Situational analysis of orphaned and vulnerable children in eight Zimbabwean districts

Biomedical Research and Training Institute
in collaboration with the National Institute of Health Research
of the Ministry of Health and Child Wellfare

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Shungu Munyati
Project Director

Brian Chandiwana
Project Manager

CONTRIBUTORS

Shungu Munyati, MSc and PhD (Cand), is the OVC Research Project Director at Biomedical Research and Training Institute (BRTI) and former Acting Director at the National Institute of Health Research (NIHR), Ministry of Health and Child Welfare, Zimbabwe.

Brian Chandiwana, BSc Econ and MBA, is the OVC Research Project Manager and works with BRTI, Harare (Zimbabwe).

Stanford T Mahati, MPhil and BSc (Hons) Sociology and Anthropology, BRTI and formerly with the NIHR, Ministry of Health and Child Welfare, Harare (Zimbabwe).

Pakuromunhu F Mupambireyi, MSc Demography and BSc (Hons) Econ, University of Zimbabwe in the Department of Business Studies.

Stephen S Buzuzi, MBA, MSc and BSc (Hons) Sociology and Anthropology, BRTI, Harare (Zimbabwe).

Wilson Mashange, Dip Med Lab Tech, BRTI and formerly with the NIHR, Ministry of Health and Child Welfare, Harare (Zimbabwe).

Stella-May Gwini, BSc (Hons) Statistics, formerly with BRTI, Harare (Zimbabwe).

Teramayi A Moyana, BSc (Hons) Sociology and Anthropology, formerly with BRTI, Harare (Zimbabwe).

Simbarashe Rusakaniko, PhD, Professor of Biostatistics at the College of Health Sciences, University of Zimbabwe.

ACRONYMS AND ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
AREX	Agricultural Research and Extension Services
ART	antiretroviral therapy
ARV	antiretroviral
BEAM	Basic Education Assistance Module
BRTI	Biomedical Research and Training Institute
CADEC	Catholic Development Commission
CAMFED	Campaign for Female Education Association
CBO	community-based organisation
CHH	child-headed household
CSO	Central Statistical Office
DA	district administrator
DAAC	District AIDS Action Committee
DAPP	Development Aid from People to People
DOMCCP	Diocese of Mutare Community Care Programme
ECD	early childhood development
EHT	environmental health technician
EU	European Union
FACT	Family AIDS Caring Trust
FBO	faith-based organisation
FGD	focus group discussion
FOST	Farm Orphan Support Trust
GMB	Grain Marketing Board
HBC	home-based care
HIV	human immunodeficiency virus
HSRC	Human Sciences Research Council
IEC	information, education and communication
IGP	income generating project
MAC	Matabeleland AIDS Council
MoESC	Ministry of Education, Sports and Culture
MoHA	Ministry of Home Affairs
MoHCW	Ministry of Health and Child Welfare
MoPSLSW	Ministry of Public Service, Labour and Social Welfare
MRCZ	Medical Research Council of Zimbabwe
NAC	National AIDS Council
NAP	National Action Plan for OVC
NGO	non-governmental organisation
NIHR	National Institute for Health Research
OI	opportunistic infections
OVC	orphans and vulnerable children
PLWHA	people living with HIV and AIDS
PMTCT	prevention of mother to child transmission
PPTCT	prevention of parents to child transmission
PSI	Population Services International
RAAAP	Rapid Assessment, Analysis and Action Planning Process
RDC	Rural District Council
SADC	Southern African Development Community
SPW	Student Partnership Worldwide
STI	sexually transmitted infection
TBT	Tjinyunyi Babili Trust
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
Unicef	United Nations Children's Fund
USAID	United States Agency for International Development
VAAC	Village AIDS Action Committee
VCT	voluntary counselling and testing
VCW	village community worker
VFU	Victim Friendly Unit
VHW	village health worker
WAAC	Ward AIDS Action Committee
WFP	World Food Programme
WHO	World Health Organization
ZAN	Zimbabwe AIDS Network
ZHDR	Zimbabwe Human Development Report
ZRP	Zimbabwe Republic Police

EXECUTIVE SUMMARY

In response to the AIDS epidemic and poverty, the Zimbabwe government and other organisations are implementing various programmes aimed at assisting orphans and vulnerable children (OVC) in the eight districts surveyed. It is important to have an audit of the social services and support structures available for OVC in the eight districts and to have a clear understanding of the situation of OVC, including their needs and concerns, in order to have proper prioritisation, design and evaluation of programmes that are aimed at supporting the affected children.

A situational analysis of services and support systems for OVC was conducted in February 2006. Qualitative methods were used in the study. Key informants were identified using purposive sampling. Other methods were used such as semi-structured interviews, observations, informal conversations and review of secondary data. Participants were selected from different sectors of the communities, which included rural and urban areas.

The conditions under which OVC were living, were generally unfavourable and difficult. Food was the main need that was cited by the OVC. The other needs were educational assistance and psychosocial support (including spiritual guidance). Bulilimamangwe is an area that is prone to droughts and so food shortages are quite pronounced. The proximity of the district to Botswana and South Africa was seen as a major contributor to the deaths of young people, as they engage in risky sexual behaviour when they leave their spouses behind to look for work.

Some children as young as 12 years old were heads of households. Some of the school-going children were taking care of sick relatives and were often expected to bring income by doing part-time jobs in order to sustain their families. Though the problem of child-headed households could not be quantified and was mostly reported to be low, it was quite worrying to community leaders.

Community members had positive attitudes towards OVC. This was echoed by OVC themselves, who indicated that the majority of them were well looked after and that the community at large accepted them.

Although intervention agencies have been doing sterling work in assisting OVC, they have been overwhelmed by their ever increasing numbers. Among the organisations that work in Bulilimamangwe District are World Vision, the Catholic Development Commission (CADEC) and a faith-based organisation under the United Congressional Church of Southern Africa (UCCSA) called Bongani Orphan Care. World Vision was implementing a supplementary feeding scheme for all children in Mangwe. They also had a separate feeding scheme for orphans whom they assisted with school fees. Apart from school and examination fees assistance to deserving children, Bongani Orphan Care also offered life skills to the youths through income-generating activities like gardening, soap-making and candle-making.

CADEC was running a supplementary feeding programme for different groups of people in Bulilima, Mangwe and Plumtree. The NGO had nearly 700 feeding points (pre-schools) for the children younger than five years old.

The problems that were faced by intervention agencies included poor infrastructure and shortage of materials, as well as vehicles to transport volunteers. They also faced financial constraints and shortage of food aid and other material support for OVC. The lack of incentives for volunteers was cited as a major hindrance to the effectiveness of their

programmes. There was a problem of trying to confine support to children orphaned by AIDS only, by some organisations. However, the causes of parents' deaths are not always put on death certificates and so it was difficult to identify AIDS orphans.

The National Action Plan for Orphans and Vulnerable Children (NAP) was put in place by the government with the aim of reaching out to all OVC in the country with basic services. As at the time of the study, nothing was implemented on the ground in the districts. An AIDS levy was introduced by the government to support the National AIDS Council programmes, which include caring for OVC made vulnerable due to HIV and AIDS. The districts benefited from these funds through the District AIDS Action Committee (DAAC), which was responsible for disbursing the funds. The DAAC also provided a common forum where stakeholders such as community-based organisations (CBOs), faith-based organisations (FBOs) and non-governmental organisations (NGOs) could meet to update each other on progress and difficulties.

The AIDS pandemic negatively affects orphans and vulnerable children. The situation has been heightened by the deteriorating economic situation in Zimbabwe and the weakening of support structures at all levels, that is, at individual, family and community level. Although OVC support services were in place, these were largely overwhelmed and could not meet OVC material and psychosocial needs. The burden of OVC was becoming heavy on the communities and they sometimes found it difficult to cope.

Representatives of intervention agencies expressed the desire to expand their programmes but cited inadequate funding and lack of equipment and transport as enduring hindrances, among other challenges. Nevertheless, the strengthening of the existing initiatives would prove to be beneficial in alleviating the plight of the OVC and even more so in fighting the AIDS pandemic.

Various intervention agencies, such as government ministries, NGOs, CBOs, FBOs and the community at large, are making tremendous efforts in caring for OVC. However, the efforts of these agencies are being hampered by various challenges they come across as they carry out their work. These challenges include the following:

- There is poor coordination and, in some cases, lack of coordination among the stakeholders, resulting in duplication of services, especially food handouts, where some OVC households receive double benefits.
- The harsh macroeconomic environment has led to massive price changes vis-à-vis static budgets, thereby making access to basic necessities limited for the OVC and their caregivers.
- Shortage of staff and transport (worsened by fuel shortages) for most NGOs has adversely affected monitoring of activities.
- Drought in some areas is affecting some initiated projects such as nutrition gardens.
- There is an increasing number of OVC, leading to failure by organisations to cope with the demand for services.
- Stigma associated with HIV/AIDS – some families do not want to work with volunteers from AIDS service organisations for fear of being stigmatised.
- The HIV/AIDS pandemic has affected the communities in various ways such that it is becoming increasingly difficult for the intervention agencies to meet all the needs of the OVC.
- Cultural barriers – most families are not willing to be foster parents or to take care of strangers, for fear of avenging spirits (*ngozi*).

- Difficulties in changing some OVC caregivers' views on needs of OVC, especially on the importance of vocational skills and education.
- Some caregivers feel that intervention agencies want to run the affairs of their homes and see this as an intrusion.
- Negative attitudes that people have against OVC, especially the disabled at schools.
- There are some elements of nepotism and corruption in the selection of beneficiaries; some employees convert the aid meant for OVC to their own use.
- Failure by some community members to report abuse of OVC, especially where relatives are the perpetrators.
- Shortage of basic commodities that are needed for distribution to OVC.

Conclusion

Though various issues were cited as challenges faced by intervention agencies, the major outcry was the lack of coordination of activities of the organisations, resulting in duplication of activities. Another major drawback was the prevailing harsh macroeconomic environment. Furthermore, the increase in the number of orphans due to the HIV/AIDS pandemic has resulted in the assistance rendered as only a drop in the ocean.

CHAPTER 1

Introduction

Stanford T Mahati, Shungu Munyati, Brian Chandiwana, and Stella-May Gwini

HIV/AIDS and the OVC problem in Zimbabwe

The AIDS epidemic is a national tragedy that has resulted in thousands of children orphaned or heavily affected by the multiple impacts of AIDS on their families and communities (Mahati et al. 2006; Matshalaga 2004; ZHDR 1999). The first AIDS cases were reported in Zimbabwe in 1985. Jackson (1986, cited in Gumbo 1995) states that at the end of 1986, Zimbabwe had reported only seven or eight cases of full-blown AIDS to the World Health Organization (WHO). The country has one of the highest reported HIV sero-prevalence rates in Africa. In 1999, the Government of Zimbabwe officially declared the AIDS epidemic a national disaster. In 2001, the prevalence of HIV was estimated at 33.7% (ZHDR 1999), which later declined to 24.6% in 2003, 21.3% in 2005 and 18.1% in 2006 (MoHCW 2006). In 2001, an estimated total of 240 000 children between the ages of 0 and 14 were living with AIDS (Garbus & Khumalo-Sakutukwa 2002) and in 2005, the Ministry of Health and Child Welfare (MoHCW) estimated the figure to be 115 182, as drawn from antenatal data. By 2010, it has been estimated that 34% of all the children in Zimbabwe would be orphans (FOST 1999). Regardless of the decrease in HIV prevalence, Zimbabwe is still experiencing heavy consequences of the epidemic, because not only has it affected the country's economy by taking away the economically active population, it has also left many children hopeless and in a state of destitution, as they have lost parents or even other guardians.

According to a study carried out by Skinner et al. (2004) in Botswana, South Africa and Zimbabwe, an orphan is defined as a child less than 18 years old who has lost either one or both parents, whereas a vulnerable child is a person under the age of 18 years who is living with terminally ill parents, or is dependent on extremely old, frail or disabled caregivers, or is in a household that assumes additional dependency by taking in orphaned children. Munyati et al. (2006), in a study conducted in two Zimbabwean districts, defined vulnerability of households as those where children have only one meal a day, have no caregiver and have no one to discuss problems with (child-headed households); also, households with a sick household member who has been seriously ill for at least a month, households that are not able to pay for medical fees, and households whose children have inadequate clothing and uniforms (for the school-going children). Of note is that there is no direct relationship between orphanhood and vulnerability. One can be an orphan but not vulnerable or one can be vulnerable but not necessarily an orphan. Other organisations have defined vulnerable children as 'children below the age of 18 with unfulfilled rights'. These definitions are intentionally broad, as a means of adapting to the reality of the situation in Zimbabwe, which leaves many different groups of people vulnerable (RAAAP 2004). As acknowledged in Zimbabwe's National Action Plan for Orphans and Vulnerable Children (NAP), communities are best positioned to determine the vulnerability of children and their families.

The percentage of Zimbabwe's children orphaned due to AIDS rose from 16% in 1990 to 76.8% in 2001, and it is projected to reach 88.8% in 2010 (Garbus & Khumalo-Sakutukwa 2002). One of the effects of orphanhood is the transfer of the children to various relatives who offer diverse care and support, poor nutrition and inadequate schooling, leading to poor school performance and dropping out, which, along with psychosocial scarring from

the loss of parents, results in delinquent and criminal behaviour as well as physical, psychosocial and sexual abuse (Chingono et al. 2006; Mahati et al. 2006; ZHDR 1999). Though police records show the reported cases of child abuse are low, sexual abuse of children, especially females, is believed to be widespread in Zimbabwe (Mahati et al. 2006).

The problem of orphans continues to increase, mainly due to the premature death of parents who die of AIDS and HIV-related illnesses. The hard earned socio-economic status, household income and savings gains made during the post-independence era in Zimbabwe have slowly been eroded over the last few years, due to the HIV/AIDS pandemic. AIDS is the largest estimated cause of death, especially among the young population. The most frequently identified mode of HIV infection among children is vertical transmission from mother to child. Such infection may occur prior to birth, during delivery or through breastfeeding. In 2003, it was found that HIV prevalence among children aged 2–11 in Zimbabwe's Chimanimani District was 3.3% (Gomo et al. 2006). An OVC baseline survey carried out in 2004 by Unicef and the Ministry of Public Service, Labour and Social Welfare revealed that over 40% of the children under the age of 18 years were either orphaned or vulnerable (Zimbabwe Government & Unicef 2004). According to a census of OVC carried out in Chimanimani and Bulilimamangwe areas by Munyati et al. (2006) in 2003, approximately a quarter of all children were orphans; 28% and 24% for Bulilima and Mangwe Districts respectively and about a third (30.5%) in Chimanimani District. The most common type of orphanhood was paternal and this has been the trend with other studies.

The problem of child-headed households and OVC is creating a strain upon extended families, particularly grandparents, and it has also had a huge impact on community resources (Chingono et al. 2006; Mahati et al. 2006). The OVC census conducted by Munyati et al. (2006) found that 3.2% of households in Chimanimani District were being headed by children. These children who are left to head households are vulnerable to a number of ill effects, which include the loss of their childhood (ZHDR 1999). Some of these children take up the responsibility of caring for their ill parents and, as a result, make themselves vulnerable, since they lack precautionary guidelines for looking after AIDS patients (ZHDR 1999).

The impact of the AIDS epidemic on children and families is incremental (Foster & Williamson 2000), with the worst hit communities being the already poor, who have inadequate infrastructure and limited access to basic services. In a study carried out by Chingono et al. (2006) in Chimanimani and Bulilimamangwe Districts, poverty was highlighted as the major contributor to vulnerability in OVC households; in Chimanimani, it was found that over 80% of households with OVC aged 6–14 years did not have enough money for basics. In addition to this, guardians/parents taking care of OVC reported that the main needs of OVC were food, and financial and educational support (Chingono et al. 2006). Mahati et al. (2006) also found that special education for some children in difficult circumstances, sanitation, shelter and provision of free health services were some of the major needs of OVC. As parents die, children's rights to identity are also being violated. Zimbabwe ratified the African Charter on the Rights and Welfare of the Child (1990), which emphasises a child's right to a name and nationality, and makes registration immediately after birth compulsory. But neither the Zimbabwean Constitution nor the Birth and Death Registration (BDR) Act (Chapter 5:02 of 22/2001) expressly state that a child has the right to be registered. An estimated 50% of Zimbabwean orphans and 95% of children living in institutions do not have birth certificates (IRIN 2004). It is also

reported that without proof of identity, children find it hard to access health and education services and are prone to child labour, sexual abuse and early marriage.

Responses to HIV/AIDS and the OVC problem

In the mid-1980s, Zimbabwe did not have a policy on HIV and AIDS. Nevertheless, it was evident that cases of persons affected by the virus were increasing at alarming rates. Belatedly, the government set up the National AIDS Control Programme in 1988 (which later changed to National AIDS Coordination Programme and is now called the National AIDS Council). The broad aim of the programme is to ensure coordination of the government and non-governmental organisations' (NGOs) activities that have to do with fighting the spread of HIV infection. The government also developed a short-term plan for AIDS prevention and control (GoZ 1991). It set up an HIV surveillance section, which is in the Health Information Unit. The section provides reports to the National AIDS Council (NAC).

Many NGOs have been set up to deal with different aspects of this disease. As of 2003, Futures Group (2003) reported that there were at least 200 formal organisations in Zimbabwe working with vulnerable children (Davids et al. 2006). Many community-based organisations (CBOs) and faith-based organisations (FBOs) have also been formed to assist OVC and people living with HIV and AIDS (PLWHA).

With regards to efforts aimed at mitigating the impact of HIV/AIDS and poverty on OVC, an extremely diverse range of interventions is offered in Zimbabwe, though the most common are counselling, payment of school fees and feeding programmes. These interventions are designed to meet children's most basic needs and fill in the gaps in government services (RAAAP 2004). It has been found that most OVC-related service providers were unable to give accurate and complete information on the numbers of children reached or on costing of interventions. The double-counting of children benefiting from more than one activity could not be eliminated by most organisations, resulting in inflated numbers of children reached (Drew et al. 1998). The study also revealed that organisations were constrained in their ability to effectively gather and report quantitative and qualitative data on time. They also did not have the resources and capacity needed to effectively monitor and evaluate their programmes.

To mitigate the epidemic's impact on children, the 2001 United Nations General Assembly Special Session in its Declaration of Commitment on HIV/AIDS called on countries to implement national strategies to support children orphaned and made vulnerable by AIDS, to ensure their equal access to education and other services, and to protect them from abuse and stigmatisation. Globally, only half of the countries of the world have national policies to address the needs of children orphaned or made vulnerable by the epidemic (UNAIDS 2006). In sub-Saharan Africa, 25 of 29 countries reported that they have national policies in place to address the additional HIV- and AIDS-related needs of orphans and other vulnerable children (UNAIDS 2006). Zimbabwe, together with countries like Botswana, Namibia, Malawi and Rwanda, is one of the few countries with an operating national plan to ensure that orphans and vulnerable children are able to access education, food, health services, birth registration and protection from abuse and exploitation.

In 1999, the Zimbabwean government put in place the National Orphan Care Policy (1999), which provides basic care and protection guidelines for orphans and includes a commitment to national and community support. The orphan-care policy combines

institutionalisation, fostering and community-based care. This policy has also incorporated the Basic Education Assistance Module (BEAM), which assists children from resource-poor households, mainly through supporting them with school fees.

The National Orphan Care Policy has led to the development of the National Action Plan for Orphaned and Vulnerable Children (NAP), whose vision is to reach out to all OVC in the country with basic services. The NAP lays out strategies such as fully implementing existing legislation and policies, strengthening community-based initiatives and safety nets, and strengthening an OVC Secretariat to drive the implementation of the NAP for OVC, in coordination with local and national authorities. The NAP for OVC also details a specific timeline for the completion of activities, indicators to measure the plan's progress, and a clear monitoring and evaluation process for the continuous improvement of all activities.

Other government programmes targeting OVC include the Public Assistance to Vulnerable Families, which assists with basic living costs and health costs; the Public Works Programme, which supports with regard to droughts and food shortages; and the AIDS Trust Fund (Mahati et al. 2006).

Several studies have noted that before the advent of AIDS, orphans were usually absorbed within the extended family network. The extended family, as the traditional social security system in many African countries, has been weakened because parents, aunts and uncles are dying of the disease. Beyond the effect of HIV and AIDS, the extended family is under severe strain as a result of migration, demographic changes and a trend towards the nuclear family structure (Matshalaga 2004).

As devastating as AIDS has been for Zimbabweans in general, it has had an even more pronounced impact on women and girls (Mahati et al. 2006; RAAAP 2004). Women are nearly 1.4 times more likely than men to be infected with HIV (NAC 2004). While biological differences between men and women undoubtedly play a role in women's increased susceptibility to the disease, it is equally undeniable that inequality and power imbalances that exist between the two genders contribute even more greatly (Mahati et al. 2006). Women and the elderly carry a disproportionate burden of caring for family members and supporting OVC, even though women have less access to property, employment and cash (Drew et al. 1998, cited in Matshalaga 2004; RAAAP 2004).

Most people are not able to help orphaned children because they are struggling with their own families, as seen in cases where relatives opted to leave children in charge (child-headed households) rather than take them in (ZHDR 1999). In response to this, community-based orphan support programmes have emerged and these use volunteers to visit the neediest children; some of these support programmes have the potential to complement existing coping mechanisms in a cost-effective manner (Drew et al. 1998).

RAAAP (2004) noted that Zimbabwean society's ability to respond to the OVC crisis has been constrained by the recent humanitarian crisis, hyperinflationary economic conditions and difficult social conditions, all of which have complicated OVC programme planning and implementation, reduced the ability of service providers to retain skilled personnel, and severely reduced international support to Zimbabwe. In addition, existing legal loop-holes and the recognition of both formal, codified law and customary law do not fully protect children in Zimbabwe, despite the country's adequate legal and policy framework prohibiting child abuse and neglect. The lack of resources also prevents enforcement of laws protecting orphans and other vulnerable children (RAAAP 2004).

Besides the AIDS disaster, Zimbabwe experiences recurrent droughts. As of January 2004, more than one half of Zimbabwe's citizens required food assistance, inflation remained at over 600%, and almost 80% of the population was unemployed (UN 2004). The year 2007 has been declared a year of hunger, owing again to poor rainfall. It is estimated that the year-to-year inflation for March 2007 is 1 729% (CSO 2002). Zimbabwe's inflation rate has been rising astronomically since 2000, owing to growing economic challenges and persistent foreign currency shortages. This has resulted in the prices of basic commodities, household goods and paramedic services rising beyond the reach of many households.

Despite a plethora of ongoing efforts aimed at assisting OVC, it is not very clear who is doing what, where and how in terms of assisting OVC in Zimbabwe, at both national and local levels. Consequently, among other problems, there has been a lot of duplication of activities; concentration of intervention efforts in one area at the expense of more deserving areas; oversights in meeting other important needs of children; and lack of knowledge of the best practices of interventions.

As acknowledged in Zimbabwe's National Orphan Care Policy of 1999, community-based care of children remains the preferred means of care for OVC in Zimbabwe, due to the serious challenges faced by institutions, namely, providing appropriate psychosocial care and preparation for life after a child becomes a bit older. According to Foster (2003), families and local communities have shown remarkable resilience and creativity in addressing the needs of children affected by HIV/AIDS. On the other hand, religious communities offer the most extensive, viable and best-organised network of institutions at both local and national levels. In some areas, such as in the Chimanimani District, women have formed groups that care for orphaned children in their deceased parent(s)' homes (ZHDR 1999). These women have given themselves the task of giving the children counselling on growing up and how to maintain a good code of conduct. In Masvingo and Mwenezi Districts, the communities initiated orphan care programmes where people contribute money that is used to purchase uniforms, food and clothing and to pay school fees for OVC (ZHDR 1999). However, most faith-based, congregational and personal responses are on a small scale (Foster 2003), and Mate (2001), as cited in the 1999 ZHDR, also laments that the caregivers themselves are emotionally and psychologically stressed by the impact of orphanhood on the children, as well as the demands that are placed on themselves. As a result, the volunteers opt out of the OVC programmes and the orphans are left with no caregivers.

In responding to the OVC crisis, the traditional leadership has revived the traditional safety-net concept called the *Zunderamambo*. This is a traditional system in which a chief or village head reserves a piece of land for community use. All households/families under his/her jurisdiction are supposed to contribute labour to till the land and tend the produce from the plot. The seeds are usually a donation from the government or from NGOs. The produce is harvested and kept under the control of the traditional leader, who then distributes it to families in need of food (ZHDR 1999). There have been many constraints on the sustainability of these granaries and some communities have opted for people donating one 50kg bag of maize towards the granary at the end of each harvest period, though most communities have failed to keep the *Zunderamambo* going. The scale of adoption of *Zunderamambo*, and associated problems in implementing it, most likely differ across communities, due to socio-economic and cultural circumstances; however, these details have not been documented and this study sought to fill this information gap.

Efforts to document activities that are being carried out by different stakeholders in trying to assist OVC are being pursued. The United Nations Children's Fund (Unicef) carried out a survey on OVC in 2004 and this study covered 21 districts of the 56 districts in the country. This survey preceded the Rapid Assessment, Analysis and Action Planning Process (RAAAP) that was funded by Unicef, USAID, UNAIDS and WFP. Other organisations such as the Farm Orphan Support Trust (working with OVC on farms), Save the Children UK and World Vision have carried out other studies on OVC as well. All these organisations have endeavoured to document activities in their areas of operation, with only a few covering the areas targeted by this study. Nevertheless all these studies did not assess all the services that were available to assist OVC.

Family AIDS Caring Trust (FACT) has been working in Manicaland, Mashonaland Central, Mashonaland West, Midlands and Matabeleland South provinces in projects targeting OVC, using funds provided by the WK Kellogg Foundation. In order to inform these activities with research, FACT has been working together with the Biomedical Research and Training Institute. This situational analysis was carried out to inform all the organisations working with FACT (that is FACT Implementing partners) on all activities being carried out in their areas of operation and to reflect on the areas that need to be strengthened. Not only will this documentation inform FACT Implementing partners but it will also inform other NGOs working in the same area, as well as inform the government on what has been done and what still needs to be done. This report will also be informative for interventions in other areas not covered by this study, by providing information on the challenges faced by OVC, OVC caregivers, their communities and child-related intervention agencies.

Background to the OVC project

In 2002, the Human Sciences Research Council (HSRC), together with its partners within the Southern African Development Community (SADC) region, was commissioned by the WK Kellogg Foundation to develop and implement an intervention project on OVC, as well as to support the families and households to cope with an increased burden of care for affected children in Botswana, South Africa and Zimbabwe. In Zimbabwe, the Biomedical Research and Training Institute (BRTI), in collaboration with the National Institute of Health Research (formerly the Blair Research Institute), were tasked to take the responsibility of carrying out the research for the project while FACT was appointed to implement the interventions.

FACT, the grant-maker and implementing partner, is funding various NGOs, CBOs and FBOs that are delivering services to those who are in need. The project also works in partnership with all levels of the government as well as local communities to ensure that the intervention programmes continue after the project officially ended in December 2006.

Goals and aims of the OVC project

The main aims of the project were to develop, implement and evaluate some existing and/or new OVC intervention programmes that address the following issues:

- home-based child-centred health, development, education and support;
- family and household support;
- strengthening community-support systems;
- building HIV/AIDS awareness, advocacy and policy to benefit OVC.

The other goals of the project were:

- To improve the social conditions, health, development and quality of life of orphans and vulnerable children.
- To support families and households coping with an increased burden of care for affected and vulnerable children.
- To strengthen community-based support systems as an indirect means to assist vulnerable children.
- To build capacity in community-based systems for sustaining care and support to vulnerable children and households, over the long term.

One the goals of the project was to conduct a situational analysis which identified services already available in the study areas, identify their strengths and weaknesses and suggest ways of strengthening them. The information collected is vital for the development of intervention plans to assist OVC and also for the development of indicators for monitoring the interventions.

Objectives of the situational analysis study

This is a baseline research task that was done in all the eight sites where there were OVC interventions that were funded by the WK Kellogg Foundation. The key objectives of the situational analysis were as follows:

- To assess the general social and public infrastructure services in the districts.
- To develop an understanding of the number and situation of orphans in the area under research. The description of their situation should include financial, care, acceptance, education access and health.
- To identify and describe potential and key support systems for the OVC in the communities. These would include systems at the level of the family, community, organisation, state and others that may exist.
- To identify and describe key threats and potential threats to or restrictions on OVC.
- To collect any additional background information that may be useful for the development of the OVC project.

CHAPTER 2

Methodology

Stanford T Mahati, Shungu Munyati, Brian Chandiwana, Stella-May Gwini and Simbarashe Rusakaniko

Methodology

The methodology described below was designed to extract information on the situation of OVC from organisations observing interventions in the study areas: these include governmental and non-governmental organisations (NGOs), evaluators, funders and policy-makers. It is also designed to provide background information for the generation of additional research in the communities. In each site, the research team was led by at least one member of the local liaison committee.

Operational definitions

Abuse: anything that individuals or institutions do or fail to do that directly or indirectly harms children or damages their prospects, life or healthy development.
Adolescent: An adolescent is an individual in the state of development between the onset of puberty and maturity. Definitions vary according to culture and custom (in this study, individuals from 12 to 24 years old are adolescents).
Assent: affirmative agreement of a child.
Caregiver: a person who regularly and voluntarily assists an orphan in a household whose members are related or not related to him/her in terms of doing household chores, offering advice, giving spiritual, psychosocial and material support.
Child or minor: a person under the age of 18.
Child-headed household: a household in which a person aged 18 years and below is responsible for making day-to-day decisions for a group of persons who stay or who usually reside together and share food from the same pot, whether or not they are related by blood.
Consent: affirmative agreement of an individual who has reached the legal age of participating in a medical research project.
Enumeration area: the smallest demarcation of a district that is a cluster of about 100 households.
Grant-maker: organisation that sources resources and rolls out grants to community-based organisations to implement the OVC interventions. Family AIDS Caring Trust (FACT) is the grant-maker for the OVC project in Zimbabwe.
Guardian: parent/someone who assumes responsibility for someone else's welfare on a day-to-day basis.
Head of household: a person, regardless of age, who is responsible for making day-to-day decisions for a group of persons who stay or who usually reside together and share food from the same pot, whether or not they are related by blood.
Household: a place where a group of persons who stay or who usually reside together and share food from the same pot, whether or not they are related by blood.
Local liaison teams: key people selected from the districts where research is being conducted, who spearhead the OVC project activities.
Orphan: a person under the age of 18 years who has lost either one or both parents.
Vulnerable child: a person under the age of 18 living in a household having one meal a day, receiving inadequate caregiving (child-headed households), with a sick household member who has been seriously ill for a month; households that are not able to pay for

medical fees; and households with children with inadequate clothing. It is also a child whose survival, well-being or development is threatened. The term is also often used to refer to children affected by HIV and AIDS. Of note is that there is no direct relationship between orphanhood and vulnerability. One can be an orphan and yet not vulnerable or one can be vulnerable and not necessarily an orphan.
Ward: a ward is a composition of 500 to 600 households.

Study areas

The study was carried out in eight districts of Zimbabwe (see Figure 2.1 showing the map of provinces in Zimbabwe) in February 2006. The districts were chosen on the basis that they had organisations which were implementing the WK Kellogg Foundation-funded OVC projects. The study areas are as follows:

- Nyanga District, Manicaland Province
- Mutasa District, Manicaland Province
- Chimanimani District, Manicaland Province
- Mutare Urban District, Manicaland Province
- Bulilimamangwe District, Matabeleland North and South Provinces
- Gweru Urban District, Midlands Province
- Zvimba District, Mashonaland West Province
- Bindura District, Mashonaland Central Province

Figure 2.1: Map showing provinces in Zimbabwe

Agro-ecological regions

The eight study districts cover the range of Zimbabwe's five agro-ecological regions. These regions are defined according to the average annual rainfall they receive and the kind of farming the land can support: Region I (less than 2% of the land) is confined to the Eastern Highlands and receives an average of +900mm (some areas receiving over 1500mm) of rainfall p.a. (suitable for tea, coffee, fruit, and intensive livestock production); Region II (15% of the land) is the country's primary intensive farming area and receives an average of 750–1000mm rain p.a. (suitable for maize, cotton, wheat, small grains, tobacco and intensive, livestock production); Region III receives an average of 650–800mm rain p.a. characterised by high summer temperatures (suitable for semi-intensive crop production especially drought resistant crops and livestock); Region IV (38% of the land) receives an average 450–650mm rain p.a. (suitable for drought resistant crops and semi-intensive livestock production); Region V (27% of the land) receives less than 450mm rain p.a. (suitable only for extensive livestock and game production).

In terms of the study areas, Nyanga District falls mainly within Regions I, II, and IV. Most of Mutasa District falls in Region II. Roughly 80% of the Chimanimani District falls in Region I and 20% in Region V. Mutare District falls mainly in Region II. Roughly 75% of Bulilimamangwe District falls in Region IV and the remaining area into Region V. Gweru District falls into Region III. Zvimba District is mainly in Regions II and III while Bindura District falls in Region II (Seidman et al 1992).

Fieldworkers

Data collection was done by the Biomedical Research and Training Institute (BRTI) and National Institute for Health Research (NIHR) research team, comprised of 10 people who were split into two teams, Team A and Team B. Team A worked in Chimanimani, Mutare Urban, Mutasa and Nyanga Districts, while Team B worked in Bulilimamangwe, Gweru Urban, Zvimba and Bindura Districts. In each site, the research team was assisted by at least one member of the local liaison team or a member of the FACT implementing organisation in that district. Prior to the research teams' entrance into the different districts, permission to conduct the study was sought from the relevant government offices (at national and district level), traditional leaders and local authorities. Informed consent was sought from the interviewees and assent from children.

Data collection methods and tools

The study was qualitative in design and guides were formulated to assist in the collection of data from different organisations and individuals. A general outline of the approaches used is provided below.

In-depth interviews

In-depth interviews and key-informant interviews were done with community members, government departments and support groups for people living with HIV and AIDS (PLWHA), FBOs, CBOs and NGOs, as shown in Tables 2.1–2.3. Themes covered in the interview guide included:

- challenges, needs and concerns for OVC and suggestions on how to help OVC;
- challenges for the community in providing care and support to OVC;
- attitudes of the community towards OVC, especially stigma and discrimination;
- care and support structures for OVC;

- profile of organisations working on projects targeting OVC;
- policy and legislation for the protection of OVC;
- extent of HIV and AIDS in the community and how to limit spread;
- care and treatment of PLWHA in the community;
- major sources of information on HIV and AIDS.

In addition to the in-depth interviews, there were case studies. The case studies were used to show a slice of everyday life of OVC that reveals the social dynamics and complexity of

Table 2.1: Distribution of respondents who participated in the in-depth interviews, by district

Districts covered	Care-givers	OVC	Council-lors	Traditional leaders	Members of home-based care/PLWHA Support Group	Ordinary community members	Case studies
Bindura	3	4	-	2	1	5	7
Bulilimamangwe	3	4	-	2	1	4	-
Chimanimani	4	4	1	2	-	4	3
Gweru Urban	3	4	1	-	1	4	-
Zvimba	3	4	-	2	1	4	-
Mutare Urban	4	4	-	-	1	5	2
Mutasa	4	2	1	2	1	3	1
Nyanga	5	4	1	2	-	1	2
Total	29	30	4	12	6	30	15

Table 2.2: Distribution of government departments' representatives interviewed, by district

	Districts							
Government departments	Bindura	Bulilima-mangwe	Chimani-mani	Gweru Urban	Zvimba	Mutare Urban	Mutasa	Nyanga
Ministry of Health and Child Welfare	✓	✓	✓	✓	✓	✓	✓	✓
Ministry of Education, Sports and Culture	✓	✓	✓	✓	✓	✓	✓	✓
Ministry of Home Affairs	✓	✓	✓		✓	✓	✓	✓
Ministry of Labour and Social Welfare	✓	✓	✓	✓		✓	✓	✓
Ministry of Agriculture	✓	✓	✓	✓	✓	✓	✓	✓
Ministry of Youth, Development and Employment Creation	✓	✓	✓	✓	✓	✓	✓	✓
Ministry of Local Government (District Administrator's Office)	✓	✓	✓	✓			✓	
Ministry of Justice, Legal and Parliamentary Affairs	✓		✓	✓			✓	
Rural District Council/Municipality	✓	✓		✓	✓			
District AIDS Action Committee	✓			✓	✓	✓	✓	✓
Zimbabwe National Family Planning Council				✓				
District Registrar General							✓	

the ongoing social processes. They are also meant to establish the validity of a particular theoretical principle, not by achieving statistical significance but through their ability to elaborate a theoretical principle by confronting it with the complexity of empirical reality (De Vries 1992: 68, cited in Vijfhuizen 1998: 13).

Table 2.3: NGO/CBO/FBO representatives interviewed, by district

Bindura	Bulilima-mangwe	Chimani-mani	Gweru Urban	Zvimba	Mutare Urban	Mutasa	Nyanga
Red Cross	CADEC	Red Cross	CADEC	CADEC's STRIVE	Nzeve	Africare	FACT Nyanga
Farm Orphan Support Trust	Esandleni Sothando	Save the Children (Norway)	Red Cross	Red Cross	Plan Inter-national	DOMCCP	COMFED
Farm Community Trust of Zimbabwe	Student Partnership Worldwide	Population Services Zimbabwe	Jairos Jiri Primary School for the Deaf	Murom-bedzi Vocational Training Centre	Simukai	Arise	
Zimbabwe AIDS Network	Bongani Orphan Care	Practical Solutions (formerly ITDG)	Anglican Church	Save the Children (UK)	Family Support Trust		
Hope Humana	Tjinyunyi Babili Trust	Tsuro Dze-Chimani-mani	Zimbabwe National Network of PLWHA	Justice for Children	FACT Mutare		
		Gwinyayi Trust	Gweru Legal Projects Centre	Vimbai-nesu Children's Home			
		Hope/ Tariro	Msasa Project	Batsirai Group			
			Midlands AIDS Support Organisation				

Focus group discussions

Three focus group discussions (FGDs) were held in each of the districts, each group consisting of 10 members of the community, one with adult community members (either mixed or with males or females only) and the other two with children (mixed boys and girls). A guide was used for the discussions and they were both tape recorded and transcribed after informed consent from the interviewees. The guides covered the following thematic issues:

- the living situation of OVC;
- care of OVC;
- extent of HIV/AIDS as a problem in the community;
- attitudes of the community towards OVC, especially incidents of stigma;
- care and support structures for OVC;
- profile and evaluation questions of implementing intervention organisation;
- challenges for the community in providing care and support.

Observations and informal conversations

Observations were noted during the community visits in the communities, which included observations made during conversations with members of the community. To make this a success, the researchers carried notebooks at all times during the visits. The researchers were assisted by some community members who were familiar with the whole community and with the situation of OVC. The researchers also conducted informal interviews with members of the community.

Secondary data

Secondary data sources included census reports, reports on related or overlapping issues from other research projects done in these communities, reports from organisations working with OVC or generally working in these communities, and national reports that incorporate these communities. The relevant information was extracted and used in the writing of the report. Care was taken that the materials used were public documents, so that confidentiality and other legal issues were not compromised. Any information taken from these reports was referenced. Consent was obtained to use and publish information from any material that may not be in the public domain.

Ethical issues, consent and confidentiality

Children and adolescents around the world face challenges in all aspects of their lives, including their health, education and environment. These difficulties have often been made worse by the growing impact of HIV and AIDS, making them vulnerable to many economic and social pressures (Schenk & Williamson 2005). Observing ethical standards is important for all information gathering that involves people. However, extra precautions are needed to protect young people, who are especially vulnerable to exploitation, abuse and other harmful outcomes (2005). The Medical Research Council of Zimbabwe (MRCZ) approved this study (A/1129) in 2003. Informed consent was obtained from all the participants in the study through participants signing letters of consent. The interviewer retained one copy, while another copy was given to the interviewee for their own records. Care was also taken with information obtained from personal conversations. For children below the age of 16, assent was sought from them after consent had been given by their parent/guardian. The consent forms were in English and the native language of the district. Explanation of the research project and the procedures involved were included in the consent forms, including possible risks and discomforts, benefits of participating, alternatives to participation, confidentiality and contact details of the responsible persons in the case of any queries.

Analysis and report writing

Based on the initial aims and objectives of the situational analysis, a mixture of analytic approaches was used to analyse data from interviews, observations and secondary data sources. The main method used for analysis was the content analysis method, which is drawn from the qualitative approach.

CHAPTER 3

Zvimba District

Wilson Mashange, Shungu Munyati, Brian Chandiwana, Stanford T Mahati and Stella-May Gwini

Background

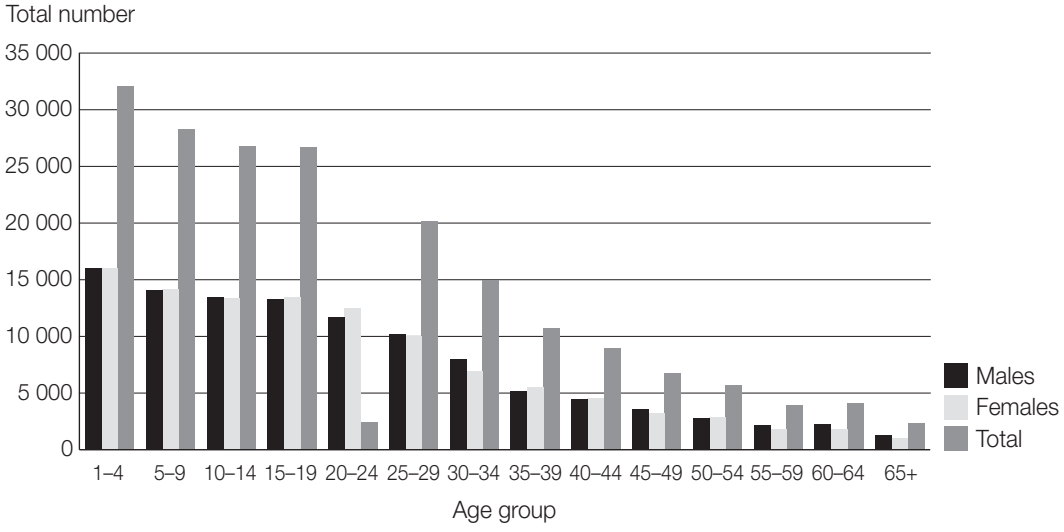
Description of the study area

Zvimba District is a rural district situated in the Mashonaland West Province of Zimbabwe. The district is in the middle-veld and is situated 71km from Harare and approximately 60km from the provincial capital, Chinhoyi.

Population distribution

The district has a total of 29 wards with a population of 220 763 and an equal distribution of males and females (CSO 2002). There are 52 630 households, with an average household size of 4.2 people. The age distribution is as illustrated in Figure 3.1. Approximately 52% of the population is 19 years old or less while about 5% are aged 60 years or more.

Figure 3.1: Distribution of population by age group and sex, Zvimba District



Agricultural activities

The population largely relies on agriculture, most of which comprises communal farms, hence farming is the major source of food and cash for most households. Very poor households that only cultivate for subsistence use rely primarily on casual work. Zvimba's proximity to Harare enables people to access the readily available markets in the capital city. Due to the reliance on agriculture, the occurrence of droughts (which have been rare) can dramatically reduce the livelihood of the communities. However, drought has become one of the major challenges during the past three years of 2002 to 2005, and other challenges include shortage of transport and change in market systems. Approximately 20% of the poor population relies on relief support (Zimbabwe Vulnerability Assessment Committee 2005).

Health facilities

The district has 33 health centres, of which 6 are hospitals and 27 are either rural health posts or clinics. The district hospital has a bed capacity of 65. According to the prevention of parents to child transmission (PPTCT) of HIV reports of 2005, 16.8% of the people tested were HIV positive.

Education facilities

The literacy level among those aged 15 years or more is 96%. The district has 164 primary schools with an enrolment of 42 430 students and there are 46 secondary schools with a total of 13 684 students, as reported by the Ministry of Education, Sports and Culture (MoESC) in 2005. Forty-four of the schools are unregistered and are situated in the former commercial farming areas. Most of the schools are in Zvimba South. The greatest challenge in the schools is acquiring teaching resources such as textbooks. With regard to education assistance, the Basic Education Assistance Model (BEAM) helps some students with school fees. Early child development centres are also found in the district and there are 30 pre-schools registered with MoESC. There are 29 schools with special classes for children with specific disabilities but, because of the lack of resources, some of the children are sent away from school. The population aged 3 to 24 years old currently attending school, the current levels of education being attended and sex distribution are shown in Table 3.1 below.

Table 3.1: Levels of education for 3- to 24-year-olds in Zvimba District

Level	Males (%)	Females (%)	Total (%)
Early education	8.15	9.12	8.61
Primary education	63.48	69.16	66.15
Secondary education	27.74	21.22	24.67
Tertiary education	0.64	0.50	0.57
Percentage	100.00	100.00	100.00
Total	32 524	28 990	61 514

Water and sanitation

The majority of the households use protected sources as their main sources of water, namely, 8.9% piped water inside dwelling unit, 20.3% piped water outside dwelling unit, 35.4% communal tap and 20.1% protected well/borehole (CSO 2002). With regard to sanitation, about 15% use flush toilets, 24.0% use Blair toilets (ventilated improved pit latrine), 24.3% use pit toilets and 28.7% have no toilet facility (2002).

Housing and energy

About 30% of the population live in traditional dwelling units, 29.8% live in mixed dwelling units and 24.2% live in detached units. Just below 5% have no proper dwelling units and live in shacks (CSO 2002). Generally, the houses are not in good condition. Some of the houses are made of poles and dagha while others are constructed with brick and mud, but with no cement, and so they are not properly built. The most common source of energy for household use is wood, although over a tenth of households do use electricity.

Conditions of OVC

Magnitude of OVC problem

The number of OVC was reported to be increasing every day as parents and guardians were dying at an alarming rate. A teacher reported that about three-quarters of each class at one primary school were vulnerable children, with orphans constituting a greater proportion. The majority of key informants and community members cited HIV/AIDS to be the main cause of orphanhood. The drought of 2005 was reported to have increased the number of vulnerable children.

Generally, the OVC were living under difficult conditions, mostly being looked after by grandparents and widows, with no reliable sources of income. Some orphans were staying with cousins, aunts, uncles and other relatives while others were staying in orphanages. In some households with old grandparents, it was often the case that children would actually assume the role of head of household. There was also a number of child-headed households in the district.

Housing conditions for OVC

Housing conditions for OVC were very poor, with the majority of the houses needing some refurbishment or upliftment. Some OVC were said to be homeless and some houses were reported to have collapsed during the rainy season. It was said that up to five grown-up children were sleeping in the same room, even if they were of the opposite sexes. There was no one to assist with repair of houses for the child-headed households and, in the farming community, OVC were living in pole and dagha huts that were in a particularly poor state.

Needs of OVC and major threats to quality of life

The OVC were reported to be facing a wide range of challenges and the commonly cited were:

- food;
- school fees and stationery;
- clothing, including warm clothes and school uniforms;
- blankets;
- shelter, especially in child-headed households;
- sanitary wear for girl children.

Failure to get these basic things was reported to be affecting the children psychologically, and so care and love for the OVC were mentioned as important needs in their lives. One child in a focus group discussion (FGD) said, *'Mwana anoda kugara nemunhu ane mwoyo muchena.'* (A child needs to stay with someone who has a kind heart.)

Child labour, rape and sexual, emotional and other forms of abuse were mentioned as the major threats to OVC's quality of life. Some OVC were traumatised and victimised by their caregivers to such an extent that they were even refusing to attend school. Caregivers indicated that OVC were overworked by their guardians.

Access to facilities by OVC

OVC generally had access to facilities such as education and health facilities. School fees for some OVC were paid through the BEAM scheme but some of the children were facing problems in getting school uniforms. OVC at schools were often given letters from their

schools to allow them free treatment and medication from the local clinics, and even those who were not at school had free access to treatment and medication if they produced letters from the Department of Social Welfare. Even though the OVC had free access to services at local clinics, they could not get the same free services at hospitals, for example, Murombedzi Hospital. Some orphans needed antiretroviral drugs and it was difficult for them to get the treatment.

OVC behaviour

Generally, the behaviour of the OVC was reported to be good, though there were cases of a few who were badly behaved. A 20-year-old youth commented on the behaviour of some of the orphans by saying, *'Nherera ukada kudzitsiura dzinoti onai zvekumba kwenyu … unoda kutonga misha mingani asi iwe uchida kumubatsira.'* (If you try to caution an orphan, they will ask you how many households you want to run. They will tell you to mind your own business.) Sometimes OVC were stealing as a coping mechanism for survival. Some OVC, especially girls, were said to be engaging in risky sexual behaviour, since they lacked guidance or people who could control them.

It was disclosed in FGDs that orphans sometimes engaged in promiscuity to eke out a living as well as due to peer pressure. Some orphans were also forced into prostitution by relatives in order to get money for family upkeep.

Property inheritance issues

Cases of property-grabbing after the death of parent(s) were reported to be few, although there were a few instances where relatives of orphans took all the kitchen utensils. However, it is part of *Zezuru* (Shona sub-dialect) culture that relatives of the late mother should take kitchen utensils, although people often take only a few just as a token. The adult FGD participants did not define the practice as property-grabbing, and one of them argued that contrary to the perception that they were depriving the children from acquiring their late mother's utensils, they would in actual fact be protecting them from avenging spirits. This community member said, 'There is a belief that if the relatives of the late mother do not take the kitchen utensils, the late mother's spirit will haunt the children for life.' Some of the property that was usually taken away by the relatives included cattle, faming implements, furniture and so on. It was established in a FGD with children aged 14 to 18 years, that sometimes headmen were intervening when a deceased parent's property was being distributed, to ensure that the children would not be deprived of important property.

Community attitudes towards and treatment of OVC

By caregivers

A number of OVC reported that they were happy with the care and support they received from their caregivers. The caregivers were reported to be trying by all means possible to reduce the suffering of OVC but were failing in some instances, due to poverty. On the other hand, it was reported that some families were not very supportive, as they first looked after the needs of their biological children before giving attention to the OVC under their care. At times, the external aid that would have been earmarked for orphans had not reached them, as caregivers gave them to their biological children. Some caregivers assigned OVC to do difficult household tasks, such as herding cattle, while they did not give their biological children the same kind of hard work. There were cases where

OVC were asked to work in the fields or look for firewood or water before going to school, and at times they would not be given food if they did not do the work. Some OVC were simply denied food while others were forced into early marriages by their guardians. Some guardians were reported to physically abuse orphans and many interviewers suspected that there were many unreported cases of children being raped. One caregiver indicated that some primary caregivers discriminated against OVC, in that the OVC were neglected and even the clothes they wore were different from those of the caregiver's biological children.

By other household/institution members
OVC and other children were said to interact very well, although one caregiver indicated that some parents were not teaching their children not to ill treat the OVC in their households. Most adults in FGDs indicated that they were teaching their children not to stigmatise the OVC. It was also reported that abuse of children who had been displaced and moved into new households after the death of their parents was a problem, as they would be given little food and had to sleep on the floor and play alone.

By community
Generally, the community at large was sympathetic to OVC's plight. Some key informants reported that although some of the OVC were being mistreated, the general attitude of the community was positive. A small section of the community members were reported to perceive OVC as people without hope in life and so did not respect them.

Orphans indicated that vulnerable children with both parents alive were having difficulties in accessing aid, as people pointed out that they were not supposed to receive assistance from donors if their parents were alive. One child underscored this by saying, '*Vane vabereki varipo! Musavabatsire!*' (They have both parents! Don't help them!) It came out in an FGD with children aged 6 to 13 years old that teachers were doing sterling work in helping with food and books (that is, buying books and selling them at lower prices). This was also echoed by the head of an orphanage who said that headmasters were also very helpful, as they did not turn away OVC when the orphanage failed to pay school fees for their children on time. Children from the FGD with 14- to 18-years-olds mentioned that almost all children played together, though there were isolated cases of a few children fearing they would contract HIV by playing with orphans. Interestingly, even some guardians told their children not to play with orphans in the community since their parents had died of HIV. Some children at school were also reportedly using abusive language with orphans.

Stigma and discrimination

Against OVC
As far as stigma is concerned, the community in general tended not to open up about this, although some community members said that stigma could not be ruled out, since society always included different people. Teachers reported that stigma did not exist in schools, except for children in the community who laughed at the OVC's tattered clothes.

The majority of the key informants said that cases of stigma and discrimination had been reduced, as meetings had been held to raise awareness in the community about the plight of OVC. This resulted in a positive change around how the community treated OVC. Some OVC reported that members of the community, especially their age-mates, had positive attitudes towards them, as they were good company and spent time with them. It was

discovered from the interviews that people in the communities did not have knowledge about how to assist OVC in dealing with stigma and discrimination.

Against those providing care to OVC
Stigma against caregivers was reported to exist, with some members of the extended family saying, '*havasi vana vako ava'* (these are not your children). Some community members falsely accused caregivers of benefiting from support that was supposed to be given to OVC. Caregivers used to be discriminated against for looking after OVC, especially AIDS orphans, but the community now appreciated the services of the caregivers.

Impact of caring for OVC on lifestyle
Caring for OVC was found to have no negative impact on the lifestyle of caregivers and caregivers themselves said they were coping. Although the number of OVC was increasing, caregivers employed various ways to cope with their situation. They dealt with emotional issues of looking after OVC by going to church to discuss issues that affected them and also to encourage each other. One caregiver said that caring for OVC could be made easier if one had the OVC under one roof, rather than having them in different households.

Suggestions of how to help OVC in the community

Study participants pointed out various ways in which OVC could be assisted and the most frequently mentioned was that all organisations, including government, must work together in assisting OVC. Other suggestions made were:

- Coordination of the non-governmental organisations (NGOs). This was said to be important as it avoided duplication of assistance to the OVC and hence would improve the quality of service as well as the number of OVC being assisted.
- Proper monitoring and evaluation of projects that assist OVC.
- Creation of a database for OVC. A member of a local NGO said that there was need for research to provide up-to-date information about OVC. Intervention agencies should carry out needs assessment studies as well, before they rolled out their programmes in the communities. It was further suggested that councillors should record all names of OVC and their needs, and present them to higher authorities.
- The community members, together with the OVC, called on the government to provide clothing, food, school fees, blankets, shelter and other things needed by OVC at school, in order to avoid OVC being denied access to donated items by their guardians. Furthermore, the government was called on to give households with OVC farm inputs, like fertilisers, so that they could be food secure. Community-based organisations (CBOs), NGOs and faith-based organisations (FBOs) could assist with money for clothing, books and other groceries such as soap. Some community members even called for provision of free education to OVC.
- The community was called on to take a leading role in spearheading activities that assist OVC. The community should not rely on the government and donors, but should also help out; even with giving salt, as well as with lending money to OVC and showing the children love.
- OVC should be counselled to help them accept their situation, and that this could be done by NGOs or social-welfare workers.
- Establishment of youth friendly corners was also called for, as there was only one youth friendly corner in the whole district. Recreational facilities were needed for OVC, such as social clubs.

- There was also a call for organisations to give OVC medical assistance. A lot of OVC could not access health facilities due to shortage of money. Some suggested that OVC should be treated free of charge at all health institutions.
- It was also suggested that people, especially caregivers, needed to be educated on children's rights and how to care for OVC.
- There was also a need to hold joint meetings with the registrar department, the National Aids Council (NAC) and MoESC to lay out plans to educate people about issues around birth certificates and children's rights to education.
- The government must strengthen laws and policies that protect OVC. The head of an orphanage in the district pleaded with the state to assist orphans in obtaining birth certificates. Some relatives refused to assist the centre in obtaining birth certificates for their orphaned relatives who resided at the orphanage, fearing that they would be asked to take the children to their homes. Thus the children's home found itself in a precarious situation when it failed to assist children under their custody to obtain birth certificates. The police also echoed the same sentiments and went further to say that this was because some communities still had the old, traditional beliefs.
- Some community members and also OVC themselves preferred to be capacitated with life skills, so that the dependency syndrome could be eliminated. One caregiver suggested that if people cooperated with projects such as keeping chickens and gardening, it would go a long way in assisting OVC. Caregivers suggested that older orphans should work hard to provide for their siblings, for example, dress-making to provide their siblings with clothing.
- Several government departmental heads suggested that there be someone employed to specifically take care of the welfare of OVC and to identify their needs.
- Holding workshops with caregivers and care facilitators would motivate and encourage them to continue doing their work and to release stress.
- The introduction of incentives to caregivers and care facilitators was cited as one of the ways that would motivate the caregivers to continue caring for OVC.
- Some community members called for FBOs to assist the OVC with spiritual guidance, so that they would not engage in drug abuse and other self-destructive behaviours. The members emphasised that churches should be at the forefront in restoring moral values in children, including OVC, and that they needed to hold prayers with vulnerable households.
- Communication between guardians and their children, especially OVC, should be improved. A head of the vocational training institute at Murombedzi Growth Point lambasted the behaviour of some parents and guardians who generally dismiss children when they talk about their concerns and challenges.
- Justice for Children urged the government to improve the economy so that cases of looting of children's estates (property and money left by their late parents) by relatives would be minimised. They went further to ask the government to stop migration of people to foreign lands, so that children would not have to live with relatives who might abuse them.
- The respondents emphasised the need to establish a database on OVC so that organisations coming into the area could easily identify the needy areas and where they could assist.

Commitment of caregivers in assisting OVC was not questioned, but their service was said to be ineffective because of lack of resources, as well as the unfair distribution of resources. The husbands of care facilitators were also said to be committed to helping; for example, if the care facilitator was not at home, the majority of husbands and children would assist representatives of NGOs. Some NGOs' commitment towards assisting OVC

was questionable, as at times they failed to attend scheduled meetings on food distribution.

Care and support structures for OVC

Providers of care and support

Structures that were providing care and support to OVC were present in the district. These included the extended family members, NGOs, FBOs, government departments and the community at large.

Family care and support structures

Relatives such as uncles and aunts were said to usually assist OVC with clothes, although their assistance was hindered by financial constraints. It was disclosed in an adult FGD that the extended family system had collapsed and some men attributed this to women who generally do not want to take in their late relatives' children. One man summed it all up by saying, *'Hurumende yechikadzi haidi kuti mapoto awande.*' (The household controlled by women's government doesn't want an increase in their household size, as it leads to them having to cook in bigger pots.)

Care and support from caregivers

Caregivers reported that they were using proceeds from their gardens to support their dependents. The sale of their produce was hampered by lack of markets. Their efforts were also being affected by the recurrent droughts and shortage of agricultural inputs. In addition, the caregivers were engaged in casual work to get money or they exchanged maize for other goods. They also made contributions towards the purchase of books for OVC.

The head of an orphanage complained that the community members had the perception that the orphanage had a lot of money. The community usually sold goods to the orphanage at exorbitant prices compared to those charged other community members and organisations.

Despite the criticism from the community members about failing to properly look after the OVC, the caregivers were nevertheless reported to have skills to care for OVC; however, execution of their duties was affected by poverty.

Assistance from the community

At community level, OVC were assisted with various basic needs. They were also assisted in establishing small projects such as vegetable gardens and selling sweets and *maputi* to raise money for food and soap. It was reported that the community used to have the chief's granary, *Zunderamambo,* but that it had disintegrated. However, there were plans to resuscitate the scheme. The community had established a nutritional garden and the produce from the garden was given to orphans for consumption. The community was also providing school uniforms at a local school. The district had one orphanage that provided a home to several OVC, mainly those from Mashonaland West Province.

Care and support structures provided by the government

The Ministry of Public Service, Labour and Social Welfare (MoPSLSW), in collaboration with the Ministry of Education, Sports and Culture (MoESC), runs the BEAM scheme, which

assists children with school fees. Participants reported that the scheme was not regular with its assistance and did not pay for other levies. The Ministry of Home Affairs' Victim Friendly Unit (VFU) was in place in the district, but most people were not aware of its existence and how to make use of it. The VFU was working in collaboration with the following ministries and organisations on community awareness of VFU: Ministries of Justice and Legal Affairs, Health and Child Welfare, Social Welfare, Childline and Red Cross.

Care and support structures provided by NGOs, CBOs and FBOs

SAVE the Children UK, Red Cross, Batsirai Group and World Food Program were assisting OVC with food and clothing, though the support was said to be inadequate. One community leader mentioned that there was corruption in the distribution of food in the district. Red Cross, Catholic Development Commission (CADEC) and District AIDS Action Committee (DAAC) were assisting with payment of levies, provision of school uniforms, fees, tracksuits, pens and stationery. The JF Kapnek Charitable Trust had built a pre-school and gardens in the community. DAAC was also assisting with sanitary wear to girl children; this was started after DAAC received reports that some girls were missing school during their menstrual periods because they did not have sanitary wear. Some OVC reported that they used to get support from donors but their names were cancelled, as donors wanted to assist those who had not been assisted before.

Congregations of the Roman Catholic and Methodist churches were making donations to OVC in the form of money, blankets and clothes.

Desirability and effectiveness of structures for care of OVC

Generally, government and other organisations were offering assistance that was wanted by the OVC. A council representative pointed out that they always encouraged the community to keep the orphans within the nuclear family, emphasising that taking OVC to orphanages must be a last resort.

The effectiveness of the care support system in the communities was evident, since there were no children on the streets of Chinhoyi when the research was conducted. One caregiver said some organisations were providing OVC with food and educational assistance. Resources for OVC were scarce and therefore very few OVC were being assisted. BEAM was said to be more effective in assistance to primary school children than to those in secondary schools. It was reported that it was not easy for children to continue getting assistance through BEAM from primary up to secondary school. There were also reported cases of delays in payment of fees by the BEAM scheme. Some caregivers indicated that Batsirai was effective, but Red Cross was facing transport problems and sometimes failed to ferry goods to respective distribution points.

Most NGOs paid school fees, but neglected other critical areas, for example, uniforms, stationery, sanitary wear, medical fees and so on. In short, the respondents agreed that the support structures were not assisting holistically, that is, they did not provide for all the OVC's needs such as food, education, shelter and so forth. A factor that was raised as affecting the effectiveness of the support system was the lack of human resources.

Impact of services

The indicators of success for systems of care were mentioned as:

- Income generating projects (IGPs) that were being run by OVC were very fruitful, as some OVC could buy clothes, food and pay school fees from proceeds from IGPs.

- Nutritional status of children was also said to have improved. Some OVC said they were managing to have two meals per day instead of one and also accessing medical facilities.
- Some guardians were now knowledgeable about laws and policies that protect children and this was after they had received education from social workers; some even confessed their ignorance of the laws and that they had been abusing children without knowing it.
- School attendance had improved. A representative of an NGO said that the number of children who had gone to school up to 'A' level and even tertiary level had increased tremendously. A caregiver also echoed that the services were having positive effects, since the orphans were back in school and no longer attended school with hungry stomachs.
- There was an increased knowledge on OVC, which had greatly improved their living conditions.

Sustainability of these systems of care

In terms of sustainability of what had been achieved as the indicators of success, respondents pointed out that the assistance at community level could only be sustainable if they received good harvests every year. One caregiver indicated that the community had initiated a nutritional garden and a portion was given to OVC, but that the donor only provided the fencing materials and seeds. Projects such as gardening (for example, herbal gardens) were sustainable as they used local resources and they could be easily continued even if organisations pulled out. However, some of the projects were not successful, since they were not community driven, while other intervention programmes were not sustainable, as they had a top-down approach system.

Challenges in providing care and support

The major challenges faced by the community in their effort to care for OVC were in providing basic materials for OVC. The major challenge was that of poverty, which was worsened by the harsh economic situation. Most of the caregivers could hardly give adequate assistance with basics such as food, shelter and clothing. The following were the other challenges mentioned:

- Selection criteria for the OVC were biased; some OVC who were supposed to benefit from support such as the BEAM scheme were not benefiting because of this bias.
- Some children said that grandmothers were no longer able to look after OVC because they were old and frail.
- There was also lack of transport to take sick children to hospitals, since most of the major hospitals were in urban areas. Some of the respondents reported that commercial farmers used to take children and other members of the community to hospitals in the urban areas, but since the land reform programme, that service was no longer available. Shortage of transport to go and investigate cases of child abuse was also noted as a problem by the VFU.
- Medicines were too expensive, to the extent that many people, including OVC, could not afford to buy them.
- The issue of poor nutrition was a major challenge, since a number of the OVC were malnourished. Community leaders reported that getting food was a problem because it was too expensive.
- Some carers were failing to take proper care of OVC, due to poverty, and this was forcing some OVC to engage in prostitution.
- The community could not mobilise resources to assist OVC.

- There was no system to evaluate the services provided by various intervention agencies and the community was not aware of the role they were supposed to play in assisting the OVC.
- Ignorance of the caregivers was also a challenge. Some caregivers did not have the knowledge that they were ill treating OVC, for example, child labour or cases of early marriage, as the caregiver would claim that he/she could no longer afford to take care of the OVC. In any case, child labour was not recognised in most communities, because people argued that children had to be taught life skills.
- Inadequacy of incentives for volunteers was a challenge. It was felt they needed a token of appreciation (for example, soap) to boost their morale; some caregivers dropped out, since they thought they would get assistance.
- A legal officer with Justice for Children Trust indicated that one of the major challenges OVC face is lack of money to engage the services of lawyers. She also pointed out that some children had animosity towards laws that gave rights to stepmothers, whom they would perceive to be unfairly benefiting from their late fathers' estates. She called for the education of orphans on the need to respect the rights of their step-parents, so that there could be more harmonious relations within the home.
- Access to documents that describe such laws was difficult and these documents were not available in common bookshops, but were being sold in two government-owned shops only, which were in Bulawayo and Harare. Furthermore, most people were not aware of the location.
- The migration of parents to the diaspora, leaving children under the care of guardians who usually cannot make legal decisions, was making it very difficult for children to obtain important documents like birth certificates. It was also difficult for the community to help such a child.
- It was stated that corruption was undermining efforts to assist OVC, because child abusers were bribing some prosecutors.

Suggestions on how to overcome challenges

- Volunteers needed to be given incentives, as this would make them work more effectively.
- Caregivers needed to be assisted with food and educational materials.
- Community leaders suggested inviting other organisations to come in and assist, in addition to the few already working in the district.
- There was need for collaboration among organisations assisting OVC, so that there would be no duplication of services.
- Continuity of support structures, such as a food-for-work programme, would also go a long way in helping many people, including OVC.
- Some community members called for parents to prepare for the future of their children before they die, for example, by making savings through investment.
- Foster caregivers and care facilitators should be trained to provide care and counselling to OVC.
- Communication at all levels was essential in terms of holding meetings to sensitise beneficiaries and caregivers about the rights of OVC, especially on issues of negligence.
- Identification of the caregivers' shortcomings and weaknesses was needed so that other stakeholders could participate; or even training of caregivers could be provided.
- The majority of the key informants called for the establishment of a database for OVC. They even asked for support from the census of the OVC that was in process

during the time this study was being conducted. It was envisaged that the database would help in assessing the number of OVC, in providing assistance to OVC, in establishing their needs and in improving the selection criteria of OVC in the whole district.

- Organisations should have a thorough background and knowledge of the community they want to work with.
- The organisations needed to closely monitor and evaluate their structures to check if the intended beneficiary gets the aid.
- There was also a call for the state to develop a strong financial base.
- Other respondents suggested that OVC should not be given assistance directly, but that it should rather be given to the family head, to avoid family disintegration.
- There was a call for coordination of organisations that assist OVC, so that programmes run smoothly.
- Views across the board in the district indicated that the role of the social welfare department was not well defined and communicated to the intervention agencies and community at large. Participants said the department was not coordinating the NGO activities well.

Policy and legislation for the protection of OVC

Knowledge of laws, policies or practices to protect OVC

One legal officer with a legal organisation estimated that less than 30% of the general population were aware of the laws that protect children and how to enforce them. Key informants from the MoHCW stated that some government employees themselves, who were supposed to be custodians and the ones enforcing the policies, were not aware of the policies and laws that protect children. Other study participants also supported this view and they particularly mentioned that the majority were not aware that prevention of child labour was one of these laws.

Although the majority of the community members were not aware of the laws, children were aware of the Children's Act (Chapter 5:06 of 14/2002), Sexual Offences Act (Chapter 9:21 of 22/2001) and Labour Act (Chapter 28:01 of 17/2002). The Ministry of Home Affairs (MoHA), through the Victim Friendly Unit, also held campaigns to educate children about the laws and their rights.

Attitudes towards such regulations

The attitude of participants in this study towards polices and regulations that protect OVC varied a lot. Some had positive attitudes towards the laws while others were breaking them at will. One community leader went on to say that some community members were not happy with some of the acts, especially the Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996), as they felt that children should remain under the guardianship of their parents, regardless of their age. Furthermore, adults in an FGD indicated that there was a conflict between modern and traditional laws, especially on child labour.

Regardless of the attitudes that some guardians had regarding the laws, some parents had changed their attitudes on the ways in which they treated children, and this indicated that those parents did support the laws. The majority of the respondents understood that children had the right to education. Some participants said that they found it difficult to tell someone that he/she was abusing his/her children.

Challenges faced in enforcing laws that protect children

The children were not free to report cases of abuse, because they were told not tell anyone. There were also cases of resistance from guardians. A community leader stated that some people continued to rape children even though they knew that it was an offence, hence there was a need for stiffer penalties, so that people desist from such abuse. One respondent went on to say that the child protection laws needed to be reviewed, as they were not adequate.

Limitations of existing laws

Laws on birth registration were not flexible. In the event that both parents died, it was difficult for relatives to obtain a birth certificate for the child, since the law stipulates that there must be both maternal and paternal relatives. The law does not always accommodate affidavits, as it states that the death certificates of both parents should be presented. At times, it was difficult for relatives to get these, especially when the parents had separated under acrimonious circumstances, which could lead to other relatives not wanting to cooperate.

Some women thought they could not take the child's birth certificate in the absence of the father, because they felt that as the mother she had no power to do so. At the same time, mothers who were educated abused the law by unilaterally registering their children under their names and by so doing, a child would lose his/her paternal identity.

- A legal officer with Justice for Children pointed out that it was difficult to get maintenance from fathers who were informally employed. Although they were known not to be earning a lot, such fathers had a tendency of understating their monthly incomes to the courts and the courts lacked adequate measures for dealing with them.
- The Sexual Offences Act was particularly difficult to implement, as it was difficult to prove who infected who.
- Even though the amended Deceased Estates Succession Act (Chapter 6:02 of 6/1997) tried to protect the rights of the children in the distribution of estates, it created other legal challenges. For example, if the mother of child X dies and the father remarries and later dies, child X would not inherit the estate because property is inherited by the surviving spouse.
- One matron from an orphanage stated that the Department of Social Welfare stopped assisting OVC when they turned 18 years old, which made it difficult for the orphanage to abandon the OVC, because they would not have anywhere else to go. They found it prudent just to continue to accommodate the OVC and assist them without any government support.

HIV and AIDS

The study participants could not give actual figures of the number of people living with HIV/AIDS in their community but they all agreed that the cases were on the increase. All the participants acknowledged that HIV/AIDS was a problem in the district and that more people were getting infected. The majority of the participants unanimously agreed that people were now aware of HIV and AIDS, although some still had shallow knowledge about the disease. One respondent said, *'Vanhu vazhinji vavakuteta nyaya dzesex except vedoro, munongozivawo chivindi chedoro unongopinda.'* (Many people have changed their sexual behaviour except those who drink beer, you know the guts that beer gives, you end up doing things without thinking.)

One of the people living with HIV and AIDS (PLWHA), who had known her HIV status since 1992, said that people were knowledgeable, but that cases of stigmatisation were still around in some areas because people did not understand and they had not come out into the open about their status. She emphasised that people still needed information on issues of stigma.

Cases of witchcraft accusations after the death of a PLWHA were reported to be low. The respondents went further to say that when such accusations occurred, they were really just cover-ups, since people would be fully aware that the deceased had died of AIDS. This was further emphasised by the fact that community members sought assistance from Red Cross care facilitators and would say, '*… mwana wangu akauya achirwara ndinofunga kuti ane chirwere handizivi kuti munga mubatsira sei?'* (My child came and he is ill, but I think he is suffering from the disease. Can you help me?)

Impact of HIV/AIDS

State and organisational resources
The respondents reported that the government and non-governmental organisations were channelling a lot of money towards HIV/AIDS programmes at the expense of other developmental programmes. Current efforts in mitigating the impact of AIDS were said to be a drop in the ocean, while the problem is getting bigger and bigger. There was depletion in human resources and people were always attending funerals, and those spearheading programmes were also succumbing to the disease.

Community resources
Many people, especially the breadwinners, were dying, thereby leading to an increase in the number of orphans. Children were then left under the care of old grandparents who could not look after them adequately. Some children were staying by themselves and therefore increasing their susceptibility to abuse.

Social functioning of the community
Relationships within families have been strained and continued to be affected to such an extent that the extended family system no longer existed in most cases. A caregiver stated that HIV/AIDS was resulting in the breakdown of marriages and an increase in adult prostitution, saying, *'Vanhu vanopomerana mhosva kuti uyu ndiye akaunza chirwere mumhuri.'* (Spouses point fingers at each other, blaming the other for bringing the disease into the family.) HIV/AIDS had also resulted in the increase in numbers of orphans and many of these orphans had dropped out of school. People with HIV/AIDS needed extra care, hence the increasing burden on the family members. Also, people no longer had time for farming for the family. One respondent sadly mentioned this by saying, '*Vanhu vava kuswera kunhamo.'* (People now spend a lot of time at funerals.)

Suggestions on how to limit the spread of HIV/AIDS in the community

The following are suggestions that were given by the participants on how to halt the spread of HIV; these included educational and infrastructural needs:

- People should change or stop their reckless sexual behaviour.
- Provision of education on behaviour change must be done, even in churches and bars, and those infected must be taught not to infect others. Education should be continually communicated to people, in other words, to talk about it every day.

