
Chapter 1 - Introduction

UNICEF commissioned this report on orphans and other vulnerable children. The purpose of the report is to present a synthesis of five commissioned and one supported study on various categories of vulnerable children. The studies were all undertaken between 1999 and 2000. In presenting the synthesis, the report aims to bring to the fore information on the extent and the factors that drive the vulnerability among Zimbabwean children. The report goes further to synthesize reflections on the prevention and mitigation measures as well as identify some gaps that if addressed would make a positive impact on the situation of these children. Through the presentation of such issues, UNICEF hopes that the report will contribute towards the development of a comprehensive long-term strategy aimed at improving the realization of the rights of Zimbabwe's most vulnerable children.

The Background Studies

The studies commissioned towards the preparation of this report were as follows:

- *A Study on Children Affected by AIDS in Zimbabwe – Mrs. C. Makufa*
- *A Study on Children Infected with HIV in Zimbabwe – Dr. B.B. Nyathi*
- *A Study on Children and Adolescents with Disabilities in Zimbabwe – Mr. R. Chimedza*
- *A Study on Street Children in Zimbabwe – Mr. B. Muchini*
- *A Literature Review on the Phenomenon of Working Children in Zimbabwe – Dr. L. Dube*

In addition to the commissioned studies, there was one supported study. The supported study was undertaken by the Department of Social Welfare in the Ministry of Public Service Labour and Social Welfare. This study that had multiple objectives, focused on the *enumeration of orphans and other vulnerable children*.

Background Study Methodology

The background studies used various methods. Use was made of both primary and secondary sources. A variety of techniques including literature searches and reviews, observation, individual and group interviews, structured questionnaires, and stakeholder consultations were used. Participation in the studies ranged from children themselves to their families, heads of institutions and government departments. The scale of the research varied to reflect the differences in study objectives. An illustrative example is that of the enumeration exercise undertaken by DSW which sought to establish numbers and locations of orphans and other vulnerable children that covered 96 215 cases. By contrast, the in-depth study on street children covered 260 children.

A common conceptual/analytical framework was used to guide the preparation of the analytical studies. The conceptual/analytical framework is presented separately later in the report.

The report was presented at two sub-national level workshops: in Bulawayo, October 23 and 24, and Nyanga, October 30 and 31. A national level one was held in Harare on November 28. At these workshops the findings were presented and discussed and the participants validated the emerging gaps and recommendations.

Presentation of the Report

The report is presented in *three parts* made up of *seven short chapters*. The first part of the report focuses on understanding the situation of vulnerable children. The second part of the report focuses on the strengths, weaknesses and gaps in existing interventions in relation to the circumstances of vulnerable children. The final part of the report draws on the first two parts to present some priority areas for action as well as recommendations.

In order to present the situation of vulnerable children, the *first part* of the report is made up of *four chapters*. The first of these is the introduction to the report. A presentation of the definitions for the categories of children and an overview of the conceptual/analytical framework used for the studies follow this. The third chapter presents an overview of the socio-economic context within which the issues discussed in the report should be understood. The final chapter in this part presents an assessment and analysis of the extent of the problems relating to each of the categories of children. This final chapter concludes with a summary that examines the aspects that are common to the various categories of children and draws on information from the preceding chapters to highlight the implications of socio-economic trends. *Part two* of the report focusing on interventions and is made up of two chapters. The first of these examines the interventions being made in relation to each category of children. In examining

these interventions, deliberate attention is paid to four specific categories of intervention - namely, policy, legislation, programmes and research/knowledge generation. The *second chapter* examines the common threads between the different categories of children, highlights the gaps in services, legislation and policy and makes a case for a more comprehensive approach for provision and programming for vulnerable children.

The *final part* of the report consists of a *single chapter* that focuses on priority areas and recommendations for action, if a significant difference is to be made in the lives of the most vulnerable children.

Chapter Two - Child Rights, Categories of Children and the Analytical Framework

The process of undertaking the background studies began by seeking to establish among participants a consensus on a number of issues. Among these was the establishment/confirmation of a common understanding of child rights, defining the categories of children, and agreeing on and ensuring capacity to apply the conceptual framework.

Child Rights

Within the context of child rights, the content and fundamental principles of the Convention on the Rights of the Child were emphasized. The principles emphasized and carried through the analysis were:

- Non-discrimination;
- The best interests of the child;
- Survival and development; and
- Participation

These four guiding principles define the relationship between children, as a rights holder and active participant in his/her life, and society and its institutions as duty-bearers. Rights imply obligations, roles and responsibilities. The recognition of this fact was also carried through the analysis.

Categories of Children

For the purposes of the background studies that fed into this report the various categories of children were defined as follows:

- Vulnerable children : children whose rights are negatively impacted upon by HIV/AIDS, orphanhood, disability, street-life and need to work
- Orphans : children under 18 years whom both parents are dead
- Children infected : children living with HIV/AIDS
- Children affected : children under 18 years impacted upon by caring for parent, sibling or relative due to HIV/AIDS
- Children with disabilities : children under 18 with a physical, mental or sensory disability, including a visual, hearing or speech functional disability, giving rise to physical, cultural or social barriers inhibiting the children from participating at an equal level with other members of society in activities open to the others
- Working children : children working for wages with no flexibility and exploitative relations with the “employers”
- Children on the street : children who work and/or sleep on the street

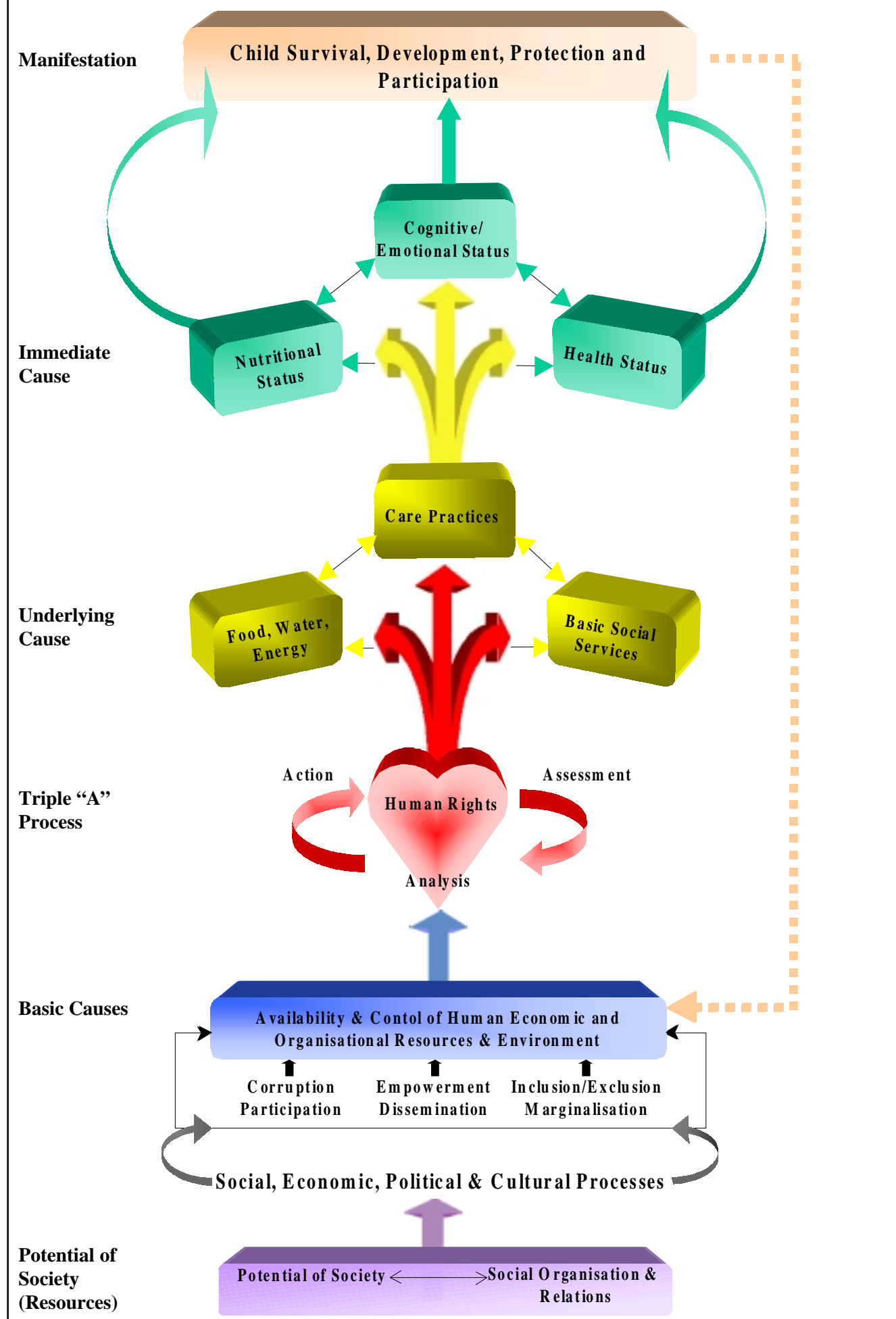
The Conceptual/Analytical Framework

The conceptual framework used for this report and the analytical background papers, is one that has been in use for several years in UNICEF. Originally developed and used within the context of nutrition, the conceptual framework has found wider application within the context of human rights and community capacity development. This analytical framework was applied to the various categories of children.

The conceptual framework starts from the premise that that which is visible only represents a *manifestation* or outcome of underlying problems. Only sound understanding and structured analysis of those problems can facilitate effective intervention. For it to better inform interventions, the analysis must take into account issues as diverse as information availability and state of knowledge, causes, roles, capacities, communication, resource availability, as well as institutional power and gender relations. The conceptual linkages between these issues are presented diagrammatically in Figure 1.

The figure suggests that the problems that are visible (top of the diagram) are an outcome of occurrences of the child – these include the physical, nutritional, emotional status, as well as other factors that have a bearing on the potential of the child. The factors that determine the potential of the child are in themselves outcomes of weaknesses lower down (**underlying causes**). The underlying causes largely reflect the extent to which goods and services are available to support the realisation of the child’s potential. At this level factors such as the availability of say clean water, nutritious food, the care practices, availability and access to health and education infrastructure are examined.

Figure 1. Conceptual Framework: Causality Analysis



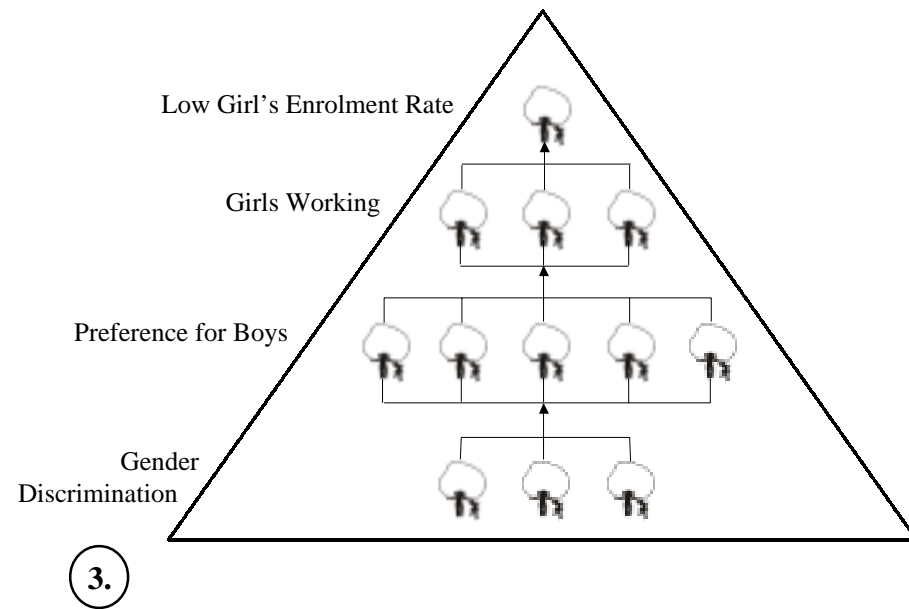
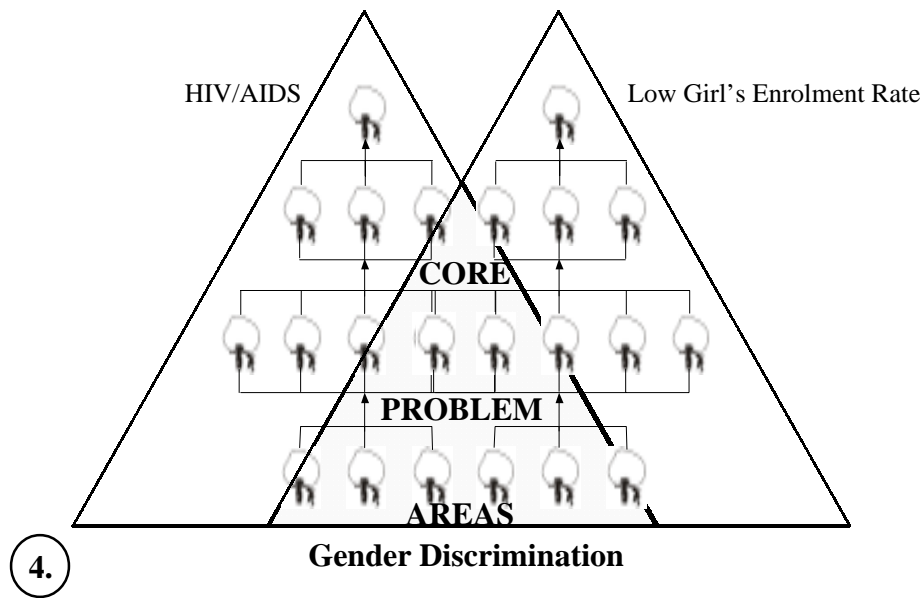
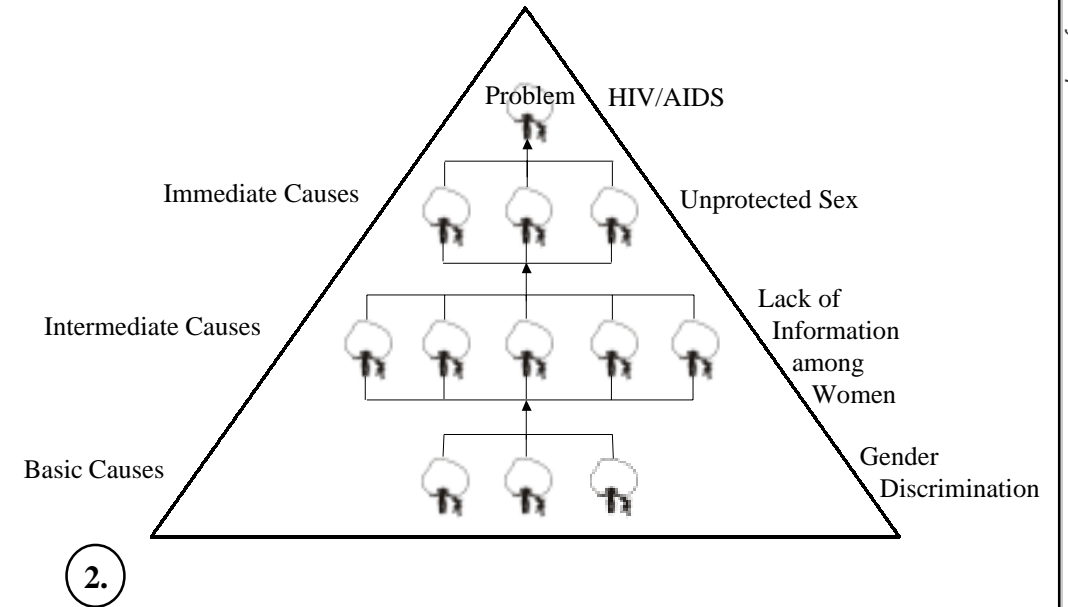
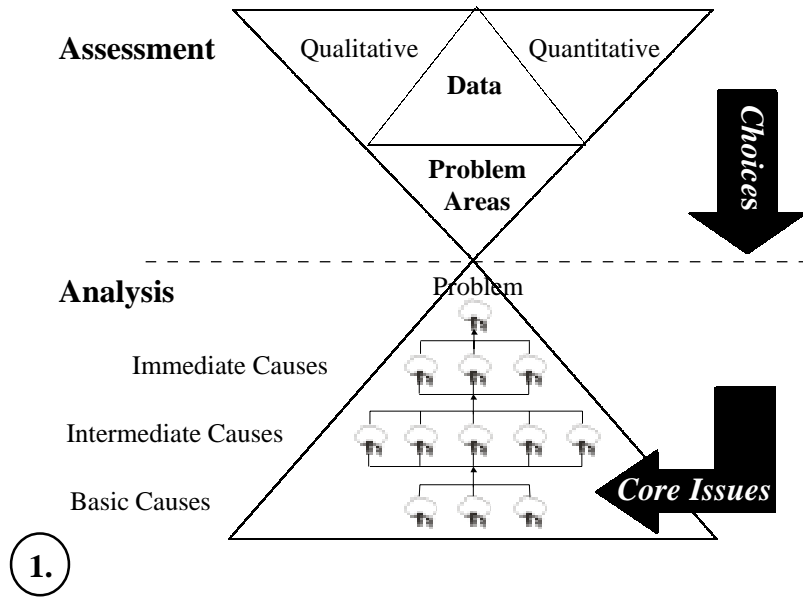
The underlying causes are reflective of decision-making processes as well as the basis for the decisions. Thus, a need to understand the *decision-making processes* at various levels exists. In order to better understand the decision-making process and what informs/shapes the decisions, there is a need to understand the societal context and dynamics (**basic causes**). At this level factors such as access to and control of resources, culture/tradition, participation/exclusion, marginalisation, and social, political and economic processes must be examined. In understanding basic causes attention must be paid to the *potential of the society* - as defined by the natural and created capital.

