Children **in**

Residential Care

THE ZIMBABWEAN EXPERIENCE

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Children in Residential Care
T H E   Z I M B A B W E A N   E X P E R I E N C E

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Foreword

In common with other countries in Sub-Saharan Africa, Zimbabwe has been severely affected by the HIV and AIDS pandemic. One of the most tragic consequences of the disease has been an orphan crisis, which has seen some 1,200,000 Zimbabwean children losing one or both parents to the disease. It is predicted that the number of orphans will continue to increase over the next ten years.

Thankfully, the response of ordinary Zimbabweans to this tragedy has been remarkable and demonstrates the strength and resilience of communities when confronted with a seemingly insurmountable challenge. In keeping with long-held cultural values, extended families have taken on the burden of care for well over 98% of these children and have done so against a backdrop of economic hardship, which has placed many families under considerable stress.

The Government of Zimbabwe, as early as 1999 and in response to the impeding crisis, developed and adopted a National Orphan Care Policy, which sought to support traditional methods of care and discouraged forms of care which removed children from their communities and culture. This policy recommended foster care and adoption as the desired alternatives for children who did not have extended families and recognized that institutional care should be discouraged. It clearly stated that placing a child in an orphanage should be regarded as a last resort and utilized only after all efforts to secure a better form of care have been exhausted.

This report, which provides an analysis of the current situation of children within institutional care in Zimbabwe, is particularly useful as it permits comparison with a similar study carried out a decade earlier in 1994. It demonstrates how, despite government policy to the contrary, the institutionalization of children has continued and is in fact increasing. The development of new orphanages is often a result of the well intentioned but misguided efforts of groups from overseas who have little knowledge of our national policy and priorities. The study makes strong recommendation on measures the government might take to guide the efforts of well-wishers and ensure that Zimbabwean orphans continue to be nurtured within their communities and culture. It also suggests how existing institutions can be modified to improve the quality of care and better meet the psychological and developmental needs of children already in institutional care.

We commend you to utilize this document and join the government of Zimbabwe in ensuring that all children affected by HIV/Aids enjoy their right to a loving and secure family life.

L C Museka

SECRETARY FOR PUBLIC SERVICE
LABOUR AND SOCIAL WELFARE

Table of Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BEAM	Basic Education Assistance Module
BYO	Bulawayo
CRC	United Nations Convention on the Rights of the Child
DSS	Department of Social Services
FGD	Focus Group Discussions
GOZ	Government of Zimbabwe
HIV	Human Immune Deficiency Virus
MoHCW	Ministry of Health and Child Welfare
NGO	Non Governmental Organisation
NPA	National Plan of Action
OVC	Orphans and other Vulnerable Children
SCF (UK)	Save the Children Fund (United Kingdom)
UNAIDS	United Nations Global Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
ZNCWC	Zimbabwe National Council for the Welfare of Children

Study of Residential Care in Zimbabwe

Background and Context

Zimbabwe is one of the many countries in sub-Saharan, which have been devastated by the HIV/AIDS pandemic. A tragic side effect has been a burgeoning orphan crisis. Current estimates place Zimbabwe's total orphan population at 1,000,000 of which 761,000 are believed to be a consequence of AIDS[1]. The number of orphans is expected to rise to 1,300,000 children by 2005[2].

The initial reaction of many well-wishers to the orphan crisis in Africa focused on the construction of orphanages. However, it was soon apparent that this was an economically unsustainable and culturally inappropriate response. More importantly, historical studies had conclusively demonstrated that long term institutionalisation could cause permanent psychological damage to children and this form of care had long been abandoned in the developed world. The approach adopted by international agencies and governments of affected countries was to strongly discourage the construction of orphanages and direct their efforts at re-enforcing the traditional family system and improving the capacity of local communities to provide care.

Despite these widely accepted policies, residential institutions continued to be built by well meaning donors. This study, following on a similar study a decade earlier, examines the current status of residential care in Zimbabwe.

Child Welfare Policy and Practice in Zimbabwe

In contrast to many countries in sub-Saharan Africa, Zimbabwe had a highly developed social welfare system backed by an effective legislation directed at the care and protection of children, at the onset of the orphan crisis. The key legislation is contained in the Children's Protection and Adoption Act, the implementation of which is the responsibility of the Department of Social Services (DSS) in the Ministry of Public Service, Labour and Social Welfare.

However, the DSS, starved of resources for over 20 years and recently suffering a catastrophic loss of professional staff, fleeing the economic crisis currently besetting Zimbabwe, is no longer able to carry out its obligations effectively. This has had a particularly adverse effect on children in care and other children in difficult circumstances.

Modalities of Care

The strongly rooted African tradition of caring for orphans within the extended family is well preserved in Zimbabwe with over 98% of the countries orphans finding refuge with their relatives. However, rapidly increasing poverty and rising numbers of deaths of adults from AIDS has placed the extended family under extreme pressure. Increasing numbers of orphans and vulnerable children are now falling through cracks in the system and governments and NGOs are faced with the mounting challenge of providing them with an alternative form of care. This may be provided through either adoption, foster-care or institutionalisation.

There is strong cultural resistance to the concept of adoption in Zimbabwe and insignificant numbers of children have been placed with adoptive parents since the onset of the orphan crisis. Foster-care, on the other hand, has been well accepted. Increasing numbers of both formal and informal fostering of orphaned and abandoned children to non-relatives are being arranged.

However, of the three options, institutionalisation is being utilised more and more for the care of children in this category. The placement of children is the responsibility of the Officers of the DSS who are severely hamstrung by lack of resources in carrying out proper investigation. Consequently,

[1]Zimbabwe National HIV/AIDS Estimates, 2003 (Ministry of Health and Child Welfare, Centres for Disease Control, and UNAIDS: 2003)
[2]Children on the Brink (UNICEF, UNAIDS, USAID: 2002)

they are often forced to fall back on orphanages as the only readily accessible solution.

Study Findings

There are currently 56 residential institutions for children in Zimbabwe with a registered capacity of 3279 children. Three thousand and eighty children are currently in care, including 67 children in unregistered orphanages. These figures represent more than a 100% increase on the number of children in residential care since the last study in 1994 and twenty four new homes have been built during this period.

Faith- based organisations have initiated of over 80% of these new homes with Pentecostal/non-conformist churches accounting for well over 90% of these.

Fifty-five percent of homes were located in rural areas and the remaining 45% were urban or peri-urban. There is a growing trend for new homes to be constructed in remote rural locations.

Children in Residential Care

This section is the result of an analysis of all case files of 625 children in a representative sample of 10 institutions. Comparison is made with the 1994 study.

The study revealed a continued predominance of males (60%) in care. The average age of the institutionalised population had increased with a significant number of children remaining institutionalised after the statutory age limit of 18 years. This reflects the failure of institutions to make adequate preparation for the transition of youth to the outside world.

The orphan status of inmates has also changed significantly since the last study. The number of children with no contactable relatives has increased from 25% to 41%. The number of children with both parents alive had decrease from 22% to 7%. These figures probably reflect a maturing AIDS pandemic but might also indicate more selective admission policies. However as in

1994, the majority of children in Zimbabwean institutions have contactable relatives and therefore have the potential of re-integration with their families.

Lack of access to identity documents remains a major problem for children in care. Despite aggressive advocacy campaigns by Child Welfare Organisations, a majority (60%) of institutionalised children remained without birth certificates. This proportion is identical to that in 1994.

The dramatic decline in the ability of the DSS to oversee and protect the rights of children in institutional care is reflected in the remarkable increase in the time taken to renew court orders. The failure of the Department has meant an increase in children unnecessarily admitted to residential care and their prolonged institutionalisation because of their probation officers failure to review their cases.

Psychosocial Assessment

One hundred and eighty nine youth from 10 institutions completed questionnaires and participated in focus group discussions to ascertain their psychological well-being and their response to institutional care. It was found that children in care scored higher than control populations on an instrument measuring psychological disturbance. Children in dormitory style institutions scored significantly higher than those in family-based units.

The youth expressed a strong desire to re-establish or maintain links with their families and valued visits from or holidays with family members highly. Many felt they had been rejected or abandoned by their extended families and were acutely sensitive about their orphan status.

The study revealed that care staff in some dormitory styled homes verbally abused children by taunting them with references to them being abandoned by their families or to the fact that their parents died of AIDS. Several cases of physical abuse, again in dormitory styled homes, were identified with severe beatings being administered as a form of discipline. No cases of sexual abuse were recorded.

The youth reported concerns about their future after leaving the institution as the thing that worried them the most. They stressed the importance of their institutions developing transition programmes and providing them with vocational training

Bedwetting was identified as a serious problem in most institutions. It was generally badly managed and added to the psychological stress and lack of self esteem of those afflicted.

Main Conclusions

The role of the Department of Social Services should be re-defined

Urgent action needs to be taken, to re-capacitate the DSS through a significant injection of human and material resources. At the same time functions and procedures of the Department should be adapted to increase efficiency. This process should include:

i)   The introduction of specialisation within the DSS, with selected officers having exclusive responsibility for children in care. It would be essential that these officers are given the necessary resources, especially with regards to transport to carry out their responsibilities.

ii)   The delegation of some of the responsibilities of the DSS, especially the duties of Probation Officers, to qualified social workers employed by private Child Welfare Organisations. The legal basis for the latter course already exists in the recently amended Children's Protection and Adoption Act. This would enable the Department to adopt a more supervisory role and reduce the burden of implementation.

Residential care facilities have continued to proliferate

Although the Zimbabwean Government has a clearly enunciated policy declaring institutional care a last resort, the number of residential care facilities has doubled in the last 10 years. Faith based organisations and in particular non-

conformist churches, have been almost exclusively responsible for this expansion. A majority of these new institutions continue to utilise a dormitory model despite clear evidence that this type of institution deprives children of a family life and may result in permanent psychological damage.

The Department of Social Services has failed to regulate the development of new institutions, largely because of weaknesses in the current registration process. However a lack of understanding of the undesirable effects of institutional care on the part of social welfare officers in the DSS was a contributing factor.

Institutions can have a wider role in the provision of care for OVC

A number of institutions have initiated orphan care programmes in the surrounding communities. In doing so, they can extend their reach and assist a much larger number of children at considerably less cost than those in residential care.

This trend should be encouraged and supported as it provides a mechanism through which institutions can make the transition from long term residential care to short-term placement facilities, supporting comprehensive community-based orphan care programmes

Foster-care is a viable alternative to institutionalisation in Zimbabwe

Several successful examples of both formal and community fostering have been identified. If adequately promoted and supported foster-care can be an effective way of removing children from institutions and placing them in secure family settings.

The main constraint to formal fostering has been the inability of the DSS to screen prospective parents and to process their applications. These constraints can be overcome by providing sufficient resources or allowing social workers outside of the department to function as Probation Officers.

Psychosocial needs of children are still neglected

Many institutions still focus on meeting children's physical needs while ignoring more important psychological and social needs. The study revealed that many institutional caregivers contributed to the psychological stress of children and youths because they failed to appreciate they were dealing with a traumatised and vulnerable group who required special support and encouragement. Training for caregivers in the provision of psychosocial support should be mandatory.

The introduction of transition programmes should be given high priority

The management of many institutions have failed to develop transition policies that would enable youth to be safely assimilated back into society. The steady rise in the average age of children in care indicates that this problem will become increasingly acute over the next 5 years.

Programmes to prepare youth for an independent existence after they leave care should be developed as a matter of urgency if a dramatic build up of "over-age" children in institutions is to be averted.

Main Recommendations

Department of Social Services

The Department of Social Services should:

- Request the Minister of Public Service, Labour and Social Welfare to implement the provisions of the Child Protection and Adoption Amendment Act as soon as possible to appoint social workers employed outside of the DSS to be appointed as Probation Officers.

- Review the current generic approach to casework to allow specific social welfare officers to be assigned responsibility for children in care. These designated social workers would assume the role of probation officer for all children in residential and foster care within their assigned geographical region.

- Develop a brochure summarizing the National Orphan Care Policy which should be made available to all organizations and individuals wishing to initiate OVC programmes in Zimbabwe. The brochure should set out government's funding priorities in this area and explain the protocol to be observed in the establishment of such programmes.

- Fully exercise the authority vested in it to regulate the establishment of residential institutions. It should review the current registration process to ensure that it is centralised and that *prior* approval is mandatory before any construction is commenced.

- As a matter of policy, forbid the construction of new dormitory styled institutions and de-register existing dormitory styled homes which have not converted to family-based homes within a specified period of time. The DSS should lobby donor agencies to assist institutions to secure funding for this transition.

- Introduce compulsory certification of care staff employed in institutions through a process of training and examination and incorporate a maximum child to care-giver ratio into the regulations governing institutions.

- Ensure that sufficient resources are made available for the efficient processing of applications for formal foster-care and adoption of infants and children.

Zimbabwe National Council for the Welfare of Children

The ZNCWC should:

- In cooperation with the Department of Social Services, adopt a leading role in the development and implementation of a

National Standard of Care Index for residential care facilities in Zimbabwe. In furtherance of this role, it should provide coordination and technical assistance for activities designed to improve standards of physical and psychosocial care in Zimbabwean institutions and promote cooperation and mutual assistance between them.

- Ensure that basic training in child-care and psychosocial support is available to all care staff in residential institutions. Training programmes should be standardised and access widened to ensure that all institutions benefit. Donor funding should be utilised for this purpose and large institutions, which have developed their own programmes, should be supported through donor funds to offer scholarships to staff from smaller homes to participate.

- In consultation with the DSS and MoHCW, develop a standardised policy for children in residential care who are infected with AIDS which would include guidelines on issues such as testing, treatment, care and disclosure.