Opportunistic infection (OI) clinics must educate people daily and simple language must be used to teach children about AIDS in schools.
- Sharing of razor blades and needles needs to be stopped.
- PLWHA should give testimonies during educational campaigns so that people could understand better. For example, one woman who was being harassed by a man ended up showing him her Zimbabwe National Network for people living with HIV/AIDS (ZNNP+) card, and the man ran away!
- Introduction of anti-AIDS clubs; dramas on HIV/AIDS to be performed at schools.
- People should curb prostitution. Prostitutes must be assisted in starting IGPs, so that they can be occupied and kept away from bars.
- Partners should be encouraged to be faithful to each other in their marriages.
- Child rape must be stopped and stern measures/sentences put in place to safeguard minors.
- Encourage youths to engage in projects to keep them occupied, so that they would not engage in risky activities.
- Intensify voluntary counselling and testing (VCT) services and increase mobile VCT centres in the district.
- Condoms have to be made readily available and people should be educated about the correct use of condoms.
- Children and youth should be taught to practise abstinence before marriage, because they did not honour marriage now and when they reached puberty, they started experimenting with sex.
- People should be tested for HIV before the *nhaka* (wife inheritance) process.
- Home-based caregivers should teach relatives of PLWHA how to care for them, in order to avoid HIV infection while caring for them.
- There was a need for increased access to health facilities through building more clinics and hospitals.
- Peer education must be strengthened as a tool in giving out information on HIV/AIDS.
- Introduction of well-monitored youth friendly centres.
- Introduction of social facilities, such as football and netball, so that youth would be occupied and have an opportunity to change their behaviour.
- Improve accessibility of PPTCT services to the communities.
- Address poverty and housing problems: it was stressed by some respondents that some people were emulating people who were HIV positive, because they were getting food assistance.
- Churches must intervene with prayers, as people were not changing their sexual behaviour, especially with regard to prostitution.
- Workplace HIV and AIDS prevention programmes must be introduced to all sectors, for example, in schools, as some teachers and health workers were said to be unaware of some of the simple facts about HIV/AIDS.

Care and treatment of PLWHA in the community

Services available to PLWHA were home-based care (HBC), VCT, PPTCT and OI clinic services, as well as antiretroviral therapy (ART) programmes; however, ARVs were only available at one hospital. Red Cross and Batsirai Group provided HBC services in the district. Some of the key informants rated the HBC programme run by the Red Cross as the best in southern Africa. Red Cross and the Chinhoyi Catholic Diocese were also spearheading the cultivation of herb gardens.

One PLWHA said that drugs, especially Cotrimoxazole, were available for prophylaxis, but the problem was that some PLWHA were not aware of the availability of ARVs at Father O'Hea Hospital. Relatives were reportedly taking care of PLWHA, but the PLWHA were always complaining and demanding several things that their relatives could not afford.

People's attitude towards PLWHA was said to have greatly improved, to the extent that cases of stigma and discrimination were now few.

One community member indicated that PLWHA were looking better and their nutritional status had improved. The PLWHA were welcoming these services and were giving testimonies. Even men were accepting the PPTCT services to the extent of accompanying their wives to get the treatment.

The VCT services were said to be inadequate and were centred in the urban areas only. One PLWHA indicated that ARVs were available and also cheap, but that the test for CD4 counts was very expensive, a test that has to be carried out before one commenced taking ARVs. She further said that HBC services were not efficient and so called for the PLWHA to be trained as caregivers, because other general caregivers did not give proper care to the PLWHA. There was also a call to train caregivers in counselling skills.

Advantages and disadvantages of disclosing one's HIV status

The following are the merits and demerits of disclosing one's HIV status that were stated by the study participants:

Advantages

- It enabled one to get help, such as food, clothing, soap, seeds and fertilisers to start herbal gardens.
- One could live longer and plan for your future, especially regarding inheritance issues.
- One would have good peace of mind.
- HIV prevalence could be reduced and quality of care improved.
- Disclosure made the problem of HIV/AIDS real.
- People would know how to help you, interact with and look after you.
- One could teach others how to protect themselves and also how to protect partners and household members.
- One could get a nutritional guide.
- Disclosure of one's status would reduce finger-pointing among family members.

Disadvantages

- People would laugh at you.
- Some accused you of lying and you were stigmatised and discriminated against to such an extent that you might be given your own spoon, plate, cup, bed and so on. One OVC said that, *'Vamwe vanokushungurudza vamwe vanokusema vachiti wava kuvazadza chirwere.'* (They stigmatise you and say you infect them.)
- PLWHA were accused of negligence.
- Women were subjected to domestic violence and the husbands would verbally abuse them.

Risks of HIV as a result of violence

The main form of violence that increased risk of HIV was child abuse. Participants indicated that child abuse, that is, child labour, rape and sexual assault cases, did exist but were not very prominent. According to the VFU, more than five cases of child abuse were reported in 2005. Rape cases constituted more than 60% of child abuse cases that the police dealt with while 40% included rape against women, incest and sodomy. Cases of children being raped by the family members were not being reported, as people were afraid to break family ties and also to lose dignity. Some of the cases were of men who took advantage of young girls who needed assistance; for example, there was a case of 32 girls who were sexually abused by one man who had the source of water for drip irrigation in Zvimba South.

The main targets for abuse were primary school children or young defenceless girls. Main perpetrators were unemployed youths, neighbours, teachers and male adult household members, even including biological fathers. Reasons for raping were either based on the myth that if someone sleeps with a virgin he/she is cured of HIV or after instructions from traditional healers to have sex with children in order to prosper in business.

Counselling services for the abused were reported to exist, but were said to be insufficient. A qualified nurse was employed by the Red Cross to provide counselling at the clinic and at the youth friendly centre. The VFU, school psychological services and the rural district council's social welfare arm also offered counselling services to the abused children.

Prostitution was said to be rampant, especially at Murombedzi Growth Point. Cases of children involved in prostitution were also reported and these included OVC. A community leader reported that young girls were not even ashamed: *'Vanokuti wedzera imwe mari iyi ishoma'* (They actually ask for larger payments); that is, after having provided sexual service. Some people who were involved in commercial sex work were unmarried women and divorced men, as well as PLWHA. OVC were engaging in prostitution to earn a living while some were doing it to get luxury items.

Major sources of information on HIV/AIDS

Schools, clinics, VCT centres, radios, televisions and peer educators were cited as sources of information on HIV and AIDS. NGOs and MoHCW were also named as vital sources of information.

The following were suggestions on how the provision of information on HIV/AIDS could be improved:

- Husbands should be targeted during awareness campaigns, as they are the ones who make final decisions, especially on sexual matters.
- Parents should learn to communicate with children about HIV and AIDS instead of giving that responsibility to aunts. Children in an FGD of 14- to 18-year-olds emphasised that parents should not be shy to talk to their children on issues concerning HIV/AIDS, sexual abuse, reproductive health and child abuse.
- Community leaders must also be involved in educational campaigns, as they are influential people in the community.
- Peer education must be strengthened to improve distribution of information.
- The public must be allowed to contribute to the development of HIV/AIDS educational materials.

- Increase the number of dramas on the television and radios about HIV and AIDS.
- Schools should offer lessons on HIV and AIDS.
- Information on HIV and AIDS should also be provided in the local languages, so that all people of different ethnic origins will understand.
- Information about HIV/AIDS should be programmed in a way that is sensitive to age differences in the population.
- NGOs should cover the remote areas when giving out information on HIV/AIDS.

Profile of government departments

Several government ministries and departments were involved in the delivery of services to children, and in particular to OVC. Government ministries that were assisting OVC in one way or another in Zvimba District follow below.

Ministry of Health and Child Welfare

Background

The ministry did not have programmes directly targeting OVC, but it did cater for all children, including OVC. The ministry provided free services that included medical and surgical treatment to all children aged five years and under. Other free services for these children, including OVC, were immunisation, the Child Supplementary Feeding Programme and PPTCT. With regard to immunisation, there was the Expanded Programme on Immunisation (EPI), which had an outreach component. The hospitals had trained many village health workers (VHW) and used to have both communal health workers and farm health workers. Hospitals also worked closely with NGOs and other government departments in HBC programmes.

Activities

- With regard to OVC, the ministry provided free services (which included medical and surgical) for children under the age of five.
- Immunisation of children was free and all children accessed these with the help of outreach programmes.
- OVC and even those children aged five and above were also catered for in the ministry's Child Supplementary Feeding Programmes.
- Prevention of mother to child transmission (PMTCT) was also done in a way that catered for OVC, through the provision of infant formula in the event of the mother's death.
- Provision of HBC services in rural areas, which were coordinated through their nurses, who then did follow-ups on their clients. The nurse-in-charge provided information to the caregivers.
- Provision of ARV drugs.
- Offering counselling services to the OVC, affected both physically and emotionally, at Family and Child Health (FCH) and OI clinics.

Challenges

- The major challenge was that of transport, with no transport to take patients to hospital and also shortage of transport for the hospital staff to use during outreach programmes such as the EPI.
- The accessibility of ARVs and some other drugs was a problem.
- The ministry had a shortage of both human and financial resources.
- The hospital did not have machines in their laboratories.
- Shortage of HBC kits, although sometimes accessible from partners.

- Hospital services, for example, laboratory tests (CD4 and liver function tests) were very expensive.
- There was no good collaboration between hospitals and the Department of Social Welfare, except in the case of abandoned babies.

Plans
- There were plans to upgrade the Banket hospital.

Recommendations
- Coordination of the state and NGOs, in order to provide better services than those already provided, was needed.
- In-house training, such as workshops and tutorials, for people who worked with children was needed.
- Continuous education and provision of information were needed.
- There was a need to educate men in particular, because they often missed out on education at hospitals.
- Workplace HIV/AIDS campaigning programmes should be strengthened.
- Laboratory machines were needed.

Ministry of Youth Development and Employment Creation

Background
This ministry was initially formed to cater for the welfare of the youths, in collaboration with other stakeholders like NGOs, the Ministry of Social Welfare and the Ministry of Health and Child Welfare. This was done so that the ministry would create a solid structure that would be able to bring up a child. The ministry included National Youth Training Centres that taught youths the country's background and self-reliance, that is, to manage their own business, such as projects that were given funds. The ministry had also facilitated the enrolment of youth into nursing and teacher training institutions. There were officers in all the 29 wards who were responsible for writing lists of all the names of the youth in their respective wards, before sending the lists to the district office. The ministry also had ward coordinators who identified households with orphans and prepared registers of the orphans. The ministry had six training camps in the country.

Activities
- Seeking employment for children heading households immediately after finishing training.
- Liaising with organisations like the World Food Programme (WFP) in the provision of food to OVC.
- Assisting youth with writing project proposals and supporting their projects.

Challenges
- Having limited resources.
- Biased selection of youth.

Achievements
- They had managed to secure employment and training courses for a number of OVC.

Recommendations
- NGOs focusing on HIV/AIDS issues should be involved in the National Youth Training in the area of HIV/AIDS.

Ministry of Agriculture

Background
The department of Agricultural Research and Extension Services (AREX) was part of the OVC committee in Zvimba District. It had a nutrition programme that assisted children under the age of five, including OVC in the district, and was funded by donors. The department also trained farmers on good farming methods and had 89 officers in the whole district.

Activities
- Supervising nutritional gardens.
- Providing expert advice in farming.
- Providing seed and fertiliser to the community for the *Zunderamambo* (chief's granary).

Ministry of Education, Sports and Culture

Background
The major contribution to the OVC's education was reported to be the Basic Education Assistance Module (BEAM) scheme, which is a collaborative programme between the Ministry of Public Service, Labour and Social Welfare and the Ministry of Education, Sports and Culture. The BEAM scheme is one of the various forms of social protection the government was providing to vulnerable groups, through various ministries. This component was a tuition fee, levy and examination fee assistance module targeting vulnerable children. BEAM replaced the school fees programme that was located under the Department of Social Welfare. The primary objective of BEAM was to reduce the number of children dropping out and to reach out to children who had never been to school due to economic hardships. BEAM assisted children in the following circumstances:
- Children in school failing to pay or having difficulty in paying tuition fees, levies and examination fees.
- Children who had dropped out of school due to economic reasons.
- Children who had never been to school, due to economic reasons, but were of the school-going age.

The district education office employed a remedial tutor who was responsible for the schools' psychological services and for working closely with OVC. The district also had special classes for children with mental disability (at the mental retardation school in Zvimba North, called Kuwadzana Primary, and at the hearing resource centre, called Mariga). There were 29 special classes in the district and, out of these, 10 teachers had training in special education. The majority were currently pursuing studies in BSc Special Education with Zimbabwe Open University (ZOU) and also a diploma in special education from United College of Education (UCE). The Ministry of Education, Zvimba, is part of the child protection committee, which is chaired by the Social Welfare Department.

Specific BEAM activities
- Paying tuition fees at urban primary, urban secondary and rural secondary schools.
- Paying examination fees for rural and urban, primary and secondary schools.
- Assisting child-headed households to get first priority on the BEAM register.
- Assigning community selection committees to identify orphans, including child-headed households.
- Investigating allegations of ill treatment of children and asking Social Welfare or police to assist if allegations were substantiated.

Challenges
- Shortage of teaching resources.
- Monthly returns were not forthcoming; there was a need for an OVC focal person at each school throughout the whole district.
- There was no school for the visually impaired children.

Plans
- Plans to open seven more special classes.
- Plans to open early childhood development (ECD) centres.

Recommendations
There is a need for a school that caters for the visually impaired children.
Each school in the district should have a teacher responsible for the OVC's welfare (that is, creating a register for OVC, monitoring OVC and having a register for NGOs that assist children).

Ministry of Local Government, Public Works and Urban Development

Background
The Social Services Department in the council is the custodian of the OVC in the district. They are service providers for the disadvantaged communities and vulnerable groups and, as a government department, they were said to have saved the community.
The ministry had different departments with various functions, and the Social Services Department was one of the major departments in the council. This department was tasked to work with the National Action Plan (NAP) in the Ministry of Public Service, Labour and Social Welfare, and these two departments also interchanged chairmanship for the Child Protection Committee for Zvimba. There were four social workers in the district, one village community worker (VCW) per village, and one farm community worker in each farm.

Activities
- Writing proposals on OVC and sourcing funding.
- Coordinating meetings of all stakeholders dealing with OVC.
- Ensuring organisations working with OVC did their mandated work.
- Vetting NGOs that wanted to work in Zvimba.
- Taking stock of NGOs that worked in the community, so that there would be no duplication of services.
- Training and giving refresher courses for VCWs.

Challenges
- The WFP Tool for poverty assessment was not suitable for the Zvimba set-up; for example, those with homesteads built with bricks did not benefit, and so it was not a good selection criterion.
- VCWs were displaced, due to the land redistribution programme of 2000.

DAAC

Background
In 1999, the government introduced the National AIDS Council (NAC) programme in response to the plight of the HIV and AIDS pandemic. As part of the NAC, DAACs were set up in each district, with the mandate to ensure that the most deserving people would benefit from the AIDS levy, which included caring for OVC made vulnerable due to HIV

and AIDS. Under the DAACs was the Ward AIDS Action Committee (WAAC), which was based in the ward, and then the Village AIDS Action Committee (VAAC), which was right in the village. At the same time, DAAC provided a common forum for all NGOs, CBOs and FBOs in each district to meet and update each other on progress and difficulties they were encountering.

The district had one District AIDS Coordinator and an accountant. The DAAC office had one vehicle, donated by the Global Fund Project, which was now being used to transport goods such as food packages for OVC.

The wider vision of the committee is to be recognised as the leader in reduction of HIV and AIDS and impact in Zimbabwe and beyond, while its mission is to be a committed provider of quality and effective leadership for a comprehensive and coordinated multi-sectoral response to HIV and AIDS in Zvimba District. Their specific goals are to empower communities to reduce HIV transmission and to minimise the impact of the AIDS epidemic on families and society.

Objectives

- To ensure effective leadership and coordination necessary for multi-sectoral responses to HIV and AIDS.
- To spearhead advocacy, social and resource mobilisation towards scaled and accelerated action against HIV and AIDS.
- To monitor and evaluate multi-sectoral responses to HIV and AIDS to enhance their impact.

Activities

- Giving stationery (exercise books, pens, rulers, etc.) to school children.
- Supplying sanitary wear to girl children through Ministry of Education, Sports and Culture.
- WAAC to have a focal person who identified OVC that were being abused and stigmatised, and refer them for counselling services.
- Assisting OVC under mitigation in the majority of cases.
- Identifying OVC who needed assistance and refer them to MoESC.

Challenges

- There was no database for OVC, hence the problem in identifying OVC and their needs.
- Some NGOs were not forthcoming with reports.

Recommendations

- Address accommodation and land issues for OVC.
- Introduce a system that accommodates OVC at schools, so that they would not be turned away from schools.
- All stakeholders should come together and work in collaboration to improve their service to the OVC.
- OVC census should be carried out annually.
- Volunteers should be given incentives, for example, tennis shoes, soap and so forth.

Ministry of Home Affairs (Police)

Background
The police department created a VFU that was mandated to provide victim friendly services to sexually abused victims, including OVC. The unit enabled the victims to report directly to the VFU instead of the charge office where everyone else reports.

The province had seven sections and each section had one district coordinator. Their area of coverage included Zvimba, Banket, Mhangura, Rafingora, Mutorashanga and Chinhoyi.

Activities
- Awareness campaigns that included how people should react in the event of an attack by abusers (four campaigns per month).
- Being invited to workshops to give lectures, mainly on forms of child abuse, children's rights, effects of abuse, and signs and symptoms of abuse.

Challenges
- Victim friendly coordinators lacked counselling skills, since they were not trained.
- The need for pre-trial and post-trial counselling services for the abused OVC and other children.
- Resources were a problem; lack of office accommodation was a major setback.
- The need to consistently check data, but they had no place where the data were easily retrievable, especially statistics on various cases.
- The community was not aware of the VFU services.
- Victims were not examined promptly.
- Cases took time to be heard and, in some instances, children forgot what happened to them.

Recommendations
- The need for trained personnel to handle victims, both OVC and abused children generally.
- The need to identify clinics for the victims, instead of leaving them to queue for service with the other patients in general clinics or hospitals.
- The importance of having a conducive environment for the children in order for them to feel free; for example, toys were needed in the VFU, so that the child would at least forget that he/she was speaking to a policeman.
- The need for a computerised system.
- The need for an outreach programme to make people aware of the VFU services, as some people did not have TVs.
- There should be a victim friendly clinic where the victims could be examined immediately.
- The need to fast track the cases before the child forgot what had happened.

Murombedzi Vocational Training Centre

Background
The vocational training centre falls under the Ministry of Youth Development and Employment Creation. It offered training to the disadvantaged youth, that is, those who would have failed to go to the polytechnics or university and those who would have failed to satisfy certain grades. Students who were enrolled should be in a position to initiate projects on their own.

The centre needed to access resources from the government budget and also from some projects that bring in income to the centre. It also included production units, like the carpentry unit, which made a good profit. The centre's catchment area is Zvimba South, North and Manyame. The centre's staff included a centre head, lecturers, administration staff and general helpers.

Activities
Offering training in metal work, carpentry, joinery, basic mechanics, agriculture, brick and block moulding, cooking and computer skills to youth, women and the unemployed. Mandated by the Minister of Higher Education to conduct trade tests.

Table 3.2: Student enrolment for year 2005 at Murombedzi Vocational Training Centre

Discipline	No. of students	Males	Females
Clothing technology	13	–	13
Carpentry and joinery	6	6	–
Motor mechanics	16	16	–
Welding and fabrication	8	8	–
Total	43	30	13

Profile of NGOs and other organisations

Representative of PLWHA

Background
This is a support group for PLWHA that was started in 1992, getting support from Batsirai Group. Due to economic hardship, the support group did not have projects that assisted OVC, hence they referred cases to the Ministry of Public Service, Labour and Social Welfare, DAAC, Batsirai and Ministry of Education, Sports and Culture. The representative of the group indicated that they initiated the OVC programmes run by Batsirai, after realising that the members had a large number of orphans and were failing to look after them.

Challenges
- The support group did not have funding to start OVC projects.
- Ordinary people were not aware of ARVs; only the rich were aware of where to buy them.
- CD4 tests were very expensive.
- HBC services were not efficient.

Recommendations
- The need to empower and support PLWHA, so that they could live longer.
- The need to train PLWHA in caregiving work and counselling skills, so that they could give best care to their fellow PLWHA.

Catholic Development Commission (CADEC): Support to STRIVE

Background
CADEC is the development arm of the Zimbabwe Catholic Bishop's Conference and a member of Caritas International. The Support to Replicable Innovative Village/Community Level Efforts (STRIVE) is a pilot project commissioned by USAID and co-funded by

Catholic Relief Services (CRS). Its vision is to promote, support and sustain the development of the whole human being as part of the evangelisation mission of the Church. It offers various programmes for supporting OVC. The goal of the project is to strengthen community efforts and ensure quality care and support for OVC in Murombedzi.

The mission statement of STRIVE is to spread solidarity and social justice throughout Zimbabwe. It draws its inspiration from Christian scripture, tradition and the social teachings of the Church, as well as the lived experience of those they served. STRIVE intended to work to create a country in which the dignity of the human being is paramount and in which exclusion, discrimination, violence and dehumanising poverty are no more.

Activities

- Education assistance: direct school fees assistance to primary and secondary school OVC; block grants, that is, assistance in developmental work at the schools, such as purchase of textbooks, repair of school chairs, minor repairs of classrooms, and the purchase of school sports uniforms.
- Food security: provision of food crop seed packs to households affected by AIDS. In addition, it also provided support to nutrition gardens and money accrued from sales from the garden were earmarked for assisting OVC in acquiring educational materials, such as exercise books and pens.
- Psychosocial support: provision of psychosocial support to children with sick parents and the orphans. There were eight operational social clubs. The clubs performed various activities that included sports, drama, music, peer counselling and youth camps. Village childcare-givers also offered counselling to those children.

Challenges

- The programme was limited, because of the shortage of funds.
- Attitude of caregivers fluctuated, as they did not have incentives.

Recommendations

- Provision of adequate funding.
- Introduction of a token of appreciation to boost the morale of the caregivers.

Save the Children UK

Background

Save the Children UK started to work in Zvimba District in October 2005. The NGO's aim was to feed 30% of the population, of which 90% were in the priority wards, namely, wards 1–12.

The organisation had covered wards 1 up to 12, 15, 17, 20, 21 and 26–29. They provided food for vulnerable households, especially those with OVC. There were 95 000 households eligible to be fed, according to their selection criteria, but the organisation had only managed to feed 60 000 households.

The district office was run by a coordinator and also had a warehouse supervisor, five fieldworkers, a data-capture clerk, a tally clerk, off-loading personnel, security guards and a driver.

Activities

- Providing maize and beans to vulnerable groups, especially households with orphans.

Table 3.3: Monthly tonnage of food distributed

Month	Number of beneficiaries (ME)	Cereals (maize) (ME)	Pulses (ME)	Total
Nov 2005	45 408	454.6	44.950	499.55
Dec 2005	46 174	462.1	–	462.10
Jan 2005	60 207	602.6	45.996	648.59

Challenges

- The main problem was that most households claimed to have orphans.
- There was no database for OVC.
- The food provided for the feeding programme was not enough.

Recommendations

- The need for more food to feed the target population.
- Child-headed households should be registered (database for OVC), so that organisations that want to assist can identify them easily.

Justice for Children Trust

Background

Justice for Children Trust is a lawyers' organisation that concentrates on issues that affect children. The trust has offices in Harare. It started to work in Chinhoyi Province in October 2005, but did not have offices in the district; they did have a mobile site. They had two vehicles and received fuel coupons from donors. They covered the whole country, including the farming communities, and targeted the vulnerable children who could not afford to take care of themselves. The trust worked with guardians directly and indirectly. They also worked hand-in-hand with the Ministries of Justice and Education, and organisations such as Childline and Batsirai. The Southern African Trust was funding the organisation. Two lawyers and two legal assistants ran the offices.

Activities

- Mainly dealing with birth certificates, guardianship and maintenance issues.
- Representing children in courts.
- The trust also included the Child Law Forum, which was a lobbying and advocacy project; it called on children to identify the gaps in various laws and then worked to improve the laws and educate the children. The forum was a school programme addressing various topics, in which everything, including child abuse, was discussed.
- Offering poetry and drama.
- Offering lectures on legal issues.

Challenges

- Lack of financial resources to hire lawyers or to set up offices in different parts of the country.
- Lack of money to produce a lot of materials on legal issues that needed to be distributed to people, and so was not able to reach out to all children.
- Could not be on the air (radio) for a long enough time, as they did not have enough funds.

- Could not represent the abused in court, as the prosecutors represented them; some prosecutors were bribed and were therefore biased.
- Difficulty in accessing money for maintenance of children from people who were informally employed; courts ignored this.
- It was not possible to prove that a person who raped a victim was the one who infected the child, as it was not mandatory that the accused be tested for HIV.

Recommendations

- Curb corruption and improve the checks and balances of the systems.
- Improve the monitoring of child abuse cases.
- Have more NGOs lobbying for the protection of children.
- There should be no confidentiality regarding the Maintenance Act (Chapter 5:09 of 22/2001), and there should be a law that gives the right to access bank accounts of the informally employed.
- It should be mandatory that everyone get tested for HIV in the case of rape, namely, the accused and the victim.

Batsirai Group

Background

Batsirai Group is a welfare organisation that was founded in 1988 by a group of individuals concerned about the spread of HIV/AIDS in Chinhoyi. Since then, the organisation had grown to the level of a provincial organisation and served the whole of Mashonaland West.

The organisation was located in Ward 1 of the Makoni District, which is in the Mashonaland West Province. The activities of the organisation were centred in the communal, peri-urban and resettlement areas of the province.

The main objective of the organisation was to actively support the Government of Zimbabwe in its national campaign against HIV/AIDS, through empowering people and communities to respond to problems caused by the HIV epidemic, building the capacity of CBOs and sister organisations to implement effective HIV interventions, and to promote awareness on HIV/AIDS issues.

There were five programmes run by the organisation, namely: VCT Programme; Home-Based Care Programme; Prevention of HIV/AIDS Programme; PMTCT Programme and OVC Programme.

The OVC Programme started in July 2003 with an intended coverage of 12 000. The initial coverage was approximately 2 500 and had risen to about 5 000 over the past year. Currently, the programme covers OVC in four wards, which are Mboma (1 768), Kasanze (2 015), Jari (1 059) and Alaska (554). The activities under this programme were community initiated after the communities had heard of the work of the organisation in other wards or community gatherings, such as shows and meetings.

Even after the involvement of the organisation in the communities' activities, the communities' participation had been at a very high level. This had been encouraged by their involvement in the initial stages of the project in the areas. In addition, the whole community – beneficiaries, community members, community leaders and government/ local authorities – had received the organisation's work very well.

In the process of trying to achieve the desired objectives, the organisation worked hand-in-hand with other organisations, for example, Oak Foundation, ACTION AID, CARE Zimbabwe, AREX, Ministry of Health and Child Welfare, Social Welfare, Justice for Children Trust and the Zimbabwe Republic Police.

Objectives of the OVC programme

- To improve the capacity of CBOs to deliver quality care, support and prevention activities to benefit OVC and their families.
- To improve the economic base (income, finances, etc.) of OVC households, through supporting them with income generating projects.
- To increase access to quality education to OVC.
- To provide psychosocial support by utilising community support systems.
- To provide medical and material support to needy OVC.

The OVC project had a staff complement of eight: one had a Diploma in Nursing (Midwifery), three had a Certificate in Child Counselling and the other four had either one or two Ordinary Level subjects. In addition to these qualifications, the staff members had gone through training in Participatory Rural Appraisal (PRA), Stepping Stones (which is a manual that includes tools for sensitisation and a new approach to lessons in HIV/AIDS, mitigation and prevention), and monitoring and evaluation workshops provided by the organisation.

Activities

- Offering educational materials, school fees to OVC. The Kellogg-funded OVC programme was paying school fees for 30 children from three schools.
- Sending boys and girls for international summits.
- Teaching children how to run IGPs, for example, making lotion and drip irrigation, so they could earn money for their needs.
- Training volunteers who in turn care for OVC.
- Training in selection and planning management (SPM), where OVC were taught how to choose projects and how to manage them. This was being done in six communities.
- Offering VCT and PPTCT services to the community.
- Working in collaboration with MoHCW on the provision of HBC services.
- Having peer educators who were once commercial sex workers, so they could target those people who were already in commercial sex work.

Challenges

- There were conflicts among organisations working in the district, hence the working environment was not conducive.
- The need for incentives for volunteers.
- Shortage of resources was a great challenge.
- Movement of staff was restricted because of fuel shortages.
- Although the staff members had undergone some training, there was need for continued education, training in documentation, proposal writing and data management.

Plans

- To establish a pharmacy.

Recommendations

- All stakeholders should work together and discuss how to assist OVC, so that their activities are coordinated.
- Give volunteers incentives to improve their commitment to the caregiving work.
- The volunteers and chairpersons in the wards also needed improved modes of transport, since they travelled long distances.
- Volunteers needed uniforms, so that the community members could easily identify them.

Vimbainesu Children's Home

Background

This orphanage was founded by Ms Chidarara in the 1960s and the land where the children's home was built was donated by Mr John Madzima (former Zimbabwe Football Association [ZIFA] president). It all began at Ms Chidarara's home and was then registered in 1983. The first structure was built with the assistance of World Vision in 1992 and later used in 1993. They built some other structures of the home on their own and the Board of Trustees then looked for donors, for example, the Lions Club of Norway, to construct further buildings.

The home could accommodate 40 children, but then was not able to take as many as 40, due to shortage of food and other resources. The first child that the home looked after was mentally ill and also had been a pre-term baby. They had 30 children in the orphanage at the time of the study, which included 8 boys and 22 girls. Children were brought to the home by the Department of Social Welfare. Some orphans were more than 18 years old, because they had been brought to the home at the age of 15 or 16 and so reached 18 when they were still in school. Social Welfare would not support children above 18, because they claimed it was against the law. The home received donor assistance to support such children, as it felt obliged to keep children who were above 18, since these children had nowhere else to go.

The home's catchment area was Mashonaland West, which included Kariba, Karoi, Chegutu and Kadoma, and in rare instances, the orphanage would take some children from other areas. The home mainly received donations from NGOs and FBOs, for example, JF Kapnek Charitable Trust, Save the Children, Rotary Club and Anglican Cathedral. There was a library, which also benefited the community and received books from Kapnek. A matron headed the orphanage, with a staff of one assistant and one security guard. The matron had been awarded eight certificates on childcare from the Zimbabwe National Council for Protection of Children. She had also trained in child healthcare at a clinic for two years.

Activities

- Looking after the children at the home.
- Running a pre-school at the home.

Challenges

- The department of Social Welfare did not support children who were 18 years old and above, as they said it was against the law.
- The orphanage did not have enough money and equipment to farm all the 15 acres of land and could only manage three hectares.

- People from the community surrounding the home were afraid to take care of the children whose origins were unknown to them, for instance, those from Harare Chinyaradzo Children's Home.
- Some NGOs, such as the Red Cross, refused to give food to the home, as they said the home had its own donors.
- Limitations on the amount of mealie-meal the home could buy from the Grain Marketing Board (GMB); for example, they were only allowed to buy 200kg, instead of their monthly requirement of 400kg.
- The home did not have a car for use at the centre.
- The first-aid kits did not contain enough materials, because the home could not replenish them.
- No mosquito nets to protect the children from mosquito bites.
- Could not afford medical fees; only 14 children were registered on medical aid and the other 16 were not; some children had scabies.
- Shortage of school uniforms, to the extent that some of the children moved up to Grade 7 without uniforms.
- Shortage of food.
- Some relatives only wanted to take back OVC so that they would benefit from the aid from NGOs like Red Cross.
- No telephone; the service provider was reportedly failing to service the phone.
- Shortage of staff.

Recommendations

- People needed to be educated that the orphanage children were just children who needed their care, regardless of their origin/tribe.
- Assistance in buying mealie-meal from GMB.
- Assistance for filling the medical kit.
- Recruitment of three or four mothers to assist in looking after the children.

Red Cross Society

Background

- Had an OVC programme.
- Worked closely with MoHCW in the training of volunteers.
- Had 53 care facilitators, of which only two were men; all the 53 were in Zvimba South.
- Had a youth friendly corner in the district, stationed at Murombedzi.
- Worked with children from in and out of school (for example, showing them tapes on sexually transmitted infections [STIs] and holding discussions afterwards) for four days a week, that is, Mondays, Wednesdays, Thursdays and Saturdays.

Activities

- Construction of two-bedroomed houses for the child-headed households; eight had been constructed at the time of the study. The community had assisted with labour, supervised by the kraal-head.
- Provision of school fees, food, clothes and sanitary wear.
- Training volunteers who provided HBC services to PLWHA. They also replenished HBC kits with Panadol, Betadine, Jik (bleach), soap, blankets and gloves.
- Running social clubs, such as soccer and netball.

Challenges

- Lack of transport to go to investigate child abuse cases and to carry out other routine duties was a major problem.
- Incentives, such as soap and toothpaste for volunteers, were not adequate. Men complained that the incentives were very low.
- HBC kits were inadequate, as there were many sick patients to treat.

Plans

- Plans to expand to Zvimba North (former commercial farms) to provide HBC services.

Recommendations

- Provision of bicycles to volunteers.

Conclusions

The size of the OVC problem was reported to be increasing every day. This was negatively affecting the resources of the individuals, communities and organisations that were helping OVC. The majority of study participants attributed the increase in the number of OVC to HIV/AIDS. The OVC were generally living under tough conditions and grandparents and widows were looking after the majority of them. A number of orphans were heading households and some were living with sick parents, such that they were actually taking the role of head of household.

The main needs of the OVC were food, clothing (including warm clothes) and shelter, especially for child-headed households, as well as school fees, blankets and sanitary wear for the girl children. The housing situation of OVC was wretched, with some sharing a room and others living in dilapidated pole and dagha huts. Generally, the orphans had access to education and health facilities at local clinics. They could not get free services from hospitals and it was also difficult for children to get ARVs.

The quality of life of OVC was under threat because of rape and physical, sexual and also emotional abuses. Poverty, as well as peer pressure, was forcing these children into early marriages, prostitution and in some cases, stealing.

There were no major property-grabbing cases. The only notable cases of property grabbing were those where the maternal relatives were taking properties of their deceased relatives. Several respondents supported this, as they indicated that it was according to Zezuru culture. The need for continued education on the importance of writing a will cannot be overemphasised.

A number of orphans indicated that they were happy with the attitude of the majority of their caregivers and community members. There were a few cases of OVC who were mistreated by either their guardians or community members. There were also only a few cases of OVC who were still being stigmatised and discriminated against, which was due to meetings that were held to alert the community about OVC.

Participants suggested various ways in which OVC could be assisted, but they unanimously agreed that NGOs, FBOs, CBOs and the government must work together for the cause of OVC. It was indicated that the Department of Social Welfare in the MoPSLSW was not coordinating the activities of intervention agencies.

Community members and the OVC themselves called for the provision of basic needs such as clothing, food, shelter, educational support and blankets. The community should initiate OVC programmes and donors while the government should only support the programmes for them to be sustainable. Representatives of the government and other organisations called for the establishment of a comprehensive database on OVC that could inform them of the important needs of the OVC. They also pointed out that OVC interventions should be informed by research and that a monitoring and evaluation system needed to be put in place for interventions to have any impact on the lifestyle of OVC. There was also a call for educational campaigns about policies and laws that protect children, as the majority of the community members were not aware of these issues. Empowerment of the orphans was called for, as assistance from donors was not sustainable. This included training in life skills and also support for OVC's income generating projects.

The main providers of care and support to the OVC were extended family members, NGOs, FBOs, government departments and the community members. They were mainly helping with school fees, food and other school requirements such as stationery and uniforms. DAAC in particular was assisting with sanitary wear to girl children. The majority of the respondents, including OVC, concurred that the government and NGOs were offering the assistance that was desired by the orphans. There were several indicators of success of the interventions, which included increase in school attendance by OVC, increase in knowledge about laws that protect children, improvement of nutritional status of the children and so on. The effectiveness of the care and support was affected by the fact that the structures were not assisting holistically (provision of all basic needs) and also ecause of shortage of human resources in facilitating the work. The respondents indicated that there was no way that the interventions could be successful if they were not initiated and supported by the community.

Poverty was the major challenge the community was facing in trying to assist OVC. In short, the community did not have the capacity in terms of resources to care for the OVC. The caregivers had no means to provide basics to the orphans they were looking after. Poor selection criteria to identify OVC, coupled with corruption, were reportedly undermining the efforts made by intervention agencies.

The majority of the community members were not aware of policies and laws that protect children. Other respondents further echoed this, pointing out that even some government employees were not aware of these laws. Participants had different attitudes towards the laws; some had positive attitudes while others were breaking the laws at will. There were also indications that modern laws were clashing with traditional laws, especially with regard to child labour.

Although the study participants could not offer actual figures for the number of PLWHA in their respective areas, they all agreed that HIV/AIDS was a major problem. People did have knowledge about HIV transmission, prevention issues and AIDS in general; this was evidenced by the low instance of cases of witchcraft accusation after the death of a PLWHA. HIV and AIDS had impacted differently on community, state and organisational resources. It had affected the social functioning of the community and people were always attending funerals. The death of people from AIDS had resulted in many child-headed households in the community. The state and NGOs were channelling a lot of money to HIV/AIDS programmes, neglecting other diseases of public health importance and developmental programmes.

People need to be empowered with education on HIV/AIDS. PLWHA should be involved in educational campaigns, as this could make an impact on behaviour change, for instance. Churches were also called on to take part in the dissemination of information on HIV/AIDS, because they could reach larger audiences. Services such as the VCT, PMTCT and OI clinics were also equally vital in limiting the continual spread of HIV, hence their accessibility must be improved. Poverty alleviation programmes must be strengthened, since poverty was fuelling the spread of HIV.

The care and treatment services that were available for PLWHA in the district were HBC, VCT, PPTCT, ART and the OI clinic. The Red Cross HBC programme was rated as one of the best in the southern African region by most of the respondents.

Study participants mentioned schools, clinics, VCT centres, NGOs, MoHCW, radios, televisions and peer educators as sources of information on HIV and AIDS. In order to improve the provision of information on HIV/AIDS, the respondents called for involvement of the husbands and community leaders, as they were influential in decision-making, for example, husbands' decisions on sexual matters. The provision of information on HIV/AIDS and sexual abuse should start with parents/guardians at home.

Priorities for action

The following are the recommendations made from the key findings of this situational study:

- More support should be channelled to OVC, especially since they were reported to be increasing in number. Programmes must also be put in place to cater for child-headed households and also grandparents who were looking after the orphans in the majority of cases. The government, NGOs, CBOs and FBOs must work together in assisting OVC and their caregivers.
- The Department of Social Welfare (MoPSLSW) must coordinate the activities of organisations assisting OVC. This is important to avoid the duplication of activities or assistance.
- Educational campaigns on policies and laws that protect children should be carried out regularly, as children were prone to sexual and physical abuses.
- The government should try to alleviate poverty, as poverty was reportedly pushing some orphans into early marriages and prostitution.
- A comprehensive database on OVC is needed. This is important for identifying the OVC and also for the provision of research-informed interventions.
- The government should repair or buy vehicles for key government departments such as the MoHCW and MoHA (Police). Investigations of some rape cases could not be done, due to shortage of vehicles.
- The government must assist orphans in acquiring birth certificates, as the majority of them indicated that they were facing problems in getting them.
- HIV educational campaigns should be scaled up to all sectors of the district, especially the farming areas, and they must be done regularly. The respondents indicated that HIV/AIDS was still a problem in the community and that some people were still engaging in risky sexual behaviour and prostitution.
- Mobile VCT services must be introduced, especially in the rural and farming areas.
- There is need to give volunteers incentives to improve their commitment to the caregiving work, for example, tennis shoes, soap etc.
- Workplace HIV/AIDS campaigning programmes should be strengthened.

CHAPTER 4

Bindura District

Wilson Mashange, Shungu Munyati, Brian Chandiwana, Stanford T Mahati, Stella-May Gwini and Simbarashe Rusakaniko

Background

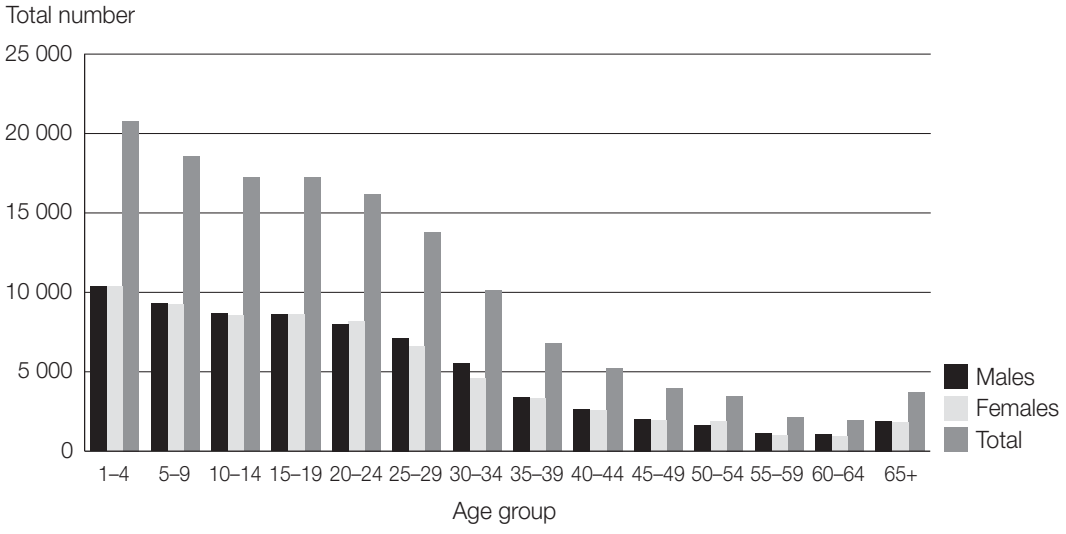
Description of study area

Bindura District is situated in the middle-veld of Zimbabwe and is named after the provincial capital of the Mashonaland Central Province. The main agro-ecological region is Region II. Bindura area is divided into two districts, Bindura Urban, with 8 wards and Bindura Rural, with 18 wards, of which 10 wards are communal areas, 2 are small-scale commercial areas and 6 were once large-scale commercial areas that have since been reallocated through the land redistribution process. There is one growth point, Manhenga Growth Point, and two rural service centres, Nyava and Rutope.

Population distribution

Bindura Rural has 90.8% of its population in rural areas and Bindura Urban is completely urban. The Bindura Urban population was 33 637 in 2002, while the Bindura Rural population was 108 594 (CSO 2002). Bindura Rural District's urban centre is Trojan Mine, with a population of 6 162 (2002). The male to female sex ratio for the urban area was slightly higher (104.2) than that of the rural areas (101.5). The district has 33 646 private households, of which 75.4% are in the rural areas (2002). Figure 4.1 illustrates the distribution of the population by age group and sex.

Figure 4.1: Distribution of population by age group and sex, Bindura District



Just over half of the population were less than 20 years of age and 721 of the households in the Rural District were headed by a person of less than 20 years, while in the Urban District, 219 of the 8273 households were headed by a person of 19 years old or less (CSO 2002). The predominant languages are Zezuru and Korekore, and the most common religion is Christianity. There were a large number of aliens on the commercial farms, especially Malawians and Mozambicans.

Economic activities

The district houses the Ashanti Gold Mine, which is the biggest gold mine in Zimbabwe, and Bindura Nickel Mine, which is the largest nickel mine in southern Africa. As of 2002, 41.4% of the population aged 15 years old and above (total of 84 562) was economically active and of these 8 036 were unemployed and were seeking employment (CSO 2002). Among the 15- to 19-year-olds, about 40% were economically active (2002). The main economic activity in Bindura Rural District is agriculture (65.7%), while in Bindura Urban District close to a quarter are in the service industry, 15.1% in the mining and construction industries, 9.4% in the law and security industries, and 7.8% and 7.2% in the manufacturing and agricultural industries respectively.

The district is located in the prime agricultural land of the country that used to be large-scale commercial land, but has recently been allocated to A1 farmers (communal farmers with approximately 6ha of land who are semi-commercial farmers). Agriculture in the communal areas is dominated by vegetable gardening, maize and millet (the food crops), while in the commercial farming areas, maize, soya beans, cotton and bananas are predominant. The other crops grown are groundnuts, sorghum, sunflower, cotton and paprika (the cash crops). Better-off farmers obtain their annual cash income through the sale of farm produce (cash crop and livestock). The farmers find ready markets in local urban centres and Harare (87km from Bindura town) and much of the region benefits from its relative proximity to Harare. Fluctuating world prices and changes in marketing structures or buyers also affect the farmers' returns. The present economic turmoil, with its associated disruption of transport and marketing systems, are hurting farmer incomes and causing shifts in crop selection. Poor households, by contrast, sow most of their land to food crops. For income, they rely primarily on casual work found locally or on gold-panning along Mazowe River. At the illegal gold-mining camps, prostitution is rampant and has become a source of livelihood for some women.

Health facilities

The district has one district hospital with a capacity of 120 beds and there are 11 health centres. With regard to other health services, there are four prevention of mother to child transmission (PMTCT) of HIV centres, four voluntary counselling and testing (VCT) centres and one centre offering antiretroviral drugs (ARVs). The first release of ARVs was in June 2005 and 200 people were being assisted with the medication at the time of the study. Clinics are not easily accessible to most of the population in the rural areas, because they are far away and at times the clinics do not have adequate medicine stocks. The major challenges being faced by the providers of health facilities are transport, bad road networks and human resources.

Education facilities

The literacy level was 95% and 98% in Bindura Rural and Urban areas, respectively (CSO 2002). Although most of the households are relatively poor, education assistance from the Basic Education Assistance Model (BEAM) has helped a lot of children. The educational facilities in the district are adequate in the communal areas but are scarce in the large commercial farming areas. In total, the district has 52 primary schools of which 8 are unregistered, and out of the 20 secondary schools, only half are registered. The population aged 3 to 24 years old currently attending school, the current levels of education being attended and sex distribution are shown in Tables 3.1, 3.2 and 3.3 for Bindura Rural District, Bindura Urban District and the whole of Bindura District respectively.

Table 4.1: Levels of education for 3- to 24-year-olds in Bindura Rural District, by percentage

Level	Males	Females	Total
Early education	8.67	9.89	9.24
Primary education	65.08	70.66	67.68
Secondary education	25.90	19.19	22.78
Tertiary education	0.33	0.26	0.30
Not known	0.01	–	0.00
Total (N)	16 520	14 385	30 905

Table 4.2: Levels of education for 3- to 24-year-olds in Bindura Urban District, by percentage

Level	Males	Females	Total
Early education	6.28	6.08	6.18
Primary education	56.57	58.20	57.38
Secondary education	33.50	32.98	33.24
Tertiary education	3.63	2.70	3.16
Not known	0.02	0.05	0.04
Total (N)	4 301	4 230	8 531

Table 4.3: Levels of education for 3- to 24-year-olds in Bindura District, by percentage

Level	Males	Females	Total
Early education	8.18	9.02	8.58
Primary education	63.32	67.83	65.45
Secondary education	27.47	23.32	25.04
Tertiary education	1.01	0.81	0.92
Not known	0.01	0.01	0.01
Total (N)	20 821	18 615	39 436

Water and sanitation

Generally, water and sanitation in the communal areas are good, but poor in the commercial farms. The water table is high and therefore water is easily accessible to most of the population. The majority of the households in Bindura Rural have protected water sources; 19.0% have piped water either inside or outside the dwelling unit, 29.9% use communal taps and 31.1% have protected wells/boreholes. Close to 3% fetch their water from rivers/streams/dams, while 16.9% use water from unprotected wells. The 2002 National Census found that the common types of toilet facilities in Bindura Rural were Blair toilets (ventilated improved pit latrine) (27.0%) and pit toilets (21.2%), while more than a third had no toilet facilities. In Bindura Urban, 85.4% used flush toilets and less than 5% had no toilet facilities. Regardless of it being a service centre, Nyava has a sanitation deficit, since it has no sewage reticulation, which is a factor that discourages a lot of investors.

Housing

In Bindura Rural, over two-thirds of the households live in either traditional dwelling units (38%) or mixed dwelling units (37.7%), while in Bindura Urban, about half of the households live in detached houses and over a quarter in semi-detached houses (CSO 2002). In general, the housing structures can be classified as poor, since a sizeable number are made of pole and dagha.

Transportation and energy

The road network is fairly good, as most of the areas in the district are accessible, though some of the roads are damaged and lack repair. Since Bindura Rural is predominantly rural, the common source of energy is wood (88.8%), although 22.5% of the households have electricity, while in Bindura Urban, most of the households' source of energy is electricity (69.7%) and just about a fifth use wood (CSO 2002). The popular rural electrification programme has had a huge impact on the district, since approximately 90% of the district has been covered.

Conditions of OVC

Magnitude of OVC problem

It was reported that there were many orphans in the community and that their number was on the increase. A chief echoed the same sentiments, as did caregivers, councillors and other community members. The OVC were said to be living under difficult conditions, due to shortages of basic needs and the harsh socio-economic conditions that were prevailing in the country at the time of the study. Women, who were either elderly people or other caregivers, were the ones mainly looking after orphans.

Deaths from AIDS-related diseases were cited as the main cause of orphanhood in the district. Poverty at times drives people to risky behaviour and as a result, they succumbed to HIV infection. A female village head said that the increase in the number of orphans was mainly due to *'kusazvibata ndiko kwakonzera unherera vanhu vave neruchiva'* (lack of sexual control has resulted in orphanhood, people now have lust). A key informant indicated that the closure of some of the mines in Bindura contributed to the problem of OVC and people were left in poverty.

The problem of child-headed households (CHHs) was reported in the district and this was said to be mainly due to the fact that most parents of these children would have been immigrants and, when they die, the children would have no relatives to care for them.

Housing conditions for OVC

The housing conditions of the OVC were said to vary from one household to another. The majority of the OVC were living in inadequate houses. The OVC who were living in very good houses had nobody to maintain them. Caregivers said that some of the houses, mainly in the farms, were built from pole and dagha. Some orphans were left homeless after the government's Operation *Murambatsvina* (Clean-up) exercise. Houses were said to be a problem, especially in the new resettlement areas, as most children did not have permanent homes; they were constantly on the move, as new farmers had no places for them to stay. One orphan reported that some of them were sleeping at friends' houses due to accommodation problems. One caregiver reported that some children were exposed to rape and sexual abuse, since they could be found roaming outside at night

saying, *'Mama vachirikumboita mari'* (Mum is still making money through commercial sex work) – in other words, the children had to go outside, because they would all be staying in a one-roomed house.

Needs of OVC and major threats to quality of life

The needs and challenges faced by OVC are listed below:

- food, including milk for orphaned babies;
- school fees and stationery;
- clothing, including warm clothes and complete school uniforms;
- blankets;
- shelter, especially in child-headed households;
- medical fees and money for drugs;
- sanitary wear for girl children;
- psychosocial support, that is, counselling services, including on issues of inheritance.

Other needs that were cited included soap, shoes, parental/guardian love and birth certificates. One challenge that was mentioned by a number of OVC was verbal abuse from their guardians. Skills training as well as identification and promotion of talents among OVC were also called for, as this would help them fend for themselves. Caregivers further indicated that OVC needed money for transport to go to secondary school. There was a call to assist caregivers with financial assistance to run income generating projects (IGPs) that would assist OVC.

The major threats to the quality of life of OVC were sexual and physical abuse. Poverty and hunger were also said to be major threats to their lives, as OVC were forced into early marriages, drug abuse, gambling and prostitution. Other problems that were mentioned included lack of basic material needs and psychosocial problems that traumatised the children. Some OVC had deteriorating health because of food shortages and poor diets. The female OVC were reportedly exposing themselves to vaginal infections by using dirty materials (newspapers, torn cloth, tissue papers, etc.) as a substitute for cotton wool, because they did not have sanitary wear.

As a way of coping with the challenges they faced, the OVC indicated that they received money for fees from the casual jobs they did during weekends and school holidays on surrounding farms. They reported that they sometimes received sugar, soap and cooking oil as payment for the causal work. As a means of coping with their many problems, some orphans, especially girls, got married as early as 14 years old. *'Vasikana kungobuda mazamu kwakutoroorwa'* (Once girls have reached puberty, they get married), said one caregiver. They also made ends meet by gold-panning.

Access to facilities by OVC

Generally, OVC had access to health and educational facilities, although they had problems with money for medical fees as well as school fees and uniforms. A councillor reported that OVC did not pay at the local clinics, although it was indicated that there were problems with transport to health centres. Caregivers from other wards like Foothills indicated that children had to walk 20 to 30 kilometres to go to secondary schools and as a result, most children dropped out of school soon after Grade 7. There were very few satellite schools, which had been set up during the land reform programme. Psychosocial support services to the OVC were being provided by local NGOs such as Farm Orphan Support Trust (FOST). The children in the urban district had access to a youth friendly

centre that was run by the Red Cross. An officer with the Department of Social Welfare said that some CHHs were registered under the Public Assistance scheme, whereby the children had free access to education and health, as well as sometimes getting bus warrants for travelling to health centres.

Challenges and complications in providing care and support to OVC

The community as a whole was reported to be facing a range of challenges and complications in their efforts to help the orphans and other vulnerable children. These could be found in providing material support or in offering psychological support.

The majority of the study participants, including caregivers, concurred that there were food shortages in the households with OVC; this was further exacerbated by the drought of 2005. The community could not provide money for food, school fees and medical services and the food obtained through donations was usually not enough. In some cases, orphans were not able to pay for grinding the maize after getting it from donors. Most caregivers were old and frail and so they also needed assistance to earn a living. It was also reported that at times it was difficult to keep some children in school, as the quick money they made from illegal gold-panning and prostitution lured them away. Child labour had become a problem and a lot of the OVC were working on farms.

Corruption among some community members was affecting the normal operation of the NGOs and government programmes. Most needy children were not benefiting from the BEAM scheme or even from the Fort Hare scholarships, even though they would have been selected, while children of prominent families were benefiting. Moreover, some of the food meant for the OVC was reportedly being given to undeserving people.

Another challenge was that clinics were far apart and drugs were not available. Furthermore, OVC failed to purchase the prescribed medication, even though they had free access to health facilities. Selection of beneficiaries was not properly done and also assistance received from the Department of Social Welfare was inadequate.

The community was also facing problems in getting birth certificates for OVC, as some of the parents of these children did not even have identity cards themselves.

There were further reported cases of caregivers who were taking in OVC for material benefits from donors. In addition, some of the respondents reported that in some cases, the political situation in the district was not conducive to working, especially for the NGOs.

Many children, mostly double orphans, were only assisted in dealing with emotional trauma during the funerals and after that, they were left to take care of themselves. Therefore, there was no continuous emotional support offered to the majority of the orphans. Generally, people do not know how to counsel children who have lost their parents and so training of caregivers in this regard is vital. A regional prosecutor went on to indicate that there were no adequate resources, such as counselling services and institutions to care for victims of violence, especially OVC. There was also no counselling given to victims of violence, even though the police had the responsibility to do so. The participants were not happy with the sentences imposed on child rapists, as they believed that they were not heavy enough to deter the perpetrators.

As a way of overcoming these challenges and complications, organisations should put more resources into helping OVC in the community. The community should also take responsibility for looking after OVC and stop handing over that role to the government alone.

OVC behaviour

Some OVC were reported to be resorting to stealing to supplement their food resources. Others had bad manners, mainly because they did not have anybody to advise them. One interviewee indicated that, generally, children think it is good to play with those of the opposite sex these days, and some were already on contraceptive pills. The children wanted nice food and money, and so they engaged in sexual activities at an early age, risking their lives. The double orphans were the ones mostly involved in such activities, since they were the ones who would be trying to make ends meet; that is, they were driven by poverty to go out with 'sugar daddies'.

Property inheritance issues

Cases of property-grabbing were reported to be few, though there were cases of relatives who inherited goods, but then refused to look after the orphans. The majority of the reports were on cases of property that was sold before the parents died in order to raise money for the household needs or medical fees. Most people reportedly rejected the issue of wills; as one the respondents said, *'… mungateedzera zvemufi?'* (How can you follow what was said by the deceased?)

In the case of the death of a mother, the property was either distributed or her relatives took it. One community member summed it all up by saying, *'Govai zvinhu zvaana amai vanomuka ngozi, midziyo yaanamai kashoma kusara mumusha mune vana inonzi ngaiende kunevabereki vavo.'* (Distribute all of her things, otherwise she will become an avenging spirit. A woman's property does not normally remain in her marriage home where the children are, it goes to her parents.)

Attitudes of the community towards OVC

Treatment of OVC

OVC indicated that the majority of the community treated them well, but it was also reported that in some instances, some families treated them well because the OVC would be getting assistance from organisations such as NGOs or District AIDS Action Committee (DAAC). A few cases of ill treatment were reported and this usually came in the form of insults, being denied food or being overworked, for instance, being made to weed fields at a very young age and working in the fields when it was raining. Cases were also reported of other children physically beating OVC, and some OVC were being treated as domestic workers. At times, some children would laugh at OVC, who would not have used Vaseline or skin lotion, saying: *'vane shena'* (they have ashen skin); or sometimes they laughed at OVC who wore torn clothes or had no shoes.

Some caregivers were reported to be discriminating against OVC in favour of their own children. For example, in one case, a grandmother would first put stones in the OVC's plates and then the sadza on top, so that the share of sadza she gave to her own children would look the same as that given to the OVC. It was disclosed in focus group discussions (FGDs) that some stepfathers were not buying food and that there were also assumptions that they might rape the girl child. Abuses against OVC by stepmothers were also

reported. Double orphans in particular had several problems, because they did not have guardians.

Due to overcrowding in the households, some OVC were subjected to mental abuse, as parents engaged in sexual activity in the presence of the children, thinking they were asleep.

Perceptions and attitudes on the issue of OVC

The community
The OVC were marginalised as a result of relatives neglecting them and failing to offer them social and emotional support. This was, however, aggravated by the harsh economic conditions, so the children were left to suffer. Some people did not want to take OVC into their households, but preferred to take care of them while they stayed on their own somewhere else. General community attitudes towards OVC were governed by individual perceptions that were said to range from good to bad. Some OVC were verbally abused in the households; for example, some guardians said to the OVC: *'Handisirini ndakauraya amai vako.'* (I am not the one who killed your mother.) Awareness workshops on care and treatment of OVC carried out in the area had encouraged people to accept these children. It was pointed out that people in the community were viewing the SOS Children's Village as an alienated community, although there were some changes in attitudes as people became more conscious of the issues affecting OVC. There were some people who thought the OVC problem was the responsibility of the government.

The caregivers
Representatives of NGOs agreed that caregivers generally had a positive attitude towards OVC, but the problem was that they did not have enough resources. As a result, the OVC were prone to abuse and ended up being forced to look for casual work, in some instances even quitting school. Some of the caregivers' attitudes had changed because of campaigns carried out by peer educators. The caregivers with basic education on care of orphans knew how to care for the OVC; the problem rested with those who were not trained.

Other household/institution members
OVC interacted well with other children in their respective houses or schools, and other children had been taught not to stigmatise the OVC. However, as there were notable material differences between orphans and non-orphans, such as clothing and shoes, some orphans did not feel free to play together with non-orphans.

Stigma and discrimination

Against OVC
There were few cases of OVC who were stigmatised by either their caregivers or the community. One community member mentioned that orphans were being looked down upon and some would say to them, *'vabereki venyu vakafa ne AIDS'* (your parents died from AIDS) or, 'you were picked from a rubbish bin'. Some school teachers were unknowingly stigmatising children by using such statements as, '*Vana veAIDS ngavauye kuno.'* (Those children supported by AIDS programmes should come here.) However, it was indicated that stigma was dying out, due to successful educational campaigns.

Irrespective of the few cases of stigma and discrimination, teachers were in a position to assist OVC in dealing with the issues, since a number of them had qualifications in

counselling and were also taking practical lessons on counselling with Connect, a counselling training organisation in Zimbabwe.

Against those providing care to OVC
One caregiver reported that she was experiencing no stigma as a result of providing care to OVC and said that people actually respected her for the work she was doing. However, other caregivers said that some members of the community were ridiculing them by saying, *'Murikuda kushamisira nokutora nherera dzisiri dzenyu.'* (You want to show off by taking in orphans that are not yours.)

Impact of caring for OVC on lifestyle
Some caregivers were already struggling to make ends meet even before taking in OVC, to the extent that the inclusion of OVC into the family had become very stressful for them and was therefore affecting their lifestyles. On the other hand, other caregivers were not affected at all and were actually happy to look after OVC.

Care and support structures for OVC

Providers of care and support

Structures that were providing care and support to OVC were mainly family members, CBOs, FBOs, NGOs and the government. The general comment was that community members, especially females, were committed to helping OVC.

Grandparents and other extended family members were mainly supporting orphans with food and at times the community members also helped. One grandmother summed it up as, *'Vana ambuya ndisu tatosara tave mhandara, dzokuunganirwa nevana* and we are struggling to survive.' (We grandmothers are the only young women left with children around us and we are struggling to survive.) Family members were eager to support the orphans, but did not have means to do it. A chief in the district said that the fabric of the family was breaking down, to the extent that family members could no longer support each other. Non-orphans were also helping the OVC by giving them clothing and temporary shelter.

The *Zunderamambo* (community/chief's granary) was reported to be developing in the district, but it was still in its infancy. As a stopgap measure, members of the community were providing food to the OVC and some were even reported to be taking in orphans into their households. In winter, they helped OVC to plough and taught them how to grow vegetables in the gardens. Some women in the community had started a baking club for producing buns, which they sold to raise money for OVC.

The NGOs (Red Cross, FOST and Farm Community Trust of Zimbabwe [FCTZ]) were mainly providing food. Some of the NGOs were paying for school fees and other educational materials. FOST was helping with vocational training, life-skills training and running of IGPs, as well as school fees and school uniforms. Educational campaigns on health issues were also conducted, as well as educating people on how to start and run IGPs. Other activities that were being carried out by NGOs included social activities that brought all children together, including OVC; the organisers ensured that OVC were able to attend by paying for their transport and food expenses. In addition, foster parents were educated on care of OVC, and OVC were provided with farming implements such as hoes and watering cans.

The CBOs were assisting OVC through proceeds from baking. SOS children's home was providing shelter for children under the age of 19 years old. The FBOs, in most cases, were giving psychosocial and moral support to OVC and the Roman Catholic Church was helping OVC with maize seed, fertiliser and farming inputs.

The state was helping the OVC through the BEAM scheme, which is a collaborative scheme managed between the Ministry of Education, Sports and Culture (MoESC) and the Ministry of Public Service, Labour and Social Welfare (MoPSLSW). Food and financial assistance was given from the Department of Social Welfare. DAAC structures were in place in the community and they were supporting with providing food, especially to child-headed households. DAAC was also providing school fees and uniforms.

Desirability and effectiveness

OVC and other key informants unanimously agreed that assistance being given to OVC was the desired support, since many of them suffered food shortages. At the time of the study, a number of OVC were getting money from IGPs (for example, kids' clubs, bee-keeping, gardening, sewing and bakery) that were initiated by various NGOs. Provision of school fees has resulted in OVC going back to school.

The BEAM scheme's effectiveness was negatively affected by the poor and biased selection criteria of beneficiaries; some beneficiaries were not eligible and the needy cases were left out. In contrast to this, some study participants from the government departments pointed out that there was a selection committee for BEAM that ensured transparency in the selection of beneficiaries and that the names of these children were displayed on the schools' notice boards; those with queries were free to approach the committee.

A large number of OVC were under the care of grandparents and therefore the care they received was not effective, since the majority of these guardians had no means to look after the OVC.

Regardless of all the constraints faced by service providers, the living conditions of OVC were reported to have improved, because of IGPs and because some OVC were now back in school.

Sustainability of the systems of care

Programmes where OVC were directly assisted with food or fees were not always sustainable and if the support was withdrawn, the OVC would start to suffer again. An orphan pointed out that what was needed were 'community driven and initiated programmes' that can be continued after donors pull out. She gave bakeries as a good example, pointing out a thriving bakery in the village. There was also need for continual community commitment so that the support structures could remain effective and functional.

Suggestions of how to help OVC in the community

Study participants mentioned several ways whereby OVC could be assisted, with the majority calling for the provision of basic needs, which included food, decent accommodation and educational support, such as fees, books, pens, uniforms and shoes. It was also pointed out that identification of OVC's talents – for example, art, drama, football and poetry – and nurturing of those talents was important, as this would help some OVC sustain a living.

Role of the state

- Provide houses for OVC.
- Assist OVC in getting birth certificates.
- Train OVC in life skills and provide them with farming implements for gardening and maize production to help them become self-reliant.
- One caregiver suggested that the government should support IGPs, especially gardens, as they are easy to manage.
- Assist OVC in securing employment, especially those living on farms.
- One chief pointed out that the government should work with the chiefs in assisting OVC, for example, by resuscitating *Zunderamambo*; then a day would be set aside for community members to work in the fields for the benefit of orphans, so that the community could also support *Zunderamambo* in ways that effectively support OVC.
- Spearhead awareness on children's rights; some children elope at only 15 years old, for instance, because of continual child abuse in their respective homes. Parents should also be made aware of these policies and legislation, since only the children were being taught about these rights by various NGOs, such as FOST and FCTZ.
- Give priority to children heading households when awarding bursaries. The selection for awarding these should not be based on academic results only, but the child's background should also be considered and how it had affected his/her academic results.
- Prioritise the allocation of resources; for example, to give the Department of Social Welfare a bigger grant towards the assistance of OVC.
- The Department of Social Welfare should establish counselling services for victims of violence.
- Victim friendly courts needed to be maintained, so that they would always be in good working condition.
- The National Action Plan (NAP) for OVC should try to identify all the needs of these children and issues that affect them; adequate financial support should be given to the NAP.

Role of individuals and community

- Generate support for OVC from within the community; external support should be mainly in the form of capacity-building, as community empowerment is important.
- Put a stop to the donor syndrome. The community should initiate projects to help OVC and should help the OVC periodically.
- A female village head said that there was a need for older children in CHHs to be taught how to take care of younger children in the household, so that there would be no need to take these children into other people's households or orphanages.

Role of NGOs, CBOs and FBOs

- NGOs and FBOs should work together with the council and other government departments in appropriately identifying the needs of the children.
- Computerise the OVC database, so that it would be easily accessible to all organisations and would avoid duplication of services, therefore improving the service to the OVC.
- All stakeholders should constantly meet to discuss OVC issues. Staff from NGOs emphasised the need to carry out research to find out about the orphans' problems from their own perspective, so that interventions would be informed by such findings.

- Organisations should not abandon children when they reached 18 years of age if they are not yet in a position to fend for themselves. OVC should be weaned off their support systems when they are in a better position to assist themselves.

Suggestions to all

- In addition to the campaigns conducted by the state/government, all stakeholders needed to increase educational campaigns on policy and legislation that protect children, as the majority of community members were not aware of these policies.
- To advocate heavier sentences for people who abuse children and for the courts to establish stronger penalties (for example, the death sentence).
- The police should give first priority to cases involving orphans, especially regarding sexual abuse cases.
- With regard to the Birth and Death Registration Act (Chapter 5:02 of 22/2001), a key informant said that the OVC should be registered, even if their parents did not have identification documents.
- The Public Health Act (Chapter 15:09 of 14/2002) should be strengthened and people should go to the hospital, regardless of their religious affiliation; there should also be laws to regulate churches in relation to the protection of children.
- To educate children on the importance of education, since some children on the farms thought that Grade 7 was the final stage. The responsible authorities should ensure that children go to school, especially those on the farms.
- There must be accountability and transparency in the administration of the BEAM scheme.
- The number of youth friendly centres should be increased, as these would assist children, especially OVC. Most current programmes targeted adults.
- Orphanages must be established on farms so that orphans could be supported whilst staying there.

The need for collaboration of organisations that assisted OVC was emphasised, so that all the needs of the OVC could be met. A chief said that if the government bought books, then the parents should look for uniform and school fees. He also went on to say that there was a need for government to work with traditional leaders on the revival of traditional practices. Monitoring and evaluation of the whole system, namely, from selection of beneficiaries to how the assistance is distributed and used, was also of paramount importance.

NGOs or the state should educate the community on how to treat or care for OVC, especially on the farms. There was a need for an office responsible for monitoring resources, particularly the finances, and also for marketing products and sharing the profits among the members of a community group.

A call for a survey on the needs of OVC was also made. The aim of the survey would be to ascertain the extent of the problem and also to estimate the assistance that would be required. It was emphasised that there was a need for research-based interventions, so that the OVC would be assisted according to their needs and no gaps would be left in providing this assistance. The Child Protection Committee in the district was encouraged to involve community leaders. It was proposed that the structure should start at village level, so that the real needs of the children would be understood. Furthermore, it was suggested that children have their own committees, so that their voices would be heard from grassroots level.

Policy and legislation for the protection of OVC

As a way of protecting and caring for children, both the national government and the international world have set policies and legislation in place. These have been received with mixed feelings in all sectors of society. In this section, we address how the Bindura District has reacted to the different policies and legislation that affect the way children are cared for.

Knowledge of laws, policies or practices to protect OVC

A regional prosecutor indicated that few community members were aware of the policies and legislation that protect children. Caregivers echoed the same sentiments as the prosecutor. 'People are not aware of the laws and are ignorant of policy and legislation that protect children,' said one caregiver. Another caregiver pointed out that some people were not even aware of the importance of obtaining birth certificates for children, especially in the case of double orphans.

Child labour was said to be rampant, especially in the farming areas where children were used as cheap labour. There were also reported cases in which children, especially orphans, were not paid their money for working on the farms, as the farmers would claim to pay for their fees instead; yet the school fees would be far less than the amount of money due for the services rendered.

Key informants from some NGOs indicated that the majority of the community members were knowledgeable about the policies that protect children. 'This is evidenced by the ever-increasing number of cases they refer to us,' said a legal officer with a legal centre in Bindura. One representative of an NGO said, 'The blanket conclusion is that the people are aware, especially of children's rights, but not aware of birth and death registration.' Implementation of these policies was mainly hampered by poverty.

Attitudes towards such regulations

There was reluctance among those who were aware to assist the affected children; for example, if a neighbour's daughter was raped, people felt that if they assisted, they were being used. Other people were afraid to report cases or to give evidence if the perpetrators were their relatives; such cases were usually settled at home. People were generally ignorant about the regulations and some girls as young as 13 were forced into early marriages.

Challenges faced in enforcing laws that protect children

- Poverty was mentioned as the major challenge in trying to enforce these laws. As a result, OVC would be subjected to child labour and even sexual abuse.
- A chief indicated that the conflict between culture and some legislation also posed huge challenges in enforcing the laws; for example, children were supposed to be taught how to work, according to culture, but the law would view this as child labour.
- Some chiefs presiding over child sexual abuse cases were tampering, or allowing other people to tamper with evidence, to the extent that when the case reached the criminal courts, some of the evidence was destroyed.
- Many cases were not being reported. In some communities, for example, in Muzarabani, a mother could not report when a child was raped if the father was not there; the mother therefore had to wait for the father to return.
- Some respondents felt that law enforcement officers were not doing their work.

HIV and AIDS

HIV and AIDS had affected different communities in different ways. The majority of people were aware of HIV and AIDS, especially prevention and transmission issues, although they could not provide the actual number of people living with HIV and AIDS (PLWHA). The participants unanimously agreed that HIV/AIDS was still a problem in their community, as people were being buried every day. Poverty was the major reason given to explain why there were increases in the number of people being affected by AIDS. Some respondents reported that poverty was affecting behaviour change among people, because they resorted to prostitution in order to earn a living. OVC, however, pointed out that they did not have adequate knowledge on HIV/AIDS, even though they read about it in books at school.

Cases of witchcraft accusations were still prevalent when someone died of HIV-related diseases, although they were now few compared to previous years.

Impact of HIV/AIDS

State and organisational resources
The state and other organisations were reported to be losing a lot of experienced and productive workers to the disease, hence negatively affecting the economy. Some participants were even worried that some young graduates were dying before they paid back their government loans. There was also concern about the fact that more resources were being channelled towards the care of PLWHA, thus neglecting other keys areas.

Community resources
Community resources were now depleted and people could no longer cope with the ever-increasing number of orphans due to HIV/AIDS deaths. Some farming communities also lost a lot of skilled workers due to this disease and this affected their income as well.

Social functioning of the community
HIV has impacted heavily on communities, as people attended funerals almost on a daily basis. In some cases, only close relatives were attending funerals because people were dying in such large numbers. The increased deaths and illnesses among the older people had resulted in CHHs and a number of children taking care of their sick parents. In addition, grandparents had been left with the burden of taking care of orphans. HIV/AIDS was also reported to be resulting in the disintegration of families and hence the social fabric in general.

Suggestions on how to limit the spread of HIV/AIDS in the community

Study participants mentioned various ways to limit the spread of HIV and these ranged from educational and infrastructural approaches, to interventions at a social level. The suggestions were as follows:

- Abstinence, that is, no sex before marriage, was mentioned as key in limiting the spread of HIV, especially for those who had not started engaging in sexual activities; they felt that teaching them how to use condoms would make them decide to engage at an early age. For those who would have already engaged in sexual activity, it was suggested that they should be encouraged to get tested and be taught to use condoms.
- Faithfulness to one partner for all age groups.