The *causality analysis* is followed up with examining the roles that different actors have at the different levels. The role analysis is followed with a *capacity analysis*. The capacity analysis examines the capabilities and constraints faced by the various actors in performing the roles expected of them. Deliberate attention is paid to the availability of information and communication among the various actors. This latter aspect is termed *communication analysis*. Beyond the causal analysis, the focus is on identifying gaps that can be attended to, that is, strategic areas for intervention.

The analytical framework presented, although explained in negative terms, can also be utilized in understanding positive outcomes.

As one proceeds with the analysis of different problems facing a society, the basic causes become broadly similar with variation occurring only in the specific practices. By looking at the linkages/connections between the different categories of children as manifestations of deeper problems, this report goes further than the background analytical reports. Figure 2. presents diagrammatically an example of the connections that may occur between different problems.

Figure 2. Conceptual Linkages between Causes



Chapter 3 - The Socio-Economic Context

The socio-economic context surrounding the CEDC in Zimbabwe has been characterized by many challenges – two of which are: the scourge of HIV/AIDS and a deteriorating economic trend. These two problems have arguably reduced the potential of households to cope with ‘normal’ risks and at the same time put up the necessary system to facilitate treatment and care of those who are ill. Understanding the relationship between the HIV/AIDS and the economic situation is crucial in the general understanding of the socio-economic context under which CEDC live.

Any discussion of the socio-economic context of children’s vulnerability in Zimbabwe today has to be made in the shadow of HIV/AIDS. From the mid-1980s, when the first cases were reported, the disease has rapidly increased throughout the country – by 1997 about 650,000 people had developed AIDS. Of that total, 140,000 were estimated to be in the 15-49 age group – (about 25.8% of population) - the economically active. The peak of infection seems to be among the 20-29 years for female and 30-39 for males – these groups are the most active reproductively and thus tend to have young families. The ratio of female to male cases is 5:1 – suggesting high risks faced by girls who tend to engage in sexual activity with older men fuelling the spread of HIV/AIDS into the next generation (Woelk, 1997). Two tendencies can be said of the trend in HIV/AIDS: 1) the rapid increase in infection amongst girls and youth, and 2) the encroachment into rural areas via increased rural-urban migration.

Because of HIV/AIDS life expectancy has fallen from 62 and 58 years for female and males in 1990 to the figures of 57 and 52 respectively (DHS, 1999). Equally, infant mortality has increased from 53 per 1000 live births in 1994 to 65 in 1999 (DHS, 1999). Currently, it is estimated that 1 400 people die a week due to HIV/AIDS related ailments. It arguable that the health sector has been hit very hard as it tries to deal with the consequences of opportunistic infections.

The most immediate consequence of the epidemic has been the disruption of the social fabric of Zimbabwean society as the number of children orphaned increases. It is estimated that about 543 000 children have lost at least one parent to HIV/AIDS (1998) and it is projected that at least 910 000 children will be orphaned by 2005 (Hunter and Fall, 1998). Many of the children are then absorbed into relatives’ families putting further stresses an already weak welfare delivery system.

It could also be argued that HIV/AIDS has also exacerbated poverty. Households have lost revenue from loss of labour, reallocation of productive labour to care-taking, reduced remittances due to death of wage earners and shifts from cash to subsistence crops. The death of a breadwinner due to AIDS in peasant areas leads to a 61% fall in production (Kwaramba: 1997). As noted above, over 25% of the Zimbabwean adult population are HIV positive, (UNAIDS: 1999) and the death rate has doubled between 1990 and 1997, probably due to HIV/AIDS related illness (MoHCW: 1998). The impacts of HIV/AIDS and deepening poverty has undermined the capacity of the family to provide appropriate care and support for children. Children that are particularly vulnerable are orphans and those infected and affected by HIV/AIDS, street and other working children and the disabled.

The scourge of the HIV/AIDS has gotten worse on the back of a worsening economic environment. Broadly, between 1980 and 1990, economic growth as gross domestic product (GDP) per annum averaged 4.3%, with per capita GDP estimated at 1.1%. From 1990-1996, however, the GDP per annum declined to 1.8%, with the GDP per capita exhibiting negative growth of –1.3% per annum, (UNDP: 1998). The GDP per capita in 1997 of Z\$2 025 (at 1990 prices) was barely higher than at independence in 1980 (Z\$1 980) and 7.5% lower than in 1975. Zimbabwe’s economic performance since 1990 has even fallen behind that of the Sub-Saharan Africa region as a whole (UNDP: 1998). Estimates of unemployment indicate that the unemployed as a percentage of the work force has increased from 20% in 1982 to 32% in 1996. This rate has since risen considerably and may be approaching 50%. Equally, Zimbabwe has been vulnerable to bad weather. Most drought years were associated with sharp drops in output and a subsequent lag in recovery. Inflation has been broadly in double figures and the balance of payments pressures persistent. But these were symptoms of underlying difficulties of the Zimbabwean economy. Poverty in absolute and relative terms has continued to increase (see CSO 1998 and Table 1).

The following two tables show the character of resource distribution has been eschewed in favour of the well off and with a bias to the urban areas. The level of poverty in the country is thus undermining the abilities of families to carry out the necessary social investments – such as sending and keeping their children in school, providing

members of family with good health care, nutrition, etc.. Indeed, the pressures from poverty and HIV/AIDS are arguably undermining the extended family network as a coping mechanism.

Table 1-: Overall Poverty Indices Trend

¹ Poverty Index	People		
	1990/91	1995/96	% change
Prevalence	52.8	75.6	43.2
Depth	40.5	38.3	-5.4
Severity	21.4	23.2	8.4

Source: CSO (1998:36).

Poverty has clearly increased - of which most of the Zimbabwean poor and rural (see Table 2), without formal employment and/or access to quality land (see Table 2).

Table 2-: Poverty Indices by Place of Residence

Residence	Prevalence (%) of		Poverty Indices		Distribution (%) of	
	Poverty	Extreme Poverty	Poverty Gap Index	Poverty Severity Index	Poor	Extremely Poor
<u>Households</u>						
• Rural	76.2	50.4	50.6	30.5	76.2	89.5
• Urban	41.1	10.2	35.4	16.9	23.8	10.5
• All Zimbabwe	63.3	35.7	47.0	27.3	100	100
<u>People</u>						
• Rural	86.4	62.8	47.1	29.6	77.0	89.7
• Urban	53.4	15.0	20.2	10.0	23.0	10.3
• All Zimbabwe	75.6	47.2	38.3	23.2	100	100

Source: CSO (1998).

At the level of government, the strain is also showing in terms of declines in social spending. While expenditure on education as a percentage of GDP grew from 4.9% in the 1980s, to a peak of 6.5% in 1987, it declined to 5.7% in 1996 (UNDP: 1998). Similarly, real spending per capita on health having increased to a peak of Z\$57.72 in 1995/96, (an increase of over 60% since 1980), declined to a level lower than at independence.

The government of Zimbabwe has long back acknowledged the difficulty surrounding the country in terms of the problem of HIV/AIDS and a weak economy. On the economy, from around 1991, the government embarked on a project of reviving the economy. The poor economic performance and policy shifts (first the Economic Structural Adjustment Programme [ESAP], then ZIMPREST) and the recent Millennium Economic Recovery Programme. In general, the attempts at reform – especially of the macro-economy have not born much fruit. Recent data from the CSO shows that there are continuing declines in the major sectors of the economy. Maize output in 2001 is expected to be 31% down on 2000 levels, and that of cotton and tobacco 19% and 20% respectively. Manufacturing shrunk by 4.7% in 2000 from its 1999 levels. Tourism continues to be badly affected where hotel-bed occupancy rates fell from 30.4% for the first five months of 2000 to 27% for same period in 2001. Inflation is running at the rate of 60% per month. Equally, it is estimated that the unemployment rate is close to 60% and with 2 500 retrenched in the first half of 2001.

The immediate consequences of HIV/AIDS and a declining economy are wide-ranging as implied above. First, HIV/AIDS is undermining the character of production in the economy as it increases mortality and morbidity amongst the economically active. Both the quality of labour and character of consumption are compromised. Secondly, HIV/AIDS and the weak economy are putting considerable strain on the social system as it tries to cope with such a large number of people infected and affected by HIV/AIDS through the provision of care and support and also deal with increasing poverty. As will be apparent in this report – the burden and stress on the traditional extended family network are considerable. Thirdly, HIV/AIDS care and support is putting considerable pressure on ever declining socio-economic resources and forcing families and communities to make harsh choices in terms of their (resources) allocation between care and investments/consumption. Finally, the combined effects of HIV/

¹ Prevalence index=people below TPL/Total population; depth index=shortfall of consumption from TPL, poverty severity index=degree of inequality among the poor.

AIDS and rising poverty are compromising the status of the child in Zimbabwe. Many children have been orphaned and many of them are forced to seek coping mechanisms outside the traditional family. The outcomes of these forces have also seen the rise in the number of working children, street children, children who are sexually abused, etc. Overall, these forces have increased the vulnerability of CEDCs.

Children Infected and Affected by HIV/AIDS

HIV/AIDS has affected children in a number of ways. These include orphans, children infected by HIV, children living with sick or dying parents, relatives and guardians, working and street children. The full extent of children affected by AIDS is not known. However, it is estimated that 25% of all children are living in a family with at least one HIV positive parent. In absolute numbers, this represents a large number of children. With the extent of HIV positive persons in the population and the rapidly growing death rate, there has been an increasing number of children being orphaned. By 1997, half a million children had lost one or both parents to HIV/AIDS, and by 2005, the number of orphans is projected to be 1.1 million, a third of all children under the age of 15 years (NACP). Orphans are vulnerable to a number of ill effects, not least of which is the loss of their childhood and other infringements of their rights. These effects include poor socialization through transfer to various relatives with variable care and support, poor nutrition, inadequate schooling through poor school performance and drop out, psychological scarring from the loss of parents, and consequent delinquent and criminal behaviour, and physical, psychological and sexual abuse. In addition to the vulnerabilities associated with orphanhood and the experience of being infected with HIV, are those resulting from the adoption of new roles and responsibilities in families. This is when children have to care for sick parents and younger siblings, or the quality of life is reduced when household assets and income are severely depleted through illness and death of the breadwinner, or through the transfer of money to other relatives living with HIV/AIDS. Overshadowing the already disadvantaged state of orphanhood is the stigma associated with HIV/AIDS. This stigma distorts and magnifies the effect of the loss of parents and deepens the sense of isolation and alienation. The stigma creates the context for various forms of abuse.

An estimated 57 000 to 100 000 children are living with HIV infection (UNAIDS: 1999, NACP: 1998). Though some of these children may be infected through sexual abuse and commercial sex work, the overwhelming majority are infected by their mothers during pregnancy, delivery, and through breast-feeding. Approximately 30% of pregnant women are infected with HIV. Between 25% and 40% of women with HIV pass the infection to their babies. In response to the HIV/AIDS situation there has been a proliferation of activities aimed at preventing its spread and mitigating its effect. HIV infected children as a special group, however, have received minimal attention. While the greater number of children infected with HIV, particularly during pregnancy and child birth, will die within two years, increasing numbers are surviving to school age and become school going. These children have special needs, as do the ones who die sooner. Many children with HIV have frequent and severe episodes of illness, which would benefit from effective treatment. However, treatment protocol are frequently lacking, and access to health care is often limited. They are also likely to be vulnerable to malnutrition and psychosocial problems. This is especially the case where these children are living with sick parents or sick relatives.

In presenting the analysis, a distinction is made between children who are infected and those who are affected but not infected.

Children Affected by HIV/AIDS

Taking into account the various geographic and socio-economic areas in the country, 253 orphans, children with sick parents and relatives caring for children affected with AIDS were interviewed using a structured questionnaire containing closed and open-ended questions. Focus group discussions were held with community leaders and with affected children. Group interviews were held with 36 representatives of 19 institutions. The respondents were selected by AIDS service organisations in the various areas sampled. Table 3 presents the number of respondents individually interviewed by area, setting and gender.

Over half of the respondents (54%) were children under 18 years of age, with an additional 16 aged between 19 and 24 years. There were 49 child-headed households, and 60 grandparent-headed households interviewed. One hundred families were living with a surviving sick parent and 98 relatives were caring for children affected by AIDS, of which 62 were maternal and 36 were paternal relatives.

Table 3-: Number and Gender of Respondents by Area and Setting

Area	Setting	Male	Female	Total
Buhera	Rural, growth point	4	33	37
Bulawayo	Urban	2	19	21
Harare	Urban (Mashambanzou)	5	10	15
Hurungwe	Resettlement	4	17	21
Muchena	Mining	14	8	22
Rusape	Commercial farms	14	21	35
Sakubva	Urban	11	23	24
Zimunya	Peri-urban	6	9	15
Zvishavane	Mining	25	28	53
Total		85	168	253

Orphanhood

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

Limited Access/Performance of CABA in Education

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

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

Difficulty in Acquiring of Birth Certificates

The issue of national documents was highlighted as a major problem. Some of the children affected by AIDS do not have birth certificates. This presents a problem as some are not enrolled in schools unless they acquire such certificates, and they are not allowed to write public examinations either. For those children with no extended family members willing to help, they will not be able to acquire such documents. The National Orphan and CEDC Enumeration exercise found out that among the children in the sample of 96 235, 38.8 % did not have birth certificates. The proportion of children without birth certificates stood at 40.+7 % among orphans and 38.1 % for the rest of the sample. Because of this, children could not show the registration offices any proof of the death of parents; hence no assistance could be received. Many people in the rural and resettlement areas highlighted the fact that they do not acquire these documents because the registration centres were too far away and inaccessible.

Health and Nutritional Difficulties

Poor access to good health and nutritional care makes those children affected by AIDS vulnerable. It might be expected that the health of orphans and affected children - especially those in the care of elderly and adolescent care-givers would be worse than the other children. Substitute care-givers may be un-informed about good nutrition, oral re-hydration and treatment for diarrhoea and recognition of serious illness (Foster G 1998). The current health system tends to invest more education in mothers as primary health care-deliverers, hence adolescents and elderly care-givers may tend to be un-informed about health issues and have poor access to health delivery services.

Children Heading Households

When households come to be headed by a child, everyone therein becomes vulnerable. Child-headed households were mainly found in farming and mining sectors. This is mainly due to migration, as families were isolated from relatives and the extended family when they moved from the rural areas into mining or farming areas. These families rarely, or never, visited the extended family mainly due to economic and social reasons such as stigmatisation.

Table 4-: School Levels of Children Heading Households

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

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

In rural areas, there were relatively limited numbers of children heading households. This was mainly because the people in the rural areas are, to some extent, still practising traditional ways of caring for children and the sick. For example in Buhera, wife inheritance is widely practised and accepted, thereby protecting children. (One man inherited 3 wives and is looking after 25 children as his own. About 15 of these children are under the age of 12).

The National Orphan and CEDC Study found 27 male and 77 female care-givers aged 15 years and less. A further 181 males and 165 females were aged between 16 and 18 years inclusively. Field validation will confirm the roles and capacity of the extended family and communities to care for children affected by AIDS. There is need to understand new phenomenon of children or adolescents and elderly grandparents heading households. For some children, heading households may be the best option when faced with a limited number of bad options; e.g. children may lose their property to step-parents after inheritance by relatives. It might be necessary to allow a family of children headed by a sibling to remain intact while taking steps to enable this household to cope economically and socially. The head of the household will remain rights' holder and the extended family and community, the duty-bearers with a role to socialise the children. The distribution of children and dismembering the family by dispersing siblings can be a certain route to greater psychological distress and emotional disturbance. The prevalence of child-headed households may not necessarily indicate the failure of the extended family coping mechanism. Most child-headed household studies in Zimbabwe indicate that there were some members of the extended family who would have taken care of the children but were not willing to do so for various reasons. In as much as child-headed households can be seen as a coping mechanism, it can also be taken as a sign of abandonment of the children.