- Introduce a programme of networking visits and exchanges, both for staff and children between institutions. In conjunction with these, there should be regular workshops for heads of institutions for capacity building and to allow them to share experience. Large, well-resourced institutions should be assisted to provide a mentoring role for smaller institutions.

Institutions

Institutions should:

- Convert dormitory style institutions to family based units, either through re-modelling of existing buildings or through construction of new units. Donor funding should be sought for this purpose where necessary.

- Develop transitional and vocational training programmes which will equip youth with the necessary skills for independent living and employment. Such programmes should guarantee ongoing contact with and support by the institution after discharge. Larger, well resourced institutions should assist smaller institutions with vocational training through technical support and scholarships.

- Develop and/or support community based orphan care programmes within their surrounding communities. Large institutions with established community programmes should provide technical assistance to smaller, less well resourced institutions to develop their programmes.

Donor Agencies

Donor agencies should assist these activities through:

- Support posts within the DSS and/or within established child welfare organisations (should amendments to the Child Protection and Adoption Act be implemented) for trained social workers who will have specific responsibility for children in care. It is essential that these officers be provided with the necessary resources, including vehicles, to perform these duties.

- Identify and support programmes, which aim to improve the psychosocial well-being of institutionalised youth and children. These might include training programmes in child-care and counselling for all institutional care givers, camps, excursions and sporting activities for youth, networking and exchange visits between institutions for staff and children.

- Make funds available for the conversion of dormitory styled institutions to family based homes. Such funding should include provision for the selection and training of care staff for his transition.

- Establish a fund, accessible to probation officers responsible for children in care, to support family re-integration and foster care. The funds would be utilised for the payment of school fees and uniforms and, where necessary, for the provision of material support to families offering to provide care.

- Support programmes to promote formal foster-care as an effective means of preventing or reversing the institutionalisation of infants and children. This should include funding of media and community-focused campaigns to raise awareness and acceptance of his form of care.

- Provide support for programmes promoting early intervention and family re-integration of street children.

Background and Context

Zimbabwe has one of the highest HIV/AIDS infection rates in the world, estimated to be 24.6% in 2001[3]. As a result of parental deaths associated with the pandemic, there are currently an estimated 761,000 orphans in Zimbabwe[4]. The orphan population is expected to increase until 2010, at which time as many as one in five Zimbabwean children will be orphaned. A similar situation prevails in many sub-Saharan African countries where 95% of the 15 million children, orphaned by AIDS worldwide, reside[5/6].

The unfolding tragedy of Africa's orphan crisis received wide publicity in the West and created a groundswell of individuals and organisations wishing to provide assistance. Although most of the resultant support was channelled through international donor agencies, small NGOs, faith-based organizations and individual philanthropists also made significant contributions. Initially, these interventions were a spontaneous, knee jerk response to what was being portrayed as an emergency and in keeping with traditional perceptions of orphan care, they focused on the construction of orphanages. In the first few years of Uganda's AIDS epidemic over 50 new orphanages came into operation[7].

However seasoned international development agencies and child-care professionals were quick to recognize that institutional care was an inappropriate and unsustainable response.

The sheer scale of the problem precluded residential care as an economically feasible option for all but a small fraction of the potential orphan population. Of greatest concern was the adverse affect this form of care has on children's social and psychological development. This had been well documented in Western countries several decades earlier and had led to the abandonment of this form of care and the closure of orphanages in these countries[8].

Subsequent experience, backed up by operational research in a number of affected African countries, has led to the development of widely accepted strategies for addressing the orphan crisis[9]. In a number of countries, including Zimbabwe, these have been incorporated into official orphan care policies[10]. They have in common the recognition that orphans are best cared for in families and that the extended family, which forms the foundation of African society, was best able to provide this care. These policies affirm that institutional care should be discouraged and regarded as the last resort.

Despite longstanding evidence of the damaging effects of institutional care on children's psychological and social development, significant numbers of children worldwide continue to be placed in residential care. In Africa, well-intentioned individuals and organizations continue to construct orphanages to house children orphaned by the AIDS pandemic.

Recent initiatives, spearheaded by a group of international Child Welfare Organizations, have sought to draw international attention to this problem and to promote the re-integration of institutionalised children into their communities. The campaign invokes the United Nation's Convention on the Rights of the Child and, in particular, the right of a child to enjoy family life[11].

This study examines the current status of residential care in Zimbabwe and the findings are compared with the results with a similar study carried out a decade ago.

[3]   Zimbabwe National HIV/AIDS Estimates, 2003 (Ministry of Health and Child Welfare, Centres for Disease Control, and UNAIDS: 2003)
[4]   Ibidem.
[5]   UNAIDS/USAID (2002) Children on the Brink
[6]   UNICEF (1999) Children Orphaned by AIDS: Front Line Responses from Eastern and Southern Africa
[7]   Salole, G. et al (1991) Managing Uganda's Orphan Crisis. Pritech Consultants
[8]   Rutter, M. (1982) Prevention of Children's Psychosocial Disorders-Myths and Substance Paediatrics 70; 883-884
[9]   UNICEF (2002) Principals to Guide Programming for Orphans and other Children Affected by HIV/AIDS: UNAIDS Best Practice Collection
[10] Govt. of Zimbabwe (1999) National Orphan Care Policy
[11] Children in Residential Care – Alternative Strategies. Introduction to an International conference in Stockholm, May 3-6 1999

Building on longstanding and comprehensive child welfare legislation, the Zimbabwean Government (GoZ) has been a regional leader in developing policies and practice, which would enable it to mount an effective response to the growing orphan crisis. It was an early signatory to a number of international conventions affirming children's rights including the United Nations Convention on the Rights of the Child, and the African Charter on the Rights and Welfare of the Child. In response to guidelines established at the World Summit for Children in 1990, the GOZ developed a National Programme of Action for Children, which sought to prioritise children's issues in national development.

In 1999, after wide consultation the GoZ adopted the Zimbabwean National Orphan Care Policy, which set forth its response to the orphan crisis. The policy affirmed the importance of family and community care and clearly stated that institutional care should be regarded as a last resort.

In 2003, the GOZ, recognising the need for a coordinated and expanded response to the mounting numbers of orphans and other vulnerable children, organised a national stakeholders' conference with the support of the Social Services Action Committee of the Cabinet. This consultative process secured broad-based support for a National Plan of Action for Orphans and other Vulnerable Children. The plan envisions the development of a national institutional capacity to identify all orphans and other vulnerable children and to reach at least 25% of them with service provision by December 2005.

A number of pieces of legislation address children's rights under the law. However, most Zimbabwean law concerning the care of children is embodied in the Children's Protection and Adoption Act, (Chapter 5:06). The Act, which was amended in 2001, provides for the protection, welfare and supervision of children.

The Act makes it an offence with specified penalties for any parent or guardian to neglect, ill-treat or exploit a child or young person. Ill-treatment and neglect arise if the child has been assaulted, ill treated, neglected, abandoned, exposed to an extent to be injurious to his health, morals or physical well-being or the parent or guardian fails to pay for adequate food, clothing, lodging or medical treatment.

The Act also defines the reasons a child may be taken into care and the legal procedure to be followed. Placement options for children declared in need of care by the juvenile court include return to parental custody, with or without supervision of a Probation Officer, placement in foster care or committal to a registered institution for a specified period. Prior to a Juvenile Court hearing a child may be detained on a Place of Safety Order in foster care or in an institution. The requirements for the formal adoption of children are also set forth in the legislation.

The Department of Social Services in the Ministry of Public Service, Labour and Social Welfare has responsibility for implementation of the Act.

The Department of Social Services

From its inception in 1936, the Department of Social Services has been primarily concerned with child welfare. Its position as lead Ministry in this area is confirmed in the following pieces of legislation:

The Children's Protection and Adoption Act (chap 5.06)

Guardianship of Minors Act

Maintenance Act

Criminal Procedures and Evidence Act

Social Welfare Assistance Act

*Private Voluntary Organisations Act
(Chapter 17:05)*

Disabled Persons Act

Included in the Department's responsibilities is a crucial role in the regulation and overall function of residential care facilities. This role includes:

1) Registration, supervision and inspection of residential care facilities.

2) Controlling admission and discharge of children from these facilities through casework, preparation of Juvenile Court reports and statutory supervision.

3) Investigating and processing access to alternative forms of care including foster care and adoption.

Over the years, many additional areas of responsibility have been added to the Departments functions, but child welfare remained intrinsic to its function. It successfully developed a decentralized network of provincial and district offices, staffed by well-trained professionals, who were able to offer effective care and protection to children in need.

At the beginning of the orphan crisis in the mid 80's, in contrast to many African countries afflicted by the AIDS pandemic, Zimbabwe had a sophisticated social welfare infrastructure. This was backed by a strong legislative and policy framework, and if it had received the necessary resources, could have mounted a credible and sustained response to the orphan crisis.

Unfortunately, resources were not forthcoming and the Department experienced a prolonged period of chronic under-funding, compounded over the last 5 years by the growing socio-economic crisis in Zimbabwe. These factors severely eroded the Department's ability to fulfil its responsibilities. An ongoing exodus of qualified social workers particularly to the United Kingdom and other western countries, lured by the promise of better remuneration, has gravely aggravated the situation. Of a total establishment of 174 officers, only 116 posts are currently filled. Eighty of the present staff are recently recruited university graduates with no formal training in social work prior to joining the department.

The contribution of outside agencies to the dramatic decline of the Department of Social Services deserves mention here. Over the last five years, local authorities in the United Kingdom have actively recruited Zimbabwean social workers to meet a demand for these professionals in Britain. At their behest, UK based employment agencies sent representatives to this country to offer social workers salaries some twenty-fold their local equivalent plus travel and relocation expense to Britain. As a result of this exercise, the Department was deprived of a large number of officers, including its most experienced, senior level staff and its ability to assist children in difficult circumstances was severely compromised (resignations 2002 43, 2003 17, and 2004 2).

This has had a particularly adverse effect on children in care and those needing care. The legal safeguards, protecting the rights of these children and guaranteeing the periodic review of their cases have been severely compromised as they are totally dependent on the effectiveness of their Probation Officer.

Key Role of Probation Officers

Under the Department of Social Services' generic approach to casework, the officer assigned to the case will prepare a report and represent the child in the Children's Court. When the care order is made, he/she will be assigned to be the child's probation officer and will remain so unless transferred to another province or resigns from the Department. The probation officer has sole responsibility for ongoing investigation, periodic review of the child's case and for the renewal of the court order every 3 years.

The generic system discourages specialization and worked reasonably well until the rapid decline in the Department's capacity over the last decade. Now, under-staffing and lack of resources, particularly with regards to transport, preclude proper investigation of the child's case and children presented to the Department tend to be admitted to institutions because these represent the only easily available placement option.

Once an institutional placement is achieved, it is increasingly found that no further investigations take place and the probation officer only revisits the case when requested to

do so 3 or more years later by the institution, whose government grant for the child is dependent on renewal of the court order. Here, the institution's task is made more difficult by the fact that it has to deal with a multitude of probation officers in a variety of offices.

This problem might be addressed in two ways. Firstly by revising the current generic system to allow specialisation and secondly, by implementing legislation that would allow social workers outside of the Department to be appointed as Probation Officers.

Prior to amendment, the Child Protection and Adoption Act restricted the role of Probation Officer to serving officers of the DSS. However, the Act now allows for qualified social workers employed outside of the department to be eligible for appointment. This potentially would relieve the situation and restore normal safeguards for children in care. Unfortunately, the DSS is yet to implement this change. The delay had been occasioned by the failure of the Ministry to appoint the Council of Social Workers, which the Act stipulates must register social workers prior to their appointment. However, the Council has now been appointed.

Modalities of Care

The vast majority of Zimbabwean orphans (98%) are cared for by relatives. This mode of care, derived from the deeply rooted extended family system, operates informally with decisions concerning the child's future being made by family elders without recourse to official government agencies. Those appointed as guardians have no legal standing, and are not entitled to government benefits available to those who legally foster. Government however accords these informal arrangements de facto recognition as any attempt to formalize them would overwhelm the Children's Court system.

This study is largely concerned with those children who come to the attention of the Department of Social Services and are placed in institutional care. They represent a small fraction of the orphan population and effectively are those who have fallen through the cracks in the extended family system. A significant proportion of these children are not orphans but require care for other reasons.

The Children's Protection and Adoption Act defines the reasons for which a child may be taken into care. These include amongst others:

i)   A child who is destitute or has been abandoned

ii)   A child whose parents are dead or cannot be traced and who has no legal guardian.

iii)   A child whose parents do not exercise control or who are unfit to exercise control over her/him.

iv)   A child who is being maintained in circumstances detrimental to his welfare

v)   A child who is in the custody of a person convicted of committing upon him offences such as abduction, child-stealing, assault, any sexual offence or bodily injury.

vi)   A child physical or mental disability who requires special care and treatment which the parent or guardian are unable to provide.

When a child comes to the attention of the DSS for any of the prescribed reasons, the Probation Officer has the authority to remove a child temporarily to a Place of Safety (Section 14 of the Children's Protection and Adoption Act). As soon as possible the officer is required to investigate the child's home circumstances and present a report to the Juvenile Court proving that the child is in need of care and recommending placement in some form of care. Unfortunately, that recommendation is often for institutionalisation.