- Correct and consistent use of condoms, and that they should be made available to all people. Educational campaigns were said to be continuing, even in schools. It was also said that the campaigns against HIV should be intensified and should especially target young people who have resorted to going out with older men or women. Boys say, *'Gogo ndivo vanoita uyezve havacosty nekuti vakakura kudhara.'* (Grannies are the best, since they are less costly, because they are already grown up.) And girls say, *'Vana sekuru vanobhadara, vana vadiki vakaomera.'* (The old men pay well, the young men are stingy.)
- Introduction of mobile VCT services was said to be important. If anyone found out that they were HIV negative, it was vital that they should not continue with risky behaviour. As one respondent said, *'iwe uchiziva kuti wakapunyuka'* (when you know that you have escaped it).
- Commercial sex work must be discouraged by teaching commercial sex workers to be self-reliant, for example, by running IGPs. It was emphasised that this also applied to those single mothers who engaged in prostitution because of poverty. It was further said that peer education should be encouraged among the commercial sex workers.
- Some respondents mentioned that people needed to be shown the statistics of those succumbing to HIV/AIDS, so that they would change their behaviour.
- Parents too were encouraged to teach their own children about HIV/AIDS issues and not to be embarrassed to do so. In addition, those who directly dealt with children, for example teachers, were encouraged to complement the efforts of the parents.
- Education of caregivers on good care and treatment of OVC was highlighted, as these children might otherwise engage in risky behaviour if not properly cared for.
- Pamphlets and handouts on HIV/AIDS must be produced, using all local languages as well as other languages such as Nyanja and Tonga, rather than just using Shona, Ndebele or English.
- The need to review HIV/AIDS policy, especially the section on confidentiality, namely, revealing one's HIV status to spouse and caregivers.
- People ought to learn to talk openly about HIV and AIDS at all forums, including social gatherings like weddings, funerals and even in churches.
- There must be continual provision of information, education and communication (IEC) materials, since these could lead to behavioural change.
- The government should eradicate poverty, which was fuelling the spread of HIV.
- VCT, PMTCT services and condom distribution programmes needed to be strengthened and expanded to all areas.
- The continuing need to mobilise people around the importance of using services like VCT, PMTCT and opportunistic infections (OI) clinics. Emphasis was put on the need to educate men on PMTCT, as some men refused to allow their spouses to go for PMTCT.
- The need to encompass everyone in AIDS education, especially the gold-panners who believed the myth that 'womanising brings money', thereby promoting prostitution.
- People must change their behaviour for the spread of HIV to be limited.
- Also, the need to deal with cultural practices such as *kugara nhaka* (wife inheritance), which is still practised in some communities. It was suggested that if people go for *nhaka*, they must be tested for HIV first before having sex.

Care and treatment of PLWHA in the community

The main services that were available to PLWHA were home-based care (HBC) and antiretroviral therapy (ART). Food targeting PLWHA was mainly provided by NGOs and

DAAC. There was a kids' club that was assisting PLWHA with household chores. The PLWHA were also reported to be helping each other through their support groups and also herbal gardens.

There were reportedly no VCT, PPTCT and ART services in the farming areas. These services were based in town and transport costs were inhibiting people's access to them. Even PLWHA in Bindura Urban were not benefiting much from the programmes, as the district hospital where they were offered had to cater for all PLWHA in the whole province and therefore the services had been ineffective. In contradiction to this, MoHCW officials said that ARVs were available and that people were accessing them.

Advantages and disadvantages of disclosing HIV status

The respondents were asked what they considered to be the advantages and disadvantages of disclosing one's HIV status and the responses were as follows:

Advantages

- One could easily get assistance if one opens up, for example, advice on eating nutritious food that boosts the immune system.
- Disclosure would reduce the spread of HIV/AIDS; for instance, this was what had happened in Uganda.
- If one was open, he/she was able to educate others in the community and also plan for the future.
- Enabled people to live positively.
- Life could be prolonged, as opportunistic infections could be noticed and treated easily.

Disadvantages

- People would discriminate against and stigmatise those who opened up about their HIV status, and some would say, '*wakutofa*' (you are already dying), which stresses the PLWHA.
- One might lose many friends.
- Might be victimised and lose jobs.
- Could get stressed to the extent of committing suicide.

Risks of HIV as a result of violence

Child abuse, rape and sexual assault were mentioned as factors that could increase a child's risk of HIV infection as a result of violence. Child labour, verbal abuse, physical beating and emotional abuse cases were also reported to be rampant in the communities. There were a few cases of rape and sexual abuse and the main perpetrators were people close to and known to the children. The main targets of the perpetrators were young girls. The majority of the girls were being raped by relatives; these included their fathers, uncles and close family friends. One OVC girl said that, 'some boys aged 15 to 17 years old threaten to beat me or falsely accuse me of stealing their money when I reject their love proposals'. Some church prophets were also reportedly raping children. Even though community members reported a decline in cases of sexual abuse and rape, there were some individuals who still believed that having sex with a virgin cured HIV/AIDS. Some were said to be doing it for ritual purposes, for example, so that their businesses would prosper. Sodomy cases were reported, though not pronounced, such as the case of a grandmother in her 80s who sodomised her grandchild.

Counselling services were available to cater for the affected children, although gaps were evident; for example, there were no programmes to provide post-trial counselling for victims of violence. In some cases, family members, such as aunts, also provided counselling to the abused children. There was interaction between OVC and non-OVC through a kids' club that was formed in one of the farming communities. They entertained each other by playing football and performing drama together.

Regardless of the efforts of organisations to teach people about HIV as well as to equip them with skills for IGPs, there were still reported cases of both children and adults engaging in prostitution. Their primary objective was to earn money or get food. An OVC from Uronga farm said, 'Even people aged 60 do it, as it is the culture in compounds in these farming areas.' Widows, widowers and OVC were the ones who were the most active in prostitution, and this was mainly due to poverty and high unemployment rates. This was further exacerbated by the fact that the new farmers employed very few people and therefore a lot of people were now not employed. Even some community members seemed to be encouraging it, as some bar owners were reportedly taking in some prostitutes in order to attract customers. Some prostitutes came from as far as Harare (87km away) in search of the gold-panners, who usually flashed a lot of money around in exchange for sex. Rutope, Nyava, Manhanga and small-scale mines (gold-panning areas) were reported as 'red spots' for these commercial sex activities.

Sources of information on HIV/AIDS

Study participants mentioned several sources of information on HIV/AIDS. The major ones included government departments, NGOs, CBOs and peers. The government ministries included MoHCW, MoESC, and Ministry of Home Affairs (MoHA). The print and electronic media was also reported to be playing a part in disseminating information on HIV/AIDS, although this had brought its own problems since the majority of people could not afford to buy either the newspapers or batteries for the radios. It was mentioned, in FGDs, that DAAC/Ward AIDS Action Committee (WAAC) coordinators, village health workers (VHWs) and HBC caregivers were also providing information on HIV/AIDS.

Study participants were asked what they thought had to be done to improve the provision of HIV/AIDS information and they pointed out various ways, as listed below:

- The MoHCW should conduct regular awareness campaigns on HIV/AIDS. It must also emphasise prevention and condom distribution, as some people could not abstain.
- Dramas on HIV transmission modes and prevention must be performed regularly.
- Pastors in churches must emphasise to children that fornication is a sin and that they must fear God. This could assist in limiting the spread of HIV/AIDS.
- It was stressed that provision of information on HIV/AIDS should start at home from the parents themselves, before the children heard about it from outsiders.
- HIV/AIDS campaigns should also cover farming areas, as they are normally left out.
- There was a call to involve PLWHA in awareness campaign programmes.
- The need to subscribe to journals, so that organisations could access publications on the latest information on HIV/AIDS.
- Provision of internet services to key government departments and NGOs was said to be vital, so that information could easily be accessed.
- Newspapers must be made available on a daily basis to schools, as access had been limited.
- The need to cultivate a reading culture among people.

- IEC materials/pamphlets on HIV/AIDS should be distributed widely, even in the rural areas.
- The need to train more peer educators and more organisations to give OVC lectures on HIV and AIDS issues.
- It must be mandatory for all clinics in all wards to give health education.

Profile of government departments

The following were the government ministries that were helping OVC in Bindura District.

Ministry of Justice, Legal and Parliamentary Affairs

Background

The main department of the ministry that directly worked with issues that pertained to OVC was the court. The court had a victim friendly court (VFC) that used a camera to film the child from another room, in order to create a favourable environment for the child to be able to narrate what happened and answer questions without any discomfort. In the VFC, a child would demonstrate what was done to her/him, using anatomically appropriate dolls. If the camera was not working, the courtroom was cleared or the magistrates' chambers were used. Child abuse cases were given first priority, to avoid further trauma to the child through delays. Police were encouraged to bring the parties (accused and complainant) to the court as soon as they finished investigations. The department worked in such a way that it did not have backlogs; in fact, it had no backlog of cases at the time of the study. The victims and perpetrators were tested for HIV and if the perpetrator was HIV positive, the prosecutors advocated a stiffer sentence.

Activities

The VFC was involved in the following activities:

- Dealing with rape cases, some of which involved orphans as victims.
- Advocating that OVC be taken care of after judgement, and even change of guardian. If the perpetrator was the guardian, the victim was taken to a children's home, such as SOS or Mathew Rusike, until the trial was over.
- Holding interdepartmental meetings between the police's Victim Friendly Unit (VFU) and the department's own staff.
- Working with MoHCW and MoPSLSW in helping orphans to deal with legal matters.

Challenges

- Breakdown of equipment in the VFC.

Recommendations

- The need for the VFC equipment to be serviced constantly.
- Stiffer penalties to be given to those who rape children; maybe raise the maximum sentence to 20 years imprisonment.
- The need for all stakeholders to work together to ensure that the victimised children are given post-trial counselling.

Ministry of Public Service, Labour and Social Welfare

Background

The most active department of the ministry with regard to children's issues was the Department of Social Welfare.

Activities

The activities of the department are as listed below:

- Offering rehabilitation services to orphans.
- Providing children's homes.
- Offering fostering and adoption services.
- There was a probation officer for the children in court for cases of abuse.
- Assisting children to obtain birth certificates, especially those in children's homes.
- Facilitating paupers' burials.
- Teaching parents on children's rights.
- Coordinating NGOs working in the district.
- Spearheading the NAP for OVC.
- Providing educational assistance to OVC through BEAM, in collaboration with MoESC.
- Holding meetings with the Prosecutor's Office to discuss issues on OVC, especially child abuse cases.

Challenges

In the process of trying to achieve its goals, the department had been faced by many challenges, some of which are listed below:

- The department was short-staffed, had only one district social services officer and a deputy, and one office orderly, without a clerk or a secretary.
- Transport problems/shortages caused some reported child abuse cases not to be investigated thoroughly, so that the courts had to rely on second-hand information.

Recommendations

- The need to re-activate child protection committees.
- The need to amend policies on birth and death registration in order to accommodate OVC.
- All stakeholders who sit on Child Protection Committees needed to meet and discuss such issues as the NAP for OVC.
- The NAP for OVC should reach out to all OVC in the country and identify their needs and any other issues affecting them.
- The need for financial assistance for the NAP for it to be a success.

Ministry of Education, Sports and Culture

Background

The Ministry of Education, Sports and Culture facilitated the provision of educational needs at primary and secondary level, as well as pre-school and post-school education, such as adult literacy. The ministry was very committed to fulfilling children's rights, especially their right to education. The ministry's source of information on OVC was a database that was kept at district level and was also used to work in collaboration with FOST. The selection of the children incorporated in the ministry's assistance schemes, such as BEAM, was done through structures that had been set up in the community, among which were the chiefs. In recent years, the district had experienced an increase in the number of teachers who had pursued further education in counselling, indicating their interest in dealing with problems faced by children.

Activities

The activities of the ministry are given below:

- Assisting OVC, including children from CHHs, with school fees, levies and exam fees, through BEAM scheme.

- Having a joint programme with the EU, called Educational Transition and Reform Programme (ETRP), which focused on OVC, particularly in Bindura. In this programme, OVC were assisted with school fees (even school dropouts were brought back to school), and provision of corrective surgery (artificial limbs) for disabled children.
- Identification of CHHs, in consultation with the community selection committees.
- Offering guidance and counselling to all children in schools, through the provision of a Guidance and Counselling teacher. It was mandatory that every school had such a teacher.
- Providing the district with a remedial teacher who assisted OVC, especially the disabled ones.
- Investigating allegations of ill treatment of children and asking social welfare or the police to assist if allegations were substantiated.
- Providing rehabilitation facilities to disabled children.
- Offering guidance and counselling to OVC.

Challenges
- The BEAM scheme was overwhelmed, since school fees had gone up.
- Shortage of teachers, due to deaths caused by HIV/AIDS-associated diseases.

Recommendations
- The government and other stakeholders should introduce school-feeding programmes; these would enable OVC to have one decent meal per day.

Ministry of Agriculture

Background
The Ministry of Agriculture's main responsibility was to ensure food security. It also offered training to commercial and subsistence farmers through the Department of Research and Extension Services. Bindura District had 32 officers, of whom 28 were agricultural extension workers and 4 were agricultural extension officers. There was one field orderly and one clerk. The post of district head was vacant. The ministry did not assist OVC directly, but assisted anyone who was involved in agricultural activities, including OVC themselves.

Activities
The ministry's main activities were:
- Assisting in the distribution of inputs, such as fertilisers.
- Offering training to both subsistence and commercial farmers through the Agricultural Research and Extension Services Department.
- Working hand-in-hand with other organisations in the *Zunderamambo* programme.

Challenges
In the process of assisting the community with all agricultural extension services, the ministry was faced by challenges, as shown below:
- Shortage of inputs to give farmers, especially newly resettled ones.
- Lack of transport to monitor and evaluate farming activities.

Recommendations
- The government should urgently repair, buy or even source vehicles from donor agencies for use by the ministry in their monitoring and evaluation activities.

- The need for collaboration between government and other intervention agencies in all the activities.
- The need to provide inputs to *Zunderamambo* and also to the OVC themselves.

Ministry of Home Affairs (Police)

Background
The ministry included the Police Department, which mainly dealt with children directly. The district had three police stations, one police post and eight bases.[1] The department included Victim Friendly Units, which were found at police stations only. The VFUs dealt with domestic violence and all forms of abuse, both inside and outside the home. At the time of the study, the units did not have any specific programmes that dealt with OVC, but they happened to assist OVC during their daily duties. The district had two fully-trained victim friendly officers, a trainee and four officers who had basic knowledge from having had in-house training. Officers at the district central police station coordinated all the district stations.

Activities
The major activities of the department, with regards to children were:
- Carrying out awareness campaigns on child abuse and children's rights.
- Investigating and preparing dockets on sexual abuse and rape, targeting all age groups.
- Liaising with the MoHCW in the provision of free medical treatment to abused children.

Challenges
- Shortage of trained VFU police officers.
- Shortage of food to feed the abused when they are brought to the station.
- Transport problems, which often led to delays in investigating cases; such delays at times resulted in loss of evidence; for example, specimens that must be taken before a victim takes a bath or before blood dries up.
- Children usually delayed reporting cases, due to various reasons, such as lack of knowledge on what to do in the event of abuse and what constitutes sexual abuse.

Recommendations
- The need to train more police officers in counselling.
- The government and NGOs should provide food to the abused children while they are waiting to be served.
- A car must be assigned to the VFU officers at each station, in order to speed up their investigations.
- The abused children should be given first preference and not wait in queues when they go to hospitals for investigations.

Ministry of Health and Child Welfare

Background
The district medical officer headed the district hospital. In its activities, the ministry also worked together with the Department of Social Welfare, and the public relations officer was the intermediary between the two. Bindura District Hospital's capacity was 120 beds, with an establishment of 120 posts.

1 A police base services a very small community.

Activities

- Providing free services (which included immunisations, medical and surgical treatment) for children under the age of five, including OVC.
- Working hand-in-hand with the Department of Social Welfare, especially in the referral of children who needed extra medical assistance or foster homes.
- The ministry included the Child Supplementary Feeding Programme, which supports children below the age of five and also OVC above five years of age.
- Working in conjunction with DAAC and the police in assisting children who needed temporary accommodation.
- Providing HBC services.

Challenges

- Transport was a major problem and the district had a poor road network and therefore it was difficult to access some areas during immunisation programmes.
- Financial resources were not adequate.
- Poor communication systems, as there were no phones in some areas or even radios.
- Shortage of human resources, with the most affected departments being Environmental Health, Health Information, and the Expanded Programme on Immunisation and Rehabilitation.
- No adequate IEC material to dispatch to communities.
- Shortage of female condoms.
- Shortage of doctors who would normally examine victims of rape and sexual abuse; nurses were not allowed by law to examine the victims or to give evidence in a court of law.
- Shortage of infant-feeding milk and nappies for orphans whose mothers had died in the hospitals.

Recommendations

- The need for all stakeholders to pool resources together in helping children, for example, by assisting each other with transport.
- The examination protocol for rape and sexual abuse cases needed to be amended, as doctors were the only ones mandated to examine the victims, and yet nurses were also capable of carrying out such examinations.
- The need to give doctors and even nurses attractive remuneration packages to alleviate shortage of staff.
- The government and other stakeholders should help the hospitals with milk, nappies, clothing and so on.

District AIDS Action Committee

Background

In 1999, the government introduced the National AIDS Council (NAC) programme in response to the plight of the HIV and AIDS pandemic. As part of the NAC, District AIDS Action Committees (DAACs) were set up in each district. The DAACs' mandate was to ensure that the most deserving people would benefit from the AIDS levy, which included care for OVC who had been made vulnerable by HIV and AIDS. Working under the DAAC were the Ward AIDS Action Committee (WAAC), based in the ward, and then the Village AIDS Action Committee (VAAC), based right in the village. At the same time, DAAC provided a common forum for all NGOs, CBOs and FBOs in each district to meet and update each other on progress and difficulties they were encountering. DAAC obtains information about OVC from community structures, that is, traditional leaders, Children

Welfare Forum and the BEAM selection committee. The Bindura District had one District AIDS Coordinator and an accountant.

The vision of the committee was to be recognised as the leader in the reduction of HIV and AIDS and its impact in Zimbabwe and beyond, while its mission was to be a committed provider of quality and effective leadership for a comprehensive and coordinated multi-sectoral response to HIV and AIDS in Bindura District. Specifically, their goal was to empower communities to reduce HIV transmission and minimise the impact of the AIDS epidemic on families and society.

Activities

The activities of DAAC were to:

- Support OVC in and out of school with their material requirements.
- Provide stationery and uniforms to OVC in schools.
- Work in collaboration with organisations such as FOST, MoESC (ETRP) and FTCZ in providing psychosocial support to OVC.
- Coordinate activities of all stakeholders in the district, so as to avoid duplication of services.
- Compile a comprehensive database for OVC in the district.
- Finance community structures such as *Zunderamambo.*

Challenges

- Shortage of basic commodities such that there was rationing of the few existing resources.
- Poor communication due to lack of transport and phones.
- Some headmasters were not complying with the MoESC's requirement that all names of BEAM beneficiaries should be posted on school notice boards, to ensure transparency, avoid duplication and for accountability purposes.
- Some organisations or government departments like the MoESC were reluctant to share information.
- Some organisations thought that DAAC was after their money and so when there were meetings for all stakeholders, they would send junior staff who could not make any decisions on behalf of the organisations during the meetings.
- Other organisations were failing to submit monthly reports on their activities to DAAC.
- Favouritism in the selection of OVC, so that undeserving children sometimes benefited instead.
- Some adults altered undergarments given to the OVC girl children, to their own use.

Recommendations

- The need to have a comprehensive and up-to-date database for OVC, so that these children would be more easily accessible and assisted.
- The need for decentralisation of departments such as the police, especially into the farms.
- The road network and also communication systems should be improved.
- Organisations should send people who are in a position to make tangible decisions on their behalf during stakeholder meetings.
- Organisations should ensure that they comply with the requirement of submitting monthly reports on their activities to DAAC.
- There must be transparency in the selection of beneficiaries and it must be ensured that the support reached the intended beneficiary.

Profile of NGOs and other organisations

Zimbabwe AIDS Network

Background
Zimbabwe AIDS Network (ZAN), a national network of NGOs that deals with HIV/AIDS, is a non-profit-making organisation, founded in 1992. ZAN is a membership organisation comprising AIDS service organisations, both faith-based and private. It had a membership of over 260 NGOs, private-sector groups and individuals and, at the time of this study, was still in its infancy. They were given information about OVC from AIDS service organisations.

Activities
- Initiating, facilitating and coordinating activities in the areas of information exchange, networking, advocacy, capacity-building and resource mobilisation of its members and stakeholders.
- Providing services to OVC and also offering HBC and PMTCT services.
- Building capacity for organisations, facilitating conferences, and helping organisations to write abstracts, give mini-grants to organisations and attach students (preference being given to OVC). While on attachment, these students were assisted in report writing and also given technical support.
- Assisting OVC in collaboration with Hope Humana.
- The coordinator sat on the Social Welfare Committee on children's issues.
- Providing psychosocial support to OVC by facilitating exchange visits and their visits to Masiye camp, through intervention organisations.
- Working with NAC to empower communities on advocacy, through participatory rural appraisal (PRA).
- Had produced a training manual (Community Mobilisation and Empowerment for Improved Access to Care, Support and Treatment) to prepare communities on HIV/AIDS issues.
- Funding the documentation of herbal gardens for Catholic Health Care Commission.

Challenges
The following were the challenges the organisation had faced:
- PLWHA were not worried about prevention but just wanted the money for treatment.
- Shortages of workers, as people were moving to other organisations.
- Inadequate funding, due to the dwindling of donors (examples of donors that had pulled out were Global Funding, UK Department for International Development [DFID] and Canadian International Development Agency [CIDA]).

Recommendations
- The organisation needed to mobilise communities, including PLWHA, on HIV/AIDS issues, because communities needed to be prepared.
- Needed to develop good donor mobilisation, in order to receive more funding.

Bindura Legal Project Centre

Background
The centre is a charitable organisation, with its headquarters based in Harare. Lawyers are based in Harare and visit the centre once a month. Paralegal officers handle minor cases and complicated matters are referred to the lawyers on their monthly visits. The centre offers free legal assistance and their main target population is the vulnerable population.

Their mandate is to assist people with social and legal problems. At the time of the study, 70% of their clients were women and most of their clients were between 18 and 45 years old. A means test was done to assess whether one qualified to get their assistance. The office had two paralegal officers and the common cases they dealt with were child abuse, inheritance, birth and death registration, and maintenance of minors. The centre worked in partnership with government departments, such as Social Welfare, DAAC and VFU, as well as NGOs in the area; at times, they held joint programmes.

Activities

- Engaging in mediation and negotiations, writing interdicts, referring cases, giving advice, drafting peace orders, drafting exploitation orders (to people who would have grabbed property) and writing affidavits.
- Assisting OVC and their guardians on how to obtain birth and death certificates.
- Carrying out outreach programmes, that is, distributing pamphlets on various Acts and raising awareness about laws during community meetings/workshops.
- Assisting in the application for custody of minors.
- Investigating cases, such as ownership of houses, on behalf of clients.
- Dealing with public interest cases, for example, road accidents, by assisting injured people to claim compensation.
- Running a radio programme on Radio Zimbabwe called *Zivai mutemo*, which was presented by their parent organisation, the Legal Resource Foundation.

Challenges

- The centre's lawyers did not represent their clients in court and so some clients failed to present facts well in court, resulting in them losing their cases.
- They did not offer counselling services to victims and instead referred clients to an organisation called Connect, in Harare. Most of their clients failed to raise money for the bus fare to Harare to seek counselling services.
- Shortage of transport, hence they only worked in areas that were accessible.
- Men had negative attitudes towards the Maintenance Act (Chapter 5:09 of 22/2001) and in most cases it takes a very long time for complainants, who are mostly mothers, to obtain the maintenance.
- Maintenance money could only be deposited into Post Office Savings Bank (POSB) accounts and those mothers who did not have identity cards or birth certificates, especially those in farming communities, could not open bank accounts in order to receive the money.
- The mammoth task faced by rape victims to get compensation after their case had been tried in the criminal court; they had to go to the civil court to claim compensation and most people found that very costly and time consuming.
- The procedure for registering estates was very long and costly and so many people ended up not pursuing it.
- The majority of people were not conversant with the Deceased Estates Succession Act (Chapter 6.02 of 6/1997), hence some relatives refused to attend edict meetings (choosing the executor of estates), especially when the marriage was a customary one.
- It was difficult to obtain birth certificates in the area, as a significant number of the people were aliens.

Recommendations

- The government should make alternative arrangements for paying out maintenance money, for example, by paying it through NGOs or legal centres.

- Registration of deceased estates and civil marriage (see Marriage Act Chapter 5:11 of 22/2001) should be decentralised to magistrates' courts.
- To overcome the costly problem of registering estates, the officers suggested that a waiver should be put on advertising small estates in the press, because this very expensive advertising would swallow up the value of the estate that was being claimed.
- The need for educational awareness campaigns, especially regarding the Deceased Estates Succession Act.
- Mechanisms needed to be put in place for aliens to be able to get birth certificates for their children.

Red Cross Society

Background

The organisation had three field officers in the district, which allowed one to focus on food security, one on distribution of school fees and one on HBC. The organisation covered 10 wards in Bindura Urban. The OVC programme started in 2001 and by December 2005, they were assisting about 100 OVC, although their target had been 710: 341 boys and 369 girls, from ages 5–18 years old. Members of the community referred orphans to the organisation and some were identified through the HBC facilitators.

Activities

- Supporting OVC with food handouts containing cooking oil, beans, maize meal or maize, and a blend of corn and soya, once a month.
- Offering wet feeding to children aged three to five years old.
- Providing a recreational centre for children under five.
- Paying school fees and buying uniforms for OVC.
- Running a poultry project for OVC.
- Running a resource centre where OVC could read or study; the centre was equipped with textbooks for Grade 1 to Form 4.
- Offering psychosocial support services to OVC.
- Providing an HBC programme; volunteers were given uniforms, bicycles, bus fare, lunch and food handouts once a month.
- Having a quarterly budget allocated for medical assistance, which would allow OVC with medical problems to be examined by specialist doctors.
- Providing shelter for CHHs; Red Cross had built houses for five households that had been affected by Operation *Murambatsvina* (Clean-up).
- Initiating a memory project where parents were asked to prepare a memory book containing special events, family values, pictures and some information they were unable to disclose to their children.
- Inviting lawyers to teach people how to write wills.

Challenges

- Shortage of teachers for the recreational centre.
- Immigration of families for different reasons; for example, Operation *Murambatsvina* had displaced some children, so they could not be followed up.
- Lack of resources, such as material to build a proper fowl run for the poultry project.

Recommendations

- More youth friendly corners should be set up in the district so as to cater for all the children.
- More volunteers should be trained for the care of OVC.

- The community should not only be given handouts but should be empowered to start and run IGPs, in order to reduce the donor dependency syndrome among the people.

Farm Orphans Support Trust

Background
Farm Orphans Support Trust of Zimbabwe (FOST) is a registered private voluntary organisation committed to finding sustainable ways of reducing the impact of HIV/AIDS, as well as mitigating the effects of HIV/AIDS on children and young people in farm communities. The long-term goal of FOST is to achieve sustainable care for orphaned children in farm communities, by encouraging responses emanating from the community itself that would be within the capacity of the community as a whole to achieve. It also aims to create an environment where all children can grow and develop to their full potential. The organisation was working in wards 2 to 7, though it was mainly concentrating on wards 3, 4, 6 and 7.

Activities
- Providing educational assistance (school fees and uniforms) to both primary and secondary children.
- Training focal persons at each school on psychosocial issues, who in turn would train other teachers in the school; these teachers provided counselling services to children.
- Providing block grants to schools for the purchase of materials to benefit the school and, in turn, the children in the school.
- Providing vocational training to OVC, in areas such as garment- and handbag-making, bicycle repair, bee-keeping, fence-making and so forth.
- Providing training to OVC in low-input gardening.
- Running youth programmes to facilitate interaction between OVC and non-OVC; providing balls for various games.
- Working with Justice for Children Trust on awareness issues, such as child abuse, in some of the wards.
- Providing counselling services to CHHs, quarterly.
- Assisting OVC with clothes and blankets.

Challenges
- The organisation was failing to expand its operations or to increase the number of children being assisted, due to the high inflation rate.

Recommendations
- Provision of psychosocial services, material items (blankets, clothing and kitchen utensils) and financial support needed to be improved.
- The need for an OVC database in the district.

Farm Community Trust of Zimbabwe

Background
The Farm Community Trust of Zimbabwe (FCTZ) was established in 1996 to respond to the development needs of farm workers on large-scale commercial farms throughout Zimbabwe. Its main objective is to improve the quality of life, address the needs and to lobby for the rights and welfare of the vulnerable group in the former commercial farming areas. The organisation operates in eight wards (1–8) but had fully covered ground in six

wards (2, 3, 5, 6, 7 and 8). The organisation was assisting 100 students in 5 schools (20 children in each) and, of these, 60% were girls.

The FCTZ's vision is to grow and develop into an effective and efficient, responsive, dynamic and respected local NGO that implements demand-driven, sustainable livelihood programmes to benefit vulnerable groups in former large-scale commercial farming and rural informal settlements.

Activities

- Providing OVC with educational assistance in the form of school fees, levies and uniforms.
- The organisation was part of the child protection committee, which monitored sexual abuse of children and took measures to protect vulnerable children.
- Holding workshops on child abuse in collaboration with the police.
- Providing teaching and learning materials for the resource centres.
- Offering a life-skills programme to empower OVC, which in turn assisted school dropouts to earn a living. This programme was also helping schools with obtaining textbooks.
- Building and establishing early childhood education and care centres that aimed to improve the well-being of children in former large-scale commercial farming areas and rural informal settlements. Three play centres were established and were in wards 2, 7 and 8, and nearly every farm had one.
- Running a health programme that covered sanitation, HIV/AIDS issues, peer education and family-planning services, through training depot holders and developing HBC services.
- Providing a gender programme that would cover topics such as gender roles, wills and inheritance, child abuse, domestic violence and estate administration.
- Facilitating access to and control of resources by vulnerable women.
- Through the Micro-Finance programme, helping community members to establish and run credit and savings projects, and IGPs such as sewing projects.
- Through the Sustainable Livelihoods programme, assisting communities to start IGPs (mushroom production, bread-making, nutrition gardens, conservation farming, heifer and 'small livestock pass-on' schemes, community-based seed multiplication projects and establishment of water points). Some women now sewed uniforms for their own children.

Challenges

- The organisation was overwhelmed by the number of OVC, resulting in its failure to provide some OVC with uniforms, psychosocial support and integration within families.
- Failing to assist CHHs with finance for the basics like food and shelter, to the extent that some children left school to look for illegal gold-panning work.
- Due to lack of resources, the organisation was now failing to provide food to families with bed-ridden members.

Recommendations

- The need to increase support to OVC, as current NGOs and the government are failing to cope with the situation.
- The need to educate the communities, including community leaders, on issues of stigma and discrimination.

- Child protection committees should involve community leaders (for example, the District Child Protection Committee). These structures should start at village level and then move to ward level, before going to the district committee, so that the real needs of the children come from grassroots level.

Farai Munashe Women's Group

Background
The group, which is a CBO, was started by one person in 2004, who was later joined by other women towards the end of the same year. The CBO had nine members at the time of the study. The group meets once a week, usually Fridays, to bake and sell, depending on availability of flour. All members now know how to bake and they also teach OVC this skill. A committee, which comprises an overseer, chairperson, secretary, vice-secretary, treasurer and two committee members, runs the group.

Activities
- Running a bakery (baking buns) and proceeds used to purchase pens, soap and uniforms for OVC.
- Teaching OVC how to bake.
- The women also taught children about life skills, health and education issues, especially those in CHHs who usually came to them for assistance.
- Also teaching OVC games, which had enabled the children to interact with others.

Challenges
- The organisation's growth hampered by the shortage of basic ingredients, such as flour, which was reported to be very expensive.
- Failing to assist all OVC in the community, as the numbers are increasing and resources are limited.
- Shortage of balls for children to use during games.

Recommendations
- The need to have an increase in funding in order to expand the bakery.
- Also the need for resources for the group to be able to impart skills to children on cutting and designing clothing, soap-making and crocheting.

Hope Humana People to People

Background
This organisation has five elements, namely: Health Services, which offers VCT services; Conduct and Training; Opinion Forming; Outreach Programmes, which assist OVC and advise them on positive living; and the Operational Research arm. The organisation is also a part of the NAP for OVC. At the time of the study, it was working only in two urban wards. According to the organisation, their services were well accepted by the community and were very effective, especially since the children's guardians were asking for more programmes, because they were helping their children psychologically.

Activities
- Paying school fees and providing uniforms.
- At times, giving food to OVC.
- Offering counselling services and psychosocial services to OVC.

Challenges
- The shortage of funds and vehicles, restricting the organisation to working in two wards only, which are in town.
- Shortage of office space and furniture.

Recommendations
- Need for funding to scale up programmes.
- Need for transport, to be able to reach all areas, and to increase office space and furniture.
- The need to increase the number of counsellors.
- The need for mobile VCT services.

Christian Fellowship Church (a faith-based organisation)

Background
The church is situated in Dandry Farm in Bindura. It assists OVC in and around the farm, but has no particular structure set up to investigate the needs of OVC and to plan the type of assistance to be offered to them. The church collects donations through a box situated in the church premises and the collected items are distributed whenever enough have been gathered. Information on OVC is obtained from the clinics and other churches. The media is also instrumental in informing the church on issues pertaining to OVC.

Activities
- Assisting more than 20 orphans from different farms with clothing, money and food such as maize.

Challenges
- The church had no funds or regular supply of money to buy food and pay school fees and medical fees for the orphans.

Recommendations
- Church members should donate more clothes.
- The need for external donors to support the FBO's activities.

SOS Children's Village

Background
SOS Children's Village is an independent, non-governmental social development organisation that has been working to meet the needs and protect the interests and rights of children for 55 years. Abandoned children requiring care and support and disadvantaged families are the focus of its work. SOS Children's Villages are the main focus and point of departure for the organisation's global activities. Every village offers a permanent home in a family-style environment to children who have lost their parents or can no longer live with them.

Each SOS Children's Village family comprises an SOS Children's Village mother and 4 to 10 children living together in a house of their own. The village itself is usually made up of between 8 and 15 such families. The SOS Children's Village mothers are the product of strict selection and thorough training procedures, and qualified educational and psychological personnel help them in their work.

Normally, children are admitted to the villages up to the age of 10. Siblings are not separated; they live together in their SOS Children's Village family. Every child receives individual support, and an education and training in keeping with his or her needs and abilities. The village takes responsibility for their charges until they achieve self-reliance.

Bindura SOS Children's home can accommodate 180 children. A quarter of the children at the village were from Mashonaland provinces. As of February 2006, there were 50 youths (semi-independent) and 180 children in the home. The home gives first priority to abandoned children and the orphans, although some of the children are taken from the streets.

Activities

- Looking after OVC and providing all their basic needs.
- Working with the Department of Social Welfare in assisting OVC.
- Providing education assistance to the children in the home. Those who excelled in school were sent to Heimman Gammainer International in Ghana, and some to universities.
- Offering children vocational training.
- Providing ARVs to children living with HIV and AIDS.

Challenges

- The huge demand for vacancies at the village.
- Resources were inadequate.
- Children taken from the streets were stigmatised.
- Shortage of funds to train caregivers in caregiving work.

Recommendations

- The great need to involve community members, so that they would also assist the village in the care of OVC.

Conclusions

The magnitude of the OVC problem was reported to be high, although many efforts had been put in place to try and curb its impact on individuals, households and communities. As in all cases, the Bindura community still attributed its increase in the number of orphans to the AIDS pandemic. The burden of caring for OVC was still left to the females, especially the frail and old grandmothers, who could barely earn a living for the children under their care. Besides the effort being put in by every household to provide all the basic needs for its household members, the harsh economic situation in the country continued to erode the little resources available. The existence of child-headed households in the communities was a strong indication of the effects of hardship being faced by people, since they could not take more members into their households; it also demonstrated the weakening of family support networks.

Most of the needs of the OVC were material, for example, food, clothing, shelter, school fees, blankets and the one major need that is barely remembered in most interventions, the provision of sanitary wear for the girls. Children's access to health and educational facilities was good, showing that the NGOs, CBOs, FBOs and state interventions were effective. However, there was a need for all the stakeholders to work together, in order to reduce the duplication of assistance and to ensure the effective use of available resources.

Counselling services were lacking in the district, including provision of emotional support after the death of parents, as well as counselling for victims of violence after trials.

Sexual and physical abuses were noted as major threats to the quality of life of the OVC. Poverty was forcing these children into early marriages, prostitution, drug abuse and even stealing.

The challenges that the community had faced in their efforts to care for OVC were that the community had no capacity, in terms of resources, to care for the OVC; prostitution and child labour were common; corruption among some community members; inadequacy and inefficiency of health services, such as clinics and hospitals; involvement of politics in non-political organisations; and guardians who did not have the capacity to counsel children. In light of all these challenges, it was indicated that it had been very difficult for the community itself to assist OVC, without assistance from outsiders and the government.

Corruption was reported to be rampant in the communities, which called for a more functional approach to the monitoring of all assistance given to the community. The selection of beneficiaries was biased.

Property-grabbing was not a problem, indicating that the organisations that were advocating equity in the distribution of the assets of the deceased had created effective programmes. However, there was a need for continued education on the importance of will-writing and also the need to abide by the will of the deceased.

Attitudes towards the orphans held by the majority of caregivers, community members and members of the households were generally positive. There were a few cases of OVC who were mistreated by either their stepmothers or stepfathers. There were also only a few cases of OVC who were stigmatised and this was attributed to the positive impact of educational campaigns.

NGOs, CBOs, FBOs, government departments and family members were the main providers of care and support to OVC. They had been helping mainly with food, school fees, stationery and the initiation of IGPs. The assistance to OVC, especially provision of school fees, was effective, as evidenced by the number of orphans who had gone back to school. The majority of the respondents agreed that interventions had to be initiated by the community itself for them to be sustainable.

The majority of the study participants indicated that OVC should be assisted with basic needs, such as food, shelter, educational support and clothes. The state, individuals, communities and other organisations, like NGOs and FBOs, must play their part in helping the OVC. The state should especially assist orphans in getting birth certificates, since several orphans had no birth certificates, particularly in the farming areas. The community should initiate OVC programmes and donors should only support them towards making the OVC programmes sustainable. NGOs and FBOs ought to work hand-in-hand with the government and there should be proper coordination of activities to avoid duplication of assistance. A monitoring and evaluation system needed to be put in place for interventions to be successful. Overall, OVC interventions must be informed by research, so that the actual needs and problems of OVC are addressed.

The majority of the community members were not aware of policies and laws that protect children. Some of those who were aware were reluctant to implement them, and the main challenges that were faced in enforcing these laws were poverty and culture.

The majority of the people acknowledged that HIV/AIDS was still a problem in the district and that they were still burying people on a daily basis. People had knowledge on HIV transmission and prevention issues, although this could not be translated to behaviour change. Poverty was said to be fuelling the spread of HIV and some people were resorting to commercial sex work as a source of income. HIV and AIDS had impacted negatively on community, state and organisational resources and it had also affected the social functioning of the community.

Empowerment of people with education on HIV and AIDS is a milestone in HIV prevention. Services such as the VCT, PMTCT and OI clinics are also equally important in limiting the continual spread of HIV. There is a need to introduce these services in the farming and rural areas, as they were reported to be in towns only. Curtailing poverty and prostitution is also another way of fighting HIV and AIDS.

The HBC programme was one of the services that was available for the care and treatment of PLWHA, but it brought its own problems along with it, the major problem being the shortage of replenishment kits.

The major sources of information on HIV and AIDS were the NGOs, CBOs, government departments and peers. There was a call for regular educational campaigns on HIV/AIDS and that provision of information should start with parents/guardians at home.

Priorities for action

This section makes recommendations from the key findings of this situational study; they are as follows:

- The government, NGOs, CBOs and FBOs should increase their support to OVC and their caregivers, as orphans are continuously increasing in number. The majority of caregivers are grandparents without any resources to support the orphans and so the intervention agencies should provide the material needs of OVC. School-feeding programmes must be introduced so that the OVC can have one decent meal a day, as some were starving due to food shortages.
- Intervention agencies and guardians must provide orphaned girls with sanitary wear, as the girls were at risk of getting infections. The majority of the girls were reportedly using materials like newspapers and old, dirty clothes, and some would miss school during their menstruation period days.
- Programmes must be put in place to cater for child-headed households, as they were found to be facing a lot of problems.
- Organisations assisting OVC need to be coordinated to avoid duplication of activities, and areas of cooperation must be identified. The NGOs in the district were not working together, because there was no one to coordinate their activities.
- Education on policies and laws that protect children must be strengthened, as the quality of life of OVC was under threat from sexual and physical abuses. Stiffer penalties must be imposed on those who rape children.
- Poverty was seriously affecting the community in its efforts to help OVC. The government should alleviate poverty, because it was reportedly pushing some orphans into early marriages and prostitution.

- There was a need to monitor the selection of beneficiaries, since there was no transparency; the assistance was being given to undeserving children.
- Equipment in the victim friendly courts must be serviced regularly so that trials on rape cases can be conducted without any problems. If the equipment is functioning, the victim can give evidence without any problems.
- The government must repair or buy vehicles for key government departments like the MoHCW, MoHA (Police) and MoPSLSW for them to be able to carry out their duties in time. Investigations of some rape cases could not be completed, due to shortage of vehicles.
- The government should put in place mechanisms to retain staff, such as doctors, nurses and counsellors. These are key professionals in the examination of victims of rape and also in the provision of counselling services. The need to train more police officers who work in Victim Friendly Units cannot be overemphasised.
- A comprehensive database is needed for OVC; a census and needs assessment on OVC also needed to be conducted. This is important for identifying the OVC and also for the provision of research-informed interventions.
- The government must assist orphans in acquiring birth certificates, as the majority of them indicated that they were facing problems in obtaining them.
- HIV educational campaigns must be scaled up to all the sectors of the district, especially the farming areas, and they must be done regularly. The respondents indicated that HIV/AIDS was still a problem in the community and that some people were still engaging in risky sexual behaviour and prostitution.
- Mobile VCT services must be introduced, especially in the rural and farming areas.
- All parties should work together in the provision of information on HIV and AIDS. Parents must complement the efforts of FBOs, NGOs and the government.

CHAPTER 5

Nyanga District

Stephen S Buzuzi, Shungu Munyati, Brian Chandiwana and Pakuromunhu F Mupambireyi

Background

Description of study area

Nyanga District is situated in the mountainous province of Manicaland, on the eastern border of Zimbabwe, which is 108km north of Mutare Urban. Most of the land in the district falls in agro-ecological Regions I and II, although Region IV is found in a few areas. Regions I and II are characterised by high rainfalls and the land is suitable for cash-crop farming. The district has 31 wards.

Population distribution

The district has a total population of 117 279, of which 53% (61 853) are female (CSO 2002). The CSO reported crude birth and death rates in Nyanga of 30.57 and 14.14 per 1 000 respectively, and a rate of a natural increase of 1.64%. There are 29 029 households in the whole district and the average household size is 4.01. The CSO also noted that the district had 168 and 49 male and female child-headed (<15 years old) households respectively. The main language is Manyika, a sub-dialect of Shona.

Agricultural activities

Agriculture is the most common source of livelihood in the area and this includes forestry, orchards and crop irrigation. Most of the soils are sandy loam. The major crop grown is maize. The other crops grown are beans, potatoes, tomatoes, sunflower, rapoko, groundnuts, cowpeas, paprika, round nuts and wheat. Fruits grown in this area include apples, peaches, avocados, mangos and paw-paws. Due to the rugged terrain, the majority of the people plough using hoes. Besides growing crops, almost every household in the district owns some livestock, either cattle or goats, or both, and the average number of livestock per household is five (CSO 2002).

Health facilities

Table 5.1 shows the number of health service centres in the district.

Table 5.1: Clinics and hospitals in Nyanga District

Health service centre	Total number
Number of hospitals	5
Number of clinics	21
Health institutions run by:	
Government	6
Mission	4
Council	11
Number of nurses (in all institutions)	88
Number of volunteers	175

Education facilities

Table 5.2 shows the percentage of the population aged 3–24 years old who are currently attending school, and their current level of education and gender.

Table 5.2: Levels of education for 3- to 24-year-olds in Nyanga District, by percentage

Age	Males	Females	Total
Early education	8.60	9.66	9.10
Primary education	66.74	69.82	68.21
Secondary education	24.07	20.13	22.19
Tertiary education	0.59	0.38	0.49
Total (N)	20 895	18 963	39 858

The district has a total of 85 pre-schools, 85 primary schools and 28 secondary schools. The district was reported by the Ministry of Education, Sports and Culture (MoESC) in 2005 to have adequate staff in all schools. Dropout rates in the district ranged from 30% among the girls to 40% among the boys. Most of the schools were run by missionaries and the District Council and only one out of the 28 secondary schools was run by the government. According to MoESC, there were approximately 1 500 and 800 orphaned boys and girls respectively among the school-going pupils.

Water, sanitation and housing

The district has a wide supply of protected boreholes but when the boreholes break down, people get water for drinking from rivers, as an alternative source, since they cannot repair the boreholes themselves. There was an increase in the number of toilets of acceptable standards in the district, since some NGOs were providing building materials, such as cement, as well as education and awareness on hygiene and sanitation. Most of the houses are built of dagha and are grass thatched, while the floors are polished with cow dung.

Transportation and energy

There is a network of tarred roads in the district and these roads are in good condition. These major roads are connected to timber plantations and other farming areas. However, the network of dust roads is in bad condition, owing to damage by rains, heavy vehicles, which have hugely damaging effects to the infrastructures, and lack of maintenance. These dust roads are slippery during the rainy season, particularly as some of the soil is clay. The public transport system connecting Nyanga town and the city of Mutare is quite efficient, but the movement of traffic connecting to other outlying areas is not so good. Most of the commercial farming areas have electricity while the major source of energy in rural Nyanga is firewood. Agricultural produce is transported to the markets using trucks and buses via the Mutare route. However, this is not easy for some of farmers in the remote areas, where bus services are not regular.

Conditions of OVC

Magnitude of OVC problem

The general perception was that the OVC problem was increasing astronomically, indicative of the fact that there were many funerals, especially for people of the

productive age groups, due to HIV and AIDS. However, incidences of child-headed households were reported to be low. The problem was reportedly being worsened by the fact that average family size in the district was large and so when a parent died, he/she left many orphans. Average family size was said to be even higher among the apostolic sects, in which there are many wives and children. An NGO representative stated that the problem was quite pronounced, given that most of the households they worked with had orphans. Some caregivers echoed the same sentiments and stated that, although the problem was big, there were no material resources to support the OVC. Another NGO representative from Family AIDS Caring Trust (FACT) related some of the driving forces behind the problem: 70% of the area was largely farming and people in the area focused more on production, at the expense of sending children to school; there were also no recreational facilities and so many people spent their time in beer halls, thus exposing themselves to HIV. A councillor reported that labour migration and poverty, compounded by drought, were other driving forces, especially as wages from the agricultural sector were not enough. A representative of an FBO, Rekai Tangwena Children's Home, indicated that over the years there had been an increase in the number of OVC they were taking into their orphanage. The district education officer mentioned that not all intended beneficiaries were receiving assistance. Most NGO officials were concerned that the resources that were put into addressing the problem fell far short of the requirements.

Retarded development emanating from the loss of skilled human resources such as teachers and nurses, in other words, the productive labour force, was reported as one of the most enduring impacts of HIV and AIDS. The social welfare officer mentioned that the fact that there were more paternal orphans than maternal orphans signalled the persistence of poverty and deprivation, because fathers were the breadwinners in most rural households.

Sources of knowledge about OVC

The communities had various structures that worked with OVC and these structures had registers from which the numbers of OVC in their respective areas could be located and counted. Community members reported that they had come to know about OVC through village heads and home-based care (HBC) programmes. HBC areas were divided into clusters and each cluster was required to keep a database of OVC and families that they served. Most of the information about OVC was gathered by volunteers working with NGOs, caregivers, District/Ward Aids Action Committee (DAAC/WAAC) officials and environmental health technicians (EHTs). Relatives of the deceased also informed the local structures about OVC, but this happened mostly in cases where they wanted assistance. This implies that OVC who were looked after by caregivers and did not require any external assistance might have been left out of the statistics, even though they still might require psychosocial support. For quick collection of data about OVC, caregivers and volunteers also were informed about OVC through funerals they attended. Some NGO officials reported that they found out about OVC through community leaders and caregivers who helped in targeting OVC. Some NGOs gathered information through support groups of mothers and youths in the communities in which they worked. Other NGOs, such as FACT, reported that they conducted their own baseline surveys to identify OVC who should benefit from their interventions. The district education officer reported that school headmasters compiled registers of OVC, with the assistance of local leadership, which they then used for the Basic Education Assistance Module (BEAM).

Housing conditions for OVC

Some community members indicated that some houses were in a very poor state and that the situation was worse for those children who were still very young when the houses were incomplete at the time of their parents' death. Communities were not taking on the responsibility for rehabilitating the houses. The same sentiments were confirmed by some OVC who stated that they were living in dilapidated houses, some of which had part of the roof of the house ripped off and remained unrepaired, even during the rainy season. There were reports of displaced children who had been forced to go and live with relatives and neighbours, because the houses were not fit for human habitation. A caregiver noted that some of the OVC were living in overcrowded, small houses. An NGO Campaign for Female Education Association (CAMFED) representative stated, 'According to one NGO official, surveys done in the communities showed that the condition of most houses were bad and in some cases boys and girls as old as 16 years were sleeping in the same room and they ended up abusing each other.' A caregiver reported that the housing plight of some of the OVC was worsened by the government clean-up campaign (Operation *Murambatsvina*). In her case, they were now using only two rooms after the clean-up, with women sleeping in the kitchen and males in the other room. A local chief was of the view that the housing conditions of OVC depended on the economic status of the deceased parents. Housing conditions of OVC, whose parents had been working, were described as 'not bad'. The focus group discussions (FGDs) for the 6- to 15-year-olds and 16- to 18-year-olds indicated that those in the town slept in the same rooms as their parents; the children would sleep on the floor, but such cases were few in the rural areas.

Major threats to quality of life of OVC

Major threats that were reported included the following:

- Lack of food, clothes, shelter and school fees.
- Ill treatment by caregivers, especially step-parents and relatives.
- Alienation and stigmatisation among orphans, who had become withdrawn as a result of labelling, if their parents had died of HIV and AIDS.
- Lack of finance caused children to withdraw from school and some did not have proper uniforms and so did not feel comfortable at school; some were expelled from school when they failed to pay fees and they therefore lagged behind in progress with their school work.
- Little girls were enticed by men with money and then abused.
- Some children were born with the HI virus and were therefore sickly all the time.
- Poverty.
- Child labour.
- Emotional depression, stress and trauma due to the absence of adequate care and support; such problems were reported to be associated mainly with lack of food, clothes, school uniforms and so on, and this would make the children wish their parents were still alive.
- Child abuse and neglect, because sometimes the guardians did not look after OVC well.
- Non-disclosure of cases of abuse when the children were getting money from their abusers.
- Lack of parental guidance and counselling; OVC were the last category of people to be recognised in the community.
- Promiscuous behaviour by remaining parent, especially mothers; the children end up emulating such bad behaviour.

Types of orphans and problems they face

Maternal

- Lack of adequate food.
- Abuse by their fathers.
- It was difficult for someone who was not an OVC's biological mother to properly look after them.
- Some fathers may re-marry and forget the children.

Paternal

- Lack of money to pay school fees and buy clothes.

Double

- Failure to obtain basic necessities like food, clothing and toiletries, such as bath soap, were problems OVC were facing.
- Absence of someone to take a leadership role and offer guidance to children in the household.

Paternal orphans were reported to be in a much better position compared to that of the other two types of orphans. One of the respondents argued that mothers were better caregivers than fathers: *'Nyangwe vana mukavabvunza kuti ani atange kufa, vanototi baba nekuti amai vanochengeta mwana kusvika muguva.'* (Even if we were to ask children who they would prefer should die first, they will tell you it's the father, because mothers can give better care to the child.)

The district education officer mentioned that communities were not offering much to OVC other than sympathy, because of the harsh economic conditions. He further stated that the major threat for orphans was lack of parental care. An officer in the Ministry of Youth Development and Employment Creation stated that even though communities wanted to assist OVC, they did not have the resources to provide care. The same sentiments were shared by the Agricultural Research and Extension Services (AREX) officer, who added that droughts had been the main challenge in the communities' efforts to help OVC.

Loss of personal possessions

Although not many, cases of asset-grabbing were happening in the community. One of the OVC reported that some of the family's property (sofas, plates etc.) were taken away by their paternal relatives after their parents' death. However, most OVC indicated that they did not lose anything, as the relatives only focused on the customary distribution of the deceased's clothes, leaving the valuable assets behind. A mixed FGD for the 15- to 18-year-olds stated that relatives rushed to grab all properties and left the children with nothing, if the deceased parents were rich. One of the children said, *'Munosiyirwa zvisina basa.'* (They take everything and leave things that are of little value.) In most cases, the relatives would take away the good things and leave behind worn out or old property. The children also stated that there were cases where relatives distributed assets according to the will, but if the deceased parents were poor, they might sell property in order to raise money to cater for funeral expenses. Children in a mixed FGD for the 6- to 15-year-olds indicated that some OVC lost livestock to their relatives. The adults who participated in the FGD reported that wills were not always followed.

Main needs and problems of OVC

The major needs of OVC were specified as:

- Food: a caregiver said, *'Vanhu vari kushushikana nadzo nherera nekuti vamwe vanenge vasina chikafu chokuzovapa.'* (Some people who are taking care of orphans are stressed, because they do not have the food to give them.)
- School requirements (school fees, pens, books and uniforms, and paraffin for them to use as light when studying).
- Clothes, blankets and shelter.

Some OVC were discriminated against and did not receive assistance on the basis that they had no one to represent them at distribution points, or simply that their purported relatives who were supposed to assist them would not do much to help the OVC under their guardianship.

OVC access to facilities

Health

A local councillor stated that OVC have to pay for services at clinics unless the village health workers give them free medication. The DAAC coordinator further stated that it was difficult for them to access ARVs from pharmacies if children had HIV, because the drugs were expensive. Access to healthcare was also restricted due to distances, because most OVC families could not afford the transport fares required for them to travel to health facilities. However, abused children had easy access to health services once the cases are reported, as NGOs and other interested government departments quickly came in to assist.

Education

Children from families that could not afford to pay school fees were reportedly benefiting from the BEAM programme. However, a local councillor stated that OVC access to education was still limited, because the BEAM programme could assist only a limited number of children, neglecting others who required assistance. There were reports that some parents and relatives did not value the fact that children should go to school. One chief stated that, *'Vamwe vabereki vazhinji vanoti mwana akasvika "Grade 7" zvatoguma.'* (Some parents think that when a child finishes Grade 7, they have gone far enough and the child stops going to school.) The district education officer further mentioned that BEAM catered for primary school children but not for secondary school children and consequently there were more dropouts in secondary schools. A CAMFED officer and an officer in the Ministry of Youth Development and Employment Creation stated that some OVC were not given any educational support, because the numbers were too many at a time when their budgets were already stretched. Some children were reported to be paying school fees for themselves through doing casual work, but a caregiver noted that some children in child-headed households were finding it difficult to get casual work and therefore failed to pay school fees and then dropped out of school.

Finance

Most of the respondents indicated that OVC did not have direct access to financial resources, because their relatives or caregivers were also poor; this situation was compounded by the prevailing harsh economic conditions. A local chief said, *'Ndinombofunga kuti kana isu semadzimambo tichishaya mari, ko nherera isina kana chokubata? Zvinonditambudza zvikuru mupfungwa dzangu.'* (I imagine that if we as

chiefs do not have money for basics, what about the orphan who does not have anything? This troubles my mind very much.) The chief added that there were isolated income generating projects (IGPs), such as sewing, poultry and gardening, which were initiated by women and were benefiting OVC by paying for school fees, buying uniforms and giving direct income support for the participating families. There were few OVC families who reported that they received remittances from relatives working in the towns and they also mentioned that they did not receive such support on a regular basis. A caregiver stated that the Department of Social Welfare was giving Z$100 000 per month and indicated that the money was not enough (this amount could buy only two loaves of bread at the time of this research). The district administrator confirmed that financial resources, food, blankets and clothes for OVC were available through DAAC. Most OVC obtained income to meet other requirements through engaging in casual work.

Community resources

Zuvarabuda Orphan Club and women's support groups were engaged in projects such as gardening, poultry and selling books. Proceeds from the project activities went towards supporting OVC. The villagers who were engaged in these activities were assisted by school teachers in identifying OVC who should benefit from their projects by payment of school fees. However, their coverage was reported to be low, owing to the high cost of inputs that threatened the viability of the projects. The chief reported that there was *Zunderamambo* (chief's/community granary) in his area, but a caregiver in Chief Hata's area stated that they had not seen the impact of this facility, since there was no evidence of any OVC who had benefited from it. Assistance from other members of the community was reported to be very low and a councillor for Ward 19 attributed this to poverty; however, he stressed that they nevertheless chipped in with the little they might have to spare. A local chief summed it up when he said, *'Hapana zvizhinji zvavanobatsira nazvo, vazhinji vari kungochema nzara.'* (There isn't much assistance that they are giving; most communities are stricken with hunger.) A caregiver also stated that community support was limited and said, *'Nenhamo yamazuwa ano, mumwe anogona kukupa cup imwe yesugar yeporridge yemwana asi haisvike kure.'* (With the prevailing economic hardships, one can give only a cup of sugar for porridge and the assistance will not go far.) Chief Hata reported that community members in his area assisted OVC with firewood, mealie-meal, clothes and so forth, but emphasised that all of this depended on the goodwill of the community. A representative from FACT mentioned that community resources that were available were human resources, in the form of caregivers and volunteers. Some churches were reportedly helping caregivers with money to support OVC under their care, but the caregivers indicated that they had to approach their churches on their own personal initiative to seek assistance for the orphans. The district administrator asserted that people were obliged to assist OVC because of the nature of their culture, thereby stretching what little resources they might have. Some caregivers reported that they were only providing food, and not education and healthcare, to OVC under their care, because they did not have the financial resources for everything.

Challenges and coping mechanisms

The major challenge that was reported was lack of livelihood alternatives, which culminated in the inadequacy of financial resources for basics such as food, clothing, blankets, educational requirements (school fees, books and uniforms) and decent shelter, among other things. The Grain Marketing Board (GMB) was reported to be failing to avert the food crisis in the area and support from other government departments and NGOs was inadequate. OVC reported that some community members sometimes laughed at

them, because they were not properly dressed and lacked food, and that very few people were sympathetic to them. The FGDs for the children revealed that financial problems were the major challenge, as their caregivers failed to get employment to help them look after the OVC and the burden was getting much heavier, because they also had their own children to look after. The children also reported that there were some OVC who had nobody to share their problems with as they used to do with their parents. In addition, they mentioned that some orphans failed to get caregivers who could look after them. Children in the FGD for the 6- to 15-year-olds revealed that they knew OVC who were subjected to ill treatment and abuse by their caregivers and some who did not have identity documents, because the caregivers were not making an effort to make sure that they obtained them.

Coping mechanisms that were adopted included the following:

- Some OVC resorted to begging from their neighbours for food, whilst some parents went to beg for school requirements like books and pens.
- Caregivers engaged in subsistence farming, buying and selling agricultural produce (crops), including livestock and poultry.
- Some caregivers had started a fund whereby each of them would pay a certain amount to buy books for the OVC, but this scheme had stopped at the time of this research.
- Some OVC and their families engaged in casual work as a strategy to survive.

Adult females who participated in an FGD mentioned that farming was the main coping strategy and the desire to produce their own food was very high, but most of the households could not afford to buy the necessary inputs. They therefore reaped lower than the potential yields and for as long as this problem remained, the burden of care for the OVC would also remain too heavy.

Attitudes, stigma and discrimination

There was a general perception that every household was in some way affected by the OVC problem and as a result, communities were sympathetic to their plight. Some OVC reported that they were not discriminated against or stigmatised by the community, because most households had orphans. NGOs, caregivers, volunteers and support groups were all working on awareness programmes aimed at building positive attitudes and encouraging good care for OVC. However, this was not to say there were no cases of stigma, as one of the respondents said, *'Nyaya yekusarudza nekupatsanura inosiyana pavanhu, vamwe vanoita kuera chaiko vamwe havana moyo murefu.'* (Stigma and discrimination come in many forms; some people just look down on OVC and others do not have the heart to offer assistance.)

A government official stated that some of the OVC were stubborn and engaged in a lot of mischief, resulting in them being stigmatised. One of the respondents tried to explain the mischief by saying, 'Some OVC resort to stealing if they don't have food and when people see them stealing they start stigmatising them, saying orphans are thieves (*nherera dzinoba imbavha*). What they will not be appreciating is what will have forced these OVC to resort to stealing.'

Reports from the OVC themselves showed that they were stigmatised and discriminated against. Respondents in an FGD of mixed boys and girls aged 15 to 18 years old alleged that they were given more work and less food compared to that given to the caregiver's

children. They further reported that caregivers gave their children new things, such as clothing, and OVC were given used and sometimes torn clothes (*zvinenge zvasakara*). They also indicated that they were sometimes discouraged from going to church on Sundays, because they did not have presentable clothes. The discouragement of OVC by caregivers was mentioned in the same FGD when one of the boys said, *'Ukada kuti uitewo chimwe chinhu zvinonzi nherera iyi ingaiteiwo.'* (People don't think there is anything good that can be done by an orphan. You would therefore feel discouraged to do anything that is meaningful.)

A government official indicated that some OVC were told things that would trigger their emotions. For example, when children were emotionally affected and crying over the death of their parent, you would hear a caregiver saying, *'Kana uchida kuchema enda unochemera paguva ravo.'* (If you want to cry, go and do it at your parent's grave site.) Or when introducing OVC to a visitor, they would say, *'Ava ndivo vana vanhingi akafa nezvamazuwa ano.'* (This one is the child of so-and-so who died of HIV/AIDS.) Other respondents noted that some relatives were not keen on taking in any OVC, fearing that what killed the children's parents might also catch up with them.

Some government and NGO representatives indicated that OVC may not necessarily be discriminated against, but the name *nherera* or 'orphan' has an element of labelling that is perceived negatively. The government official mentioned that some comments that caregivers and community members made might have negative effects on the children. Some kinds of stigma and discrimination were not necessarily intended and people might not be aware or conscious of it. Overall, most respondents felt that attitudes were changing and were generally positive and that some people in the community were even identifying the OVC and giving them assistance.

Treatment of OVC

The general treatment of OVC by caregivers and community members was reported to be good. Some NGO representatives stated that some caregivers had received training on how to take care of OVC. However, there were reports of instances where OVC were told not to go to school, but to do paid work; some were even being denied food until they finished the work. Respondents in two FGDs (mixed 6- to 15-year-olds and adult females only) revealed that most OVC were ill treated by stepmothers, who made them sleep outside, or gave them less food or sent them to school without bathing them. Some of the respondents mentioned that some caregivers might be perceived as not looking after OVC properly, but that this was really because they did not have anything to give the OVC. There was a case of a child who bought rat poison, with the intention of killing her mother, so that she could qualify to be an orphan and be given the food handouts and other forms of support that NGOs distributed to OVC.

Challenges and complications

Providing shelter and food

The main challenge in providing care for OVC was poverty. Poverty implies that caregivers were incapacitated in terms of providing money for school fees, health requirements, food and clothing. The prevailing economic conditions were reported to be worsening the situation of deprivation among caregivers. Caregivers reported that they could not cope with an additional burden. Accommodation was reported by some of the respondents as a major challenge to some caregivers and cases of overcrowding were also reported.

Another challenge was that most OVC were being cared for by grandparents who had no capacity to provide care, because some were advanced in age. Other grandparents were not employed and neither could they work in the fields. Most caregivers reported that they were struggling to look after their own families and only took the additional burden of OVC out of their own humanitarian motivation.

Some beneficiaries of food handouts reported that NGOs providing food were not reliable. An NGO representative indicated that limited resources, especially funding and foodstuffs for supplementary feeding for children below five years of age and including the frequency at which they were disbursed, presented challenges to the effectiveness of their programmes. A government official alleged that some caregivers were using OVC as fronts to receive support and that whatever they were given did not benefit the OVC in their care.

Dealing with emotional issues

A government official reported that not much was being done in dealing with the emotional issues that affected the OVC. One caregiver stated that people in the communities were more worried about the material needs of the OVC, such as food, clothes and blankets, and were therefore ignoring the emotional issues that were critical in the development and growth of the children. An FGD for adult females only revealed that home visits by caregivers and volunteers were constrained by transport problems, because they had to travel long distances to provide care and support to OVC. Another government official said that there was a bad mentality among some orphans, to the extent that they thought they should be treated differently (too nicely) from other children, when in fact, they should be taught to participate in other activities like any other child. He further reported that the behaviour of some of the OVC was appalling, to the extent that they would provoke caregivers to physically beat them, so that the caregivers would be accused of abuse.

Attitudes of caregivers to OVC

The respondents indicated that generally caregivers had positive attitudes towards OVC, but noted that stepmothers did not treat OVC the same as their own children. OVC were normally sent on errands more often than the stepmothers' own children. A government official stated that most OVC have to do a lot of work before they go to school and therefore often went to school late; as a result, some would not attend school at all, fearing that their teachers would beat them because of being late for school. Positive attitudes were attributed to the training that caregivers were receiving on care of OVC.

Interaction of OVC with others

The interaction and relationships of OVC with other children in the households in which they were living were reported to be cordial. The respondents indicated that instances of stigma could not be ruled out at schools and that this kind of stigma was related to OVC deprivation, in terms of lack of school requirements. The age at which OVC were taken in by caregivers was reported to be important in determining the quality of the relationship between OVC and other children in the household. OVC who were taken in while still very young were easily integrated into the household and would see caregivers as their parents. However, respondents in an FGD for 15- to 18-year-olds reported that caregivers' children sometimes bullied them and the OVC could not fight back for fear of being chased away by their caregivers. An NGO representative stated that sometimes OVC isolated themselves and it therefore became difficult to assist them to deal with their emotional situations.

Impact of caring for OVC

Some felt good about their duties of looking after OVC and one of the respondents reported, 'It was my first time to take care of children as I have no children of my own and this uplifted me, since I am taking care of people who are not my relatives, which others thought was impossible.' Others noted that it was not easy to take care of OVC, because it led to enlarged families at a time when there were economic hardships and the resources were limited. Some caregivers indicated that this was stressful and required them to do more work than they normally would do if the OVC had not been taken in.

Experiences of stigma as a result of providing care to OVC

Caregivers reported that they could be stigmatised if they did not give the OVC under their custody the appropriate care. A social welfare officer also confirmed this assertion and said that when a child was abused, the guardian was stigmatised, as people would assume that the guardian was not giving proper care to the OVC. A local chief reported that some community members were saying bad things about the good work being done by the volunteers, claiming, *'Vakadzi ava vanopiwa zvinhu asi havazosvitsi kunherera dzacho.'* (These women are given material things meant to assist orphans, but they do not forward the things to them.) The respondents reported that sometimes people who cared for OVC were discouraged by others, so that they ended up not doing much for the OVC in their care; others were told that OVC did not appreciate the help they were receiving. The general perception, though, was that caregivers were not being stigmatised but were being praised for the good work they were doing.

Suggestions to overcome challenges

Most caregivers stated that IGPs would go a long way in counteracting some of the challenges they were facing in providing care for OVC. A government official supported the idea of IGPs and stressed that they needed to have agricultural inputs at the right time, so that inputs would not have a negative impact on agricultural outputs. Training of caregivers in how to care for OVC was mentioned as an effective measure to address the isolated cases of ill treatment. Another government official suggested that sensitisation of the community was important, so that communities could also help caregivers when they had problems.

Suggestions on how to help OVC

Role of individuals/organisations

Most caregivers and FGD participants were of the view that if government and NGOs should assist them with inputs for projects, they would be able to help OVC in a much more effective way. Some of the caregivers called for proper needs assessments to be done, 'as support providers tend to overestimate the capacities of families to provide care to OVC', and also for government to assist OVC in acquiring birth certificates. The need for service providers to network and work together to complement efforts and to provide a more holistic support network at all levels was highlighted as key to providing support to OVC. These sentiments were shared by some of the caregivers, who mentioned that there was sometimes 'double-dipping', meaning that some OVC were receiving the same kind of support, such as food, from two different organisations, but their educational needs were not being met at all. The community should participate in the rehabilitation of houses, or even building new houses for the OVC, especially for child-headed households. On the subject of education, the respondents pointed out that government should put

more funds into BEAM, so that the number of beneficiaries could increase just as the number of OVC was increasing. Stakeholder participation in policy formulation was mentioned as critical to devising policies that were friendly to the children and to the communities who take care of OVC. Government should also do more to create awareness of both policies and legal provisions. An FBO representative reported that OVC who were not adept in academic subjects should be developed in other identified skills, such as running IGPs like poultry, gardening and so on. OVC themselves were of the opinion that community members should mobilise material resources such as clothes and food for OVC.

A government official suggested that the government needed to help OVC support structures with transport/vehicles, so that they could be effective in reaching OVC in every corner of the district. Another government official stated that assistance should be given directly to the OVC to avoid diversion of resources to non-vulnerable groups. Respondents in an FGD of mixed boys and girls aged 15 to 18 years old advocated that educating children on the laws that protect them would empower them to report cases of abuse. Spiritual support was mentioned as one of the things neglected among OVC and the respondents felt that FBOs should play a critical role in this area, as it would also help improve the behaviour of OVC. Some government and NGO representatives indicated that more should be done towards psychosocial support and that support organisations should finance OVC to go to boarding schools, rather than to cheap, rural day schools. An NGO representative suggested that OVC care should be dramatised on television and radio so that awareness would be improved. An education officer further suggested that head-masters and teachers should visit the homes of OVC, as a courtesy, to see how they were living. This would enable them to understand and to be in a better position to assist OVC appropriately.

Commitment

Commitment was reported to be high at all levels, ranging from the caregivers to support organisations and to government departments. A government official reported that communities now understood the OVC problem and were keen to help. However, most of the respondents noted that resource constraints were the major problem.

Care and support structures for OVC

The reports from the study respondents underscored the role that the extended family was playing in providing care to OVC. Relatives were taking OVC into their households. Boys and girls who participated in an FGD for the 6–15 age group reported that relatives, especially grandparents, aunts, sisters and sisters-in-law, were the main caregivers of OVC and that they were helping with both emotional support and financial support for school fees. The caregivers were reported to be resorting to farming, gardening and even vending as coping strategies in their efforts to assist OVC. An adult FGD of females only, indicated that most caregivers had the desire to take good care of OVC, but that the main problem was a lack of adequate finance to achieve this.

Some community members were assisting OVC with clothes, firewood and food. Some volunteers were trained in providing care to OVC and were in turn teaching caregivers to improve the quality of care that they were giving to OVC. Volunteers were also teaching OVC life skills and about issues of reproductive health and HIV and AIDS. Children in the 15–18 age group reported that the quality of care that they were receiving was poor, because their relatives did not perceive them as people who deserved proper care,

assistance and recognition. The general sentiments were that the extended family was supportive, though its capacity was greatly reduced by the prevailing economic recession in the country.

Home-based care support groups such as Munyaradzi HBC, as well as churches, were assisting OVC with blankets, school fees and books, emotional and psychosocial support and counselling. The HBC support groups supplied the community with sanitary wear and protective clothing used in providing care to the sick and also distributed medical kits supplied by clinics and NGOs. A boy in an FGD of mixed boys and girls aged 15 to 18 years old, said, *'Vanonyaradza uye vanobatsira nezvinhu zvakasiyana-siyana.'* (They comfort and also help with many other things.) However, some of the caregivers reported that some churches were helping their own members only. There were also community structures (village committees) that helped in identifying children in need.

The government, through DAAC and the Social Welfare Department, was reported to be assisting with food parcels and HBC kits. Communities and organisations referred OVC to the Department of Social Welfare for assistance. The district education officer reported that government assistance through BEAM had been expanded, due to the increasing magnitude of the OVC problem. The government had created structures at the community, ward and district levels to deal with issues around OVC. The social welfare officer stated that DAAC was also assisting with clothes, seed and fertiliser to support agro-based IGPs. The Ministry of Health identified children with nutritional deficiencies and the DAAC, in collaboration with social welfare, provided food parcels to the OVC. Some children reportedly obtained letters for free health treatment from social welfare, but the problem was that the quality of the health services had deteriorated, due to shortage of drugs and equipment, among other things. The district administrator stated that councillors were working with NGOs to help OVC.

There were a number of NGOs that were working in the district. These included FACT, CONCERN, Catholic Development Commission (CADEC), Diocese of Mutare Community Care Programme (DOMCCP), CAMFED, EU and World Food Programme (WFP). The assistance provided by these organisations was in the form of food, clothes, school fees, home visits and support in IGPs, through agricultural inputs (seed, fertilisers), starting capital and drip-kit equipment. Drip kits comprised low-cost irrigation equipment consisting of narrow tubing or hoses, sometimes porous, that are brought close to the plants so that water is allowed to trickle very slowly, but at a constant rate, thus avoiding wastage of the already scarce water. Some types of assistance such as clothes and school fees directly targeted the child, while some targeted the family, especially those aimed at improving household food security.

Desirability and effectiveness

The support and care structures that the service providers offered were reported to be highly desirable, in so far as they addressed identified needs of OVC and the communities in general. However, there were widespread perceptions that the support communities were receiving was inadequate and in some cases too narrow in scope, so that most of the needs of the families were left unsatisfied. A social welfare officer said, 'The assistance given is desirable but it does not cover all the needs of OVC and their families.' Contrary to these views, the district administrator stated that he was happy that the support was adequate, but was worried about psychosocial support and the weak financial positions of the support structures.

An NGO representative said, 'Communities are tricky, when they know that you offer a certain service they say that is what they want. They are susceptible to pre-planned services. Society is poor, anything that comes they grab. There is a need to sit down with them and discuss their needs. They do not have power, for example, when they see PLAN International coming into their areas they will talk about toilets, that is, they mirror back what they know the service provider offers. For example, the issue of drip kits, even those without water sources wanted the kits.'

While the desirability of the support was high, the operation of the programmes was fraught with many problems. A local chief said that some of the support structures were not effective because of non-payment of volunteers and so people would rather not be involved if they would not get anything in return. Organisations were engaging demotivated volunteers to drive their programmes at the local levels. Some respondents alleged that there was corruption in the distribution of food and said, *'Mazuva ano zvakunetsa nekuti vanenge vanoita zvekuzivana.'* (It's difficult these days because of corruption and nepotism.) A local chief shared the same sentiments and said, *'Munoziva zvinoitika pachiAfrican, unotanga watarisa vekwako.'* (You know what happens in the African setting, you start looking after your own kith and kin.) This presented problems in the correct targeting of beneficiaries. Another local chief stated that although the porridge distribution was desirable, the only problem was that the porridge was given to children at school and crèche, thereby leaving out those who were not attending school. The payment of school fees through the BEAM programme included problems of late payments and because of this, children experienced a lot of disturbances at school and were even being turned away from school. Overall, the respondents felt that the support given was desirable but not enough, due to limited resources.