Lack of Social Housing

There is a serious problem of social housing in Zimbabwe. Children affected by AIDS have major problems with accommodation. Women who were members of PWA support groups identified the same problem. They live in one or two-roomed houses with their children, both boys and girls. When the mother is sick with TB, she fears passing on the infection to the children. Some PWAs lived in a shack with their children, after they were chased away by relatives. Sometimes when they are ill with diarrhoea or vomiting, infection control is very difficult with children in the same room. One woman reported that she was living in a two-roomed house with her seven children. Another woman was living in one room with her two children and their stepfather. This puts the children at high risk of sexual abuse. In another family, the 26 year old sister caring for siblings sleeps in one room with a 19 year old young man. This affects children both physically and psychologically.

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

Stigmatization

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

- They are laughed at because of their poverty. Some of the children said they could not go and play with others

because they will laugh at their tattered clothes. One boy said he had no friends at school because they all said he wanted their food. During break-time and lunch hour, other children share their food, but because he has nothing to share, other children shun him.

- Other children take away the younger orphan's money which would have been saved up for lunch. "They gang up and take the money by force," said a 9 year old girl while she sobbed.
- Other children were stigmatised by relatives and community members who said their families are cursed because there are so many deaths. Others will openly say, "Your mother died of AIDS and your father will be dying soon too", and thus they do not want to be associated with such children. One child witnessed a terrible incident when her mother asked for water from a certain household. Soon after drinking the water, the mother at that household broke the cup saying no one else should use it in case they would also become infected.
- At school, these children are stigmatised by other children. The older girls reported that community members no longer treated them as children, even though they treated other girls of the same age with parents, as children. The community now saw these girls as "mothers" and expected them to work hard to care for their siblings. As a result, the girls had no friends except those who were in similar circumstances.

Abuse

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

Poverty and Economic Factors

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

Most children affected by AIDS are easily identified in communities because of their poor economic status. It is worthwhile to note that these children start to be affected by the harsh economic environment when their parents are very sick and leave employment. Most children seen were involved in several economic activities to supplement the income in the household. In the rural areas, child indentured labour was a widely accepted practice of supplementing income in the home. It is thus difficult to have a clean cut-off point as to when children start to feel the burden of caring for the family economically.

Inheritance

The character of the inheritance system seems to work against the security of children affected by AIDS. After the loss of a parent, family loyalties tend to shift usually with them: eschewed asset redistribution. Children are thus left without adequate economic and social security.

Table 5-: Causal Analysis

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

Children Caring For Sick Parents and Siblings

Child-carers become vulnerable as they lack precautionary guidelines for looking after PWA/the sick. Other respondents, especially from the PWA support groups interviewed, raised issues regarding infection control. The children caring for sick parents may not have the necessary training or knowledge on proper infection control. In a few instances, the children are too young and even when provided with gloves, these are too big for the child to use. These children found it difficult to care for younger children when they were sick. In many instances, these children heading households do not realise the extent of the sickness until the illness is at an advanced stage. Health officials refuse to treat unaccompanied children, i.e. children who do not come with an adult. These children are supposed to ask their neighbours to escort them to the clinic, and the neighbours are not always available to do so. Below is a summary of economic casual factors:

Table 6: Analysis of Economic Casual Factors

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

Infected Children

This section examines causal factors from the aspects of transmission of HIV from mother-to-child and the aspect of problem manifestations. Most of the discussion following is from interviews with 213 care-givers of children living with HIV country-wide and 38 health care workers.

The following factors have been identified as having causal effects on the childhood HIV problem manifestations. The primary physiological cause of the problem is HIV-infection, perpetuated by a high prevalence of HIV-infection in the child-bearing age groups and a high prevalence of heterosexual spread in the community. On average, 30% of pregnant women in Zimbabwe are infected with HIV and 30% on average transmit the HIV to their babies during pregnancy, during delivery, or through breast-feeding. It follows that one of the basic causal factors for HIV-infection in children is inability of existing national systems to mount an effective campaign to limit the spread of the HIV virus in the community.

Gender and Mother-to-Child Transmission of HIV

In Zimbabwe the masculine gender is culturally dominant over the feminine. This extends to sexual matters and choices. The majority of women have no choice and no negotiating powers or skills for safer sex. Similarly, many women have no choice over the bearing of children and breast-feeding.

Pressures from the husband and extended family leave the woman little choice on whether or not to get pregnant, even if she knows or suspects that her husband or herself are HIV-infected. In addition, for many mothers their image and relevance in a marriage or in society in general depends on her ability to produce children. These issues almost guarantee that more HIV-infected children will continue to be born for some time to come.

Early sexual experience seems to make children vulnerable. Results of the 1994 Zimbabwe Demographic and Health Survey showed that the percentage of teenagers below 18 years of age (i.e. children) who were mothers or pregnant with their first child was: 15 years - 4.4%; 16 years - 9.8%; 17 years - 18.8%. For 18 year olds, some of whom had children before that age, the figure was 29.7%. It has been reported that the age group 15 -19 years is particularly vulnerable, being 4 to 6 times more likely to be infected as males in the same age group [61]. The legal age of consent for sex in Zimbabwe is 16 years while the legal age of majority is 18 years. In the Zimbabwe situation of high HIV prevalence it can therefore be expected that many teenage children will legally engage in sexual activity, become HIV-infected, and give birth to HIV-infected children.

Limited Access of Pregnant Women to Appropriate and Relevant Health Care Services and Information

The study on infected children seems to suggest that there is limited access by pregnant to appropriate and relevant health care services. Data from the National Health Profile 1997 indicates that nationally 74% of pregnant mothers have access to antenatal care and 44% deliver in health institutions. The figures are lower in the rural areas than in urban areas. Those not covered for antenatal care and delivery have no access to information or other HIV preventive intervention specifically targeted at pregnant women through antenatal services.

For those women who have access to antenatal care individual management of the women is not adequate. Information about HIV-infection, in particular about the woman's vulnerability and implications for the expected baby, is not given. Men, who are the decision-makers in most of Zimbabwe society, are traditionally left out of antenatal care activities and consequently remain ignorant of whatever information may be given to the women.

The practice in public antenatal clinics has not changed much from the days before AIDS. HIV is mentioned only as part of STDs. Rarely are pregnant women and their partners in public institutions given the full facts about HIV. Consequently many prospective parents go through pregnancy unaware of the vulnerability of their babies and options available for reducing the risk of transmission of HIV to the baby. Testing is not practised and consequently the greatest majority of HIV positive pregnant women go unnoticed and unknown. All health workers interviewed agreed that providing full information to pregnant women about HIV should be an integral part of managing pregnancy, and that practical national practice guidelines to that effect should be put in place.

Comprehensive management of all infected mothers, exposed children and infected children requires extensive infra-structural and human resources organisation to ensure increased antenatal care services, more time and personnel for counselling about HIV and breast-feeding, appropriate accommodation for counselling, laboratory infrastructure and consumables for HIV and other diagnostic test; nutritional support and regular follow-up for

infants on replacement feeding; increased access to family planning, and increased need for health care for children who are not breast-fed e.g. diarrhoea, malnutrition. These requirements are grossly inadequate at present.

In recent years, the capacity of health institutions to provide adequate care has declined considerably. This was confirmed by a commission appointed by the government to look into the problems of the health sector in 1999. For example, only 28.7% of the target posts for doctors were filled, while for nurses, pharmacists and dentists the figures were 55.6%, 18.7% and 32.6% respectively [42]. Such a situation compromises the health care of the children and the capacity of the health workers to counsel the care-givers, to follow up the children into the community and to establish meaningful contact with the community for subsequent home care of the children. It also compromises the capacity to manage a problem of such serious proportions as the current HIV/AIDS epidemic.

Inadequate Access to and Utilisation of, Voluntary Counselling and Testing

The majority of mothers were counselled for the first time when the child became ill. Only 2.9% during pregnancy and only 1% was before pregnancy. Clearly there is too little intervention too late. Many care-givers are aware of how HIV can be prevented (Table 7). However only 3.8% mentioned testing for HIV before marriage and only 8% mentioned testing before pregnancy. This represents a serious information gap among the care-givers and possibly among the general population. Voluntary counselling and testing is not routinely offered except in the ten VCT centres country-wide, which are presently under-utilised grossly, and the three zidovudine pilot study centres. These few centres are all in urban areas.

Prevention	Numbers	Percent
Careful conduct of oneself	109	51.4
Avoiding breastfeeding	53	25.0
Not to get pregnant when HIV positive	44	20.8
Prevention and/or treatment of STD	28	13.2
Don't know	27	12.7
Testing for HIV before pregnancy	17	8.0
Treatment of mother during pregnancy	14	4.6
Stop Child sexual abuse	9	4.2
Testing for HIV before marriage	8	3.8
Treatment of baby after birth	2	0.9
Other	34	16.0
Total	212	100

Inadequate and Ineffective Testing

Facilities for HIV testing are limited to only a few centres in central hospitals and in provincial hospitals and some mission hospitals. In provincial hospitals, it may take up to several months to get the results and therefore testing under such conditions is of little value.

All health workers felt that testing in antenatal clinics is desirable but there were many differences regarding the way forward. Some felt that HIV screening in ANC should be routine in the same way that institutions screen pregnant women for syphilis, with either group pre-test counselling or no pre-test counselling at all, followed by post test counselling where necessary. Most felt there should be either full individual pre-test and post-test counselling, or group pre-test counselling, followed by optional testing. Others felt that testing should be accompanied by an offer of antiretroviral drugs for preventing HIV transmission.

Inadequate Training in Counselling

Too few health workers are trained in counselling. Counselling training would need to be accelerated in order to effectively manage antenatal counselling - with or without HIV testing.

Lack of Preventive Medication with Antiretroviral Therapy

For the few who are known to be HIV-infected the public health sector has no effective measures to prevent transmission of infection to the baby. Specifically neither the zidovudine nor the nevirapine regimens, which have been proved to be effective, are offered. The health workers interviewed thought that use of preventive drugs would be welcome and most would like to see this in place without delay. However the following constraints and

observations were noted:

- Most health workers have little information about the drugs used in the prevention of mother-to-child transmission of HIV. Many have only heard about this from the newspapers and radio. They expressed the need for a forum to keep them abreast of developments;
- Some health workers considered that the health delivery system at present requires considerable improvement. It may be wiser to concentrate on improving the system as a whole first, before embarking on the mother-to-child HIV prevention programme;
- The programme can be easily overwhelmed once it gets going and the system may not be able to sustain it; and
- The AZT regimen is very expensive and there are cheaper alternatives such as nevirapine.

There were suggestions that a substantial portion of the AIDS levy be used for the development of programmes for the prevention of mother-to-child transmission of HIV.

Lack of Feeding Options or Unsustainable Feeding Options

It was reported that to most health workers feeding options present a real dilemma. They expressed a need to strike a balance between child morbidity and mortality from HIV-infection and that from malnutrition, diarrhoea and infections resulting from lack of breast-feeding. The cost of breast milk substitutes and affordability by most mothers was a universally held concern. Some warned against promised free or subsidised supplies of formula milk from multi-nationals as experience indicates that it is rarely sustainable in the long term. Some workers cautioned that most mothers do not have the authority to make decisions regarding breast-feeding and advocated intensive family counselling. But some health workers have expressed reservations about the widely held opinion that mothers cannot make their own decisions regarding breast-feeding. They are of the opinion that many mothers of today are able to make individual decisions about their breast-feeding, and that what they need is support from health professionals.

There was a widely held view that at present there is a strong stigma attached to HIV and opting for not breast-feeding will lead to stigmatization of the mothers and families. In contrast, others argued that the wish for the child's survival is much stronger than the fear of stigma and that with support, mothers are likely to get round the problem. Some feeding options such as boiling breast milk or stopping breast-feeding are generally considered impractical. Furthermore staff are torn between the promotion of the baby-friendly breast-feeding initiative and the advice to avoid breast-feeding. There is scepticism about breast milk substitutes, particularly with regard to sustainability and cultural factors. One doctor related how an HIV-infected mother, who had newly delivered, resolved after appropriate counselling not to breast-feed the child but to use formula milk instead. The mother returned a only few days later with the baby on full breast milk, the mother having been quickly and overwhelmingly prevailed upon by the family to abandon the bottle.

Inadequate Obstetric Care

In the centres visited, some obstetric care modification has already taken place. The centres discourage artificial rupture of membranes, and routine suction of the baby has largely been discontinued. However, information about HIV is not given and counselling on feeding options for example exclusive breast-feeding or exclusive replacement feeding and avoidance of breast-feeding is not the practice. Counselling is also not provided to the HIV negative pregnant mothers to use barrier methods during sexual intercourse to avoid infection during the current pregnancy and breast-feeding, which is known to carry a high risk of mother-to-child transmission of HIV infection. Caesarean section is not an option in the public health sector, but is practised in the private sector. These latter options are of course dependent on the HIV status being known, which is not the case in the majority of situations.

Limited Access to Health Care by Children

Increased medical fees have been attributed to a drastic reduction in the utilisation of health services by children. This results in children either coming late for treatment or not going to hospital at all. During the field study 63% of those care-givers who delayed taking their children for treatment for more than three days cited lack of money for user fees as the reason, while 48% were reportedly waiting and hoping that the child would get better.

The present system of payment of health fees and purchase of drugs by all patients effectively denies poor children access to health care and stands against the country's declared commitment to upholding children's rights to health care, as signatories to the Convention on the Right of the Child. There are no safety nets to cover those who have no means of paying for the services.

Inadequate Case Management of Individual HIV-Infected Children

All children that are born of HIV-infected women are exposed to HIV-infection. The present study found 54% of children living with HIV/AIDS to be in the age group 5 - 14 years, 34% in the 1 - 4 years age group, 9% in infants less than 1 year and 3% in the age group 15 years and above. This situation offers scope for selective management of the different groups, and to even prioritise for specific treatment of those children that have inherently better chances for survival. This requires bold and informed decisions and policies, which so far have not been made. The study argued that for optimal care these children:

- should receive a 6 week course of AZT or one dose of nevirapine;
- should not breast-feed;
- at 6 weeks, prophylaxis for pneumocystis carinii pneumonia (PCP) should be started and continued until the child's infection status has been ascertained through virological studies;
- if infected, PCP prophylaxis should continue for a year; and
- if negative, further virological evaluation should be done between 1-2 months of age and again at 4-6 months.
- management of MCT framework needs to be set and strengthened.

None of these procedures is carried out in public health institutions. Some of these activities, especially those relating to virological estimations, are clearly not feasible logistically and economically at present. However, no reasonable attempt at carrying out or at least modifying some of the procedures to suit the deficient resources is evident in the institutions, including central hospitals and medical school teaching hospitals. A major limiting factor is of course the fact that the exposed infant is simply not known.

With the exemption of counselling and physical examination, the majority of the assessment cannot be carried out because of inadequate laboratory facilities and cost constraints. Ultimately even those assessments such as counselling and assessment of the social situation of the family are usually also abandoned. Antiretroviral therapy has not yet reached discussion stage because of assumed cost implications.

General Supportive Care of Infected Children

Presently this is about all that is done for the infected child. However, some of the main elements of supportive care are deficient such as:

a) Nutrition

In addition to the wasting effects of HIV disease many of the children do not have enough to eat. On a number of occasions during the study the investigator came across families who had virtually nothing to eat for the next meal.

The role of nutrition in sustaining adequate immune function is well-documented. Medical experts and both individual and institutional care-givers stressed the importance of good nutrition and cited a number of illustrative cases from their experience of how nutrition makes all the difference. Therefore the prevalence of insufficient food for the children represents an important factor in the poor survival of HIV-infected children. There is thus a need for better monitoring and provision of children's nutrition in the community.

b) Management of Opportunistic Infections

There are several factors that adversely affect this aspect of care. Firstly, there is no agreed policy and practice regarding prophylaxis against common and preventable conditions such as PCP and tuberculosis. The result is that some health workers practise this on an individual basis while the majority do not. As noted earlier these conditions are among the main causes of repeated illness in HIV-infected children. Secondly, there is inadequate and unpredictable supply of medicines for treating opportunistic infections. The field study showed that 65.2% of the patients were able to obtain only some of the medicines and 10.1% were not able to obtain any of the medicines prescribed, and finally, patients are required to pay for their drugs. Because of the prolonged nature of the illness even those who could initially afford the medicines soon run out of funds.

Identification of Children with HIV-Infection and the Management of Families

There is no standard approach to diagnosis and management of the family both nationally and within the same institutions except in specialist clinics. Broadly, each doctor does as they see fit and the most common approach is to do the minimum counselling necessary for the immediate care of the sick child. As a result most parents are not aware that their child is suffering from or has died of AIDS. Parents remain unsuspecting as they are often free of

symptoms themselves, since the child's illness tends to precede the parents' illness by several years. Experience through contacts with hospitals during preparations for the field study and during the actual visits to some hospitals indicates that in the existing scenario most families are never officially informed about the child's HIV status.

