS.
- Specific monitoring indicators which measure the success or failure of programmes based on, time, materials, money, manpower and the extent to which stakeholders and politicians are willing to support the child care programmes, have not been developed at policy and programmatic levels.
- Zimbabwe, despite having ratified the CRC, has not universally acknowledged the CRC's recommendations regarding Child Participation. Apart from isolated cases to child participation, for example, the urban orphan care model, children and adolescents are not actively involved in planning for their own future survival, development and protection.
- Community-based childcare activities place a heavy workload on women who already work long hours. Stakeholders have not included in their action plans, how men and women can share the responsibility of caring for orphans and other vulnerable children. This important issue, including issues arising from the Convention on the Elimination of Discrimination Against Women (CEDAW) have not been addressed at both policy and programmatic levels.
- Current approaches to pilot projects lack clearly defined project monitoring mechanisms which provide information regarding sustainability and replication of project activities at policy and programmatic levels.

Gaps in Programme Implementation for OVC

Despite existence of Orphan Care and HIV/AIDS policies, there is still lack of clarity as regards to overall leadership and co-ordination of the various role players. Other gaps include:

- Lack of awareness programmes on child protection and child rights and limited awareness of the roles of government and other actors by communities;
- Mechanisms in place at hospitals and clinics are not accommodative of children carrying out adult functions; e.g. children not accompanied by adults are denied treatment in health centres;
- Insufficient involvement of children in the issues that affect them;
- Absence of adequate monitoring structure and documentation of best practices;
- Limited interventions that raise awareness on stigmatisation attached to CABA due to HIV/AIDS;
- Unclear programming for children who are currently assuming adult responsibilities;
- Potential for external agencies to undermine community responses of implementing CABA care programmes (especially by offering monetary incentives);
- Lack of follow-up and feedback of research findings to communities which leads to research fatigue in communities most researched; and
- There has been no evident factoring of the gender implications during planning. Inadequate resources, espe-

cially human resources in relevant departments that deal with CABA issue, e.g. Social Welfare Department and Health Department.

Recommendations

It is recommended that the Government of Zimbabwe, with support from other organisations strengthens service provision through the dissemination of policy and programmatic information to all sectors of the community and through capacity building and resource allocation.

Policy/Legislation Level

- The Government needs to clarify the responsibility of various departments in implementing and monitoring child care and child protection activities at policy and programmatic levels. This move will assist support organisations and other stakeholders to co-ordinate their activities effectively and to direct specific resources to the appropriate ministries.
- The NPA Secretariat should encourage all stakeholders to support project, which have as their major focus, **the Best Interest of the Child**. Results of the field validation exercise and the literature reviewed have revealed efforts made by some stakeholders to shift from dormitory type child care facilities to family based facilities. This positive shift of emphasis needs to be encouraged at policy level, before it is overshadowed by other issues and developments.
- Zimbabwe should strengthen the provision of basic services, since these services are key to the survival and development of orphans and other vulnerable children.
- The Government of Zimbabwe needs to disseminate policy information to all communities and service providers through a variety of media and languages. These policies assist community members to make informed decisions regarding child-rearing practices. The policies also benefit service provision because they reinforce the right of the child to remain within the biological nuclear family and, they assist various stakeholders to develop strategies that support national needs.
- Laws linked to registration of births, inheritance and property disputes should ensure that all children are identifiable and that orphaned children inherit their parents' property. **Legal education** should also be an integral component to community-based awareness programmes.
- Enforce and monitor existing policies that protect children with special emphasis on:
 - Protection of children against neglect and abuse;
 - Protection of inheritance rights' of orphans;
 - Right of children to education (both primary and secondary); and
 - Increase availability and accessibility of social welfare support for children affected by HIV/AIDS.
- Mechanisms should be put in place for CABA to benefit from AIDS Levy;
- Improve access to health facilities especially for OVC;
- Empower personnel in relevant departments to provide counselling services to CABA (e.g. DSW, Health and MOH).