Indicators of success

Some programmes were reported to be successful; for example, a number of OVC were sent by NGOs for life-skills training at institutions such as Magamba Training Centre. Other reported indicators of success were that school enrolment and access to facilities such as health, education, material items (clothes, blankets, soap) and nutrition (beans, porridge) had improved. Another important impact of the services was a change in societal attitudes; for example, one sick community member used to refuse to go to hospital, fearing to be tested for the HI virus, but the HBC caregivers had managed to convince that person to seek medical assistance. Cases of stigma had also reduced, due to increased knowledge and awareness about OVC. A government official stated that some OVC were successfully placed in an orphanage home and were looking better and healthier, and that many more OVC were not living on the streets anymore.

Sustainability

An officer in the Ministry of Youth Development and Employment Creation reported that communities were being empowered through the various programmes, so that they could become self-sufficient. An NGO representative indicated that 80% of the activities were driven by the communities themselves and that they planned and implemented programmes using their own personnel. There were also trained local counsellors in the communities. Those people who were engaged in poultry projects that supported OVC indicated that the projects were not sustainable, due to inflationary increases in the prices of stock feeds.

Most of the respondents reported that food distribution programmes were not sustainable, because the communities had no role to play except receiving the food packs that were coming from outside, which was happening against a background of dwindling foreign aid and increasing demand. Others also noted that there was no fairness in the distribution of food, as the leaders selected their kin to benefit from the programmes, instead of those who were in need. An AREX officer indicated that the problem of giving people food packs and food handouts created a dependency syndrome and to a certain degree, laziness, thereby denying communities the opportunity to develop their own internal capacities. One of the caregivers suggested that it was not prudent to give only food and no school fees to a child who was not going to school; this practice was therefore not sustainable, because the child would not be able to do much in the future to escape the dependency situation. She said, *'Mwana iyeye haana ramangwana,'* meaning that food assistance only does not give a future to the child.

Requirements for programmes to work

- Input support for IGPs: seed, fertilisers and equipment like hoes and chemicals for them to improve agricultural yields.
- The establishment of a committee that coordinates NGO activities for the provision of better services.
- The need to motivate more people to do voluntary work in order to reduce distances that each volunteer covers.
- Information dissemination and education of communities about HIV and AIDS and emphasising the continuous updating of information.
- The need to motivate the volunteers and the communities to continue the programmes and to empower them to be self-sufficient, through training in running IGPs.
- More financial resources needed to be put into the education of OVC, so that they could continue with school to higher levels of education.
- Caregivers should be given money instead of material resources, so that they could prioritise according to their household needs.
- Volunteers needed incentives for the programmes to continue, since they were involved in most of the programmes at the community level.

Impact of services

- Improved care to people living with HIV and AIDS (PLWHA), due to availability of care facilities and medication.
- Improved quality of life for OVC taken into care or given adult caregivers.
- Increase in awareness about HIV and AIDS.
- Attitude change among community members – community now appreciating role of HBC.
- Increase in OVC enrolment and attendance in schools.
- Decrease in cases of asset-grabbing.
- Increase in awareness about child abuse.
- Community awareness about problems of OVC.

Policy and legislation for the protection of OVC

The most commonly cited pieces of legislation were the Education Act (Chapter 25:04), the Children's Act (Chapter 5:06 of 14/2002), the Sexual Offences Act (Chapter 9:21 of 22/2001) and the Birth and Death Registration Act (Chapter 5:02 of 22/2001). Awareness

of such pieces of legislation was high among government and NGO representatives. The other respondents were not aware of the particular laws or policies that were meant to protect children, but they could list some of the things that should or should not be done to children (for instance, provision of food, blankets, bathing, and no child abuse). For example, one of the chiefs said, *'Vana havafanire kushandiswa kuripa ngozi uye chigadza mapfihwa kana kugara nhaka hatidi kutombozviona.'* (Children should not be given as repayment to appease evil spirits [*ngozi*]. We do not allow girls to inherit a sister's husband when the sister dies and we also discourage the practice of wife inheritance; we do not want to see these things happening.) Respondents in an FGD of mixed boys and girls aged 15 to 18 years old reported that most children were not aware of the policies that protected them and they could end up being raped or subjected to child labour. They mentioned that such ignorance caused children to suffer without seeking redress or reporting the cases to the responsible authorities. However, children who participated in an FGD of mixed 6- to 15-year-olds reported that they were aware of the Sexual Offences Act and Education Act. These children indicated that the community was supportive of the laws, especially the Education Act, to the extent that if a child missed school, community members would want to know why. Another FGD comprising only adult females supported this perception of the children and indicated that some community members were even reporting cases of suspected abuses to the police.

Implementation and support of regulations

Most of the government and NGO officials felt that the laws were well enforced and that offences were receiving the punitive measures that they deserved. However, the FGDs for the adults revealed that there were some married men who were falling in love with school girls; reports were made to the police in these cases, but nothing was ever done. They further reported that the perpetrators were being released from police custody too soon and that some of them were repeating the same offences, to the extent that it was weakening the whole issue of reporting cases. Police officers in turn reported that community members did not have the knowledge to handle evidence correctly; they suggested that communities should be sensitised and trained in this area, so that reported cases did not just fall away on the basis of lack of substance in the evidence.

Challenges in enforcing laws

Some challenges were reported in relation to the implementation of existing legislation and policies. A local chief reported that some apostolic sects were reluctant to send girl children to school and also forced them into early marriages. The most commonly highlighted challenge was the non-reporting of child abuse cases perpetrated by relatives. The reasons for keeping quiet were varied, including fear of straining family relations and losing breadwinners. One caregiver stated that children might not enjoy their rights to the fullest, owing to poverty. Some caregivers were not sending children to school, not with the motive to deprive them of their rights but because they did not have the money to pay school fees. School authorities did not always realise the problems that caregivers have and therefore sent children home for not having proper school uniform. Ignorance among the general populace was noted as the main challenge faced in the proper and effective functioning of laws and policies.

Some sections of the community viewed the Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996) and the Sexual Offences Act as presenting challenges, because at 18 years old, children were not mature enough to make decisions on their own: *'Mwana haasati akura.'* (At 18 years, the child is not yet mature.) An NGO

representative said, 'If the sexually abused child was 16 years old and had sex with an older man/woman with her/his consent, people would say that the child was old enough, but she/he will still be a child, hence the age needs to be revised.'

HIV and AIDS

Awareness and knowledge of HIV/AIDS

The level of awareness of the existence of HIV and AIDS was perceived to be very high by the respondents and this was attributed to the efforts of NGOs, support groups and government structures that were working in the communities. HIV and AIDS education has also been integrated into the school curriculum and children were being taught about the issues. Denial and non-acceptance were also reported, in that some people tended to ignore the issue and find other scapegoats when sickness happened in their households or to them. A local chief revealed that he once gave a speech at a local school where an awareness campaign was being conducted and said, *'Imi kana mukaramba muri vanadambakuudzwa imi tichazokupai mhosva nekuti tirikuona kuti ruzivo murikupihwa…dehwe rinopetwa richiri nyoro.'* (I told the children that it would be their fault if they do not take heed of the message because they are given the knowledge at an early age, before it's too late. It's easier to adopt good practices when one is still young.) He was implying that children should be taught about HIV and AIDS at an early age. He also said, 'In the past a person could just pick up a razor and shave their beard, but nowadays this is not happening anymore.' Although awareness was reported to be high, behaviour change was noted to be a problem. A caregiver said, 'Some people do not care whether they are infected or not, so they are careless in their behaviour.' Another added, *'Vanoti hazvina basa, mafuta ekuzora.'* (Some people do not fear contracting HIV; they engage in risky behaviour without caution and say that it's a common disease.) A government official echoed the same sentiments, stating that awareness was high, even though many still engaged in risky behaviour and were careless. An NGO official reported that people lacked the knowledge on where to get services such as ARVs, VCT, treatment for opportunistic infections and so on.

There were a few respondents who thought that awareness was low, arguing that the fact that people were dying was indicative of lack of knowledge, and some reported that there were people who thought that AIDS was a disease only affecting people in the towns.

Estimates of number of people infected

The general feeling among the respondents was that the problem was already big and getting worse. According to one community member, people were spending more time at funerals, thus wasting productive time and financial resources. To illustrate the magnitude of this problem, she said, *'Mafoshoro ave kushandawo senge spoon dzekubikisa muriwo, kare taisaziva nezve ndufu dzakawada saizvozvo.'* (There are so many deaths these days, unlike in the past.) The main indicator that respondents used was the number of people dying from HIV-related illnesses in a week or a month. Some of the conditions that respondents associated with the high levels of infection and deaths were overcrowded areas and commercial areas, such as farming communities.

Impact on state and organisational resources

The respondents reported that the available state and organisational resources were inadequate to cope with the pressure exerted by the epidemic. Organisations became strained because they needed to support families of workers who were ill and who might

not be productive. A government representative said, 'Organisations have to keep sick employees who cannot do the work, because they cannot dismiss them, hence they are liabilities but are still paid at the same rates as productive employees.' The high mortality rates deprived the state of human resources and the implementation of continuous training on the part of employers and government. The increase in deaths had resulted in a strain on pension funds, because these funds are being claimed for the benefit of dependents left by young parents. A government official specified the AIDS levy and BEAM as examples of resources that could have been used productively elsewhere, had there been no AIDS.

Impact on community resources

Reduction in the productive agricultural capacities of households that were affected by illness related to HIV was reported to be one of the main impacts on community resources. Households would sell family assets such as livestock and furniture, trying to raise money for medication and food for the sick person. A government official reported that some people were going so far as to sell food and other material support they had received from NGOs and government for the benefit OVC, to raise money to cater for the needs of the sick. The elderly were left to care for the OVC. One respondent said, *'Vanoshanda vari ivo vatinotarisira kuchengeta mhuri ndivo vazere nacho saka zviri kukanganisa upfumi hwe mhuri nehwenyika.'* (The able-bodied people, who are also the breadwinners, are the ones who are mostly affected and this in turn adversely affects family and national resources.) The death of breadwinners was reported to be causing poverty in the community.

Impact on social functioning of the community

The social fabric of society was reported to be disrupted by witchcraft accusations and the displacement of children. The increase in the number of orphans was causing the extended family to become overstretched in terms of resources; some of the children were left with the disease, while some households became child-headed. A social welfare officer noted that the displacement of children had negative psychological consequences for them, especially when the children did not get proper care and treatment. Stigma was identified as a strain on the functioning of communities. A local chief said, *'Vanonyenyeredza vamwe vachitoti taimutaurira. Vamwe vanototadza kana kumukwazisa chaiko.'* (Some community members do not even greet those who have HIV/AIDS and others say that they once warned these people before.) He added that some said that AIDS was a 'luxury'. A government official said that people were not able to do their normal chores or work because they had to attend to the sick.

OVC behaviour in relation to HIV

The children who participated in a mixed FGD of 15- to 18-year-olds stated that not many parents/caregivers talked to children about HIV, due to shyness and cultural inhibitions, but that children did have guidance and counselling teachers at school. The children said, *'Vanotanga kuita misikanzwa, vamwe vanotanga kuita zvevakomana vachiedza kuti vawanewo zvavanoshaya.'* (Some OVC succumb to peer pressure and start having boyfriends, so that they can get material resources that they see other children have.) Adult females revealed in an FGD that some OVC were not behaving well, because there was no one to keep an eye on them and that the main problem was the absence of psychosocial support and counselling. They also indicated that there was a need for prayer for the OVC to understand the teachings on HIV and AIDS, since some of the OVC were absconding from counselling sessions, claiming that they did not like them.

Other issues relating to HIV/AIDS

ARVs were reported to be too expensive, so that most PLWHA could not afford them and would rather die without the medication. Stigma and discrimination were present in the communities, as there were reports that people were looked down on because they were either infected or affected (OVC). A caregiver reported that there was evidence of behavioural change in some members of the community and another stated that divine intervention was needed if HIV/AIDS was to end.

Care and treatment for PLWHA

Availability of services

HBC services were reported to be available in many parts of the district and HBC groups were mostly supported by NGOs and DAAC. HBC offered services such as counselling and materials like towels, soap, lotion and food to PLWHA. The sustainability of HBC was questionable, since their services were driven by the spirit of voluntarism. Some respondents reported that NGOs, in collaboration with DAAC, were also distributing food packs to PLWHA and promoting the establishment of herbal gardens. Herbal gardens provided an alternative and cheap treatment for opportunistic infections. Support groups also provided counselling on positive living and nutrition. The respondents indicated that VCT services were available at the hospitals and in some cases mobile VCT services were provided. However, ARVs were reported to be unavailable at the clinics and hospitals used by the communities. A caregiver stated that PLWHA go to hospitals to get treatment, but the quality of services at the clinics/hospitals had deteriorated. He aptly summed it up when he said, *'Vanorapwa kwete kuti chirwere chipere, kurapwa kwacho ndekwe kungoti munhu arege kugumbuka.'* (The sick are given medical attention, not really for them to get healed or feel much better, but to ensure that they do not get angry that nobody attended to them.)

Impact of services

Attacks of opportunistic infections were reported to be on the decline, due to the use of herbs promoted by NGOs and DAAC. HBC and support groups were said to be helping a lot as far as the emotional well-being of PLWHA was concerned. The services were playing a critical role in creating acceptance of the disease at community and household level. It was also reported that people were now receiving preventative materials such as condoms from HBC. Some respondents reported that some people who were diagnosed with the HI virus and became very emotionally unstable (for instance, threatened to commit suicide), were now living positively after counselling by HBC and support groups.

Views on access and availability of ARVs and VCT

Access to ARVs was reported to be very limited, the rationing factor being cost. Many people in the communities could not afford to buy ARVs. There were mixed responses to VCT services. Notable challenges were that people were scared to get tested and some of those who were tested by mobile services failed to collect their results. A caregiver reported that people in the community were now accepting HBC, unlike in the early days of its introduction, when people thought that HBC members had nothing to offer, but only wanted to spy on their health. A local chief stated that the availability of the services encouraged people to open up and some were giving testimonies at community meetings. An NGO representative stated that ARVs were not available and they referred patients to Mutare Provincial Hospital, which is 105km away.

Suggestions on how to limit the spread of HIV/AIDS

Behaviour change

The respondents generally agreed that the level of awareness as well as knowledge on methods of prevention were very high. An NGO representative suggested that what was needed was to encourage people to put the knowledge they had into practice. Most respondents indicated that to encourage behaviour change was also also required. Teaching people about the correct and consistent use of condoms was mentioned mostly by NGO representatives and government officials as one key measure that can be employed to limit the spread of HIV. However, members of the community had different views on condoms. Some believed the use of condoms was encouraging prostitution, through creating a false sense of security. A caregiver said, *'Ma condom auraya vana, kana vazukuru hatichina. Isu takaroorwa tiri vasikana asi kuti udzidzise mwana maitiro semusikana havachatereri.'* (There is false security in the use of condoms and that is killing many people. During our time, sex would wait until marriage, but these days you cannot tell a young girl how to behave, they won't listen.)

Support groups were said to be necessary to help those who had tested positive, and even for those who tested negative, so that they could stay negative. The question asked was, 'I have tested positive/negative, so what is next?'

Abstinence and being faithful to one partner were the behaviour-change strategies that the respondents emphasised most. FBO representatives and some chiefs asserted that they did not encourage the use of condoms, but abstinence. A bishop stated that in his church they discouraged condoms and encouraged abstinence; he said that they used a book called *AIDS in Africa* during church sermons. One of the government officials said, 'Behaviour change is not encouraged by the use of condoms; people should be told the truth to be faithful and to abstain.' In addition, a chief said, *'Mushonga we AIDS uripo, kuzvibata ndiko kukuru.'* (There is a cure for AIDS; abstinence or being faithful is the answer.)

Attitude change

It was notable that a number of respondents reported that some people's attitudes towards the disease and preventive measures were negative. A local chief said you heard people saying the following about use of condoms: *'Hapana anoda kudya sweet iri muplastic.'* (No one wants to eat the sweet from its plastic wrapper.) A caregiver suggested that more education was necessary to reduce the negative attitudes that some members of the community had about the disease. There were also reports that some infected people were spreading the virus purposely. Others engaged in risky behaviour, but were reluctant to know their HIV/AIDS status, and even some pregnant women were afraid to know their status. A community member reported that such behaviours promoted the spread of the disease and the solution was to produce appropriate strategies to deal with the negative attitudes. However, due to religious and cultural beliefs, condom distribution programmes were not accepted by some community members and chiefs: *'Mave kutadzisa mvura kunaya.'* (It is from promoting things like condoms that we have misfortunes such as droughts.) An OVC suggested that people should be encouraged to go for HIV tests before they get married and to stay with only one partner.

Income generating projects

Some of the respondents suggested that support through IGPs (drip kits, inputs such as seed, fertilisers etc.) to reduce poverty would in turn reduce promiscuity, because women

were only engaging in promiscuity as a livelihood strategy to provide for their families, pay school fees for children and so forth.

Promoting good morals

A local chief believed that children should be taught about spiritual issues, not just given education to pass exams; for example, catechism used to be taught in school and at church: *'Vana ngavazive kuti upenyu haudi kukasikira. Iye zvino vave kushandisa zvinodhaka nekuita pamuviri vachiri kuchikoro.'* (The young should be taught to wait. These days some youths are using intoxicating drugs and some fall pregnant while still in school.)

Improving access to information

An NGO representative suggested that access to information should be improved. Existing infrastructures such as hospitals and schools should be used to spread the message about HIV and AIDS. An OVC underscored the need to employ more personnel who were able to move around conducting outreach programmes and teaching people about transmission and prevention of the HI virus.

Awareness campaigns through performance of dramas were perceived to be a more powerful means to teach young people to change their behaviour. The use of print materials and media to reinforce messages on HIV and AIDS was mentioned as a method that would reach a lot of people. The social welfare officer suggested that parents should teach children about the disease at an early age and that VCT and condom distribution should be scaled up to limit the spread of the virus.

Provision of facilities

The respondents attributed sexual indulgence to the absence of recreation facilities. Recreation facilities would provide people with something to do, rather than going to beer halls.

Controlling prostitution

The respondents reported that there seemed to be no end to prostitution and consequently suggested that a lasting solution to the problem must be found. Some indicated that people should be taught about the dangers of such risky practices. One caregiver suggested that the time that beer halls stayed open should be reduced, and said, *'Dai tapihwa mapurisa anotomira pasuwo rebhawa varume vese vadzoke kumba kana six o'clock dzemanberu dzakwana.'* (We wish that we could have a police officer manning every beer hall with a duty to close it at six o'clock in the evening, so that all the men go back to their homes early.) Some noted that Operation *Murambatsvina* assisted in removing prostitutes from Nyamhuka Business Centre, and that this strategy had actually reduced the spread of HIV/AIDS.

Educational needs

The communities were satisfied with educational initiatives in their area, but stressed that children should be taught about the disease at an early age, that is, from Grade 4 or 10 years old upwards. Furthermore, some of the respondents felt that parents should observe who their children played with, because there was a lot of peer pressure from friends.

Health services

HBC materials to facilitate care were reported to be inadequate and caregivers had to bath patients without any protection. Health institutions referred patients to chemists and pharmacies, because of the unavailability of drugs. Human resources and equipment were reported to be available at the health institutions. However, clinics and hospitals were facing transport problems, due to the shortage of fuel and ambulance services. VCT services were being offered by big hospitals, only because of the unavailability of testing materials at the clinics. A government official reported that resources were so limited that a sick person would think they were being stigmatised when they realised the poor quality of service they received from the health institutions.

Major sources of information on HIV/AIDS

Print and electronic media sources

The main sources of information on HIV and AIDS were printed material from NGOs. These included pamphlets, handouts and posters that were being distributed by the organisations. Some government department representatives and caregivers reported that those who could afford newspapers, radios and televisions were the ones who got information from media sources. Some of the NGOs were reportedly showing educational videos at workshops that they organise.

Organisational and state services information

NGOs, the DAAC, clinics/hospitals and FBOs were mentioned as the main organisations that were disseminating information on HIV and AIDS. NGOs and DAAC were working through their sub-structures at grassroots level and also conducted awareness campaigns. NGOs were mostly working with support groups, usually HBC and DAAC, along with other government structures such as the councillors and local community leaders, for example, chiefs and village heads. Some chiefs reported that they held meetings every one or two months at which they shared information on HIV and AIDS with community members. The media used to communicate the information were varied, including songs and drama, especially at community meetings. Many OVC and some government representatives asserted that schools were major sources of information on AIDS. The district education officer said, 'Schools are playing a role in educating children about HIV.' A caregiver reported that they had witnessed so many people dying of HIV/AIDS and therefore had learned from this. *'Ruzivo tinoruwana kana taona vanofa nevanacho chirwere chacho.'* (By seeing those who are dying, we also get to know about the disease.)

Peers and colleagues

Some NGOs were teaching children through peer counselling at camps that they organised. The peer educators also educated their colleagues in schools and in their communities. Follow-ups were done through volunteers to observe what the children would be doing and noting changes in their behaviour. However, some community members were sceptical about the impact of the child peer counsellors on the behaviour of the other children they counselled. One community member said, 'There isn't much peer education going on; the children just copy each other's behaviour, just like fashion, by indulging in sex.' This is contrary to the opinion of one of the government representatives who reported that children obtained their information from peer educators in schools and that this was effective.

Improvement of information

Scaling up educational campaigns and continuously reinforcing messages on HIV and AIDS were common suggestions for improving the provision of information on the disease. Some NGO representatives felt that their organisations should brainstorm together to share ideas and also to share costs in the dissemination of information on HIV and AIDS. Community members and caregivers suggested that HIV and AIDS information should be given out and taught at all community gatherings and meetings. The use of role models in society in information dissemination was also suggested, the idea being that such prominent figures could be emulated. A local chief suggested that the elderly people could be used to disseminate information, since they were less affected and could tackle the issue from a cultural point of view. An NGO representative emphasised that there was a need to work on encouraging openness about the disease, if provision of information was to be successfully improved. Some OVC suggested that there should be more educational programmes on both radio and television, so that the spread of information can be widened. People in the rural areas felt that centres should be opened for HIV/AIDS information dissemination. The needs to continuously update information on HIV and to maintain village-level information disseminators were mentioned as critical imperatives. Some NGO and government representatives suggested that parents should be taught and encouraged on how to talk to their children about HIV and AIDS; however, the challenge here is that culturally, parents are not that free to talk about sex issues with their children.

Profile of government ministries and departments

Table 5.3: Profile of government ministries and departments

Background	Activities	Challenges	Plan to assist OVC
Ministry of Youth Development and Employment Creation			
Formed to cater for the welfare of the youths aged 9 to 30 years. Established national youth training centres. Works with other stakeholders like NGOs, ministries. Works with ward development committees.	HIV/AIDS awareness campaigns at ward level. Facilitates IGPs for the youth, to discourage them from immoral ways of earning money such as promiscuity. Facilitates employment for youths in government institutions. Training of youths in business management, running IGPs, writing proposals for sourcing of funds, leadership skills; more focus on school-leavers.	Limited resources. Staff shortage: only half of the requirement. Limited coverage.	Establishment of more youth centres for life-skills training.

Background	Activities	Challenges	Plan to assist OVC
District AIDS Action Committee			
Part of the National AIDS Council. Had structures at ward (WAAC) and village (VAAC) levels. Works with other organisations like FACT, Zimbabwe Republic Police (ZRP).	Food distribution (*matemba* and beans) to schools, clinics, partner NGOs, ward and village structures. Provision of blankets, stationery and uniforms to OVC in the district. Provision of milk to young OVC.	Limited resources. Cannot cover the whole district at once. No vehicles for them to improve their coverage and services.	To source more funding to support IGPs like poultry, livestock rearing and tuck shops.
Ministry of Public Service, Labour and Social Welfare			
Get information on OVC from councillors.	Disbursement of money: (Z$30 000/child/month; Z$60 000/adult/month). Food distribution (maize: one bag per household). Support to people engaged in IGPs. Relief work: giving out one 50kg bag plus Z$30 000 per household per month.	No longer provide school fees to children. Limited resources.	No information reported.
Registrar General			
Part of the Ministry of Home Affairs. Two sub-offices in the district. Get information on OVC from councillors and hospitals.	Registration of births and deaths. Mobile birth registration unit once a year. Part of referral system for Department of Social Welfare.	Lack of transport: constraints on mobile services.	Seeking more funding and vehicles for outreach programmes. Planning on allowances to give to chiefs who report births and deaths in their communities.
Ministry of Education, Sports and Culture			
Has office responsible for providing psycho-social services to OVC. Gets information on OVC from school heads.	Assists with school fees through BEAM. Looks for donors to assist OVC with school requirements. Special classes for children with mental disability or learning problems.	Financial constraints: assists only a few children in secondary school. Other stakeholders seem not to be forthcoming in assisting OVC.	Lobbying for more money so that BEAM coverage is expanded. Intending to source more funds to support OVC (especially child-headed households) from the business community.

Background	Activities	Challenges	Plan to assist OVC
Zimbabwe Republic Police: Victim Friendly Unit			
Department deals with offences and cases of abuse against children. Office staffed by officers trained in working with children and handling cases of abuse. Aim is to create conducive environment for victims of abuse; cases dealt with in secluded places to make the victim more comfortable. Get information from victims themselves and anonymous calls from community, hospitals and suggestion boxes.	Handling cases of child abuse. Sending victims to hospital/clinics for medical examinations. Assisting victims in the victim friendly courts. Identifying witnesses to help victims of abuse in the courts. Provision of post-trial counselling to victims of abuse. Referring victims of abuse to support organisations for continued support. Awareness campaigns to educate the public about child abuse. Receiving and investigating anonymous calls from the community.	No food for victims, but they can keep them for a long time. Cases involving OVC not easily identified. Public not understanding that the police cannot provide material support, such as food and clothing. Some witnesses, especially guardians, may not tell the truth where relatives are perpetrators; may not report at all.	Seeking funds to purchase things like dolls and other equipment for their VFU rooms to be more friendly and to help the victims relax.
Department of Agricultural Rural Extension			
Department falls under Ministry of Agriculture. Involved in farmer training (good farming methods). Department has 58 officers out of a total requirement of 128 officers.	Distribution of agricultural inputs, like seed and fertiliser, from the government. Teaching caregivers with nutrition gardens about good farming methods and how to maintain their projects.	Short-staffed: there are only 58 officers out of total establishment of 128 officers. Limited resources, especially vehicles; visit some areas only once a month.	No information reported.

Profile of non-governmental organisations

Table 5.4: Profile of non-governmental organisations

Background	Activities	Challenges	Plan to assist OVC
Concern Worldwide			
Currently operating in five wards in Nyanga north: wards 1, 2, 3, 5 and 6. Their target groups are the elderly, the widowed, disabled and orphans. Selection criterion adopted from the WFP: based on income and assets owned by household. The community leaders and ordinary community members assist them in targeting the vulnerable groups.	Distribute agricultural inputs like maize, sorghum and groundnut seed and fertilisers. Borehole rehabilitation and establishment of nutrition gardens. Distribution of monthly food handouts: maize grain (10kg per person in family) and beans (1kg per person). Raising awareness on the disease and teaching on modes of HIV/AIDS transmission and prevention.	Food baskets may not come in good time for distribution, for example, in rainy season, due to the poor state of roads.	Plan to expand the vulnerable group feeding programme to cover more wards, in addition to the current 16 wards. Aiming to cover a target of 60% of the district. To initiate long-term projects to assist people, since food assistance was short lived.
Family Aids Caring Trust, Nyanga			
The organisation goes into the community to ask them how they want be helped and they also design their programmes with the community. Estimated coverage around 65%. Constructed a baseline with the Social Welfare Department before implementing programmes.	Food assistance, school fees and psychosocial counselling etc. Vocational skills training in agriculture, woodwork, secretarial skills, motor mechanics etc. Offers protection against abuse, in collaboration with ZRP, Social Welfare, DAAC and Ministry of Health.	Inadequate resources; funding too little compared to the work that has to be done. Inflation was affecting them such that the donor money was eroded and would not cover the needs it was supposed to address.	To have more volunteers working with the community in identifying OVC.

Background	Activities	Challenges	Plan to assist OVC
Campaign for Female Education (CAMFED) Association			
The organisation was established in 1993, after the realisation that poverty was causing widespread exclusion of girls from schools in rural Zimbabwe. Target group for this facility is young women who are mostly school-leavers and dropouts.	Provision of school fees and social support to children in the district; they have a safety-net group where mothers generate funds at village level to pay school fees, mainly at primary-school level. Have IGPs such as gardening, buying and selling, soap-making, making mats and baking buns and selling them. Offer seed money (capital) to members and monitor progress of the recipients for six months and, if doing well, they will be eligible for soft loans.	Lack of funds to scale up their operations in the district.	Aiming to do more to build capacity within communities to plan, deliver and monitor activities to support the education and protection of vulnerable children. Establish partnerships with local and national institutions; to mobilise financial resources and other support at national and local levels.

Conclusions

The magnitude of numbers of OVC was reported to be high and increasing astronomically in Nyanga, due to HIV and AIDS. The growth of the problem was accompanied by a number of challenges that have had detrimental effects on the well-being of the OVC. These included the inadequacy of material and financial resources, which in turn deprived the children of access to basic needs such as food, clothing, school fees and other school requirements. In the most deprived areas, OVC were exposed to child labour, some at the expense of going to school. Poverty was also compounded by recurrent droughts that forced the communities to be dependent on donor assistance, with most of these organisations assisting with food and school fees. For those who worked in the farming areas, the wages were low at a time of hyperinflation in the country. Not all OVC who required educational assistance were getting it, and most NGOs and government departments assisting in that area reported that their coverage was low.

Poor housing conditions and overcrowding were reported to be problems in most of the OVC households, and communities were not taking responsibility for rehabilitating or erecting new structures for OVC. The general feeling was that communities should play a major role in the area of housing, since this required local materials and therefore would be cheap for communities to assist.

The communities did not have the capacity to address the psychosocial needs of OVC and even the organisations that work in the communities did not have the expertise to conduct or train local people in counselling. Parental guidance was lacking. According to the reports, some OVC were abused physically and neglected by their caregivers, especially step-parents. The study revealed that most of the cases of abuse were perpetrated by people known or related to the OVC and these constituted the majority of the unreported cases. However, cases of asset-grabbing by relatives were very few and reported to be on the decline, but relatives sometimes sold part of the family property to meet funeral expenses.

Access of OVC to facilities such as healthcare was difficult, because they have to pay for the services and the long distances to health facilities present additional restrictions. Children who fall victim to rape and other injurious forms of physical abuse had ready access to health services, once the cases were reported. Most of the children who needed education assistance were obtaining such assistance through the BEAM programme and NGOs operating in their areas, but more dropouts were reported at secondary-school level, because BEAM assisted children in primary school only.

There were a few projects (gardening, poultry and sewing) in the communities that were established for the benefit of OVC, and these were mostly run by women's groups. The major challenges facing these projects were the high cost of inputs, poor returns and inflation. The impact of *Zunderamambo* in addressing the food requirements of OVC was not clear to the communities, and the chiefs blamed this on inadequacy of inputs such as seed and fertilisers. Other support from community members was low, owing to poverty and economic hardships. Even though external organisations were trying their best to assist OVC, the general perception was that assistance from both NGOs and government was inadequate.

The main complication in providing care was that most caregivers were not employed and the burden was getting heavier, especially because they had their own children to care for as well. They engaged in casual work, subsistence farming and begging as livelihood alternatives, but elderly caregivers were incapacitated as far as such survival strategies were concerned. The general treatment of OVC by their caregivers was reported to be good, though a few cases of ill treatment were reported.

The situational analysis revealed that the extended families were conforming to the cultural obligation to look after orphans left by their relatives, irrespective of the economic hardships that persist in the country. Some community members, HBC support groups, NGOs, FBOs, CBOs and government departments constituted the care and support structures for the OVC and offered various kinds of support, all of which addressed some of the identified needs. However, there were problems in the targeting of beneficiaries for their programmes and some were not reliable in the delivery of their services, due to their own incapacity and inadequacy of resources (staff, transport, finance, equipment and so forth).

Attitudes towards OVC were generally positive, although in some households OVC were given more chores to do, compared to the work that caregivers assigned their own children. Stigmatisation and discrimination were low and interaction between OVC and other children in the households was generally cordial and supportive.

Awareness about the existence of HIV and AIDS was high, thus reflecting the impact of educational campaigns by NGOs, government, support groups, schools, FBOs and CBOs, among others. However, this did not indicate total elimination of risky behaviour in the communities and so more needed to be done. While the functioning of the HBC programmes was highly applauded, service delivery by clinics/hospitals to PLWHA was poor, due to unavailability of drugs, staff, equipment and transport.

Priorities for action

Government

Stakeholder participation in policy formulation was mentioned as critical to the production of policies that would create a favourable environment for support organisations, and would be friendly to the children and communities who take care of the OVC.

Government should also do more to create awareness of both policies and legal provisions. There was evidence that most people in the community were not aware of the legal provisions that protect the rights of children. However, awareness of issues of child sexual abuse and rape was evident, but people seemed only to become aware of some of the provisions after violating such laws. It is imperative that the government embark on a massive awareness campaign, especially on laws governing child labour. The results showed complications in defining child labour and this is an area that government should make clear to the people.

There were complications in children's access to healthcare, even though there is a government scheme that seeks to provide free services to vulnerable children. The government should improve the operation of this scheme. The non-availability of drugs and equipment in hospitals seems to be a major constraint in the implementation of this scheme.

The Department of Social Welfare should improve the quality of information on OVC and do more to obtain data on OVC, rather than relying heavily on referrals at a time when people in the communities are ignorant about the department's services. The department should also ensure that welfare grants are adjusted upwards, to be realistic and meaningful to the beneficiaries.

State institutions should work on addressing staff shortages and the problem of lack of transport, so that their staff can easily go to the communities to deliver services to people closer to their homes. This will improve communities' access to services.

Non-governmental organisations

Perceptions in the communities were that services provided by NGOs addressed some identified needs, while leaving other needs unsatisfied. In some cases, various NGOs were assisting the same household with the same kind of support, such as food. In regard to this, NGOs should form partnerships to provide a holistic service and better coordination of their activities.

There were complaints that the distribution of food was not fair and that households who deserved to be assisted were being left out of the programmes. NGOs should improve their monitoring and evaluation activities, so that they can deter non-deserving families from benefiting from support and prevent such diversion of resources. They should find ways to improve vulnerability assessment of households, so that a system of social justice and equity is introduced into their service-delivery systems.

Some beneficiaries of food handouts reported that NGOs providing food were not reliable, that is, they did not bring the food at regular intervals, due to logistical and sometimes financial constraints. NGOs should have programmes for capacity-building in communities, rather than encouraging their dependency on donor support.

Community

It was quite apparent from the findings that there was a gap in the area of psychosocial support for OVC, as people in the communities did not have the capacity to provide such services. With the help of the relevant government departments and NGOs, the communities should be capacitated to address psychosocial issues among children. People in the community are the ones who are closer to the environment in which OVC live, and so they should be ready to address emergent needs for psychosocial counselling and support.

Access to financial resources remains a constraint for communities to provide meaningful support to the OVC in their areas. Communities should be more involved in IGPs, with input support from NGOs. This is a more sustainable alternative for the community and much cheaper for the support organisations. The communities need to be trained in the running and management of the IGPs.

Ignorance about the legislation protecting the rights of children was high among the caregivers and community members. Educational campaigns and specific activities to raise awareness about children's rights should be implemented to save the situation.

OVC felt that community members were not doing enough to mobilise material resources such as clothes and food for them. It was noted that few people had the goodwill to assist OVC meet some of their pressing needs. Communities should assume the responsibility to care for OVC in their area and not wait for external assistance from NGOs and government departments.

CHAPTER 6

Mutasa District

Stephen S Buzuzi, Shungu Munyati, Brian Chandiwana, Pakuromunhu F Mupambireyi and Teramayi A Moyana

Background

Description of study area

Mutasa District is situated in the mountainous province of Manicaland, on the eastern borders of Zimbabwe, which is 55km north of Mutare Urban. Most of the land lies in agro-ecological Region II. The district has 27 wards.

Population distribution

The district has a total population of 166 646, of which 47% (78 470) are males (CSO 2002). According to the same report, the crude birth and death rates were 29.25 and 17.76 per 1 000 respectively, with a rate of natural increase of 1.15%. There are 39 596 households in the whole district and the average household size is 4.18. The CSO also noted that the district had 147 and 48 male and female child-headed (<15 years) households respectively. The main language is Manyika, a sub-dialect of Shona.

Economic activities

Agriculture is the most common form of livelihood in the area. The major crops grown by the communal farmers are maize, beans, potatoes, tomatoes, sunflower, rapoko, bananas, groundnuts, cowpeas, paprika, roundnuts and wheat. Fruits found include apples, peaches, avocados, mangos and pawpaws. The district has expansive land covered with commercial plantations of wattle, pine and eucalyptus trees.

Housing

Type of dwelling

According to the Central Statistical Office (CSO), type of dwelling unit refers to the kind of housing occupied by the household. Mutasa is commonly characterised by traditional dwelling units, which are found in the old-style family settlements in which a number of buildings are made of pole and dagha/bricks, with thatched roofs.

Education facilities

The district has 137 pre-schools, 86 primary schools and 38 secondary schools.

Table 6.1: Number of school-going children enrolled in 2006

Enrolment	Males	Females
Pre-school	2 154	2 543
Primary school	20 062	20 190
Secondary school	9 665	8 616
Dropouts	285	215

Table 6.2: Levels of education for 3- to 24-year-olds in Mutasa District, by percentage

Age	Males	Females	Total
Early education	10.03	10.73	10.37
Primary education	61.72	64.75	63.18
Secondary education	27.05	23.16	25.17
Tertiary education	1.20	1.36	1.28
Total (N)	30 798	28 757	59 555

Water and sanitation

The district is endowed with many rivers and streams because it is a high rainfall area and is also a watershed. Many of the households fetch water for drinking and cooking from rivers and streams. Recently there were many initiatives by NGOs to provide boreholes and protected wells. Most of the households use the improved ventilated pit latrines.

Transportation and energy

Most of the locations are well connected with tarred roads and they are in good condition, whereas the dust roads in some parts were not good, because of the rains and lack of maintenance.

Conditions of OVC

Magnitude of OVC problem

The study respondents generally concurred that the OVC problem was growing bigger by the day and it was even more interesting to note that some caregivers asserted that there were more vulnerable children than orphans as a result of poverty. The concomitant results of the growth in number of OVC were high dependency on donor assistance and many children who were looking for employment at a very tender age. The living situation of OVC was being made worse by the current economic hardships and most households were struggling to eke out a living, making it difficult for them to assist OVC.

The district registrar reported that the problem was attributed to the fact that more and more parents were dying of HIV/AIDS-related illnesses. Government officials and other service providers stated that even though there were no official statistics, the major cause of death was AIDS, as most people below the age of 35 were dying and leaving many OVC. The social welfare officer reported that there were about 3 566 orphans in the 27 wards of the district at the end of 2005. The problem was reported to be accompanied by OVC dropping out of school and shortage of food, leaving the community failing to cope. The focus group discussion (FGD) for mixed male and female adults revealed that many of the OVC were being left in the care of grandparents who had no means to provide adequate care for the affected children.

Sources of knowledge about OVC

Grassroots structures, such as the councillors, chiefs, village heads and other local leaders, were the main sources of information on OVC. Traditional leaders at the lower echelons of the hierarchy of authority obtained information from volunteers, home-based care (HBC) groups, environmental health technicians (EHTs) and support groups, among others. An HBC officer for Africare aptly summed it up when he said that all the stakeholders, which

included government departments, local leaders and community structures, were part of the referral system and information on OVC was relayed from the grassroots structures upwards.

Housing conditions for OVC

The condition of houses for OVC was reported to be very poor and the social welfare officer concurred with this assessment. Some caregivers mentioned that most of the houses had thatched roofs that were leaking. Deteriorating housing conditions were so widely prevalent and reported, because there was no one to maintain them for the OVC. The district registrar highlighted that those children left in poor housing conditions were unable to rehabilitate these structures. The FGDs for both children and adults revealed similar findings and emphasised that the main problem was the need for rehabilitation of structures, not the absence of structures. Some of the other available structures had fallen in or were leaking heavily, leading to overcrowding. Orphans left in houses with corrugated iron roofs were in much better conditions, because these do not deteriorate so quickly. Even though it was reported that boys and girls sleep in the same rooms, incidence of sharing was not very common. It was not clear whether there was any age limit imposed for boys and girls sharing rooms. According to the council chief executive Officer, housing conditions were appalling, especially in the farming communities, but he also mentioned that in the rural areas, the conditions were largely dependent on the age of the parents; for example, young parents may die while still building and nobody takes responsibility to finish the structures. In order to avert such bad housing conditions, the District Aids Action Committee (DAAC) coordinator stated that his organisation used to provide OVC with materials for roofing, but were not doing so any more.

Major threats to quality of life of OVC

The major threats reported were:
- Lack of food, clothing, blankets and school fees.
- Child labour, where children were given tasks that were too heavy for them.
- Discrimination against some children, because of benefiting from outside assistance.
- Ill treatment by caregivers, because they cannot afford to take care of OVC.
- Physical and sexual abuse affecting young girls below the age of 14.
- Sexually transmitted infections (STIs) and early pregnancies.
- Poor access to health.
- Loss of property to relatives.
- Absence of psychosocial support, because communities do not have the capacity.

Types of orphans and problems they face

The respondents agreed that the different types of orphans encountered different types of problems. Below are some of the problems that were mentioned:

Maternal
- Abuse by stepmother if the father remarries.
- Neglect by the father who may not regularly stay at home.
- Dropping out of school.
- Vulnerability to rape.
- Absence of psychosocial support and care; children are generally closest to their mothers, compared to their fathers.
- Lack of education on reproductive health among girls.
- Strained relations with maternal grandparents when the father remarries.

Paternal

- Inadequacy of basic items like clothes, food and school fees.
- Children resorting to selling their labour to earn a living.
- Most mothers do not have paid work, so children drop out of school due to lack of funds to pay school fees.
- Disobedience by children, especially boys; they listened more to instructions from the father than to those from the mother.
- The mother may lose property to other relatives, thus making the household more vulnerable.

However, adults who participated in an FGD stated that the problems faced by paternal orphans were fewer and less severe compared with those faced by maternal orphans, because mothers would take better care of the children.

Double

- Some double orphans often forced to work at an early age, due to poverty.
- Girls susceptible to early marriages for the same reasons as above.
- Children succumb to peer pressure, leading to uncontrolled behaviour.
- Displacement, because different relatives take different siblings, thus separating them.
- Shortage of basics like food, clothing, school fees.
- Emotional disturbances, due to loss of their parents.
- Absence of psychosocial support and care; relatives may not help.
- Abuse by caregivers, for example, rape, child labour, physical beating and verbal abuse; orphans fail to report abuse, due to fear.

Loss of personal possessions

Most of the OVC reported that when their father or mother passed away, no family assets/possessions, other than clothes, were taken by relatives. Only one 17-year-old girl reported that relatives took all the household goods, except the bed. The respondents who participated in the FGDs reported that family assets were generally taken by relatives who were vested with the custody of the children, but most of them failed to give the children proper care. Property that was lost to relatives usually included both household items and livestock. A mixed FGD for 16- to 18-year-olds indicated that children most susceptible to losing property were the very young; assets were taken on the pretext that the children would not be able to look after the property and keep it in good condition, and that the property would be returned to them when they grew up. However, the children often would not get the assets back later, either, because they would have greatly depreciated and would have lost their value, or would get stolen, or the caregivers would not even disclose to OVC that the property had belonged to them. One of the children in a mixed FGD for 16- to 18-year-olds felt that it was good for family assets to be given to caregivers, because they could sell property in order to buy food, pay school fees and so on, if the assets were not left in the custody of OVC themselves.

Main needs and problems of OVC

The major needs of OVC mentioned by the respondents were:

- food;
- school fees, uniforms and stationery;
- clothes and blankets;
- soap and other basics like lotion;
- skills such as personal hygiene;

- psychosocial support and counselling, since most OVC were reported to be troubling their caregivers;
- access to medical facilities.

Access to facilities

There was concurrence among the respondents that access to facilities such as healthcare, education and social services was mainly dependent on household access to financial resources. An HBC officer for Africare stated that the high cost of facilities deprived the communities of access to resources and the situation was worse for those who were not receiving any assistance. The district registrar reported that access to resources could not be differentiated along the lines of orphanhood status and that most OVC were receiving assistance from different NGOs. However, the social welfare officer had different sentiments: Some caregivers and community members reported that the number of OVC who had access to facilities was far lower when compared with the number of those who needed the assistance. A local chief reported that access to facilities was compromised because the grandparents who were left with the care of OVC could not afford to take care of them and provide all that they needed.

Health

There was general consensus among the respondents that OVC access to healthcare was limited due to high costs of transport and medical fees. Some community members reported there were many groups that were working towards improving the health of OVC and were giving support in providing their health requirements. For example, HBC groups and NGOs assisted families affected by HIV and AIDS with medical kits. It was reported that there was a government facility for some OVC to receive free medical treatment, but the respondents pointed out that the system was fraught with many problems. In this regard, the chairperson of Development Aid from People to People (DAPP) Rujeko Support Group stated that clinics and hospitals demanded their clinic/hospital fees irrespective of whether a child was an orphan/vulnerable or not, or had the written approval for free treatment. It was not easy to obtain drugs, as the clinics often wrote prescriptions and referred patients to provincial hospitals or to the assistance of NGOs.

Education

NGOs were playing a critical role in the provision of education requirements for OVC, but the provision of stationery and school textbooks was highlighted as a neglected area of support. Most schools had registers for pupils supported by NGOs (such as PLAN International and DAPP) and others under the government's BEAM programme. However, the coverage was not a hundred per cent, as there were reports of many OVC who were left out of both the government and NGO programmes. NGO representatives generally felt that it was not possible for them to support all the OVC, because their resources were not only limited but also dwindling at the same time, due to withdrawal of donor support from the country. The chairperson of DAPP Rujeko Support Group stated that some OVC dropped out of school even though there was BEAM support, because the programme had to work with limited budgets, irrespective of the numbers of children who needed educational assistance; furthermore, the school fees had gone up. The programme manager for Diocese of Mutare Community Care Programme (DOMCCP) stated that OVC access to education had improved due to support from NGOs, but the main problem was truancy (*kurovha*) because of the lack of other things such as food, moral support and other basic necessities. DAAC was assisting OVC with uniforms, but the coordinator stated

that the list of intended/potential beneficiaries was quite long and preference was therefore given to the most vulnerable.

Financial resources

The respondents mentioned that OVC families had no direct access to finance and could acquire income mostly through selling their labour, that is, both OVC and their guardians engaged in casual work to earn a living. Support organisations were only assisting with material resources and not money. The chairperson of DAPP Rujeko Support Group stated that the failure of OVC families to buy food and other basic necessities was evidence of lack of access to financial resources. Some have resorted to smuggling goods for resale in Mozambique, so that they can have some income. The DAAC coordinator indicated that they had obtained a fund from the Social Welfare Department to cater for OVC, and were also running some income generating projects (IGPs) at community level to help OVC. It was reported that the funds from the social welfare were too little, as the money was not even enough to cover the transport costs of coming to collect it.

Social services

DAPP had provided a playground for children to come to play football. They also provided a centre where they showed films.

Community resources

There were gardens established by caregivers, so that the produce and proceeds from sale of produce would be directed to OVC, but one of the caregivers pointed out that the gardens were not really helpful, because the OVC still did not have adequate school fees. The chiefs were reported to have established a *Zunderamambo* (chief's/community granary), but most of the respondents were sceptical about its effectiveness. One of the chiefs indicated that *Zunderamambo* was not doing well, as there were no inputs like seed and fertilisers, although workers were available from among the community members. A community member reported that DAPP had a support group that had established a poultry project for people living with HIV and AIDS (PLWHA) and OVC, but that it had just started and not much had been produced from it as yet. The general perception was that support from the community was minimal. The chairperson of DAPP Rujeko Support Group summed it up when she said, *'Vanhu vanosiririswa nguva yashaya vabereki, asi pakazonzi tipei rubatsiro hapana anozorangarira nherera, nekufamba kwenguva vanodziisa kumacheto.'* (People only sympathise with orphans during the short time after the death of parent[s] and afterwards nobody would remember the orphans when assistance was required.)

The district registrar reported that communities were being encouraged through their local leadership to mobilise resources to assist OVC, and in some cases to refer OVC to organisations that could assist them. The social welfare officer mentioned that there were no community projects to assist OVC, owing largely to the prevalent harsh economic conditions. It was recognised among the support organisations that the communities had to share responsibilities with support organisations, but the real problem was their resource capacity. The programme manager for DOMCCP stated that communities in their areas of operation do many things, including fundraising (*kupemba*, to write proposals to funding organisations and business people), engaging in IGPs to raise money for OVC, mobilisation of materials (clothes, grain etc.), moral support and counselling, among other activities.

Children who participated in the FGDs mentioned that some churches were providing clothes; there were also some cooperatives in their community who were involved in livestock and crop farming, and that part of the proceeds from their sales were used to assist OVC. The FGDs for adults revealed that there were CBOs engaged in projects like gardening to help OVC, and some of the community members even built a house for one of the child-headed households in the community.

Challenges and coping mechanisms

The main challenges that were reported by the OVC were: displacement and separation of siblings, which had emotional ramifications; ill treatment by guardians; self-denial, leading to carefree or risky conduct; and lack of access to basic necessities.

In order to cope with challenges like lack of school fees and other basics, the OVC reported that their caregivers were engaging in farming, with the aim of producing and selling surpluses, so that they could then help the OVC. One of the OVC affirmed that some OVC were resorting to extremely good behaviour, in order to impress their caregivers and avert ill treatment.

Attitudes, stigma and discrimination

The general view among the respondents was that communities sympathised with OVC but that they unfortunately did not have resources. One of the local chiefs had similar sentiments and further pointed out that any case of stigma and discrimination should be brought before his court (*dare*). Most government officials stated that people in the community were aware of OVC and were willing to help, but lacked the necessary resources to provide proper care. Support organisations reported that they were providing education on good care and treatment of OVC to the communities. The reduction in stigma and discrimination was said to be one of the impacts resulting from the numerous support groups operating within the communities in the district.

However, one government representative indicated that an element of stigmatisation was still there, but the availability of support/assistance had helped to change attitudes, because an OVC then had resource power to offer. Whole families were benefiting from the food handouts that support organisations distributed to households with OVC. He added, 'Whoever is poor becomes a social outcast, no one wants an additional burden of taking care of OVC in these times of economic hardships.' Communities want to be seen to be accepting and understanding of the plight of OVC, so that they can benefit from the support that is available.

OVC reports linked lack of material things or having numerous unmet needs (such as poor clothing and lack of food) with the possibility of being stigmatised. Others stated that their desperate situation invited accusations, especially related to theft. One of the OVC said, *'Vanhu vanongoti tisu takanganisa kunyangwe tisirisu.'* (People blame us for everything, even if we would not have done it.) Respondents in a mixed FGD of adults revealed that OVC were usually blamed for any criminal offences that occurred in their area, even when they were not responsible. Children in a mixed FGD of 6- to 15-year-olds reported that most of the discrimination was around caregivers having to buy new clothes or uniforms and pay school fees for their own children as well as for OVC. OVC claimed that poor quality things were bought for them. A member of a support group summed it up when she said, *'Vanhu vanoti nherera inoguta musi unofa mai. Ukasvika pamba pane*

nherera unongozviona kuti vana ava havasi kuenzaniswa. Unoona nemapfekero avo uye mabasa avanopiwa, nherera inopiwa basa rakaoma uye pane zvechikoro nherera inogara ichidzingwa.' (If you approach a household where there is an orphan, you will be able to see how orphans and non-orphans are treated differently, especially through what they wear, the kinds of chores they are assigned; and when it comes to education, the orphans are constantly chased away from school due to non-payment of fees).

Another dimension of the problem was that OVC might be stigmatised as a result of having caregivers who are too lazy to work for the OVC and therefore ask for handouts (*kupemba*) from other community members. Some of the caregivers may not be lazy but do not have money to buy inputs, such as fertilisers, and therefore produce very little from their agricultural activities.

Caregivers reported that they were working on minimising stigma through bringing together orphans and non-OVC at their support groups and counselling them together. The involvement of local leadership, the encouragement of community members to assist, and the formation of various support groups set up by government and non-government organisations, were forces that respondents associated with reduction in stigma and discrimination in the community.

Treatment of OVC

The OVC reported that they were generally treated well, but the FGDs revealed that some OVC were subjected to child labour or forced to work in difficult conditions, such as herding cattle when it was raining. The HBC officer for Africare reported that they have heard of cases where the OVC were not being properly treated by caregivers, for instance, reports of physical abuse, lack of adequate food and failure to go to school.

Challenges and complications

Providing shelter and food

Persistent droughts were reported to be limiting agricultural production. A local chief said, *'Tine makore akavanda tichitambudzika nenyaya yechikafu saka tiri kutadza kubatsira.'* (For so many years we have needed food support due to droughts, so we also fail to provide any meaningful support to OVC.) The coping mechanisms of caregivers were reported to be unsustainable, as most of them depended on rain-fed agriculture and casual work (mainly weeding), and these were seasonal. This therefore compromised their capacity to provide food, healthcare, education and clothes for OVC. Also related to lack of food production was the inadequacy and, in most cases, unavailability of agricultural inputs such as seed and fertilisers, among other things. Some NGO representatives mentioned that one of the challenges was that the number of OVC was increasing against a background of dwindling resources. A government official further said that the major challenge was that communities were too dependent on donors, to the extent that some no longer wanted to produce their own food and just waited for food handouts.

IGPs were identified as a panacea for some problems related to income and food security. The main problem mentioned by caregivers was lack of training in running the IGPs. Most IGPs were supported by NGOs and DAAC. Officials from these organisations reported that resources to support the IGPs were limited, as prices of inputs such as fertilisers, seed and chemicals had gone up due to hyperinflation.

A social welfare officer noted that lack of awareness of the availability and location of services was one of the major challenges; for example, some OVC had no access to facilities, such as educational assistance provided by NGOs and BEAM, simply because their caregivers were not aware of the existence of such facilities.

The children indicated that being cared for by the elderly presented challenges to them and their caregivers, because some were pensioners and others too old to work and provide for the OVC. An OVC explained that the age of her grandmother who was looking after them was a challenge, since she earned a living through casual work and could not do heavy tasks anymore, because of her advanced age. Children in an FGD of mixed boys and girls aged 16 to 18, reported that some parents died leaving their children without birth certificates and it became difficult for the elderly caregivers to make arrangements to obtain them, especially as they did not always see the necessity for them.

Dealing with emotional issues

An HBC officer for Africare stated that the capacity to provide psychosocial support was poor and that experts should be called in to help. A government official supported this opinion by mentioning that most caregivers, including those who already performed the role of counsellor, were not trained in counselling, and yet some situations they encountered with OVC were very difficult emotionally. Most community members and caregivers reported that there were no counsellors assisting emotionally disturbed OVC. A caregiver asserted that, *'vanoda kunyaradzwa'* (OVC need more emotional care). Another caregiver agreed that there were problems with emotional support, but felt that the community was trying as much as possible to comfort the OVC in their area. A support group member suggested that caregivers should not listen to everything that OVC said; for example, they would sometimes say, *'Haunditsiuri nokuti hausi mubereki vangu.'* (You cannot tell me what to do, because you are not my parent.) She suggested that this might be indicative of emotional problems and that the caregiver should not use these words as justification for them to abdicate their role of looking after OVC.

A government official reported that emotional and psychosocial services were normally provided by NGOs and some of the organisations took OVC to places outside the country that non-OVC had never visited, which could build OVC's self-esteem and ambition. He stated that they also went to workshops where they could interact with others. An FGD of mixed adults revealed that some OVC became difficult because they were forced to work in the fields while other children would be playing; the OVC were therefore continuously stressed.

Interaction of OVC with others

The interaction of OVC with non-OVC was generally perceived to be good, but some reported that there were isolated cases of stigmatisation. A few respondents reported that since non-OVC were getting most of the things they needed in life, they tended to laugh at the OVC who did not have some of the things they had, such as school uniforms. Non-OVC's knowledge about the cause of the death of orphans' parents could lead to stigmatisation, particularly when the cause was AIDS. A caregiver related an incident where a non-OVC said to an orphan, 'Your father died of AIDS' and the orphan asked his mother, 'Is it true that my father died of AIDS?' One of the community members gave an example of a case where some OVC were beaten up or bullied by the other children, who would say, *'Hamusi vepano.'* (You don't belong here.)

Attitudes of caregivers

A community member stated that some caregivers pretended to treat OVC well, so that they could get donor support. A local chief said, '*Chakafukidza dzimba matenga, zvinonetsa kuona zvinenge zvichiitika mudzimba asi kana tichiona vachifamba tinoti vari kugara zvakanaka.*' (There could be so much going on, but some things are secretive, and because of what we see on the surface, we think that they are treated well in the households in which they live.) Ill treatment of OVC was sometimes reported and took the following forms: giving them too much work, physical beating and verbal abuse. A caregiver summarised it by saying, *'Vamwe vane utsinye, vanopa vana vavo kudya kwakanaka vachinyima nherera zvinhu zvakaita sesipo, nherera dzinoshanda mumunda kana kuenda kuchigayo asi vana vepo havaiti mabasa aya.'* (Some caregivers who are hard-hearted give their own biological children good food, soap etc., but deprive orphans of these things; and they give them more work, such as working in the fields and going to the grinding mill, but they would not assign their own children such chores.) A support group member also said, *'Vanhu vane pfungwa yekuti vabereki vacho vakafa nenyaya yokuda kufara havo. Pfungwa iyoyi inoita kuti vana vanenge vasara vazotadza kuchengetwa zvakanaka.'* (Some caregivers think that the parents of the orphans died because they wanted to satisfy their sexual desires, and so the orphans will pay for the sins of their parents. This kind of attitude presents difficulties for such caregivers to provide proper care for orphans.) One of the concerns raised was that some of the caregivers mobilised resources from support organisations and communities by using the names of OVC, but the acquired resources would not eventually benefit OVC themselves.

A government official reported that some caregivers had negative attitudes towards OVC. He gave an example of orphans whose family assets, including roofing materials and livestock, had been removed by an uncle (*babamukuru*). When the community members assisted the orphans with power during the drought, they were asked who they were, and the uncle then installed his son at the homestead; the orphans were therefore displaced and had to go to live with a maternal grandparent. The main challenge in the community was to break through the social norms; that is, for instance, when outsiders helped a child next door, this would be likely to trigger conflict between neighbours. A government official, however, reported that caregivers had positive attitudes towards OVC, even though the economic environment was not conducive to carrying the extra burden.

OVC access to care facilities

Access to facilities was reported to be dependent on the situation of the household in which any one of the OVC was living. The assistance that the OVC were receiving from NGOs was helping to reduce stress around the provision of basics, as well as reducing marginalisation.

Impact of caring for OVC

Caregivers reported that they felt the burden of providing care and their resources were being stretched. One of them commented, *'Mariritiro andaiita kare naizvozvi handichamagoni.'* (The quality of care that I used to give has deteriorated.) Another indicated that at her age she was forced to work extra hard to make things work. A community member noted that those who look after OVC were becoming poorer, as they struggled with their own lives. A local chief said, 'For some, there has been the depletion of resources, depending on what they had before taking in the orphans.' A support group member reported that some caregivers were left with very young children (under five years old) and this affected their productive capacities and work, especially for those who

survived through casual work (*maricho*). Children who participated in an FGD of mixed boys and girls aged 16 to 18 years old reported that the money with which some of the caregivers were supposed to buy their own luxuries was being used to take care of OVC instead. The FGD for adults revealed that some of the older OVC failed to appreciate the efforts made by their caregivers and this could make it difficult to provide care for OVC; some caregivers even suffered from hypertension as a result.

Experiences of stigma as a result of providing care to OVC

The stigmatisation of caregivers was reportedly targeted mainly at those who were not giving adequate care to OVC. One caregiver stated that stigma may be there, especially when the OVC did not have clothes to wear; another said, *'Ukasavabata zvakanaka, kana kutuka vana paunofamba unosborwa.'* (If you do not treat the children well or you abuse them verbally, you will be stigmatised.) Similar findings arose in the two FGDs for children of 6 to 15 and 16 to 18 years old. Some community members were reported to play a role in discouraging caregivers from doing their work. A government official said, *'Vamwe vanobvunzwa kuti muri kuenda kunobatsira nherera kwako uri kuitei.'* (Some caregivers and volunteers are told they should be doing something for their own benefit, rather than looking after orphans.)

Suggestions to overcome challenges

Some community members suggested that they needed training in running IGPs, in order to help reduce poverty in the community; they also felt that organisations should give them capital and inputs to start IGPs. Caregivers suggested that the challenges could be overcome through training on how to care for OVC. A government official suggested that those community members who wanted to assist could give portions of land within their own gardens over to OVC. This would enable OVC to be self-sufficient and also ward off interference by relatives.

The DAAC coordinator emphasised that caregivers needed to be trained and constantly visited by stakeholders and that they also needed supportive resources to facilitate care of OVC. A social welfare officer expressed concern over the duplication of activities by NGOs, as, in the end, some OVC were doubly benefiting, at the expense of other equally deserving OVC; it was therefore suggested that activities of NGOs should be coordinated.

Children in an FGD for the 16- to 18-year-olds reported that some caregivers were doing casual work such as weeding, and others worked in IGPs such as poultry projects, in order to cope with challenges they were currently facing. However, they further stressed that those running IGPs like poultry projects were faced with shortage of inputs like stock feeds, which threatened the viability of their projects.

Skills of caregivers

The responses from the children's FGDs showed that the children thought their caregivers did not have the skills to take care of OVC. According to the children, this manifest lack of care skills was exhibited in various types of abuses (verbal abuse, physical beating, excessive labour, deprivation of food, education, clothes and so on) that the OVC were subjected to by their caregivers. The FGDs for adults shared the same sentiments, adding that there were many cases of discrimination in the community. However, some community members thought differently and stated that some caregivers were so poor that their expertise in providing care was not easily seen, due to their position of acute social and material deprivation.

Suggestions on how to help OVC

Role of individuals/organisations

A support group member stated that NGOs should support IGPs and summarised her point when she said, *'Ukapiwa project unenge vapiwa nhaka.'* (When you have a supported project, it means you have something that is long term.) Some government officials noted that assistance from donors should not address just the issue of school fees and food, but many other aspects of life like love, care and emotional and psychosocial support. An HBC officer for an NGO suggested that having support clubs at community level would help coordinate the fragmented initiatives that different support organisations were bringing to the communities. The government was urged to create awareness about their services, so that people knew where to go when they needed the services. A government official suggested that bureaucracy should be minimised, so that there would be no delays in the distribution of assistance meant to benefit OVC. A programme manager for an NGO emphasised the need to inform communities and train them about OVC care, using the existing structures. Court officials reported that there was little awareness on laws that protected the rights of children and suggested that the chief and other community structures should participate in building awareness, especially on maintenance laws; people should also be told where to get help. Community members were encouraged to give the little they had to OVC, to pay them home visits to support them emotionally and to assist in the rehabilitation of houses for the OVC. The problem of child labour was highlighted as a difficult one and the state was called on to provide suitable legislation and policies to prevent caregivers from exploiting OVC. FBOs were encouraged to come in and support OVC through teaching good behaviour and morality.

Some caregivers suggested assistance must be given at village levels and not at ward levels, because diversion of resources was frequently happening. As a result, they called for NGOs to monitor their programmes to see whether the resources were reaching the intended beneficiaries or not. Community members and caregivers stated that the BEAM programme should be improved to include provision of uniforms, books and pens, to make it easier for the OVC and their families. A government official stressed the importance of growing drought-resistant crops, such as cassava and sorghum, as a measure to ensure food security, while a support group member suggested that all the stakeholders should support the herbal gardens programme, which would guarantee cheap treatment for both OVC and PLWHA.

Commitment

The respondents reported that most of the NGOs that were working in the district were committed to their work. A caregiver said, *'Unoona kuti vanhu ivava vanerudo.'* (You can actually see that these people have compassion for others.) Some of the caregivers rated their own commitment from the viewpoint that even their own relatives could not assist them for three full months, and therefore they were sacrificing a lot. However, one government official noted that though commitment was high, there were some who were opportunists and that this compromised the effectiveness of the programmes: 'You find a nurse looking at the clock while attending to a patient and it may not be clear on the part of individuals whether it would be a calling or just a job.'

Requirements to facilitate contributions

There was general consensus among the respondents that support organisations should do more to empower communities to be self-sufficient and promote projects that were

sustainable, rather than just giving out food parcels. Community members and caregivers highlighted the imperative to encourage communities to support each other, so that OVC received enough care and support. Some of the OVC mentioned that they needed agricultural inputs to grow crops for themselves and improve their household food security.

Care and support structures for OVC

The OVC in the communities were being taken care of by grandparents, neighbours and relatives. The boys and girls who participated in an FGD for the 15 to 18 age group mentioned that maternal relatives were taking care of most of the OVC in their community. Other members of the community were reported to be assisting OVC with money, clothing, food, rehabilitating houses and providing the grass for thatching. Some churches, especially the Anglican Church, were helping OVC with food and clothes. A 17-year-old female OVC claimed that Islamic groups would help with school fees and food, but only for those who went to their mosque. There were trained volunteers who worked with NGOs operating in the community. HBC support groups such as Rujeko assisted with medical kits for vulnerable children who were looking after sick parents, as well as with training relatives of the sick in providing care to PLWHA. The support groups that conducted needs assessments also kept registers of OVC in the community who needed assistance.

The government assisted OVC mainly through the BEAM programme and distribution of food through the Social Welfare Department and DAAC. The BEAM programme was mostly assisting those OVC in primary school. The Ward AIDS Action Committee (WAAC) supported OVC left by parents who had died of HIV-related illness with school fees, cooking oil and porridge; however, reports from caregivers showed that they assisted only a few families and the food was not adequate. The DAAC and WAAC also assisted PLWHA with medication and sanitary materials, and they also trained community members and families in establishing herbal gardens. An Agricultural Research and Extension Services (AREX) officer stated that there was a *Zunderamambo* at ward level that was meant to assist OVC and the poor. An officer in charge of the Victim Friendly Unit stated that government departments like Social Welfare, Public Prosecutions, the Law Society and the Judicial Court all supported the enforcement of children's rights, including OVC.

General sentiments were that the extended family would not cope without the support from NGOs. Non-governmental organisations such as DAPP, Plan International, Pump Aid Zimbabwe, Africare, World Food Programme (WFP), Kubatana, Arise, Trias Hill, DOMCCP, Catholic Development Commission (CADEC) and Njopera Trust Fund were assisting OVC with school fees, clothes, vocational training and life skills, food, clean water sources, drip kits, nutrition gardens and other IGPs. Some of the organisations involved in food distribution were giving monthly supplies to the households they supported. The food parcel included porridge, maize, cooking oil, peas and beans. Some organisations, such as WFP, extended their programmes to include supplementary feeding schemes in schools.

The council chief executive officer stated that some programmes directly benefited the child, such as providing education and healthcare, whereas some took an umbrella approach in supporting the whole family. Some of the NGOs, such as Plan International, were implementing community-based projects.

Desirability and effectiveness

The programmes and services that the communities received were perceived by most of the respondents as very desirable, but they also underscored the need to train caregivers and other local stakeholders in two areas: to train beneficiaries of IGPs on how to use the money they earn from the activities, and also to educate primary caregivers about caregiving work. There were fewer concerns about the desirability of the support received, but more concern about the adequacy of it. For example, NGOs provided school fees but not the necessary stationery or school uniform, thus leaving the child supported with fees but without a complete package; therefore, the state of deprivation was not completely alleviated. To sum up, a caregiver said, *'Rubatsiro rwatiri kuwana rwakanaka, zviri kushanda uye zvimwe zviri kusvikira pane mazano kare, saka tinoitawo zvimwe nokuti hazvikwane kana uine mhuri yakakura nekuti haugone kungomirira zvokupihwa chete.'* (The assistance that we are getting is quite helpful, but we realise we have to play our part to help ourselves, because what we get is not enough if you have a big family, and you cannot wait for handouts only.)

There were also indications among some of the respondents that they received whatever was given to them, whether desirable or not. The chairperson of DAPP Rujeko Support Group asserted, *'Chibage chete hapana zvimwe zvinhu zvatinopihwa, vanhu vanozongogutsikana zvawo kuti todii ndezvekupihwa, ndizvo zvavanogonawo kutipa izvozvo zvavanenge vanazvo.'* (We are given maize grain only and nothing more. We have no option but to receive it, because the assistance is for free, and we believe that is what the support organisations can offer.) The council chief executive officer observed that the problem was more about identification of the needs of the communities; he gave an example of a child who was given educational support (fees), but the child did not want to go to school. Another example he gave was of food assistance given to a family where the father was working for the Grain Marketing Board (GMB), and so eventually the food given to them was sold on the market, because the family already had access to food through the GMB. An HBC officer for Africare, however, reported that they consulted with community leaders and shared ideas before implementing programmes, so that the input from the communities provided a reflection of their needs, as represented by their leaders. The programme manager for DOMCCP affirmed that their services were desirable, since most of them were informed through baseline surveys.

One of the areas of discontent among recipients of support was that a child had to be supported by one organisation only; for example, in cases where a child was given food by Plan International, that same child would not be eligible for payment of school fees under Plan International or BEAM, and therefore had to find his/her own sources for school fees.

Indicators of success

There was a reported increase in the number of former OVC dropouts who had finished school up to 'A' level. Caregivers reported an increase in school attendance among OVC, because they were no longer turned away from school for failure to pay fees. Many of the IGPs were running well (herbal gardens and orchards for OVC). There were improved water sources in the communities (Pump Aid and Plan International's initiatives) and the prevalence of water-borne diseases was reduced, especially among children. A support group and HBC officer for an NGO stated that there was an improvement in nutrition and food security at household level, especially among those who received food assistance.

The establishment of psychosocial clubs improved the social interaction of OVC and reduced stigmatisation in the communities.

Sustainability

The main obstacles to the sustainability of most of the agriculture-based IGPs were spelt out as:

- Lack of skills to manage the projects.
- Harsh economic environment and high input costs.
- Resources used were mostly from external sources.
- Partial or no input support; for example, given seed but no fertilisers and chemicals.
- Poverty: most of the families involved in the projects did not have the capacity to support the projects.

An NGO official reported that food distribution programmes were not sustainable, because communities were not being taught how to produce food, and yet donors were pulling out of the country. Resources being channelled to support the programmes were limited, leading to sub-optimal outputs. However, most programmes were community driven and community members were actively participating, therefore making the programmes more sustainable.

Requirements

- Support organisations should monitor and evaluate their programmes to ensure that what they are giving is reaching the intended beneficiaries; they also need to know what is needed, so that they can help appropriately.
- To source more funds to finance programmes; more resources need to be mobilised, since the number of OVC is ever increasing.
- Input support for IGPs, such as seed, fertilisers and chemicals.
- Water sources to support agriculture-related programmes.
- The government should create a more conducive environment for support organisations to provide efficient and effective intervention programmes.
- To provide information and educational initiatives, so that the programmes can be successful.
- To identify the people who matter, namely, people who are responsible for looking after the OVC, as there were cases of some households that were benefiting, even though they were not looking after any OVC.
- To scale up educational funding to cover more children who are in need.

Impact of services

- Decrease in school dropouts among the OVC.
- Reduction in the levels of poverty, since people have obtained food for consumption.
- Basics (food, clothes and school fees) provided for the OVC.
- Improvement in quality of life among OVC.

Policy and legislation for the protection of OVC

Knowledge of law

Knowledge of the legal provisions and policies seemed to be concentrated among NGO and government officials. Most NGO officials reported that they were using the United Nations Convention/Charter on Children's Rights, while government officials had

knowledge of laws such as the Labour Act (Chapter 28:01 of 1985), Sexual Offences Act (Chapter 9:21 of 22/2001), Children's Act (Chapter 5:06 of 14/2002) and Education Act (Chapter 25:04). Community members knew about provisions in the Acts but not the actual names of the Acts of parliament, though a few did mention some specific names, especially the Sexual Offences Act, Education Act, Public Health Act (Chapter 15:09 of 14/2002), Guardianship of Minors Act (Chapter 5:08 of 2002) and Labour Act. For example a local said, *'Mwana anofanira kurohwa zvekuraira kwete zvekushusha nekuti hunenge husiri hupenyu.'* (A child should be beaten as part of disciplining and this should not amount to ill treatment.) Among some of the child rights identified by some of the caregivers, were: the right not to be subjected to abuse, right to education, right to have a proper place to sleep and right to have adequate and good food. A local chief stated that children should have the right to play and have time to study, rather than being subjected to too much work. Police used to conduct awareness campaigns on laws that protect OVC, so the level of awareness on particular provisions of pieces of legislation was reported to be high among those who attended the meetings. Children who participated in the FGDs were aware of the rights to education and to be free from abuse. However, one government representative stated that there was little knowledge at the grassroots level; for instance, some caregivers were not aware of the right of OVC to go to school; even the right of their own children to go to school was not known.

Attitudes towards such regulations

Some caregivers reported that community members compromised their adherence to the legal provisions, especially those relating to child labour. Some sections of the community perceived child labour as part of developing life skills for the child. Others felt that attitudes might appear to be negative, but the problem was ignorance about the policy frameworks and legal provisions. A community member said, 'People are not adhering to the laws because they do not know the laws, but there are others who just want to exploit the children.' Contrary to these views, a government representative reported that naturally those people who abused children in various ways did not like the regulations. The officer in charge of the police's Victim Friendly Unit stated that the communities had positive attitudes towards the legislation, although in some cases they tried to solve the cases on their own, without police involvement. A support group member supported this view, affirming that attitudes towards these pieces of legislation were good, as community members, especially neighbours, reported cases of children who dropped out of school or were abused.