It is common for couples who have lost a young child to proceed without delay to replace the lost child. It is also common for couples to lose more than one child to HIV before they know what is happening. It therefore came as no surprise that a number of parents had previously lost a child from illnesses suggestive of HIV disease but had not been informed. This denies the parents, often desperate for a surviving child, the opportunity to decide about future pregnancies, and options such as breast-feeding.

A number of reasons were advanced for the failure to counsel the parents and test the child including:

- unreliability of the test before 18 months;
- testing will not change management of the child;
- results take very long to come. In one hospital it was stated that it took 5 months to get the results - long after the patients have been discharged or died;
- doctors are not trained in counselling and many would rather not introduce the subject of HIV; and
- testing is costly and must be balanced against benefits to be derived;
- few trained counsellors and in most cases, only the mother is counselled.

Poor Management of Parents of HIV-Infected Children

Inadequate training in counselling for medical personnel and lack of preparedness to discuss issues of a terminal nature make infected children vulnerable. Several health workers interviewed expressed statements to the effect that doctors are not trained in counselling and therefore either counsel badly or not at all, or that health workers are afraid of discussing life-threatening untreatable conditions. The problem is to some extent exacerbated by the fact that no specific medication can be offered to the children and the parents.

Management Guidelines

Most staff, both doctors and nurses, suggested the introduction of management protocol/guidelines. Most admitted that everyone did their own thing at present and felt the need to have a standard approach to the common problems.

It was suggested that as wide a team as possible, including specialists and administrators should be involved, and that the guidelines be monitored and updated regularly.

Confidentiality

Many, both within the health profession and outside, have expressed the opinion that health workers have turned confidentiality into secrecy about HIV/AIDS and in so doing are unwittingly fuelling stigma in the country. For example HIV/AIDS is one of those few conditions that is not referred to by name in hospitals and clinics. Doctors and nurses refer to it as "new serology", "NS", "immune deficiency", "retroviral disease" - all designed to keep the patient and the lay public in the dark. It is also believed that when dealing with HIV/AIDS, individual human rights are given precedence at the expense of public health principles that protect the rest of society.

Liaison with AIDS Service Organisations

It was noted that some institutions work closely with AIDS service organisations, non-governmental organisations and support groups that assist with counselling and follow-up. Examples are Birchenough Hospital and Rujeko Home-Based Care, St. Teresa Hospital, etc. In such institutions, counselling and family care seemed to be more effective. This arrangement seems to be at least a temporary answer to the problem of lack of counselling skills among health workers as well as the lack of time and human resources.

Inadequate Social Support

The main sources of sustenance for the child were the care-giver/parents and relatives (78%), followed by support groups and voluntary welfare organisations (14.4%) and churches (7.1%). Social welfare was mentioned in only 8% of cases. The sources of support are summarised in Table 8.

Table 8-: Main Sources of Support for the Child

Source of support	Numbers	Percent
Self (care-giver, if not the parent)	76	35.8
Mother of child	96	45.5
Father of child	38	18
Relatives (specify)	31	14.7
Social welfare	17	8.1
Medical Aid	2	0.9
Church	15	7.1
Begging	11	5.2
Other	30	14.4

Most of the support was from personal and family resources in the majority of cases. The church and government and social welfare played a supportive role to the care-givers and the children.

The following were identified as underlying causal factors.

Inadequate Knowledge, Skills and Material Resources for Optimal Management of HIV-Infection in Children

The leading problems in relation to care are inadequate skills and material resources. Staff conceded that they basically lacked counselling skills, and also possibly lacked time for counselling. All interviewed felt that counselling should be an integral part of the management of childhood HIV disease. This thinking is not official policy in government and therefore needs to be raised with the relevant authorities.

Another area is inadequate technical skills and information about childhood HIV, namely prevention of mother to child transmission, skills for early identification of the infected child before the appearance of classic signs in the child, general management of the child and nutrition. It seems the problem is more of lack of update in line with technological development than absence of skills.

Lack of guidance through policy guidelines is a major problem. Faced with such an enormous public health problem and inadequate resources, it is necessary that there be guidelines to ensure cost effective use of available resources and to ensure minimum levels of care of the infected children. The guidelines should cover the entire spectrum of care from prevention of MTCT to management of both parents and the children. It may be necessary to lay down a practice framework covering different categories of children, for example by age group, severity of the disease and anticipated prognosis. It would be necessary to involve a wide spectrum of health workers, including obstetricians, paediatricians, and administrative policy makers.

Care-Giver Guidelines

Opinion was divided regarding guidelines for care-givers and how they make children vulnerable. Some of the views voiced were:

- Guidelines will stigmatise the families concerned;
- It is preferred that children return to the institution for further care if necessary;
- Guidelines will empower care-givers of some patients who live far away from institutions; and
- Guidelines would reduce frequent attendance.

Community Mobilisation, Support Groups and Counselling

More than half of the care-givers interviewed were not aware of any social programmes run by the community, local authority, central government or other organisations. Only 12% knew of any community run programmes, 11% were aware of church programmes, and 13% knew of social welfare programmes. This is illustrated in Table 9.

Table 9-: Knowledge of Programmes in the Community

Programmes Known	Number	Percent
None	109	51.2
Community home-based care	25	11.7
Church	23	10.8
Social welfare	27	12.7
Other	70	32.9
Total	213	100

The majority of care-givers did not know of any social programmes. For rural care-givers 70% of them were not aware of social support programmes in their community. This implies either lack of such programmes in the community or lack of information for those who need the services. Either way there is an important gap in the social support or information for care-givers of HIV-infected children.

Communities are not at all clear about their vulnerability to HIV-infection and that of their children. They are unclear as to what action needs to be taken at community level in order to protect themselves from the effects of the epidemic. As a result, there are no effective community structures to fight the AIDS epidemic, and no systems for identifying infected and affected children and providing support for the same. Most of the so-called community programmes are mainly externally run by voluntary and non-governmental organisations with minimum participation of the local community as a group. There are no adequate mechanisms for disseminating information about vulnerability and use of safety nets.

The majority of care-givers have not fully come to terms with their problem. However, a distinct difference was noticed between those who are members of active support groups and those who are not. The former discussed their problems more readily and appeared to be more at peace with their circumstances while the latter took much more time to establish rapport with, and were the more likely to breakdown during the interview.

Effective counselling had a similar effect. Many care-givers testified to how their lives changed for the better after they received counselling. However, the impression derived from the study is that a substantial proportion of the care-givers have not had access to such support groups. The reason appears to be the fact that the groups have not been established at convenient local community levels.

Policies to Facilitate Access to Health Services and Care of the Infected Children are Lacking or Inappropriate.

The fee policy for consultation and drugs aimed at cost recovery has effectively made medical care inaccessible to many HIV-infected children. There are no effective safety nets, especially after the collapse of the social dimensions fund. Social welfare services are surrounded by impenetrable bureaucracy and offer grossly inadequate support at the end.

Home-based care has taken the place of hospital care of the terminally ill adult, but there is no clear policy and strategies to ensure a continuum of care between hospital, clinics and the home for the HIV-infected child. There is total silence on the use of antiretroviral drugs in managing childhood HIV-infection and no provision for their supply. It is noted that very expensive drugs for use, for example in the treatment of cancer secondary to HIV-infection, are available in some referral institutions. There would seem to be justification for the selective use of antiretroviral agents in children based on prognosis.

The causal factors are summarised in Figure 3.

Fig. 3: Causal Factors in the Problems of Children with HIV-Infection

Problem Manifestations

- Chronic illness (leading to sickly, thin, underweight, stunted child with a variety of disabling, disfiguring and life-threatening conditions)
- Psycho-social and physical stress (leading to permanent misery, lack of energy, inability to go to school, seclusion/isolation)
- Premature death

Immediate Causal Factors

1. Inadequate services for voluntary counseling and testing
2. Limited access of pregnant women to appropriate and relevant health care services
3. Inadequate case management of infected pregnant women
4. Limited access to health care by children
5. Inadequate case management of individual HIV-infected children
6. Poor management of parents of HIV-infected children
7. Social support is lacking or inadequate

Underlying Causal factors

1. Inadequate knowledge/skills & material resources for optimal management of HIV Infection in children
2. Weak social support programmes in the community
3. Lacking or inappropriate policies to facilitate access to health services and care of infected children
4. Lack of clear strategies to implement existing public health policies

Basic Causal factors

1. Inadequate national capacity to mount an effective campaign to limit the spread of the HIV virus in the community and to provide support to the infected and affected.
2. Inadequate health services capacity to provide appropriate health care
3. Poor community mobilisation
4. Traditional and cultural beliefs and gender imbalance
5. Adolescent sex and pregnancy

Street Children

Many children leave home when conditions became unbearable, and when family disruption and dysfunction prevent adequate care and support from adults. It is estimated that there are over 12 000 street children country-wide, of which about 5 000 are in Harare, the capital city (UNICEF: 2000). Street children are generally described as “on” or “of” the street. Children “on the street” beg or work on the streets by day and return home at night. Children “of the street” work and live on the streets and have little contact with their families. There is however, a thin line between the categories of these children. Some children of the streets maintain links with family members, while children on the streets may sometimes sleep on the streets and sometimes at home. In recent years there has been an explosion in the population of street children. Street children are viewed as dirty, aggressive, abusive, anti-social, violent and dangerous. They are likely to have their rights completely disregarded. Street children are vulnerable to violence and bodily injury, sexual abuse, sodomy and rape, casual and commercial sex. In addition, they are prone to criminal activities, drug taking, various health problems, including sexually transmitted diseases and HIV/AIDS. Street children are a category of working children, distinguished by their place of work being the streets.

Street children in the urban centres of Harare, Bulawayo, Mutare, Gweru and Kadoma were interviewed using a structured questionnaire with closed and opened-ended questions. Focus group discussions were also held with the street children and with the street adults in Harare and Bulawayo. Child-care workers were interviewed using a structured questionnaire. Contact with the street children was initiated through street child-care workers and volunteers. The technique of snowballing was then used where street children interviewed referred their friends and colleagues to participate in the study. Although 450 street children were contacted only 260 provided complete data. The study is based on the data provided by these 260 children, all of whom were 18 years and below and with an average age of 13. One hundred and thirty-five street children were interviewed in Harare, 55 in Bulawayo, 27 in Mutare, 28 in Gweru and 12 in Kadoma. There were 220 males and 40 females. Twelve child-care workers (10 males and 2 females) were also interviewed.

A careful analysis of the street children phenomenon reflects a number of immediate, underlying and basic causes. Available literature on street children in Zimbabwe from academic presentations, journal articles, books by researchers and situational analysis and survey reports show a plethora of causal factors and effects to the street children problem.

The phenomenon of street children in all countries seems to be a social institution with basic social, economic and environmental causes (Auret, 1995; Bourdillon, 1991; Dube, 1999; Muchini, op. cit., Muchini and Nyandiyamba-Bundy, op. cit.). It appears to have basic causes in the polity, the economy and other basic social factors such as public social policies about employment, housing and land ownership.

On average for the larger number of street children, the underlying and basic causes for pushing children onto the streets lie in the increasing number of families surviving under extreme poverty, unemployment, lack of opportunity for social mobility and strained family relationships (Bourdillon, op. cit.; Grier, op. cit.; Muchini, op. cit.). These seemed to be confirmed by street children themselves.

The study found out that the majority (35.3%) of the street children gave earning income for their families as their main reason for being on the streets (Table 10.). Just over thirty percent (30.7%) said they were orphans and did not have care-givers while 18.3% said they were abused by parent(s), 7.3% were employed to work on the streets and 6.4% had committed a misdemeanour and had run away from home.

The reasons given in interviews with children were confirmed in the focus group discussions with street children and street adults. Both groups identified poverty, seeking food and employment and being orphaned as the reasons why children moved onto the streets. Social and economic factors appeared to be primary in pushing children onto the streets. Poverty, disability (mostly blindness) and death of parent(s) appeared to be the key factors resulting in families' inability to look after their children properly. Children of blind parents, mostly girls, assist their mothers in begging and moving around town. Focus group discussions with street adults showed that most of these blind beggars were single parents. Death of parents resulting in orphanhood and poverty, have created a vacuum in child-care responsibilities by removing and/or incapacitating those with duties to provide for children's basic needs.

Table 10-: Reasons for Being Street Children

Reasons	Percentage
Orphanhood	30.7
Abused by parent(s)/guardians/care-givers	18.3
Committed an offence and ran away from home	6.4
Employment	7.3
Earning income for family	35.3

Focus group discussions suggested that many of the street children had lost, either through death or divorce, their biological parent(s). Such children moved onto the street, away from staying within step-parent settings – with either a male or female step-parent, and/or from staying in extended family settings. This was especially true for children of the street. In the focused group discussion, step-parents or extended family members reportedly physically and sexually abused such children. Poverty alone was not seen as a sufficient factor in pushing children onto the streets. Street adults and child-care workers mainly saw the antecedent factors as family dysfunction and/or disruption. Such factors, as already noted above, included abusive families, child-headed households, death of a primary care-giver, inadequate care and support, and over-extended families.

Many other studies have shown that the environment, both animate and inanimate, influences and affects children's development (e.g. Tudor, 1981; Ennew, 1986). Thus, a psychologically impoverished environment may lead to physical and social problems in children who grow under such conditions.

Working Children

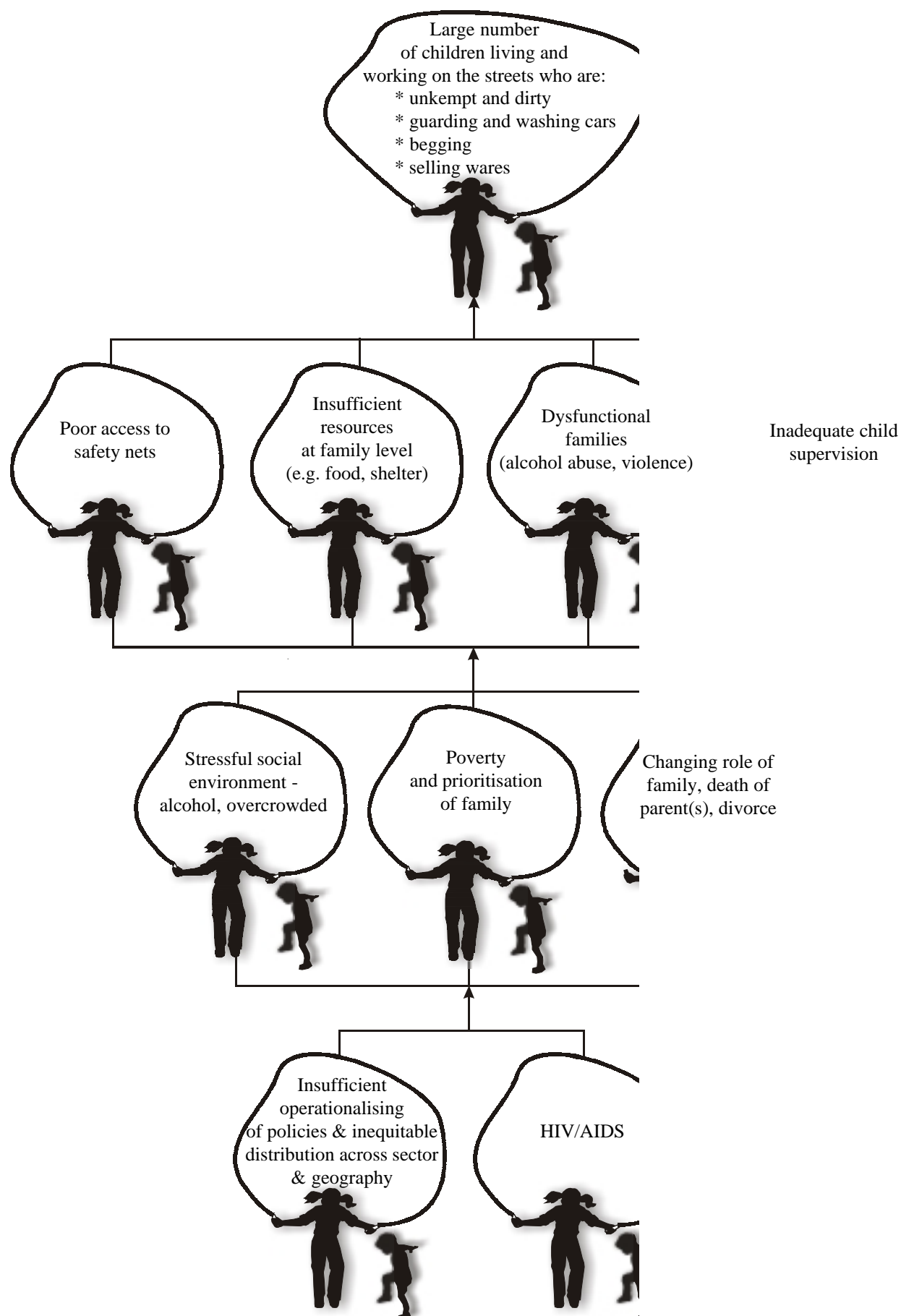
Working children, usually called child labour, is distinguished from child work as it represents an exploitative, hazardous, deprived and disempowered situation for the child. There is a very thin line between child work and child labour distinguished primarily by the extent to which the rights of the child to non-discrimination, safeguarding the best interest of the child, survival, life and development and participation in decisions that affect them. There is little information on the extent and impact on child welfare of child labour in Zimbabwe. Working children are found in the communal and commercial farming sectors, being involved in small scale and informal mining activities, serving as domestic workers in urban households, and in the urban informal sector as vendors, beggars, parking attendants, commercial sex workers and pick-pockets. In the urban informal sector, some of these are street children, while others may be located in suburbs where for example, they maintain stalls, vend and wash cars. Threats to the child's welfare from child labour include inadequate socialisation, loss of schooling, exposure to pesticides and chemicals, risk of injury, physical exhaustion, little opportunity for socialising and leisure. In addition, street children and domestic workers are especially vulnerable to rape and sexual abuse. Reported child rape cases increased 27% in 1996 from 1 125 in 1995 (UNICEF: 2000). There appears to have been an increase in the prevalence of child sexual abuse and it is important to consider that reported cases are only a fraction of the actual number of incidences. During the period 1993 to 1996, 11 085 cases of sexual abuse were reported (ZRP). From January 1998 to April 1999, 1 353 new cases of child sexual abuse were referred to the Family Support Clinic in Harare for counselling and medical services (Kembo: 2000).