A fundamental reappraisal of this approach has since taken place. This was not simply a recognition of the fact that the shear number of children who would require care precluded institutionalisation as a practical solution, but signalled a growing recognition that this form of care was inappropriate and potentially harmful to the child's development.
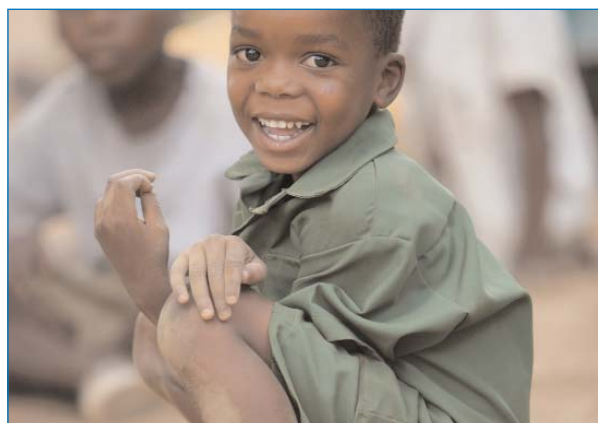
Rights Based Approach

The Government of Zimbabwe has ratified both the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child and in doing so acknowledged its obligation and committed itself to ensure the survival and development of its children. In developing policy on children, the government now adopts a "rights-based approach" in compliance with the Convention and recognizes the over-riding principle that in all determinations involving children, the "best interests of the child" should be of paramount concern. This approach is reflected in the Zimbabwe National Orphan Care Policy and will be embodied in the National Plan of Action for Orphans and other Vulnerable Children[12].

Rights Based Approach continued

The preamble of the UN Convention states "the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding". This emphasis on the centrality of the family to a child's life and normal development is a recurring theme in the articles of the Convention.

In interpreting Article 20 of the Convention, which deals with children, who, for what ever reason, grow up without family, the UN Committee on the Rights of the Child identifies care within their extended family or by others who are close to the child as the most desirable option. If this fails, an alternative family environment through foster care or adoption is preferred. The Committee is uncompromising in its interpretation of Article 20, with regards to institutional care, when it declared that this should be considered "the very last resort". In 1998, these guidelines were incorporated into the official Zimbabwe National Orphan Care Policy[13].

Article 12, which establishes the right of the child to participate in all decisions affecting his future in accordance with his/her age and maturity, has particular application for children in institutional care, but often conflicts with traditional cultural norms regarding the status of children in Zimbabwe.

The exercise of rights guaranteed by the Convention is not solely dependent on their incorporation into government policy and legislation. The non-availability of resources, both human and material, for implementation and the need to educate populations to accept concepts and attitudes, which are alien to their culture, are major constraints. The options available to those responsible for children in need of care are restricted for the same reasons.

In Zimbabwe today, as mentioned before, the vast majority of orphans and other children in need of care are absorbed into their extended families. This study is mainly concerned with those who fall through the cracks in this system. For these children the following care options exist:

Community Care

This refers to informal fostering of orphans by non-relatives from within their community of origin. This form of care is likely to be successful in stable, long established and well resourced communities in which the orphan's parents were known and respected. It has been successfully utilized in worker's compounds on commercial farms and in rural villages where traditional leaders may be instrumental in initiating and overseeing these arrangements[14]. Community based programmes encourage this mode of care and frequently include the recruitment and training of volunteers to support and assist care-giving families.

Voluntary support of child headed households by neighbours and other community members through mentoring, guidance and the provision of material support, make a valuable contribution to keeping these families intact and avoiding the necessity for residential care[15].

Adoption

Deeply held cultural beliefs and attitudes militate against adoption becoming a realistic option for the care of orphaned and abandoned children in Zimbabwe. Of 187 formal adoptions processed in the country over a 4 year period, only 35 were to black families, Most of the black adopting couples had a middle class and Westernised outlook and were consequently unafraid of the cultural taboos[16].

Government policy generally discourages foreign adoption of Zimbabwean children and Ministerial approval is required for such an adoption to take place.

This policy correctly supports the right of a child to be raised within his or her race and culture and may also reflect Zimbabwe's wish to avoid the unseemly commercialised system of international adoption, prevalent in Eastern Europe and Asia.

[12] UN Convention on the Rights of the Child (1989)
[13] UNICEF 1998; The Implementation Handbook for the Convention on the Rights of the Child.
[14] Jackson, H. et al (1996) Orphans on Farms: Who Cares? SAFAIDS
[15] UNICEF (2002) Principals to Guide Programming for Orphans and other Children Affected by HIV/AIDS UNAIDS Best Practices
[16] Powell, G. et al (1994) Child Welfare Policy and Practice in Zimbabwe (UNICEF)

However, when the choice is between an orphan languishing unloved and neglected in an institution and experiencing a normal and loving family life in a middle class environment, albeit overseas, it is doubtful if the current policy is consistent with the doctrine of "Best Interests of the Child". In light of this, the government may wish to revisit its policy and adopt a less rigid approach, considering each case on its merits and being guided by the principle of best interests.

Foster Care

In discussing foster-care, it is important to distinguish between informal and formal arrangements.

In the Zimbabwean context, care provided within the extended family and community, although a form of fostering, is rarely formalized through recourse to the courts. Family elders or community leaders decide on the placement of orphans without the participation of outside agencies and the placement is not officially registered.

Formal foster-care, which is less common, is a legal procedure in which a child, who through a court order is given into the temporary custody of a couple or individual who has applied to the Department of Social Services to become a foster parent.

The procedure involves the preparation of a report by the child's Probation Officer, which includes an assessment of the potential foster parent's suitability to act in this capacity. On submission of the report to the Juvenile Court, the Court may make an order giving the child into the custody of the foster parents. The order is valid for 3 years and then subject to review. The order may be renewed. The child remains a ward of the State and the arrangement may be terminated if the Probation Officer determines that the level of care is unsatisfactory or if the foster parents wish to return the child. In theory, a foster child is entitled to assistance with education and health care and a monthly grant payable to the foster parents for his or her upkeep. However process of accessing these benefits on a monthly basis is often difficult and time consuming and the grant has been eroded by inflation to an insignificant level.

Although not widely promoted, formal foster-care probably represents the most practical and

satisfactory method of achieving the de-institutionalisation of children who are abandoned or have no contactable relatives. It appears to be more culturally acceptable and on the occasions it has been promoted, the response has been extremely encouraging.

One Harare-based institution had secured donor funding for media and community campaigns to raise awareness and recruit potential foster-parents. It successfully fostered over 30 infants in the first year of the programme's operation. They reported that, while significant numbers of couples offered to foster, most preferred infants under 6 months of age and were generally reluctant to take older children. A majority of couples were recruited through a component of the campaign, which targeted church congregations. It was encouraging to note that most foster-parents declined to accept financial support even though it was offered. The major limitation of the programme was the lack of capacity in the under-staffed DSS to perform the screening of potential parents and preparation of the reports required by legislation. However, the Department has now assigned 3 officers to work with the project and the number of foster-care placements successfully processed is expected to increase. The organisation is hopeful that it will be able to foster most infants referred to it for institutional care.

Another Harare based welfare organization reported that it has successfully fostered several hundred orphans and vulnerable children to non-relatives mainly through church structures. These, however, were informal fostering arrangements, completed without court sanction, and would be best characterized as community foster-care.

Boarding School

This variation of care by the extended family appears to be prevalent in middle class families. The relatives in these cases, although accepting responsibility for the orphans, do not wish to be involved in their day to day care. The orphans are therefore sent to boarding schools with the fees being paid either from money inherited from their parents or by well off relatives. These children commonly spend school holidays with their relatives.

The Heads of several rural boarding schools, contacted in the course of his study, reported that

these children made up a significant proportion of their student populations and have been noted to have a greater than normal prevalence of emotional problems. It is likely that recently orphaned and traumatized children, consigned to dormitory styled boarding schools, without appropriate emotional support or counselling, may face the same problems as those admitted to institutional care under similar circumstances. This phenomenon requires further documentation.

Institutional Care

Institutional care in the context of this study is defined as round the clock residential care for children, which results in their separation from their biological families and communities.

Historically, institutional care has been associated with regimented, depersonalised environments in which children have no opportunity to experience a caring family life. As a consequence, they often failed to acquire normal life skills and the capacity for independent thought and motivation. The condition of dependency and expectation that resulted became known as the Institutional Syndrome. In addition, institutionalised children commonly endured chronic abuse and emotional deprivation, which gave rise to a lasting inability to form loving and trusting relationships. These factors combined to make it difficult for children who experienced long term residential care to cope outside of the institutional environment[17/18].

The realization that institutions had the capacity to cause permanent psychological and sociological damage led to the abandonment of this form of care in Western Europe and North America.

Unfortunately, this enlightened approach has been slow to find acceptance in much of the developing world where old-style institutions remain a common care option.

When the AIDS pandemic generated an orphan crisis in East and Central Africa in the 1980's, well-meaning groups and individuals in the West responded by building orphanages to house these children. This trend alarmed international child welfare organizations. Following the lead of the Save the Children Fund (UK), whose intervention in the early years of the pandemic in Uganda, was successful in closing down many of these new facilities, they developed strategies to promote community-based care which became accepted as the best option for children orphaned in the pandemic[19/20]. Institutions are now generally regarded as the last resort in the care of children orphaned by AIDS and many international funding agencies have made it policy not to support their construction or running costs.

Modern institutions have sought to correct many of the deficiencies of their predecessors by creating family units within the institutional environment[21]. However, despite these improvements, institutionalisation remains an inappropriate intervention in the African context of mass orphan hood. Their ability to provide care for only a small number of children at disproportionately high cost and their tendency to undermine traditional methods of care are common criticisms. More insidious is their propensity to alienate children from their extended families, communities and culture. This can have serious implications for the eventual re-integration of orphans into their communities and for their future happiness.

Case Study	The father of a two- year old girl, whose mother had recently died, found he was unable to cope with her care and requested the Department of Social Services to take her into their charge. The child was placed in an institution in a middle class Harare suburb. Five years later the father re-married and requested the return of his daughter from the orphanage. At that time the family were living in a one-roomed house in a high-density, working class suburb of Harare.
	Following her return to her family the child was desperately unhappy and ran away from her new home back to the orphanage on three separate occasions. There she told the matron that she didn't want to live with "those people" because they were too primitive. She complained that she had to sleep on a mat on the floor. There was no television, no hot water tap for bathing and the toilet was outside.

[17] Johnson, D. (1999) Perspectives on Institutional care and Consequences for Children. Paper at he Conference on Children in Residential Care, Stockholm
[18] Young People Leaving Care SC UK (1995) Position Paper
[19] Bukenya, S.(1999) Children in Residential care Prevention. The Ugandan Experience. Ministry of Gender, Labour and Social Developments.
[20] UNICEF (2002) Principals to Guide Programming for Orphans and Other Children Affected by HIV/AIDS. UNAIDS Best Practice Collection
[21] Itzkowitz, A. (1989) Children in Placement: A Place for Family Therapy in Combrinck-Graham L. Children in Family Contexts: Prospectives on Treatment. Guildford Press, New York

Models of Residential Care

The study considered two basic models of care, dormitory style and family-based units. Homes could be further classified by their architectural design, either western style or traditional. The latter refers to thatched rondavels, which reflected the style of housing found in rural communities.

1. Dormitory style

These are conventional institutions in which children are housed in dormitories and share communal dining and living areas, with staff undertaking a variety of domestic, administrative and care giving roles. Dormitories are usually segregated by age and sex.

This model deprives children of the experience of normal family life and has been associated with a poor level of psychosocial care and support.

2. Family Based

Reflect modern concepts of residential care and aim to replicate a nuclear family setting where children have a constant relationship with a parental figure(s) and a number of siblings of varying age and sex. The "family" lives as a unit and prepares food, eats and performs household chores as they would in a normal home.

The great majority of Zimbabwean institutions have been constructed in conventional, Western building style as required under the current regulations for the construction of children's homes, drafted during the colonial era. In several cases, however, a waiver was obtained and rural children's homes have been built utilizing traditional, thatched rondavel style. These are less obtrusive in rural areas and may assist the home's integration with the local community. They also allow the children to grow up in a culturally less alienating environment.

The Village Concept

Many family-based institutions have utilized the concept of "the Children's Village" for their construction. These villages consist of a group of up to 10 self contained houses placed in a landscaped setting. A family is established in each house with a village manager overseeing the whole complex. Some of the larger "villages" incorporate other amenities such as clinics, preschools and primary schools.

Administratively efficient and aesthetically pleasing, the children's village is also an attractive marketing strategy, appealing to overseas donors and reminiscent of the "Boy's Towns" which caught the popular imagination in the 1940's. Despite these advantages, villages tend to perpetuate many of the negative aspects of institutionalisation.

Instead of integrating and blending with the surrounding communities, the villages' contained environment, architecture and superior quality of the housing set them apart from the community and causes the children resident there to be readily recognised as orphans. The inmates are often perceived as privileged by the surrounding community and this has the effect of engendering resentment and increasing stigma. These reactions are more common in rural communities where disparities are more obvious.

Ideally, family based units should be completely integrated into communities and the residents indistinguishable from their peers in those communities. This may be best achieved through establishing families in individual houses randomly located in normal urban settings. There should be no signage or other identifying features on the houses and the children in such homes should enjoy the same freedom and activities as any other child in the community.

Several examples of this type of home are in operation in Zimbabwe and they represent a more cost-effective strategy than constructing purpose built villages. Although concerns have been raised about potential difficulties with logistics and the supervision of this model, these were not reported as problems by the existing homes.

Conclusions

The need to re-define the role of the Department of Social Services

The AIDS pandemic coupled with a mounting social and economic crisis in Zimbabwe, has been associated with a dramatic increase in the numbers of children in difficult circumstances. This has placed an enormous strain on the resources of the DSS. As will be evidenced in this study, the Department is no longer able to fulfil its obligation under the Children's Protection and Adoption Act to safeguard the rights of children in its care. This applies particularly to children in institutions.