Implementation and support of regulations

Some community members and caregivers reported that the laws were being implemented well and people were required to report matters of abuse to village heads and other local leaders. An NGO representative stated that the presence of the police was too thin in the communities and that effective implementation and support hinged on creating awareness in the communities.

Challenges in enforcing laws

The police officer in charge of the Victim Friendly Unit reported that the major challenge their unit faced was delay in reporting of cases of abused children, especially where double orphans were involved. Other problems were that physical evidence might have disappeared or it might be difficult to find witnesses. He added that the courts were overburdened and they were taking too long to finalise some of the cases.

The harsh economic conditions were emphasised as a challenge to the fulfilment of children's rights to food, health, education and so on, since most of the caregivers were not employed. A support group member said, 'The main challenge is poverty, in as much as caregivers want to ensure that children enjoy their full rights, they cannot afford to cater for all their needs.' Some government officials highlighted that there was a high level of ignorance in the community about the laws and policies. An HBC officer for one NGO said, 'There is too much ignorance and some abuses are a result of ignorance. For example, with children's right to health – some religious sects in the community deny children such rights.' Among the recommendations was the imperative to sensitise communities and to empower individuals and children in particular, so that they would know what to do when denied their rights. Adults who participated in an FGD of mixed males and females reported that child labour was common in the area, but the abused OVC could not complain, as this might result in them being sent away from home.

Another government official highlighted that communities and their leaders should support the police, because people complained that some offenders were quickly released back into the community. The main problem relating to this issue was the handling of evidence, which was reportedly flawed on the part of the communities. A court official stated that the implementation of maintenance laws was fraught with problems in cases where the court took three quarters of the salary of a father who had refused paternity of a child; as such, the father might not find it worth continuing with work and therefore quit his job. Some policies and legal provisions were becoming outdated and taking too long to be reviewed and were therefore becoming ineffective.

HIV and AIDS

Awareness and knowledge of HIV/AIDS

Awareness of HIV and AIDS was generally perceived to be very high. A local chief said, *'Vanhu ruzivo vanarwo asi nharo ndodziripo, vanoti ndicho chega here, rufu mutemo vamwar.'* (People have the knowledge, but they say that death is God's rule; you will die anyway.) Awareness programmes were being conducted by NGOs and many programmes were being conducted in schools, churches and organisations, even though others did not change their sexual behaviours. However, respondents noted that people were usually slow in changing their behaviour. A support group member said, *'Nyangwe ruzivo rwuripo, havagoni kuzvidaira kana kuzvibvuma kana chirwere chapinda mumba.'* (Although awareness is very high, when the disease comes into their homes, people fail to accept it.) A government official pointed out, 'If a person falls sick you hear people talking about the sexual history of the sick person, but you see men inheriting wives of their brothers.' He further stated that another manifestation of awareness was that people would go to the extent of using plastic freezits as condoms when they had sex with commercial sex workers. A representative from social welfare illustrated the high level of awareness by saying, *'AIDS tava kudya tichitauranezvayo, tichirara tichitaura nezvayo.'* (We talk about AIDS when we are having meals, even when we go to sleep, it's part of our bedtime stories.) Furthermore, there was also a lot of publicity through the national television network about HIV and AIDS.

Estimates of number of people infected

The DAAC estimated that at the end of 2005, the district had 6 102 people living with HIV and AIDS, of which 45.9% were males. Deaths through HIV-related illnesses, as well as new infections, were reported to be high and increasing. A support group member stated

that there were many people affected by the disease, based on HBC registers as well as registers for people who were receiving food assistance from DAAC. An NGO representative estimated infections at 20%, based on the surveys that were done in the district. One caregiver was of the view that the problem was decreasing, as fewer people were dying of HIV and AIDS, and she further claimed that only 5 out of 70 households they were assisting in her village had someone with HIV.

Impact on state and organisational resources

A health official reported that there was an influx of patients with HIV/AIDS at hospitals, resulting in a drain on the greater part of the budget for the health sector. Another government official added that the consumption of private medicine nationally had gone up more than 10 times; hospital first-time and repeat visits and ward occupancy rates, had all gone up, as well as the use of ambulances.

The respondents emphasised the negative impact that the disease was having on the young, skilled and productive workforce and on production at both organisational and national levels. People with work experience were dying right across sectors of the economy and in some cases it was becoming difficult to replace them. Therefore the general economy and development of the country was being negatively affected. A local chief stated that the funds that organisations and the state should have been using for other development projects were being channelled towards helping OVC and treatment of PLWHA, for example, through the AIDS levy.

Impact on community resources

A local chief said, *'Shanduko iripo ndeyekuti chirwere chinodzosa vanhu mumashure, munhu haasi mombe saka kana arwara mari yaida kushandiswa kutenga tumwe tunhu yave kushandiswa kumurapisa, mukasadaro zvinonzi mave kundirasa.'* (One of the impacts is the diversion of resources, otherwise set aside for other purposes, to the provision of medical care for the sick person. A person is not like an animal that you can leave to die; if you do not care for them they will say they are discriminated against.) Some OVC who had experienced the ravages of HIV and AIDS reported that families sold assets in order to obtain the right foods to keep them healthy or to get treatment. According to an 18-year-old OVC, productive time was lost when community members abandoned developmental projects to attend to sick people or to attend funerals. The general perception was that the disease was bringing in more poverty. A caregiver said, *'Chinodya mari zvakanyanya icho chirwere ichi.'* (The disease requires a lot of money to manage it.) To illustrate the drain on community resources, a government official added, *'Parufu hapasisiri pekuuraya mombe.'* (It's not the time anymore to slaughter a beast at a funeral, because of the depletion of family assets.) Family assets were being depleted as a result of the prolonged illness that is characteristic of the disease. A social welfare officer stated that the impact of the disease was more severe among the poor, who could not afford to buy antiretrovirals (ARVs).

Impact on social functioning of the community

The death of parents led to change in the orphans' living standards, because they had to be taken in by someone else and this could bring problems for them. Some OVC stated that cultural safety nets were breaking down, because of the increasing burden of care of orphans. Caregivers noted that the burden of looking after orphans was shifting to the elderly, especially the grandparents, who had no capacity to provide adequate care and support. A community member reported that relations were strained in households where

there were inadequate resources, which then affected the distribution of resources between a caregiver's children and those taken in. Stigma was reported as one of the social issues that strained community relations. A government official indicated that some children were fulfilling the roles of adults, because they had assumed the role of household heads; they therefore had a lot to do and think about and had less time to do their school work. An NGO representative pointed out that negative attitudes led to the break up of relationships, as families would accuse each other of witchcraft. A support group member stated that family conflicts might arise as a result of having a sick member in the household, especially in terms of roles and contributions towards care of the sick person.

OVC behaviour in relation to HIV

Delinquent sexual behaviour was reported, especially among girls aged between 15 and 18 years old, to the extent that some of them were not even sleeping at home. The FGD for 6- to 15-year-olds revealed that OVC behaviour was dependent upon the extent of psychosocial support, adult care or guidance, and deprivation that OVC experienced. Most OVC were sexually misbehaving due to peer pressure, as well as trying to make ends meet. The FGD for 16- to 18-year-olds also reported that some cases of sexual immorality among OVC was attributed to poverty, making them resort to promiscuity to earn a living, while the FGD for adults felt that some of the OVC might have seen the same behaviour from their late parents, so it would not be easy to teach them to behave differently.

Communication on HIV

The children who participated in the FGD for 6- to 15-year-olds stated that their parents were talking to them about AIDS. They further mentioned that teachers also taught them about HIV and AIDS in their guidance and counselling lessons. NGOs such as DAPP conducted counselling sessions that included HIV and AIDS and reproductive health issues. There were mixed responses on these issues among children in the FGD for 16- to 18-year-olds, with some reporting that their parents were communicating about such issues, because they feared that their children might try what they were telling them not to do; they also wanted their children to know that it was AIDS that was killing people. Others, however, reported that their parents were not communicating about these concerns, because they thought that the children were being taught about them in school in their science subjects (biology). The FGDs for adults revealed that some parents were too shy to talk about such issues at home and that some children were being taught in churches.

Care and treatment of PLWHA

Availability of services

The local community had established HBC services with the help of NGOs and DAAC. NGOs and DAAC supplied the HBC with materials for distribution to PLWHA. Materials included gloves, betadine spirit, linen servers, soap, drugs and some food packs. HBC also trained both caregivers and patients in counselling and nutrition support. Structures at grassroots level were overseeing the administration of herbal treatments, the management of herbal and nutrition gardens at household level, and teaching community members how to care for the sick. Most of the respondents indicated that HBC did not have drugs to facilitate their services. Other services provided by the HBC included home visits for spiritual and psychosocial support. The respondents reported that there were mobile voluntary counselling and testing (VCT) services, but those who wanted the services could

go to the hospital at any time. Mobile VCT was carried out in collaboration between NGOs and New Start Centre, which was driven by Population Services International (PSI). A community member stated that community response to VCT was low, due to people's negative view about the disease. Some of the respondents reported that HBC and mobile VCT services were not covering the whole district.

The DAAC was reported to be giving food packs to PLWHA. Most of the respondents asserted that ARVs were not available and even if they were, many of the PLWHA would not be able to afford to buy them. A government official reported that his department had disbursed Z$10 million to the communities, so that they could buy herbs for their gardens and reduce the overall cost of treatment.

Impact of services

Most of the respondents reported that HBC services had a positive impact in a number of ways. Some said that the clinics were short-staffed and HBC therefore helped to reduce the burden of care on the clinics. Others stated that HBC was helping to reduce stigma and discrimination through counselling. Caregivers reported that HBC was teaching the affected household members about care (for example, how to bath and feed the sick) for PLWHA. A local chief indicated that HBC was initiating care at the community level and thus one would go to the clinic after having received at least some care and treatment already. Another chief noted that the problem with HBC was that some of the members providing this service were helping only their own relatives. An OVC added,
'Vanobatsirwa vanomboita nani kwete kwenguva yakareba nokuti zvinodzokazve.'
(Those who get assistance get better, but not for a long time.)

Views on access and availability of ARVs and VCT

Most of the respondents reported that there were no ARVs in their health institutions. The response to VCT was reported to be low, as most people were still too shy to get tested. However, one government official noted that awareness of the availability of VCT services was high, and so more people were using the services than before. A social welfare officer stated that initially people were reluctant to know their status, but this had since changed. Herbal gardens were established at most households and traditional herbs were reported to be effective in reducing opportunistic infections.

Suggestions on how to limit the spread of HIV/AIDS

Educational needs

Some of the ideas that the respondents suggested would help reduce HIV and AIDS were as follows:

- It was emphasised that educational programmes should be scaled up, so that the messages about the disease were continuously reinforced.
- Teach people, especially in schools and particularly those children of a very young age, so that they appreciated the concepts of the disease.
- People need to be taught how to treat PLWHA.
- People should be encouraged to get tested.
- Married people should be open with each other about their HIV status.
- Clinic staff should tell people about their real problems and counsel them.
- People should be tested before marriage.
- Behaviour-change programmes need to be initiated.
- Educate people on the use of herbal remedies to control opportunistic infections.

One support group member suggested that educational messages should emphasise abstinence as the key/best prevention measure. She added, *'Kukanganisa kwakaitwa pakudzidzisa vanhu kuti condom rinodzivirira.'* (The mistake was made when people were taught that condoms can protect them from being infected.)

Infrastructural needs

Ideas on infrastructural needs for the control of HIV and AIDS were as follows:

- VCT and prevention of mother to child transmission (PMTCT) services should be made available in the community in order to reduce the rates of infections.
- Awareness of the availability and use of PMTCT, VCT and ARVs must be increased.
- Accessibility of ARVs should be improved.
- Those who sell or distribute condoms should not deny children access to prevention measures.
- Services at rural hospitals should be improved.

Interventions at social level

Some suggestions to control the spread of HIV at the social level were also put forward. These are summarised below:

- Income generating projects should be introduced to reduce promiscuity.
- There should be gender balance in terms of economic opportunities.
- Programmes aimed at reducing stigma should be initiated, so that people would not be afraid to find out their HIV status.
- Introduce legislation to deter those who have the virus from wilfully spreading it.
- Strengthen community support structures such as WAACs and Village AIDS Action Committees (VAACs), so that they can improve awareness at community level.
- Promote the use of condoms to prevent HIV.
- Peer education as a solution to reduce promiscuity and as a medium for information dissemination.
- Encourage traditional practices such as virginity testing as a way of reducing premarital sex.

Quality of health service

Most of the respondents reported that there were no drugs, vehicles and equipment at the available health institutions. Some of the respondents also reported that there was no means of communication, because some of the clinics did not have phones. Visitors to the clinics or hospitals were reportedly being diagnosed only, but not given any medication; patients therefore had to buy their own medication from the pharmacies. There were also some isolated reports that staff at the health institutions were below the qualification requirements.

Major sources of information on HIV/AIDS

Print and electronic media sources

Television, radio, newspapers and information, education and communication (IEC) material, such as pamphlets and printed T-shirts, were mentioned as sources of information on HIV and AIDS.

Organisational and state services information

The main sources of information were NGOs and HBC services that were working mostly under and supported by the NGOs. NGOs were conducting workshops and performing drama with HIV/AIDS messages. Schools, through their curriculum and drama, were main sources of information for OVC. Government departments such as DAAC and the Ministry of Health used their structures to disseminate information and were also conducting awareness campaigns at community meetings. Awareness campaigns were reported to be regular among NGOs and infrequent among government departments. Different organisations were distributing IEC printed materials in the communities. The respondents also recognised the role that churches were playing in the dissemination of information about HIV and AIDS.

Peers and colleagues

Youth peer educators were trained by one of the NGOs that ran a youth counselling corner where children could discuss HIV and AIDS issues among themselves. Adults in the community also obtained information from their peers. A local chief reported, *'Vanhu rume tinotaurirana nezvechirwere ichi tisingaziviwo zvinoitika kuvakadzi.'* (Men talk about this disease, not knowing whether women also do the same.) Some of the respondents emphasised the need to have peer educators in schools.

Improving provision of information

Some community members suggested that PLWHA should give testimonies about HIV/AIDS, so that others could learn from their experiences, and that there should also be meetings at village level where people could be taught about HIV and AIDS issues. The reinforcement of messages about HIV and AIDS was emphasised and reflected in this statement by one of the community leaders: *'Dzidziso yakafanana nesora mumunda, ukasakura kamwe hazvirevi kuti zvapera, zvinofanira kuramba zvichiitwa.'* (Educating people should be done regularly; it's like weeding in the field – you cannot do it once and think it's over, you have to do it continuously.) Some respondents expressed the view that there should be community peer educators if the dissemination was to be more effective and to make sure that the information would quickly filter down to the grassroots. The medium of dissemination of the information was also considered to be very important for effectiveness; the respondents thought that showing people educational videos would improve the provision and effectiveness of information dissemination. There was a negative perception that some advertisements, such as 'Speed kills, Condoms save', promoted promiscuity among the youth. A government representative stated that they encouraged NGOs to produce reports on campaigns, so that there was some mechanism for monitoring and evaluation of activities on information provision. An NGO representative stated, 'There is need to continuously remind people about the messages and encourage people to go for testing and taking the testing services to the people.' Some health officials noted that IEC materials should be written in a language that people understand, as some members of society are not able to understand, though able to read, the English language, which is used in most materials.

Profile of government ministries and departments

Table 6.3: Profile of government ministries and departments

Background	Activities	Challenges	Plan to assist OVC
Ministry of Youth Development and Employment Creation			
The centre has a total enrolment of 70 students. No age restriction on starting the courses.	Offers training in: carpentry and joinery; welding; motor mechanics; sewing.	Equipment is getting old. Lack of accommodation facilities for their students. Funds from government inadequate, so cannot replace equipment.	Expecting a greater enrolment. Introducing a new course.
District AIDS Action Committee			
Works with most of the NGOs operating in the district and also other government departments. More emphasis is put on to those areas without NGOs. Get information on OVC from their WAAC and VAAC committees.	Provision of inputs for farming. Awareness campaigns on HIV/AIDS in the community.	Lack of coordination of aid organisations in the district for their work to be more effective. Weak monitoring and evaluation systems. Inadequate resources.	Setting up more support groups in all the wards in the district. More awareness campaigns.
Ministry of Public Service, Labour and Social Welfare			
Provides safety nets.	Places abused children in places of safety. Pays school fees for children in institutions like orphanages. Food distribution.	Mobility: transport a great problem. Limited resources: poor coverage. Increasing number of households requiring assistance.	No information reported.
Registrar General			
Can recruit staff from other departments when doing their mobile registration services. They may carry out mobile services about every two years, especially when there are elections. Improved statistics in registration to about 10 times more people.	Assists guardians on how to get information about obtaining birth certificates for orphans, as many OVC were finding it difficult to obtain these documents. Have mobile registration services where people come for their service. Arranges with the Social Welfare Department to go into orphanages to do the registration.	People not utilising mobile registration programme. Lack of financial resources limiting their mobile registration services.	Sensitisation of community leaders to identify children without identity documents, gather the relevant information and bring them to the mobile registration.

Background	Activities	Challenges	Plan to assist OVC
Ministry of Education, Sports and Culture			
School heads are part of these OVC committees. Gets information on OVC from the school heads.	Holds workshops with school heads to identify OVC for the BEAM facility. Identifies OVC needs through school heads. Remedial tutor who works with school heads and attends to issues of children in need of special care. Assists children through the BEAM facility	Resources to help OVC are very limited. Teachers trained in basic counselling.	To visit different households in the community to assess the problems that the OVC might be having. To offer counselling where necessary, because only having the names at schools was not very helpful.
Zimbabwe Republic Police: Victim Friendly Unit			
Enforces the following Acts: Sexual Offences Act (including Indecent Assault clause, Chapter 9:26 of 8/2001) and the Children's Act.	Attends to cases of sexual abuse involving children under the age of 16. Carries out crime awareness campaigns.	Human resources shortage. Lack of transport a big problem. Queuing at hospitals with other people was delaying their operations.	No information reported.
Department of Agricultural Rural Extension			
	Provision of agricultural inputs such as maize seed, fertilisers and chemicals to support food production. Provision of technical support (good farming methods). Food security support programmes for child-headed households. Assisting farmers with advice on post-harvest management.	Short-staffed and had 49 vacant post in the department. No accommodation for their staff members, leading to high labour turnover. Transport problems: terrain does not allow them to use bicycles.	No information reported.

Background	Activities	Challenges	Plan to assist OVC
Ministry of Health and Child Welfare			
Works with village health workers at the grassroots level. Gets information on OVC from village heads and clinics.	Provision of milk (infant formula) to children orphaned at a very young age. Immunisation of young children. Offer treatment to children who fall victim to sexual abuse. Provision of counselling services to victims of abuse. Refers cases of abuse to ZRP. Supports child supplementary programmes. Supporting HBC with medical kits.	Staff shortage. Non-availability of drugs and medical kits.	Looking forward to having people who assess the needs of OVC in their communities and then reporting to the responsible authorities.

Profile of non-governmental organisations

Table 6.4: Profile of non-governmental organisations

Background	Activities	Challenges	Plan to assist OVC
Arise			
They have 9 trained counsellors. Operating in 10 wards of the district. Coverage: 10 secondary and 21 primary schools. School teachers assist them in identifying children with problems.	Offers counselling services to abused primary and secondary school children. They also talk to and counsel parents of those children having problems. Works with the ZRP (VFU) and the hospitals.	Poor transport systems and road network. Non-disclosure of some cases of abuse.	To train some children in peer counselling and life skills.

Background	Activities	Challenges	Plan to assist OVC
Diocese of Mutare Community Care Programme (DOMCCP)			
Operates an HBC and orphan care centre in the district. Strong community involvement through structures like village volunteers, village care committees, community care committees and community management board. Coverage of 15 wards in Mutasa, 9 in Makoni and 2 in Nyanga.	Their HBC services include home visits and material support in the form of protected linen servers, soap and gloves. Medical, nutritional, spiritual, psychosocial support and counselling. Orphan care programme offers education assistance and training in survival skills, child rights. Assists communities in running IGPs such as carpentry, tie-dyeing, buying and selling, internal savings and lending.	Understaffing, due to weak financial support base. Funds not adequate.	To capacitate communities to help themselves, for example, to do their own fund-raising activities, such that communities have to be able to continue with HBC and orphan care programmes from November 2003, when external assistance stopped.
AFRICARE			
Targeting vulnerable groups such as the poor, elderly, disabled, OVC and families affected by HIV and AIDS etc. Mainly addressing issues around food security and nutrition. Emphasis on the building of capacities of communities.	Provides households with monthly food rations in return for them providing educational support to OVC. Provision of agricultural inputs to improve food security. Food assistance: cereals, vegetable oil, beans, corn, soy blend (porridge). People on TB treatment and with other chronic illnesses are referred to Africare by hospitals for food rations.	Dependence on donor funding. Inadequate financial resources.	Intent to link with other stakeholders to provide a holistic service. To establish support clubs at community level, so that initiatives by external organisations can be sustained. To strengthen psychosocial services (PSS) in schools and among caregivers and guardians.
Development Aid from People to People (DAPP)			
The organisation is community-based and works with existing local structures. Aims to improve living standards of children and to develop their full potential. Utilises school authorities as sources of information on OVC.	Direct payment of school fees. Skills training and running IGPs in schools and communities. Food support to pre-school children. Running HBC programme and offering psychosocial support. Education on herbal remedies and establishment of the herbal gardens. Referrals to support institutions (government ministries, other NGOs etc.).	Increase in the number of OVC. Duplication and double benefiting.	Would continue to establish support systems through support groups: add value to monitoring and evaluation (M&E) and targeting. Talk shows and road shows to create and/or improve awareness. More projects targeting children in and out of school, so that they acquire life skills.

Support group: DAPP Rujeko Support Group

This support group was formed in 2005 under the auspices of DAPP, with the aim of supporting households affected by HIV and AIDS. The support group represents the general interests of children who have lost their parents to HIV/AIDS or have HIV positive/sick parents, for example, with food distribution. Currently the group works with the VAAC, WAAC and other NGOs in their area.

Scope of activities
The support group has a piggery project belonging to their members, to support children with education assistance, food and other basics. The members share ideas and support each other in projects to raise income for their families. The group also offers psychosocial support and counselling (nutritional, positive living and so on) to members, as most of them are infected with HIV. They keep registers for the OVC requiring support from external organisations and carry out needs assessment for the children in their community. They also monitor programmes that benefit their members and do audits to see who is benefiting from what, and from which organisations. The group plays key roles in programmes designed to reduce stigma, teaching the community to accept HIV and AIDS through encouraging their members to disclose their status and give testimonies at community gatherings.

Challenges faced
The IGPs that the group runs are small, due to limited financial resources, and thus they have low returns. The group representative indicated that there was a lack of cooperation from the community, especially around mobilising material resources. The other challenge mentioned was the focus of NGOs and government on food handouts, when in fact they would prefer to be supported in their IGPs. The challenges were not many, as this support group had only just been formed at the time of this study.

Conclusions

According to the respondents, the number of OVC in Mutasa has been increasing, thereby presenting more challenges and complications in their care. Many parents were dying of HIV and AIDS. It has been highlighted that there were more vulnerable non-orphans, compared to the number of orphans, because of the poverty that was being exacerbated by the prevailing harsh economic conditions. The accompanying social ills contributing to the increase in OVC were: children looking for paid jobs at an early age and dropping out of school; early marriages of young girls; provision of care by grandparents without the means; poor shelter and overcrowding; food shortages in their households; and the existence of child-headed households (though these were few).

The main needs of OVC in the district were food, school fees (including uniforms and stationery), clothes and blankets. Psychosocial support for OVC was a neglected area, as most of the support organisations provided material support only.

The extended family carried most of the burden of care for OVC and other members of the community were assisting with material things. HBC support groups played crucial roles in assisting children in households affected by HIV and AIDS. Several NGOs and the government, through DAAC, were helping OVC with food and education, life skills and funding IGPs. However, the beneficiaries of these various kinds of support felt that all this was inadequate, but nevertheless appreciated the humanitarian efforts.

The available community resources were inadequate to support OVC and were reported to have minimal impact on their lives. Shortages of inputs threatened the viability of *Zunderamambo* and other agro-based projects run by caregivers to support OVC with school fees. Much of the communities' failure to provide material support to OVC was attributed to poor resource capacity and poverty.

There was a decline in the support given to OVC households by NGOs and other support organisations. This decline was attributed to strained budgets and economic hardships, leading to failure to provide the level of material support that the organisations used to supply. Externally funded organisations also mentioned inadequacy of financial resources as a major challenge. The deprivation of access to such facilities as education and healthcare suffered by OVC was attributable to the dwindling financial resource bases of most of the support organisations, who themselves also reported that their coverage was below the intended targets.

Cases of asset-grabbing were not many and in cases where orphans were left at a very young age, family possessions were distributed to relatives taking custody of the children. Some relatives sold family assets in order to meet the needs of the orphans, such as food and school fees, but in most cases they had to do casual labour together with the OVC.

The diversion of material things distributed to people looking after OVC was a problem, as there were reports that the donated materials, especially food stuffs, were sold to meet other needs in the household. This problem might be linked to inappropriate needs assessment, but it should be noted that households have different needs at different times.

The general attitudes of caregivers and other children towards OVC were perceived as positive, even though there were isolated cases of discrimination. Manifestations of such discrimination were around the unfair allocation of household work between caregivers' biological children and OVC, quality of clothes and preferences in paying school fees, among others.

Stigmatisation and discrimination towards OVC were low in the communities, who were in fact willing to assist, but did not have the resources. The proliferation of support groups was indicative of the willingness of people in the community to support OVC. However, there were indications that OVC were used in some households as instruments to attract resources from NGOs, and others gave preference to their biological children when it came to buying clothes or uniforms and paying school fees.

The provision of care for OVC was made more complicated by recurrent droughts that affect food production, especially as most of the caregivers were subsistence farmers. This compromised the caregivers' capacity to provide food and generate income to pay for healthcare products/services, clothes and education for the OVC.

Services to address the psychosocial well-being of the OVC were non-existent or inadequate, due to the absence of expertise to conduct counselling sessions for OVC in the community. Support groups were trying to help in this situation, but most were equipped only with very basic training in counselling.

Awareness about HIV and AIDS was perceived as very high, but behaviour change was the main problem, as people were slower in changing their sexual behaviour. Deaths through HIV-related illnesses were reported to be high and increasing.

Priorities for action

Government

At the level of policy, the government should be prepared to deal with the unexpected increases in the number of OVC, particularly the establishment of support mechanisms and planning in advance for relevant services, to avoid shocks and situations of desperation among both government institutions and caregivers.

There were reports implicating a general reduction in subsistence agricultural production as a consequence of critical shortages of inputs. The government should rescue the situation through input support (seed, fertilisers) for agro-based projects, as this would go a long way towards the improvement of food security in the communities.

The government has failed to deal with the perennial problem of droughts, thus reflecting its lack of disaster preparedness and therefore its planning and capacity to respond to situations of emergency.

The reported decline in the support by NGOs implies that the government should strengthen its institutions for quality service delivery and close the gaps left as a result of withdrawal of funds by donors. This can be done through adopting more cost-effective strategies, so that quality is not compromised, but at the same time coverage is increased. This needs to involve stakeholder participation, so that the roles of interested parties and their obligations are clearly spelt out.

The government should develop, improve and maintain infrastructures such as roads, transport, clinics and VCT in the rural areas, so that services are easily accessible; the construction of social facilities for children, such as playgrounds, is also vital.

Non-governmental organisations

Most of the NGOs reported that their coverage was far too low compared to what they had planned, and some were scaling down operations due to financial constraints. The alternative solution would be to adopt other cost-effective strategies similar to the block funding that most of them had already adopted. This concept of block funding can also be extended to additional spheres of assistance other than education only. Another alternative would be to empower communities to run sustainable projects, by making it mandatory for them to give their own contribution to the initial capital/resources to start projects. More should then be done to help capacitate the communities, through training in running and managing the finances of the projects.

Proper monitoring of NGO programmes is required in order to avoid double benefiting, which appears to be a problem in the district. This can also be curbed if the various NGOs working in the area coordinate their activities and keep databases of the beneficiaries.

The effectiveness of NGO activities seemed to be crippled by the lack of differentiation of services that they provided. The findings revealed that most NGOs were providing food and educational assistance, thus leaving other needs unaddressed, yet they were competing to provide the same service. The problem, however, relates to the particular interests of the donor community. More needs to be done to move towards needs- and research-based interventions. Forming partnerships would help them address the identified needs of communities in a holistic manner.

NGOs should work towards finding and adopting new financing models to make their activities more sustainable. The reliance on external donors alone has debilitating consequences in the event of withdrawal of support. Local NGOs should raise funds from the business community and the public to augment funds from the external sources.

The criteria that NGOs use in the assessment of the vulnerability of children seemed to be unclear to the communities. Nepotism was suspected and reports pointed out that most of the beneficiaries were kith and kin of community leaders who helped in the implementation of the programmes, most particularly those involved in the selection process. Standard scientific models of assessment can be developed for use in the selection of beneficiaries and the process has to be understood by the community. The idea is to integrate equity and justice into their systems and operations.

Community

There should be members in the community who are trained in addressing psychosocial issues among children. This is critical in so far as the psychological state of mind of OVC can determine the kind of life choices that they make and, consequently, their behaviour, mental well-being and future prospects in life. Leaving them to themselves can lead to personally destructive behaviour such as prostitution and drug or alcohol abuse.

Due to the limited resources that the government, NGOs and the communities have available, the implementation of IGPs that are designed to promote self-sufficiency and sustainability becomes an imperative for communities to deal with food shortages (including the associated problems, such as malnutrition and stunted growth in children) and lack of financial resources.

The local leadership should take the responsibility to educate people in their communities about laws that protect the rights of children. This can be done with the help of the relevant government institutions in their areas and NGOs. The problem of child labour, which was reported widely in the district, can then be dealt with at this level of leadership, since it is a phenomenon that may be not so clear and therefore needs to be addressed as and when it happens.

The communities should play a key role in the provision of shelter for OVC, especially in the rehabilitation of structures/homes. Community leaders should sensitise their people about the requirement for them to take responsibility for providing care for children in need, so that community members themselves can augment government and NGO initiatives in their area. The extended family must be strengthened and morally supported.

The community should be part of the surveillance system in the prevention of diversion of resources originally destined for the benefit of OVC. Critical to this surveillance is the detection of cases of abuse of children in the communities, as well as creating awareness about handling evidence and the channels for reporting cases of abuse.

CHAPTER 7

Mutare District

Pakuromunhu F Mupambireyi, Shungu Munyati,
Brian Chandiwana and Stephen S Buzuzi

Background

Description of study area

Mutare District is situated in the central mountainous province of Manicaland, on the eastern borders of Zimbabwe and is 263km from Harare, the capital city. The greater part of the district falls in agro-ecological Region II, with rainfall ranging from 700mm to 1 050mm (Rukuni & Eicher 1994: 42). The minimum mean temperature is 7.6^{0}C in July and the maximum mean is 27.6^{0}C in October. Mutare city serves as a provincial capital as well as a gateway to Mozambique to the east. To the north, the district borders with Mutasa District, Mutare Rural to the south, Makoni to the west.

Population distribution

The district has a total population of 170 466, representing about 10.87% of the population of the whole province. Of this population, 85 006 are males and 85 460 are females (CSO 2002). The sex ratio is 99.48. In terms of marital status, the majority (57.3%) of the population is not married and 3.13% is widowed. There are 44 820 households in the district, with an average household size of 3.74. The Central Statistical Office (CSO) also reported the crude birth and death rates for Mutare Urban as 32.92% and 12.45% respectively. The predominant language is Manyika, a sub-dialect of Shona. Of the economically active persons in the district, 62.65% of them are males and, of these, 22.58% are paid employees.

Housing

According to the CSO, in 2002, 91 of the households in Mutare Urban lived in dwelling units with electricity. The most common type of dwelling in Mutare (40.85%) is detached (a structurally separate dwelling unit which is built of materials other than pole and dagha), followed by a semi-detached type of dwelling (20.08%). Typical of an urban setting, 90% of the households use flush toilets.

Education facilities

The population aged 3 to 24 years old currently attending school, the current levels of education being attended and sex distribution are shown in Table 7.1.

Table 7.1: Levels of education for 3- to 24-year-olds in Mutare District, by percentage

Age	Males	Females	Total
Early education	11.94	11.81	11.88
Primary education	50.77	52.29	51.53
Secondary education	32.16	31.09	31.62
Tertiary education	5.13	4.81	4.97
Total (N)	23 838	23 915	47 753

The literacy rate for the population aged 15 and above, by sex, shows that Mutare Urban had 99% for both males and females. The CSO also reported on the population of 3- to 24-year-olds, by sex, who had never attended school, indicating that 6.85% and 6.84% of males and females respectively had never attended school.

Water and sanitation

Only an approximation of the proportion of households using what could be regarded as safe water could be obtained. Without applying rigorous health or hygienic standards, 99% of the households in Mutare Urban had access to safe water. Almost all the residents of Mutare Urban use tapped water at their premises for both drinking and cooking. With regard to the distance of water source to the household, almost all of the people had water on their premises or fetched water from within a distance of less than 500 metres.

Road network

Most of the locations are well connected with tarred roads. However, a lot is left to be desired on the state of some of the roads, which are littered with potholes.

Conditions of OVC

Magnitude of OVC problem

No survey has been conducted in the district to determine the exact number of OVC and, as a result, there is no centralised database for OVC. However, there are a number of non-governmental organisations (NGOs), support groups, home-based care services (HBC) and individuals that are working with OVC in the district, and these have their own registers or numbers of OVC they are assisting. Key informants interviewed, therefore, based their assessment of the magnitude of numbers of OVC in the district to a large extent on the number of OVC they were assisting. Officers in the Ministries of Education, Sports and Culture, and Youth Development and Employment Creation concurred that the OVC problem was actually getting out of hand, as approximately 50% of the children in schools were OVC. A programme manager (Simukai Child Protection Programme) suggested vulnerability levels as high 60% to 75% and attributed this to economic hardships as well as to persistent droughts that the country had been experiencing of late.

A community member stated that the problem of OVC was growing, because of harsh economic conditions; relatives were therefore not willing to take in any orphans, because they could not even manage to look after their own children. An HBC chairperson echoed the same sentiments by mentioning that HIV and AIDS were largely contributing to the huge OVC problem in the district. In addition to HIV and AIDS, accidents were also contributing to orphanhood, as reported by a mixed focus group discussion (FGD) for 6- to 15-year-olds at Chikanga Primary School. Another community member reported that the OVC problem was manifesting in the increased number of OVC in the streets, some turning to prostitution and engaging in criminal activities, because they generally lacked parental guidance. This view was also shared by a mixed FGD for 16- to 18-year-olds at Munyoro Secondary School in Zimunya, which reported that the OVC problem was big and some of the OVC ended up dropping out of school. There was also an increase in the number of child-headed households, as mentioned in an adult female FGD at Nzeve Deaf Centre.

The programme manager for care and prevention at the Family AIDS Caring Trust (FACT) reported that the magnitude of the problem was very high and demand for services was

also high. The economic situation was worsening the problem and the extended families were overstretched, because resources were limited. She stated that the other dimension was that the burden of care had shifted to the elderly. She further noted that children's moral values had decreased, because of the absence of people to provide counselling to children, particularly those in child-headed households. The outreach and training officer for Family Support Trust reported that the OVC problem was large, based on reports of sexually abused children they were receiving from all over the province.

Level of emotional and physical care

An OVC reported that they were psychologically affected because at times they were scolded and denied food. The mixed group FGD for 6- to 15-year-olds at Chikanga Primary School disclosed that some OVC experience psychosocial problems due to ill treatment from the people they were staying with, *'Ukagara nemunhu asiri kukubata zvakanaka unogona kunyora zvisizvo mumatests uchifunga vabereki.'* (If you are staying with someone who is not looking after you well, it may negatively affect performance in school, as your attention at school will be distracted.)

Dealing with emotional issues

A caregiver reported that emotional disturbances were evident in the children, especially after the first few days after their parents' death. The caregiver further stated that emotional issues were evoked when problems, such as going to school on an empty stomach and being sent out of school for failure to pay fees, happened: *'Mwana anoenda kuchikoro asina kudya anogona kufunga kuti vachasara iwo vachibika izvo chikafu chacho hapana.'* (An orphan may go to school without eating anything, thinking that she/he is being denied food, yet it will be an issue of the food not being there.) Another community member reported that police officers had been moving around the community teaching people about child abuse, but of late they were no longer doing this. An official in the Ministry of Youth Development and Employment Creation commented that there were no trained counsellors to provide counselling services to OVC and that this was compounded by lack of adequate resources. A senior remedial tutor in the Ministry of Education, Sports and Culture (MoESC) supported this view by further mentioning that very few caregivers had the skills to take good care of OVC; when caregivers thought they were counselling children, they in fact were possibly saying things that would make the children's depression worse. Even at schools, teachers were only trained in very basic counselling. A district social welfare officer in the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) expressed concern that most people and donors were eager to quickly assist OVC with material needs, whilst forgetting the emotional needs of OVC.

Housing conditions of OVC

Many interviewees were of the view that the housing conditions of most OVC were appalling, to say the least. In addition, some of the houses were small and overcrowded. Overcrowding was largely attributed to Operation *Murambatsvina*, where most wooden cabins were demolished during this government clean-up operation, especially in the urban setting. A community member gave an example of a family of five people who were sharing one room. In an adult female FGD at Nzeve Deaf Centre, a woman confessed that she was living with her children and grandchildren in a single room. She further said that 'some children are too old to sleep in the same room with adults'. A community member stated that there were some OVC who were crowded in one room and were letting out part of the house, so that they could get money to buy basic necessities. Another community member revealed that parents would sleep on the bed,

whilst children would sleep under the bed. An OVC gave an example of six children (four boys and two girls) who where sleeping in one room. There were also OVC who were of no fixed abode, who then resorted to roaming around the streets, which was reported by another community member and an officer in charge of the Victim Friendly Unit (VFU). Because of the poor housing conditions in towns, some OVC had relocated to stay with their grandparents in the rural areas. A small number of interviewees, however, indicated that there were some OVC, though few, who were living in houses that were in good condition.

The problem of housing was even worse for child-headed households, as reported by the senior remedial tutor in the Ministry of Education, who said that houses in the rural areas were mostly dilapidated and grass thatched. In the urban area, OVC were living in wooden or plastic shacks before the clean-up exercise. A manager for care and prevention at FACT mentioned that what makes the OVC housing situation even worse was the fact that most NGOs (except Red Cross), did not have a component addressing rehabilitation of houses.

OVC needs

Most interviewees reported that the major needs for OVC were food, money for school fees and stationery, medical care, clothing and accommodation. A caregiver who was looking after 11 orphans indicated that shelter was such a big problem that she had to close the veranda of her house, in order to create a room for the orphans to sleep in. She further said, *'Dai muchifamba nechirongwa chenyu huri husiku mainyatsoona kukura kwedambudziko racho. Vana vanorara vakatsvikinyidzana zvekuti vanorara vachitukana nokuti munhu anotadza kuchinja rutivi rwokurara narwo.'* (If your study was done during the night, you could have witnessed for yourselves how big this problem is. Children are very crowded, especially the sleeping arrangements at night.) The FGD for 16- to 18-year-olds at Munyoro Secondary School in Zimunya reported that OVC also needed soap for bathing and psychosocial support. A few OVC mentioned that they needed some chemicals to spray mosquitoes, especially during the rainy season.

Major threats to OVC quality of life

A community member pointed out that lack of care and love were major threats to the quality of life for OVC. In addition, lack of control was a problem among OVC, because they had no one to control their behaviour and give guidance on good norms and values. Some OVC exhibited criminal tendencies because of the way they were brought up, according the officer in charge of the VFU. Another community member cited rape of OVC by elderly people and being beaten in the streets, with no one around to show concern and care for them, as further threats to OVC. An education officer stated that OVC were stressed and psychologically depressed when they saw others at school with good clothes and eating good food, which tended to lower their self-esteem, confidence and performance in class and might also lead to isolation. This view was shared by the chairperson of a FACT HBC. The director of Nzeve Deaf Centre reported that there was a lack of employment and barriers in communication among deaf children when they were still young, and therefore they were not able to develop proper relationships. A Plan International HIV and AIDS coordinator reported that poverty could force OVC to engage in early sexual activity, thereby compromising their future and putting them at risk of HIV.

Loss of personal possessions

An OVC reported that sometimes clothes, utensils and property such as furniture, houses and even livestock, are taken by relatives. These problems were very common among paternal orphans. An FGD for 16- to 18-year-olds at Munyoro Secondary School in Zimunya revealed that property-grabbing was a big problem in their community. They indicated that this practice was worsening the plight of OVC. If the assets were taken away when the orphans were still young, it became difficult to reclaim the property when they were grown up. According to a 6- to 15-year-olds' mixed FGD at Chikanga Primary School, some relatives were taking in those children who were written as beneficiaries in their parent's will, not out of concern for the children, but for the sake of the money or property left to the OVC. According to an FGD at Nzeve Deaf Centre for adult females, there were also instances of orphans living in towns who had sold houses, to the detriment of other siblings.

Access to facilities

Education

A number of OVC were benefiting from the Basic Education Assistance Module (BEAM), as indicated by most informants. However, their concern was that because of the ever-increasing numbers of OVC, not all of them would be catered for, especially those at secondary-school level. The reason why some OVC were dropping out of school at primary level was because they were forced to look after their younger siblings. One OVC reported that apart from government, some NGOs and churches were also assisting OVC with education.

Health

The Mutare district nursing officer mentioned that OVC access to healthcare was limited, because some did not even have the bus fare to go for free treatment at hospitals or clinics. The officer in charge of the VFU also mentioned that those OVC who were on the registers of Family Support Trust had easier access to healthcare at public health centres.

Finance

A chairperson of a FACT HBC reported that OVC had no direct access to financial resources. There were concerns from OVC about people who were getting money on their behalf, but not passing it on to them. The director for Nzeve Deaf Centre reported that there were no financial resources available for deaf children in the district. An education officer further noted that financial resources were inadequate and did not only affect families with orphans, since most of the people were failing to afford basic necessities.

Social services

A chairperson of a FACT HBC stated that nothing was being done by individual community members to assist OVC. It was only caregivers who were occasionally assisting with mealie-meal, and pastors with clothing and food. A community member concurred by also pointing out that those OVC who were disabled were in an even worse predicament. An OVC said that neighbours would sometimes give them mealie-meal and that their maternal uncles would sometimes give them money to buy clothes. FGD 16- to 18-year-olds at Munyoro Secondary School in Zimunya stated that community members gave OVC casual jobs, such as herding cattle, weeding and fencing gardens, so that they could earn money to pay for school fees. They also stated that the community was not

doing much to help OVC. In another FGD for females at Nzeve Deaf Centre, they claimed that nothing material was coming from the community, other than advice and food from World Food Programme (WFP). A district nursing officer supported this by mentioning that as a community, people were not doing much to assist OVC, and that it was mainly donors who were assisting.

The director of Nzeve Deaf Centre reported that they had a basketball court where OVC engaged in sporting activities, although more sporting equipment was needed. The centre also provided a social club for OVC. A manager with FACT Mutare reported that Practical Solutions held sporting and psychosocial support galas for OVC.

Attitudes, stigma and discrimination

A caregiver highlighted that there were mixed attitudes in the community towards OVC. Some had positive attitudes towards OVC, while others looked down on them, saying, *'hamuna zvamunazvo'* (OVC do not have anything). A community member stated that the community was showing positive attitudes towards OVC and that there were no cases of discrimination. However, in contrast to this, an OVC reported that stigma against OVC did exist: *'Vanhu vanenge vachiti onai tubhutsu twake utwu.'* (People will be saying, 'just look at their torn shoes'.) The OVC further indicated that some people pretended to be good by visiting OVC, but really had the intention of finding out more information so that they could laugh at them or spread bad stories about their predicament. The chairperson of an HBC group stated that community members looked down on OVC mainly because they perceived OVC as very stubborn, because they lacked proper parental guidance. Some say that OVC did not respect elders within the community, so even if the community members had wanted to assist them, they ended up not doing so. However, as another community member reported, ill treatment of OVC by caregivers could be attributed to poverty. Another OVC said that some community members did not want their children to play with OVC. The child further revealed that some community members were even taking advantage of OVC by raping them, since the OVC did not have anyone to report the abuse to and were always accused of everything anyway, even if they were not the wrongdoers.

FGD 16- to 18-year-olds at Munyoro Secondary School in Zimunya reported that some caregivers were stigmatised for not giving proper care to the OVC. There were also some who were taking in OVC only so they could exploit them, by giving them too much work and less food. A female adult FGD at Nzeve Deaf Centre stated that some mothers who gave birth to disabled children were stigmatised, and that some people went so far as to say, *'Wakazvara sei chirema? Kukanganisa rudzi ikoko.'* (Why did you give birth to a disabled child? You have spoiled the genetic make-up of your family's future children.) The group further divulged that deaf children were being discriminated against, because the community perceived them as people who could not do anything in life. One of the girls in the FGD mixed group for 6- to 15-year-olds at Chikanga Primary School related how people in the community thought that they (herself and her sister) were prostitutes, just because they wore trousers and fashionable clothes. Children in the same FGD said that some community members tended to accuse OVC of theft and any other misdemeanours, even if they were not the perpetrators.

A senior remedial tutor in the Ministry of Education reported that their department conducted awareness campaigns in schools to reduce negative attitudes towards OVC. The tutor further mentioned that awareness of OVC was now high and attitudes more positive,

unlike in the past when the OVC problem was not so common. This was also reiterated by the FACT-Mutare programme's manager of care and prevention, as well as by the district social welfare officer in the MoPSLSW. The officer in charge of the VFU suggested that certain community members were willing to assist OVC, although economic hardships were crippling such efforts to help. Plan International's HIV and AIDS coordinator reported that there was passive stigmatisation, such as people saying, *'nherera dziri kubatsirwa nePlan'* (orphans are being assisted by Plan International). He also held the view that most community members were in fact willing to help OVC, but that the prevailing harsh socio-economic environment was posing a great challenge. The programme manager of Simukai Child Protection Programme reported that attitudes in the community were sympathetic but not empathetic, since they did not have the resources to support OVC. The outreach and training officer for Family Support Trust observed that OVC were stigmatised, particularly the orphans – people were seeing an orphan first, before seeing a child. The OVC made mistakes just like any other children, but people would start saying, *'nherera dzinonetsa kuchengeta'* (orphans are difficult to take care of).

Challenges and complications

Caregivers in an adult female FGD indicated that they felt psychologically relieved whenever they went to Nzeve Deaf Centre to share experiences about the OVC they were caring for. A senior remedial tutor in the Ministry of Education stated that OVC lacked access to education and healthcare (health personnel rarely looked at the referral letters for free treatment and so OVC were forced to pay) and were also subjected to many kinds of abuse, such as sexual abuse, child labour and neglect.

The majority of the OVC caregivers saw poverty, shelter and food as the main challenges they were facing and that support from relatives was not regular, with some giving only once in a year. A community member indicated that corruption was the main problem, because not all that was meant for OVC was getting to them. An adult female FGD at Nzeve also confirmed this by saying, *'Huori huri kukura, nherera dziri kupotswa nerubatsiro rwacho.'* (Corruption is becoming a big problem and orphans are left out of the beneficiaries' lists.) At times, councillors demanded money for items like fertilisers that were meant to be free, indicating that it was just a loan. A caregiver explained that if they tried to start any income generating projects (IGPs), the police always gave them trouble: *'Ukangoisa kamusika kako mapurisa anobva akusunga.'* (If you put up a vending stall, the police will arrest you.) The FGD for 16- to 18-year-olds at Munyoro Secondary School in Zimunya mentioned the shortage of food for OVC as the main challenge and also that the grandparents might be too old to work for the OVC. An adult female FGD at Nzeve further pointed out that people had reservations about the *Zunderamambo*. They argued that chiefs were getting inputs like seed, but they had never witnessed an occasion where the proceeds from the *Zunderamambo* initiative were distributed to OVC. An official from the Ministry of Youth Development and Employment Creation highlighted that those who were providing care and support to OVC were not getting anything in return; therefore, it was purely voluntary work and as such, their commitment was sometimes questionable. The senior remedial tutor in the Ministry of Education felt that economic hardships forced communities to shun OVC, because they did not have anything to give them.

An education officer in the Ministry of Education stated that communities did not have financial resources to provide basics (shelter, education, health and care). A district social welfare officer in the Ministry of Social Welfare also suggested that one of the challenges was that OVC were being taken care of by elderly people: 'Providing a pen to a child

being taken care of by an old woman is a challenge, even if school fees are being paid for by BEAM.' As for the police, their main challenge was that some cases were reported too late and therefore it would be difficult to gather evidence to prosecute the perpetrators and the damage would already have been done. The director of Nzeve Deaf Centre explained that if a deaf person had to go to hospital, then they needed an interpreter. Meeting the psychosocial and emotional needs of OVC was another major challenge, according to reports from the Plan International HIV and AIDS coordinator. He further mentioned that when some parents died, they would not have made any succession plans for the children, thereby making them even more vulnerable to relatives grabbing all the property left behind. Furthermore, the support structures were collapsing at a time when the number of OVC was increasing.

A manager with FACT-Mutare reported that selection of beneficiaries and motivation for volunteers were the other challenges, as the caregivers were not paid and had to balance supporting OVC with fending for themselves. The other challenge she highlighted was the mobility of beneficiaries (displacement) who may have moved to faraway places where they would not be able to continue with their education.

Suggestions on how to help OVC

A community member suggested that the government and NGOs should assist OVC carers and OVC themselves by imparting life survival skills, such as IGPs, as most of them were able-bodied people. This would help to reduce the criminal activities associated with OVC. One caregiver suggested that caregivers should work to reduce stigma and discrimination between OVC and non-OVC, and stressed that they should be impartial when solving problems between children, because this would have psychosocial implications for the children, who might otherwise feel that they were being unfairly treated. Another caregiver also stated that government should provide food handouts in the towns, as they did in the rural areas: *'Mutaundi munewo vari kutambudzika hatina rubatsiro rwatiri kuwana.'* (In towns, there are also vulnerable people who need assistance.) Giving food handouts only to the rural community was felt to be discriminatory.

A community member suggested that community organisations that were involved in the selection of beneficiaries and the distribution of support materials should be transparently constituted by honest, trustworthy people with integrity, so that diversion of resources to unintended uses or beneficiaries could be reduced. Another community member felt that children should be consulted about who they would want to stay with if they ever had to leave their deceased parents' home. The other suggestion was that organisations and companies should be encouraged to give employment preference to OVC, as long as they had the relevant qualifications. An OVC indicated that people should be educated not to stigmatise or discriminate against OVC, as this caused further emotional stress. A district social welfare officer suggested that they needed to compile a complete OVC database in the district that would profile the magnitude of OVC numbers, where they were living and their needs. He further mentioned that, other than material things, communities should also give love and affection to OVC.

Family members of OVC should be at the forefront of assisting them and non-relatives should also complement these efforts by fostering children, as suggested by the district nursing officer. The director of Nzeve Deaf Centre held the view that in terms of government assistance, for instance, payment of school fees and medical fees, priority should be given to children with disabilities. She also believed that, for deaf children,

NGOs, CBOs and FBOs needed to have poster campaigns to increase awareness, as well to conduct sign language workshops in communities and to develop sign language materials. An HIV and AIDS coordinator with Plan International reported that NGOs and government should deliberately aim to strengthen local structures around the child by capacitating the local childcare centres, pre-schools, schools and health centres, if OVC programmes were to be sustainable.

The programme manager of care and prevention with FACT suggested that the government should play a facilitating role in ensuring that services offered to OVC were not duplicated and concentrated in only a few areas. She also highlighted the following needs: that NGOs, CBOs and FBOs should do needs assessments and prioritise the most deserving needs, as well as doing more towards skills development; that communities should be involved at every stage of programme development, have their own structures and that their participation should not be passive; and that FBOs should help OVC spiritually.

The Ministry of Youth Development and Employment Creation emphasised that there should be special clauses in the country's legislation that protect the rights of children; for instance, a clause was needed to deal with diversion of resources, intended to benefit OVC, by caregivers or organisations that assist OVC to other unintended users. In addition, there was also the need for legislation that protects family assets from being taken away from children who are under age.

The director of Nzeve Deaf Centre called for government to remove duty on assistive devices for disabled people. A district social welfare officer further emphasised the need to capacitate communities through skills training, so that they could engage in IGPs.

Care and support structures for OVC

NGOs**,** FBOs, government, churches, community members and relatives were all playing different roles in assisting OVC. The assistance was mainly coming in the form of food, clothing, school fees, and emotional and psychosocial support. The OVC themselves sometimes resorted to doing casual work. A community support group, Batsirai Varombo, would source food (mealie-meal and cooking oil), blankets and clothes from retail wholesalers like Bhadella, to help OVC. One OVC insisted that most caregivers were not taking good care of OVC under their care, and other OVC reported that they were emotionally stressed by their caregivers. The director of Nzeve Deaf Centre indicated that Hilltop FBO had developed a specific outreach programme for deaf children. The centre was also receiving financial assistance for school fees from Lilliana Funds (Netherlands) and Catholic Relief Services (CRS). Provision of school fees was quite effective, because children who would have dropped out of school would continue going to school. Quite a number of OVC had also finished their secondary education (Form 4). Some churches had committees that were working with community members in identifying the most deserving OVC. In their selection criteria, they looked at the family's inability to buy food, to pay for school fees, to provide good shelter, dependence burden and family sources of income. For instance, Methodist Hilltop had a comprehensive programme, because they were paying for school fees as well as buying uniforms and groceries for those at boarding schools. While government was providing educational assistance through BEAM, the only problem was the late disbursement of the funds.

A caregiver stated that Simukai had a feeding programme for children in schools and there was an improvement in the health of the children. A considerable number of OVC were being taken in by uncles and aunts, as reported by the 16- to 18-year-olds' FGD at Munyoro Secondary School in Zimunya. They further mentioned that some FBOs do take OVC for counselling. They felt that counselling sessions were very important as a deterrent for children who may have suicidal tendencies or those who may be thinking of going to the streets. The same FBOs were also taking OVC to bible schools and assisting in the reunion of divorced parents, in order to reduce the number of vulnerable children. Children's homes were also playing a major role in removing OVC from the streets, as indicated by the 6- to 15-year-olds' mixed FGD at Chikanga Primary School.

The Zimbabwe Parents of Handicapped Children Association carried out home visits for disabled children and that intervention was certainly desirable, as it reduced stigmatisation and discrimination. The director of Nzeve Deaf Centre reported that children had learned to develop their communication skills and create relationships; the centre had successfully lobbied government to provide facilities for the education of the deaf in schools and had also established a social club for the benefit of the deaf children.

The programme manager for care and prevention at FACT reported that the effectiveness of programmes might be hampered by lack of transparency in the selection of beneficiaries. With regard to indicators of success, she highlighted that there was an increase in the number of children who had been enrolled and retained in schools, and the number of school dropouts was decreasing. On the requirement for the programmes to work effectively, she emphasised that there was need for consistent funding and active participation of the communities. The programme manager at Simukai Child Protection Programme reported that they had rehabilitated 509 street children and sent them back home as of December 2005; 150 were sent to school and 24 for vocational training, all of which was an indication of some of their successes.

Policy and legislation for the protection of OVC

Knowledge of law

Informants from various government departments and the NGO fraternity were more knowledgeable about laws and policies that protect children than were ordinary community members and the OVC themselves. Laws protecting children that were commonly cited by most interviewees were: Children's Act (Chapter 5:06 of 14/2002), Sexual Offences Act (Chapter 9:21 of 22/2001), Education Act (Chapter 25:04) and Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996), with the least mentioned being the Guardianship of Minors Act (Chapter 5:08 of 2002), Labour Act (Chapter 28:01 of 17/2002) and Maintenance Act (Chapter 5:09 of 22/2001). The general feeling was that more needs to be done in terms of sensitising the communities about the existence of these laws, so that they would not continue to deny or violate them, to the detriment of the OVC. The mixed 16- to 18-year-olds' FGD at Munyoro Secondary School in Zimunya stated that children should not be beaten, verbally abused, deprived of food, chased away from home, exploited for their labour or denied access to education; they should not to be forced into early marriages and should be allowed to inherit the estates of their parents. The director of Nzeve Deaf Centre reported that deaf children were not enjoying full rights, such as the right to education, because of the lack of infrastructural support.

Implementation and support

A community member stated that attitudes towards such regulations were positive, but noted that the circumstances in which the children were growing up might be inhibiting; for instance, sexually abused children felt that if they were to report the cases, then they would have no shelter, food, education and so on, especially if they were under the custody of their abusers. The other challenge was the implementation of these policies, as there were no resources to carry out awareness campaigns. With regard to enforcement of the legislation, an HBC member stated that some cases of sexual abuse were reported too late and some were taking too long to be finalised at courts.

Another community member stated that the police were trying very hard to enforce these regulations whenever violations were brought to their attention. A district social welfare officer stated that Zimbabwe had the best policies and legislation to protect children, but the weakness lay in implementation strategies. Of concern was the flagrant violation of the Labour Act (Chapter 28:01 of 17/2002), where children were being subjected to child labour; however, the irony was that the majority of the children were not reporting such cases, according to the officer in charge of the VFU. Most girl children were employed as domestic workers and some were even used to carry smuggled goods overnight into Mozambique, selling freezits in the streets, just to mention but a few of such violations.

HIV and AIDS

Awareness of HIV and AIDS

Across the whole spectrum of interviewees, the response was the same, that people were fully aware of HIV and AIDS. The high level of awareness was manifested through high usage of condoms, significant behaviour change, especially among the youth, as well as relatives who were now sympathetic and were buying drugs for people living with HIV and AIDS (PLWHA). The situation, however, was not the same for older age groups, who were reported by many to be too impulsive and rash when it came to behaviour change. Children were being taught in schools about health education, which also covered HIV and AIDS issues. The director of Nzeve Deaf Centre reported that awareness among the deaf was very poor, as the commonly used mechanisms for transmitting HIV and AIDS information were not at all user-friendly for them. The programme manager of care and prevention at FACT-Mutare stated that while awareness was high, behaviour change was lagging behind. Another problem she mentioned was that of lack of proper knowledge, as some people still had misconceptions such as the belief that one can be cured of the virus if he had sex with a young child: *'Kana ukavata nemwana mudiki AIDS inopera.'* (If you have sexual intercourse with a child, you will have cured AIDS.)

Magnitude of HIV and AIDS

Most people interviewed were not in a position to give accurate statistics about the number of people living with or who had died of HIV and AIDS. However, there was consensus that the disease was a major problem, judging by the number of HBCs and the rate at which people were dying in the community. An OVC estimated the number of infected people with HIV to be around 12%. The magnitude of the problem was also evidenced by the ever-increasing numbers of OVC who were left behind. Plan International's HIV and AIDS coordinator reported that, in some cases, one third or half of the children in the schools were orphans. In contradiction to this, the Mutare district nursing officer reported that the number of new HIV infections was actually on a decline.

The director of Nzeve Deaf Centre reported isolated cases of deaf children who were dying of HIV-related illnesses.

Impact on community resources

A community member stated that most of the family income was being spent on trying to get treatment for PLWHA. An FGD at Nzeve for adult females revealed that HIV was killing a lot of young people and at times most resources were exhausted while trying to access medication; in the end, the children were left with nothing for their survival. An officer in the Ministry of Youth Development and Employment Creation believed that time and energy spent in taking care of OVC could have been spent in doing productive agricultural work in the fields, or elsewhere. A district social welfare officer stated that the productive capacity of households was compromised, in the sense that elderly people were left to fend for the OVC. Plan International's HIV and AIDS coordinator reported that safety nets were overwhelmed as a result of the disease. The programme manager of care and prevention at FACT indicated that the disease was impacting badly on communities, because treatment, drugs and food were very expensive, leading to a drain on the meagre resources available.

Impact on social functioning of community

An OVC stated that some breadwinners were dying and thus creating poverty and economic strain in the affected families. Another OVC revealed that some people would say they were bewitched when they fell sick. The OVC also stated that the virus could be passed from husband to wife, or vice versa, thus crippling the productive capacity of the family. A community member stated that people were now changing their behaviour for fear of being infected, *'Zveubenzi zvadzikira*' (promiscuous behaviour has gone down). A caregiver emphasised that HIV was resulting in the increasing number of orphans and poverty in the community. She further said that it was also causing some children to resort to prostitution, especially in cases where there was no caregiver; HIV was also causing a strain on extended families, thus resulting in family conflicts. The director of Nzeve Deaf Centre reported that the social functioning of the community was stretched if a child was deaf and the parents died; the extended family then would have problems communicating with the child.

Suggestions on how to limit the spread of HIV and AIDS

Behaviour change was cited by many as the most effective vehicle for limiting the spread of HIV and AIDS. Of great concern was the fact that whilst people were being given the knowledge on transmission and prevention of the disease, they were not changing their sexual behaviour. Below are some of the suggestions which were proffered by the varied respondents on how to limit the spread of HIV and AIDS:

- The need for continuous communication about HIV and AIDS issues within the household.
- People should not live in overcrowded places.
- Virginity testing as a practice to ascertain girls' sexual purity should be encouraged and hence discourage engaging in sexual activities before marriage.
- People should be tested for HIV before they get married.
- People should be taught to correctly and consistently use condoms.
- Women should be encouraged to dress properly, so that they would not attract 'sugar daddies'.
- Married people should be faithful and desist from promiscuous sexual activity with others.

- People should not use the same razor blades or needles.
- The need for more education and more economic support, particularly for women, as they are more vulnerable to promiscuity and risky behaviour; that is, promote economic empowerment of women, so that they are economically independent.
- There should be more educational campaigns about the disease on the television and radio.
- The need to have peer educators to teach people in beer halls and schools.
- Information on HIV and AIDS should also be available in the vernacular languages and sign language for deaf children.
- Scaling up of sexual behaviour-change programmes.
- People should be discouraged from *kugara nhaka* (inheriting their relatives' wives or husbands).
- Prevention models (voluntary counselling and testing [VCT], antiretrovirals [ARVs] and prevention of mother to child transmission [PMTCT]) should be scaled up and must be decentralised, so that the majority of the people, even those in rural areas, can also have access to them.
- Reproductive health education must be promoted among the youth and treatment literacy given priority.

Health services infrastructure

Staff
Most interviewees reported that most clinics were understaffed. This increased their work load, thereby compromising on the delivery of good service. Many people visited these clinics and at times were referred to general hospitals.

Equipment
The equipment was old.

Drugs
There were no adequate stocks of drugs at most clinics, according to one community member. She further stated, *'Varwere vanongonzi idyai michero/mafruits.'* (Patients are sometimes told to go and eat fruits.)

Care and treatment of PLWHA

Services available

The majority of community members and OVC mentioned that whilst HBC and VCT services were available, this was not the case with provision of ARVs. A community member stated that those PLWHA who registered with DAAC were receiving assistance, though the supplies were sometimes erratic. For someone to receive the DAAC assistance, one had to go for HIV tests and be positive. The HBC chairperson stated that the impact of the services was positive and it had changed the livelihoods of affected people in the community; for example, living positively and knowing what to eat and the types of drugs appropriate for them. She further said that the community had accepted the work of the HBC and encouraged them to continue with their good work. HBC mainly bathed PLWHA and provided emotional support. The main concern was about ARVs, which were reported to be very expensive and, at the same time, were not readily available. A community member indicated that HBCs were helpful, as people were very happy about the services they were offering. Furthermore, she pointed out that those who were no longer able to walk or work on their own were given priority. A caregiver stated that PLWHA were

sometimes a problem, as they demanded good food, which might be beyond the means of their carers. She went on to mention that in situations like these, HBC usually came in to help with counselling.

The Mutare district nursing officer reported that ARVs were available at the provincial hospital and some people were travelling as far as Chipinge to get them. There were no drugs for sexually transmitted infections (STIs) such as gonorrhoea and people were told to buy their own drugs at pharmacies. She further stated that, unlike PMTCT, VCT units were more concentrated in towns and so there was a great need for such services to be decentralised to rural areas. She also emphasised that the main problem was that when cases of HIV/AIDS were first reported, the disease was associated with promiscuous people and as result there was still an element of stigmatisation of those infected and affected.

Plan International's HIV and AIDS coordinator reported that VCT, ARVs and PMTCT were available, but that the government was not well resourced to continue funding them. The programme manager of Simukai Child Protection Programme reported that some people had access to spiritual care, as pastors were doing home visits, but that kits for HBC were in short supply.

Impact of services

A caregiver reported that sick people who were accessing ARVs were improving in their general health. An OVC also reported that HBC had a very positive impact, because people were taught how to look after themselves well and were given food. The director of Nzeve Deaf Centre reported that counselling at VCT centres was of a high quality and people were responding by going to the centres, as they knew they would get treatment and assistance.

Views on access and availability of ARVs and VCT

A caregiver stated that there was a need to scale up treatment, especially ARVs, and also to assist the infected with good nutritional foods and counselling, so that they could live longer. She further stressed that the Ministry of Health should embark on nutritional counselling. Another caregiver reported that there were no ARVs in their community; she indicated that people were just tested for HIV and no further assistance was offered: *'Vanhu vanotozozvionera.'* (People have to buy their own medicine after being tested.)

Respondents were also asked about their views on the issue of knowing one's HIV status and openness about it. Below were some of the advantages and disadvantages which were given:

Advantages

- Knowing how to take care of oneself (what to eat, type of job one can do, etc.).
- Can access treatment and also teach other people about the disease.
- Can avoid spreading the virus to others.
- Can get help early, before it is too late.
- Can get the proper advice on how to live a longer life.
- Can assist others to change their behaviour by being a living example.
- Can make future plans for children and spouse, if one has a family.

Disadvantages

- Can be psychologically stressed, because people may stigmatise you (pointing fingers or laughing at you).
- May spread the virus to others if one does not disclose one's status.
- Can develop suicidal tendencies.
- Can deliberately and knowingly spread the disease to other people.
- It brings anxiety and fear unless one receives adequate counselling and one may lose hope and feel destroyed.
- It may be traumatising for children if parents do not disclose and they hear it from elsewhere.
- May be discriminated against at work or denied promotions, if people disclose their status.

Major sources of information on HIV/AIDS

Sources of information

The major sources of information on HIV and AIDS commonly cited by community and caregivers were through the print and electronic media (radios, television and newspapers) as well as HBC. However, most OVC indicated that schools were also playing a significant role in disseminating HIV and AIDS information. Clinics were also distributing booklets, but these could only be obtained if one visited the clinics. In addition, HIV and AIDS issues were being discussed at community meetings. The director of Nzeve Deaf Centre reported that there was a low literacy rate among deaf people and so print material was not very effective and that most rather learned through clubs for the deaf or friends, using appropriate communication means, such as drama. In the remote areas, the main sources of information were NGOs and CBOs, as reported by an official in the Ministry of Social Welfare. Peer education, especially among school-going children, was another cited source.

Improving provision of information

The informants gave suggestions on how the provision of HIV and AIDS information could be improved, some of which are listed below:

- Peer educators and NGOs should travel around communities teaching about the disease through drama and workshops, because pamphlets were not so effective when people often do not read them.
- Information about the virus should be continually repeated at any forum where people gather.
- Those who have the virus should be open and testify to other people.
- HBC people should be given badges for easy identification by those who may want assistance from them.
- Books on HIV and AIDS and pamphlets should be written in the vernacular and should be distributed at churches and community gatherings.
- More time should be allocated on television for health educational programmes and the screening of the programmes should be timed so that they catch a wide audience.
- Scaling up of awareness campaign programmes and targeting children at an early age.
- Information, education and communication (IEC) materials needed to be continuously improved and updated.

- Children should be involved in the development of IEC materials; discussion forums for children needed to be established and existing systems needed to be strengthened.

Risks of HIV/AIDS as a result of violence

Child abuse

An OVC reported that there were too many cases of child sexual abuse in their community and the main perpetrators were relatives, community members/neighbours and sometimes even fathers or stepfathers. The targeted victims were children aged 5 to 18 years old, especially disabled children. The worrying thing was that most of the cases of abuse go unreported. The same OVC further stated that some pay bribes to police, so that the perpetrators are not prosecuted. In some cases, sexually abused children were paid in the form of mealie-meal and other food stuffs. Some of the abused children were given assistance at clinics and hospitals, as well as at the police VFU.

Shortage of accommodation was also exacerbating the cases of abuse; for instance, a family might be staying in one room partitioned only by curtains. The father might be staying with the children in town alone, whilst the mother was staying in the rural areas. There were also cases where teachers were reported as perpetrators.

Profile of government departments

Ministry of Health and Child Welfare

Scope of activities and coverage
The ministry identifies OVC in need of support and then refers them to organisations that can help them, such as the Department of Social Welfare. Village health workers also assist in the identification of OVC who need assistance.

Challenges
The ministry indicated that they were short-staffed and they also needed more resources. Their coverage of the distribution of ARVs was limited, as they only covered a radius of about 40km from Mutare General Hospital.

Home-based care

Scope of activities and coverage
Depending on availability of funds, HBC assists OVC with food, school fees and uniforms. Every Thursday, they use drama, marimba, singing and poems to unite OVC. Their target group is children aged below 14 years old. The HBC is assisting about 60 OVC from Sakubva community.

Challenges
HBC reported that they needed accommodation where they could house those OVC who had no one to care for them.

Ministry of Education, Sports and Culture (School Psychological Services)

Scope of activities and coverage
The ministry is providing educational assistance to children through BEAM. This facility started in 2000. There is an allocation for each school. The beneficiaries are selected

through committees comprised of school authorities and the local community leadership. BEAM caters for both primary and secondary school children. The names of selected beneficiaries are then submitted to the Ministry of Labour. The ministry reported that they were covering about 65% to 70% of the children under BEAM. There is also the School Psychological Services Department, which offers counselling services and OVC placement. The counsellors move around wards teaching people to display positive attitudes towards OVC.

Challenges
BEAM is only providing school fees for OVC and not funds for stationery. Some children are being left out because of budget limitations. The names of beneficiaries are submitted at the beginning of the year and those who are orphaned during the course of the year are left out. They also indicated that some selection committees have their own interests and therefore deserving beneficiaries may end up being left out.

The Department of School Psychological Services does not have vehicles to carry out outreach programmes. Furthermore, the department does not have enough funds to buy items such as hearing aids to help some of the children they deal with.

Ministry of Agriculture (Agricultural Research and Extension)

Scope of activities and coverage
The ministry distributes seed packs from government and donors to communities. They obtain seed from donors and government to distribute to communities. The ministry also offers technical knowledge on better farming methods. Furthermore, they encourage communities to engage in gardening. They are covering the whole district.

Challenges
Transport problems were hindering some progress, as some of their officers had to travel more than 40km on bicycles. The department was also short-staffed, with a complement of 78 instead of 120 staff members.

Plans to assist OVC
The ministry wishes to facilitate the construction of irrigation canals and promote production to improve OVC standards of living. They also plan to work with different donors to improve the production of the amaranth grain (similar to rapoko), which has medicinal value.

Ministry of Public Service, Labour and Social Welfare

Scope of activities and coverage
The ministry is responsible for identifying OVC in need of assistance and then referring them to relevant government departments, where they can be assisted; for instance, BEAM, which is part of the Ministry of Education. They are covering the whole district.

Challenges
The ministry also cited transport and fuel problems. They have staff shortages, especially at ward level.

Ministry of Youth Development and Employment Creation

Scope of activities and coverage
The ministry conducts periodic meetings under the child welfare forum, where OVC are identified through ward development committees, and then formulate interventions to help OVC; for example, recommending donors to help with food and school fees. They also work in liaison with other structures such as DAAC and WAAC. They were training youths in the following areas: agriculture, building, metal fabrication, cooking food, motor mechanics, secretarial skills, carpentry, garment-making and clothing textiles.

Challenges
The ministry does not have vehicles to enable their staff to move around the district to monitor various projects they are involved in.

Profile of non-governmental organisations

FACT-Mutare

Scope of activities and coverage
This organisation is a grant-maker; that is, it provides funding to implementing partners. Its other activities include: monitoring and evaluation, capacity-building of projects and fund raising for their implementing partners. They get feedback from their partners, so that they are able to improve and strengthen operations. Their partners submit quarterly financial and narrative reports and an annual report at the end of the year.

Simukai

The organisation was formed in February 2000 as a response to the problem of children living in the streets. At its formation, the organisation's name was Simukai Street Youth Programme, but was later changed to Simukai as a way of avoiding stigmatisation of children who live on the streets.

Scope of activities and coverage
The organisation reunites children with their families and places abandoned and abused children in 'safe homes or places'. They liaise with other organisations in the rehabilitation and reunification of these children with their families. The objectives of Simukai are:
- To lift OVC out of their undesirable conditions.
- To develop OVC, so that they can realise their full potential.
- To assist OVC, so that they become productive members of the society.

Simukai's strategy of tackling the problem of street children is on three levels:
- Assisting the rehabilitation of street children.
- Working with the children's families.
- Working with the community to address issues regarding childcare and protection.

Simukai has the following functional departments:

Family Department
This department's responsibilities are, among other things, to reunite children with their families and to ensure a safe shelter is found for children; to provide psychosocial support and recreational and sporting activities. At its inception, the department had registered the following statistics: 615 children have visited Simukai; 515 children (408 boys and 107

girls) have been repatriated. Out of the 515 who were initially repatriated, 63 of them went back to the streets. Simukai has managed to institutionalise 14 children.

Education Department
This department caters for educational needs of former street children, facilitates their placements in formal schools, and carries out livelihood projects with parents. It has managed to provide education assistance to 126 children. It has a feeding scheme in Sakubva Township, with an average of 35 children being fed per day. Twenty-six children have been supported with food, stationery and clothing. To date, the department has held 15 parenting skill seminars, 6 reproductive health motherhood workshops for young mothers, and 10 HIV/AIDS workshops with parents and children. The department has also enrolled 67 children in schools.

Prevention and Advocacy Department
This department's main responsibility is to sensitise the community on all forms of child abuse and their consequences. The department has dealt with 84 cases of children in difficult circumstances. Of the 84 cases, 34 were sexually abused, 40 were neglect cases and 10 were cases of physical abuse.