Historical Legacy

The curse of history has made many children become vulnerable as they have been forced to work. The issues of working children can be traced way back to colonial Rhodesia. Children were an integral part of the cheap agricultural labour force of colonial Rhodesia. Children were very popular with white farmers who said that their "nimble" fingers were ideal for certain farming tasks. Children were drawn into the labour force through: the system of labour tenant families, as children of residents living in reserves near a farm, and as the children and siblings of migrant workers. Tenancy agreements were made between the farmer and the African head of the household (Grier, 1996; Schmidt, 1992).

By emphasising as causes, factors such as, parental neglect, family disintegration, and the lure of the city, colonial officials conveniently ignored the underlying causes of the phenomenon of unaccompanied children in cities, towns and mining areas. The underlying forces - land dispossession, overcrowded reserves, growing rural poverty, and low wages - the direct consequences of colonial policies designed to create and reinforce the conditions of

Figure 4: Causes of Street Children Phenomenon



settler capital accumulation², were deliberately ignored as causes (see Grier, 1996:4). Thus Grier implores any researcher on children's issues in the colonial or post-colonial period to be grounded in an understanding of the dislocations of the colonial political economy: landlessness, rural poverty and urban poverty, changing family authority patterns, migrant labour, gender and age inequalities, and child labour (ibid, p 4).

In these efforts to increase labour supply in the colony, the settler economy also exploited African child labour through three mechanisms:

- i) The labour tenancy system;
- ii) The Master and Servants Act; and
- iii) Tax and Pass Laws. (Grier, 1994, 34).

By the time of the birth of independent Zimbabwe in 1980, it was clear that a number of factors had influenced the growth of the phenomenon of working children. These included a low wage structure linked to a migrant rural-urban labour reproduction process, large-scale land alienation, and challenges to the patriarchal structures of African families. This means that attempts to confront the problems of working children must be linked to the broader question of wage levels, land reform and patriarchal domination in the family. These are huge problems, which demand committed political intervention, appropriate legislation and organisational structures, and, in the long term, an international economic order that provides space for such structural changes.

Since independence, a number of policies and continuities in structural inequality have contributed to the growth of the phenomenon of working children. The 1992 drought as well as the adverse effects of the Economic Structural Reform Programme (ESAP), have tended to increase poverty in the country, hence leading to a rise in vulnerable children.

Structural Adjustment and Its Effects

Stoneman (1989) contended that at independence in 1980, Zimbabwe had a more diversified and industrialised economy than any other country south of the Sahara, with the exception of South Africa. Zimbabwe then ranked as a middle-income country. It has since slipped into the ranks of the low-income countries. Muzvidziwa (1999:115) contends that the economy is in shambles.

By the end of the first decade of independence in Zimbabwe, it was clear that Zimbabwe was facing the familiar malaise of other countries in Africa, namely - stagnant real growth in G.D.P.; rapidly increasing unemployment and under-employment in the formal sector; deteriorating fiscal and external balances; declining terms of trade; minimal foreign investment; and shortage of foreign exchange.

In 1990 the government of Zimbabwe adopted ESAP whose first phase covered 1991 to 1995, with a view to jump-start the ailing economy³. In 1996 the government further announced a second phase, known as ZIPREST (Zimbabwe Programme for Economic and Social Transformation). Successful implementation of the second phase depended largely on donor funding to boost investment in the productive sectors. However, the International Monetary Fund (IMF), which has been the largest donor and promoter of the reform programme, suspended its financial assistance and further commitment citing lack of financial discipline and the failure by the Zimbabwean government to meet its economic targets set during phase one of ESAP. Muzvidziwa (1999:116) notes that resumption of IMF support "is a tall order given the government's past record characterised by financial undiscipline". Economic pressures have continued to push children to work to earn extra income.

HIV and AIDS

The report notes that Zimbabwe ranks among the highest hit by the AIDS epidemic in the world. UNAIDS (1998) reports that 25.8% of the Zimbabwean population carries the HIV virus. HIV/AIDS affects production and savings

² The history of the creation of Zimbabwe's labour reserves, sometimes referred to as the strangulation of the traditional African economy, does not need to be repeated here as it is a well documented subject - see Arrighi, (1967); Arrighi & Saul, (1973); Palmer, (1977); Davies, (1979). Yet because colonial officials did not want to portray the truth, that they were deliberately undermining the black people's economic supremacy, they therefore perpetuated a fallacy that communal lands have surplus labour (also see Reynolds, 1991:xxvi) instead of shortage of land.

³ This marked the shift from welfarism to the introduction of the structural adjustment programme (ESAP), where spending in the social sector was reduced considerably. Throughout most of the 1980's the Zimbabwean state carried out welfarist policies to accommodate the demands of its largely rural constituency. For example primary school enrolment increased from 1,235,994 in 1980 to 2,230,573 in 1992, while enrolment at secondary level grew from 74 321 in 1980 to 656 344 in 1992. (Dzvimbo, 1993)

at the household level through loss of labour, forced disposal of productive assets (to pay for medical care and funerals) and through disruption of the “traditional” social security mechanisms for the care of children. Some of the coping mechanisms have been found to render households insecure and vulnerable. The net effect is that when the parents die, children find themselves in a worse off position and thus are forced to eke out an existence for themselves through hard work. Work for children becomes a coping strategy⁴. McGee (1979) identified the following mechanisms:

- mechanisms meant to minimise expenditure patterns;
- mechanisms meant to augment incomes and resources; and
- poor people’s life-styles and attitudes.

The School System

The commitment by the Government of Zimbabwe to “Education for All” has existed since independence in 1980. However, during the 1990s successive droughts and ESAP have combined to undermine the gains made in the school system in the 1980s. In the 1990s, unemployment has spiraled and government revenues have fallen, with the effect that cut-backs have been made in education⁵ and health spending. The payment of “user fees” was introduced in 1992 for children in primary school level in urban areas. Inflation has pushed up the cost of school uniforms, stationery, and public examination fees, and bus fares. The worsening economic climate has caused many children to drop out of the school system, although an exemption facility was established for all children from households earning less than Z\$400 per month (see Cotton, 1997, Dube, *et al*, 1998). Difficult access to education has equally forced children to work – although at times parents ‘voluntarily’ remove children from school due to other pressures (see Cotton, 1997).

The School Timetable

In Zimbabwe’s cities, the school timetable offers room for children to be engaged in work. As Judith Goode (1987:5) noted in Colombia, the nature of schooling in the city contributes to the recruitment of street and working children. In Zimbabwe, since independence, as has been noted, in order to manage with limited resources public school sessions are limited to half a day.

Delay in the Payment of School Fees

The way in which some parents delay in paying school fees has a bearing towards recruitment to work by their children. A child may be forced to leave school owing to the temporary inability by parents⁶ to pay school fees (and levies) or to buy a school uniform. The temporary inability to pay fees and levies might arise at the beginning of each term and delays a child’s return to school.

This kind of disruption makes some children lose interest in schoolwork. Lack of interest in schoolwork may result from failing to catch-up with classwork, resulting in discouragement, embarrassment, development of problems with teachers and a general fear of the school environment⁷. A child in such a situation might find work and the streets more interesting than the school environment.

Parents’ Attitudes

By virtue of financial need and other socio-economic problems, poor parents have no true understanding of the importance of regular attendance, without which the education system cannot be effective. Attendance is very casual and haphazard, as many parents do not enforce regular attendance. The children therefore fail to grasp the importance of education because their parents are not supportive in any way apart from sometimes paying fees and other expenses.

⁴ For a summarised analysis refer to the Conceptual Framework of Causality Analysis, Figure 4 in Annex.

⁵ According to Chisvo and Munro (1994:9) real government expenditure per pupil in primary school reached a peak of Z\$ 112 in 1980 to 1981 and has never been this high again. Although after the introduction of ESAP it rose to Z\$ 101 in 1990 to 1991, but in real terms real per pupil primary education expenditure had fallen to Z\$ 72 if inflation is taken into account, representing a fall of about 29 percent. The levels of real spending per pupil in 1993 to 1994 and 1994 to 1995 are the lowest in post-independent Zimbabwe.

⁶ Of late it is the Department of Social Welfare that delays in the payment of school fees for those children from poorer backgrounds who, in principle the Department has agreed to cater for their school needs⁴ A number of scholars on education argue that Zimbabwe’s school system is characterised by rote learning, rigidity and authoritarianism. Teachers tend to favour children who fit well within the requirements of the school system - requirements such as regular attendance, punctuality, respect for the teachers and general deference to them. Some scholars further argue that the school system was never intended to give working-class children academic excellence or even social mobility but meant to instil in children of working-class background, an ability to learn to be obedient, punctual, clean and deferential to authority and an equally strong emphasis on moral education and discipline apart from writing and arithmetic (see Chigwedere, 1996; Zvobgo, 1991; and Dumont, 1966 in a general account with reference to Africa). According to Gittins (1985) education for children of working-class parents was meant to substitute what were seen as the deficiencies of working-class families.

Pooling of Labour

In some situations “pooling” of family labour is achieved by cutting down on expenses through withdrawing children from school. In other situations children of the poor have to work daily before or after going to school. They grow up assisting their father or mother, or grandmother, in the family field or garden; by the market centre or roadside stall; and in other activities in the informal sector. As the children participate in work, values of industry, thriftiness and individual initiative are also inculcated in them.

Harmful Religious Practices

There were reportedly some religious groups that facilitate child labour. For example in Chitungwiza’s Korstern Village, there is (reportedly) a religious sect of the Apostolic Faith whose children are not allowed into school by their parents. The *va Postori* (people of the Apostolic faith) have, over the years, not been keen to send their children to school, to have them vaccinated against the major childhood killer diseases, and to encourage them to take employment outside the sect community. Children from Korstern Village accuse the elders of the sect of running an informal apprenticeship system⁷. The young Apostles (children of the Apostles) are no longer willing to be so rigidly controlled by the elders and religious sanctions are continually ceasing to wield a dominant influence (see Dube, 1999).

Children with Disabilities

Children and adolescents with disabilities live in very difficult circumstances. Disabled children are uniquely vulnerable because they are often subject to abuse and neglect resulting from the fear, ignorance and superstition of others. Disabled children may be made more vulnerable as they may also be abandoned, orphaned or have lost one parent (UNICEF: Enumeration report on Orphans and Children in Especially Difficult Circumstances: 1999). Parents may feel shame and guilt, in some cases believing the child to be the result of a curse. Consequently the children may be hidden away, as parents seek to cope with their affliction and retain social equilibrium. The child may spend long periods in isolation, confined to a bed or small room, sometimes tied to a tree or pole. The child can expect relatively little in health care, therapeutic and support devices and services, education or recreation. Children with disabilities can serve as the basis for a divorce. While some cases are a result of genetic inheritance, (such as Down’s Syndrome), many are a consequence of preventable causes, such as birth trauma (access to antenatal care), accidents, vaccine preventable disease (polio, measles), poor nutrition or avoidable medical emergencies. There is evidence also that HIV disease is associated with disabilities in children, through increasing the risk of premature delivery. Many preventable disabilities occur because parents do not have access to (through distance and or cost) or utilise (through ignorance or other reasons) health services and treatment. Estimates of children and adolescents with disabilities range from 57 232 (Inter-Censal Demographic Survey: 1997), to 150 000 (UNICEF: 1997).

Care-givers, children and adolescents with disabilities and institutional officials participated in the study.

Three structured questionnaires were used to collect data: one for care-givers; one for the disabled children and adolescents; and another for officials of institutions and integration units. Focus group discussions were held with hearing impaired, visually handicapped and physically disabled children, and with parents. Altogether 6 focus groups were conducted, one for each category of disabled children and 3 parent groups. One parent focus group was held at Mhangura, representing the mining community, another at Gokwe representing the rural Shona speaking community and the third one was held in Bulawayo, representing the urban community and consisted of Ndebele speaking care-givers. Children with mental disabilities were observed according to an observation schedule.

The causes of vulnerability for disabled children are equally wide ranging just as in the other categories of CEDC.

Lack of Support Devices and Equipment (e.g. wheelchairs)

Disabled children become vulnerable partly due to lack of support devices such as wheelchairs, hearing aids, etc. For example, care-givers, especially the mothers, had to carry the child on their backs. As the children get older and bigger it became very difficult for the mothers to carry the children around. Most of these children did not have wheelchairs in their homes. Their care-givers did not have the money to buy the wheelchairs. One of the

⁷ Sarah Oloko’s research (1996) in Nigeria could be of interest to those researchers who would like to pursue the “apprenticeship system” of the *va Postori*, as Oloko’s research, among other issues, discusses the traditional informal apprenticeship systems in Nigeria. The report would be useful for comparative purposes.

care-givers was so desperate that she persistently asked the researcher to give her work so that she could manage to buy her child a wheelchair and send her to school. Parents of children with severe to profound multiple disabilities felt their children's conditions needed them to be hospitalised. To them, using the local school was out of question. They preferred schools with hospitals such as the one in Bulawayo, which unfortunately it is the only one in the country and is always full.

Disability Care Practices

Poor child care and supervision practices, including not taking children for immunisation and poor nutrition, as well as poor maternal health during pregnancy (STI; HIV/AIDS), were identified as immediate causes. Other factors included inadequate and in some cases, poor management of family resources, limited access to health, education and counselling services. The following diagram illustrates the analysis of causal factors.

Negative Attitudes and Beliefs

Both the review of literature and the field validated attitudes, beliefs and stigma that are negative to children and adolescents with disabilities featured prominently. For instance, disability was associated with witchcraft, promiscuity by the mother during pregnancy, punishment by ancestral spirits or by God, evil spirits, etc. These negative attitudes disable people with disabilities. Generally, society reacted with horror, fear, anxiety, distaste, hostility and patronizing behaviour to children and adolescents with disabilities. This leads to isolation, discrimination and prejudice against some of them (see for examples: Dep. Social Services, 1982; Addison, 1986; Chimedza, 1999).

Poor Educational Provision:

The Schools Psychological Services and Special Education section of the Ministry of Education, Culture and Sports is responsible for providing education for children and adolescents with disabilities. It specifically runs programmes for children with the following disabilities: mental, physical, visual, hearing, speech and language and specific and general learning disabilities (Annual Report of the Secretary of Education and Culture, 1995 presented to the Parliament of Zimbabwe 1998).

The Education Statistics (1996), gives the total number of students in schools to be 3 244 140. It does not say how many of these students have disabilities. However the study on Children in Especially Difficult Circumstances in Zimbabwe (UNICEF, 1995) puts the total number of children with special educational needs to be 19 096. The breakdown of the figure was as follows: children with major disabilities (mentally retarded, blind, deaf, and physically disabled) numbered 4 247, children in special classes were 7 898 and children with disabilities "wildly" integrated in ordinary schools without support were 6 951. The total comes to 19 096. Considering that the ICDS (1997) registered 57 232 children and adolescents (0-19 years of age) in the country, we can estimate that 33 percent of children and adolescents with disabilities in Zimbabwe are in school. The rest (67%) are not in school. The National Orphan and CEDC Enumeration Report (December 1999) says school enrolment figures for children with disabilities reveal a high level of non-enrolment. Among those aged between 7 and 12 in a sample of 1 327, 40.9 % of the males and 44.6 % of females were not enrolled. For this age category, the non-enrolment figures are more than four times those for all children in especially difficult circumstances. The exercise found out that among children in the 13 to 16 age range, 47.2 % of boys and 57.7 % of girls were not enrolled in school. Among those aged 17 to 18 years, 69.7 % of males and 84.9 % of females were out of school.