The current scarcity of trained professional officers in the Department has meant that casework and preparation of reports on children being received into care and those already in care are usually inadequate or subject to prolonged delays. As a consequence children are admitted to institutional care unnecessarily and statutory review of their cases is often delayed.

The situation demands that current departmental policies pertaining to child welfare be reviewed. Recent amendments to the Children's Protection and Adoption Act have made it possible for many of the responsibilities for implementation of the Act to be shared with the non-government sector. This would allow the Department to assume a more supervisory role, as is presently the case with sister departments in South Africa and the United Kingdom.

Many private child welfare organizations already employ or have the capacity to employ qualified social workers who could assist the over-burdened officers of the Department with casework, preparation of reports and court appearances. This could lead to a significant improvement in the management of children coming into care and permit increased exploration of alternatives to institutionalisation such as family placement and foster-care.

More effective utilization of human resources within DSS

The generic approach currently adopted by the Department prevents specialization and spreads responsibility for children in care among its officers. While the logic of this approach was sound when the department was well resourced, in the present day, it works against the interests of children in care. The most adverse effect of this approach is that in any one institution, a multiplicity of probation officers from different parts of the country may be responsible for individual children and only a child's designated probation officer can represent his/her interest.

A more logical approach would allow for the appointment of child welfare officers with specific responsibility for children in care. All children who are to be the subject of court orders would be referred to them and they would be appointed as probation officer. Their primary role would be to act as "gatekeepers", preventing long- term institutionalisation through the aggressive promotion of family re-integration and foster-care. They would work in close liaison with the management of institutions and would also assume a supervisory role.

Their numbers might vary from province to province, depending on the number of children in care and their effectiveness would depend on the resources available to them. Adequate access to transport and the ability to provide necessary support to foster-parents and extended family members willing to provide care would be essential. It is doubtful that the DSS would have the resources to establish these posts in the current circumstances, and donor funding should be sought for this purpose.

Children's Institutions

There are currently 56 residential care facilities for children in Zimbabwe and these form the focus of this study. In addition there are 8 institutions and remand homes operated by the Department of Social Services. With one exception, the latter group will be reviewed by a parallel study of children in care because of delinquent or criminal activities.

Twenty-five new orphanages have been established since the National Orphan Care Policy was officially adopted and these were not included in the 1994 study of children in residential care. Two-thirds of these new institutions have been constructed in the last 5 years. Over 85% were initiated or funded by Faith Based Organizations, the majority of which (90%) were Pentecostal churches.

Seventy percent of new homes were located in rural areas. Overall, 11 new institutions (46%) followed a family-based model and the majority were dormitory style. Of the 16 homes constructed in the last 5 years, two-thirds were dormitory style.

Capacity

The official capacity of institutions registered or which have applied for registration with the Department of Social Services is 3279 children. A total of 3013 children are currently resident in these homes, giving an overall occupancy rate of 92%. A further 67 children are being cared for in un-registered institutions giving a total of 3080 in residential care.

In 1994 there were 1405 children in care and the official capacity at that time was 1518. This means that the number of children in institutional care has more than doubled over the last decade. However, if compared to the estimated number of children orphaned by AIDS in Zimbabwe during this period, there has been no increase in the proportion (<0.5%) admitted to institutional care. The study confirms the previous finding that, in terms of numbers, residential care makes an insignificant contribution to the care of Zimbabwe's currently estimated 761,000 orphans due to AIDS.

Thirteen homes cared for less than 20 children each. Nineteen homes had a capacity of between 20-50 children and 24 larger institutions accommodated between 50 and 120 children each. There has been a trend over the last decade for more homes to be constructed in the middle category.

New Institutions

Although the Zimbabwe National Orphan Care Policy, officially adopted in 1999, declared that institutional care should be considered a last resort, residential care facilities have continued to proliferate. Astonishingly, despite widely accepted evidence that dormitory style institutions are damaging to children's development and that family-based homes are the preferred alternative, the majority of new institutions utilized the dormitory model. In fact, the proportion that does so has actually increased.

The statutory right to approve and register new institutions lies with the Department of Social Services in terms of the Children's Protection and Adoption Act. However, the Department has singularly failed to exercise its authority in determining the appropriateness, number and situation of these institutions. To be fair, the current retrospective nature of the registration process in which application is made after construction of the institution is completed, effectively presents the Department with a fait accompli.

For example, three new orphanages (not included in this study) are currently under construction at different sites in the country. The Department of Social Services is unaware of their existence and will only become so, if and when they apply for registration. ▶

Individuals and organisations, who establish orphanages, commonly arrive with their own preconceived and firmly held ideas about what is required. Not infrequently, they are responding to requests from a poorly informed but well-intentioned local leadership or church group. In any case there is usually no attempt to seek expert advice or to consult the Department of Social Services before proceeding with construction.

This situation is often compounded by the fact that Social Welfare Officers at local level, unable to carry out proper case studies because of a lack of resources, tacitly support the establishment of orphanages in their areas to provide themselves with an option for the emergency placement of children in need of care.

Building regulations, currently in operation for the construction of children's institutions, offer a further complication. These have not been reviewed since the colonial era and impose urban building codes of a high standard and a Western style of architecture. The regulations are applied equally in rural areas and thus disallow the use of traditional building styles. As a result, rural orphanages are being built to modern urban designs, which are obtrusive and of a much higher quality than surrounding traditional huts. The inmates of the orphanage are thus perceived as especially privileged, leading to resentment and their stigmatisation by the local community.

Location

Thirty institutions (55%) were located in rural settings and the remaining 26 (45%) were situated in urban or peri-urban areas. Of the rural homes, 11 were part of large church missions communities, which commonly incorporated primary and secondary schools, hospitals, farms and supporting structures. Many of the remaining rural institutions were in remote and poorly accessible communal lands.

Seventy percent of homes established since the last study were located in rural areas. This trend may reflect the rising cost of land and construction in urban settings. While it may be argued that rural institutions give the children greater exposure to traditional culture, in reality, there is little interaction with the surrounding communities. In addition, children in rural homes are frequently disadvantaged in terms of access to quality education and, later, to formal employment.

There is an uneven distribution of children's homes in Zimbabwe (see Table 1) and this has resulted in children from poorly served provinces being referred to institutions far removed from their community of origin.

Table 1: Location of Registered Institutions

Province	Number of institutions for children in need of care
Manicaland	14
Mashonaland Central	3
Mashonaland East	8
Mashonaland West	5
Matabeleland North	0
Matebeleland South	3
Midlands	3
Masvingo	5
Harare	8
Bulawayo	7
TOTAL	56

Authority

Thirty-five institutions (64%) are run by Faith-Based Organizations. Pentecostal churches constituted a majority of these and this group was responsible for initiating and/or funding 76% of the new institutions constructed over the last decade.

Fourteen institutions (23%) are operated by local NGOs and 6 by foreign NGOs. One institution for OVC is run by the Department of Social Services.

Disadvantage of Rural Institutions

The growing trend to establish orphan "villages" in remote rural locations may be influenced by low land prices and farming potential, but children placed in these homes are significantly disadvantaged both educationally and socially.

Inadequate staffing and paucity of resources result in a generally poor standard of education in rural schools where only the exceptional child obtains a pass grade in leaving exams. Institutionalised children, who usually struggle academically, face an additional handicap by attending these schools.

Most youth growing up in the rural areas, although disadvantaged compared to their urban counterparts, have strong roots in their communities and enjoy a traditional right to land allocation if they fail to achieve academically. Institutionalised children enjoy no such right and on graduating, may be compelled to migrate to cities to live and find employment. Here, having had no previous experience of urban life, they lack the sophistication and connections to compete in the job market and are doubly handicapped by their sub-standard education.

By contrast, children growing up in orphanages located in cities have access to superior schools, have experience of urban life and develop a familiarity with modern technology. Their institutions often have established links with the local business community, which can facilitate their access to formal employment.

The trend to establishment new institutions in isolated rural communities, even if these are of the "village" model, should be discouraged unless family based and fully integrated with the local community. In addition to imposing a lasting disadvantage on their charges, they undermine the strong tradition of family and community care, which is generally intact in these communities.

Admission Policies

The vast majority of homes only admitted children through the Department of Social Services, although some accepted referrals through churches or the local leadership structures. One institution, catering mainly for street children, routinely admitted children and youth from a street children's drop in centre without reference to the Department.

Some homes offered private placements on the request of and at the expense of relatives. These homes have permission to do this under their certificate of registration however several instances were encountered of children being institutionalised by their parents in this manner while the parents went overseas in search of work.

Age and Sex Restrictions

The number of homes with restrictive admission policies has decreased compared with the 1994 study. All new homes admitted children of both sexes and did not transfer children to other homes when they reached a certain age. Several older homes, in which these policies had operated previously, have converted to family based models and abandoned the practice.

Only three homes persisted with a policy of transferring male children to another home once they reached 6 years of age. This practice is extremely traumatic and psychologically damaging for children and often resulted in the separation of siblings.

A number of family-based homes, restricted admission to children who were less than 8 years old, although children were able to stay in the home until they were18 years or more. This policy is designed to prevent the admission of older children and youth who may have

established social or emotional problems, which could disrupt the family environment. Over three-quarters of all institutions refused to accept street children, based on a similar rationale.

Integration with local community

Sixty-percent of homes had some community representation in their management structures and two-thirds reported some active community contribution in terms of cash or kind towards the running of the home. However, this support tended to come from prominent individuals in the community and there was often little involvement at a grass roots level.

Unfortunately, many homes continue to operate in isolation from their surrounding communities, focusing their efforts and resources exclusively on their own inmates.

This resulted in some communities developing a negative perception of the institution and this was more likely in rural settings. Because they normally had superior living conditions, children in these institutions were viewed as privileged. For example, orphans from a rural institution were the first to be excluded by a parents committee tasked with selecting children from the community for a school fee support programme (BEAM). Other institutions reported that their children were the only pupils to have uniforms and books at their local school.

These disparities caused resentment and increased stigmatisation of institutionalised children. Paradoxically, they also fuelled the perception within those communities that orphans are better off in institutional care. This undermines traditional care systems and leads to orphans, already placed within their extended families, being unnecessarily committed to institutions.

Institutions can do much to reverse these perceptions through the development or support of community based orphan care programmes in their surrounding communities. One urban home, which had provided residential care for 0 children, identified and assisted 1500 orphans in the suburb immediately surrounding the home

after it launched a community care programme. Another large organisation, which operates several residential facilities in Zimbabwe, reported that it had initiated a community based programme which was caring for orphans at a quarter of the cost of children in their institution.

Overall, twenty homes (39%) have initiated programmes to assist orphans and vulnerable children in the surrounding communities. This assistance commonly consisted of school support and feeding programmes. A few institutions have developed more sophisticated community based orphan care programmes, which include the training of community volunteers and psychosocial support activities.

Quality of Care

1. Facilities

To ensure valid assessment, visits to institutions were on the whole unscheduled and unannounced.

Two-thirds of the institutions were assessed as providing an adequate physical environment and half of these were rated as good to very good. The facilities in the remaining third were assessed as poor with 5 institutions being assessed as very poor. Almost without exception, institutions were found to be well ordered and to maintain a high standard of cleanliness. Low rating were more often a reflection of inappropriate design, poor maintenance or scanty furnishings than poor hygiene. In most cases these could be ascribed to a lack of financial resources. However, in many dormitory style institutions, an over-concern with tidiness and regimentation created an austere atmosphere and only a few of these facilities had created something approaching a relaxed family environment.

2. Quality of physical care

Nutrition

Although nutritional levels were adequate in all homes, the current economic crisis had made the procurement of sufficient quantities of food

increasingly difficult. Some homes had been able to source donor food and were receiving regular supplies of basic foodstuffs. However, poorly coordinated distribution networks prevented other homes securing food from this source.

Many rural and some urban homes had small scale farming projects and were able to supplement their food supplies. A few homes were self sufficient in food staples.

Complaints about the lack of variety and the quality of food, in particular the absence of meat from the diet in many homes, were the commonest issues raised by children in focus group discussions and in questionnaires. The situation is significantly worse than it was during the 1994 study and is likely to deteriorate further should the economic crisis deepen.

There consequently is an urgent need for the Department of Social Services to liaise with food relief agencies to develop mechanisms that will ensure that registered children's homes receive adequate supplies until the current food crisis is over.

Clothing and Hygiene

Most homes received regular supplies of second hand clothing from national and international donors and institutionalised children in general tended to be well clothed. A number of homes received surplus supplies of clothing and sold them to raise funds.

Because of rising costs, a majority of homes reported difficulties securing adequate supplies of bath soap and other toiletries.

Health

Health records

Only 32% of children had Health Cards confirming they were fully immunized and that their growth was being monitored. For children under 5 years, records were available in 51% children but for rural institutions the percentage was significantly lower. Most institutions assumed that children, who were 5 years or older at the time of admission

were fully immunized and no further action was taken if there was no documentation.

The low immunization rate may be more a reflection of poor record keeping than immunization status, as most institutions reported that their children were fully immunised despite the unavailability of records.

It should be mandatory for all institutions to maintain a current Health Card for children under 5 years showing an up to date immunization schedule and regular growth monitoring.

Hospital admissions

Almost half of the institutions admitted at least one child to hospital in the preceding year with a mean of four admissions per home. Hospitalisation was more commonly reported by institutions caring for infants and children under 5 years.

Many admissions were probably AIDS related. However infants cared for in nurseries in dormitory styled institutions are particularly prone to recurrent respiratory and diarrhoeal illnesses due to repeated cross infection in this susceptible age group. Historically, significant morbidity and mortality were recorded in children in this situation before the onset of the AIDS pandemic.