Nzeve Deaf Centre

Scope of activities and coverage
The organisation started as a pre-school for deaf children and has since grown to include the mothers of these children. The mothers come once a week to learn sign language and other issues relating to deaf children. They have IGPs for the deaf, including envelope-making, T-shirt dying and growing mushrooms. Their main targets are children below the age of seven, but they also have older children who are slow learners. They also conduct health education sessions with 150 schools in the district. In addition, they have 25 pre-scholars and 10 children with multiple disabilities.

Challenges
Some of the challenges being faced by the organisation are as follows:
- Lack of long-term funding.
- Shortage of staff for them to be able to run outreach programmes.
- Shortage of hearing aids for children to take home.
- Lack of a reliable school vehicle.
- Shortage of classrooms for the deaf, because boarding schools were now very expensive.

Family Support Trust

Scope of activities and coverage
The organisation deals with sexually abused children and works with the Department of Social Welfare. They refer all their clients (abused children) to the appropriate authorities, such as social welfare. The organisation is working closely with the VFU and also plays a part in the examination of abused children and all the court procedures. They keep an OVC register in which they have recorded their problems and needs. The trust also works in liaison with the registry department in assisting those OVC without national identity cards. In addition, the trust teaches community leaders (chiefs and district administrator) about child abuse, so that they can in turn spread the message.

The organisation provides group therapy services for abused children and helps abused children to live a normal life like everyone else; that is, helping them move from victim to survivor. They have workshops at schools where they teach children about sexual abuse. They were also planning outreach programmes, which would include OVC and survivors. In 2003, the trust gave out nutrition packs (matemba, cooking oil, mealie-meal and porridge) once a month to poor children. The trust also campaigns against forced early marriages, especially those among the apostolic sect.

Challenges

Some of the challenges being faced by the Family Support Trust are:

- Inadequate funding (to pay for school fees, medication for infected children, and to scale up their activities into new areas).
- Lack of adequate shelter for abused children.
- Lack of transport for them to follow up children living far away from the centre.

Plan International

Scope of activities and coverage

The organisation's first operation in Zimbabwe was in 1986 and currently it is operating in the following districts: Mutare, Mutasa, Kwekwe, Bulawayo, Chiredzi/Mwenezi, Chipinge, Epworth and Mutoko. Child sponsorship is the basic foundation of the organisation. All the organisation's programmes are designed to empower communities and support their development initiatives in a sustainable way. In all interventions, Plan International promotes the active participation of children and the communities for sustainability. Plan's vision is of a world in which all children realise their full potential in societies that respect people's rights and dignity.

The organisation works with children, their families and communities in the following focus areas:

- child survival;
- immunisation and nutrition;
- education for children and adults;
- good living environment for children;
- income-generating activities and food security at community level;
- building relationships.

Plan International is also assisting communities by building classroom blocks, sinking wells, drilling boreholes, water and sanitation programmes like malaria control, and HIV prevention programmes such as PMTCT. They also have child sponsorship programmes whereby they help OVC from different backgrounds. Furthermore, they have youth development programmes that offer vocational skills training. Plan International's HIV and AIDS programmes look at succession planning, memory books for children to retain their identity, and peer education.

Conclusions

The greatest challenge being faced by the district is the ever-increasing number of OVC against a backdrop of static or dwindling budgets for most intervention agencies. HIV and AIDS have been cited as largely contributing to this problem. The burden of caring for these OVC is becoming unbearable, even more so when one looks at the obtaining economic conditions, where prices of basic commodities are beyond the reach of the

general population. Furthermore, another worrying development is the fact that it is the elderly grandmothers and aunts who are being burdened with having to care for the OVC. Top of the list of OVC needs are food and money for school fees and uniforms. The educational assistance from government, through BEAM, is inadequate and it often comes late. Whilst a lot is being done by government departments and non-governmental organisations, as well as the communities themselves, the problem seems far from being solved.

As Mutare District is an urban area, a number of households were affected by the Clean-up Operation in May/June 2005, and this has consequently led to accommodation problems. This problem has resulted in overcrowding, forcing some families to share single rooms. This kind of environment is not conducive to the good upbringing of children. Some OVC have been sexually abused, although the majority of such cases go unreported for fear of reprisals against the victims.

The other challenge is that there is no coordinated approach amongst all the players assisting OVC. There are arguments that because of the lack of an audit of who is doing what and for whom, there are chances of some OVC 'double dipping'. This is a situation where some OVC are benefiting from more than one organisation, at the expense of other deserving OVC.

Most urban dwellers are aware of children's rights and laws that are meant to protect them. However, the challenge remains in the implementation of these laws. More needs to be done for people to translate their knowledge of these rights and laws into action for the benefit of the OVC. Cases of child labour are rampant. Girl children are more vulnerable, as they are sometimes forced into early marriages or prostitution. Much needs to be done by all stakeholders in terms of life-skills training, if these children are to be spared from some of the abuse.

HBCs are doing a sterling job in caring for PLWHA under difficult circumstances. They bath and provide emotional support to PLWHA. Their major concern for PLWHA is the unavailability of drugs at most hospitals and clinics, especially ARVs. This is an area which needs urgent attention from both government and intervention agencies. Whilst the high levels of awareness of HIV and AIDS are quite commendable, a lot is left to be desired when it comes to behaviour change. People do continue to behave recklessly. This calls for more vigorous and concerted educational campaigns, focusing primarily on behaviour change. HIV and AIDS has caused a lot of strain on both state and community resources, not to mention social costs, which are difficult to quantify.

Openness about one's HIV status is still a sensitive issue. Few people are at liberty to openly talk about their status. Some of the advantages which were mentioned for being open were that you may be assisted; you may make future plans for the family, in the case of those who are married; as well as avoiding spreading the disease to others. The fear of being discriminated against or stigmatised, developing suicidal tendencies, or just being reckless with one's life, are some of the problems which were cited regarding being open about one's HIV status.

Print and electronic media are playing a very critical role in the dissemination of HIV and AIDS information. Peer education and teachers are the main sources of information for school-going children.

Priorities for action

First and foremost, the district should have a centralised database for OVC, which should be continuously updated. In addition, a proper needs assessment should be conducted, as this would help for planning purposes. Cases of 'double-dipping' would be minimised or eliminated, and hopefully more OVC would be assisted.

There is a need for transparency in the selection of beneficiaries. The selection committees should be as broad-based as possible in terms of their membership. If the systems are transparent, it will instil donors with confidence so that they will not tire in their efforts to alleviate the suffering of OVC.

Emotional stress is a major issue amongst most OVC and therefore resources should be mobilised to train counsellors for OVC. Intervention agencies should not just concentrate on material needs but also on psychological needs. Relatives should desist from the practice of dispossessing OVC of property left behind by their deceased parents, since this is exacerbating their plight. Discrimination against and stigmatisation of OVC should be discouraged at every opportunity, be it at school or in the localities. More campaigns are needed in this regard.

Campaigns should be intensified throughout the various community structures for abused children to be able to report such cases to the police or elders in their vicinity. The fact that only a handful of the cases are reported is no indication that there are no children who are being abused.

Emphasis should be on imparting life skills to those OVC who are out of school, which will help in keeping them from indulging in criminal activities and other forms of misbehaviour. The perpetrators of abuse should face the full wrath of the law, for instance, those who infect children with HIV.

There should be more VCT centres for those people who may want to know their HIV status. Financial resources should be mobilised to procure ARVs for PLWHA. In addition, the drugs should be given at subsidised prices for those people who cannot afford them.

CHAPTER 8

Chimanimani District

Pakuromunhu F Mupambireyi, Shungu Munyati, Brian Chandiwana and Stephen S Buzuzi

Background

Description of study area

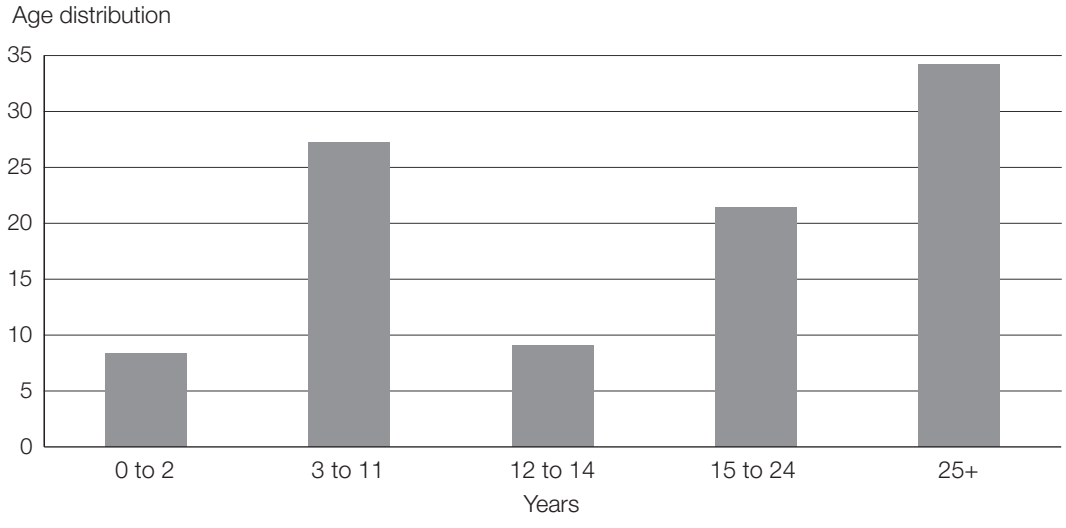
Chimanimani District is in Manicaland Province of Zimbabwe. It is one of the districts that cover the Eastern Highlands. The district, which is predominantly rural, is 155km south-east of the provincial capital Mutare and borders Mozambique to the east, Buhera District to the west, Chipinge District to the south and Mutare District to the north. The district covers 3 450.14km^2 (Davids et al. 2006).

All five agro-ecological zones in Zimbabwe are found in the district. Natural Region I covers approximately 1 875.47km^2, while close to a fifth of the district is covered by the arid Region V. The high and rugged terrain in the eastern side at 6 000m above sea level precipitates high rainfall, while the low-lying flat lands in the western part at 1 600m above sea level are characterised by a very erratic rainfall pattern. The average rainfall is 1 000mm per annum on the eastern side, dropping down to 200mm in the west.

Population distribution

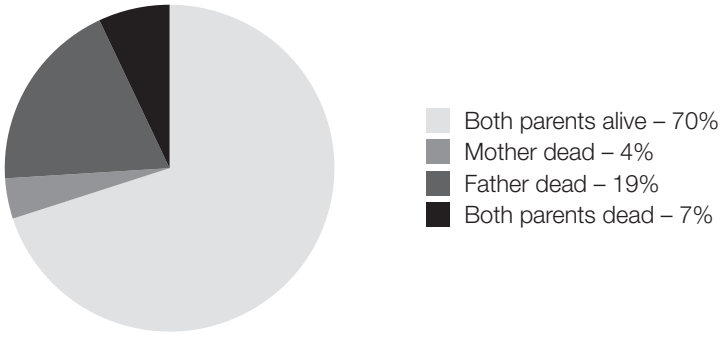
The district is divided into 23 wards, with 147 villages and a total population of 107 120 (Munyati et al. 2006), 51.9% being female, while the 2002 National Census estimated a population of 115 250. More than a third of the population is adults, that is, aged 25 and above (Figure 8.1); children under a year constitute about 3%; and 16% of the population is under the age of 5. The population density is 33.40 per m^2. There is a total of 24 495 households (Munyati et al. 2006), with an average household size of 4.4. The predominant language is Ndau, which is a Shona sub-ethnic group.

Figure 8.1: Chimanimani age distribution



Close to a third of children in the district under 18 years old are orphaned (Munyati et al. 2006). The OVC Census reported that there were more paternal orphans (19.3%) than maternal orphans (4%). Figure 8.2 below shows the distribution of orphanhood.

Figure 8.2: Orphanhood among children under 18 years



Source: Munyati et al. 2006: 29

Economic activities

The main economic activity in the district is agriculture. Ward 15, named after the district, is the only urban area in the district and all the administrative offices of the district are found there. The district has two growth points and six busy business centres. Some of the wards, for example, Tilbury, Charter, Martin and part of Nyahode, are covered by timber plantations. The district has 86 commercial farms, of which 5 are small-scale farms. There are 24 A1 farms (substitutes of communal areas with 6 hectares) with 2 127 farmers, and six A2 farms (commercial farms that are 50 hectares to 800 hectares) with 102 farmers. Of the 23 wards in the district, 17 are in the communal areas. The district has agricultural depots for cereals and cattle-sale pens.

There are structures set up for animal health in the district. These include 3 extension services, 5 animal health centres, 35 dip tanks and 4 feedlots.

Health facilities

The district has five hospitals (two mission hospitals, one council hospital and two government hospitals). One of the mission hospitals acts as the district hospital. Primary healthcare centres include clinics, hospitals, rural health centres and aid posts (Table 8.1). The two mission hospitals are in wards 1 and 21, the government hospitals are in wards 8 and 17 and the hospital in ward 15 is owned by the council. There are four wards (wards 2, 4, 5 and 18) with neither a clinic nor hospital, while ward 16 has three clinics run commercially. The district offers an intensive prevention of mother to child transmission (PMTCT) service at Mutambara Hospital and also through outreach programmes. There are 3 permanent voluntary counselling and testing (VCT) centres in the district, in which 649 people were tested; Cashel (Mutambara Hospital), Ngorima B (Muchadziya Clinic) and Tilbury (Chisengu Clinic). There are also some outreach VCT programmes and in 2005, 568 people were tested under the outreach programme. Mutambara Hospital offered outreach services to 11 peripheral health facilities in the first three months of 2005. The hospital has a bed capacity of 120. An antiretroviral therapy (ART) programme is yet to start at Mutambara hospital. Eleven out of the 23 wards have got environmental health technicians.

Table 8 1: Clinics and hospitals in the district

Type of institution	Total
Number of clinics	20
Number of hospitals	5
Health institutions run by:	
Government	7
Commercial	8
Mission	2
Council	8

Table 8.2: District staff complement, by designation

Designation	Total
Post	Filled post
District medical officer	0
District nursing officer	0
Sister in charge, community	1
Community health sister	1
Health promotion officer	0
Environmental health officer	12
District health information assistance	0
Assistant nutritionist	1
Field orderly	5
Health orderly	1
Nurse (in all institutions)	71
Volunteer	478

Education facilities

The district has close to 90 crèches. There are a total of 73 primary schools in the district, with an average of 3 schools per ward. The total enrolment as of 2005 was 32 046 pupils (CSO 2002). The district has only one government primary school, situated in the urban ward, Chimanimani. The district has 23 secondary schools and only one is a government school, located in Ngorima A. Wards 12 and 14 (Tilbury and Charter, respectively) have no secondary schools.

There are a total of 776 teachers in primary schools of which only 30 are not trained. Regarding secondary schools, out of a staff complement of 505, 35 of the staff are not trained. The number of OVC who are benefiting from BEAM is 877 boys and 838 girls in secondary school, while there are 6 322 boys and 6 502 girls in primary school. One secondary school offers special classes and so do 7 primary schools. Special classes in primary schools have an enrolment of 12 boys and 6 girls and in secondary schools there are 20 boys and 20 girls. The school dropout rate is about 2% in both secondary and primary schools. Table 8.3 shows the levels of education for the population of the whole Chimanimani District as at 2005.

Table 8.3: Levels of education for Chimanimani District

Level of education	n	(%)
Pre-primary	5 633	(7.0)
Primary	45 927	(56.8)
Secondary	27 495	(34.0)
High school	551	(0.7)
Tertiary: non degreed	1 007	(1.2)
Tertiary: degreed	257	(0.3)

Note: N = 80 870
Source: Munyati et al. 2006: 29

Water and sanitation

The major sources of water in the district are wells/boreholes (36.0% protected and 19.7% unprotected), while the other sources are piped water (22.6% outside the house and 5.5% inside the house, in ward 15), communal taps and rivers/streams/dams. The district has 273 boreholes, 53 dams, 18 piped water schemes and 148 deep wells. With regard to toilet facilities, 36.4% use Blair toilets (ventilated improved pit latrines) and 34.1% use pit toilets, while almost a fifth does not have toilets at all.

Transportation and energy

The district has one main tarred road which links Chimanimani with the Mutare-Masvingo main road. The main road is linked with several dirt roads. There are few electrified houses, representing less than 5%. The major source of energy for cooking and lighting is wood.

Conditions of OVC

Magnitude of the OVC problem

A community member reported that the OVC problem was quite large in the district and was continuing to grow, as more and more parents were dying, mostly from HIV and AIDS-related illnesses. According to an officer with Save the Children Norway, there were approximately 13 000 OVC in the whole district and they were registering new OVC each time they gave out food at the feeding points. Another representative from Intermediate Technology Development Group (ITDG) put the prevalence of orphanhood in the district at 35%. In some schools, as of last year, about 30% to 60% of the learners were orphans. The chief executive officer of council stated that the OVC problem was too great to manage. With regard to child-headed households, a mixed focus group discussion (FGD) for 16- to 18-year-olds stated that there were few households in the community that were being headed by children. According to one community member, the impact of the OVC problem in the community was multi-faceted. Some children dropping out of school, lack of protection exposing them to risky sexual behaviour, and displacement and loss of parental possessions, were some of the major challenges that OVC faced. Some children were resorting to work, thereby taking on responsibilities and roles of parents at a very young age. However, a local chief downplayed the magnitude of the OVC problem, by mentioning that, in an African setting, there were no orphans as long as there were other surviving relatives of the parents.

Most respondents mentioned that they found out about the magnitude of numbers of OVC from schools, churches, home-based care (HBC) services and non-governmental organisations (NGOs) operating in their areas. The communities also informed their local

chiefs about any deaths in their localities. There was an officer designated to collect data on OVC in the council. The officer was working in conjunction with community structures like the District AIDS Action Committee (DAAC), the Ward AIDS Action Committee (WAAC) and the Village AIDS Action Committee (VAAC) in compiling OVC statistics.

Level of emotional and physical care

An OVC indicated that they were sometimes disturbed by the fact that they did not have anyone to take good care of them. If OVC were scolded, they became emotionally stressed and started to ponder about their deceased parents. Another orphan reported that they were sometimes physically beaten by their guardians over very trivial things and at times they were made to sleep outside. There were also times when OVC were sent to perform certain tasks or household chores, while other children, especially those of guardians, were doing nothing. This, the orphans said, was emotionally distressing.

Dealing with the emotional issues

There were no trained community counsellors to assist orphans to deal with the emotional stress of having lost parents. Red Cross was offering counselling services to OVC who visited their centre. At the centre, the orphans and other vulnerable children would share experiences of how they were coping with life. This was helping in relieving emotional stress, although some of the orphans were not appreciating the need for counselling. Relatives, neighbours and FBOs were trying to comfort the orphans by visiting them and listening to their problems. Community members interviewed stated that caregivers should not discriminate against orphans, since this may emotionally worsen their plight. Poverty was also contributing to the emotional stress of orphans.

With regard to physical abuse, OVC mentioned that they were afraid of reporting their guardians for fear of being chased away from home, especially the double orphans. Another OVC reported that their major challenge was to be obedient to those looking after them. As a coping mechanism, some were resorting to selling wild fruits and gold-panning in order to raise money for basics. The mixed FGD for 6- to 15-year-olds revealed that those OVC who were eking out a living through vending, were always engaged in running battles with the police.

Housing conditions of OVC

The housing conditions of OVC varied from family to family, as reported by many interviewees. Some were living in good houses (brick with roofing sheets) left by their departed parents, whilst others were staying in pole and dagha huts. The latter was typical of cases where the young parents had died before building good houses for their children. A community member reported that in such cases, apart from the houses being in bad condition, there might not be enough rooms, so there would be boys and girls sleeping in the same room. The worst cases were of those who were staying in dilapidated wooden cabins with leaking roofs.

OVC needs

The mixed FGD for 6- to 15-year-olds stated that the needs of OVC were food, school fees, uniforms and stationery. These needs were further confirmed by a mixed FGD for 16- to 18-year-olds. The main challenge in acquiring these needs was the fact that the majority of the caregivers were unemployed. The other need for OVC was psychosocial support, as reported by one community member. Proper accommodation was the other commonly cited need for orphans and some OVC had houses with leaking roofs.

Major threats to OVC quality of life

A caregiver stated that the major threats to the quality of life for OVC were lack of basic necessities such as food, clothing, education and protection. A representative from Save the Children Norway echoed these same threats to OVC's quality of life. She further indicated that if caregivers did not keep a close eye on the situation, some OVC might be exposed to bad friends and this might result in bad behaviour or delinquency. Some OVC lacked proper upbringing, especially double orphans, who might resort to all sorts of criminal activities.

A community member reported that some girls who were desperate and vulnerable could be enticed into sex, thereby exposing themselves to the risk of HIV and AIDS infection. A local chief stated that the girl child was more at risk of being raped, even by her father or other relatives. An NGO representative (Red Cross) mentioned that other major threats to OVC were child labour and physical abuse (beating). According to the council chief executive officer, property-grabbing by relatives after the death of parents was another practice that was threatening the quality of life of the surviving children.

Loss of personal possessions

An OVC reported that most children were losing their property not only to relatives but also to community members after the death of their parents. Those OVC who were spared from property-grabbing were those whose parents would have written wills or made plans for their children before they died. However, the challenge arose when some relatives dishonoured these wills or plans. A community member reported instances where some fathers died before finishing paying lobola and relatives of the wives would therefore take everything as payment of the debt.

Access to facilities

Education

Only a limited number of OVC had access to education through BEAM, as reported by a community member. A Ministry of Education official mentioned that the major challenge was that there was an ever-increasing number of OVC, as against a static financial base in BEAM. The money was sometimes dispersed late and, by then, some OVC would have been turned away from school.

Health

OVC had access to health clinics where they did not have to pay consultation fees. The only problem was that the clinics were not adequately stocked with drugs. Another community member reported that some of the clinics were far away, often more than 7km, and so some caregivers were reluctant to walk such distances with sick OVC.

Finance

A representative of Red Cross Society reported that there were no financial resources available for OVC. He further suggested that there was a need to establish income generating projects (IGPs) for them. Some OVC were resorting to casual work to acquire financial resources. However, the challenge they faced was that of being underpaid for their work. A local chief stated that some OVC were raising money for their survival from selling fruits such as bananas. The prevailing economic conditions were making the

situation worse for OVC, who would be expecting to receive financial resources from their caregivers or NGOs.

Social services

The only reported social services available to OVC were sporting activities, as well as recreational facilities. These included athletics, football, volley ball, netball and drama. There was a youth friendly centre where young people could come to watch videos that both entertained and educated them.

Attitudes, stigma and discrimination

The communities, by and large, were no longer stigmatising and discriminating against OVC, according to one of the caregivers. It was realised that almost each and every household had an OVC and so this has helped to minimise cases of stigmatisation. The caregivers were mainly grandmothers and aunts. A local chief stated that OVC were actually given preference when it came to distribution of food handouts and clothes from donors and well-wishers. An OVC indicated that people were showing positive attitudes to all OVC in the community and that there were no cases of stigmatisation. However, a community member reported that there were still isolated cases where OVC were receiving negative treatment within some households. For instance, OVC might be given more household chores to do than other children, and this was particularly common amongst maternal orphans. In the majority of cases, those OVC who misbehaved were the ones who were stigmatised and discriminated against, a view that was echoed by members of a 16- to 18-year-olds' mixed FGD. Again, the group mentioned that most people were displaying positive attitudes towards OVC.

Members of a mixed FGD for 6- to 15-year-olds stated that some OVC were discriminated against and exploited through being made to do all the household chores as well as being used as cheap labour, especially during the agricultural season when they weeded fields. A mixed FGD for 16- to 18-year-olds reported that there were some community members who took advantage of the vulnerable position of orphans in the community. They employed orphans, but at the same time were unwilling to pay them. They would therefore harass the children towards the end of the month, so that some of them might run away without ever being paid. The harassment came in different forms, such as being given too many chores to perform or not being given enough food. An FGD of mixed adults (middle aged) felt that the use of the word *nherera* (orphan) by some community members was itself stigmatising. There were also isolated cases of some OVC being denied food by their caregivers over trivial things. If parents died of HIV and AIDS, then the orphan might be stigmatised even more.

Challenges and complications

A caregiver stated that the difficulties they faced were in providing food, clothing, school fees and shelter to OVC. If the caregivers had their own children, then the OVC became an extra burden, since it would entail more household expenses. It was easy to send the OVC to school if one's own children had completed school. Another community member indicated that because of the current economic conditions, ordinary community members did not have enough to provide for themselves, so it was difficult for them to offer help to OVC. As reported by a caregiver, there were too many OVC in the community and the resources that were coming in were inadequate. In most cases, caregivers were failing to raise money to take OVC who fell sick to hospital for treatment. The caregiver also stated

that the local clinic did not have enough medicines, so people were referred to distant hospitals for which they would not have bus fares. A Save the Children Norway representative reported that transport costs were also a big problem for them when they ferried aid from Harare to Chimanimani, and then from Chimanimani depot to other parts of the district. This was further compounded by a poor road network system, which made other areas inaccessible. The council chief executive officer stated that the challenge in caring for and supporting the OVC was a difficult one because of their ever-increasing numbers. He also mentioned that people who were affected by HIV and AIDS moved from towns and came to the rural areas, therefore leaving OVC to grandparents when they died. The other problem he mentioned was of community members who were giving donations to their relatives, at the expense of deserving OVC.

The FGD of mixed group adults (middle aged) indicated that caregivers did not have skills and experience in giving care to OVC. The group further mentioned that it was very difficult to cope with caring for OVC, because the area was very dry and their survival was largely dependent on a good agricultural season.

Suggestions on how to help OVC

A community member suggested that the committee responsible for selecting deserving OVC should be broad-based (to include many stakeholders), so that no one was left out. In addition, the NGOs should put mechanisms in place to ensure that their donations would reach the intended beneficiaries. A local chief suggested that those who engaged in corrupt activities with donations meant for OVC should be dealt with severely. A representative from the NGO sector indicated that there was need for greater coordination among stakeholders working in the district, in order to avoid duplication of efforts (providing the same services to the same beneficiaries or wards). In addition, this would also minimise cases of orphans double-benefiting at the expense of others also in need.

The NGO representative further suggested that if building materials could be provided for those OVC without proper accommodation, then people in the community could assist by building houses for them. He also suggested that they should be given seed money or inputs for them to engage in IGPs like gardening and poultry. This suggestion was supported by the local chief, who stated that emphasis should be placed on creating employment opportunities for OVC, rather than continuing to give them things like food and clothes. A Ministry of Education official indicated that priority should be given to OVC in awarding government-related scholarships and places at tertiary institutions. In addition, he mentioned that BEAM funds should be disbursed on time, so that OVC would not miss lessons by being sent out of school because of late payment. Resources permitting, all OVC should be assisted with free education, right up to tertiary education level.

There was also a need to categorise help, according to type of guardianship, so that those OVC living with the elderly and the sick would get more than those left with single, able-bodied parents. The council chief executive officer suggested that there was a need to raise awareness in the community about the laws and policies on protection of OVC. These laws should also be seen to be enforced. So-called 'sugar daddies' should refrain from taking advantage of the predicament of the OVC and from exploiting them as sexual objects. One OVC suggested that they should be actively engaged in consultations about any initiatives that were meant to assist them. This was echoed by a chief, who indicated that there should be proper needs assessments carried out before any assistance was offered to OVC.

Commitment of those assisting OVC

A community member stated that most of those people who were assisting OVC had demonstrated a lot of commitment, especially community-based organisations (CBOs). Their work was quite commendable, as they were doing it free of charge. However, there were other organisations that were using OVC as fronts for their own benefit. There were also some NGOs that were using OVC to raise money and ended up spending almost half of their budgets on administration. Some of their workers, maybe because of underpayment, were not very committed to their work.

Community resources

There was the *Zunderamambo* (a community field where people work and the proceeds benefit OVC and other needy people in the community) and community members went once every week to help out in the fields. However, the persistent droughts had compromised the output from the *Zunderamambo*. Village heads, together with the chief, were responsible for the distribution of the proceeds. In addition, there were the nutrition gardens where, again, community members helped through ploughing and weeding. Proceeds from the gardens would also help in paying school fees and buying stationery for OVC.

Since the area had gold deposits, a chief in the area stated that there were plans to request mining rights and the proceeds would then be given to OVC in the area. According to a community member, churches and CBOs were also doing a sterling job in offering psychosocial support to OVC. OVC stated that the United Baptist Church occasionally held parties for OVC in their community.

Care and support structures for OVC

Women (grandmothers and aunts) were cited as the main caregivers of OVC and were also reported to be better caregivers than fathers. Some of the initiatives in the district that were meant to care for and support OVC were as follows:

- Foster parent programmes in wards like Chakohwa.
- Wet and dry feeding schemes for school children by World Food Programme (WFP) (community women were cooking the porridge at schools).
- Government, through BEAM, was providing educational assistance.
- Provision of agricultural inputs for *Zunderamambo*.
- Food parcels for the OVC from Red Cross.
- Strengthening CBOs in wards, so that they would be better able to assist OVC.
- District and ward child protection committees, which would deal with any issues affecting children. Members of the committees were drawn from the NGO sector, local leadership and government.
- Churches, especially the United Baptist Church, were making material donations to OVC.
- FOCUS was providing clothing, blankets and food to OVC.
- Towards Sustainable Use of Resources Organisation (TSURO) dzeChimanimani had developed an agricultural field and its produce was then given to OVC.
- Businessmen in the community also sometimes came in to help pay fees for OVC.
- United Baptist Church sometimes paid school fees for some OVC.

According to most OVC interviewed, the support structures were working well and were also desirable. Regarding indicators of success, a community member stated that most

children were now going to school and more food parcels were being distributed. On the issue of commitment, some caregivers and CBOs were reported not to be fully committed. Some of the caregivers were even diverting assistance meant for OVC for personal use. It was also of concern to some OVC that people volunteered at their parents' funeral to take care of them, but never in fact came back to check on them or take care of them.

Desirability and effectiveness

A caregiver stated that the available care and support structures were desirable. The food parcels that were being given to OVC were very helpful, even more so in light of the hunger being faced by most communities. However, some OVC reported that whilst they appreciated the assistance they were being given, it fell short of their expectations, since they were mainly being given food and yet were also in need of clothes. Caregivers, community members and OVC themselves had reservations about the effectiveness of the support structures, especially food parcels. The complaint was that the supplies were coming infrequently, for instance, only once in three months. One chief summed it up by saying, *'Vanopihwa havangasarudzi zvavanoda,vanongototora.' (*A beggar is not a chooser; you have to accept whatever you are given.)

The educational assistance through BEAM was most welcome, although the concern was that, more often than not, the money was coming late and was not catering for all those in need. Some of the successes of the support and care structures were noticeable increases in enrolment figures at schools, as a result of the feeding schemes and BEAM. Some children were also trained in running IGPs. The district chief executive officer, however, further mentioned that there were cases of teachers who were fired from the Ministry of Education because of child abuse.

Sustainability

The sustainability of the support structures, especially the feeding schemes, was in doubt, since most of the assistance was external. For sustainability, the suggestions were that people should be equipped with skills to run and manage IGPs that benefit OVC. Support organisations were also encouraged to provide people with agricultural inputs such as seed and fertiliser, instead of continuously handing out food parcels.

Interaction of OVC with others

By and large, most OVC were interacting very well with other children in the households they lived in, or at school. There were isolated cases reported of ill treatment or discrimination. The OVC were also getting encouragement from their peers at school not to lose hope. They would hear stories of people who had made it in life after losing parents.

Attitudes of caregivers

Attitudes of caregivers towards OVC, according to the local chief, differed from family to family, but generally caregivers were trying their level best to care for OVC, despite times being difficult. However, there were a few cases where some caregivers were using abusive language against OVC and were sometimes too stubborn to listen to the advice given them by members of the community on how best to care for OVC. The FGD for mixed group adults (middle aged) asserted that some OVC would not listen to their caregivers and that was what brought ill treatment from their carers. The FGD further stated, however, that some caregivers were not passing on to OVC the support resources they had received on the OVC's behalf.

Communities were no longer stigmatising those people who were looking after OVC and, on the contrary, people were encouraging each other to care for and support OVC. Caregivers reported that sometimes it was difficult to give OVC work, because when neighbours saw OVC doing work, they would think that they were being abused, when in fact the caregivers were helping the OVC to be responsible people in the future. A handful of caregivers felt that they were negatively affected economically as a result of caring for OVC, because it was stretching their limited resources.

Policy and legislation for the protection of OVC

Knowledge of law

Most respondents were knowledgeable about policies and pieces of legislation that protect children. Organisations like Save the Children Norway, teachers, child protection committees and other stakeholders were raising awareness of these policies and legislation at community gatherings. Cited rights of children were education, food and shelter. Some of the laws which were specifically cited were:

- Labour Act (Chapter 28:01 of 1985)
- Sexual Offences Act (Chapter 9:21 of 22/2001)
- Children's Act (Chapter 5:06 of 14/2002)
- Guardianship of Minors Act (Chapter 5:08 of 2002)
- Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996)

Whilst most people were aware of children's rights, providing for these rights was a major challenge. A community member stated that the harsh economic conditions obtaining in the country were making it difficult for the majority of people, especially OVC caregivers in the rural areas, to provide decent shelter and food for their children. Children were dropping out of school because of the high fees being charged, thereby denying these children the right to education.

There were also some challenges on the implementation of laws that protect children, with specific reference to the Labour Act and the Sexual Offences Act. Child labour was very common, the worst instances being when OVC were made to work and payment would be given to the caregiver. There were also some cultural arguments that for children to be better and responsible people in the future, they had to be taught to work at an early age. Cases of children, especially female maternal orphans, being sexually abused were also reported.

HIV and AIDS

Awareness and knowledge of HIV/AIDS

Almost everyone interviewed indicated that the level of awareness and knowledge about HIV and AIDS was quite high in the district and the country at large. An ITDG representative even suggested that the level of awareness might be as high as 99%. This was largely attributed to publicity campaigns conducted through the print and electronic media, as well as through the Ministry of Health and Child Welfare and other stakeholders. The worrying thing, though, was that people were still behaving recklessly, despite their high knowledge levels of HIV and AIDS. They say, *'Kwese kufa.'* (People still die, whether as a result of AIDS or no AIDS.) A mixed FGD for 6- to 15-year-olds reported that OVC

were being taught about HIV and AIDS, as well as reproductive health issues, by their teachers at school.

Magnitude of HIV and AIDS

Most respondents indicated that it was difficult to state the number of people who were infected with HIV. The difficulty arose due the fact that some of those who were infected did not disclose their HIV status. However, suggested estimates were that about 50% of the people in the district were infected with the virus.

Impact on state and organisational resources

A caregiver indicated that many people were dying from the disease, hence the loss of a critical mass in terms of labour force. This was then translating into losses in productivity or retardation of economic growth. An OVC stated that financial resources which could have been used for other purposes were now being spent on treatment and care for AIDS patients. An NGO representative (ITDG) reported that HIV and AIDS issues had taken centre stage and overshadowed other diseases such as malaria. There were more resources channelled to AIDS than any other disease. The representative further mentioned that some developmental projects had suffered because of the diversion of resources to the HIV and AIDS problem. Other impacts of HIV and AIDS also manifested in the workplace, where sick people were not contributing fully to production, taking time off work to acquire ARVs and to attend funerals. A district chief executive officer also stated that the time taken in discussing HIV and AIDS issues at different forums could have been otherwise productively utilised, if there was no AIDS.

Impact on community resources

A caregiver stated that HIV and AIDS were imposing a tremendous burden on grandparents, in having to take care of their grandchildren when their parents died of HIV and AIDS. What made it worse was the fact that these were old and unemployed people. If a family member was suffering from AIDS, other members of the household were affected, because they had to look for items such as food and medicine to take care of the sick person. This obviously would put a strain on their household resources. A local chief stated that some families had to sell their cattle in order to raise money to buy medicine for the AIDS patients. An OVC commented that AIDS was impacting negatively on the community, because when parents died they would leave behind many orphans with no one to take care of them. A community member stated that the disease had negatively affected population growth.

The council chief executive officer stated that the community faced too many problems and the children's talents were being lost (for example, good footballers, teachers, doctors and professors) due to dropping out of school. Also, even if some children were going to school, they might still have other physical or social problems, due to the environment at home.

Impact on social functions

Some people were being denied the chance to socialise or attend social gatherings, because they were attending to a household member who was suffering from HIV and AIDS.

Suggestions on how to limit the spread of HIV/AIDS

Educational needs

Different suggestions were proffered that would limit the spread of HIV and AIDS. Some of the suggestions were:

- The Ministry of Health and Child Welfare should intensify its campaigns, with emphasis on behaviour change, by putting up posters at clinics and film theatres.
- NGOs should conduct more workshops on AIDS awareness, so that people learn more about what AIDS is.
- Elders should teach children about traditional practices, for instance, abstinence from indulging in sexual activities until marriage.
- More print material is needed, such as pamphlets, posters and billboards on major roads, spreading the message on HIV and AIDS.
- People should desist from the practice of adultery.
- People needed to be taught about VCT and ARVs.

Infrastructural needs

More VCT centres needed to be established in the communities and people should be encouraged to visit them. However, people had problems in accessing the services available, because the clinics were few and far away. The poor road network system was not helping the situation either: *'Hatichina maroads dzatovenzira chaidzo.'* (The roads are so bad that they are more like paths.) PMTCT services were also not available at most clinics and more distribution centres for condoms were needed in the district. Those caring for people living with HIV and AIDS (PLWHA) should be given gloves so that they would not get infected in the course of their caring duties. Some of the health institutions did not have electricity.

Interventions at social level

An NGO representative (Red Cross) stated that people needed to unite in the fight against stigma. Community leaders should play an active role by conducting workshops to teach people about HIV and AIDS issues. If there were more community projects, households would be able to raise financial resources to take care of PLWHA.

Care and treatment of PLWHA

Services available

HBC and VCT were the main services available for the care and treatment of PLWHA. PMTCT services were also available and accessible at clinics for pregnant mothers. People were being educated about these services when they visited clinics.

A community member stated that village health workers had books in which HIV and AIDS patients in the community were recorded, and they continuously monitored and helped these patients. PLWHA were being helped with drugs from the clinics, although the drugs were frequently out of stock at most rural clinics. HBC kits and food parcels were being provided periodically by DAAC for PLWHA. An NGO representative (ITDG) stated that the Global Fund was also providing ARVs. In addition, herbs and traditional medicines were being used for treatment of HIV and AIDS patients. An officer at a rural council was responsible for coordinating all efforts and activities for PLWHA.

There were mixed reactions on the impact of the services available for PLWHA. Some were of the view that there had been a tremendously effective impact, especially of the HBC, whilst others felt that the lack of drugs (ARVs) and HBC kits was not helping the situation. Furthermore, most people did not have money to buy drugs.

Views on access and availability of ARVs, VCT and PMTCT

The community response towards these services was positive. People in the communities were now accepting VCT services and were going for testing. PMTCT services were not easily accessible, as they were too far for pregnant mothers to reach; the services were found only at mission hospitals such as Mutambara, but not at rural clinics.

Advantages of knowing one's HIV status

- One can make informed decisions.
- Teaching others about HIV/AIDS.
- One can get material and financial assistance.
- One can live positively and even prolong one's lifespan.
- One can be helped at home and at hospitals.
- One would be able to maintain a good diet.

Disadvantages

- One may face stigmatisation and discrimination at home or at work.
- One may get suicidal thoughts or tendencies.
- People may not give you the support and assistance you may require.
- One may continue to live a reckless lifestyle or deliberately infect other people.
- One might get stressed by the fact that she/he has the virus and will die.

Major sources of information on HIV/AIDS

Print and electronic media sources

The commonly cited sources of information on HIV and AIDS were radios, and posters and pamphlets at clinics and hospitals. In addition, there were some billboards with information on HIV and AIDS. There were also some people who were able to get HIV and AIDS information from newspapers and from televisions in the higher areas where there is transmission. Teachers were reported as another major source of information for school children about HIV and AIDS. There were also nurses who visited schools to disseminate HIV and AIDS information. People in general were being educated about HIV and AIDS at community gatherings and through their peers.

In addition, workshops conducted by peer educators were reported to be more effective in spreading information on HIV and AIDS. Transport problems, though, were affecting the smooth running of teaching people about HIV and AIDS issues.

Improving provision of information

It was suggested that village heads and councillors should hold more meetings for HIV and AIDS information dissemination in their communities. The other suggestion was that caregivers and guardians would be better educators on HIV and AIDS issues, especially for OVC under their care.

Profile of government departments

Department of Local Government and Urban Development

Scope of activities and coverage
The department has an officer who is designated to collect information on OVC and who also works very closely with other district structures such as DAAC, WAAC and VAAC in identifying the OVC in the district. The rural district council also assists in identifying potential donors to assist the OVC. A committee had been set up in schools to identify children who benefit from BEAM. There is also a one-way referral system whereby any NGO that wants to operate in the district would first have a briefing from the district council and then would be given guidelines on which wards are in greatest need of assistance.

Challenges
More financial resources are required to cater for all deserving children, especially BEAM.

District Action AIDS Committee

Scope of activities and coverage
DAAC operations cover all wards in the district. Below are some of the activities of the department:

- Monitors the disbursement of financial and material resources to PLWHA.
- Provision of HBC kits and food parcels.
- Procurement of resources for onward disbursement to schools.
- Initiates IGPs for OVC such as nutrition gardens and tailoring, carpentry in Guhune ward, buying and selling tomatoes and agricultural produce in Rupise, tailoring in Ngorima B, poultry in Nyahode ward.
- Holds workshops to educate OVC and other children on stigma and also to discuss any problems affecting them.

Ministry of Youth Development and Employment Creation

Scope of activities and coverage

- The focus of the ministry is to empower communities through training.
- Endeavours to make OVC self-reliant.
- Covers the whole district.
- The ministry deals with training the community in development projects and also monitoring of the projects. Organisations identify the type of training needed and the ministry then trains the relevant target group.

Challenges

- The ministry does not own vehicles and is thus restricted in terms of mobility.
- Inadequate financial resources to finance OVC training in running IGPs.

Ministry of Education, Sports and Culture

Scope of activities

- Assists in the identification of children to benefit from BEAM.
- Teachers also counsel OVC to lessen their psychological distress.
- Disseminates information on HIV and AIDS to children.

Challenges

- Needs material, for example, pamphlets and peer-counselling training material.

Ministry of Health and Child Welfare

Scope of activities and coverage
The ministry provides education through the various structures, such as the nursing department and community health departments; it also recommends that feeding programmes target OVC first. Vaccination for children is done on a monthly basis and includes growth monitoring of all children, not just OVC.

Challenges
Not all wards had environmental health technicians (EHTs); there were 11 out of the required 23. Transport was another problem, since there was no ambulance available. Some of the vehicles were too old and not working. Drugs were in short supply, for example, folic acid and ferrasulphate; cotrimoxazole for pregnant mothers. There was also no equipment (haemogloblinometer) to measure haemoglobin (Hb) levels.

Ministry of Agriculture

Scope of activities
- Assists OVC activities with knowledge and agricultural inputs.
- Assists in the *Zunderamambo* with expertise and maize seed packs.

Challenges
- The department is understaffed. They had a staff complement of 40 instead of 53.
- Financial resources are needed for the department to effectively cover the entire district.
- Lack of transport is another major problem.

Ministry of Public Service, Labour and Social Welfare

Scope of activities and coverage
Together with other local structures, the ministry is responsible for identifying OVC who are supposed to benefit from BEAM.

Challenges
Fuel shortages were affecting the smooth running of their operations.

Ministry of Home Affairs (Zimbabwe Republic Police)

Scope of activities and coverage
- The ministry is covering the entire district.
- Offers counselling services to sexually abused children in the Victim Friendly Unit.
- Refers OVC who need assistance to relevant government departments, such as social welfare for food, or government for school fees, and even to NGOs who can help.
- Investigates child abuse and rape cases whenever they are reported.

Challenges
- Transport and fuel problems are hampering their efforts.
- Sometimes officers have to walk when they are conducting investigations.

Profile of non-governmental organisations

Red Cross Society

Scope of activities and coverage

- Red Cross is operating in five wards, namely, Ngorima A, Ngorima B, Chikukwa, Manyuseni and Chimanimani Urban.
- Offers training to communities on home-based care, first aid, advanced first aid, advanced nursing aid and basic industrial first aid.
- Pays school fees for some children.
- Helps OVC and HBC clients with food every month, such as mealie-meal (10kg), beans, porridge (3kg), cooking oil (500ml).
- Offers counselling to OVC and abused victims who visit their centre.

Challenges

- Transportation of food from Mutare to Chimanimani and then to the wards is a problem, because of shortage of fuel.
- Needs financial resources to start projects such as gardening, dress-making and poultry for the OVC themselves.

Save the Children

Scope of activities and coverage

- Save the Children covers almost the entire district.
- Provision of porridge to OVC who are aged 18 years old and under, at schools and clinics (they have two kinds of feeding schemes: wet feeding, that is, feeding children on the spot, and the dry feeding, that is, children take the food home).
- Emergency feeding in times of disasters by providing, for example, material and financial assistance, HIV mitigation and psychosocial support, and campaigning against violence and sexual abuse.

Challenges

- Transport is a big problem: for example, carrying aid from Chimanimani depot to other parts of the district, or from Harare to Chimanimani.

Practical Action (formerly Intermediate Technology Development Group)

The organisation started operations in the district in 1998 and to date they are covering 21 of the 23 wards of the district. Below are some of their activities.

Scope of activities

- Practical Action offers grants as seed money for project start-ups or assists already existing projects such as nutrition gardens, candle-making, poultry, livestock rearing and harvesting.
- Offers training for OVC in life-skills projects.
- Offers training to caregivers and OVC in basic counselling skills.
- Facilitates registering of CBOs.

Challenges

- Financial resources were inadequate to cater for all their activities.

Conclusions

The commendable thing about the district is the fact that there is an officer based in the office of the district rural chief executive officer, whose duties and responsibilities, among other things, include compiling data on OVC. The officer works in close liaison with the National Aids Council structures, such as DAAC and WAAC. This has enabled the district to at least have a database of some sort, which they use for intervention work when NGOs move in to the district with assistance. The district currently has approximately 13 000 OVC, and this number is ever increasing.

Lack of food, school fees, uniforms and stationery were the predominant needs that were reported by the OVC. Such challenges are forcing some children to assume adult roles at very early ages. For instance, some OVC have to sell fruits and do gold-panning to eke out a living. Girl children become even more vulnerable when they are enticed into sexual relationships and given money in return. Not all OVC have access to free education, because of the inadequacy of financial resources. Whilst OVC are entitled to free health services, the problem is that of lack of drugs at clinics and that some of the clinics are even too far away.

Most people were exhibiting positive attitudes towards OVC in their communities. This is a positive development, which helps in reducing the emotional stress of OVC, who are at times stigmatised and discriminated against. They feel the need to be part and parcel of the communities they live in and not to be treated as social outcasts. Orphans themselves believe the word 'orphan' itself has connotations of stigma, and so are not comfortable being called by that name.

The harsh economic environment was complicating the community's efforts to assist OVC. Taking OVC into their households brings with it the added burden of providing them with basic necessities. The *Zunderamambo* is one initiative where community members work together and the farm produce benefits OVC. On the other hand, NGOs are having transport and fuel problems in transporting food to needy people. People who are diverting assistance meant for OVC are making the children's predicament even worse. Such behaviour is deplorable.

Churches and CBOs are also doing excellent work in ameliorating the hardships that OVC are facing in the district.

Awareness of HIV and AIDS is quite high, with suggested figures of informed community members as high as 99%. This is attributable to the efforts of the Ministry of Health's educational campaigns about the disease. It is still proving to be a huge challenge for those who are infected to disclose their status. As a way of limiting the spread of the disease, people are encouraged to teach children early on about reproductive health issues and abstaining from sex before marriage, among other preventive measures. At the same time, it is felt that adults should desist from practising adultery.

The services available for PLWHA were VCT and HBC. However, there were mixed responses on the effectiveness of the services, in light of the shortage of drugs such as ARVs and the lack of mobile VCT services.

Priorities for action

The right of children to education is facing serious challenges, because of the high cost of school fees, uniforms and stationery. Maybe it is time the government should reconsider the policy of free education to all children in primary school. The BEAM funds can then be given to those OVC in secondary schools. Headmasters and the community leadership should play a key role in keeping up-to-date records for OVC. This will make the work of intervention agencies a lot easier. There is also need for a formalised and coordinated approach, at all levels, to handling OVC issues in the district. This would minimise duplication of efforts and therefore would benefit more OVC. The government should expedite the disbursement of the BEAM funds, so that the benefiting OVC would not lose out by being turned away from school due to late payment of fees.

Diversion of funds meant to benefit OVC, either at community level or at NGO level, is another problem that also needs attention. Mechanisms should be put in place to ensure that funds are properly monitored and accounted for. All unscrupulous people who abuse OVC funds should be severely dealt with.

Communities should also take an active role in assisting OVC in their localities, rather than always waiting for external assistance from NGOs. For instance, they can assist OVC by rehabilitating their leaking houses, and by just visiting them and talking and listening to them. The *Zunderamambo* initiative is commendable and communities should be fully supportive of this project, since it improves food security for OVC. As a way of dealing with the dependency syndrome, communities need to be capacitated with donated seed capital to start IGPs, which would ensure sustainability for the future.

Resources need to be mobilised to train caregivers, so that they can improve on their caring roles. The concern was raised by some community members that caregivers lacked enough training to enable them to deliver better services to those under their care. Men should also take an active role, rather than relegating these duties entirely to women.

Relatives should desist from seizing the property of orphans after the death of their parents. These actions are not only traumatising but also emotionally distressing for the orphans.

If the AIDS scourge is to be mitigated, then people should redouble their efforts in changing their risky behaviour. For those infected with the disease, ARVs should be made available at subsidised prices. PMTCT services should be offered at all rural health centres and the Ministry of Health should ensure that health institutions throughout the district are adequately stocked with drugs.

Local authorities should do more to maintain the road network, especially during the rainy seasons when some of the roads become impassable. This would facilitate easy transportation of food by those NGOs that are assisting OVC with food.

CHAPTER 9

Bulilima and Mangwe Districts

Stanford T Mahati, Shungu Munyati, Brian Chandiwana and Wilson Mashange

Background

Description of study areas

The study was conducted in Bulilima and Mangwe Districts, which together used to be called Bulilimamangwe District. In 2002, the government recognised that Bulilimamangwe was too large in terms of administration and decided to split it into two districts, namely, Bulilima and Mangwe. Plumtree town is in Mangwe District and attained its town status in August 2002. However, for the purpose of this study, the two districts will be called Bulilimamangwe, although at times the districts will be distinguished from each other.

Bulilimamangwe, located in Matabeleland South Province and bordering with Botswana to the west, is in Region V, which is characterised by very low rainfall patterns. The landscape is a Savanna type of climate. About 75% of the Bulilimamangwe area is located in Region V of the agro-ecological zones, while the rest falls into Region IV. The area has a total of 35 wards, specifically, Bulilima in the north with 19 wards, Mangwe in the south with 12 wards and Plumtree District, which is between Mangwe and Bulilima Districts, with 4 wards.

According to the Kellogg Foundation Report of 2003, communities in Plumtree town and Bulilima and Mangwe Districts face major challenges of starvation, poverty, HIV and AIDS and unemployment (Bulilimamangwe Rural Master Plan Report 1999). The two districts are marginal areas for commercial crop production, due to generally low rainfall levels (400–500mm annual rainfall levels) and recurrent droughts. As a result, it is estimated that 40% of the population depends on relief aid (SNV's Western Portfolio 2005).

During the past few years, Plumtree town has experienced massive investments in terms of housing and business development, partly because of its proximity (10km) to the main border with Botswana. The town, as the only urban area in Bulilimamangwe, has banks, fuel stations, small shops, butcheries and other key government, non-government, quasi-government and private-sector institutions. Most of the rural service centres and business centres in the two districts are small, with little development, and are normally characterised by a few general dealer-store and bottle-store outlets.

Demographics

The populations of Bulilima, Mangwe and Plumtree Districts were 81 984, 62 324 and 9 012 respectively (Munyati et al. 2006). An overwhelming majority of the population are black Africans and the dominant ethnic groups in the districts are Ndebele and Kalanga. The average household size for Bulilima is 5.1 and Mangwe is 5.3. There were more females than males across all the three districts, with a sex ratio in Plumtree of 85 males per 100 females, 84 and 83 males per 100 females in Mangwe and Bulilima respectively (Munyati et al. 2006). The national census of 2002 showed that the population of Bulilimamangwe was 172 788 (Bulilima 94 361 and Mangwe South, 78 427), with 54% being female. Over half (56.3%) of the population in this district was 18 years old or under (Munyati et al. 2006). Close to 60% of the population in Mangwe is aged less than 19. Over 70% of the households in the districts had children. The distribution of the populations of Bulilima, Mangwe and Plumtree Districts are illustrated, by age group and

sex, in Table 9.1. Close to 7% (6.8%) of households in Bulilima were headed by children, while Mangwe and Plumtree had 2.3% and 4.6% child-headed households respectively.

Table 9.1: Distribution of population by age group and sex in Bulilima, Mangwe and Plumtree Districts

Sex	Bulilima N = 81 984 n (%)	Mangwe N = 62 324 n (%)	Plumtree N = 9 012 n (%)
Females	44 850 (54.7)	33 925 (54.4)	4 886 (54.2)
≤ 18 years	46 169 (56.3)	36 206 (69.1)	4 317 (47.9)
Above 18 years	35 815 (43.7)	21 118 (33.9)	4 695 (52.1)

Magnitude of orphanhood

The 2003 Biomedical Research and Training Institute (BRTI) OVC census, conducted by Munyati et al. (2006) in the two districts, defined a 'child' as aged 18 and under and the total number of children was 86 692. As shown in Table 9.2, around one quarter of all children in each district was orphans (28%, 23% and 25% for Bulilima, Mangwe and Plumtree respectively).

Table 9.2: Size of orphanhood, by district

Orphanhood	Bulilima N = 46 169 n (%)	Mangwe N = 36 206 n (%)	Plumtree N = 4 317 n (%)
Size	12 880 (27.8%)	8 592 (23.7%)	1 058 (24.5)

Source: Munyati et al. 2006

The most common type of orphan across the three districts was paternal (17.7%, 15.6% and 14.6%), followed by those who had lost both parents (5.7%, 4.3% and 6.8%) for Bulilima, Mangwe and Plumtree respectively (Table 9.3).

Table 9.3: Population distribution by orphanhood status, by district

Orphanhood status	Bulilima N = 46 169 n (%)	Mangwe N = 36 206 n (%)	Plumtree N = 4 317 n (%)
Both parents alive	33 289 (72.1)	27 614 (76.3)	3 259 (75.5)
Mother dead	2 086 (4.5)	1 369 (3.8)	169 (3.9)
Father dead	8 157 (17.7)	5 682 (15.6)	631 (14.6)
Both parents dead	2 637 (5.7)	1 541 (4.3)	258 (6.8)

Source: Munyati et al. 2006

Economic activities

According to the 2002 National Census, Bulilima had 38 086 economically active people (19.8% aged ≤ 18 years), while in Mangwe there were 32 167 (18.6% aged ≤ 18 years). In the same survey, unemployment rates were at 7.9% in Bulilima and 7.4% in Mangwe.

Agriculture is the main source of livelihood in the Bulilimamangwe area, with 85.8% in Bulilima and 73.1% in Mangwe (CSO 2002).

The major land-use patterns and tenure systems in Bulilimamangwe include communal lands, and large- and small-scale commercial farming areas. Due to its proximity to Botswana and South Africa, most men and young people from the area cross the borders legally and illegally to seek employment.

Agriculture in this area is largely in the form of animal husbandry/livestock rearing, although crop production is common in areas where there are irrigation schemes. The most common types of livestock are poultry, cattle, sheep and goats. The benefits from the livestock are in the form of manure, milk, meat, animal draught power and income. The major crops grown are millet, sorghum, soya beans and maize.

Livestock rearing

Bulilima and Mangwe Districts are arid regions that are well known for keeping farm animals. An economic mapping study done by a Netherlands development organisation, SNV (Western Portfolio) in 2005, found that 84% of the households in Bulilima and Mangwe Districts rely economically on livestock. In another study done by Munyati et al. (2006) in 2003, it was found that over three-quarters of the households in Bulilima (79.7%) and Mangwe (78.7%) had farm animals. However, a census by the Department of Veterinary Services in 2005 in Mangwe and Bulilima communal areas revealed that there has been a decline in the numbers of livestock over the past five years. Poor management of both the livestock herd as well as grazing land have resulted in the quality and quantity of livestock decreasing, since supplementary feeding is not widely practised and is also expensive.

Currently, World Vision International and other non-governmental organisations (NGOs) are assisting with re-stocking livestock through locally purchased stock. In 2005, the Reserve Bank of Zimbabwe, in collaboration with Agribank and Cold Storage Commission (CSC), introduced a livestock development scheme that aimed to assist in revitalising the livestock industry.

Irrigation agriculture

There are two large irrigation projects in the area. One is run by the Agricultural Rural Development Authority (ARDA) in Ingwizi (Mangwe District). The scheme's area is shared by the local community and the parastatal organisation. The other scheme in Somnene ward (Bulilima District) has 20 hectares and is run by 86 plot owners. The full production potential of the scheme has not been met and there is need to continue encouraging people to use the land commercially and also to improve the accessibility and availability of production inputs, identification of markets, storage space for perishable products and diversification.

The most preferred crop in the schemes is maize, although tomatoes and other vegetables are also grown. Some plot holders grow winter wheat while others grow paprika and garlic. Small vegetable gardens (averaging 100m^2) are common in the area and they are managed at either individual or group level. Most of the produce is consumed by the households. The selling of any surplus vegetables is hampered by lack of transport and storage facilities.

Other agricultural activities
The marula fruit has historically been gathered in Bulilima and Mangwe Districts. People drawn from eight wards, from both districts, have organised themselves to form Tjinyunyi Babili Trust (TBT). Among other activities, the trust is involved in gathering, processing and marketing marula products and they have currently set up a processing plant within the Bulilimamangwe Business Incubator premises, where they undertake oil-pressing as well as the manufacture of marula butter.

There are twice as many marula trees per hectare in Bulilima than in Mangwe. In Bulilima, the mean annual fruit yield per tree ranges from 3 973 in Somnene to 6 426 in Ndolwane. In Mangwe, the mean fruit yield per tree ranges from 3 467 in Empandeni to 4 389 in Sanzukwi (TBT and National University of Science and Technology [NUST] research). Domestication and commercialisation of marula has the potential to promote development in Bulilima and Mangwe Districts.

Both Bulilima and Mangwe Districts, as well as surrounding areas, are naturally endowed with mopane trees. These trees yield a lot of *amacimbi* (mopane worms). These worms play a pivotal livelihood role as a source of income and food for most households in the two districts. The Bulilima Rural District Council (RDC) facilitated the construction of an *amacimbi* processing factory, but its completion has been delayed due to lack of funding. An Amacimbi Trust (community initiative) has been established to organise the communities to market mopane worms and conserve the mopane trees.

Formal employment
More than a third of the population are informally employed (entrepreneurs in the micro-, small- and medium-scale enterprises), while a quarter relies on temporary or seasonal employment. Remittances from relatives account for about a fifth of the population's source of income and about 16% are in civil service. The rest of the population lives on pensions and government grants.

There is a high number of 'cross-border jumpers', because the area is so close to the Botswana border and fairly close to South Africa's border. Due to its geographical advantage, Plumtree town is the gateway to Botswana and therefore there is a significant influx of cross-border traders crossing to and from Botswana. Estimates show that eight in every ten households have a member who is either in neighbouring Botswana or South Africa.

Health facilities

The two districts share one government hospital (Plumtree Hospital). Mangwe has 1 mission hospital owned by the Roman Catholic Church (St. Anne's Hospital), 1 rural hospital (Embakwe Rural Hospital) and 7 health centres, situated in 7 of the 12 wards in the district. There are 6 clinics run by local authorities, 7 rural health centres and 1 mission clinic. St Anne's Hospital at Brunapeg has a bed capacity of 180 and Embakwe Rural Hospital, which is also owned by the Roman Catholic Church, has a bed capacity of 40. There are 2 prevention of mother to child transmission (PMTCT) sites in Mangwe, one at Plumtree Hospital and the other at St Anne's Mission Hospital. Bulilima District has 11 health centres.

Disability
Table 9.4 shows that one in every five households with children in Bulilima and Mangwe Districts has at least one person who has a disability, while in Plumtree it is about 10%.

Table 9.4: Prevalence of disability in households with children, by district

		Bulilima	Mangwe	Plumtree
Households with children (N)		14 047	10 109	1 648
Households with children and a disabled person	n (%)	3 227 (23.0)	2 313 (22.9)	155 (9.4)

Water and sanitation

Plumtree town is serviced by piped water, while growth points in Bulilima and Mangwe are serviced by both tapped water and boreholes. Close to 60% of the population in Bulilima uses water from wells/boreholes, with close to 5% of them unprotected, while almost a third of the population fetches water from the rivers, streams and dams (Munyati et al. 2006). Likewise, in Mangwe, 53.1% fetch water from protected wells/boreholes, 3.9% from unprotected wells/boreholes and 34.8% from rivers/streams/dams. In contrast, more than half of the households in Plumtree have access to piped water inside their houses and about 29.5% have piped water sources outside their houses (Munyati et al. 2006). The OVC census also found that the majority of the Bulilima and Mangwe populations had water sources either outside a radius of 500m (35.3% and 36.6% respectively), or more than a kilometre away (36.7% and 30.4% respectively).

The OVC census done by BRTI in 2003 also showed that 62% and 50.8% of the households in Bulilima and Mangwe respectively had no toilets, while about a third (32.6%) in Bulilima and 42.2% in Mangwe used the ventilated improved pit latrine (VIP). The latter is commonly known as the 'Blair' toilet and is a non-waterborne, improved pit toilet facility that is promoted in Zimbabwe's national rural water and sanitation programme. In contrast, more than three-quarters of the Plumtree town households had flush toilets.

Education facilities

Early childhood education has been recognised by the Ministry of Education, Sports and Culture (MoESC) as crucial to Zimbabwe. Bulilima has 111 centres for early childhood education and care, with only 29 of them being registered. The enrolment in the centres is 8 519 and the teacher/pupil ratio is 1:41. At the time this research study was carried out, several schools were in the process of implementing the recent MoESC policy that every primary school should have Grade 0 classes. There are 59 primary schools in the district, with an enrolment of 23 820, and 16 secondary schools, with an enrolment of 6 915 (MoESC 2005). The average teacher/pupil ratio in the primary schools is 1:37, while in the secondary schools it is 1:24.

Mangwe, on the other hand, has 103 early childhood development (ECD) centres, 45 primary schools and 12 secondary schools. Enrolments in the schools are 6 415, 15 757 and 5 014, for ECD centres, primary schools and secondary schools respectively. The teacher/pupil ratio is relatively low in this district with 1:22 in the ECD centres, 1:29 in primary schools and 1:27 in secondary schools. Both districts have adult and non-formal education centres, that is, 18 in Bulilima and 7 in Mangwe. The enrolment is 163 and 78 in Bulilima and Mangwe respectively, with more females than males in the programme (82.8% in Bulilima and 87.2% in Mangwe).

The majority of secondary schools in Mangwe District offer 'A' level education (Grades 12 and 13). Classrooms are inadequate, especially for secondary schools, although over 85%

of the schools are capable of accommodating their students. Over a third of the schools in the district suffer a huge shortage of furniture.

Bulilimamangwe has one vocational training centre, which is in Mangwe District and does not have any technical or teachers' colleges.

According to the OVC census done by Munyati et al. (2006) in 2003, in all the three areas, over three-quarters of the people had ever attended school: 82.8%, 78% and 76.9%, for Plumtree, Mangwe and Bulilima respectively. The reported levels of education attained among those who indicated that they had gone to school are summarised in Table 9.5. The table shows that the largest groups in Bulilima and Mangwe were those that had reached primary school level (71% and 70.3%), with only about 21% having attended secondary school; in Plumtree, the urban area, there were slightly more people (46%) who had reached secondary school.

Table 9.5: Population distribution by level of education attained in the districts

Education level	Bulilima N = 59 900 n (%)	Mangwe N = 47 068 n (%)	Plumtree N = 7 185 n (%)
Pre-primary	3 652 (6.1)	3 429 (7.3)	247 (3.4)
Primary[1]	42 792 (71.4)	33 107 (70.3)	3 172 (44.1)
Secondary[2]	12 636 (21.1)	9 789 (20.8)	3 320 (46.2)
High school[3]	334 (0.6)	331 (0.7)	203 (2.8)
Tertiary (no degree)	314 (0.5)	268 (0.6)	128 (1.8)
Tertiary (with degree)	172 (0.3)	144 (0.3)	115 (1.6)

The BRTI/National Institute for Health Research (NIHR) 2005 OVC census also found that a variety of reasons was given for those children who had never gone to school, and these are summarised in Table 9.6. The major reason given was that the children were 'still too young' (an average of 82% across Bulilimamangwe), followed by 'financial constraints' (an average of 10%).

Table 9.6: Reasons for children who had never gone to school in the districts

Reason for no education	Bulilima N = 14 920 n (%)	Mangwe N = 10 396 n (%)	Plumtree N = 1 343 n (%)
Financial constraints	1 796 (12.0)	767 (7.4)	98 (7.3)
School too far	241 (1.6)	177 (1.7)	7 (0.5)
Ill/sick	237 (1.5)	208 (2.0)	10 (0.7)
Still too young*	11 784 (79.0)	8 779 (84.4)	1 205 (89.7)
Other	862 (5.9)	465 (4.5)	23 (1.8)

** Zimbabwe's Ministry of Education, Sports and Culture policy states that a child must start going to school at the age of seven years. However, for this exercise, determination of the numbers of those who were too young to attend school were not analysed according to school-going and non-school-going age groups.*

2 In Zimbabwe, primary education covers Grades 1–7.
3 In Zimbabwe, secondary education covers Forms 1–4 or Grades 8–11.
4 In Zimbabwe, high school covers Forms 5–6 or Grades 12–13.

Energy, transportation and communication

Bulilima and Mangwe Districts are characterised by roads that are in a poor state and are impassable during the rainy season. The main modes of transport are buses, commuter omnibuses, private motor vehicles and taxis, but still these are inadequate and make the transport system unreliable, particularly public transport. Besides hindering easy movement of people, the lack of transport also affects the movement of agricultural produce, since key services such as the Grain Marketing Board (GMB) depots are available only in Plumtree town.

The area is serviced by two departmental post offices, four sub-post offices and two postal agencies. Mobile network operators barely cover the area, save for Plumtree, which is covered by all three mobile telephone networks (Telecel, Econet and TelOne). Fortunately, some wards have Botswana mobile network coverage and many people use these Botswana mobile phone lines. A communication centre offering public telephone facilities, fax and internet services was established in Plumtree, meaning that residents in Bulilima and Mangwe have to travel to Plumtree for the services. However, the public telephones usually do not work, due to vandalism and lack of maintenance. Very few households in Bulilima (2.0%) and Mangwe (3.5%) reported that they had a telephone, while in Plumtree town, almost a third of the households (30.8%) had a telephone (Munyati et al. 2006).

Slightly over half of the households (52.8%) in Plumtree town had a functional radio, while Mangwe and Bulilima had 27.5% and 30.0% respectively (Munyati et al. 2006). The study also revealed that very few households had a functional television (Bulilima 1.2%, Mangwe 1.6% and Plumtree 25.0%). Most parts of the Bulilimamangwe area did not even receive a signal for Zimbabwean radio and television. However, most parts of the three districts received Botswana radio and television services, which either use Tswana or English (Mahati et al. 2006). Most focus group discussion (FGD) participants said they could hardly understand these languages (2006).

In the rural districts (Bulilima and Mangwe), wood is commonly used for cooking, while paraffin is the main source of energy for lighting. The majority of households in Plumtree town use electricity for both cooking and lighting (Munyati et al. 2006).

Other services

Plumtree has one commercial bank, the Zimbabwe Banking Corporation. This bank often offers loans that do not need any collateral. The district is also covered by Small Enterprises Development Cooperation (SEDCO), which funds small- and medium-scale enterprises around the country, though its funds quickly run out, since it relies on the country's budget allocation. On the other hand, Agribank, which is the country's land bank, affords farmers cropping and livestock loans at concessionary rates. There is also a village bank, Dakose Ward Bank, which operates from Masendu (Bulilima District) and gives small loans to both members and non-members. The two districts do not have a single financial institution that funds purchase of assets.

Conditions of OVC

Magnitude of OVC problem

The latest figures, published in 2003, showed that about one quarter of all children in each district were orphans, with 12 880 (28%), 8 592 (23%) and 1 058 (25%) for Bulilima, Mangwe and Plumtree respectively (Munyati et al. 2006). During both in-depth interviews

and FGDs, community members said the magnitude of the OVC problem was big and they thought their number was ever increasing. For example, key informants in Bulilima District's Masendu ward said that in 2005 they had noted a general increase in the number of child-headed households in the ward. According to a survey which was conducted in 2003 by the Ministry of Youth Development and Employment Creation, there was an orphan in almost every home. AIDS was identified by most of the informants to be the main cause of orphanhood in the Bulilima and Mangwe Districts.

Information about the OVC in the communities was forwarded to community volunteers by community members. Each volunteer was allocated a certain number of houses to visit each week and they had a register of these OVC in the community. The volunteers conducted regular home visits to OVC households to check on their welfare.

Lack of money was greatly restricting OVC's access to educational and health facilities. Financial assistance to children who needed school fees from the Basic Education Assistance Model (BEAM), TBT and Esandleni Sothando were far from adequate. The Ministry of Youth Development and Employment Creation reported that there were Presidential Scholarships available, which mainly targeted students from resource-poor households. He said that out of the four scholarship places that were issued to the Matabeleland South province in 2006, three were given to students who had either lost one parent or both. The Mangwe District administrator said the majority of OVC were in school, since the rules about fees payment were not applied so strictly to them. An official with the Ministry of Public Service, Labour and Social Welfare (MoPSLSW) indicated that another major problem for OVC, in terms of access to services, especially schooling, was lack of birth certificates.

Health services were not adequate, but generally 'affordable' for rural people, as they were exempted from paying medical fees. However, this access to free medical care was being severely eroded by the fact that most of the government health centres did not have drugs and most people could not afford to buy the prescribed drugs in pharmacies. The pharmacies are situated in Plumtree and Bulawayo, which made the cost prohibitive for most people, as they could not afford the bus fares to travel to these places. The Ministry of Health and Child Welfare (MoHCW) officials revealed that the orphans were exempted from paying the nominal medical fee. However, the problem was that most of them, just like the rest of the population, could not afford to buy the prescribed medication, which was usually unavailable in the public health centres' dispensaries. The health officials further observed that the OVC from rural areas were usually brought to hospital when their health condition had already seriously deteriorated, because they would have encountered problems in raising money for transport.

OVC had access to social services, however, as there was no need for birth certificates in order to be registered with Social Welfare. The social services programmes were available, but not adequate, especially in terms of psychosocial support for OVC. Both Bulilima and Mangwe Districts did not have a single school for children with disabilities.

Major challenges, needs and concerns for OVC

According to the OVC, their major challenges, needs and concerns were school fees, stationery, food, school uniforms, clothing, blankets, farming equipment, labour to till the land, care and love, decent shelter and medical fees. The girls specifically said they also faced problems in getting sanitary wear, soap and other toiletries. During FGDs and interviews, adults concurred that the OVC were indeed facing these challenges. They

added that poverty was escalating the number of OVC, which was straining households' resources.

Generally, OVC's houses were in a poor state, especially child-headed households, including shortage of accommodation; for example, in the Ingwizi area in Mangwe District, a family of six was sleeping in one room. The problem of overcrowding was more pronounced in high-density suburbs of Plumtree town, and one community member estimated that on average six people, regardless of sex and age differentials, were sharing a room. For example, there was a case of a family of seven in Plumtree town, who had one room that was divided into two by a curtain, with the children in one half and parents using the other. A large proportion of orphans were staying in dilapidated dagha and pole huts, and most were living with their grandparents who reported that they did not have the resources to refurbish houses or build better houses, because of their old age.

Some OVC lacked care and this problem was more pronounced in child-headed households. Participants in an FGD for adults reported seeing many girls in these households falling pregnant, which they attributed to the girls' desperate search for love and protection.

Challenges and complications for caregivers

Parents and guardians of OVC faced a number of challenges in caring for OVC and chief among them was getting food. Persistent droughts were worsening their plight. They also mentioned that providing school fees and uniforms to the OVC was very challenging. There were very few clinics in the districts and some wards did not have a clinic. Most of the caregivers were unemployed and were earning a living through being informally employed by other community members. However, some key informants suggested that while working for other community members was a good source of income, it was counterproductive, as a significant number of caregivers were no longer spending time doing the necessary domestic chores or giving the children adequate care.

Most caregivers of OVC were not involved in income generating projects (IGPs). People had been taught for a few months, before the research was conducted, on how to write proposals for sourcing funds. In any case, some caregivers could not leave the children alone and go to work, because some of the OVC under their care were very young and in ill health.

Parents and guardians of OVC reported that community members did not know how to counsel OVC and their caregivers. An official with the MoHCW remarked that 'OVC bottle up their problems'. She said that OVC agonise about their problems on their own, but if they happened to come to the hospital, then they were counselled. MoCHW outreach programmes conducted visits to communities to teach them how to interact with and counsel orphans. However, the officer complained that during field visits, 'we are affected psychologically, as we meet children with no proper clothing or food and all you can do is counsel them and provide for psychosocial needs only'. The MoCHW officials revealed that very few nurses had been trained in counselling.