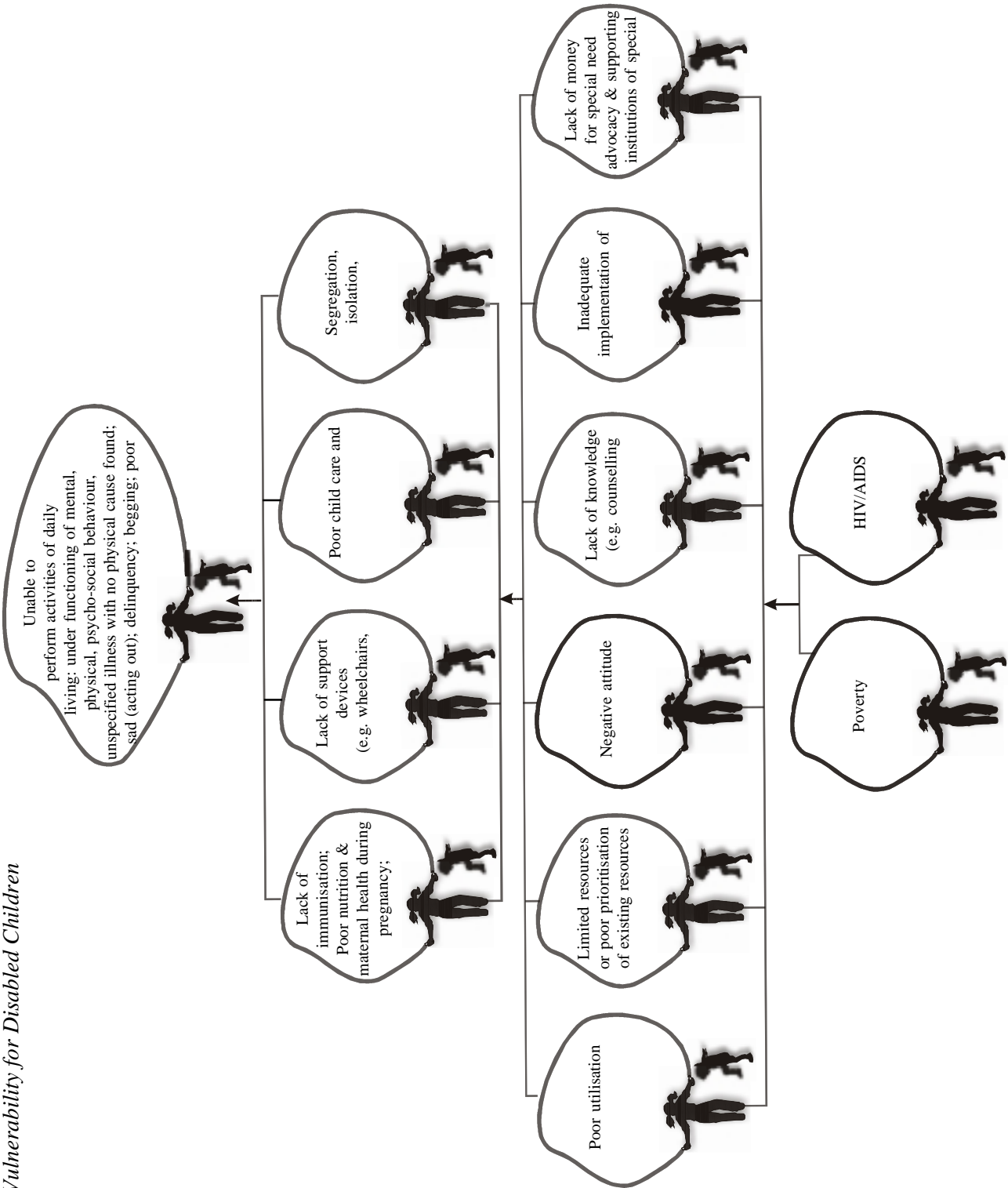
UNICEF (1999) reportedly observed that there was social stigma attached to disability, lack of awareness of special schooling possibilities and entry barriers resulting from tuition fees or transportation costs, combine to limit access of disabled children to specialized schools and rehabilitation. Virtually all disabled children receive inadequate formal education, the vast majority of disabled children receive no education at all, and girls and rural children suffer the greatest losses, spending their days idly in the company of care-givers who are non-responsive and likely to regard them as a burden.

Legal Provisions

Discussions on provision for education for children and adolescents with disability would not be complete without reviewing the legal instruments in place to safeguard the education of these students in the country. The Zimbabwe Education Act of 1987 (revised in 1996) has a non-discriminatory clause in its provision for education to the nation. Section 4 (paragraph 2) of the Act states that:

No child in Zimbabwe shall be refused admission to any school on the grounds of race, tribe, colour, religion, creed, place of origin, or social status of his or her parents.

Figure 5. Causes of Vulnerability for Disabled Children



The Act is silent on discrimination based on disability or one's abilities. In other words, children with disabilities' right to education in Zimbabwe is not protected by law. In other countries, education for children with disabilities is protected by law (e.g. U.S.A. Individuals With Disabilities Education Act 101- 476) (Hardman et. al. 1996). There is therefore a legal gap in the provision of education to children and adolescents with disabilities. In the absence of such an instrument, it is not surprising that only 33 percent of the children with disability have their right to education met and are in school.

The other policy of interest to this discussion is the Zimbabwe Psychological Practices Act (Revised 1988) which advocates for the development of individualized programmes for persons with disabilities and the placement of special needs children in the least restrictive educational environment. In other words, the Act discussed above advocates for the integration of children with disabilities in ordinary schools whenever possible (least restrictive environment). This position is well supported in the literature and is in line with the normalization principle (Wolfensberger 1972; Flynn & Nitsch, 1980) and the concept of inclusive education (Vlachou, 1997). In practice though, many children with disabilities are still institutionalized in special schools. Inadequate legal provisions thus make disabled children vulnerable.

Poverty

Of the 170 care-givers who answered the structured questionnaire in this study, 12% were in gainful employment and had steady income, 1% had businesses while 87% were unemployed. The 87% not employed did not have any other steady income to support their families with. During focus group discussions, care-givers expressed concern that disability was expensive and they did not have the money to meet its demands (constant medical care, purchase of support devices such as wheelchairs, hearing aids, tests etc.). Access by disabled children to these basic requirements were worsened by the fact that government did not provide free services.

The fact that most care-givers of children with disabilities are of a low income status was corroborated by the data from the children with disabilities when asked how many thought their care-givers could:

- Afford to pay their school fees. Only 64 (22%) were in the affirmative.
- Pay for their medication. 88 (30%) were positive.
- Pay for their food. 85 (50%) said their parents could afford.

One of the main reasons why the charity model is common as a service provision to people with disabilities is that there seems to be a positive co-relation between poverty and disability. There is likely to be a higher incidence of disability among poor people than among rich people. Also, there is likely to be a higher incidence of poverty among people with disabilities than among non-disabled people. The reason why there is likely to be a higher incidence of disabled people among poor people is because poor people cannot afford medical treatment of some of the diseases that cause disability. Ignorance/lack of knowledge also plays a part. There is need to break the cycle of poverty and disability.

Ambiguity about Role and Responsibility

On the question as to who was the primary care-giver and duty-bearer of the child with disability in their specific family, 22% of the care-givers said it was both parents, 53% felt it was the mother, 2% felt it was the father while 23% said it was other relatives, mainly maternal grandparents.

In the focus group discussions, all groups agreed that mothers were the ones looking after the children with disabilities and not the fathers. This was like a given responsibility for mothers. Fathers supported from a distance. In some cases, fathers were not even prepared to spend money on these children.

When asked further as to whether the care-givers felt it was their responsibility to look after these children or not, 95% of the care-givers felt it was their responsibility to look after these children while 5 % did not feel that way.

On the question as to who had the authority over the children with disability in the household, 9% said it was either parent, 19% said it was the mother, 52% felt it was the father and 20% it was other members of the family.

When the same issue was discussed in the focus group discussions, the participants (mostly mothers) felt that the fathers' authority over children with disabilities was mostly theoretical. In practice, mothers were making decisions on what to do with their children with disabilities because fathers did not want to be involved. However, for

the non-disabled children fathers want to exercise their authority and make decisions. In a way, for children with disabilities there was role reversal. Mothers, although they may not be the head of the household, made decisions for their children with disabilities.

Persons with disability tend to be perceived by the non-disabled as lacking in clear social role functions. This phenomenon has been described as role marginalization (Devlieger, 1998; Mpofu, Thomas & Thompson, 1998) or social liminality (Murphy, 1990).

Role marginalization may be higher in adolescents and females with disabilities than in children and males. Native Zimbabwean cultures have higher role performance expectations for males than for females (Mpofu, 1999) which bias could further marginalize females with disabilities.

Broadly, the lack of clarity on the roles and responsibility for disability care makes concerned children vulnerable.

Sexual Abuse

Child sexual abuse, defined as the use of children for sexual gratification, can have a devastating impact on the child. The effects of child sexual abuse include the occurrence of sexually transmitted diseases and HIV/AIDS, pregnancy, injury to the genitalia, child marriage, psychosomatic disturbances, emotional/behavioural problems, poor school performance and drop-out. A complication with child sexual abuse is that sexual intercourse with minors though illegal, finds a degree of social tolerance depending on the circumstances. In many cultures sexual intercourse with minors after they have reached puberty is regarded as acceptable. Other cultural, traditional and religious beliefs contribute to the occurrence of child sexual abuse. In addition, parents being away working, for example, may create a context for child sexual abuse by not providing sufficient protection for the child. Cultural, traditional and religious beliefs and the need for many parents to be away working also create barriers to the effective improvement in the circumstances of disabled children.

Due to the sensitive nature of the topic, qualitative techniques of data collection were mostly used. Focus group discussions were conducted with both children and adults, and key informant interviews were held with programme staff of organisations, the police, hospital staff, and other persons within district and national offices. Communities in Beitbridge (Matebeleland South Province), Bindura (Mashonaland Central Province) and Chikomba (Mashonaland Central) were sampled. These areas were chosen because they already had UNICEF-led activities on child sexual abuse. Altogether, a total of 18 focus group discussion were held, 6 in each of the three areas. A total of 5 key informant discussions were held, one in each area. All land use areas (commercial and communal farming, urban, peri-urban and mining) were represented in the sampling. Data were also gathered through questions that were integrated into the questionnaires for the other categories of children at risk. Court records of child sexual abuse over the period January 1998 to July 2000 were also reviewed.

The Findings

Children consistently responded with perceptions of betrayal, coercion, sexualisation and secrecy pressure. Perceptions of betrayal were noted in the responses of both girl and boy children. Two of the cultural practices repeatedly recognised as abuse of children included wife pledging and giving a child to another family to appease a spirit. It is essential that such practices resulting in sexual abuse of children are eliminated because they are a serious violation of children's rights and cannot be defended on the basis of cultural tradition. Sexual abuse is an enormous betrayal of the child by persons entrusted with that child's welfare. Data in this study indicate that most cases of sexual abuse and rape in Zimbabwe are handled privately by families rather than through the courts. The most common form of settlement was damages, where the perpetrator pays a specific amount of money to the parents of the child. Data from court records suggested that perpetrators can be as young 11 years and as old as 77 years while the victim can be as young as 8 months. Most of the abusers were persons close to the child. There was a sizeable number of instances of recurrent abuse of the child. In most cases the child did not disclose, but the abuse was discovered either when an adult care-giver notices the child having difficulty walking or when the child developed a sexually transmitted disease, with the accompanying possibility of contracting HIV/AIDS.

A total of 35 case histories from the Harare Magistrate's Court were sampled based on availability and analysed. The data reveals that all the children wanted to report the abuse but were suffering from self-blame, fear and lack of energy and fear of the authorities, i.e. the mothers, fathers, nurses and the police. The majority of the children

who were aged less than 9 years were too young to understand what had happened. It is worrying to note that quite a significant number of the girls were discovered through a sexually transmitted disease with the possibility of having contracted HIV/AIDS in the process. However, gentle or menacing the intimidation may be, secrecy makes clear to the child that this is something bad and dangerous. Ten year-old Gertrude alleges that she was sexually abused by a 38 year old mother's boyfriend. The child did not tell anyone about what had happened to her until her mother noticed a week later that she was not walking properly and when her mother queried this she said her legs were painful. This clearly shows that Gertrude knew that what the abuse had done to her was wrong and tried to hide the truth. Eleven year old Susan said she was sexually abused by her brother-in-law once. The doctors' report suggested that she was abused on more than one occasion but she denied. Seven year old Memory was sexually abused by her paternal uncle. She disclosed to her grandmother who was the abuser's mother but she did not say anything.

Unless the victim can find permission and power to share the secret and unless there is a possibility of engaging non-punitive response to disclosure, the child is likely to spend a life time in what comes to be a self-imposed exile and also from intimacy, trust, and self-validation. The adult expectation of child self-protection and immediate disclosure ignores the basic subordination and helplessness of children within authoritarian relationships. Unless there is special support for the child and immediate intervention to force responsibility on the father, the child will follow the "normal" course and retract her complaint. She will admit she made up the story.

This study also highlighted that, many young girls, however, cannot or dare not express what happened to them and this is only found out because they have become very hurt or ill or because someone else has seen the incident. The respondents favoured longer sentences for the offender, protecting the child from further abuse, removing the alleged offender from the home, and the treatment for the child and his/her family. Respondents also stated that offenders should receive treatment and should not necessarily be prosecuted if they can be rehabilitated, despite their belief in the appropriateness of stiffer sentences and their ambivalence about offender rehabilitation.

Community Perceptions of Child Sexual Abuse

The discussions were varied across gender for both adults and children and whether a child was in school or not. Further research evaluating children's understanding of their abuse is important because the literature on adult victims has only limited relevance to the experience of sexually abused children. Children, for example, may perceive the abuse experience quite differently than adults remembering their abuse several years after its occurrence. The children also endorsed perceptions of sexualisation in their responses. In order to address the topic of sexual abuse of children in Zimbabwe, some researchers have examined the relationship between child sexual abuse and more general attitudes towards sex and children in society. Parents cannot directly discuss sexual matters with their children. Several definitions of a child and child sexual abuse emerged from the study. Child sexual abuse was then defined as involving the raping of a child by a family member, relative or any other person. Within the Key Informant Discussions it emerged that child sexual abuse was seen to occur when there was deliberate and planned sexual abuse of a child by an older person; informed consent to sexual relations by a child who is regarded by the law as a minor; or the lack of knowledge/ information of laws that govern child rights and protection by both/or the child and the involved older person.

The issues of child sexual abuse were seen to be complex because of the link to child prostitution, HIV-infection and AIDS and sexually transmitted infections (STIs). Accepted cultural, religious and gender practices sometimes perpetuate child sexual abuse. The incidence of child sexual abuse among certain groups like street children appeared to remain relatively unknown.

The majority of children who fall victim to sexual abuse were in the age range 7 to 15 years. Sexual abuse of a child happens only when the child is alone with the adult abuser. Abuse by other children in extended family set-ups is also becoming common, where children of opposite sex share one bedroom. An average child never asks and also never tells. For a child within a dependent relationship, sexual abuse is not a one-time occurrence. Whatever a child says about sexual abuse, she is likely to reverse it. The problem of child sexual abuse is a major problem in this country and elsewhere too. The evaluation of available data on child sexual abuse has shown that due to the relative ease of access to urban areas in Zimbabwe, data on child sexual abuse are very heavily urban-based.

Chapter 5 - Interventions

This chapter presents some of the major interventions for each category of children within the policy and legal front, and in direct programme delivery.

Children Affected by HIV/AIDS

Policies

Following the reporting of the first AIDS case in 1985, the government responded by launching the Zimbabwe AIDS Prevention and Co-ordination Programme in 1987 and a short-term emergency plan covering the period 1987-1988. This was followed by the establishment of the National AIDS Co-ordination Programme (NACP) and the development of the medium term plans I & II (MTP1 & MTP2). The latter plan focused on Prevention of transmission, reduction of the personal and social impact of HIV/AIDS and reduction of the impact of HIV/AIDS on society.

Information dissemination in the country has apparently been executed successfully, with an impressive 96.4% of males and 90.7% of females aged 15-49 years correctly citing at least two acceptable ways of protection from HIV by 1994 (Nyathi 2000). However some intervention targeted at behaviour change efforts have been far less successful with only 38.4% women and 59.5% men aged 15-49 reporting use of condom during the most recent sexual encounters.