HIV and AIDS

Forty children's institutions (73%) indicated they were willing to admit children who were HIV positive and 80% of these were prepared to admit children who were ill with AIDS. Ten institutions have adopted a policy of testing all children on admission while others tested only when clinically indicated.

A total of 72 infants and children (2.5%) in 20 institutions had tested positive to HIV. Fifty-two of these cases were symptomatic. A further 171 suspected, but untested, cases were also reported.. The largest number of confirmed cases in a single home was 11 and 6 homes were caring for more than 6 cases. Of the suspected cases, 5 homes reported 10 or more with one home reporting 50 suspected cases.

Deaths from HIV/AIDS were reported from 19 homes in the last year with an overall total of 66 deaths, an average of 3.4 per home.

Half of the homes caring for children with AIDS were providing prophylaxis for opportunistic infection and seven homes were supplying or were in the process of supplying anti-retroviral therapy. A number of other homes were investigating the possibility of introducing this treatment.

The vast majority of institutions were confronting the problem of children with AIDS in a pragmatic and compassionate manner. No cases of stigmatization or rejection were noted and most caregivers had a sound knowledge of the disease and its management. Twenty of the larger homes had trained nurses on their staff and these homes were able to offer a better quality and continuity of care.

The question of disclosure to older HIV positive children and the management of the bereavement process with surviving "brothers and sisters" of those who die are some of the issues being dealt with by those in charge of institutions on a regular basis. Although most have evolved sensitive and insightful solutions to these problems, the need for a comprehensive programme of training to assist managers and caregivers to provide optimum treatment and support is clear. Clear national policies should be evolved concerning routine HIV testing for children entering children's institutions and on the availability of anti-retroviral therapy.

Disability

Although 11 facilities for the care of disabled children are registered with the Department of Social Services, 10 are boarding schools where children are resident during normal school terms, returning to their families for school holidays. These were not to be classified as residential institutions. Only two institutions provided long term institutional care specifically for disabled children. One large institution, which falls under the auspices of the MoHCW, currently caters for 54 children. Most of these children are severely disabled with mental, physical or mixed disability. The inmates ranged from 5-20 years with a majority being in the 12-18 year age group. There is a very high demand for places in this institution with a long waiting list and priority is given to children who, in addition to being disabled, are orphaned, abandoned or have other significant social problems.

Another small home in Harare, with places for less than 10 children, provides care exclusively for disabled children who are orphaned or abandoned. As is the case with the other two homes mentioned above, demand far exceeds the available places, and there is a waiting list for admission to each of these homes.

A newly registered, family-based institution for orphaned and abandoned children in Harare plans to admit selectively children who are disabled. It has received funding to construct a rehabilitation centre adjacent to

the residential care facility, which will be staffed by rehabilitation professionals and as well as catering for children in the institution, will also offer rehabilitation services to disabled children in the surrounding community.

Of the remaining institutions for children in need of care, 21 admitted disabled children with a total of 60 such children being cared for at the time of the study. A majority of homes (60%) declined to accept children with disability usually citing a lack of facilities as the reason.

Disabled children impose a burden of care on their families especially the single parent who may be unable to engage in employment for this reason. Such parents frequently try to have the child admitted to care or abandon them. Abandonment not infrequently takes place in hospital during an admission for a disability-related problem. Similarly, relatives are reluctant to take on disabled children who have been orphaned, because of the increased burden of care. It follows that there is considerable demand for the placement of disabled children in institutional especially for those with a severe degree of disability.

3. Care giving

The quality of care-giving varied widely. It tended to be best in family-based homes in which surrogate mothers were mature women, who had raised their own families and who had received the added benefit of a formal training in child-care. At the other end of the spectrum, young, single girls with no training or experience in raising children were employed as caregivers in dormitory style institutions.

Although no evidence of abuse or neglect by caregivers was uncovered during visits by the study team, questionnaires administered to youth in ten sample homes indicated that cases of verbal abuse, through repeated taunting and humiliation of children

about their orphan status, were common. This was more frequent in dormitory styled homes and those in which there was no formal training in child care.

Physical abuse, with beatings being administered as a form of punishment, was reported by youth in several dormitory styled homes. No case of sexual abuse by caregivers was reported.

Care-giver to child ratio

The overall child to caregiver ratio was 7.1. Family based homes averaged 6.1 children per caregiver and dormitory style 8.6. These figures are significantly better than those in the 1994 study in which the ratios were 8.5:1 and 24:1 respectively. These figures may reflect an improved awareness of the importance of meeting children's psychosocial needs.

Wasted Opportunity

The study team's visit to one institution coincided with the end of the school term and children were observed returning with their school reports. They presented them to the administrator who placed them in a file, barely glancing at them and without comment. Some children had clearly done well and craved recognition, but no words of praise or encouragement were given.

Making institutionalised children feel special and constantly building their self esteem is a critical function of caregivers but training is essential to ensure that this is understood.

Training

Formal training programmes for caregivers had been instituted in 50% of dormitory styled homes and in 70% of family-based homes. Several larger institutions have developed their own in-house training and offered training to caregivers from smaller institutions. However the majority of institutions took advantage of programmes offered by the Zimbabwe National Council for the Welfare of Children and the Zimbabwe Red Cross Society. While 80% of urban institutions had implemented caregiver training, only 47% of rural institutions had done so.

Surrogate parenting

The majority of family based homes adopted a policy of employing only women as surrogate parents. Single, widowed or divorced women were preferred in this role, although a minority were married with families of their own. Married couples were generally not accepted with concerns that the husband might abuse older girls being the most commonly advanced rationale. However, no problems of this type were reported from the homes that accepted married couples. Most managers did not think it necessary for families to have a male role model. In some homes, a male head of the institution was designated to fulfil this role for up to 120 children.

A majority of family based institutions had a policy of not allowing the biological children of the caregiver to live in the family units because of fears that the mother might favour her own children. These biological children were usually placed in the care of relatives and were visited by their mother on her off-days. The irony of a situation in which children were deprived of their biological mother so that she could fulfil this role for others did not seem to be appreciated by the management of these institutions.

Conclusions

Residential institutions for children have continued to proliferate

Despite government policy and sustained advocacy by international child welfare

organisations, residential care facilities for children have continued to proliferate in Zimbabwe. Correspondingly, the number of children in institutional care has doubled in the last 10 years. Foster, in his study of the response of faith-based organizations to the AIDS pandemic, identified a similar increase in residential care facilities in other countries in the Sub-Saharan region[22]. In Zimbabwe, faith-based organizations, especially Pentecostal/non-conformist churches, have been largely responsible for this proliferation.

Although some of these organisations appeared to be unaware of government orphan-care policy and of alternative and more acceptable modes of care, others were convinced of the benefits of residential care over other forms of community care. These were determined to established institutions despite expert advice to the contrary. Reasons commonly advanced for adopting this approach included: i) the concern that orphans were at risk of abuse and/or exploitation in their extended families. ii) the belief that residential care was efficient and permitted the orphans to develop under supervision in a controlled environment. iii) an anxiety that funding directed to extended families or CBOs was difficult to monitor and might be misused.

Organizations and individuals wishing to develop projects to assist orphans and vulnerable children must be fully informed of government policy with regards to orphan care. However, it is apparent that some organizations will insist on continuing with their preconceived plans and ignore official recommendations. It is clear that if the construction of institutional care facilities in Zimbabwe is to be properly regulated, the DSS must firmly assert the authority given to it by the Children's Protection and Adoption Act. This will require a review of the current registration process and regulations controlling the construction of institutions.

There is a continued emphasis on meeting physical needs

Although there has been an encouraging move by several old dormitory styled institutions to convert to family based models, a majority of new institutions were still constructed utilizing the

[2]Study of the Response by Faith-Based Organisations to Orphans and Vulnerable Children, Foster, G. (Draft) Unicef 2003

dormitory style. This is in spite of the fact that this form of care denies children their right to a family life and has the potential to cause prolonged psychosocial impairment. A strong focus on meeting physical needs coupled with a lack of awareness of a child's equally important psychosocial needs appears to underlie this trend.

However, there appears to be a growing appreciation of the benefits of family based care and the managers of a number of old and new dormitory styled institutions expressed a wish to convert. Most cited a lack funds as the major constraint. Here they may have been influenced by several misconceptions. Firstly, many believed that the change would involve the construction of new, free-standing houses and had failed to consider the possibility of converting of existing dormitories to family apartments. Secondly, they believed the running costs of family based homes were significantly higher. They failed to appreciate that, as in normal family situations, older children in family-based units contribute to the care of younger siblings and help with household chores, thus reducing overall staffing requirements.

The conversion of all existing dormitory style institutions to family based homes should be treated as a matter of priority and the construction of any further institutions of this type prohibited.

significant numbers of potential foster-parents. Most fostering couples preferred infants under six months of age and declined to accept financial support. The main limitation of such programmes may be the lack of capacity in the DSS to process the applications. However, this may be overcome by specifically assigning officers to this task.

Foster-care provides an effective means of preventing the long- term institutionalisation of infants in Zimbabwe and its promotion should be supported.

Institutions can play a wider role in the provision of care for OVC

A number of institutions in this study have developed innovative programmes to assist OVC in the surrounding communities. These programmes vary in scope from assistance with school fees and material support to more comprehensive initiatives, which include facilitating the establishment of community based organizations for orphan care and the training of community volunteers.

Formal foster-care can be successful in reducing institutionalization

Several successful programmes promoting formal foster-care were identified in the course of the study. Donor funded media and community focused awareness campaigns were effective in recruiting

The human and material resources contained in many residential care facilities, especially those in rural areas, can make a valuable contribution to community efforts to assist orphans and vulnerable children. By offering access to office space and equipment, communications, transport and skilled personnel, institutions can improve the capacity of communities to organize and provide care.

The community orientated programmes already established have been successful in extending the caring capacity of institutions, with up to a ten fold increase in the number of OVC receiving assistance. They improved integration and acceptance of the institution by the community and more importantly, has led to a reduction of stigmatisation of institutionalised children by the community members.

Ideally, an associated programme of supported, community foster-care of children from the institution should be encouraged with the aim of gradually transforming of the institution into a short-term place of safety with a significantly reduced number of children. The facilities thus freed up may be utilized for the establishment of community preschool/day care centres, youth clubs, etc.

Networking and sharing of experience is key to improving standards in institutions

The study revealed a wide variation in the skills and resources available to institutions. A number of large institutions that enjoyed support from international donors have developed their own training facilities for care-giving staff as well as comprehensive vocational training programmes for youth. One is already offering scholarships and training to staff and youth from less well-resourced institutions. Several smaller institutions have excellent projects to build self-esteem and independence in youth. While others have extensive experience in supporting orphan care programmes in surrounding communities.

Unfortunately there is no effective sharing of this wealth of experience. Training workshops have been organized by the Zimbabwe National Council for the Welfare of Children and others but a more comprehensive and inclusive programme is required. Previous experience indicates that exchange and networking visits for both staff and institutionalised youth is an effective way of transferring knowledge and innovation.

An expanding role for large, well-resourced institutions in mentoring and assisting smaller, less well endowed facilities should be encouraged and is deserving of donor support.
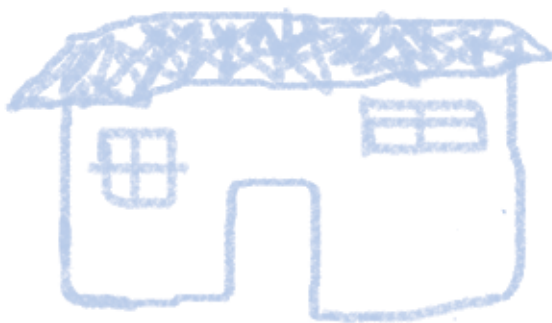
Results of file analysis

This section reports the analysis of all case files of 627 children from a representative sample of 10 institutions. There was equal representation of urban and rural locations and of family based and dormitory style institutions. Comparison was made with the findings of a similar study in 1994. Children in remand and probation facilities were not included in the current study.

The study showed a preponderance of males (60%) in care. This may reflect the perception that the extended family prefers to offer care to girls because education of the girl-child is not viewed as a necessity and they can provide cheap domestic labour.

The average age of children in institutions has risen over the last decade, with increasing numbers of children over the statutory age limit of 18 years. This reflects the fact that the preponderantly young children who filled institutions to capacity a decade ago are now maturing. It is also indicative of the failure of institutions to develop effective transitional policies.

A growing proportion of the institutional population is now in secondary school. As well as significantly increasing educational costs, this has implications for the modalities of care provided. Teenager's needs are different from those of younger children and institutions will have to adapt care strategies to meet those needs.