Challenges and coping mechanisms

Getting adequate basics such as food, clothing and education assistance in the form of school fees, uniforms and stationery, was a daunting task for most poverty-stricken parents and guardians of OVC in the drought-prone districts. Erratic rainfall patterns were affecting

livestock-keeping, crop production and the sustainability of the OVC Village Granary Project, all of which were resulting in severe household food insecurity. The NGOs added that they had not been getting enough support from GMB or council in order to support the OVC with grain. Their relief food aid was inadequate to support vulnerable families, especially child-headed families. Some NGOs said that providing OVC with shelter, especially if in urban areas, or giving them money or rent, was a problem.

The OVC were also experiencing constant abuse, especially verbal abuse, from their parents and guardians who themselves were battling to survive in Zimbabwe's hyperinflationary environment. Some of these children living under such difficult circumstances were trying to cope with the difficulties by spending most of their time away from home playing with friends, or isolating themselves from other children or by bottling up their problems. However, one community member argued that those who were isolating themselves from others would become vulnerable to sexual abuse. Providing emotional care to OVC was difficult for most people, as they pointed out that some OVC did not want to open up to others about their feelings.

The OVC, especially orphans and those children from broken families, often experienced difficulties in getting birth certificates and consequently they would have problems in accessing education. Money from BEAM was available, but was inadequate to assist many children; very often the funds were disbursed to schools very late and the child would have already been expelled from school. Many children were also reportedly failing to access education because there were no schools in their neighbourhood, and some were dropping out from school due to hunger. Though lucrative, the business of eking out a living from cross-border trading was fraught with dangers such as being exposed to risky sexual lifestyles or being robbed.

Various intervention agencies mentioned that the increase in the number of orphans was making it difficult to plan to provide education, health and care for these children. The health delivery system was characterised by shortage of essential drugs, staff and equipment. Changing the community's attitudes, especially in terms of being proactive in assisting OVC, was said to be very difficult, as some people did not want to be bothered to help OVC, arguing that 'we are not the government'.

The home-based care (HBC) services were being affected by the lack of resources, such as drugs and gloves, and naturally some carers' work was not satisfactory, because they did not want to risk their lives. Though materials for caregiving were usually supplied by the National AIDS Council (NAC) and hospitals, the supplies were not constant and were widely decentralised.

There were cases of abuse of children, especially orphans, and some of these cases were not reported to the police, due to the remoteness of the areas. Some caregivers were accused of diverting donated materials meant for OVC for their own purposes and at times giving them to their own children. One orphan interviewed reported, *'Mina izigqoko elanginika zona, umamoncane wapha abantwabakhe.'* (Clothes which were donated to me were taken by my mother's sister and she gave them to her biological child.)

Another challenge was that some parents and guardians of OVC did not want to listen to ideas from other community members about the welfare of children in their custody, as they believed that these people would 'want to run their homes'.

A large population of OVC and their parents and guardians were reportedly doing casual work and engaging in IGPs such as vending, brick moulding, gardening, catching mopane worms to sell and selling marula nuts. The few more enterprising ones were processing marula nuts to make nut butter and oil. However, some were resorting to selling their livestock and even property to get money, especially to pay for school fees and healthcare. Some parents, guardians and children as young as 13 were flocking to Botswana and South Africa to look for employment. Community members also reported that some OVC and their caregivers had turned to stealing and prostitution as survival strategies.

Some parents, especially mothers, were selling household goods as a coping mechanism after the death of their spouse. Some OVC interviewed claimed ignorance on what happened to the property of their late parent(s). There were cases of property disputes as a result of children not using the property.

Major threats to OVC's quality of life

The major threats to the quality of life of OVC in the districts were hunger, poor health, stigmatisation, sexual abuses, and lack of clothing and proper care. Consequently, because of lack of proper care, it was observed that most OVC had psychosocial problems. Household social instability, especially domestic violence (for instance, parents and guardians quarrelling), was also affecting the quality of life of OVC. Most children in child-headed households were malnourished and some unscrupulous people were taking advantage of them, especially the girl children staying without an adult, by sexually abusing them. Many of the girls therefore ended up in early and abusive marriages.

The head of the MoPSLSW in the two districts said there were many OVC who were not attending school, due to lack of money. He added that the other problem these children faced was lack of guidance, which often resulted in delinquency. Most OVC engaged in child labour as a survival strategy and, in doing so, were usually exploited. They worked under miserable conditions and were poorly remunerated.

It was reported that most girls, especially those who were orphaned and vulnerable, were being sexually abused under the traditional practice of *uMlamu*, which is still very prevalent in the area. Under this traditional practice, husbands are allowed to touch their wives' young sister's breasts, private parts and kiss them, which is claimed to be a way of sexually orientating the girls. A Ministry of Youth Development and Employment Creation official argued that the sisters' husbands' actions amounted to sexual harassment and should be banned. During the FGD for 15- to 18-year-olds, the girls reported that some sisters' husbands were exploiting this practice to lure innocent girls into having sex with them, a practice that is not even allowed traditionally. Although the Kalanga cultural custom of *Mholo wemizwane* was no longer being widely practised, some respondents believed that a number of old men were still practising it. According to this custom, the father of the newly wedded son is given the privilege of spending the first night with his daughter-in-law, even though the daughter-in-law's consent is not even sought.

Several community members pointed out that grandmothers normally understood the plight of orphans better than grandfathers, as some grandfathers would often say: '*Suka lapha, yimi engabulala unyoko?'* This means: 'Get away from here, am I the one who killed your mother?' Some non-OVC and caregivers reported that often OVC themselves were self-critical, resulting in them becoming shy and isolating themselves. It was argued that they became social misfits and failed to interact and socialise with other children.

Emotional and physical care of OVC

The general view across all the study participants, including government officials, NGOs and children, was that the OVC were being treated well by both their caregivers and community members, despite the deepening poverty. However, there were some voices of discontent towards the care of OVC, especially by the OVC themselves, who complained of harassment and physical abuse, even by the caregivers' own biological children. The chief culprits in the ill treatment of OVC were reported to be stepmothers and aunts. Some also complained that they were being overworked by being forced to do most household chores and working in the fields. Orphans indicated that they were deeply missing their late parents. Some guardians of OVC, who were experiencing difficulties in making ends meet, were verbally terrorising the orphans they were looking after in their households. These guardians were telling orphans to go to the graves of their late parents and tell them what they wanted. Because of their advanced age, some grandparents caring for OVC were delegating most of the domestic chores to these children.

The main primary caregivers of OVC were uncles, grandparents, sisters and neighbours. Of note was that some schools, for example, Izimnyama Primary School in Mangwe District, have mobilised their pupils to donate used clothes to OVC. They also sourced funds from donors and have established tuck-shops, the proceeds of which are used to support OVC in the form of school fees, uniforms and so on. Despite reeling from the effects of harsh economic problems, community members assisted OVC with books and some of them also ran gardens, using the proceeds to support OVC. BEAM, a government support scheme targeting school children from less privileged families, did not have adequate funds and one of its major shortcomings was that it did not disburse the assistance on time. The MoHCW was assisting underweight children with food, but the assistance was erratic and far from adequate.

Types of orphans and associated problems

The study revealed that double orphans were the worst off group amongst the different types of orphans, as they were facing a plethora of problems which included: not having caregivers; lack of adequate clothing; no one to pay school fees for them; inadequate food; being abused by their caregivers; trauma caused by parents' long illness, and not having money to pay for medical costs. Due to the host of problems, many double orphans tended not to socialise with other children. Large numbers of respondents observed that due to poverty and lack of guidance, some of these children resorted to delinquent behaviour such as stealing and engaging in early sexual relationships, especially the girl children, in the latter case.

Most respondents, especially children, reported that maternal orphans were living under more difficult conditions compared to paternal orphans, as far as psychosocial care was concerned. Children in all the three FGDs roundly condemned the stepmothers for causing untold suffering to OVC under their care. Fathers were accused of negligence in caring for their children when the mother had died because, as respondents pointed out, maternal orphans often had no one to cook for them; this was especially the case when fathers would frequently be away from home, leaving children from their earlier marriages or late wives at the mercy of vindictive stepmothers. People had a general perception that fathers were not as caring as mothers and they mentioned that maternal orphans often ended up doing difficult domestic chores, because they failed to find somebody old enough to do them. Stepmothers were accused of often making maternal orphans do particularly difficult household chores. One orphan aged nine said she laboured every day

to carry a 20-litre bucket of water from the borehole that is about a kilometre away from their homestead; but she could not say anything, as the stepmother would verbally and physically abuse her if she complained. Participants in an FGD with adults agreed that very often girls who are maternal orphans experienced difficulties in telling their fathers that they had been abused or asking them for things they needed, especially sanitary wear. Some respondents observed that some young widowed fathers became drunkards or womanisers, or remarried several times, leading to the children becoming disorientated, especially as far as moral behaviour was concerned.

In relation to the general living situation of paternal orphans, the main problems experienced were obtaining basic things such as food, school fees and clothing, as in most cases, their mothers were unemployed. One participant in an FGD for children between 15 and 18 years old pointed out that due to the absence of men in some households when the father had died, some young boys were forced to assume responsibilities of adult men in the household and these responsibilities weighed heavily on them. Some respondents observed that fathers generally treated children well and when they died, some of the mothers of paternal orphans became cruel to their biological children, as it had been only the father who could stop her from ill treating the children in the past. Participants in an FGD for children aged 10 to 12 years old concurred with the observation that the problem of shortage of basic things in households with paternal orphans was at times being exacerbated by mothers who would fail to get a caretaker for their very young children while they left the children to look for work. Adolescent girls who were paternal orphans were at great risk of being sexually abused by their stepfathers and the abuse often went unreported, because the children were afraid of creating tension between their mothers and stepfathers. Another problem faced by some paternal orphans was that of acquiring birth certificates, especially when the mother had remarried and former in-laws refused to cooperate with their former daughter-in-law to help her get these documents. To circumvent this problem, some children were being given the surname belonging to the new husband, who would then be willing to help. Though the children eventually obtained birth certificates, in the process, they lost their paternal identity.

Care and support structures for OVC

The extended family system was reported to be generally supportive of OVC, although it had been greatly compromised by the difficult economic conditions that were forcing community members and the immediate family to become self-centred. The system had also been eroded by westernisation and urbanisation. The extended family members were supporting OVC households with basic items, emotional support and educational support, but their support was far from adequate. People were also assisting their relatives who had OVC, by physically helping the families during crop and livestock production.

Some of the programmes such as nutritional gardens were sustainable, as the resources used were locally available. Community members in Bulilima District's Masendu ward were running a viable village bank.

There were many trained volunteers in the two districts who regularly visited OVC households to teach OVC about life skills, reproductive health issues and HIV/AIDS. The majority of the volunteers had received training on HBC and counselling. Volunteers also helped with refurbishing OVC's houses or with cleaning their houses. HBC volunteers, foster mothers and school heads helped in identifying children in need.

There was a strong presence of NGOs in the districts who were complementing government efforts by supporting the OVC with food, school fees, school uniforms and books; however, like the government, they were being overwhelmed by the magnitude of the problem. Some NGOs had specific food-aid programmes that targeted all the children aged five and under in vulnerable communities.

Food aid from donors was not consistent and people often went for two months without receiving anything. ARDA and the Catholic Development Commission (CADEC) gave some communities drip kits, but due to various factors such as shortage of animal draught power to fetch water, most of them had been abandoned. CADEC and World Vision were supporting households with seeds and livestock such as chickens. Some projects were reportedly being established in the community by donors, for example, the Joint United Nations Programme on HIV/AIDS (UNAIDS) soft loan scheme, which could only be accessed by people who had a project that had been running for a year. The few faith-based organisations (FBOs) that were operating in the two districts were providing moral support, food, clothing and counselling services to vulnerable households, regardless of whether they were members of their church or not.

There was an OVC Food Scheme (Granary Project) operating at village level in 11 wards, with a total of about 40 granary projects. The granary project scheme was aimed to meet the needs of OVC, without external service providers' support. Communities such as Masendu, Bambadzi and Izimnyama Small Scale Area have incorporated the traditional and local leaders into the system. They were supporting the volunteers in this project and it has become the pride of the local authorities, who were using the project as an example of sustainable community initiatives (TBT Health and Welfare Annual Report 2005).

The HBC had been distributing goods from donors, including medical kits, mealie-meal and shoes. Community members said the distribution of donated things to beneficiaries was generally marred by lack of transparency and fairness, and that nepotism was rife.

A six-tier system existed for the care of children in Bulilimamangwe Districts, which is as follows: parents; extended family; community; foster parent; adoption; and institution.

The community members, who were facing their own plethora of economic problems, were offering very little material support to OVC. They mainly gave OVC psychosocial support and at times contributed food, old clothes and money to assist OVC households buy basic things. Participants in an FGD with adults said that in some wards there were storage places for storing contributions from the community that were meant for vulnerable households. For example, in some wards, each homestead contributed one bucket of grain towards the OVC. Some wards were running nutrition gardens to help support these OVC. In Masendu ward, business people, including vendors, had been mobilised by community members to periodically donate money to assist OVC.

NGOs like Esandleni Sothando were teaching OVC about social-life management. Many community members, especially women, were reportedly interested in being trained in caring for OVC; for example by the end of 2004, 208 volunteer mothers had been trained, covering 11 wards, which included Huwana, Natane, Madabe and Bambadzi. Although the community appreciated the psychosocial support the OVC were getting from some community members, they were concerned that the peer educators were not well trained.

Communities had been very active in contributing towards support for OVC through initiating activities such as fundraising. According to TBT Health and Welfare Annual Report 2005, the Madabe community in Mangwe did fundraise and managed to buy material to sew uniforms for eight girl orphans. In Mphoengs, there was an OVC party initiated by the community that raised money for the orphans. There was also a three-day fundraising gala hosted and organised by Bambadzi in July 2005. The event was attended by over 2 000 people and it raised over Z$15 million to assist OVC. Many communities were implementing the idea of gift boxes, which support OVC at each gathering in the community, and Masendu and Izimnyama Communal and Small Scale communities were the pacesetters of this initiative.

Community members widely opposed the idea of putting children in institutions and rather wanted them to remain in their homes. They pointed out that placing children in institutions could result in the children becoming social misfits when they were moved out of the institution at the age of 18. People observed that some of the children who were raised in children's homes were engaging in criminal and delinquent behaviour. The police reported that communities were very vigilant in protecting children from abuse by reporting suspected cases of child abuse.

The government was assisting OVC through the BEAM programme with school fees and books. However, the fund was limited and the disbursement of money to schools was generally erratic. Furthermore, the government was assisting OVC with free medication at hospitals and clinics. Unfortunately, the medical centres were very far away and usually did not have the essential drugs, which left children with no option but to buy them in pharmacies. As well as assisting underweight children with food, the MoCHW also managed a programme of building toilets for OVC households. However, some key informants accused the MoHCW of doing their work only around Plumtree Urban. The local authorities at times assisted households through the public works programme, in which people worked for food, such as road construction. However, due to funding problems, this assistance scheme had usually been unavailable.

The NAC, through the Provincial AIDS Council (PAC), District AIDS Action Committee (DAAC), Ward AIDS Action Committee (WAAC) and Village AIDS Action Committee (VAAC), were running HIV/AIDS awareness and mitigation of HIV/AIDS impact programmes. They were assisting OVC with food, soap, school fees and clothing. NAC were working together with local authorities. In 2005, the local authorities, for example, Mangwe Rural District Council, were allocated 5% of NAC's budget towards assisting OVC. Other intervention agencies like Esandleni Sothando and TBT were complementing DAAC efforts by also paying school fees for OVC. DAAC, through the HBC programme, 'periodically' distributed medicine and medical kits to households with infected people.

Several key informants, including caregivers, reported that most of the OVC support structures were desirable and effective. However, they pointed out that the support was intermittent and far from adequate. Due to economic hardships in Zimbabwe and urbanisation, the traditional support structures needed to be capacitated. Some community members argued that resources were available in the community for the care of OVC but were latent; they therefore called for the education of communities on how to tap local resources in order to assist OVC. Indicators of success of these supporting structures were that many people were assisting the OVC voluntarily, even if mainly in terms of psychosocial support; there were no reported cases of death due to hunger; cases of malnutrition in children were decreasing; attendance of OVC at schools had improved and

children were now better clothed. The key informants said that for the support structures to work well there was need for them to urgently obtain financial and material support from the state and donor community.

Community members were generally appreciative of the work of caregivers, though some had ill feelings towards caregivers, especially the volunteers, who were unfair in distributing goods from donors. In several wards there were volunteers who were being used by their respective communities to check on the welfare of OVC through regularly visiting their homes, disseminating information on HIV and AIDS, hosting visitors, catering, documentation of community events, and so on. According to TBT Health and Welfare Annual Report 2005, this programme had been adopted by many communities and by the end of 2005 there were about 883 registered volunteers. Their good work had resulted in the mobilisation of youths to take part in community social development, such as in Masendu and Izimnyama Communal and Small Scale Areas.

A significant number of schools in both districts had at least two teachers (male and female) who had the added responsibility of assisting OVC at their school in terms of initiating and running OVC IGPs, documenting their needs, giving them psychosocial support, and mobilising support for them from other pupils and the community (Magome 2006). The OVC teachers programme was being spearheaded by the TBT. The trust and OVC teachers, in collaboration with their partners such as Matabeleland AIDS Council (MAC) and DAAC, conducted peer education sessions in schools and in communities, particularly in the clinics. School teachers also taught their pupils about sex, child abuse, reproductive health and HIV/AIDS (Magome 2006).

Asiphileni Support Group, which was a group of women who had been open about their HIV status, was active in Dombolefu Ward's village 28 (TBT Health and Welfare Annual Report 2005). They reared goats for resale to take care of the OVC under their care. They had organised themselves to such an extent that they were assisting other communities form support groups to live positively by engaging in projects that can access funding from DAAC and the National AIDS Levy proceeds. In 2005, the group started running a herbal garden and the local leadership was very firm in overseeing its management (TBT Health and Welfare Annual Report 2005).

Attitudes of the community towards OVC

The majority of community members, including non-OVC, had positive attitudes towards OVC, whilst a small section of the community had negative ones. Most people felt pity for these children and despite also experiencing a shortage of basic things themselves they still helped the OVC, especially with food, clothing and giving love. Non-OVC said that they were giving companionship to OVC and the OVC themselves acknowledged their support. The district administrator (DA) of Mangwe attributed the community's positive attitude towards OVC to the high death rate of parents, which left massive numbers of orphaned children. Parents therefore saw the high death rate as indicative of the fact that they were not immune to death, which consequently meant that their own children would also need support from the community after they (the parents) died. Furthermore, the traditionalist leadership structure of the society, which was predominantly Kalanga culture, abhorred the shunning or stigmatising of OVC.

Many community members and OVC expressed their disgust over the widespread use of the term *intandane* (orphan) by community members, including their primary caregivers,

arguing that it was derogatory. However, the researchers found that some non-orphaned children, especially those in primary school, looked down on orphans, ill treated them (with both verbal and physical abuse) and had reservations about interacting with orphans. Adults in an FGD widely agreed that the seeds of hatred towards OVC by some non-OVC had usually been sown by their parents and guardians, who regarded OVC as useless and hopeless deviants. For example, in Plumtree town's Dingimuzi high-density suburb, a mother of a school-going boy aged six with Down's syndrome, reported that her child was stigmatised by other children because of the influence of their parents. As a result of the stigma and discrimination experienced by the child, the mother had resorted to locking her child in her house to prevent him from trying to interact with the hostile children. It was also found that the way orphans were treated also largely depended on how her/his deceased parents used to relate to other people. If the late parent was aloof or anti-social, people usually showed their offspring the same kind of treatment. Furthermore, a section of the community would stigmatise orphans whose parents had died of AIDS, sometimes going to the extent of saying, *'Lo uzafuza abazali bakhe.'* (This orphan will meet the same fate which claimed the lives of his/her parents.)

In an effort to erase the perceived differences of outlook between OVC and non-OVC, some communities, for example, Izimnyama, periodically donated their old clothes to OVC in their midst. The Masendu community organised trips to tourist resorts, including both OVC and non-OVC on the trips, as well as organising Christmas parties for OVC and non-OVC.

Suggestions on how to help OVC

Stakeholders on OVC welfare, including the affected children themselves, suggested various ways of helping the OVC at household, local and national levels and they are as follows:

- Traditional leaders and NGOs said the government should strengthen its partnership with NGOs in assisting OVC, as the community cannot shoulder the burden alone. The intervention agencies, after combining efforts, should provide OVC with food, housing, educational support and clothing.
- To build children's homes for children with disabilities such as mental retardation, to shield them from being stigmatised and discriminated against.
- Government should increase the number of BEAM beneficiaries by improving its budget allocation. However, they stressed that it should not focus on their educational needs only. The government should source drugs to OVC and give them free of charge.
- BEAM should expeditiously disburse money to children, so that their schooling is not interrupted.
- The traditional leaders and caregivers said the government should formulate OVC-friendly policies that are formed at grassroots level, as the people on the ground know what is happening.
- Government should not abdicate its responsibility of looking after less privileged members of the community to NGOs. The Department of Social Welfare should be more active in helping the less privileged children. It should put in place programmes to educate people to accept OVC and also should assume the main responsibility for looking after them.
- Government should decentralise social welfare and health services, even to remote areas of the districts, so that OVC everywhere can access these services.

- The state should do more in mitigating the impact of the HIV and AIDS epidemic on vulnerable populations, for example, through the widespread provision of free antiretrovirals (ARVs). They urged the government to speed up the process of decentralising the distribution of ARVs.
- The state, through the Social Welfare, Health and Education Departments, should tighten the enforcement of policies and laws that protect OVC.
- Comprehensive and up-to-date information on who is doing what, when and how for OVC should be available to government departments, NGOs and CBOs, so that there is collaboration and no duplication of intervention activities.
- Caregivers and NGOs said there should be a coordinated approach by government departments that deal directly or indirectly with OVC welfare.
- NGOs and government officials called for the sensitisation of people about the need to make a difference in the lives of OVC, especially through the use of cheap local resources. Community members should dig deep into their household pockets and help with blankets, soap, food and clothes.
- To establish fields, especially in irrigated areas, to assist OVC; the government should pay the people working in these fields.
- Individuals should be warm-hearted and they should provide OVC with labour, for example, during crop production. Individuals should also assist OVC to start IGPs and to facilitate this process, people need education to help them appreciate the gravity of the problem. People were reluctant to participate in OVC-caring programmes and some argued that 'those people who usually assist OVC should continue doing so as they are gaining something'.
- Individuals should work together on IGPs to assist OVC. However, the local authorities were urged to relax the prohibitive by-laws they had started enforcing more stringently after the government 'clean-up' exercise (*Murambatsvina*) in 2005 (Loudon 2003).
- CBOs should facilitate the implementation of IGP projects and, to do so, they needed to capacitate the community to run them and mobilise financial backing from the local and international donor community.
- NGOs urged the communities, especially leadership, not to divorce themselves from supporting and participating in NGOs' programmes aimed at assisting OVC.
- Besides assisting OVC with fees and other educational material, FBOs should scale up their home visits to OVC households, as this brings them hope.
- Research should periodically be conducted to provide accurate and reliable data on the needs and magnitude of the OVC problem. Furthermore, even though the government had limited resources it should strive to use the data collected. Intervention agencies' work should be informed by research. Various people accused the intervention agencies, including the government, of not using research findings in their operations.
- Traditional leaders and caregivers said traditional practices of teaching children about values and norms, through aunts and uncles, should be revived. However, some caregivers and FBOs emphasised that children should be instilled with Christian values.
- To intensify outreach programmes in the community targeting both adults and children on the importance of not stigmatising and discriminating against OVC.
- Volunteer caregivers wanted to be helped with bicycles to increase their mobility in covering the community. Bicycles would help them to monitor OVC households on a regular basis. They pointed out that the volunteers in wards where World Vision had donated some bicycles to them, had made a positive impact.

- Government and traditional leaders said OVC support structures should be community driven so as to ensure sustainability.
- CBOs and NGOs should sensitise people about providing physical and emotional support as well as educational support to needy children.
- To motivate volunteers who assist OVC through giving them some incentives.
- OVC should show appreciation and respect to their benefactors.
- To train volunteers in orphan-care work, in order for them to execute their work well.
- Communities should start self-driven, community-based volunteer programmes.
- Aid agencies should continue to assist OVC until they can fend for themselves. Organisations have a tendency to assist OVC only up to a certain age limit, which is usually 18 years old. Further, they urged the government to continuously monitor the welfare of the orphaned children.
- To educate OVC and their caregivers on herbal use and how to cultivate herb gardens, as modern medication is very expensive.

Policy and legislation for the protection of OVC

Ordinary community members were generally aware of the laws that protect children from abuse, but they still needed to be enlightened on other laws, especially recent laws that also protected them. It was reported that most people were violating children's rights, not by design, but out of ignorance. Some key informants reported that there was a lack of awareness of recent or new legislation that protects children, on the part of community leaders and even officers from child-related organisations.

In an FGD with adults, the participants agreed that people were aware of children's rights and that they found these laws acceptable. They suggested that there was a need to have community meetings to discuss the laws and policies that focused on improving the legal well-being of children. For example, people should know how to assist children whose surviving parent was selling their household property. They reported that the local leadership had been trying its level best to guard against such exploitation of the situation by the surviving parent. They reported that volunteers made periodic visits in the communities, asking OVC and non-OVC if they were being treated well. Some participants found the Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996) a hindrance to efforts to assist vulnerable young populations, as the Act specified that those who were 18 and above were not eligible for support, because they were considered to be adults.

In an FGD with children in the 10 to 12 age group, it was clearly shown that children were aware of their rights, especially the right to education, food and protection. They pointed out that the policies that safeguard children's rights were not being fully respected, as some children were not attending school, even if parents could afford to send them to school, and some children were not even getting food. The children further reported that there were very few cases of children reporting child abuse, as they were either threatened or feared being victimised. In a separate interview with a key informant from the MoHCW, it was reported that some community members were not willing to implement the laws that protect children due to fears of being accused of interfering in other people's private affairs. The informant said that in a village, for example, if people knew that a particular person had exposed a neighbour for child abuse, they would then hate him/her. Cases of children being dispossessed of their late parents' estate were common, especially those orphans whose parents had been wealthy. On a positive note,

there was a legal project centre that worked closely with DAAC in assisting OVC with inheritance issues.

Contrary to perception that the common person was aware of laws that protect children, the Zimbabwe Republic Police (ZRP) reported that people were in fact not knowledgeable about these laws; for instance, during school vacations children were employed on the farms, which amounts to child labour, but the employer would think it was a form of assistance to the child, since they paid them or bought them food. They also reported that the general public was not aware of the Sexual Offences Act (Chapter 9:21 of 22/2001); for example, families were consenting to their girl children getting married at the age of 15. Furthermore, they indicated that some parents, especially single mothers, engaged in sexual activity with their boyfriends in the presence of the children and, as a result, if a child was sexually abused, she/he thought it was something normal.

The ZRP reported that the major challenge in legally protecting children was that people were not reporting cases of child abuse and rape, because they wanted to take matters into their own hands, since most abuse cases were perpetrated by relatives. In a bid to raise awareness about children's rights and how they could enforce these laws, the Student Partnership Worldwide (SPW) engaged a law firm to run a discussion forum that would bring these issues to the fore, especially among the youth.

The DA cited another challenge in legally protecting children, which was that traditional practices were at variance with some of the western laws, for example, on the right of children not be physically abused; some parents still rooted in tradition believed in corporal punishment and also believed that children should be taught to be self-reliant through being given some physically demanding household chores. In fact, there was no consensus among adults in an FGD on what constituted physical abuse and what child labour meant. Traditional practices posed a major setback in the enforcement of these laws, so there was need to marry the two. There was resistance to these laws in some communities, due to lack of understanding, indicating that there was a need for more awareness campaigns to erase this ignorance.

The TBT reported that implementation of these laws and policies had been a problem in some communities, especially in the community of Makhulela, which mainly comprised San people; according to them, there was nothing wrong with a child not attending school. Law enforcers, for example, the village heads, chiefs, police, and Departments of Home Affairs and MoPSLSW, by their own admission, said they were not effective in enforcing child protection laws, mainly due to lack of both financial and skilled human resources.

HIV and AIDS

Despite the absence of official statistics about HIV prevalence in Bulilima and Mangwe Districts, there was widespread consensus amongst key informants in these districts that HIV and AIDS had devastated households, as evidenced by the huge numbers of orphaned children and people living with HIV and AIDS (PLWHA) in the communities. A representative for the MoPSLSW said that although they did not have estimates of the number of PLWHA, they were of the view that the virus was most prevalent in males in the 30 to 50 age group and females mainly in the 15 to 35 age group, as indicated by the high death rates in these groups.

Many respondents, including those from the MoHCW, observed that the problem was not receding and they accused PLWHA of wilfully infecting others. Despite a culture of fear having engulfed the districts, as a result of too many deaths related to AIDS, respondents were unanimous in saying that people were still engaging in risky sexual behaviour. They pointed out that HIV and AIDS were mainly being driven by poverty in the country.

The majority of respondents, including children as young as eight, were knowledgeable about HIV and AIDS. They said that everyone was talking about HIV/AIDS and they were aware of how to prevent it. Many respondents reported seeing many migrant workers and deportees from Botswana and South Africa coming back suffering from AIDS-related diseases, or even in coffins. The head of the Ministry of Youth Development and Employment Creation in the two districts reported that there had been an increase in the number of migrant workers who were departing from the norm of leaving their spouses behind in Zimbabwe. He said they were now taking their wives along with them to South Africa and Botswana, so that they would not have to look for casual sex partners.

The MoHCW reported that even though there was an increase in the number of people getting tested for HIV, disclosure of HIV status, even to sexual partners and family members, was still a major problem. Mangwe's DAAC reported that in Plumtree Urban, there were close to 40 people who were HIV positive. However, the official cautioned that this number was most likely an underestimation.

The HIV/AIDS epidemic has impacted negatively on community resources and the social functioning of the community. Some community activities were constantly being postponed, because people attended countless funerals and looked after the sick; at times, such activities were entirely abandoned as the prime movers of these activities succumbed to the deadly disease. Household and community resources were often being diverted from developmental programmes, to assist orphans, PLWHA and bereaved families. Thus, besides creating orphans, the epidemic was also making many households very vulnerable to socio-economic problems. Many respondents welcomed the decay in the traditional safety-net system of widows being looked after by relatives inheriting them as wives, which was a result of people being afraid of contracting HIV; some men, however, including traditional leaders, expressed regret that this decay of the system was resulting in widows being neglected. In a related development, the research study found that the widows were having problems with instilling discipline in their orphaned children, as there was no father figure in the family.

Some senior government officials who were interviewed were not happy about the channelling of 'a lot of money' to HIV and AIDS programmes, as they were constantly forced to shelve implementing other developmental programmes, due to the non-allocation of adequate financial resources from national fiscal funds. There was a widespread acknowledgement by all the government ministries that included child-related programmes, that the state's budget was strained as a result of the huge cost of mitigating the impact of HIV and AIDS through the provision of drugs, funeral assistance to civil servants, and care and support programmes. They further said that the epidemic had also affected their operations, because they were also experiencing high death rates among the trained workforce and high absenteeism rates, due to AIDS-related illnesses and workers missing work to attend numerous funerals; all these factors were leading to staff being overworked and demoralised. A community member stated that, on average, peoples' programmes were disturbed two to three times a week to attend burials. A local leader further commented that an air of death was engulfing the area as the numerous deaths

were affecting people psychologically, as they were thinking, 'If so-and-so is dead, so-and-so is next; am I the next one?'

Care and treatment of PLWHA

There were various care and treatment services available for PLWHA in Bulilima and Mangwe Districts. There was a voluntary counselling and testing (VCT) centre in Plumtree town, but no VCT services in the rural areas. There were a few mobile VCT services that covered the two districts, but their movements were very erratic. People had to travel long distances to Plumtree town for VCT services.

Mangwe's DAAC reported that PLWHA could access ARVs at Brunapeg hospital, but just as in Bulilima District, most people were not accessing them. At the time of the study, ARVs were not available at the Plumtree District hospital, but could be obtained from Bulawayo's Mpilo hospital. Plumtree hospital provided VCT services that were funded by a Spanish organisation and the hospital also ran a PMTCT programme. The Ministry of Health officials in Plumtree reported that women under the PMTCT programme were experiencing difficulties in explaining it to their in-laws and some were being blamed for bringing AIDS into their families; another challenge for these women was that males were generally reluctant to participate in this programme. A member of a PLWHA support group said that ARVs were also available from private doctors in Plumtree town, but the cost was beyond the reach of many people. There were HBC, peer education and nutrition programmes in the districts. Treatment for opportunistic infections (OI) was available in clinics and hospitals for PLWHA.

Caregivers, ordinary community members and orphans interviewed were not aware of VCT services in the two districts and where to get the ARVs. The research study found that the VCT services were not being fully utilised, due to people's negative attitude towards getting tested. Furthermore, an official with the MoHCW pointed out that most people in outlying areas of the districts argued that there was no merit in the idea of using their limited money to travel all the way to Plumtree town to get tested, especially if one was not yet ill. There was a need for more information on ARVs at the hospitals and these ARVs should be made more easily available. A MoHCW official argued that if there were proper resources available to support HBC programmes, more people skilled in HBC work, and more VCT services available, the problem of stigma would be removed and testing would become the norm.

The respondents were predominantly in favour of being tested for HIV, rather than not being tested. They pointed out that the chief advantage for being tested was that people would give an infected person proper care and the infected person had access to donated ARVs from hospitals. They argued that being tested for HIV also led to peace of mind, proper planning of one's life and responsible sexual behaviour, though they pointed out there were some who would still wilfully spread the infection, arguing that, *'ngiyakufa labanye'* (I'll not die alone). A member of a PLWHA support group said the other advantages of disclosing one's HIV positive status was that it would help humanity, as it would raise awareness of the gravity of the AIDS problem, warn other people and help other people to see that one can live positively with HIV. People added that, at a personal level, those who disclosed their HIV status could get capital to start an IGP, be treated well by people and at work, and would not be assigned to do too much work.

In addition, the respondents, who included a member of a PLWHA support group, said that the greatest disadvantage of disclosing one's HIV positive status was the backlash from community members, family members and even fellow church members, in the form of being stigmatised and discriminated against. A community member in Plumtree town said people would accuse those who publicly declared their positive HIV status of wanting free food that is reserved for PLWHA and their households. A caregiver argued that it was stressful knowing that one was infected with the deadly virus and that, in any case, one would not get any help; yet he or she would have exposed him/herself to public ridicule.

In some wards, there were macro-finance projects targeting PLWHA, who also received supplementary food from NGOs such as World Vision. At times, the HBC services were able to get cement to build toilets. However, some caregivers said HBC were not very helpful, due to shortage of drugs, and the volunteers were finding it very difficult to look after PLWHA. DAAC provided basic food stuffs and toiletries (soap, cotton wool, Dettol, linen) to assist PLWHA and their assistance was reported by caregivers and PLWHA alike to have had a positive impact. Very few affected people were being assisted, due to shortage of resources.

The HBC services were reported to have had a positive impact on PLWHA, but their medical kits were not well equipped, thereby posing risks to those taking care of the infected people. Hospitals were overstrained and so they were putting many people on to HBC. Unfortunately, in some cases there was no one to look after PLWHA at home. Most people looking after PLWHA were not trained in HBC and they were endangering themselves by their poor caring practices. Due to lack of training on how to handle PLWHA, some caregivers were treating them in harmful ways. There were few nursing homes in the two districts and very few PLWHA were going to them, as the cost was too prohibitive.

Major sources of information on HIV/AIDS

The major sources of information on HIV and AIDS in Bulilima and Mangwe Districts were the MoHCW, through the following channels: the ministry's health centres; DAAC; WAAC; PLWHA; CBOs; NGOs (for example, World Vision, MAC, BRTI, Corridors of Hope and SPW); police outreach programmes to schools; workshops; books; pamphlets; peer educators, and community health workers. Some NGOs such as the SPW were organising sporting events, which they used as bait to attract the youth, so that they could then provide them with information about HIV and AIDS.

Bulilima and Mangwe Districts included a large population of men who were migrant workers in neighbouring countries, especially South Africa and Botswana, and this population was very elusive, making it difficult to target the migrant men with information about HIV and AIDS. The migrant workers usually came back into Zimbabwe in massive numbers during major public holidays like Christmas, but talking to them at such times was usually difficult, because their schedules would be too congested to have time to discuss health issues. A key informant in the MoHCW mentioned that another problem in disseminating information to this population was that many migrants were illiterate and illiteracy was therefore blamed for their disdain towards listening to their wives telling them about HIV and AIDS-related issues.

The other common challenge in providing information about the epidemic was that although women had access to information, especially through their antenatal visits, men did not have similar avenues for accessing this information. Consequently, many men were viewed as unappreciative of the merits of going for HIV testing and counselling.

Both the print and electronic media had low coverage in the district and were rated poorly in terms of providing sources of information about the epidemic. The Zimbabwe television and radio services, as mentioned before, had poor signals in the districts and the Botswana television and radio, which broadcast in the area, used the Tswana language, which most people could not comprehend. Most interviewees said they could not afford to buy newspapers and there were no libraries where they could read them.

Risks of HIV/AIDS as a result of violence

Community members and the police reported that cases of child abuse were low, but the police were quick to point out that a lot of these cases go unreported because they happened within the private sphere (homes). Although the MoHCW officials did not furnish the research team with statistics, they differed from the police by reporting that incidents of child abuse, rape and molestation were on the increase. The main perpetrators of child sexual abuse were reported to be close male relatives, men in general and domestic workers. Most of the victims were young girls and women.

It was widely suspected that some children either feared reporting cases of abuse or were being forced to withdraw charges by their relatives, who did not want to see the incarceration of a relative in prison. Cases of statutory rape and indecent assault were very common and, according to children, the main perpetrators were teachers. These cases again often went unreported, as the culprits, in order to save their jobs, persuaded the parents or guardians of the victims not to file charges against them by promising to marry the minor they had abused. MoESC's fight against child abuse adopted a zero tolerant policy towards teachers who have sexual relationships with pupils and several teachers had been dismissed from the teaching profession after violating this order. In most cases, these men were reneging on their promise to marry the young girls they had abused. An official with MoHCW claimed that male HIV-positive perpetrators were mainly targeting primary school-going children and, in the majority of cases, these children later tested HIV positive.

There was a counselling centre for victims of sexual abuse at Plumtree hospital and MAC satellite centre, but accessibility remained a problem for the rural populace. There was a Victim Friendly Corner at every police station in the two districts and at the SPW office in Plumtree town. The Ministry of Social Welfare reported that the Msasa Project in Bulilima's Vulindlela ward was offering counselling services to victims of abuse, especially girls and women, but it felt that Msasa Project needed to expand its services to other wards. The Legal Foundation Resource Centre was also offering counselling services, especially to victims of domestic violence. Victims of sexual abuse could also go to the New Start Centre, whose services were free, or to public hospitals, for counselling. The Ministry of Youth Development and Employment Creation said counselling services were not widely available and accessible to all members of the districts.

The practice of taking payment for sexual services was reported to be prevalent, especially among children not attending school. Commercial sex work was generally rife in the districts, especially in the border town of Plumtree, and festive seasons were characterised

by an influx of young prostitutes from as far away as Harare and Mutare, seeking the attention of *injivas* (migrant workers) who would be back in the country. Some children were also involved in border-jumping and at times were deported from Botswana and dumped in Plumtree, where they would be stranded. The girls then usually resorted to prostitution to raise money for transport to their homes or back to Botswana.

The Mangwe DA said that besides sexual abuse, children were also being beaten, verbally abused and overworked by their guardians. During FGDs and in interviews with OVC, the guardians who were mostly accused of terrorising the children were stepmothers and aunts. Many respondents, including OVC themselves, accused some caregivers of being uncouth, as they were fond of uttering vulgar words towards the children they were taking care of or of mocking the children's dead parents, for example, by saying, 'your parent(s) sourced their death'. The head of the MoPSLSW in the district reported that cases of child labour were rampant in the two districts, as the middle- and upper-class people were exploiting the desperate needs of poor children.

OVC's behaviour in relation to HIV and AIDS

Some participants in an FGD for 15- to 18-year-olds said some undisciplined OVC, especially those under the care of elderly people, were indulging in sex. They observed that girls were the ones who were mostly engaging in premarital sex, as they were lured by men who promised to give them money, food and clothing. Participants pointed out that by virtue of the fact that they were poor, most young boys were not engaging in sexual relationships. Although there was a perception among some community members that OVC were generally misbehaved, most respondents said there were no remarkable differences in sexual behaviour between OVC and non-OVC. They argued that some OVC, especially as a result of the traumatic experience they had endured in looking after their parents who died after long illnesses, vowed not to engage in sex and were not violating their vows.

Children in the 10 to 12 age group FGD, reported that their parents were not talking to them about HIV/AIDS and sex, believing that they were too young; but their teachers did discuss the issue. However, they indicated that their parents were talking to them about sexual abuse, such as rape and touching of private parts, and also instructed them to refuse to accept money from strangers. Teachers talked to children about reproductive health and also the dangers of having premarital sexual relationships.

Suggestions on how to limit the spread of HIV/AIDS

Members of the community, government officials and NGO members proffered several suggestions on how to limit the spread of HIV and AIDS in the community. The head of the MoPSLSW in these two districts suggested that intervention agencies must not tire in their efforts to fund programmes aimed at changing sexual behaviour, especially as some people have not translated their knowledge about the epidemic into positive behaviour. This view was echoed by some health workers, who also suggested setting up peer-group centres in the communities. Many key informants, including a DAAC official, called for the involvement of traditional leaders in speaking out against premarital sex and infidelity. However, some people added that the traditional leaders should be equipped with knowledge on HIV and AIDS, as most of them had scant information about it.

Participants in an FGD with adults strongly called for the urgent creation of jobs in Zimbabwe and more specifically in the rural areas, where the majority of people lived;

they noted that the lack of employment opportunities was fuelling the spread of HIV and AIDS, because married people, especially men, were leaving their spouses in search of jobs in neighbouring countries. The participants accused some of the women married to migrant workers of practising prostitution to supplement the erratic remittances they received from their husbands or of simply succumbing to 'the periodic nature's call to have sexual gratification'.

During an FGD, some adults suggested the mobile films (*amabhayisikopo*) programme targeting rural communities should be revived by the government, but with a special thrust on showing the various effects of the AIDS epidemic. This would help community members, especially children, to appreciate the gravity of the AIDS and orphanhood problem. While FGD participants said that HIV and AIDS issues should be discussed at all forums and every day, as people were generally doubtful about 'can I really contract it?', they however cautioned that HIV and AIDS should be treated like any other life-threatening disease such as diabetes and cancer. They emphasised that HIV and AIDS awareness programmes targeting commercial sex workers should be strengthened and efforts should be made to economically empower them, so that they would no longer view that practice as a viable and sustainable livelihood option.

Government officials, who included those from the MoHCW, said the PPTCT programme should be publicised and scaled up. The head of an NGO advocated the compulsory testing of all pregnant women for HIV and that all those infected with the virus should have free access to PPTCT. A representative of the PLWHA group said people should be taught how HIV was transmitted, the importance of knowing one's HIV status and how they could prevent it. She stressed that people should be taught that the deadly virus did not discriminate, as both rich and poor, married and single people were contracting it. Educational programmes about HIV and AIDS in schools should be enhanced through training teachers on how to effectively teach the subject. An official of the Ministry of Youth Development and Employment Creation called for the injection of more money into HIV and AIDS awareness programmes targeting the youth and for a review of the current strategies for fighting the spread of the epidemic among the youth.

A DAAC official suggested that there was urgent need to improve health services, since there was a serious shortage of drugs, health equipment, transport and staff. He further suggested that the HIV and AIDS policy should be revised, especially in terms of disclosure of HIV status; for example, he proposed that the HIV status of an individual should be written on their birth certificate.

Profile of government departments

The following section covers child-related government departments; members of the departments were interviewed during the situational analysis.

Ministry of Health and Child Welfare

'A well-functioning health sector is an essential element of any national response to AIDS and is crucial to meeting three of the eight Millennium Development Goals' (UNAIDS 2006).

Background/activities

Bulilima, Plumtree and Mangwe Districts share one district hospital which has 140 beds. There are 2 mission hospitals in Brunapeg and Mangwe. In Bulilima there are 13 health centres, including 2 rural hospitals, whilst in Mangwe there are 12 health centres.

The Ministry of Health and Child Welfare's main source of knowledge about OVC are registers that are kept at local health centres. The ministry does not directly help orphans but it assists them through programmes such as nutritional support, through giving food packs. The senior staff interviewed observed that the numbers of OVC were increasing, as shown by the fact that households with orphans have increased and dependents have increased the strain on the bread winner. For instance, there would be more people to look after with very little money.

Table 9.7: Statistics of PLWHA: Plumtree District Hospital

Year	Bulilima	Mangwe
2002	52	44
2003	103	86
2004	170	134
2005	223	212

Source: Plumtree district hospital, Ministry of Health and Child Welfare

Table 9.8: Staff complement: Plumtree District Hospital

Job title	Post	Filled
Nurse	98	35
Nurse aid	16	15
Matron	1	0
District nursing officer (DNO)	2	2
Community health sister	1	1
Community sister	2	1
Environmental health technician (EHT)	35	17
Field orderly	5	8
Medical lab scientist	2	1
Pharmacist	2	0
Pharm-tech	2	1
Doctor	4	1
District medical officer (DMO)	2	0
Clinical officer	1	1
Radiographer	1	0
Radio assistant	1	1
Physiotherapist	1	0
Rehab-technician	3	3
Health promotion officer (HPO)	1	1
Dental therapist	1	1

Job title	Post	Filled
Institutional domestic supervisor (IDS)	2	1
Environmental health officer (EHO)	2	2
TB coordinator (EHT)	2	1
Provincial environmental health technician (PEHT)	1	1
Sister-in-charge	7	3
Microscopist	2	2
District health services administrator (DHSA)	1	0
Accountant	1	1
Assistant accountant	1	1
Clerk	6	5
Telephonist	5	3
Health information officer	2	1
Driver	7	5
General hand	21	18
Mortuary attendant	2	2
Primary care nurse	12	16

Source: Plumtree District Hospital, Ministry of Health and Child Welfare

Challenges

The major challenges facing the MoHCW were as follows:

- Critical shortage of drugs.
- Short-staffed (have 50% or less of normal staff load).
- Critical shortage of health equipment, including vehicles (did not even have an ambulance).

Ministry of Public Service, Labour and Social Welfare

Background/activities

The Ministry of Public Service, Labour and Social Welfare, as a government arm, has a major role in caring for children. It is mandated to put in place legislation that deals with the protection of children, including policies and legislation such as the Children's Act (Chapter 5:06 of 14/2002), Guardianship of Minors Act (Chapter 5:08 of 2002) and Maintenance Act (Chapter 5:09 of 22/2001).

It has programmes for assisting OVC, including BEAM (assists children with school fees, school uniforms, stationery and so forth), which used to be SDF in the past; however, the really needy were not accessing the assistance due to exorbitant bus fares. Now BEAM beneficiaries are selected at school level and schools are given budgets from which to work. There is also the Foster Care Programme, whereby probation officers can recommend cases for foster care. Beneficiaries then get a monthly allowance from the Social Welfare Department.

Under the Public Assistance scheme, the guardian applies for assistance and is given a monthly allowance; this scheme is open to all needy cases. The Social Welfare Department, through the Assisted Medical Treatment Order, also assists, especially with regard to cases referred to Specialist Services. However, just a few cases, maybe only 20, are in fact assisted, because of shortage of funds.

Even OVC have access to social services, as there is no need for birth certificates to be registered with Social Welfare.

Selected aid programmes

Table 9.9: Distribution of BEAM beneficiaries 2005

District	Primary schools	Secondary schools	Total number of children
Bulilima	Z$265 187 000*	Z$193 791 000*	24 373
Mangwe	Z$199 720 000*	Z$145 940 000*	18 356

**Before revaluation of 21 August 2006*

Table 9.10: Food assistance (maize)

District	Amount	Number of beneficiaries
Bulilima	171.5 tonnes	3 431
Mangwe	166 tonnes	3 320

The ministry did not have statistics on poverty levels and numbers of people in need of assistance. They rely on local authorities' data for this information. The ministry works together with support structures such as MoHCW, Councils and DA's office (local government). The staff complement for Mangwe, Bulilima and Plumtree is as follows: two trained social officers, a social assistant and a clerk. It does not have the following support staff: typist, driver and office orderly.

Challenges

The major challenges facing the MoPSLSW were as follows:

- Shortage of human and material resources to assist vulnerable children. For example, building materials are too expensive. The department (NAP for OVC) is not yet very functional due to these challenges.
- Inadequate financial assistance from the government. The department lacks transport, so cannot make home visits to assess the OVC situation.
- Many OVC children not accessing some services, such as school, due to lack of birth certificates.
- Inadequate community resources. The resources may be there, but are latent.
- Lack of coordination of stakeholders in various intervention services at district level, which is resulting in duplication of activities.
- Perennial droughts are affecting rural livelihoods and in the process 'permanently' rendering thousands of children vulnerable.
- BEAM is poorly funded and there is poor selection of beneficiaries.

- Resource base among caregivers is thin.
- Difficult to measure emotional situation of OVC, so it becomes very difficult to provide appropriate intervention programmes.
- Resources are not community owned.
- No resources in communities to facilitate OVC care. Some caregivers are failing to assist OVC, due to lack of resources.
- Implementation of policies and laws that protect children is not easy, as many people are not aware of some of the laws, some of which are in conflict with traditional laws. Many parents/guardians feel that their way of life as Africans is under threat from these laws.

Ministry of Youth Development and Employment Creation

Background/activities

The Ministry of Youth Development and Employment Creation is a training ministry whose target population is the youth. It has established structures in the districts that have people working on the ground (rural development officers [RDOs]). Furthermore, every ward comprises five to seven villages and in every village there is a cadre known as a village community worker (VCW). These officials identify development activities targeting the youth in different areas. The RDOs and VCWs identify families and children, especially because the ministry specifically deals with children; in addition, a VCW is a multipurpose cadre who operates under several different ministries, but mainly under the Ministry of Youth Development and Employment Creation. The ministry is also a member of DAAC, which sits every two weeks to compile reports.

According to the ministry, any child without a parent is vulnerable to abuse and other problems and so VCWs are targeting such issues. The ministry works together with the local leadership, councillors, kraal-heads and headmen, to investigate OVC issues. They keep a register for OVC and if food comes in, they make sure that the OVC get it. In order to reach unregistered OVC, they provide help such as sending porridge to schools, so that all those who do not get enough to eat can go to the schools and have some porridge.

The VCWs regularly visit OVC homes, talking to the children and parents/guardians. The VCWs also protect vulnerable children, or any child, from abuse through being vigilant in detecting such cases in the communities.

The VCWs have to report their activities, first to the ward development coordinator (WDC), then to the RDO and finally to the district head (DH). The RDO has five sections, all of which report to the DH, which are as follows: Employment Creation, Youth Development, Skills Development, Cooperative and Gender. The OVC are given top priority to join the National Youth Service (NYS). Despite the many challenges the ministry is facing, the head of the ministry in the district reported that their activities are successful, as they have recruited many youths for the NYS and they have further recruited them to work in government departments.

Challenges

The major challenges facing the Ministry of Youth Development and Employment Creation are as follows:

- Shortage of human and material resources to assist vulnerable children. The ministry has only one team, which covers both Bulilima and Mangwe. They need more human resources, so that every ward can have a representative (VCW).
- It is very difficult to obtain adequate financial assistance from the government.

Ministry of Local Government and Urban Planning: Bulilima and Mangwe Rural District Councils

Background/activities
The Ministry of Local Government and Urban Planning works through the local authority and the Rural District Councils (RDCs) are indirectly assisting OVC in the wards. The RDCs' activities are run by the Department of Social Services. Although RDCs are service organisations, they have not done very much to help OVC. The RDCs' main role is in facilitating other organisations, such as NAC and Family AIDS Caring Trust (FACT), to work effectively in the communities. Council representatives reported that their Social Services Departments monitor and evaluate the work of NGOs. DAAC reports to the RDCs.

Challenges
The major challenges facing the RDCs were as follows:
- Lack of financial and skilled human resources to adequately respond to the material and social needs of the OVC.
- Persistent droughts since the start of the new millennium causing serious food shortages and loss of livestock.

Agricultural Research and Extension Services (AREX): Plumtree town office

Background/activities
AREX has become aware of the OVC problem through workshops on OVC. They do not work directly with OVC, but indirectly, through promotion of food security programmes. AREX promotes the *Isiphala senkosi* programme, through the provision of seeds and fertilisers. In the 2004/2005 season, they provided seed and fertiliser, but in the 2005/2006 season, provided seeds only. AREX has outreach programmes aimed at educating the communities on crop production and livestock keeping.

The staff complement for AREX is as follows: 3 officers, 1 district officer, 1 clerk, 2 office orderlies, 6 supervisors and 40 extension workers.

Challenges
AREX suffers shortage of transport, which results in failure to distribute seeds on time as well as failure to make field visits to give farmers technical advice and teach them on other farming issues. They only make use of bicycles, resulting in reduced frequency of visits.

District administrators for Bulilima and Mangwe Districts

Background/activities
The DAs' offices are involved in OVC issues through working closely with the local authorities in coordinating activities of NGOs in their areas. These offices rely on workshops, communities and feedback from local authorities, NGOs and the state for identifying sources of information on OVC. The DAs do not keep statistics on OVC, but such records are kept at the council offices.

The DAs also coordinate stakeholders and hold workshops on policy formulation and implementation. Their other role is to alert organisations on OVC needs and to sensitise community leaders and NGOs through workshops on caring for orphans.

Challenges
The major challenge that the DAs' offices are facing is lack finance to effectively conduct the coordination work. Furthermore, people expect more from the DA's office than just coordination.

Zimbabwe Republic Police Department: Victim Friendly Unit

Background/activities
There is one ZRP Department for Bulilima and Mangwe, but it has many stations. The police force's sources of information are concerned community members and NGOs. They also rely heavily on their intelligence sources.

The ZRP carry out awareness campaigns in the communities on how to fight child abuse. However, they do not know the number of OVC abused in the community, because they deal only with the reported cases. They also deal only with criminal cases and those victims who want social assistance such as counselling. Victims are referred to NGOs and Social Welfare for counselling, material needs and psychosocial assistance. The ZRP also train new police officers coming in from police training on victim-friendly and counselling services. Through the Commissioners' Fund Fare, they identify and assist the few orphans experiencing very serious problems. The selected orphans are supported with school fees, but with the ever-increasing rates of the fees, the number of beneficiaries has been further reduced. The police collect statistics on abuse cases every month and have noted that cases of abuse usually rise during the festive seasons, since migrant men (*injiva*), based in South Africa, return to the area; in 2005, there were 8 cases from January to April; cases in May to July were very low; and then 23 cases from August to December.

Challenges
The police officers in charge of the Victim Friendly Unit at Plumtree police station mentioned that one of the biggest problems they face is that some victims do not know if they have been raped or not, therefore many cases of abuse are not reported. They also said that most people were not aware of the services offered by the police and some children were afraid of the police, so they would run away when they saw them. Just like most government departments, the police do not have adequate resources to mount public awareness programmes about child abuse in the communities or to educate community members on the existing laws that are there to protect children. The other challenges faced by the police were as follows:

- The police have very few officers who are trained in dealing with cases of abuse, especially of minors.
- Lack of adequate resources to mount public awareness programmes about child abuse in the communities and educate community members on the existing laws to protect children. Consequently, most police posts in the districts do not have police officers trained in handling victims of abuse.
- The police stations and posts do not have enough staff and there are no departments where you find an officer dealing with specific types of cases, for example, officers who deal with OVC cases only.
- The victim friendly team of police officers is crippled by lack of resources, such as vehicles. Thus, for example, when the officers are supposed to visit victims of abuse to see how they are coping, they usually do not manage to do so.
- The police have problems with victims who do not have birth certificates. It is very difficult for them to verify the correct age of the abused children, especially in statutory rape cases.

Profile of non-governmental organisations

This section covers NGOs interviewed during the situational analysis. The activities of these organisations are child related.

Student Partnership Worldwide

Background
Student Partnership Worldwide (SPW) is an NGO that is currently running a Youth Adolescent Sexual Reproductive Health Promotion Programme (YASRHP), using the peer education approach to target in- and out-of-school youth in Bulilima and Mangwe Districts, among nine other districts in Zimbabwe. Its mission is to mobilise trained young volunteers to empower rural youth to take control over their own lives and shape the future of their communities. Through the use of non-formal participatory techniques, SPW seeks to empower young people to pursue health-seeking lifestyles and behaviour. SPW has six strategy projects to achieve this aim, one of which is Youth Friendly Health Services. According to the NGO, rural youths suffer from a dearth of local, appropriate and culturally sensitive health and development information.

SPW's Zimbabwe, Bulilima and Mangwe programme staff, together with the youth, identified the need to establish a resource centre (in Plumtree Urban's high-density suburb), which would feed into and supply neighbouring rural resource points to maximise information dissemination in the area. In the Bulilima and Mangwe Districts, access to Zimbabwe Broadcasting television and radio services are non-existent, with limited access for the few to Botswana radio and TV services. There is also limited internet access, as the phone lines in the area are not digitalised. The most important sources of information for youth remain: health personnel/clinics, teachers/schools, pamphlets/posters/newspapers (written materials) and radio, all of which SPW offers in the resource centre.

Overall objective
To contribute to the increased accessibility, availability and use of youth and adolescent reproductive health information, resources and services to the youth in Bulilima, Mangwe and Plumtree, over a one-year period.

Activities
Capacity-building initiatives to increase information and service provision of:
- Focal persons (community health staff who supervise SPW peer educators) conduct training in basic counselling for 20 wards.
- AIDS Action Club patrons (teachers) training in communication skills and activity planning and management.
- Library skills training for young people running the youth friendly resource rooms in the schools and clinics.
- Training of health workers in basic orientation and sensitisation to appreciating youth friendly health service delivery.

Service delivery initiatives to increase accessibility and availability through:
- Provision of a statistical resource centre in the high-density area of Plumtree.
- Provision of resource centre outreach services to the 20 rural wards.
- Sourcing and provision of information, education and communication (IEC) printed materials.
- Provision of audio-visual and training equipment and supplies.

Other activities that aim to increase sexual reproductive health and to develop knowledge and information provision, through the promotion of available materials and use of multimedia channels of communication, are as follows:

- Regular video sessions with discussions following each show at the resource centre and as an outreach activity.
- Resource centre coordinator and interns facilitate other adolescent reproductive health issues, including family planning, through group discussion and other models of entertainment.
- Weekly talk shows with guest speakers (celebrities) invited from various fields of expertise, including PLWHA, both at the resource centre and as an outreach activity.
- Regular sessions addressing violations of childcare, support and protection rights, including sexual abuse.
- Supporting out-of-school youth drama groups to provide entertainment at the resource centre and in communities.
- Sharing information with other organisations through the use of CD-ROMs.

To promote and support a good conducive environment for the youth and community to resolve the youth's sexual and reproductive health problems, through conducting community-based social mobilisation and advocacy meetings, the SPW conducts the following activities:

- Community meetings, social mobilisation, advocacy campaigns and interpersonal (one-on-one) communication, all targeting: parents; community, religious, political and traditional leadership; policy-makers, and influential others.
- Networking and collaboration with government, NGOs and others in the field of adolescent reproductive health (ARH). SPW also work with victim friendly police for child and sexual abuse cases.

Challenges

Most areas of the districts do not have phone lines and are inaccessible, and it is therefore very difficult to reach the young people in these areas. Young people are dynamic, and culture is also dynamic, so it is difficult to make the young people follow the traditional cultures. Instilling youths with values on good sexual behaviour is always very challenging. The organisation has limited funding and thus is failing to scale up its programmes or meet its targets.

Esandleni Sothando

Background

Esandleni Sothando is a community-based orphan care and youth programme. It is a faith-based organisation founded in September 2003 to mobilise communities to establish orphan-care programmes. Literally, Esandleni Sothando means 'in the hands of love', which is an isiNdebele expression. Beven Mwachande, the director, is the founder of the FBO. The project operates in Mangwe District, which is one of the eight districts of Matabeleland.

The vision of the FBO is to be recognised nationally and internationally as the pre-eminent centre of innovative, community-based approach programmes, aiming to cover 10 000 orphaned and vulnerable children's lives by 2010. Its mission is to offer opportunities to children living under difficult circumstances (socially, psychologically and economically) in border towns. Moreover, it aims to empower and strengthen the OVC with positive attitudes, stimulating experiences, fresh perspectives and information, and emotional competence in life.

The FBO covers 4 wards in Mangwe District. Each ward might have up to 10 volunteers and has a committee of its own that monitors the activities of OVC and reports cases they come across, every month, to Esandleni Sothando.

Objectives

- To mobilise the urban and rural districts' communities, community leaders, various stakeholders and the community at large to initiate and support programmes that offer psychosocial support to orphaned children and youth made vulnerable by HIV and AIDS.
- To train communities in basic standards of care and support to orphans and other vulnerable children and youth.
- To empower child-headed households in life skills and self-sustainability.
- To educate in- and out-of-school youths in HIV/AIDS awareness and prevention.

Activities

Esandleni Sothando has three interventions: psychosocial support, educational support and IGPs. The activities are as follows:

- Community mobilisation and capacity-building. Esandleni Sothando works with Unicef to provide block grants, that is, to provide, for example, chairs to a particular school or textbooks to a particular class, and to tell that school that they will be paying fees for a certain number of orphans. They then move on to another school and will not go back to the previous school for the next three years or so. They also work with DAAC.
- Enumeration and registration of all orphans' families and children living in especially difficult circumstances within the targeted villages. At the time of this study, the FBO had trained 48 volunteers acting as foster parents and these enumerate the OVC and tell the FBO about the problems faced by OVC.
- Provides psychosocial support to orphans and other vulnerable children. Esandleni Sothando also trains teachers, child professionals and the community volunteers on how to give psychosocial support to OVC. Provides community life-skills camps for OVC. The camping period is usually 10 days. The children play and have the victim friendly court officers there to talk to them about the laws to protect children, such as those on sexual abuse. During those camps, the children have time for a loss and bereavement day, when they are able to talk about their experiences and perform drama. They also have quiet times where one can tell a story, such as the story of Zaccheas in the Bible or the story of Simba, who lost his parents but found a good job in the end. After these stories are told, children can then pose questions. Storytelling is for those aged 6 to 12, but for the 12 to 24 age group, the storytellers talk about things as they really are, in other words, they neither hide anything nor tell the children parables. Some children draw pictures, especially the 6 to 11 age group, and some cry, though they are not specifically encouraged to do so. Trained counsellors will be there to deal with such issues. The children are shown inspirational movies such as *Neria* and *Yellow Card*.
- Identification of the orphan families.
- Ensuring that the material assistance given to orphan families and children living in especially difficult circumstances is relevant and being responsibly used.
- Providing HIV/AIDS material information to youth exchange information centres.
- Providing a model for community-based care of orphans and children living in especially difficult circumstances.
- Promoting the rights of children through teaching them in schools and communities.

Esandleni Sothando mobilises the communities to undertake a range of activities on behalf of the OVC, which include the following:

- helping them to clean the homesteads;
- sharing food and clothing;
- helping to rebuild broken-down homes;
- washing and mending the clothes;
- praying and sharing the bible readings and scriptures with children;
- playing with children;
- listening to them;
- helping them to care for the sick;
- taking them to the clinic and hospitals;
- counselling in bereavement;
- advocating on children's behalf;
- giving care, support and love to these children.

The FBO also encourages the community to help the OVC through donating things such as:

- blankets;
- good-quality second-hand clothing for children of all ages;
- stationery, for example, pencils, pens and exercise books;
- school jumpers and uniforms;
- children's school fees;
- general finances.

Esandleni Sothando further encourages community members to invite the FBO to their houses and share at their churches about orphaned children's issues. They are coordinating the *Zunderamambo* project and the director reported that it was easy to coordinate, as the community willingly bring resources to the chief, all of which are recorded.

Challenges

One of the major challenges Esandleni Sothando is facing is that they are overloaded with the number of OVC and have a shortage of human resources, especially caregivers. The number of male caregivers is very low, as most men prefer to go out to look for employment. Out of the 48 volunteers, they have only 10 males. Although Esandleni Sothando periodically train caregivers, the problem is that after training them, they go to Botswana and South Africa and often never come back; the FBO therefore has to retrain other people, which is a waste of resources.

Catholic Development Commission

Background

Catholic Development Commission (CADEC) is an FBO that works in five wards. The Plumtree office has four officers to implement the job for all five wards.

Activities

CADEC is running a supplementary feeding programme for different groups of people in Bulilima, Mangwe and Plumtree. The organisation is involved in a supplementary feeding scheme for primary school children in over 100 schools. Local women at selected feeding points do the food preparation and the women are paid by the community. The NGO reported that it had 690 feeding points (pre-schools) for the children younger than five years of age. Malnourished children under five years old were given porridge at clinics.

The OVC also benefit in the process, although CADEC does not have specific programmes for OVC. However, they now want to do a target feeding programme that would assist OVC. They also fund a number of nutrition gardens, both at household and community gardens.

Stakeholders regularly meet to discuss the situation of OVC, HBC and caregivers. The stakeholders give them a lot of information concerning the situation of OVC. CADEC has a programme called Livelihoods Programme Zimbabwe (LPZ), which deals with OVC. Those that stay with orphans are given first preference in providing CADEC with information.

Challenges

- The cost of living continues to trouble the communities, with prices going up on a daily basis. The problem increases vulnerability within the communities, which CADEC is fighting to reduce.
- The fuel crisis continues to affect the smooth implementation of programme activities. The food aid programme is severely affected by the fuel shortage.
- CADEC conducts a programme building toilets for the OVC, but in some cases where they build a toilet in a household where an old woman is staying with her grandchildren, she dies after a short period of time. The children than relocate to stay with other relatives and the homestead is abandoned. The toilet will then be left idle and negatively affects the programme, as it becomes a wasted resource.
- Shortage of water for the nutrition gardens.
- Shortage of human resources to implement, monitor and evaluate projects.
- CADEC wants to expand from the five wards they are already working in, but the authorities first have to sanction that development. However, it is difficult for CADEC to expand, as World Vision and Unicef are covering almost all the wards with the same kind of programme that CADEC is intending to do, which will then cause duplication of work. The problem is that World Vision and Unicef are failing to adequately assist the OVC in these areas where they are working.
- Infrastructure, especially the road network in Bulilima District, is quite bad and each time a vehicle is sent for service, there is some major repair to be attended to.

Bongani Orphan Care

Background

Bongani Orphan Care is an FBO that falls under the United Congressional Church of Southern Africa (UCCSA). Its operational area covers mainly Plumtree Urban, with 49 volunteers who include retired nurses and teachers. Although the FBO was assisting people of different religious persuasions, it is working on separating themselves from the church, in order to be 'more acceptable to the whole social spectrum', as one volunteer with the FBO commented. She felt that such a move would go a long way in erasing any misconception in the minds of people that they only help their fellow church members.

Activities

Bongani Orphan Care helps orphans who have problems in their homes and also visits them to assess their living situation. They periodically hold workshops to discuss OVC issues and to teach people to understand the OVC problem. The FBO also organises visits for orphans to Masiye camp, where they are taught life skills, given psychosocial support and so on. In the districts, the volunteers assist orphans with psychosocial support, school fees and teaching them life skills. In addition, they develop IGPs such as gardening, soap-making and candle-making. However, an officer with Bongani Orphan Care reported that

most of these projects are experiencing viability problems, mainly due to lack of capitalisation.

Challenges
The organisation needs financial assistance to implement the projects and transport assistance to enable them to periodically supervise the volunteers and visit the orphans at their homes. They cover only Plumtree town, due to shortage of resources. They are failing to provide shelter to orphans in Plumtree, as rents and other bills are now very expensive. The FBO is finding it difficult to obtain food for orphans, as they are not even getting support from the GMB or local authority.

Some caregivers are misappropriating goods meant for OVC and are giving them to their own children. The other challenge Bongani Orphan Care is facing is that some parents and guardians resent their involvement in their affairs, accusing the volunteers of attempting to run their homes.

Tjinyunyi Babili Trust

Background
Tjinyunyi Babili Trust (TBT) is a community-initiated trust that strives to provide a model for the reduction of rural poverty and the economic empowerment of the targeted communities. The TBT's vision is to create healthier, more self-reliant communities that have good collaborative skills and are imbued with a strong sense of enterprise development. TBT undertakes to work through highly empowered community members whose bias will be towards sustainable research-informed projects.

Objectives
The main objective of the Trust is to reduce rural poverty, particularly among women and the youth. Other objectives are as follows:
- To increase public involvement by encouraging participation of members of the communities in the planning, designing and execution of acceptable strategies needed for economic, social and physical empowerment and development.
- To enhance the physical and mental well-being of the members of the communities by designing, implementing and maintaining a comprehensive and sustainable public healthcare system.
- To increase community capacity towards sustainable economic development, especially among economically challenged groups.
- To generally improve the knowledge, skills and awareness of the members of the beneficiary communities.

TBT sites
The TBT focuses its activities, though not exclusively, in eight selected wards of Bulilima and Mangwe Districts and they are as follows:
- Huwana Communal in Bulilima and Mangwe Districts
- Masendu Communal in Bulilima District
- Natane Communal in Bulilima District
- Dombolefu resettlement in Communal in Bulilima District
- Somnene Small Scale farming area in Bulilima District
- Izimnyama Communal in Mangwe District
- Izimnyama Small Scale farming area in Mangwe District
- Mphoengs Communal in Mangwe District.

Activities

The OVC are assisted under TBT's Health and Welfare portfolio. After agriculture production, a certain percentage has to go to OVC; for instance, if there is a cattle sale, a certain percentage is given to OVC and also a certain percentage of food. For livestock, at least 1% of the sale of a beast is given to OVC; however, in terms of food provision, each homestead gives what they can towards Isiphala Sentandane, which happens in the Masendu, Dombolefu and Izimnyama Communal areas.

In Dombolefu, at the time of the study, there was an ongoing goat project whose proceeds are used to assist OVC. The volunteers and PLWHA sell goats and give a share of the proceeds to the OVC. TBT also provides counselling services, food and clothing to OVC. They also provide OVC with teachers (a female and male teacher at every school in the areas they are operating in) and pay fees. TBT also trains volunteer mothers to run nutritional gardens.

Challenges

The number of OVC is skyrocketing at an alarming rate, which depletes the household income and also slowly destroys the extended family systems, as well as cultural values and norms. TBT's coverage is not very extensive, as they only cover about 40% of the districts, due to shortage of resources such as finance and transport.

The high death rate of parents is making it very difficult for the organisation to meet the demands of OVC who need school fees assistance. Lack of coping strategies for the OVC to look after elderly family members who are HIV/AIDS patients is also a daunting task confronting the volunteers with TBT.

TBT is finding it very difficult to persuade the youth to delay indulging in unprotected sexual activities, as a result of poverty deepening in the communities. On a positive note, there are awareness programmes and youth cultural centres that are being used to empower children, particularly the girl child, with knowledge about STIs, including HIV and AIDS.

Erratic rainfall patterns interfere with the sustainability of the OVC Village Granary Project, resulting in severe food insecurity at family level. It has been realised that this is a cause of concern and efforts are currently underway to embark on a knowledge exchange visit to Gwanda, to learn about water-harvesting techniques that could be used for agricultural purposes, from communities that are supported by ITDG. Availability of relief food aid to support vulnerable families, especially child-headed families, also poses a challenge. There is a lack of support systems to motivate and recruit more men into the volunteer programme.

The economic instability in the country is resulting in only surface interventions with no impact and at a reduced scale of operation. Scarcity of basic public food consumables and support material is affecting support programming, especially for vulnerable children and child-headed families.

An official of TBT held the view that there are too many players whose philosophy towards sustainable development is concentrated on giving communities the 'fish', rather than teaching them 'how to fish', hence negatively affecting the idea of self-motivation and change of mindset.

Broad challenges for NGOs

The major challenges facing the NGOs operating in Bulilima, Plumtree and Mangwe Districts were as follows:

- Shortage of skilled human and material resources to assist vulnerable children. There is a shortage of staff to implement, monitor and evaluate projects.
- Lack of funding to support current interventions and to scale up current intervention work. Most of the NGOs are unfunded and consequently they are experiencing a massive drain of human resources.
- Heavy dependence on foreign donors crippling their activities, as these donors are reducing funding and taking a long time to approve budgets.
- Lack of transport and shortage of fuel to carry out activities.
- Lack of coordination of NGOs, resulting in duplication of activities and neglect of other areas.
- Inadequate community resources to ensure that the projects they initiate are sustainable.
- Deepening poverty, the HIV/AIDS crisis (increasing numbers of OVC), perennial droughts and unemployment are presenting enormous challenges to NGOs and watering down the impact of their work in supporting OVC.

Conclusions

Communities and support structures were battling to assist the multitudes of OVC in Bulilima, Plumtree and Mangwe Districts, as they have scarce material and skilled human resources to meet the various needs of these children. The main needs of the OVC were school fees, food, medical assistance and clothing. The situation of the vulnerable girl children is even more depressing, as they also lack sanitary wear and are very prone to sexual abuse. A plethora of intervention activities (both traditional and modern safety nets) are being carried out in Bulilima, Plumtree and Mangwe Districts to mitigate the OVC problems, but the intervention agencies are being overwhelmed by the problem. The basic infrastructure (roads, telecommunication and medical services and so forth) and the spirit to assist the OVC exist even among ordinary community members, but the major constraining factor towards fully assisting OVC is that communities are operating in an arid and resource-poor region. The poverty situation is fuelled by the general economic catastrophe in the country and most adults in these districts are flocking to neighbouring countries to escape the biting poverty; but in the process, they are creating more socio-economic problems.

The support structures are operating with little coordination by the resource-crippled (finance and skilled human resource) local authorities. Consequently, there is duplication of NGO activities and neglect of many areas. There is a top-down approach towards implementing intervention projects and consequently some of these projects are not desirable in the communities and are not sustainable.

There was general acknowledgement and appreciation among the community members of what the state has done towards advancing the rights of children. They stated that adequate laws and policies have been put in place to protect the children, but what are lacking are both financial and human resources to enforce them. In addition, many key informants called for the intensification of the programmes to educate people, including the children themselves, about these laws, especially the recently enacted laws like the Sexual Offence Act. There are still residues of resistance towards these laws among

traditionalists, which need to be erased from their mindsets, and parents have to be trained to desist from reaching out-of-court settlements with child abusers.