Other Government responses specific to CABA include the following:

- Development of National Orphan Care Policy and HIV/AIDS policy, following consultation over a period of about three years. The policy emphasizes amongst other things, access to comprehensive, cost effective and affordable care to people living with HIV/AIDS and also protects the rights of children and young people with, or affected by HIV/AIDS.
 - Additionally, a National AIDS Council Act was enacted in February 2000 and came into effect in September 2000. The Act established a National AIDS Council whose overall responsibility is to manage the national response to the HIV/AIDS epidemic in accordance with the National AIDS Policy Guidelines. It is yet to be seen how effective this arrangement will be.
 - An AIDS levy of 3% of gross taxable income of taxpayers was introduced in January 2000. Use of the funds will include support for programmes directed at people living with HIV/AIDS, including children. Available documents indicate that by August 2000 the fund had received approximately Z\$600 million.
- The Department of Social Welfare of the Ministry of Public Service, Labor and Social Welfare which is charged with child protection, has spear-headed several interventions to facilitate an enabling legal and policy environment. These include:
 - Legal review in favour of vulnerable children, including amendment of the Administration of Estates Act (inheritance) and the Customary Marriages Act (prohibiting the pledging of girls and women in marriage)
 - Facilitating birth registration through mobile registration units

Establishment of National Child Welfare Forum as a co-ordinating body for issues related to children and child protection with multi-sectoral representation. CWF has been decentralized to provincial, district ward and village levels in order to facilitate implementation, monitoring and co-ordination of child-related activities in the respective localities.

Programmes

The high frequency of deaths from AIDS and the presence of large numbers of terminally ill people and orphans in the community has triggered off an unprecedented response from existing organisations and the formation of new ones. The Directory of Children's Services in Zimbabwe 2000 lists 99 organisations which provide child services in Zimbabwe but cautions that this is a small proportion of the total number of organisations serving

children in Zimbabwe, while the Zimbabwe AIDS Directory 1995 lists a total of 111 organisations involved in HIV/AIDS work.

Most implementing organisations are involved in orphan care, home-based care and counselling. The organisations include children's homes, orphanages and home-based care-givers. At least one organisation in Harare specifically cares for destitute or homeless HIV-infected, including children. The majority of the organisations are religious or church-based, with local community members assisting where possible. Some of these organisations have amassed considerable experience and should be a useful resource on which to build more community-based organisations in the future. There have been no specific interventions for children infected with HIV except indirectly through orphan support by the Department of Social Welfare. DSW has also piloted Community-Based Orphan Care programmes in Masvingo (Rural Model) and in Bulawayo (Urban Model).

With the exception of a few councils in urban areas with "New Start Centres" for voluntary counselling and testing and fewer AZT pilot centres, local authority involvement is currently limited to primary prevention of HIV-infection and routine care of children when they fall sick. Some local authorities have social service departments that render limited support and advice to the destitute and other needy residents. Orphans, some of whom are HIV-infected, are usually self-referred. There is no process of active identification that might unearth more children in acute need of care. In health institutions, interventions are confined to the limited care of pregnant women and sick children.

The following are some of the major responses by NGOs & CBOs:

- Community mobilisation and capacity-building aimed at enabling communities to provide for children affected by HIV/AIDS, some NGOs provide support and guidance to communities to set up and manage programmes for CABA.
- Provision of financial and material support either through direct provision of cash and kind to the households in need or through assistance to initiate income generation activities to supplement income for these families.
- Psycho-social support for CABA and their care-givers
This includes pre- and post-bereavement counselling and training of children and their care-givers in life skills and addresses the importance of preparation for death of parents while providing guidance for writing wills and ensuring important documents for children to gain access to necessary social services.
- Development of Complementary Models of Care (Farm Model)
FOST has developed an orphan care programme on the commercial farms. Small groups of orphans will live together on a farm, looked after by a carefully chosen care-givers. Some of the challenges have been involving the Farm community at every level of decision-making and establishing a monitoring system that ensures adequate support to orphans and care-givers. Like the other models, the coverage is still predominantly limited to two to three provinces. Some of the farms running this farm model have been designated for resettlement leaving the future of the children uncertain.

Community-Based Orphan Care

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

Support Groups

These range from small informal groupings with small membership to large organisations affiliated to and supported by AIDS service organisations. They provide counselling, share experiences and members strengthen each other. They have saved many care-givers and other affected members from psychological disintegration and disaster. They give practical meaning to the concept of living positively with HIV/AIDS. Experience from the field is that care-givers who are members of active support groups are better able to accept their circumstances and have more positive attitudes about their problems and generally cope better.

In some areas a degree of community ownership has emerged, albeit without the full ingredients of a mobilised community. Examples in urban areas are the Bulawayo Health Task Forces that have been formed in most of the city suburbs. Membership usually includes the local ward councillor, a local businessman, local teacher, local police officer, local priest and other community members. The task forces work closely with some voluntary organisations serving in the area and they get technical support from the local authority management as well as from local clinic health personnel. What is conspicuously missing in the case of children, is an official direct link between locally based hospitals and clinics on the one hand and the home-based care group on the other, to enable continuation of the care of HIV-infected children between the community and health institutions.

Despite the increasing number of home-based care programmes these do not usually extend to the care of sick children, especially when the mother is alive. In situations where the care-givers have been clearly informed of the child's condition and at least verbally advised on what to do and what to expect, the children appears to fare better.

Research, Knowledge Generation and Networking

DSW undertook a national enumeration of orphans and for orphans and vulnerable children in 1999, which was complimented by a mapping exercise aimed at establishing gaps between extent of the problem and available services. The information has since been used in planning coverage of social safety nets, e.g. BEAM, as well as focusing on other community based interventions.

Numerous research activities have been conducted within communities. These have however been rather fragmented and on a very small scale, resulting in fatigue by communities. Many NGOs are pursuing partnership with CBOs in order to enhance their capability of addressing the real needs of the communities.

Working Children

Policies

The Children's Protection and Adoption Act of 1972 provides conditions for protecting children's education if child labour is taking place and it completely prohibits certain types of employment by children, notably street occupations. There has been high profile police activity in the urban informal sector, directed against the affected children themselves. In the informal sector, the main form of implementation of state regulation is through police control of vending and other informal sector activities. Although the Vagrancy Act does not apply to children under the age of 16, children found street vending or in other street occupations covered by the CPAA, are arrested by the police.

Domestically, child labour has been controlled by the Labour Relations Act and the Children's Protection and Adoption Act, although there have been problems with these two instruments. They were not specifically designed to control child labour and there have been loopholes in their enforcement.

The new ILO Convention incorporates the following:

1. Targeting the intolerable – immediate suppression of extreme forms of child labour (starting with the worst, a form of prioritisation and is country specific).
2. Time-bound programme of action to eliminate child labour (desirable, within a development framework perspective).
3. Prohibition of work for the very young (under 12 or 13 years) and special protection of girls.
4. Rehabilitation to ensure permanent removal from hazardous work.
5. Put in place preventive measures (could also be special protection measures).
6. Designation of national authority responsible for child labour.
7. International cooperation against the intolerable forms of child labour – making crimes against a child anywhere, a crime everywhere.
8. Increased financial aid to fight child labour.

What is clear of the legal framework is that it is now in line with all the ILO conventions governing response towards working children. While this is commendable in itself and the spirit and intensions of the state might be applauded, however, very often legal provisions are rarely translated into reality. They often remain in statute books being good for "public relations" as they show our good intentions that tend to remain a pipe dream. It is

thus clear that legislation alone is not the answer. Local international non-government organisations such as Redd Barna, Save the Children (UK), mainly work in partnership with local non-government counterparts such as Streets Ahead (an organisation catering for the needs and rights of street children in Harare), the Child Protection Society (an organisation that caters for the needs and rights of orphans and other vulnerable children in Harare) and other structures such as sector trade union bodies like The Zimbabwe Domestic and Allied Workers Union (ZDAWU) and the General Agricultural Plantation Workers Union of Zimbabwe (GAPWUZ) have also been involved in initiatives to meet specific needs and rights of working children.

In the wake of HIV/AIDS, children are taking on substantial responsibilities. This is clear when children become heads of households in the absence of appropriate adults. Adults must respect the children and appreciate the competencies that they show and build up on these. It is naive to assume that children, because they are simply children, are therefore incompetent.

Redd Barna Zimbabwe in partnership with ZDAWU and GAPWUZ has carried out extensive operational situational analyses and assessments with a view to establish workable strategies in dealing with the issue of working children. The same has been done by Save the Children Fund (UK) in areas of its operation such as the Zambezi Valley (including mines in Mutorashanga) and the peri-urban holding camp, Dzivaresekwa Extension and the holding camp, Porta Farm. These were settlements that were created in 1992 when squatters in and around Harare were relocated to make way for the visit of the British Queen.

In January 2000, these efforts culminated with the staging of a workshop on working children. The workshop recommended establishment of a movement of working children in order to provide support and protection to children who absolutely need to work. In this workshop children were heard and they further made a substantial contribution both in providing information about their situations and in pointing to areas that need particular attention. The children made an important announcement that they wish to start a movement for working children with the full support (facilitation) of sympathetic adults. To this end therefore, most of the interventions that are done by non-government structures are geared towards fruition of the children's request for support in establishing a movement for working children. Redd Barna Zimbabwe is leading a team of experts that are overseeing this activity which is initially being organized sectorally. So far the agricultural sector has had a seminar involving both child and adult animators to ensure that a movement is being established not for its own sake but to ensure that it focuses on topical concerns in each area. Thus, the beginning of the process is to ensure that children lead their communities in carrying out situational assessments and analyses with a view to establish collective responsibility towards action. The situational assessments and analyses are already on-going now in the farming sector. As long as children are centrally and meaningfully involved, this activity is the organization of the movement of working children.

Street Children

Policies

The Government of Zimbabwe has policy guarding the interest of each and every needy child under the age of 16 years, the Children's Protection and Adoption Act (1972), Chapter 33. Other pieces of legislation, which protect children, are in the Labour Act. The Children's Protection and Adoption Act contradicts some of the fundamental provisions for children which are enshrined by the United Nations Convention on the Rights of the Child. For example, subsections 20(2), (a) and (b) of the Act contravene the Convention and need to be deleted.

Government's traditional practice has been to round up the street children and confine them along with non-street abandoned children, delinquents, stray children and other children in need of care, in government residential facilities of remand, training centres, probation and children's homes. In some cases street children become children in need of care in these institutions. Child-care workers and street children spoke of the harsh conditions at some of the government training and remand centres. A number of government training centres have tried to be responsive to the rights of street children.

Programmes

Interviews with street child care workers revealed that all programmes for street children, be they government run or supported by NGOs, lack adequate funding, lack adequate and skilled personnel and have problems with

coordination with similar organisations.

There are a number of organisations in Zimbabwe that work with street children. In Harare organisations who are working with or have helped street children include the Department of Social Welfare, Harare Shelter for Destitute, Streets Ahead, Harare City Council/Harare Street Children's Organisation, Street Kids In Action, Shungu Dzevana, Jesuits Project, City Presbyterian Church, and Compassion Ministries.

Community Responses/Programmes

Street children are seen as “vagrants”, “illegal vendors” or “truants” by both the law and the general public. Focus group discussions with street adults confirmed what many street children felt that many people view street children as irresponsible young persons who were “criminals in the making”. Reactions to such children thus tend to be punitive and anti-social and delinquent behaviour stemming from poverty is not considered in its proper social and psychological context.

Some communities of street adults have responded to the needs of street children by offering shelter, security for personal property for a small fee (Bourdillon, op cit). The general public at times support street children by offering them money for washing or guarding their cars or just cash donations to beggars.

Children Infected with HIV/AIDS

Policies

Following the reporting of the first AIDS case in 1985, the government responded by launching the Zimbabwe AIDS Prevention and Co-ordination Programme in 1987 and a short-term emergency plan covering the period 1987-1988 [21]. This was followed by the establishment of the National AIDS Co-ordination Programme (NACP) and the development of the medium term plans I & II (MTP1 & MTP2). The latter plan focused on Prevention of transmission, reduction of the personal and social impact of HIV/AIDS and reduction of the impact of HIV/AIDS on society.

Information dissemination in the country has apparently been executed successfully, with an impressive 96.4% of males and 90.7% of females aged 15-49 years correctly citing at least two acceptable ways of protection from HIV by 1994 [2, 22]. Behaviour change efforts have been far less successful with only 38.4% women and 59.5% men aged 15-49 reporting use of condom during the most recent sexual encounters with risk [2].

With regard to policy a comprehensive national HIV/AIDS policy was published in 1999 following consultation over a period of about 3 years [43] and was officially launched by the national president in December 1999. The policy among other things emphasises:

- Access to comprehensive, cost effective and affordable care to people living with HIV/AIDS.
- The rights of children and young people with, or affected by HIV/AIDS are protected and respected.
- That children orphaned as a result of HIV/AIDS shall not be discriminated against in anyway and refused such support as is necessary to grow up with respect and dignity.
- That children and young people should be protected from any form of abuse that is likely to expose them to HIV-infection.
- Individuals and couples considering marriage or bearing children should have access to accurate information about HIV-infection and pregnancy and to voluntary counselling and testing

Mobilisation of resources internally for funding the fight against AIDS has until the beginning of year 2000 been negligible. Ninety percent (90%) of funding has been from donors and sustainability of such funding and the nature of interventions depended on relations with, and on the format preferred by, the donors, which may not necessarily be contextually appropriate.

In January 2000 an AIDS levy of 3% of gross taxable income of taxpayers was introduced. Use of the funds will include support for programmes directed at people living with HIV/AIDS including children. Available documents indicate that by August 2000 the fund had received approximately Z\$600 million. The challenge is cost effective use of the funds in addressing the problem of HIV in children.

A proposed law by government to make it a criminal offence to knowingly do an act that is likely to lead to HIV transmission, including within marriage, is still under discussion. However the subsequent mother to child transmission is not to be regarded as wilful transmission of HIV [43]. This latter provision dilutes the effectiveness of the law in protecting children from vertical transmission of HIV.

As for local authorities, with the exception of a few councils in urban areas with “New Start Centres” for voluntary counselling and testing and fewer AZT pilot centres local authority involvement is currently limited to primary prevention of HIV-infection and routine care of children when they fall sick. Some local authorities have social service departments that render limited support and advice to the destitute and other needy residents. Orphans, some of whom are HIV-infected, are increasing in their list of clients. However these clients are usually self-referred. There is no process of active identification that might unearth more children in acute need of care.

Programmes

There have been no specific interventions in the area of care except indirectly through orphan support by the department of social welfare. However there was a widely held opinion in health institutions and voluntary organisations that central government should take a clear lead in the prevention of childhood AIDS and the care of infected children. They consider that priorities and distribution of resources should reflect the seriousness of the HIV epidemic and the effect on the children. It has already been indicated that the policy of payment for health services by these children is a barrier to access because of the very high demand for the services and poor socio-economic conditions of the care-givers. Effective safety nets for children with special protection needs are missing.

Voluntary and Welfare Organisations and NGOs

The Zimbabwe AIDS Directory 1995 lists a total of 111 organisations involved in HIV/AIDS work. Most implementing organisations are involved in orphan care, home based care and counselling. The Directory of Children’s Services in Zimbabwe 2000 lists 99 organisations which provide child services in Zimbabwe but cautions that this is a small proportion of the total number of organisations serving children in Zimbabwe. Twenty-six of those listed are said to be involved in children and HIV/AIDS.

The organisations include children’s homes, orphanages and home-based care-givers. At least one organisation in Harare specifically cares for destitute or homeless HIV-infected including children. The majority of the organisations are religious or church-based, with local community members assisting where possible. They derive their strength mainly from religious devotion to the service of the under privileged and suffering. Some of these organisations have amassed considerable experience and should be a useful resource on which to build future more community-based organisations.

Health Institutions

Interventions are confined to the limited care of pregnant women and sick children. However it is considered that scope exists for non-medical interventions such as:

- Establishing effective links with local communities so that health care in the community and the local institution form a continuum and formulating strategies for the shared care (institution-based and home-based care) of children with HIV-infection in the community.
- Empowering the local community and promoting community health awareness by providing adequate and appropriate information on local community health issues such as HIV/AIDS, HIV-infected children and their care at home, healthy living, and dangerous or harmful cultural practices.
- Support the community in its efforts against stigma and discrimination for example by avoiding promoting secrecy and stigma under the guise of confidentiality, and playing an exemplary role by ensuring non-discrimination and stigmatisation in the institution.
- Help the community establish a system of monitoring the status of children in need.
- Ensure that as far as is possible both parents are counselled to encourage discussion within the family.
- Encouraging care-givers to join support groups
- Assuming the role of protectors of the rights of children by identifying children in need and referring to relevant organisations for assistance

Community Responses for Care of HIV-Infected Children

In practice in Zimbabwe community organisations tend to be organisations working within the community but run by non-community members with the community being largely recipients of assistance. In some areas a degree of community ownership has emerged, albeit without the full ingredients of a mobilised community. Examples in urban areas are the Bulawayo Health Task Forces that have been formed in most of the city suburbs. Membership usually includes the local ward councillor, a local businessman, local teacher, local police officer, local priest and other community members. Their main activities are Community Peer Education as an AIDS prevention strategy and Community Home-Based Care for the ill at home and care of orphans among whom children with features of HIV-infection are usually identified. The task forces work closely with some voluntary organisations serving in the area and they get technical support from the local authority management as well as from local clinic health personnel [40].