Fig 1: Age and Sex of Children n=501

Male
Female
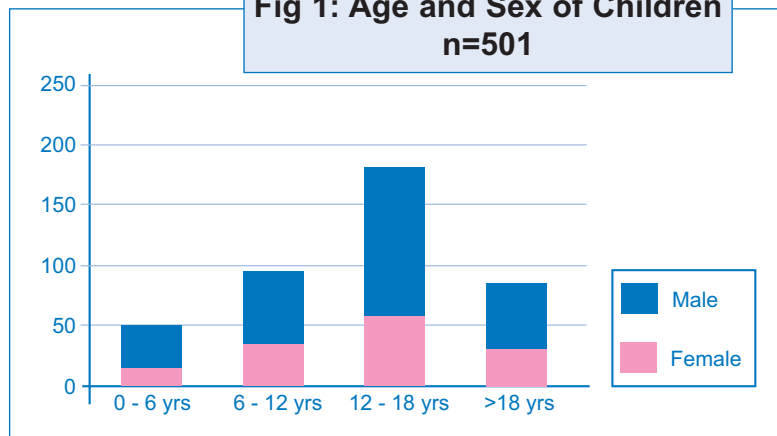
Fig 2: Age Range 1994 – 2004
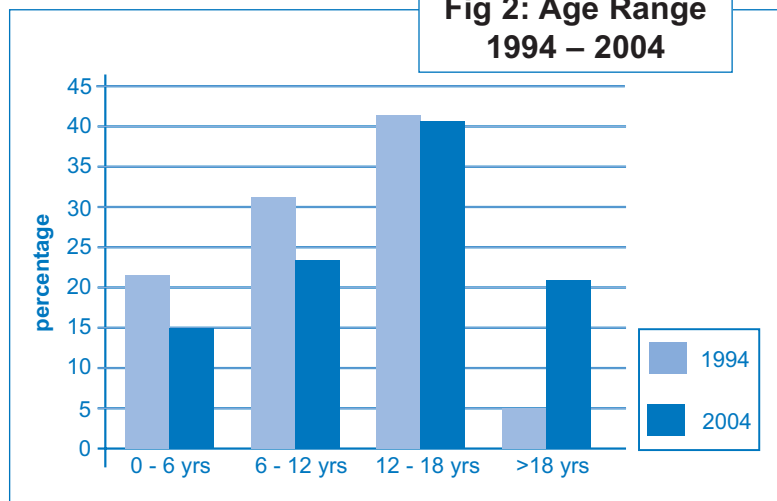
1994
2004

Fig 3: Duration of stay 1994 – 2004

1994
2004

Fig 4: Referral routes n=620

Relatives were responsible for a significant number of referrals. This was often motivated by the belief that orphans are "better off" in institutional care as their physical and educational needs were likely to be met, at a much higher standard than they themselves could hope to offer. It is likely with appropriate counselling and support, many of these relatives would be prepared to provide care.
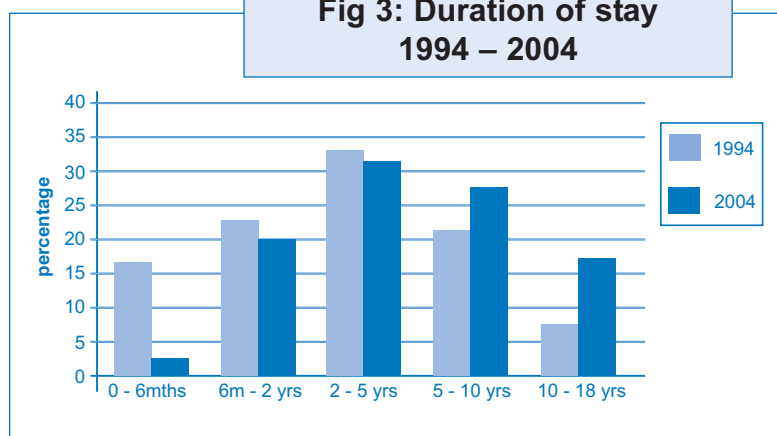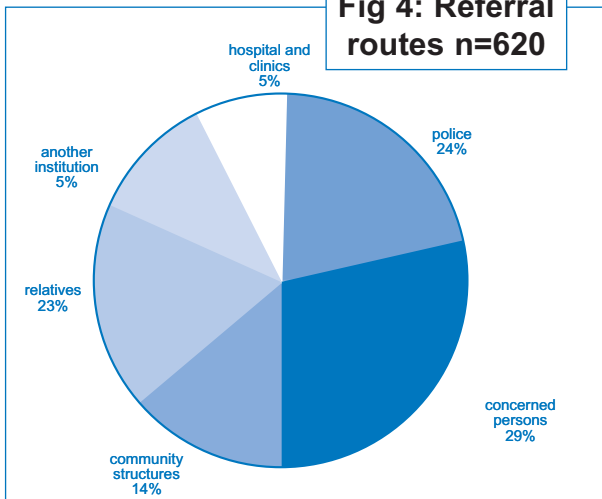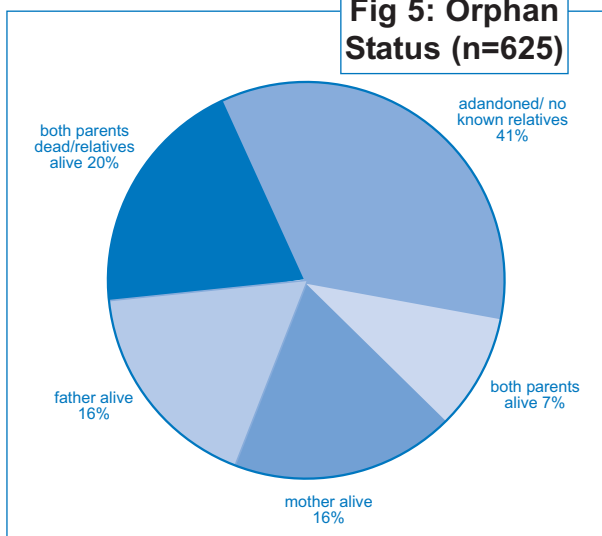
Abandoned children are frequently referred by the concerned community members who discover them. Community structures which include churches, community nurses, teachers and welfare organizations also constitute a significant referral source.

Fig 5: Orphan Status (n=625)

The study found that a minority of children (41%) had no identifiable relatives and that in 39% of cases, one or both parents were alive. In the remaining 20% of cases, the children were double orphans but had contactable relatives. (Figure 5)

Comparison with the 1994 study demonstrated a decrease in the number of children with both parents alive (7% vs. 22%) and a significant increase in the proportion of children with no contactable relatives (41% vs. 25%). This may be an indication of the maturing AIDS epidemic and perhaps a more selective admission policy targeting those children with no extended families.

However, both studies confirm that the majority of children in institutional care have contactable relatives and have the potential of being re-integrated into their families.

Economic Orphans

A disturbing phenomenon identified during the study was the use of orphanages to care for children of Zimbabweans who have emigrated to Western countries in search of better paid employment.

Many children are left behind in Zimbabwe so that their parents, fleeing the current economic crisis, can work unencumbered overseas. The more fortunate are cared for by their extended families, while others are enrolled in boarding schools, staying with relatives during holidays. However, a number of these children are being admitted to orphanages, which offer "private placements" as a means of generating income. Some institutions have a clause in their registration certificates permitting these fee-paying arrangements.

It is regrettable that this latter group of children are being unnecessarily denied a normal family life and are subjected to the same emotionally deprived environment as their orphaned colleagues.

In half the cases, abandonment was recorded as the reason for the child being in care. This is a significant increase compared to the findings of the previous study (50% vs. 27%). Although partially accounted for by a decrease in the number of children admitted for behaviour problems (Probation Hostels and remand homes were not included in his study), the dramatically worsening economic situation in Zimbabwe is probably a major factor contributing to this change.
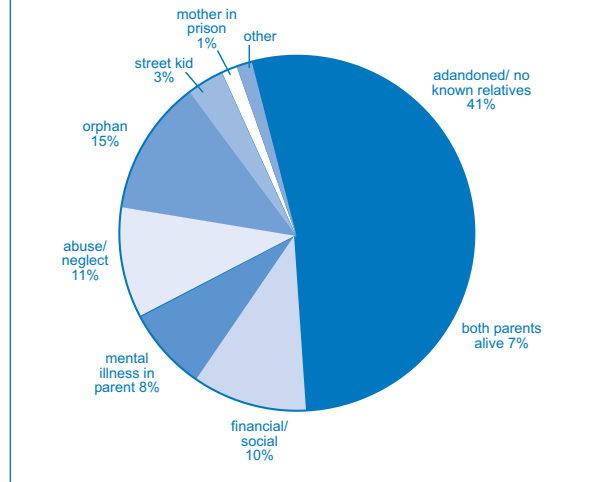

Fig 6: Reason for being in care n=515

mother in prison 1%
other
street kid 3%
orphan 15%
abuse/ neglect 11%
mental illness in parent 8%
financial/ social 10%
adandoned/ no known relatives 41%
both parents alive 7%

Street Children

Most homes had a negative perception of street children. A number reported past experience of street children repeatedly absconding, stealing and exhibiting antisocial behaviours. It was widely felt that they were disruptive and a bad influence on other children. As a result, many institutions had a policy of refusing to accept street kids while others limited the age of admission to children less than 8-10 years for the same reason. This experience emphasizes the importance of removing young children from the streets before sociopathic behaviours become ingrained.

With a few exceptions, homes had difficulty dealing with behaviour problems in older children. Disciplinary measures, which in some cases included beatings, were usually instituted without counselling or attempts to understand and treat the underlying cause. Several cases were reported of children with behaviour problems being transferred to government training institutions (reform homes), with the approval of their probation officer, but without supportive counselling or therapy.

A number of street children's organisations operate "drop-in centres" in Harare and other cities in Zimbabwe. These provide short-term shelter, food, counselling and health care for street children and

youth. All had programmes to re-unify children with their families which included support in the form of school fees and or food to the family if required. One organisation had commenced a programme of community foster-care for those street children who had no contactable relatives.

The two organisations interviewed in Harare reported an increase in the number of orphans on the streets and estimated that they now account for approximately 50% of the street child population. Step-parentage and poverty were the other common reasons for children being on the street. Very young children were being brought on to the streets by parent(s) for the purpose of begging. These findings were similar to those in a previous study[23].

Both organisations reported rampant sexual abuse of both sexes, but was more commonly reported in girls. One organisation stated that almost 100% of girls on the street had been abused and there was a high prevalence of STDs and pregnancy among these children. The perpetrators were often older street youth, but children of both sexes were lured into prostitution or were victims of paedophiles.

Street children are at high risk from HIV/AIDS and those that do not succumb to the disease are likely to suffer permanent psychological and sociological damage[24]. As the experience of residential institutions suggest, attempts to rehabilitate children, who have been on the streets for a prolonged period of time, are seldom successful. It is therefore imperative to remove new arrivals on the streets as soon as possible. Programmes, which provide temporary shelter while investigations aimed at family re-unification are carried out, should be supported. For cases in which re-unification is not possible, community fostering or formal foster-care should be explored.

[23] Muchini, B. and Nyandiya-Bundy, S. (1991) Struggling to Survive: A Study of Street Children in Zimbabwe
[24] Rutter, M. (1985) Psychopathology and Development: Links between Childhood and Adult Life.
Child and Adult Psychiatry: Modern Approaches. Blackwell Scientific Publications

Siblings in Care

Only eight percent of children had one or more siblings in care but in half of these cases the sibling was in a different institution. This family disruption was usually brought about because of age or sex restrictions in dormitory styled homes.

Birth Certificates

Sixty-five percent of the 638 children in the sample did not have birth certificates. This is identical to the figure recorded in the 1994 study.

This problem is not restricted to children in institutions and despite sustained advocacy on this issue by child welfare organizations in this country, little progress has been made in redressing the problem.

Almost without exception, managers of institutions regarded the issue of identity documents as one of the most challenging problems they faced and many complained of the frustrating bureaucracy encountered in trying to secure these documents for their charges.

Children without birth certificates have difficulty accessing education and other government services. It is particularly problematic for youth after discharge from care as they are unable to secure identity documents, open a bank account, register for employment, etc.

Contact with the community

Only sixteen percent of children in the Children's Home sample were recorded as regularly spending holidays out of the home. Half of these children visited relatives, a quarter their parent(s), and the remainder went on holiday fostering.

Lack of contact with the local community and the outside world in general was a major issue raised by children in questionnaires and focus group discussions. Apart from attending local schools, many children are confined to their institutions for years and had little experience of the outside world.

Fig 7: Delay in Court Orders
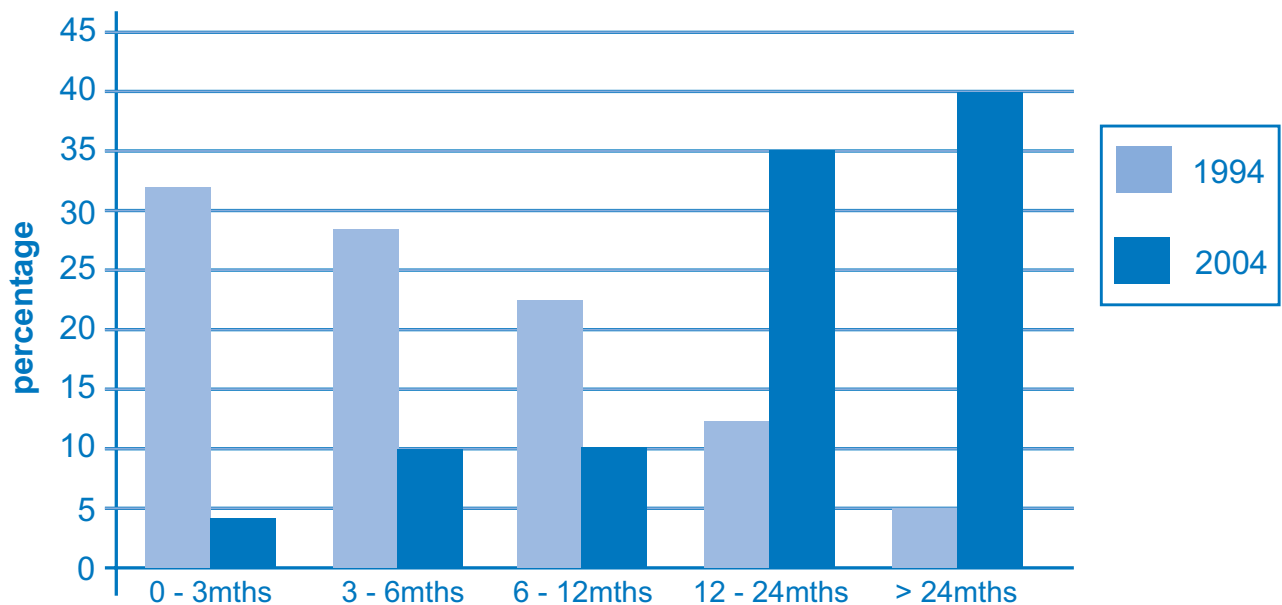
Juvenile Court Orders

Delays in the renewal of court orders continues to be a concern for administrators of children's institutions. Renewal is necessary for accessing government per capita grants and this source of income is frequently delayed or discontinued for this reason. A similar situation prevails with children admitted on Place of Safety Orders. In this case, grants are not paid until the child is formally committed, when they are paid retrospectively.