HIV and AIDS have hit the population hard and in the process this has disrupted all the support structures, both at household and community levels. The epidemic has orphaned and displaced many children after the death of the parent(s) and has worsened the living situation of many households who have taken in children or are looking after PLWHA. The general populace is very supportive of the OVC, but mainly in the form of offering them psychosocial support, as they are also finding it difficult to make ends meet. Cases of stigma and discrimination against PLWHA are on the decline, as so many individuals and households have not been spared the devastating effects of the epidemic.

Priorities for action

The following are the priorities for action and recommendations made from the key findings of the situational study in Bulilima and Mangwe Districts:

Government

The magnitude of the OVC problem is huge and the government needs to scale up its programmes aimed at assisting these children. Government also needs to urgently deal with the massive brain drain. Although government has enacted several laws and put in place policies to protect children, it needs to fund the operation of enforcing them. It should also embark on massive campaigns to educate people about such legislation. Local authorities need to be capacitated financially and in the area of human resources, so that they can discharge their mandate of coordinating NGOs under their jurisdiction.

NGOs

The major challenge faced by a number of NGOs is funding. Their major source of funding is foreign donors and the flow of such funds is erratic. Consequently, these organisations are limited in what they are able to achieve. The study revealed that there are many orphaned and vulnerable children in communities who are not receiving care and assistance. NGOs should improve the scope of their work by also developing and implementing psychosocial support programmes, instead of just focusing on providing material support. Most of them were not running research-informed interventions and, by so doing, were failing to address the needs of OVC. It has been very encouraging to note that the Research Informed Best Interventions for the OVC programme have been taken on board by the communities, through the TBT, to lead sustainable development initiatives. However, most of these programmes are not rooted in community structures, which render them unsustainable. The monitoring and evaluation component of most of the NGOs was weak and so they need to be trained in this area.

The local authorities need to improve the coordination of NGOs to avoid duplication and implementation of poorly designed projects. A forum is needed where NGOs can share their experiences, and databases should be revamped, so that there is cooperation between NGOs doing similar work.

Community/OVC

OVC-related intervention agencies should scale up their operations and also increase focus on addressing their psychosocial needs. There is a need to hold workshops and meetings in the communities, so that people can understand pertinent and intricate OVC issues.

Public awareness of programmes aimed at fighting child abuse (both in the home and outside) should be intensified and the work of the police should be demystified, especially for children, by telling them that the police are there to protect them. The mechanisms for making sure that caregivers are not misappropriating goods earmarked for OVC should be strengthened. For BEAM to be effective, communities need to be trained to ensure that the selection committees choose deserving children.

People should dig deep in their communities and support OVC by using cheap local resources, since donor support is inadequate and erratic. Community members need to be exposed to numerous capacity-development courses and exposure visits, to support the idea of replication of good interventions, from a 'look and learn' point of view. The growing OVC problem can also be tackled through trying to revive the traditional leadership system to spearhead revival of extended family systems and cultural values; this can be achieved through setting up cultural centres, as is already happening in Izimnyama and Masendu communities. Caring work is dominated by women and it is a daunting task to motivate and recruit more men into the volunteer programme. This is also a national and regional problem. TBT's suggestion that the few current male volunteers should testify and market the programme, should be considered.

Poverty, which was blamed for pushing many OVC into risky sexual relationships, should be fought through increasing educational support, food aid and supporting IGPs at household and community levels. It has always proved very difficult to persuade youth to delay indulging in unprotected sex activities, but programmes such as HIV/AIDS awareness campaigns and youth cultural centres can be used to empower children, especially the girl children, with knowledge. To support OVC livelihoods and ensure them food security, the OVC should be trained in entrepreneurship, so that they learn safe and sustainable ways of eking out a living.

CHAPTER 10

Gweru Urban District

Pakuromunhu F Mupambireyi, Shungu Munyati, Brian Chandiwana, Wilson Mashange and Stanford T Mahati

Background

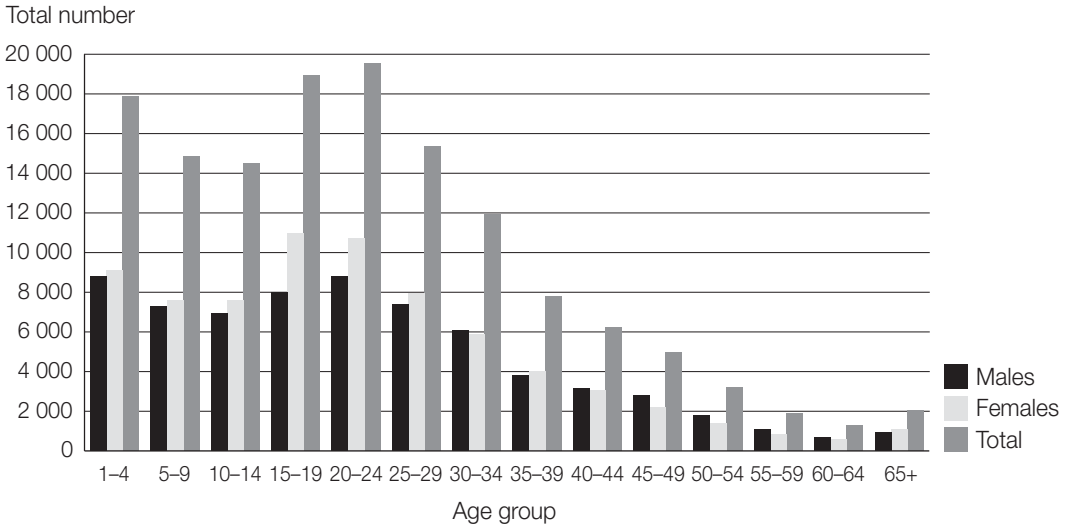
Description of study area

Gweru Urban is the provincial capital of Midlands Province, with a total of 17 wards. The high-veld district is located 275km southwest of Harare and it is wholly urban. The climate in the district is hot in summer and very cold in winter and rainfall is moderate and erratic, ranging from 650mm to 800mm. The district is situated in agro-ecological Region III, which is a semi-intensive farming area.

Population distribution

The total population of the Gweru Urban District was 140 806, with a male to female sex ratio of 92.6, as at the 2002 National Census. There are 35 303 households with an average size of 4 members. The age distribution of the district is as shown in Figure 10.1. Almost half of the population is below the age of 20 years (CSO 2002). There are slightly more females than males (51.9% and 48.1% respectively). The rate of natural increase of the population is 1.4%. Less than 3% are 60 years old and above.

Figure 10.1: Population distribution by age group and sex, Gweru Urban District



In the same census survey, it was found that 1 124 households were headed by children aged 19 and under, while 1 131 were headed by persons who were above the age of 65 years. Of the heads of household below the age of 20, 54.9% were female. Almost all the population of Gweru Urban is of African origin, with the predominant languages being Ndebele and a variety of Shona dialects, such as Karanga and Zezuru.

Economic activities

Of the 93 098 persons aged 15 years and above, close to two-thirds (62.7%) were economically active, with 21.3% unemployed (CSO 2002). Over a third (3.6%) of the population aged above 15 were communal farmers, while 4.9% were in the mining and construction industry, 11.6% in the manufacturing industry and 27.7% in the service industry (2002). The main employers in the district are BATA, Zimbabwe Alloys, the city council and the government. The informal sector is very vibrant, although flea markets, which were a source of livelihood to a huge proportion of the population, do not exist anymore, resulting in an increased unemployment rate.

Health facilities

The district has a total of seven clinics, all of which offer prevention of mother to child transmission (PMTCT) services. One of the clinics is an infectious diseases clinic and three are delivery clinics. There has been a noted increase, between 2004 and 2005, in the number of people who are making use of the PMTCT services available in the district.

Education facilities

The literacy rate in the district is at 99% (CSO 2002). As of 2002, close to 4% of the children aged between 7 and 18 years old had never been to school. At the end of 2005, the district had 178 early childhood development centres with a total enrolment of 9 889. The majority (65.2%) of them were unregistered and most of these were in the urban areas. According to the Provincial Education Director's annual report for Gweru District in 2005, enrolment in the 91 primary schools in the district was 42 200, while in secondary schools it was 20 744. Due to the inadequacy of schools in certain areas, some schools have adopted 'hot sitting', (primarily two school sessions, where one is in the morning and the other in the afternoon). In the district, approximately eight schools have two school sessions. The teacher–pupil ratio in primary school is 1:34. Established schools have satisfactorily adequate classrooms, while in satellite schools, there is a great need for more classrooms. The district also has adult literacy programmes and has 69 centres with total enrolment of 2 906. There is a need for an increase in the number of secondary schools in the high-density suburbs.

Water, sanitation and housing

Sources of water for the district's households ranged from piped water (74.7% inside house and 19.7% outside house), communal taps (4.1%), protected wells/boreholes (1.4%) to unprotected wells (0.2%) (CSO 2002). Flush toilets were the most common (91.3%). Nearly two-thirds of the population lived in detached houses (structurally separate dwelling unit that is built of materials other than pole and dagha), while 29.2% lived in semi-detached dwelling units (consisting of one of two dwelling units, with a common wall between them) and 7.0% lived in flats or townhouses. Less than 1% lived in shacks (2002).

Transportation and energy

Roads in the district are not in good condition, since they have not been repaired in a long time. Since the district is urban, 93.7% of the households have electricity (CSO 2002), though less than 90% of the households use electricity as their main source of energy and 7.6% use wood.

Conditions of OVC

Magnitude of the OVC problem

The OVC problem (especially child-headed households) was of major concern in the district, as the number was on the increase, according to a community member. She further mentioned that although there were no accurate statistics of the OVC in the district, almost every household had an OVC. The gravity of the situation calls for a concerted and coordinated approach to tackling the OVC problem. As reported by a focus group discussion (FGD) for 6- to 13-year-olds, HIV and AIDS had been a major contributor to the ever-increasing numbers of OVC. Furthermore, the group cited witchcraft, abandonment of children at birth and divorce of parents as further contributing factors. In terms of the challenges being faced by orphans, double orphans were the most affected. They lacked parental love, care and guidance. Because of ill treatment, some of the orphans were dropping out of school or running away from homes where they were staying with relatives, to roam the streets. In general, paternal orphans were said to be in a better position than maternal orphans, as reported by an FGD for 15- to 18-year-olds, for the simple reason that mothers were more caring, patient and attentive to children's concerns than were fathers. However, they might be at a disadvantage materially, if the mothers were not working. The other worrying thing, as mentioned by an adult FGD, was the fact that the burden of caring for OVC had shifted to grandmothers and uncles, who in some cases were old and frail. Fending for these OVC was proving to be a difficult challenge. Some female OVC were resorting to commercial sex in order to earn a living, whilst others are forced to indulge in criminal activities because of poverty.

Level of emotional and physical care

An FGD for 15- to 18-year-olds stated that the mere fact that one is an orphan was itself emotionally depressing. The situation was worse for double orphans, who had no one to share their problems with. The same group reported that the situation was different, at least, for those OVC who were placed in institutional homes by some NGOs. These OVC could share their problems and experiences with other children, thereby relieving them of some of their emotional stresses. An OVC mentioned that some of their guardians were not helping their situation when they physically abused them, for instance, beating them and giving them a lot of strenuous chores to do.

Housing conditions of OVC

Generally, OVC housing structures were in bad condition, for example, with cracks and leaking roofs, because some of them were left by their late parents and there was no one to maintain the houses. There were also cases where some OVC were letting out rooms in order to get money for food, which resulted in overcrowding (maybe six people sharing one room). In Senga high density area, there was an extreme case of a seven-roomed house shared by about five families, according to members of an adult FGD. Overcrowding resulted in people not respecting each other, as parents were sharing sleeping quarters with older children and might engage in sexual activities or fight in the presence of these children. Siblings were also sleeping in the same room (both girls and boys), which was not a healthy situation for the moral upbringing of children. In addition, overcrowding had led to sewer pipes continually bursting. If there was an outbreak of disease, then it would be a real crisis, as mentioned in an adult FGD. Proper maintenance of the houses was evidently lacking. Among the 6- to 13-year-olds in an FGD, it was noted that there were, however, some OVC, if very few, who were living in good housing structures.

OVC needs and concerns

OVC needs that were commonly cited by a 6- to 13-year-olds' FGD were clothes, food, school fees, uniforms, stationery and shelter. In addition, the group stated that those OVC who were not of school-going age were also in need of toys to play with. Participants in an adult FGD prioritised payment of school fees as the primary need for children, because, with good education, the OVC would have a better future. The caregivers were facing enormous challenges in trying to provide for these needs, because of the harsh economic environment prevailing in the country at the moment. An OVC reported that there was a need for caregivers to be taught how to look after OVC properly. He further indicated that those OVC who were 14 years old and above needed to be imparted with life skills, so that they could sustain themselves, rather than depending on food handouts from donors. They could be assisted with seed capital for them to engage in income generating projects (IGPs) such as gardening or be given preference in the allocation of vending stalls. OVC should not be rude and stubborn to those people who were looking after them, since this might invite ill treatment. Counselling was another OVC need that was mentioned in the adult FGD.

Major threats to OVC quality of life

The major threats to the quality of life of OVC cited by most interviewees were lack of food, clothing, uniforms and fees. Some of the OVC ended up dropping out of school and were resorting to prostitution as a way of trying to eke out a living. A community member also stated that some OVC were even contracting sexually transmitted infections (STIs). In addition, there were reported cases of OVC who were being ill treated or even abused by their caregivers. This was causing some emotional stress, which then compromised the quality of life of the affected OVC.

Loss of personal possessions

Property-grabbing was rampant in the communities, as reported by the majority of the interviewees. Paternal relatives were the main perpetrators. In extreme instances, OVC were actually being chased away from their parents' homes. Some of the OVC were losing their property to thieves, who were taking advantage of OVC, especially in child-headed households. It was mentioned in an FGD for 5- to 18-year-olds that there were some relatives who were cheating OVC by selling the property left behind by deceased parents, under the guise of wanting to raise money to take care of them. Ironically, proceeds from the items sold never benefited the OVC. Some maternal relatives were also seizing property as compensation for lobola, if the children's deceased father had not fully paid the dowry. However, some of the OVC interviewed reported that they did not lose any of their property.

Access to facilities

Education

OVC were not easily accessing educational facilities, primarily because of lack of finance. The Midlands AIDS Service Organisation (MASO) and the Basic Education Assistance Model (BEAM) were assisting some OVC, but the resources were inadequate to cater for deserving children. Disabled children were having problems in getting into special schools, although the Gweru City Council was trying its level best to assist them.

Health

There was no preferential treatment of OVC at health institutions in the city. The majority of the OVC were reportedly not in a position to afford the exorbitant hospital fees that were being charged at clinics and hospitals. The cost of drugs was also beyond the reach of many OVC.

Community resources

NGOs like MASO and Padare/Ekundleni[5] and government departments like the District AIDS Action Committee (DAAC) were playing a major role in assisting OVC. Because Gweru is an urban setting, there was not much done in terms of community resource mobilisation for OVC by the residents.

Attitudes, stigma and discrimination

As reported by most community members, people were generally exhibiting positive attitudes towards OVC. The same sentiments were reiterated by an OVC who indicated that there was not much stigmatisation and discrimination against OVC within the community. However, the problem was at school, where they were looked down on by other children, because of their tattered clothing or their lack of school uniforms. At home, they were said to be interacting very well with other children. An adult FGD reported that there were isolated cases of some caregivers who were discriminating against OVC by not paying school fees for them, or not taking them to hospital when they fell sick, or by overworking them and so forth. There were some OVC who had been taken into institutional homes because of the ill treatment they had been receiving from their caregivers. Grandmothers were reported to be better caregivers than aunts. In addition, those OVC who were being looked after by their mother's sister were also reported not to be experiencing any discrimination problems. Some caregivers would only give their children money or food when they were going to school and gave nothing to OVC under their care.

Challenges and complications

The main challenge that was being faced by caregivers was the provision of basic necessities such as food, shelter, education, health and care. The harsh economic environment was making it increasingly difficult for caregivers to provide these basics, even more so when the majority of them were not formally employed. One community member reported that, even if the desire to assist OVC was there, many community members were grappling with raising their own children. Caring for or taking in OVC was viewed as an extra burden on meagre household resources. The situation was even more pressing for those caregivers who were looking after HIV-positive OVC. They were facing a host of challenges; for example, they did not have home-based care (HBC) kits and they could not afford the drugs, which were very expensive. The dietary requirements were also beyond their means. Furthermore, the home environment was often overcrowded, without proper bedding facilities.

5 Padare/Ekundleni is an NGO that utilises the HIV and AIDS pandemic in Zimbabwe to begin to engage with men's sexual behaviour and their interrelations with women.

Care and support structures for OVC

Donor organisations were playing a significant role in mitigating some of the challenges that were being faced by the community in caring for and supporting OVC. This was mainly accomplished in the provision of basics such as food and educational assistance. For instance, MASO was paying school fees and parcelling food handouts (porridge, mealie-meal, beans and cooking oil) to some OVC. BEAM, the Seventh Day Adventist church and the Catholic Development Commission (CADEC) were also providing educational assistance. Some of the caregivers were reported to be begging for school uniforms from school-leavers for their OVC. An OVC indicated that they sometimes did casual work in order to raise money to buy stationery. Sadly, the OVC also mentioned that some caregivers abused or diverted the money they had raised for other purposes. IGPs such as gardening was another coping strategy used by caregivers to raise money for OVC.

DAAC was providing sign language courses for deaf children. Government structures were assisting with medical fees through the Department of Social Welfare and the police had put in place a Victim Friendly Unit to cater for sexually abused children. The city council were assisting OVC through the Zimbabwe Decentralised Cooperation Programme (ZDCP), with projects such as constructing factory shelves (*musika*). At the family level, aunts, a few of whom were recipients of pension funds from their late husbands, supported OVC with books and pens. Occasionally, some people in the community were helping OVC with casual employment, clothes and some other basic needs.

These support structures were reported to be quite desirable and effective, as reported by a 6- to 13-year-olds' FGD. A number of OVC had benefited, especially as some were now back at school. The group further recommended that the government should in future exempt OVC from paying school fees, as well as medical bills at state clinics and hospitals.

Suggestions on how to help OVC

A community member stated that government departments and institutions should be at the forefront of assisting OVC. Some of the suggestions on how government could assist OVC were:

- Provision of free medication at all government clinics and hospitals.
- Preference in the allocation of houses from local authorities.
- Free education.
- Care for OVC in orphanage homes.
- Provision of food through the Department of Social Welfare.
- Assist OVC, especially in child-headed households, during times of bereavement.
- More laws that protect children should be enacted.
- There should be junior courts that are friendly for children.
- Government should promote guidance and counselling in schools, especially early on in primary schools.

It was further suggested that NGOs and FBOs could also complement government efforts by assisting OVC with clothing, blankets, school stationery and paying rentals, water and electricity bills. Caregivers should be provided with seed money for IGPs as a way of capacitating them to better assist OVC. Churches should assist needy people not only from their own denominations but also those in the communities they operate in. Counselling was also deemed to be imperative for OVC.

Individuals should not discriminate against OVC. They should involve OVC in social activities such as sports, so that they could mix with other children. This would assist them in relieving their emotional depression. Girls in child-headed families should be assisted to find employment, as most were engaging in prostitution as a means of survival.

Caregivers should also be taught about good practices in caring for OVC. In addition, caregivers should have badges for easy identification by those who need their services and are not necessarily in their communities. If the programmes were to benefit the intended beneficiaries, there was a need for greater transparency in setting the inclusion criteria. The selection committee should be broad-based and should include councillors.

Policy and legislation for the protection of OVC

Many people in the district were not aware of the laws that protect OVC. However, most people expressed knowledge of policies on children's rights. They cited that children were not supposed to be denied food, clothing, and shelter or given a lot of manual work. For the few who knew some of the laws, it was felt that some of them were in conflict with cultural norms and practices. There were many cases where parents were violating children's rights, although in some cases, not by design. For instance, in terms of the right to education, parents were failing to raise the exorbitant fees being charged by some schools. Some children were forced to abandon school so that they could seek employment and supplement household incomes.

The 6- to 13-year-olds' FGD stated that the major problem in the implementation of some of the laws and policies that protect children was ignorance, especially on the part of the victims. The abused children did not know where to report such cases. Where the perpetrators were relatives, the children were afraid of reporting them to the police or other community members, because they feared reprisals. The 15- to 18-year-olds' FGD mentioned that in instances where cases of sexual abuse were reported to the police, those who were accused might engage the services of lawyers, but the poor OVC could not afford the services of lawyers. One OVC also indicated that the police were not taking some of the cases brought to their attention seriously. The recommendation of the group was that there was a need to educate people about the laws and policies that protect children if the authorities were to effectively participate in the implementation of these laws. MASO had already begun these awareness campaigns.

HIV and AIDS

The level of HIV and AIDS awareness was reported to be high by most interviewees and the FGDs. Some of the respondents expressed their knowledge by saying, *'Utachiona unouraya futi haurapike.'* (AIDS kills and it has no cure.) However, it was worrying that there were some people who were still practising risky sexual behaviour. Some of the OVC themselves were also infected with the virus. The number of deaths which were HIV and AIDS-related were reported to be as high as five per week. The problem was quite serious and was significantly contributing to the ever-increasing number of OVC.

Impact of HIV and AIDS on state and organisational resources

Part of the council's financial resources that were meant for infrastructural development was now being channelled towards HIV and AIDS orphans. NGOs therefore had to take on the burden of taking care of these children as the number OVC was increasing. The majority of people who were dying of HIV and AIDS were among the young and

productive age group. The disease was killing the country's human resources, which was negatively affecting the national economy.

Impact of HIV and AIDS on social functioning

HIV and AIDS was having a profoundly negative impact on the communities, in that it had destroyed the family fabric. Breadwinners were dying and leaving behind young people to care for other siblings at a very young age. Those infected with the disease were no longer able to work for their families, which was affecting their household incomes. Some children had to drop out of school in order to look after their sick parents. People were spending a lot of time attending funerals, because of the increasing number of AIDS-related deaths.

Suggestions on how to limit the spread of HIV/AIDS

Educational and information needs

A number of suggestions were made regarding educational and information needs that would be a way of limiting the spread of HIV and AIDS. Some of the suggestions are as follows:

- People should be taught about the importance of protected sex and also about the pandemic.
- Sex education should be introduced at a young age.
- Peer educators should also assist in providing information about HIV and AIDS.
- Government and NGOs should show videos of people suffering from HIV and AIDS as living testimonies.
- There should be more awareness campaigns such as road shows, drama and posters on HIV and AIDS.
- People should change their behaviour and start using condoms.
- HIV testing should be made compulsory.
- OVC should abstain from sex until marriage.

Infrastructural needs

Government should subsidise antiretrovirals (ARVs) so that they could be accessible to everyone suffering from the disease. In addition, more centres should be established to provide ARVs. Financial resources should be made available to construct libraries in some residential areas of the town of Gweru, to provide books for educating people about the disease.

Care and treatment of PLWHA

Availability of services for PLWHA

The services available for people living with HIV and AIDS (PLWHA), as cited by most interviewees, were voluntary counselling and testing (VCT), ARVs and HBC. PLWHA were receiving food assistance and free treatment at government clinics and hospitals. The Department of Social Welfare facilitated the accessibility of ARVs from hospitals for PLWHA. An NGO, Padare/Ekundleni, provided a programme for helping PLWHA with HBC services. People were also being taught about self-discipline and for PLWHA, in particular, to consistently use condoms whenever they had sexual intercourse.

Access, availability and effectiveness of ARVs, VCT and PMTCT

There were not enough ARVs, because of the increasing number of people suffering from this disease. VCT services were available but some people were still afraid of getting tested. PMTCT services were also available for pregnant mothers. For those people who were using ARVs, it was reported that they were very effective.

Advantages of disclosing one's HIV status
There were a number of advantages mentioned that are associated with the disclosure of one's HIV status. These included the following:

- Receiving help and advice from other people on how to live positively.
- Receiving free ARVs and living longer.
- Can refrain from risky sexual behaviour.
- Can motivate others to get tested.

Disadvantages of disclosing one's HIV status
The main disadvantage that arose from disclosing one's HIV status was that of discrimination and stigmatisation. Some people may laugh and say insulting things about an infected person's sexual behaviour.

Risks of HIV/AIDS as a result of violence

Child abuse and rape cases were happening, but some went unreported. One OVC related an incident in which her sister was raped by their uncle and he was not reported. One community member commented that the number of rapes and sexual assaults were on the decrease, as some of the perpetrators were being jailed. Girl children were the main victims and the perpetrators were often stepfathers and uncles. There were also worrying cases where girl children were used for ritual purposes. Stepmothers were the main perpetrators of physical abuse. There were also cases reported of OVC who were engaging in prostitution in order to raise money to buy basics for their survival.

Those OVC who were abused were receiving counselling services from organisations like MASO, as well as from headmasters and the police.

Major sources of information on HIV/AIDS

There were a number of print and electronic media through which HIV and AIDS information was being disseminated. Some of the media cited included: TV, radio, books and pamphlets from school and NGOs, workshops and newspapers. An OVC reported that they were also taught about HIV and AIDS at school. For those in secondary schools, peers and colleagues were also sources of HIV and AIDS information. A community member mentioned that people were also being educated about HIV and AIDS at workshops and community meetings.

A 6- to 13-year-olds' FGD held the view that there was a need for more awareness campaigns through road shows, so that people were continuously reminded of the dangers of HIV and AIDS. Churches could also be actively involved in raising awareness and knowledge about HIV and AIDS.

Communication between parents and children about HIV and AIDS

Parents and guardians were not communicating with OVC about HIV and AIDS and sexual matters. An adult FGD stated that communication was imperative if the spread of HIV was to be contained. Some parents argued that it is a taboo and they expect their children to be taught at school or from the TV about these issues. Some parents and guardians were either too shy or they simply did not have time to discuss the matters with their children.

Profile of government departments

Ministry of Local Government, Public Works and Urban Development: Department of Housing and Social Services

Scope of activities

The department had trained six facilitators in every ward to deal with OVC and their problems. Problems encountered by OVC were brought to the department's attention through these facilitators. Among other things, the facilitators collected statistics on the number of orphans, vulnerable children and street children in their respective wards. They also assisted OVC beyond school-going age on how to run projects such as tie-dyeing, screen printing, horticulture and pottery (for example, there was a white woman who trained these children in such crafts). The OVC received free training. The Gweru City Council also bought them some raw materials to use in these IGPs. In addition, the council assisted the OVC by preventing their houses from being auctioned if they were in rental arrears.

Challenges

The main problem being faced by the department was that of staff. Not all posts within the department were filled and at the time of the interview, the post of a social welfare officer was still vacant. There was also a problem of limited funding for the planned activities of the department to assist OVC. They sometimes resorted to fundraising, for instance, asking pastors to dedicate one church service to donation of funds to orphans and the Mayors Cheer Fund.

Ministry of Youth Development and Employment Creation

Scope of activities

The department is responsible for fostering developmental issues for orphaned children and PLWHA. They are also represented in City Council and DAAC meetings. The other functions of the department included lecturing to youths on IGPs and career guidance. There are also vocational training centres for school-leavers intending to go into business. These centres are community driven and so their programmes are tailor-made to suit what the community wants. In addition, the department is responsible for recruiting youths into the National Youth Service Training Centre and in the recruitment process, taking gender equity into account.

Challenges

Lack of financial resources was the main challenge facing the department in its endeavours to assist youths in the district.

Ministry of Agriculture: Department of Agricultural Research and Extension Services (AREX)

Scope of activities
The responsibility of the department is to provide technical knowledge and assistance to those people who were engaged in IGPs of an agricultural nature. Their services are not restricted to OVC only, but to all people in the district who engage in agriculture or crop production, in particular.

Challenges
Understaffing is the main problem confronting the department.

Ministry of Health and Child Welfare: Director of Health Services Gweru City Council

Scope of activities
There are a total of seven clinics in the district and they offer medical services to all residents of Gweru town. The department provides immunisation programmes for OVC. When OVC visit these city council clinics, they get free treatment.

Challenges
Shortage of drugs is their major problem.

District AIDS Action Committee (DAAC)

Scope of activities
DAAC falls under the Ministry of Health and Child Welfare and it provides orphans with food packs, toiletries for girls, skills training and psychosocial support. With regard to life-skills training, DAAC has club instructors and independent artists who train the OVC.

Challenges
DAAC was overwhelmed by the ever-increasing numbers of OVC who need assistance from them. They used to provide OVC with educational assistance but they were now failing to cope. The other challenge was that of transport and lack of fuel.

Ministry of Justice, Legal and Parliamentary Affairs

Scope of activities
The ministry interacts closely with the police, particularly in cases where the abused children are brought to the courts to testify against their abusers. There are now victim friendly courts which have been operational since 2001. The ministry also conducts annual refresher courses for prosecutors, interpreters and magistrates on how to deal with cases involving abused children.

Challenges
There were a number of challenges which were being faced by the ministry in its delivery of justice. These included:
- Relatives are interfering with evidence.
- Police are taking too long to prepare dockets for prosecution of sexual offenders.
- The trial process sometimes takes too long to be finalised.
- No money to pay bus fares for state witnesses.

Ministry of Public Service, Labour and Social Welfare

Scope of activities
The ministry deals with the courts in protecting the children in the criminal courts. Organisations and community members bring to the attention of the ministry those OVC who need assistance. The ministry annually evaluates itself to determine issues such as the number of children they had enrolled in schools and assisted with BEAM, number of children under ARV medication, and number of children whose rentals they had paid for. The ministry holds meetings and workshops with various stakeholders to discuss with them the plight that OVC were facing.

Challenges
There was no coordinated approach by the stakeholders in the district who were assisting OVC. The number of OVC visiting the ministry's offices seeking help was on the increase, yet the resources were inadequate. In addition, the ministry did not have enough computers and vehicles to effectively carry out its work. Economic hardships were also taking their toll on the operations of the ministry.

Ministry of Education, Sports and Culture

Scope of activities
The ministry works with other stakeholders identifying OVC and their needs. At schools, headmasters were expected to keep records of the number of orphans, by type, as well as vulnerable children. When it came to recruitment of temporary teachers, the ministry gave preference to those OVC who would have completed secondary education; OVC were also given preference ahead of others, even for places at teacher training institutions. On this matter, the Ministry of Education, Sports and Culture worked closely with the Ministry of Youth Development and Employment Creation. OVC were also assisted by the ministry in achieving government and private-sector scholarships awarded to those disadvantaged children who are academically gifted. The ministry also included a department for dealing with children's psychological issues, OVC included.

Challenges
Some the challenges which the ministry was facing included:
- Shortage of qualified staff.
- Not enough vehicles and fuel to frequently inspect schools.
- Not enough trained teachers for special classes, for example, for the deaf or mentally retarded children.
- Very few teachers at schools took time to teach children on HIV/AIDS, as they said their timetables were too congested.
- Some schools did not have computers and trained teachers for information technology.

Profile of non-governmental organisations

Gweru Legal Projects Centre

Scope of activities
The main role of the centre is to assist those people who are not able to hire lawyers with legal representation. About 60% of their work is paralegal, that is, empowerment of people through outreach programmes on legal matters. They also assist abused children in the courts of law as well as facilitating them in getting identity cards such as birth certificates.

The centre also networks with other organisations like MASO in educating children about their rights, as well as custody and inheritance issues. It occasionally mounts road marches campaigning against sexual abuse (for example, the Senga road march in October 2005).

Challenges
The centre was understaffed, since there was only one qualified lawyer and three paralegals, yet the number of people requiring legal representation was always increasing. Office rentals were also high and always increasing.

Catholic Development Commission (CADEC)

Scope of activities
The organisation assists OVC with school fees and school uniforms. They also have outreach programmes in which they raise people's awareness of the plight of OVC. In addition, CADEC works with some HBC services in caring for PLWHA, through the provision of HBC kits.

Challenges
A limited financial resource base was hampering the activities of the organisation in their endeavour to assist OVC. They were no longer receiving much funding from the donor community.

Zimbabwe National Network of People Living With Aids (ZNNP+)

Scope of activities
ZNPP+ introduced the AIDS levy, which has been a success. The organisation also writes work plans for what they want to accomplish for the whole year and hand it over to the National AIDS Council (NAC). As the ZNNP+ does not have any funds, they receive money from NAC. They are only able to provide support groups to help PLWHA with emotional issues.

Challenges
People cannot afford ARVs or to get a CD4+ count. PLWHA are told they have AIDS, which is for life, but are given ARVs that will only last for three months.

Red Cross Society

Scope of activities
Red Cross is a humanitarian organisation that focuses mainly on helping needy people in society. Some of the activities they are involved in include:

- Building homes for OVC.
- Rehabilitation of OVC and re-integrating street children back into their original homes.
- Assisting OVC and youths in general to start IGPs.
- Dissemination of HIV and AIDS information to the youth.
- Providing recreational facilities, such as footballs and netballs, for the youth.
- Providing food to less privileged people in the society.
- Providing psychosocial support.
- Has a youth friendly corner in Mkoba where youths come and watch educational and entertainment videos free of charge.

Challenges
Red Cross relies on donor funds and while donors are still available, there are no problems. However, as they are so heavily dependent on donor funds, if donors were to pull out, most of the projects Red Cross has initiated would collapse.

Jairos Jiri Association: Naran School for the Deaf

Mission
Jairos Jiri Naran Centre aims to provide high-quality and relevant primary education for hearing-impaired children, thus making them independent, self-reliant, productive and disciplined and enabling them to communicate positively and operate easily with their community and the outside world.

Scope of activities
The main focus of the school (which is a boarding school) is to rehabilitate the children and empower them with knowledge and skills to be self-reliant. Apart from the academic subjects offered, their bias is towards practical subjects such as carpentry, agriculture, fashion and fabrics, metal work and computer skills. Currently, the school has an enrolment of 160 pupils, of which 85 are boys and 75 are girls.

Challenges
Most of the children did not have hearing aids. Since the majority of these children came from disadvantaged families, they could not afford these aids. Shortage of special teachers for this category of children was the other problem the school was facing.

Midlands AIDS Service Organisation (MASO)

Aims
The organisation seeks to provide emotional, material and spiritual support for PLWHA, their families and friends. It provides support and guidance for those who feel they are at risk. It endeavours to prevent the further spread of HIV infection. To date, MASO has established four programmes, namely, Training, Prevention, Home-based and Orphan Care.

Objectives
MASO has a number of specific objectives that caters for its four programmes. The key objectives are as follows:

- To educate and offer training, including technical support, to PLWHA, their families, friends, companies, institutions, churches, clubs and any other sectors.
- To counsel and support PLWHA, their families and friends.
- To promote self-help activities for PLWHA and their families.
- To increase public awareness on HIV and AIDS in the community.
- To implement community-based home and orphan care.
- To mobilise and train people who can help PLWHA and their families.
- To provide a drop-in centre.
- To provide advocacy for AIDS-related issues.
- To maintain intensive contact with other organisations with similar objectives.
- To assist orphans to cope with their situation and experience.
- To encourage and strengthen the extended family and community to take responsibility and increase efforts to care for OVC.
- To lobby and advocate for needs and rights of OVC to be implemented.

MASO works closely with a number of partners and the following table summarises the organisations and the roles they play in assisting OVC.

Table 10.1: Partners involved in the project, MASO Gweru

Partners	Role(s)
Gweru City Health Department	Free treatment of OVC who cannot afford health services. Training of caregivers, volunteers, OVC etc.
DAAC	HIV/AIDS awareness to orphans and volunteers. Coordination of initiatives.
OAK Foundation Zimbabwe	Donate vehicles to MASO project and give financial assistance.
Social Welfare	Train MASO volunteers on counselling, children's rights and child abuse. Free treatment. Offer counselling services to OVC and their families.
Ministry of Health and Child Welfare	Nutrition and health.
Zimbabwe Republic Police	Educate orphans and volunteers on children's rights and child abuse.
Gweru Legal Services Centre	Inheritance and birth certificates.
Psychological Unit in Ministry of Education	Counselling orphans. Training of volunteer caregivers.
USA Government	Financial assistance, through USA Embassy in Zimbabwe, to build new offices.
Churches e.g. Seventh Day Adventist, Salvation Army, Anglican, Methodist	Recommend and provide references on potential volunteers. Mobilise donations from members (used clothes, food). Mobilise members to provide spiritual and moral support to orphans.
Business community	Make donations in cash or kind to OVC and also assist in fund-raising initiatives.
Schools and Colleges Permaculture Programme (SCOPP)	Provide technical assistance on nutrition and herbal gardens and donate seeds.
School Development Committees	Mobilise resources for orphans e.g. clothes, food.
Zimbabwe State Lottery	Donated sewing machines.
Gweru City Council	Provision of free healthcare for orphans. Donated land for new MASO site (99 year lease).
Ministry of Youth and Employment Creation	Assist children on IGPs.
Terre des Homes	Financial assistance to OVC.
Swedish Cooperation Centre	Provide seeds for sweet potato and cassava. Provide technical assistance in the growing of sweet potato and cassava – benefited Shurugwi and Zhombe.
Action AID	Provide irrigation kits and seed for nutrition gardens.
Dutch International Development Agency (NOVIP)	Supply of vehicles.
Kadoma Jairos Jiri Association	Assisted one child with school fees and uniform.

Challenges

Across its four programmes, MASO is experiencing a number of challenges, some of which are:

- Increasing number of OVC, leading to the failure of the organisation to cope with the demand for services.
- Some families do not want to work with volunteers, fearing that they would be stigmatised by other people, as MASO is associated with AIDS.
- Harsh macroeconomic environment leading to massive price changes vis-à-vis static budgets.
- Shortage of transport and staff adversely affecting monitoring of activities and home visits.
- Other civic organisations and local authorities not doing enough to assist OVC, leaving the challenge to NGOs.
- Some politicians, at times, politicise humanitarian problems.
- Poor coordination of activities of different organisations targeting OVC has often led to the duplication of initiatives, especially in food handouts, where some OVC households receive double benefits.
- Difficult to convince some OVC caregivers or families who hold archaic views, about the real needs of OVC, especially about the importance of vocational skills and education.
- The concept of fostering was not well received. Some families were afraid of staying with strangers.

Musasa Project

Scope of activities

Musasa Project educates communities on new inheritance laws, that is, that children and widows have rights concerning inherited possessions that are lost to other relatives. It also assists those who have lost their possessions to relatives, as well as assisting OVC to get identity cards. The organisation further liaises with councillors in ensuring that OVC are protected in their respective communities. Other areas in which the organisation is involved are domestic violence, maintenance and inheritance issues.

In addition, the organisation empowers women in carrying out the responsibilities that remain the woman's, even if her husband is dead, just as it was when he was still alive; for example, she has to make sure she is the one who collects the death certificate and buys the coffin, rather than letting the relatives do it for her. The Musasa Project also obtain statistics from the courts and police.

Challenges

Urban residents seem not to be keen on attending the meetings where the project educates people about inheritance and maintenance issues. The organisation also does not have its own counsellors and so refers affected children to other organisations.

Zimbabwe National Family Planning Council (ZNFPC)

Scope of activities

The main function of the organisation is to coordinate all the training in reproductive health. ZNFPC produces training manuals and curriculums on reproductive health, and also implements them after scientific inquiries. In addition, it buys condoms for distribution in the country. ZNFPC also trains peer educators and distributes condoms to youths who are sexually active and provides IEC materials through pamphlets and posters. ZNFPC networks and collaborates with other stakeholders. Of late, the organisation has also been involved in HIV and AIDS advocacy.

Challenges
The organisation's clinics were few and small, and their staff members were not well trained on issues of HIV and AIDS. Youths were shy to visit their centres to collect condoms. Volunteerism in peer education is not working very well and so something new is needed to motivate them.

Faith-based organisations: Anglican

Background
The Anglican Church supports OVC through FBOs and has five institutions in Gweru. The church supports OVC in their homes.

Scope of activities
The organisation collects and distributes food to OVC. They also source funds to pay for school fees and school uniforms for some of the OVC. In their efforts, they are partnered with District Development Trust and Christian Care.

Challenges
Serious shortage of financial resources has forced the organisation to resort to helping only those with critical cases in each parish.

Conclusions

The greatest challenge being faced by the district as a whole was the ever-increasing number of OVC, largely due to HIV and AIDS. This has put a strain on the material and financial resources of various stakeholders assisting OVC in the district. Some OVC have to abandon school to assume maternal or paternal roles at a very tender age. Double orphans were the most affected, especially those in child-headed households. They lacked parental love, care and guidance. Some girl children from such households are forced into prostitution in order to raise money for their survival.

The needs which were mentioned by most of the interviewed OVC were school fees, uniforms and stationery, food, clothing and shelter. The harsh economic environment is making it increasingly difficult for parents or guardians to provide for these basics. Housing was another problem for OVC. Some were living in overcrowded homes, boys and girls sharing a room. In some cases, OVC were going to the extent of letting out their rooms in order to raise money for food.

Cases in which OVC were being abused by their caregivers are cause for concern. This was more common among maternal orphans, by the stepmothers, who may actually have physically beaten them or given them more household chores to do than their own children. Such experiences were emotionally distressing for most OVC.

Property-grabbing by relatives was also rampant. Some OVC were actually being thrown out of their deceased parents' homes. Maternal relatives were also involved in property-grabbing, especially if the father had not finished paying the lobola.

Incidences of stigma and discrimination against OVC in the community were not that many. In general, the community had come to appreciate the challenges OVC were facing and now many people were sympathising with them. However, at schools, cases of stigmatisation and discrimination against OVC by other children were reported. This was

emanating from the way some OVC would be dressed, such as not having uniforms like other children or wearing torn clothing.

The donor fraternity was playing a crucial role in supporting OVC with some of their needs. The desire of the community to help OVC does exist, but the economic environment was making it difficult for this to be realised. Households were grappling with raising their own children, and taking in OVC therefore became an extra burden.

Quite a number of the people interviewed expressed ignorance on the laws that protect OVC. However, people were knowledgeable about children's rights. Those OVC who were sexually abused by relatives were afraid of reporting them to police, fearing that they might be chased away from home.

The level of HIV and AIDS was quite high, though it is discouraging to note that there has not been much in terms of behaviour change. The numbers of HIV and AIDS-related deaths was an indicator that people were still engaging in risky sexual behaviour. Resources that were meant for developmental purposes at both national and community levels were not being channelled towards caring and supporting PLWHA. The economy was also losing its skilled human resources due to HIV and AIDS, thereby negatively affecting household incomes, especially in cases where fathers were the only breadwinners.

Priorities for action

Life-skills training for OVC is of paramount importance. Resources should be mobilised to train OVC in income generating projects, so that they do not end up resorting to prostitution or criminal activities as a means of survival. The Ministry of Education, Sports and Culture should waive the payment of school fees by OVC, particularly double orphans, so that the right for every child to education is not compromised.

More educational campaigns are needed for people not to seize inherited family possessions from OVC. This practice is emotionally stressful and only made the living conditions of OVC worse. Maybe it is high time for a law to be passed that makes it a criminal offence to steal assets from OVC. The OVC themselves should also quickly report such cases to the police.

Discrimination against and stigmatisation of OVC should not be tolerated in all spheres of the society. It creates an inferiority complex among OVC and this may end up affecting their academic work at schools. As such, children at schools should be educated about not looking down on OVC or calling them names. It is even more traumatising to be discriminated against for those OVC whose parents had died of HIV and AIDS.

There is a need for a coordinated approach by all stakeholders working with OVC. This would minimise cases of 'double-dipping' by some OVC, at the expense of others. There should be a centralised database for OVC at district level and streamlining of each NGO's activities and targeted beneficiaries.

The high level of awareness and knowledge about HIV and AIDS is surprisingly not translated into behaviour change. People are still practising risky sexual behaviour. This, therefore, calls for continually reminding people about the dangers and ripple effects of the pandemic on the economy as a whole.

CHAPTER 11

Conclusions and recommendations

Simbarashe Rusakaniko, Shungu Munyati, Brian Chandiwana and Teramayi A Moyana

Magnitude and living situation of the OVC

The number of OVC in all the districts had been increasing, which therefore presented more challenges and complications in providing for their care. Many parents were dying of HIV and AIDS. There were more vulnerable non-orphans as a result of poverty, compared to orphans, which was exacerbated by the prevailing harsh economic conditions. Fostering was essential in communities where some households were failing to tackle the burden of caring for so many children, otherwise all of the children would suffer as a result. A number of social problems were identified, including: children looking for paid jobs at an early age; dropping out of school; early marriages of young girls; provision of care by grandparents without the means; poor shelter and overcrowding; food shortages in their households; and the existence of child-headed households (though these were few).

Care and support

Most of the caregivers of OVC in all the districts noted that they had inadequate food, school fees (including uniforms and stationery), clothes and blankets. Psychosocial support for OVC was a neglected area, as most of the support organisations provided material support only.

Home-based care (HBC) support groups played crucial roles in assisting children in households affected by HIV and AIDS. Several non-governmental organisations (NGOs) and the government, through District AIDS Action Committee, were helping OVC with food and education, life skills and funding income generating projects (IGPs). However, the beneficiaries of these various kinds of support felt that it was inadequate, although they appreciated the humanitarian efforts.

Community resources

Available community resources were inadequate to support OVC and had minimal impact on the lives of OVC. Shortages of inputs threatened the viability of *Zunderamambo* (a community field where community members work together to support orphans and other vulnerable families) and other agro-based projects run by caregivers to support OVC with school fees. There were poor resource capacity and poverty in all the communities.

Support structures

There was a decline in the support given to OVC households by NGOs and other support organisations. This decline was attributed to strained budgets and economic hardships, leading to failure to provide the level of material support that the organisations used to supply. Externally funded organisations mentioned inadequacy of financial resources as a major challenge. The general consensus among all stakeholders was that everyone from community members to local government had a role to play. Most of the orphans had no access to facilities such as education and healthcare, due to dwindling of the financial resource bases of most of the support organisations, who also reported that their coverage

was below the intended targets. Collaboration among NGOs is essential, so that there could be effective delivery of services to the OVC.

The diversion of material items distributed to people looking after OVC was a problem. A number of asset-grabbing cases were reported in Chimanimani and Nyanga, where orphans were left at a very young age. Family possessions were distributed to relatives taking custody of the children. Some relatives of OVC would sell family assets in order to meet the needs of the orphans, such as food and school fees.

Community attitudes towards OVC

The general attitudes of caregivers and other children towards OVC were perceived as positive. Physical abuse of OVC was reported where there was unfair allocation of household work between caregivers' biological children and the OVC. Stigma and discrimination against OVC were low in the communities. In fact, communities were willing to assist OVC, but they did not have the resources. The proliferation of support groups was indicative of the willingness of the people in the communities to support OVC. However, a number of OVC were used in some households as instruments to attract resources from NGOs and in others, caregivers would give preference to their biological children when it came to buying clothes or uniforms and paying school fees.

The provision of care for OVC was made more complicated by recurrent droughts in all the districts, which affected food production, especially as most of the caregivers were subsistence farmers. This had compromised the caregivers' capacity to provide food and generate income to buy healthcare products/services and clothes and to pay for education for the OVC.

Services available for OVC care

Services to address the psychosocial well-being of the OVC were either non-existent or inadequate, due to the absence of expertise in conducting counselling sessions for OVC in communities. Most of the NGOs in the districts mostly concentrated on food support and other income generating projects and did not focus on psychosocial well-being of the OVC. Support groups such as HBC groups tried to help in this situation, but most of them were equipped with only very basic training in counselling.

Awareness of HIV and AIDS

In all the districts, awareness of HIV and AIDS was high, but sexual behaviour change was always the problem, as people were slower in changing their sexual behaviour. Deaths from HIV-related illnesses were increasing. High levels of awareness were being manifested through the increasing usage of condoms, a significant behaviour change, especially among the youth; another change was that relatives were now becoming more sympathetic and were buying drugs for people living with HIV and AIDS (PLWHA).

Recommendations

- The right of children to education is facing serious challenges because of high cost of school fees, uniforms and stationery. Maybe it is time the government should reconsider the policy of free education to all children in primary school. Educational funding should be scaled up to cover more children who are in need.

- There is a need to source more funds to finance programmes; more resources need to be mobilised, since the number of OVC is ever increasing.
- Input support for IGPs, for example, seed, fertilisers and chemicals.
- Water sources to support agriculture-related programmes.
- The government should create a favourable environment for support organisations to provide efficient and effective intervention programmes.
- Information and educational initiatives are needed, so that the programmes can be successful.
- There is a need to identify people who matter, the people who are responsible for looking after the OVC, as there were cases of some households that were benefiting and yet they were not the ones looking after the OVC.
- Community-based organisations (CBOs) and NGOs should sensitise people to provide physical and emotional support as well as educational support to needy children.
- Motivate volunteers who assist OVC, through giving them some incentives.
- OVC should show appreciation and respect to their benefactors.
- Train volunteers in orphan-care work, in order for them to execute their work well.
- Communities should start self-driven, community-based volunteer programmes.
- Aid agencies should continue to assist OVC until they can fend for themselves. Organisations have a tendency to assist OVC only up to a certain age limit, which is usually 18. Furthermore, the government needs to continuously monitor the welfare of the orphaned children.
- Comprehensive and up-to-date information on who is doing what, when and how for OVC should be available to government departments, NGOs and CBOs, so that there is collaboration and no duplication of intervention activities.

APPENDIX: INTERVIEW AND DISCUSSION GUIDELINES

1. Interview schedule for study of the situation of orphaned and vulnerable children (OVC)

The key areas to be covered in the interviews are in bold. Below are prompts that may be used to elicit discussion, plus the particular areas that need to be covered in the interview. For each interview, different sections of the interview schedule will have to be prioritised, and some of the areas of discussion may fall away. Do not use the prompts unless the respondent finds it difficult to talk about the area. Responses are sought beyond the immediate prompts, as long as the discussion stays within the broad subject.

Sectors to be interviewed include the following:
- OVC (O);
- immediate carers (C);
- NGOs (N);
- CBOs (B);
- faith-based organisations (F);
- state (S);
- ordinary community members (K).

Background of person being interviewed (all)

This should serve as an icebreaking section. Before you meet the participant you would have been given some brief information about the participant, who he/she is and how you came to interview him/her. Before asking the participant to talk about his/her experiences and needs of an OVC, first explain the study in detail.

Why the person is being interviewed. ***Umuntu lo ubuzelwani.***
His/her position in the community. ***Uyini esigabeni.***
How he/she came to be in this position (B, F). ***Wafika njani kulesisigaba.***

Major challenges, needs and concerns for OVC (exclude OVC)
Okuswelakalayo kakhulu njalo lokuhluphayo mayelana labantwana abazintandane lalabo abaswelayo

The living situation of OVC, ranging from the best off to those in the worst situations, including the number of OVC in the community. ***Inhlalo yentandane labantwana abaswelayo lobunengi babo.***
Definition of orphan and vulnerable children. ***Yibaphi abantwana elibathi zintandane kumbe abaswelayo?***
What is your or your organisation's source of knowledge about OVC? ***Wena kumbe inhlanganiso yakho, ulwazi mayelana lentandane labantwana abaswelayo liluthathangaphi?***
What do you think is the size/magnitude of the problem and what impact is it having on this community? ***Ngombono wakho uhlupho lolu lukhulu/lwande kangakanani njalo lungabe luphambanisa njani inhlalo yabantu kulesisigaba?***
Housing conditions, examples of good and bad. ***Izindlu abahlala kuzo zinjani (zinle kumbe zimbi).***
Access to facilities by OVC, particularly educational, health and social services. ***Amathuba entandane labantwana abaswelyo ekutholeni imfundo, impilkahle, lokunye okuswelakalayo/okudingakalayo ekuhlaleni kwabo.***
Financial and social resources available for OVC. ***Intandane labantwana abaswelayo zikhona indawo abangathola khona imali lokunye okungenza babe lenhlalakahle.***

Community resources available for the care of OVC. ***Izinto ezikhona esigabeni ezingaphathisa lababantwana.***
Major threats for OVC's quality of life (at the levels of physical, emotional). ***Yiziphi izinto ezinkulu ezingaphambanisa inhlalakahle yentandane labantwana abaswelayo (emzimbeni yabo, emicabangweni/emoyeni).***

Major needs and concerns for OVC (O)
Okuswelakalayo kakhulu njalo lokuhluphayo mayelana labantwana abazintandane lalabo abaswelayo

Care of OVC. ***Ukugcinwa kwentandane labantwana abaswelayo.***
OVC's own reflection on situation. ***Umbono wakhe mayelana lenhlalo yalababantwana.***
Housing, access to facilities, resources they have access to. ***Izindlu abahlala kizo lezinto abanela ukuzifinyelela.***
Loss of personal possessions. ***Mayelana lezelifa/ukulahlekelwa lilifa labo/izinto zabo.***
Level of emotional and physical care. ***Bagcinakale njani kwezomoya/kwezeqondo langezomzimba.***
Challenges and coping methods. ***Inhlupho abahlangana lazo njalo lendlela abazama ukuqeda ngazo lezinhlupho.***
Support structures. ***Inhlelo ezikhona zokubancedisa.***
Attitudes to carers, key influencing figures in their communities. ***Indlela ezinhle kumbe ezimbi abakhangela ngazo abagcinayo lababantwana labakhokheli bezigaba zabo.***

Attitudes of the community towards OVC, especially incidents of stigma and discrimination (all)
Indlela ezinhle/ezimbi isigaba esikhangelela ngayo intandane labanye abantwana abaswelayo ikakhulu udaba lokubakhangelela phansi lokubehlukanisa ngenxa yesimo sabo
Ask community members themselves; participants here should be aware of attitudes towards OVC, whether they are accepted/rejected in communities. Rejection could be either overt or covert; probe for these. If time allows, try to probe for concrete examples of these issues, for example, whether they know any OVC who are being treated badly either within the family or in the community. Ask NGOs and state officials' views about the *community's* attitudes towards OVC and, if these attitudes are negative, ask about programmes aimed at changing them.

Perceptions and attitudes (negative or positive) towards OVC of the community. ***Indlela ezinhle kumbe ezimbi ezitshengiselwa kuntandane labantwana abaswelayo.***
Stigma against OVC. ***Ukukhangelelwa phansi kwabantwana abazintandane labaswelayo ngenxa yesimo sabo.***
Treatment of OVC. ***Indlela intandane labantwana abaswelayo abaphathwa ngayo.***

Care and support structures for OVC (all)
Ukugcinakala kwentandane labantwana abaswelayo lezinye izinto ezikhona zokubaphathisa

Indications of who is providing this care and support. Include examination of systems at the level of the family, community, organisational, state and others that may exist. ***Izitshengiselo zokuba ngobani ababagcinayo lababapha lokhu kuphathisa.***

Sikhangelisisa indlela zokugcinwa kwalababantwana kumuli, kusigaba, kunhlanganiso, kuHulumende labanye abangaba khona (zisebenza njani).
Desirability and effectiveness of the different structures for care and support. *Izinto ezikhona zokubaphathisa yizo abaziunayo na njalo zisebenza ngandlela bani.*
Indicators of success of systems of care. *Okudingakalayo ukuba indlela lezi zokuphathisa ziqubeke ziphathisa kuhle, lababantwana.*
Check sustainability of these systems of care. *Indlela lezi zokugcina lababantwana zingaqhubeka zisebenza kuhle na kungela ncedo oluvela ngaphandle, izinto ezisetshenziswayo ziyatholakala kuyonalindawo, ngobani abakhokhela uhlelo.*
Requirements of these structures to be able to provide a better service. *Yiziphi izitshengiselo zokupumelela kwezindlela zokugcina lababantwana (emulini, esigabeni, enhlanganisweni).*
Impact of services. *Indlela abancedwa ngazo zisebenza kuhle na kumbe ziyabaphambanisa lababantwana. Yiziphi impumela ezimayelane lemisebenzi ephathisa lababantwana.*

Profile and evaluation questions of implementing intervention organisations (N, F, S, B)
Ukudingisisa ngesimo langokusebenza kwenhlanganiso eziphathisa kulesisigaba kuntadane labantwana abaswelayo

What work does your organisation do and how do you assist OVC? (N, B, F, S)
Inhlanganiso yakho yenza msebenzi bani njalo incedisa njani laba bantwana?
Knowledge of the intervention organisation, structure and past activities. *Ulwazi mayelana lenhlanganiso leyi, langemisebenzi asebayenzayo kanye lokuma kwayo.*
Perceptions of the organisation and their capacity to do the work (coverage, resources). *Inhlanganiso yenu ilubona njani uhlupho lwentandane labantwana abaswelayo njalo lenelisa kangakanani umsebenzi wenu?*
Ideas of how to facilitate the organisation's work. *Imicabango/imbono engaphathisa ukuba inhlangiso yenze umsebenzi wayo kuhle.*
Indicators of success of the implementing organisation. *Izitshengiselo zokuphumelela komsebenzi walinhlanganiso.*

Challenges and complications for the community in providing care and support (N, F, C, S, B)
Okuhluphayo kulesisigaba ekugcineni lekuphathiseni intandane abantwana abaswelayo
What state officials, NGOs, CBOs, FBOs representatives think are challenges faced by communities in providing care and support for the OVC and how these could be overcome.

Providing the basics of shelter, food, education, health and care. *Ukupha ukudla, indawo zokuhlala, imfundo, ukugcinakala kuhle kanye lezempilakahle kulababantwana.*
Dealing with the emotional impact of orphanhood or vulnerability, e.g. mourning. *Imizamo yokuqeda ukuhlupheka emoyeni/enhlizweni kwentandane labaswelayo e.g. ukukhala ngokufelwa.*
Interaction of the OVC with others in the household/institution. *Indlela abaphilisana/ abahlalisana ngayo labanye kuzimuli kumbe endaweni abagcinwa kuzo.*
Attitudes of carergivers to OVC. *Izenzo zabagcine lezintandane labantwana abaswelayo.*

Assisting the OVC to deal with stigma and discrimination. ***Ukuphathisa intandane labantwana abaswelayo ekuqedeni udaba lokweyiswa lokwehlukaniswa.***
Experiences of stigma as a result of providing care to OVC. ***Ukwahlukwaniswa elihlangana lakho ngenxa yokugcina intandane labantwana abaswelayo.***
Access to resources to facilitate care. ***Ukwenelisa ukufinyelela/ukuthola okokuncedisa ekugcineni kwalababantwana.***
Impact of caring for OVC on lifestyle. ***Impumela yokugcina lababantwana empilweni yalabo ababagcinayo lababantwana. (Impilo iyantshintsha yini?)***
Suggestions on how to overcome challenges and complications in providing care and support. ***Kuyini okungenziwa ekunqobeni inhlupho lezi?***

Policy and legislation for the protection of OVC (S, N, C, B, K)*
Indlela ezikhona lemithetho ebekiweyo mayelana lokugcinakala kwentandane labantwana abaswelayo
Ask about policies and legislations aimed at protecting OVC, their views about these, including strengths and limitations and whether they would like to see them amended. If no policies and legislation currently exist, probe for reasons for this. For example, is it because OVC are not a priority in the government/NGOs/carers or that these are still in progress?

Knowledge of law, policy or pre-established practices to protect OVC. ***Ulwazi ngemithetho lendlela ezikhona mayelana lokugcinwa kwentandane labantwana abaswelayo.***
Attitudes towards such regulations. ***Indlela ababona ngayo imithetho leyi/abakwenzayo ngemithetho leyi.***
Implementation and support of these regulations. ***Ukulandelwa lokuphathisa okukhona mayelana lale imithetho.***
What are the challenges in enforcing laws that protect children? ***Yiziphi inhlupho abablangana lazo ekulandelweni kwemithetho leyi?***

Suggestions of how to help OVC in the community (all)
Okungenziwa ukuze kuphathiswe intandane labantwana abaswelayo esigabeni

Role/actions the individuals, CBOs, NGOs, FBOs and state structures/government departments should take to assist OVC. ***Okungenziwa ngabantu nje, zinhlanganiso zesigaba, zinhlanganiso ezisebenza zodwa, zinhlanganiso zesiKristu lezigaba zikaHulumende kumbe uHulumende ekuphathiseni intandane kumbe abantwana abaswelayo.***
What is needed to facilitate these contributions? ***Kuyini okudingakalayo okungakhwezela ukuphathisa kwalababantu abaqanjiweyo?***
Assessment of the commitment on the part of these structures to assist. ***Ukukhangelisisa ngokuzinikela okwenziwa yilezinhlanganiso, ekuphathiseni kwazo.***

* Relevant Zimbabwean legislation
Children's Act (Chapter 5:06 of 14/2002)
Maintenance Act (Chapter 5:09 of 22/2001)
Guardianship of Minors Act (Chapter 5:08 of 2002)
Sexual Offences Act (Chapter 9:21 of 22/2001)
Birth and Death Registration Act (Chapter 5:02 of 22/2001)
Labour Act (Chapter 28:01 of 17/2002)
Public Health Act (Chapter 15:09 of 14/2002)
Education Act (Chapter 25:04)
Legal Age of Majority Act (under General Law Amendment Act Chapter 8:07 of 15/1996)

Extent of HIV and AIDS as a problem in the community (all)
Ukwanda kohlupho lweHIV/AIDS esigabeni
Ask partcipants to estimate the extent of the HIV and AIDS problem in the community. State officials and NGOs, especially those who provide social services and those who work in vulnerable communities, should be aware of the magnitude of HIV/AIDS in their communities. Ask if there are statistics on the situation available and, if not, ask them to estimate what the magnitude of the problem is. Participants might not have the exact numbers but should merely say how big/small the problem is. It is also important to know the impact of HIV/AIDS on resources and social functioning in general. For example, does it result in increase of orphans? Does it result in family conflicts, blame and infighting within communities, accusations of witchcraft etc.?

Awareness and knowledge of HIV/AIDS. ***Ulwazi mayelana ngeHIV/AIDS.***
Estimates of the number of people with HIV/AIDS. ***Ubunengi babantu abale HIV/AIDS.***
Impact of HIV/AIDS on state and organisational resources available. ***Umnotho welizwe lowezinye inhlanganiso uphambaniseka njani ngaloluhlupho lweHIV/AIDS.***
Impact of HIV/AIDS on community resources available. ***Umnotho wesigaba uphambaniseka njani ngaloluhlupho lweHIV/AIDS.***
Impact of HIV/AIDS on the social functioning of the community. ***Ukusebenza kuhle kwesigaba kuphambaniseka njani ngaloluhlupho lweHIV/AIDS.***

Suggestions on how to limit the spread of HIV/AIDS in the community (all)
Okungenziwa ukuze kuqedwe udubo lokumemetheka komkhuhlane weHIV/AIDS
Ask what interventions they think are required to limit the spread of HIV/AIDS in the community. Is it education, infrastructure, reduction of stigma, improvement of health services, gender equity etc.? Also, who should take responsibility to provide these within the government?
NB: *Expert opinion should be sought from the Ministry of Health and NGOs/FBOs/CBOs working on campaigns to reduce spread of HIV.*

Educational and information needs. ***Okuqondane lokufundisa lokwazisa abantwana ngeHIV/AIDS.***
Infrastructural needs, e.g. PMTCT, VCT and condom distribution. ***Izimiso ezikhona eziqondane le PMTCT, VCT, condom distribution, ekuzameni ukuqeda udubo lweHIV/AIDS.***
Interventions at the social level, e.g. stigma, gender discrimination, promiscuity. ***Okungenziwa ukuphathisa ukuqeda ukukhangelelwa phansi lokungenangena (promiscuity).***
Check on the health service (availability of resources, e.g. equipment, vehicles, drugs, staff). ***Khangelisisa ngezempilakahle okungaba njenga maphilisi leminye imithi, imitshina, izimota, izisebenzi. Kukhona yini?***

Care and treatment of PLWHA in the community (all)
Ukugcinakala lokuphathwa kabantu abaphila legcikwane esigabeni, labagula ngalumkhuhlane
Ask about their knowledge about care of people living with HIV and AIDS. If services are available, ask for details and whether PLWHA access them. What are their views about these services and if anyone of them tests positive would they utilise them? If not, what are the reasons? Ask about services provided by the government and this department (and others) for the care of PLWHA.

Availability of services for PLWHA (HBC, VCT, ARV). ***Ukutholakala kwenhlelo eziphathisa abantu abaphila legcikwane, labagula ngalumkhuhlane.***
Impact of services. ***Impumela ngalezinhlelo.***
Views on access, availability, effectiveness of community response to VCT, PMTCT and ARVs. ***Imbono ngokutholakala, lokufinyelela langokwamukela kwalezinhlelo esigabeni, lango kusebenza kuhle kwazo.***
Advantages and disadvantages of being open about one's HIV status. ***Ubuhle lobubi bokuchaza ngesimo sakho nxa ulegcikwane, kumbe usugula ngalo umkhuhlane.***

Risks of HIV as a result of violence (all)
Ingozi engenza umuntu athole igcikwane ngenxa yokuhlukuluzwa/ukubanjwa ngamandla
Ask about the incidence of these behaviours that may place people at risk of HIV/AIDS. Ask in general whether these practices exist in the community, who is likely to engage in them and why.

Child abuse. ***Ukuhlukuluzwa kwabantwana.***
Rape and sexual assault. ***Ukubanjwa iganyavu lokuhlukuluzwa mayelana ngendaba zemacansini.***
Main perpetrators, target groups, and why? ***Ngobani abandise ukwenza lokhu, bekwenza kubobani njalo bekwenzelani?***
Caring for victims of violence. ***Ukuncedisa labo abayabe behlukuluziwe.***
Taking payment for sexual services. (Who is doing it and why?) ***Kupihwa muripo mushure mekunge vanhu vasangana pabonde (ndivanani vanoita izvi uye vanozviitirei). Ukuthatha imbadalo kumbe ezinye izipho ngemva kokuya emacansini. (Ngobani abenza lokhu njalo bekwenzelani?)***

Major sources of information on HIV and AIDS (all)
Ulwazi olunengi baluthola ngaphi mayelana leHIV/AIDS
This last section asks about sources of information about HIV and AIDS, ask them to also rank these services: Which one provides the most useful information? Which one do they utilise often and how could the provision of information about HIV and AIDS be improved?

Media sources. ***Indlela ezitshiyeneyo ezinjenga maphephandaba, iradio, itelevision.***
Organisational and state services information. ***Inhlanganiso ezitshiyeneyo lezigaba zikaHulumende ezipha lezinhlelo mayelana leHIV/AIDS.***
Peers and colleagues. ***Abanye bakhe/abangani bakhe kanye labasebenza bonke.***
How could the provision of information about HIV and AIDS be improved? ***Kuyini okungenziwa ukuze ulwazi ngeHIV/AIDS lwengezelelwe?***

NOTE: PLEASE ASK THE FOLLOWING

Service centres and available services
Economic conditions
Main agricultural crops
Education facilities, location and intake
Road network and distances from other towns
Water, housing (include common types of houses) and sanitation situation
Languages spoken and ethnic groups
Population distribution by age group and sex

2. Case study guide for children

This case study guide aims at getting an in-depth understanding of the lives of orphaned children in eight Kellogg districts in Zimbabwe, including coping strategies they employ for survival.

District _____

Date _____

Interviewer _____

Profile of the child

1. Name of the child _____

2. Age _____

3. Sex _____

4.

Type of orphan	Duration
i. Maternal	
ii. Paternal	
iii. Double	Mother Father

5. Relationship to caregiver _____

6. Background history of the child

7. Coping mechanisms

8. Challenges in life

3. Focus group discussion guide for adults and children

This FGD guide aims at assessing the situation of OVC and activities of the various organisations involved in OVC projects in eight Kellogg districts in Zimbabwe, from the adults' and children's perspective.

District name _____

Location (ward/village/suburb) _____

Date and time (e.g. 15-01-06 & 13:20) _____

Facilitators _____

Description of participants (list ages of participants, sex)

1. Living situation of OVC *Magariro ari kuita nherera nevana vanotambudzika*
What are the definitions of an orphan and vulnerable children? *Vana vamunoti nherera nevanotambudzika ndevapi?*
Describe the types of orphans and their associated problems (maternal, paternal and double). *Ndedzipi mhando dzenherera nematambudziko adzinosangana nadzo?*
Who are the people who mostly look after OVC? *Ndevapi vanhu vanowanzochengeta nherera nevana vanotambudzika?*
What is the magnitude of the OVC problem, including child-headed households, in the community? *Munofunga kuti dambudziko renherera nevana vanotambudzika nevana vari vari musoro wemba rakakura zvakadii munharaunda yenyu?*
What are the main causes of orphanhood in this community? *Ndezvipi zvikonzero zviri kunyanyoita kuti nherera dziwande munharaunda ino?*
How would you describe the housing conditions in this community – population density? *Dzimba dzamuri kugara dzakamira sei, uye makawanda zvakadii mudzimba umu?*
What community resources are available for the care of OVC? *Ndezvipi zvinhu zviri munharaunda zviripo kubatsira kuchengeta nherera nevana vari kutambudzika?*

2. Needs of OVC and caregivers *Zvinodiwa nenherera nevana vari mumatambudziko uye neavo vanovachengeta?*
What are the needs (both material and immaterial) of OVC and their primary and secondary caregivers? *Ndezvipi zvinodiwa nenherera nevana vari mumatambudziko neavo vanovachengeta?*
Are there any challenges in getting these needs for the above three? *Pane matambudziko amunosangana nawo mukuwana zvinhu izvi?*

3. Caregivers' coping mechanisms *Zviri kuitwa nevari kuchengeta nherera kuti ivo vabatsirikane*
How do caregivers make ends meet? *Vachengeti venherera nevana vanotambudzika vari kuedza kurarama sei?*
What are the caregivers' constraints/challenges of looking after OVC? *Ndeapi matambudziko arikusangana neavo vanochengeta nekubatsira nherera nevana vari kutambudzika?*
How are the caregivers of OVC affected by their responsibilities? *Vachengeti venherera nevana vari kutambudzika vari kukanganiswa zvakadii nemabasa avanoita?*

Do you experience stigma as a result of providing care to OVC? *Pane kushorwa kwamuri kusanga nakwo pamusoro pekuchengeta vana nherera nevana vari kutambudzika here?*
Do the primary and secondary caregivers have the skills and capacity to care for OVC? *Vanochengeta nevanogara nevana ava vane unyanzvi here uye vari kukwanisa here kuita basa ravo?*

4. Attitudes of the community towards OVC, especially incidents of stigma *Maonero anoitwa nherera nevana vari kutambudzika nevanhu vemunharaunda takanyanyotarisa nenyaya dzerusaruro*
Perceptions and attitudes (negative or positive) of OVC by the community. *Maonerwo anoitwa nherera nevana vari kutambudzika nevanhu vemunharaunda.*
Stigma against OVC. *Kushorwa kunoitwa nherera nevana vari kutambudzika.*
Treatment of OVC. *Mabatirwo anoitwa nherera nevana vari kutambudzika.*

5. Care and support structures for OVC *Zvirongwa zviripo maererano nemabatirwo anoitwa nherera nevana vari kutambudzika*
What emotional and physical care do you give to OVC? *Zvii zvamunoitira nherera nevana vanotambudzika kuti vagadzikane mundangariro nepamuviri yavo?*
What support structures for OVC exist in this community, such as source of support, type; established systems at the level of the family, community, organisational, state and others that may exist? (Include extent of services.) *Ndezvipi zvirongwa zviripo maererano nemabatirwo anoitwa nherera nevana vari kutambudzika takanangana nemhuri, nharaunda, masangano, hurumende uye nevamwewo vakazvimirira vega?*

6. OVC's behaviour in relation to HIV and AIDS *Kuzvibata kwenherera nevana vanotambudzika takatarisana neutachiona nechirwere cheHIV/AIDS*
Do you communicate with children about HIV/AIDS, sex, abuse, reproductive health? *Munombokurukura here nevana mearerano nezvechirwere cheHIV/AIDS, nyaya dzepabonde, dzekushungurudzwa uye dzekubva zera/kuyaruka?*
In your own opinion, how do you see the sexual behaviour of OVC? *Mumaonero enyu, nherera nevana vanotambudzika vanozvibata sei panyaya dzepabonde?*

7. Policy, legislation and practices for the protection of OVC *Zvirongwa nemitemo iripo maererano nekuchengeta nherera nevana vari kutambudzika*
Are OVC and community members aware of policies and legislation that protect OVC? *Vanhu vemunharaunda, nherera nevana vanotambudzika vane ruzivo here pamusoro pemitemo, tsika nezvirongwa zviripo zvakanangana nekuchengetwa kwenherera nevana vari kutambudzika?*
What are the OVC and community members' attitudes towards these laws which protect children? *Maitiro enherera, vana vari kutambudzika nevanhu vemunharaunda maererano nemitemo nemirau iyi?*
Implementation and support of these regulations. *Kushandiswa nekutsigirwa kwemitemo nemirau iyi.*
What are the challenges in enforcing laws which protect children? *Ndeapi matambudziko ari kusanganwa nawo mukuteedzerwa kwemitemo nemirau yekuchengetedza vana?*
Loss of personal possessions. *Zvinhu zvavo zvavakarasikirwa nazvo.*

4. Interview guide for state, traditional/political leaders

This interview guide aims to assess the situation of OVC and activities of the child-related organisations in eight Kellogg districts in Zimbabwe, from the perspective of the ministry representatives and political/traditional leaders.

District _____

Ward _____

Position of chief respondent _____

Date of interview _____

1. Name of organisation/department _____

2. Type of activities and target groups

Target group		Type of activities
Gender	Age	

3. How were the activities initiated?
   a) Community initiated
   b) Donor initiated
   c) Government initiated

   Reasons why the intervention was initiated?

4. What is your organisation/department's source of information about OVC?

   1 _____

   2 _____

   3 _____

5. What are the challenges in enforcing laws which protect children?

6. What are the needs of OVC in your community?

7. What are the needs of primary and secondary caregivers in caring for OVC?

8. Are there any challenges in getting these needs?

9. How would you rate the level of community participation in OVC projects in this community?
   Very good
   Good
   Moderate
   Poor
   Very poor

10. What are the reasons for your response in 9 above?

11. What are the challenges/constraints your department is facing in caring for OVC?

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