Programmatic Level

Traditional coping mechanisms to child-care are currently weakened by poverty, HIV/AIDS and the increasing number of households which are in need of support. This development has resulted in community members losing confidence in their ability to care for their own vulnerable children. However the GOZ, supported by various stakeholders can ensure sustainable development of programmes by empowering community members to implement and monitor their projects. COPE, an NGO in Malawi provides a demonstrable example on how to foster the confidence of community members during programme implementation. Attempts to sustain programmes can also be done through:

- **Costing** community based child-care activities. This helps determine the impact of service provision. FACT, an NGO in Zimbabwe, has demonstrated the possibility to cost time, personnel and material inputs.

- Adopting a **holistic approach to service provision** at community level. This can be achieved through the development of a mechanism that ensures the involvement of community members to assess, register and monitor the needs of vulnerable children. Community members can also be involved in determining the support required at household level, the impact of service provision and the constraints encountered.
- The provision of comprehensive **Professional and Life Skills Education** for children and adolescents since they need to access appropriate, non-discriminatory counselling and reproductive health facilities. Their participation will enable them to make informed decisions about their own lives.
- Strengthening and supporting **sustainable and replicable** community based child protection initiatives which:
 - localise the allocation of resources;
 - reinforce the management and marketing skills of CBOs;
 - train stakeholders on designing, managing, monitoring and evaluating project activities;
 - establish non discriminatory fora for NGOs and CBOs to exchange ideas and experiences; and
 - build links between donors, Government, NGOs and CBOs to ensure a co-ordinated approach to service provision at community level.
- **Community-Based Income Generating Initiatives**, such as savings and credit schemes, which rely on community participation to ensure sustainability. The main role of support organisations is to facilitate the process through awareness raising, training and the provision of time, personnel, and financial and material inputs. Concerted efforts should be made through community-based structures. The Child Welfare Forum could involve the private sector to participate more in supporting these initiatives because the private sector is strategically placed to provide the business and marketing expertise needed to sustain Income Generating Initiatives.
- **Strengthening the capacity** of the Department of Social Welfare (DSW) to effectively manage, implement, monitor and document community based responses to child-care. The DSW, through the Ministry of Public Service, Labour and Social Welfare, is mandated with the responsibility for the care and protection of children. The DSW is also responsible for co-ordinating the functions of the **Child Welfare Forum**, the **only** structure which has decentralised child welfare activities.
- Reports and documents compiled by NGOs should be integrated into the national database. The Child Welfare Forum, through the Department of Social Welfare needs to develop a co-ordinated approach to data collection, reporting and documentation of community-based child protection initiatives. This approach will strengthen the quality of data for advocacy.
- Government should develop specific monitoring indicators at policy and programmatic levels to measure the impact of project activities. These indicators, by closely monitoring the coping capacities of communities, will maximise the effectiveness of community-based child protection programmes. Current approaches to managing pilot projects lack clearly defined monitoring mechanisms which provide information regarding sustainability and replication of project activities at community and policy levels.
- Stakeholders need to provide tangible benefits, which **augment the livelihoods of volunteers**, the majority of which are **women**. The women could be afforded:
 - access to education, particularly education for the girl child;
 - access to credit to run their own income generating projects;
 - preferential access to land for agriculture, including the initial inputs; and
 - membership to housing schemes, etc.
- The **participation of children** in programming community-based child-care initiatives should be encouraged. Currently, traditional culture allows children to participate in specific activities, for example, in carrying out basic household chores. Service Providers should therefore strengthen this existing approach by integrating, in a sensitive manner, other components vital to child participation.
- Provide counselling services to children living with sick parents, bereaved children and children who have assumed adult roles and responsibilities.

- Ensure that intervention benefits families in most need through a structured prioritisation process.
- Raise public awareness on the nature of the crisis and advocate against discrimination and stigmatisation.
- Strengthen the integration of orphan programming with PWA support groups, home-based care programmes for succession planning purposes. In succession planning intervention, identify children affected by AIDS before they are orphans.

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