Sixty two percent of children did not have a valid court order. Of these 47% had expired and in the other 15% there was no record of a court order in the file. Eight percent of children were on place of safety orders.

Comparison with the situation in 1994 shows a remarkable increase in the delays in renewing court orders and in 40%, delays now extended beyond 2 years. (See Fig 7)

Conclusions

Poverty is the major underlying cause for the institutionalisation of children

The single most important factor contributing to the admission of children to institutions is poverty. Relatives, although often willing, are unable to offer care because of a lack of resources, particularly for education. Rapid economic decline and rising unemployment over the last 5 years have greatly aggravated the situation.

Although Zimbabwe has effective policies and legislation to control the admission of children to institutional care and for their subsequent supervision and ongoing review, these have been rendered ineffective by the exodus of professional staff from the responsible ministry and lack of resources.

The situation in institutions themselves has deteriorated over the same period. Care Staff are demoralised and demotivated because of low remuneration and it is becoming increasingly difficult to meet the children's physical needs

The current social and economic crisis is having a devastating effect on all Zimbabwean children. However the impact on orphans and other children affected by AIDS is even greater.

Institutions contain increasing number of children without contactable relatives

The study found that the number of children in institutions who had no contactable relatives had increased significantly since 1994. While this is probably a reflection of a maturing AIDS epidemic, it may also reflect a more selective admissions policy. This finding implies that family re-integration will be impossible and alternative forms of care will have to be utilized for their de-institutionalised. Of the 3 available options, adoption, formal foster-care and informal community fostering, only the last two are realistic options.

The average age of children in institutions is rising

The infants and toddlers who filled institutions to capacity a decade ago are now teenagers and relatively few young children have been admitted in the intervening period because institutions remained at full capacity. This has created a challenge for the management of institutions now confronted with an increasing population of youths who have different needs and problems than the youngsters they were used to. The normal difficulties of adolescence are compounded for institutionalised youth by low self-esteem, lack of identity, paucity of life skills and the need to prepare for an independent existence outside of the institution.

Most Zimbabwean institutions are geared to caring for infants and children and have failed to anticipate this transition. This is evidence by the rising number of youth over the age of 18 years who are being retained in institutions because they have not been equipped with the skills necessary to survive in the outside world.

Transitional programmes, which include psychosocial support, skills and vocational training and planned re-integration of youth into the community, need to be developed in most institutions as a matter of urgency.

Lack of resources in the DSS contributes to institutionalisation

Although the proportion of children in residential care who have no contactable relatives has increased over the last decade, it still represents less than 50% of the total. Therefore the majority of children in residential care have at least the potential of being successfully re-integrated into their families. Foster-care remains a realistic option for some of those without relatives.

The study has revealed a dramatic increase in the time taken for probation officers to secure and renew court orders. This is an indication of the catastrophic decline in numbers of skilled staff and resources available the Department of Social Services over the last decade. The implication is that many children may be placed in residential care unnecessarily and once admitted, will remain permanently in care until at least the age of 18 years. The statutory reviews by probation officers, with their potential for transfer to an alternative and better form of care, can no longer be relied upon.

Access to birth certificates remains a major problem

Although lack of access to birth certificates adversely affects hundreds of thousands of Zimbabwean children, the problem is more critical for those in institutions. If discharged from residential care without identity documents, orphaned and abandoned youth, without established roots in the community, face constant harassment by police and find it impossible to secure formal employment.

Although the right to identity documents is specifically enshrined in the CRC, the Registrar General's Office has been slow to address this

national scandal. While sustained lobbying by child welfare organisations, has been successful in forcing the Registrar General's Office to agree to a decentralized and simplified birth registration process, implementation of these changes has been very slow.

Street Children are at highest risk of all OVC groupings

The extreme reluctance of many institutions to admit street children was a strong indication that many of these children have suffered irreversible social and psychological damage by the time they are removed from the streets and do not respond to efforts to assimilate them into a stable family environment.

Sexual exploitation and drug abuse are highly prevalent in this group and even the youngest children are at tremendous risk from HIV/AIDS. Those that survive are likely to be brutalised, developing sociopathic tendencies and entering into a life of criminality. Repeated round-ups of street children are futile as they do not address the underlying problems and children soon return to the streets.

Despite the very serious implications for these children and for society in general, there has been little donor interest in providing significant funding to address the problem. This may reflect donors' experience in other countries where street children's programmes have generally yielded disappointing results. It is probable that many of these failed attempts to rehabilitate street children have been made after many children have already suffered irreversible damage.

Strategies which target recent arrivals on the street, with the highest priority for children under 12 years, are likely to have more success. Aggressive re-integration programmes utilising shelters and with funds available to support education and extended families can be successful in permanently removing many youngsters from the street.

One hundred and eighty-nine children in the 14-18 yr at 10 institutions completed three questionnaires designed to elicit their attitudes to institutionalisation and to assess their psychosocial well-being. Children from family based and dormitory styles homes were equally represented and homes from urban, peri-urban and rural locations were selected.

Following completion of the questionnaires, focus group discussions (FGDs) were held with these children. The groups were conducted by two final year social work students who had undergone training in the conduct of FGD. Group numbers were limited to 10, and staff from the institutions were not privy to the discussions.

The three questionnaires administered were:

a) Self Reporting Questionnaire (Appendix 2) which has been previously validated and which had been utilised in the 1994 study. The questionnaire gives a measure of psychological disturbance with a score of greater than 7 regarded as significant.

b) Social Workers Questionnaire

c) A general questionnaire (Appendix 3) designed to elicit responses from the children with regards to their attitudes and concerns regarding institutional care.

Focus Group Discussions

The most frequent concerns raised by children in the groups were as follows:

- Lack of consultation on issues affecting them.

- Emotional abuse by care-givers and management, particularly being taunted about their orphan status and of their parents having died of AIDS.

- Being confined to the institution and having no freedom to interact with the local community.

- Lack of activities and/or entertainment.

- Not being given pocket money for school lunches and to spend on personal needs.

- Inadequate and poorly cooked food.

- Being given too much work and responsibility in the institution

- Youth complained of physical abuse at 2 institutions and this consisted of severe beating from the heads of homes and staff for misbehaviour. Both institutions were dormitory style.

- Lack of a transitional programme. Children not being adequately prepared and supported for eventual discharge from the institution.

Physical needs were more commonly an issue for children from rural institutions who complained of a lack of food and entertainment. Some also complained the amount of manual work they were expected to perform, particularly in the institution's gardens.

Emotional abuse and taunting by caregivers was a common complaint in dormitory styled institutions and infrequent in family based homes. Children were obviously very sensitive about this and found it extremely hurtful.

Several children in institutions operated by faith-based organisations complained that they were not able to attend the church of their choice and were compelled to adopt the religious persuasion of the host organisation.

Questionnaire

The responses of the 212 children to open ended questions regarding their attitudes and concerns about institutionalisation were summarised in order of frequency. Only those responses made by more than 5% of the sample were included. Less than half of the sample were orphaned or abandoned and a majority had contactable relatives.

Who do you talk to about things that worry you?

- A friend in the institution (28%)
- No-one (26%)
- Matron/warder (10%)
- Care-giver (10%)
- Parent/relative (10%)
- God (10%)
- Pastor/teacher (5%)

Do adults consult you about your needs or wishes?

- Yes (47%)
- No (53%)

No difference between family based and dormitory styled homes.

Do you worry about the future?

- A lot (43%)
- Sometimes (45%)
- Never (10%)

Do you have relatives who visit you or whom you visit?

- Yes (51%)
- No (49%)

What is the best thing that ever happened to you ?

- Being given the chance to go to school
- Being visited by relatives
- Going out of the institution for trips/entertainment
- Being taken for holidays by foster parents
- Securing a sponsor or foster parent
- Being taken into care
- Becoming a Christian and knowing God
- Going out of the institution on trips

What is the worst thing that ever happened to you?

- The death of parents/orphan hood
- Physical and verbal abuse by staff at institution
- Being rejected, deserted or dumped by parent(s) or relatives
- Separation from parents and siblings
- Being ill-treated by step-parent
- Never knowing my parents or relatives
- Being separated from my siblings and/or friends
- Being discriminated against

Twice Orphaned

In the course of the study the research team interviewed Nyasha, a 21 year old woman who had grown up in a family unit of one of the best resourced village-style institutions in Zimbabwe. She described how she had been taken into care at 5 years of age following the death of her mother. Over the next 7 years she developed an extremely close and loving relationship with her new "mother", who was the care-giver in her family unit. However, when she was 12 yrs old, her "mother" had a dispute with management of the institution and abruptly left their employ.

Nyasha recounted how this was the most devastating experience of her life and it affected her much more deeply than the loss of her natural mother. She felt betrayed by adults and never tried to develop a close relationship with her "mother's" replacement in case she was "let down" again.

What things worry you the most?

- The future after leaving the home
- Not knowing or not being visited by parents/relatives
- Continuous taunts and scolding by care staff, especially with regard to orphan status
- Physical abuse by staff at institution
- The threat of expulsion from the institution before I am able to care for myself

If you could have three wishes, what would they be?

- To have foster parents
- To receive visits from relatives
- To live in a normal family
- To acquire a birth certificate

- To have someone with whom to share worries

If you had the opportunity, what changes would you make in your children's home?

- Improve quantity and quality of food
- Improve physical environment, furnishings, etc.
- Allow freedom of worship
- Improve recreational facilities and allow greater freedom of movement
- Source more donations
- Provide pocket money for children
- Introduce vocational training and a transitional facility for older children
- Find foster-parents for children
- Acquire birth certificates for children

Self Reporting Questionnaire

This instrument which measures psychological disturbance was administered to 189 youth 15 years and above at 10 institutions. Dormitory and family based models were equally represented.

Overall, 41% of the youth had scores that were indicative of psychological disturbance (>7). Previous studies of urban and rural youth living outside residential care have shown an average score of 23%. As in the 1994 study, youth in dormitory styled institutions scored higher than those in family based (44% vs. 29%). In 4 out of 5 dormitory models, more than half of the youth had significant scores.

Bedwetting

The study revealed bedwetting to be a problem in virtually all institutions visited with approximately 25% of children over 5 yrs of age regularly wetting. This prevalence is significantly higher than that recorded in normal populations[25].

Age	Institutions	Normal Pop.
> 5 years	24.70%	5-3%

Chronic psychological stress occurring during the toddler period is associated with delay in the achievement of nocturnal bladder control. The high prevalence of bedwetting noted in this and the previous study may be indicative of ongoing psychological disturbance.

Many caregivers dealt with the problem inappropriately by drawing attention to the children by grouping them in a special dormitories. Teasing or scolding was also reported. The embarrassment and humiliation experienced, especially by older bed-wetters, tends to re-enforce the problem and leads to an increased loss of self esteem.

As well as the psychological disturbance experienced by the children themselves, the high prevalence of bedwetting imposed a significant burden on staff through the daily requirement of washing bed linen and carrying mattresses and blankets outside for drying. In several homes in which the response of the staff was inadequate, dormitories smelt strongly of urine.

Conclusions

Importance of maintaining links with family and community

It was clear that many children in institutions feel a deep need for family attachments and to have some permanent connection to the world outside of the institution. Many expressed a strong desire to trace parents or relatives and valued visits by relatives very highly. This acute awareness of a void in their lives was also apparent in their response to questions about their future. A large number of children wished for a happy marriage and to provide their children with a loving family life.

[25]Behrman et al Nelson's Textbook of Pediatrics.

The strong desire to contact relatives or to acquire foster parents or sponsors may in part be informed by concerns about what would become of them once they left the institution at 18 years. Many worried about what would become of them once they were discharged from the institution at 18 years. They recognised the need for a process of preparation including vocational training and increasing responsibility and independence.

Need for a focus on initiatives to meet psychosocial needs

Feelings of abandonment and/or rejection by their extended families were common and contributed to a lack of self-esteem in the youth. They were acutely sensitive about their status (or lack of it) as orphans and deeply resented taunts and comments alluding to this by caregivers or peers from outside of the institution. Emotional abuse of this type was more prevalent in dormitory styled institutions.

An issue, raised by children in the majority of homes, was boredom. Children were commonly confined to the institution when not at school and have little or no interaction with the surrounding communities. Children craved visits or activities outside of the home and holiday camps and exchange visits with other institutions were very popular. Boredom was a greater problem for children in homes situated in isolated rural areas.

Need to develop transition and vocational training programmes

The collapse of the Zimbabwean economy and resultant contraction of the job market have made the task of re-integrating youth at the age of 18 years more difficult. All institutions were aware of the need to prepare for this transition, but only 40 % had formal programmes in place to address this.

The typical transition programme provided youth over 16 years, with separate accommodation, more independence and responsibility for managing their day to day lives. Typically, the youth were given a monthly budget and were

responsible for purchasing and preparing their own food. They enjoyed greater freedom of movement and were able to interact much more freely with the surrounding community.

However, many homes made no attempt to prepare youth for the transition. Most assumed that on discharge, youth would simply rejoin their extended families. Ironically, this was frequently possible. Many heads of homes commented cynically, that relatives, who had previously refused to provide care, were happy to resume responsibility once the child had been educated and could make a positive contribution to the family. This was particularly so in the case of girls approaching marriageable age and the prospect of collecting roora (dowry) arose.

Institutionalised youth recognized the need for vocational training and transition programmes as reflected in their responses in FGD and questionnaires. Many listed concerns about what they would do when discharged from the institution as the thing that worried them most. Some large and well-resourced homes had instituted their own vocational training programmes in areas such as agriculture and engineering and one was able to offer scholarships to youth from smaller homes.

Recommendations

Government of Zimbabwe

The Government of Zimbabwe, as a signatory to the United Nations Convention on the Rights of the Child, must ensure that the rights guaranteed under the Convention are available to all Zimbabwean children. In the case of institutionalised children, the following rights are of special importance:

- The right to an identity
- The right to experience family life
- The right to be consulted on matters concerning them
- The right to be protected from abuse

Department of Social Services

The Department of Social Services should:

- Exercise the authority vested in it to regulate the establishment of residential institutions fully. In doing so it should introduce a two-step application process which would consist of an initial application, accompanied by a detailed proposal document and building plans, for permission to proceed with the construction of an institution. If successful, a second application for inspection and consideration of full registration to be submitted after completion of construction work.

- Develop a brochure summarizing the National Orphan Care Policy to be made available to all organizations and individuals wishing to initiate OVC programmes in Zimbabwe. The brochure should set out government's funding priorities in this area and explain the protocol to be observed in the establishment of such programmes.

- Review laid down minimum standards for construction and operation of children's institutions to bring these in line with current concepts of institutional care.

- Introduce compulsory certification of care staff employed in institutions through a process of training and examination and incorporate a maximum child to care-giver ratio into regulation governing institutions.

- Review the current generic approach to casework to allow specific social workers to be assigned responsibility for children in care. These designated social workers would assume the role of probation officer for all children in residential and foster care within their assigned geographical region.

- As a matter of policy, forbid the construction of new dormitory styled institutions and de-register existing dormitory styled homes which have not converted to family-based homes within a specified period of time. The DSS should lobby donor agencies to assist institutions to secure funding for this transition.

- Ensure that its officers are familiar with the principles guiding the care of orphans and vulnerable children. In particular they should be aware of the detrimental effects of institutionalisation and the potential of foster-care as an alternative to institutionalisation.

- Ensure that sufficient resources are made available for the efficient and timeous processing of applications for formal foster-care and adoption of infants and children.

Zimbabwe National Council for the Welfare of Children

The ZNCWC should:

- In cooperation with the Department of Social Services, adopt a leading role in the development and implementation of a National Standard of Care Index for residential care facilities in Zimbabwe. In furtherance of this role, it should provide coordination and technical assistance for activities designed to improve standards of physical and psychosocial care in Zimbabwean institutions and promote cooperation and mutual assistance between them.

- Ensure that basic training in child-care and psychosocial support is mandatory for all care staff in residential institutions. Training programmes should be standardised and access widened to ensure that care staff from all institutions benefit. Donor funding should be utilised for this purpose and large institutions, which have developed their own programmes, should be supported through donor funds to offer scholarships to staff from smaller homes to participate.

- In consultation with the DSS and MoHCW, develop a standardised policy for children in residential care who are infected with AIDS which would include guidelines on issues such as testing, treatment, care and disclosure.

- Introduce a programme of networking visits and exchanges, both for staff and children between institutions. In conjunction with these, there should regular workshops for

heads of institutions for capacity building and to allow them to share experience. Large, well-resourced institutions should be assisted to provide a mentoring role for smaller institutions.

- Develop a programme to assist institutions with the problem of bedwetting a mandatory component of caregiver training and bedwetting alarms, which can produce a rapid and permanent cure of bedwetting in older children, should be available in all children's institutions and staff trained in their use.

Institutions

Institutions should:

- Convert dormitory styled institutions to family based units, either through re-modelling of existing buildings or through construction of new units. Donor funding should be sought for this purpose where necessary.

- Family–based units should be encouraged to employ married couples as surrogate parents in order to provide a father figure. They should also permit the young biological children of caregivers to be incorporated into the families.

- Provide for the increasing number of youth who will reach the age of 18 years through the development of transitional and vocational training programmes which will equip them with the necessary skills for independent living and employment. Such programmes should guarantee ongoing contact and support by the institution after discharge. Larger, well-resourced institutions should assist smaller institutions with vocational training through technical support and scholarships.

- Develop and/or support community based orphan care programmes within their surrounding communities. Large institutions with established community programmes should provide technical assistance to smaller, less well resourced institutions to develop their programmes.

Donor Agencies

Donor agencies should support these activities by:

- In cooperation with the DSS and ZNCWC Ensure that basic training in child-care and psychosocial support is mandatory for all care staff in residential institutions. Training programmes should be standardised and access widened to ensure that care staff from all institutions benefit. Donor funding should be utilised for this purpose and large institutions, which have developed their own programmes, should be supported through donor funds to offer scholarships to staff from smaller homes to participate.

- Make funds available for the conversion of dormitory styled institutions to family based homes. Such funding should include provision for the selection and training of care staff for his transition.

- Support posts within the DSS (and within established child welfare organisations should amendments to the Children's Protection and Adoption Act be implemented) for trained social workers who will have specific responsibility for children in care. These officers will adopt the role of "gatekeeper" for children's institutions with the specific task of preventing unnecessary institutionalisation. Their responsibilities will specifically include:

a) The investigation and re-integration of institutionalised children into their extended families and communities.

b) The promotion, organisation and supervision of formal foster care placements for those infants and children for whom re-integration is not possible.

c) The renewal of court orders and issuing of free treatment orders and school fees.

d) Monitoring and supervision of institutions including the organisation of care giver training and certification.

It is essential that these officers be provided with the necessary resources, including vehicles, to perform these duties.

- Contribute to the Children's Fund, established in terms of the Children's Protection and Adoption Amendment Act, which should be accessible to probation officers responsible for children in care, to support family re-integration and foster care. The funds would be utilised for the payment of school fees and uniforms and, where necessary, for the provision of material support to families offering to provide care.

- Support programmes to promote formal foster-care as an effective means of preventing or reversing the institutionalisation of infants and children. This should include funding of media and community-focused campaigns to raise awareness and acceptance of this form of care.

- Be receptive to funding proposals from residential institutions for the development of orphan care programmes in their surrounding communities.

- Support umbrella organizations and large well-resourced institutions to mount a comprehensive programme of exchange visits, training workshops and technical assistance. Specific areas of interest would include care-giver training, vocational training and care of children with AIDS.

- Provide support for programmes promoting early intervention and family re-integration of street children.

Family-Based Institutions

Family - Based Institution	Province	Approx. No. of children
All Souls	Mashonaland East	42
Home of Hope	Mashonaland East	20
Makumbi Children's Home	Mashonaland East	81
Musha wevanhu (Marondera)	Mashonaland East	45
Eden Children's Village	Mashonaland West	36
Vimbainesu Children's Home	Mashonaland West	37
SOS Children's Village (Bindura)	Mashonaland Central	178
Fairfield Children's Home	Manicaland	45
Lucy Pruett Children's Home	Manicaland	10
Manhinga Village	Manicaland	108
Chiredzi Christian Children's Village	Masvingo	34
Chinyaradzo Children's Home	Harare	58
Empowerment Works Children's Home	Harare	16
Harare Children's Home	Harare	100
St. Marceline Children's Village	Harare	14
SOS Children's Village	Harare	221
Khayalithe Children's Home	Matabeleland North	30
Whyte Water Sai Children's Home	Matabeleland South	34
Kip Keino Children's Home	Matabeleland South	32
Mary Ward Children's Home	Midlands	70
SOS Children's Village	Bulawayo	193

Dormitory Styled Institution

Name of Institution	Province	Approx. No. of children
Ivordale Child Shelter	Mashonaland East	39
Mbuya Nehanda Children's Home	Mashonaland East	65
Mother of Peace Community	Mashonaland East	153
Shearly Cripps Children's Home	Mashonaland East	60
Karoi Women's Institute Children's Home	Mashonaland West	55
St. Agnes Children's Home	Mashonaland West	51
Kasese House	Mashonaland West	30
Montgomery Heights Christian Care Centre	Mashonaland Central	57
Ponesai Vanhu	Mashonaland Central	54
Bakorenhema Children's Home	Manicaland	38
Bonda Children's Home	Manicaland	22
Chirinda Orphanage	Manicaland	54
Chitenderano	Manicaland	20
Forward in Faith	Manicaland	21
Girl Child Network	Manicaland	5
Houtberg Child Care Centre	Manicaland	24
Mount Mallory Mission Children's Home	Manicaland	19
Ranger Moyo Home	Manicaland	12
RG Mugabe Orphanage	Manicaland	40
Sacred Heart	Manicaland	15
Alfred Walter Hostel	Masvingo	100
Alpha Cottages	Masvingo	51
Chingele Children's Home	Masvingo	6
N&B Children's Home	Harare	40
Emerald Hill Children's Home	Harare	102
Matthew Rusike Children's Home	Harare	108
New Start Children's Home	Harare	36
St. Josephs Home for Boys	Harare	53
Sacred Heart	Matabeleland South	16
Driefontein Children's Home	Midlands	47
Midlands Children's Home	Midlands	58
Emthunzini Wethemba	Bulawayo	61
John Smale	Bulawayo	75
Queen Elizabeth	Bulawayo	29
St. Francis Home	Bulawayo	45
St. Gabriel's Children's Home	Bulawayo	6
Thembiso Children's Home	Bulawayo	56

SELF-REPORTING QUESTIONNAIRE

NAME / ZITA RENYU ....

AGE OR DATE OF BIRTH ....

1.	Do you often have headaches?	YES / NO
	Munogara muchitemwa nemusoro here?	HONGU / KWETE
2.	Is your appetite poor?	YES / NO
	Munonzwa kusada kana kusafarira kudya here?	HONGU / KWETE
3.	Do you sleep badly?	YES / NO
	Haurare zvakanaka here?	HONGU / KWETE
4.	Are you easily frightened?	YES / NO
	Munokurumidza kuvhundutswa here?	HONGU / KWETE
5.	Do your hands shake?	YES / NO
	Mune nhetemwa dzemaoko here?	HONGU / KWETE
6.	Do you feel tense, nervous or worried?	YES / NO
	Munonzwa kusunzvikana kana kutambudzika mufungwa here?	HONGU / KWETE
7.	Is your digestion poor?	YES / NO
	Kana madya, munonzwa kufufutirwa, kana kunzwa, chirungurira here ?	HONGU / KWETE
8.	Do you have trouble thinking clearly?	YES / NO
	Munonetsekana here nekufunga zvakanaka?	HONGU / KWETE
9.	Do you cry more than usual?	YES / NO
	Munochema here sezvamakanga musingaita?	HONGU / KWETE
10.	Do you feel more unhappy than usual?	YES / NO
	Makasuruvara here sezvamakanga musingaita?	HONGU / KWETE
11.	Do you find it difficult to enjoy your daily activity?	YES / NO
	Zvinokuomerai here kufarira zvinhu zvaunoita mazuva ose?	HONGU / KWETE
12.	Do you find it difficult to make decisions?	YES / NO
	Munozviona zvakakuomeri here kusarudza Zvokuita?	HONGU / KWETE

13. Is your daily work suffering?   YES / NO
    Mabasa emazsuva ose haasi kufamba zvakanaka here?   HONGU / KWETE

14. Are you unable to play a useful part in life   YES / NO
    Hamukwanise kuita zvinhu zvinobatsira mvupenyu here?   HONGU / KWETE

15. Have you lost interest in things?   YES / NO
    Hamuchafirira zvinhu here?   HONGU / KWETE

16. Do you feel that you are a worthless person?   YES / NO
    Munozviona somunhu asina kukodzera here?   HONGU / KWETE

17. Has the thought of ending your life been in your mind?   YES / NO
    Munomobofunga here zvokuda kuzvipfundza?   HONGU / KWETE

18. Do you feel tired all the time?   YES / NO
    Munonzwa kuneta nguva dose here?   HONGU / KWETE

19, Do you have uncomfortable feelings in your Stomach?   YES / NO
    Munonzwa kufufutirwa mundumbu here?   HONGU / KWETE

20. Are you easily tired?   YES / NO
    Munokurumidza kunzva kuneta here?   HONGU / KWETE

QUESTIONNAIRE TO ASSESS VIEWS OF CHILDREN
(To be administered in conjunction with the self reporting questionnaire for children)

1. What is your current age? ....years

2. What is your sex   Male / Female

3. At what age were you taken into care? ....years

4. Are your parents alive? (circle)   mother

    father

    both

    unknown

5. Do you have relatives who visit you or whom you visit?   YES / NO

6. Please describe how you came to be in the children's home:

   ....

   ....

7. What is the best thing that ever happened to you?

   ....

   ....

8. What is the worst thing that ever happened to you?

   ....

   ....

9. What things worry you the most?

   ………

   ………

10. Who do you talk to about things that worry you?

   ………

11. If you could make three wishes, what would they be?

   i) ……

   ii) ……

   iii) ……

12. Do you feel that adults consult you about your wishes or needs?   YES / NO

13. If you were put in charge of your children's home what changes would you make?

   ………

   ………

14. What are your plans for when you leave the children's home?

   ………

   ………

15. Do you worry about your future?   never / sometimes / a lot