Despite the increasing number of home based care programmes these do not usually extend to the care of sick children especially when the mother is alive. Thus the care-giver may battle alone, without community support, with inadequate information and inadequate management of the sick child. In situations where the care-givers have been clearly informed of the child's condition and at least verbally advised on what to do and what to expect, the children appear to fare better [36]. On prevention most communities seem helpless and look to the government, and specifically to the Ministry of health and Child Welfare, for salvation [42].

Most organisations are concerned with the problem of orphans due to AIDS and children with HIV-infection get included incidentally in the process. The main reason is that most of the children with HIV-infection have not been tested. However care-givers are now able to recognise the more common features of HIV-infection in children, and the fact that parents died of AIDS tends to complete the picture and prompts the institutions to seek official confirmation. When a child turns out to be infected they continue to care for the child and arrange and pay for medical care. Most of the children's homes spoken to care for the child in the home until the time of death. They felt that the care they offered was preferred to that offered by hospitals. Health officials do not support this practice as they consider that it may lead to children with treatable conditions dying too prematurely without treatment.

Support groups range from small informal groupings with small membership to large organisations affiliated to and supported by AIDS service organisations. They provide counselling, share experiences and members strengthen each other. They have saved many care-givers and other affected members from psychological disintegration and disaster. They give practical meaning to the concept of living positively with HIV/AIDS. Experience from the field is that care-givers who are members of active support groups are better able to accept their circumstances and have a more positive attitudes about their problems and generally cope better.

Children with Disabilities

Programmes

Parents of children with disabilities and their children got assistance from various institutions. Special schools and integration units in their local areas featured prominently among these. Of the children with disabilities going to school 38% are in integration provision, 6% are in total inclusion provision while 56% are in special schools. However it is important to note that many students with disabilities are not in school. Some are not in school because their school types are full (e.g. severe to profound multiple disabled children) or they have dropped out due to high fees and the harsh economic circumstances.

The Schools Psychological Services and Special Education section of the Ministry of Education, Culture and Sports is responsible for providing education for children and adolescents with disabilities. It specifically runs programmes for children with the following disabilities: mental, physical, visual, hearing, speech and language and specific and general learning disabilities (Annual Report of the Secretary of Education and Culture, 1995 presented to the Parliament of Zimbabwe 1998).

The Education Statistics (1996) gives the total number of students in schools to be 3 244 140. It does not say how many of these students have disabilities. However the study on Children in Especially Difficult Circumstances in Zimbabwe (UNICEF, 1995) puts the total number of children with special educational needs to be 19 096. Consid-

ering that the ICDS (1997) registered 57 232 children and adolescents (0-19 years of age) in the country, it can be estimated that 33% of children and adolescents with disabilities in Zimbabwe are in school. **Sixty-seven percent are not in school.** The Situation Assessment and Analysis of Children and Their Families (UNICEF, 1999) observed that social stigma attached to disability, lack of awareness of special schooling possibilities, and entry barriers resulting from tuition fees or transportation costs combine to limit access of disabled children to specialized schools and rehabilitation. According to the same analysis, virtually all disabled children receive inadequate formal education, the vast majority receive no education at all, and girls and rural children suffer the greatest losses, spending their days idly in the company of care-givers who are non-responsive and likely to regard them as a burden.

The Zimbabwe Education Act of 1987 (revised in 1996) has a non-discriminatory clause in its provision for education to the nation. Section 4 (paragraph 2) of the Act states that “No child in Zimbabwe shall be refused admission to any school on the grounds of race, tribe, colour, religion, creed, place of origin, or social status of his or her parents. “ The act is silent on discrimination based on disability or one’s abilities. Therefore law does not protect children with disabilities’ right to education in Zimbabwe. There is therefore a legal gap in the provision of education to children and adolescents with disabilities. In the absence of such an instrument it is not surprising that only 33% of the children with disabilities have their rights to education met and are in school.

The Zimbabwe Psychological Practices Act (Revised 1988) advocates for the development of individualized programmes for persons with disabilities and the placement of special needs children in the least restrictive educational environment. This would suggest advocacy for the integration of children with disabilities in ordinary schools whenever possible (least restrictive environment). This position is in line with the normalization principle and the concept of inclusive education. In practice though many children with disabilities are still institutionalized in special schools. Evidence suggests though that new provision is expanding more in integration provision than in segregated special schools.

The clinics and local district hospitals still conduct rehabilitation sessions for children with disabilities. Most of these institutions are run by private voluntary organizations (e.g. churches, NGOs). There were a few government centres.

Community Responses

Care-givers were asked if they knew of any programmes in their community that assisted them and gave them support in caring for their children with disabilities, 95% of the care-givers did not know of the existence of any such programmes within their communities. All the participants did not know of any intervention on disability championed by their local government authorities (both urban and rural councils). Care-givers gave the following suggestions for community support:

- Assistance for Food
- For those in urban areas, transport to carry their children with disabilities to and from school.
- Activities to educate communities on issues of disability, including information.
- Sharing information in support group meetings.
- Employment in order to afford a decent living.
- Play centres for children with disabilities.

Support Groups

Some parents of mentally and physically handicapped children in urban areas knew and used the services of parental support in sharing information and to learn skills that they could use at home. They also had play centres where children with disabilities spent part of the morning. Unfortunately parents in the group discussions said the facilities were too few. The care-givers in the study did not know of support groups in other disability areas.

Also the support of parents of children with disabilities were not known in most rural areas visited by the researchers. These support groups were championed by an organization of parents of handicapped children. Only 5% of the participants knew of any government policies or laws that protected the welfare of children with disabilities, they had little knowledge though of the provisions for children with disabilities. Only 7% of the participants knew

of any programmes run by central government that directly assisted children with disabilities. Asked how the central government could support their children with disabilities, the following were suggested:

- Support equipment such as wheelchairs, hearing aids, special boots, etc. Most deaf children in schools and units for the deaf for instance had hearing aids that belonged to the school and could not take them home. One parent said, “Its like leaving your ears at school when going home simply because one is poor.”
- Free health and education services for children with disabilities, including post-secondary training programmes.
- Schools for children with multiple disabilities.
- A budget for special needs education from Government revenue for institutions running these services.

Sexually Abused Children

Policies

Children Protection and Adoption Act prohibits sexual activities with anyone under the age of 16. However, data shows that most offences are not reported, being dealt with privately by the family. Also the Act conflicts with certain cultural beliefs and practices and is not enforceable in some instances.

Programmes

Family Support Clinic at Harare Hospital attempts to provide support and treatment for children and adolescents who have been sexually abused. However, this only deals with small fraction of the assistance of sexual abuse. There is no mandatory requirements for reporting, and no specific program on creating awareness on child sexual abuse.

Chapter 6 - Commonalities in Interventions and Emerging Gaps

Interventions for the various categories of vulnerable children have demonstrated some positive factors that augur well for facilitating a conducive environment and enhancing programme delivery.

Optimisation and Dissemination of Existing Legislation and Policies

There exists a policy framework which guides the development of community based child-care programmes by all stakeholders. There is need to disseminate policy information to all communities and service providers, through a variety of media and languages. These policies assist community members to make informed decisions and benefit service provision because they reinforce the rights of the children. Use of the AIDS levy to partially defray the cost of care should be considered, especially for children diagnosed with HIV-infection. This policy should apply at all levels of health care in public institutions including mission and local authority health services. There is need to assess new technologies for affordability, cost effectiveness, sustainability, and appropriateness for local conditions.

The RDCs can provide an enabling environment through the process of decentralization and good governance. The facilitating factors to enable effectiveness of this level of support, such as good infrastructure and the legal and policy mandate for the Child Welfare Forum, exist already. The Child Welfare Forum has been set up and is a very strong structure with demonstrated potential. Also, there is a new structure that includes village assemblies designed to facilitate community representation and participation.

There is need to integrate the needs of children with disabilities across ministries. Cultural reform of traditional beliefs and practices that perpetuate gender imbalances, that in turn make women and children vulnerable to HIV, infection, require sustained and consistent advocacy. Programmes should have a target bias towards men.

Legislation should be considered to strengthen policy, for example, wilful infection of another person with HIV including the infection of unborn children with HIV.

Legislation linked to registration of births, inheritance and property disputes should ensure that all children are identified and that orphaned children inherit their parents' property. Legal education should also be an integral component to community-based awareness programmes. Enforcement of existing policies that protect children with special emphasis on protection of children against neglect and abuse, protection of inheritance rights for orphans, right of children to education (both primary and secondary) and increase availability and accessibility of social welfare support for children affected by HIV/AIDS, should be vigorously pursued.

A Development Approach to Vulnerability

Adopting a holistic approach to service provision for vulnerable children is vital. However, the fact that children's issues and policies are currently pursued from a welfaristic approach (Health & Child Welfare, Department of Social Welfare) limits opportunities for vulnerable children, also evidenced by the policies related to disability. The weakness of the welfare approach lies in its reactivity, though well-intentioned, that results in a concentration of interventions on manifestations instead of causalities, with the net-effect of undermining holistic and sustainable interventions aimed at sustainable human development. With the projection of 1.1 million orphans by 2005, such an approach undermines the noble objectives it is aimed at accomplishing. Intervention and responses to children's rights therefore need to note that they will only succeed if the community is prepared to support, respect, protect, defend and create opportunities for children.

Multi-sectoral collaboration among Government, NGOs, CBOs, religious groups and traditional structures can be fostered through strengthening linkages between donors, Government, NGOs and CBOs aimed at fostering a coordinated approach to service provision at community level. It should be noted that communities do not differentiate between categories of children, but consider all children as vulnerable and in need of support.

Research, Knowledge Generation and Networking

It is important for programmers in child welfare and development to invest in research on the causes and effects of vulnerability. Village committee members have thus far demonstrated the ability to maintain registers of vulnerable children within their midst. To ensure consistency in and useability of information at all levels, it is impera-

tive that the Child Welfare Forum, through the Department of Social Welfare, be strengthened to develop a co-ordinated approach to data collection, reporting and documentation of community-based child protection initiatives, which integrates reports and documents compiled by NGOs. Training on designing, managing, monitoring and evaluating project activities should be provided.

The establishment of non-discriminatory fora for NGOs and CBOs to exchange ideas and experiences would further enhance sharing of best practices and contribute towards a co-ordinated approach to service provision.

Strengthening Community Initiatives and Optimising Use of Existing Structures

The acknowledgement by stakeholders of the need to effectively utilise available resources and the urgent need for additional resources which enable service providers to deliver appropriate community-based services to all children in need of protection augers well for strengthening and supporting sustainable and replicable community-based child protection initiatives which localize the allocation of resources while reinforcing effective management and marketing skills of CBOs.

One very positive factor is the spirit of volunteerism within communities. This cannot however be taken for granted, especially in view of the ever-increasing numbers of children requiring various forms of support. Additionally, the willingness by local chiefs to provide agricultural inputs for orphans, for example, Zunde reMambo should be complemented through facilitating access to credit to run income generating projects and preferential access to land for agriculture, including provision of initial inputs as well as other complimentary mechanisms like affording them membership to housing schemes, etc. through existing community based structures, for example, the Child Welfare Forum. Support organizations should concentrate on complimenting community roles through awareness raising, training and the provision of time, personnel, financial and material inputs. Concerted efforts should be made to involve the private sector in supporting these initiatives, given their strategic placement as regards provision of business and marketing expertise needed to sustain Income Generating Initiatives.

Participation of Children and Adolescents

The participation of children in programming community-based child-care initiatives should be encouraged. Currently, traditional culture allows children to participate in specific activities, for example, in carrying out basic household chores. Service Providers should therefore strengthen this existing approach by integrating, in a sensitive manner, other components vital to child participation. In order to facilitate meaningful participation, it is necessary to provide comprehensive Life Skills Education for children and adolescents, including access to appropriate, non discriminatory counselling and reproductive health facilities should be prioritised. Provision of counselling services to children living with sick parents, bereaved children and children who have assumed adult roles and responsibilities. Their participation will enable them to make informed decisions about their own lives.

Emerging Gaps

Children Affected by HIV and AIDS

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

Policy/Legislation Level

- A policy on prevention of mother-to-child transmission of HIV, taking into account new and effective technologies has not yet been developed.
- There is an absence of clear strategies for enforcing, monitoring and reviewing national policy on HIV/AIDS.

Programme Level

- Despite existence of Orphan Care and HIV/AIDS policies, there is still lack of clarity as regards overall leadership and co-ordination of the various role players. Lack of awareness programmes on child protection and child rights and limited awareness of the roles of government and other actors by communities.

- Most of the activities in relation to orphans need to be more integrated and scaled up. Indeed, most of the interventions still tend to be in the form of pilots.
- Although support provided to various governments by donors, NGOs and CBOs has improved the quality of life of orphans and other vulnerable children at community level, this support poses some limitations, which include poor organizational management skills by service providers, lack of adequate funding and limited technical support at community level to sustain projects when donors pull out.
- Current approaches to pilot projects lack clearly defined project monitoring mechanisms that provide information regarding sustainability and replicability of project activities. Specific monitoring indicators which measure the success or failure of programmes based on, time, materials, money, manpower and the extent to which stakeholders and politicians are willing to support the child care programmes, have not been developed.
- Strategies aimed at ensuring a continuum of care for HIV-infected children between the institution, home-based care-givers and the home care-givers are not yet in place.
- Mechanisms in place at hospitals and clinics are not accommodative of children carrying out adult functions; e.g. children not accompanied by adults are denied treatment in health centres.
- There is lack of guidance in programming for children who are currently assuming adult responsibilities, as well as insufficient involvement of children in issues that affect them.
- Limited follow-up and feedback of research findings to communities which leads to research fatigue in communities most researched.
- There has been no evident factoring in of the gender implications during planning.
- Pilot programmes on orphan care in mining communities have not hitherto included communities involved in illegal and informal gold mining. Justification to their exclusion is that these communities are highly mobile, rendering it difficult for the members of the Child Welfare Forum to follow up and monitor the survival, development and protection of OVC.
- Guidelines for management of HIV-infected children and their parents at all main levels and areas of care such as health institutions, schools and departments of social welfare, as well as on appropriate management of young children exposed to, or infected with, HIV.
- There are no strategies to facilitate early identification of HIV-infected parents and children.
- There is an absence of effective systems that facilitate proper identification of children (and families) in need including HIV-infected children.
- Focused provision of counselling, education and psychological support for home care-givers of HIV-infected children and for of individual parents on HIV-infection in children is still absent.
- There is limited knowledge and awareness within communities on existing safety nets, and appropriate information on managing sick children.

Children with Disabilities

- There are no clear policies and laws on the education of children and adolescents with disabilities in Zimbabwe.
- There is a lack of awareness on the existing policies related to service provision for children and adolescents with disabilities. Care-givers seemed to grope in the dark and shopped around for assistance without guidance.
- Inadequate resources for key ministries with departments that deal with disability issues.
- There is no nationally representative data on people with disabilities in the country.
- There are no programmes specifically to provide counselling services for children and adolescents with disabilities.
- Negative attitudes, beliefs and stigmas towards disability are prevalent in Zimbabwe. Specifically, husbands and male care-givers featured prominently either as not being involved with their children with disabilities or as being negative to the whole situation.
- Programmes that empower care-givers to generate independent financial resources to be able to care for their disabled children are extremely few.

Street Children

Current programmes for street children do not evidence a holistic approach that embodies their personal needs, freedom of choice and the environment of family and community; they have largely tended to address symptoms rather than causal factors.

Working Children

Local international non-governmental organisations working in partnership with local non-governmental counterparts and other structures such as sector trade union have been involved in initiatives to meet specific needs and rights of working children.

What is common in all these intervening bodies, is that there is a clear understanding that working children or children who labour, are not the problem. Most of these efforts are geared towards ameliorating suffering and exploitation of children, through attempts to ensure that children meaningfully contribute in seeking solutions to ameliorate their suffering.

NGOs have carried out extensive operational situational analyses and assessments with a view to establishing workable strategies in dealing with the issue of working children. In January 2000, these efforts culminated in a whereby it was recommended that a movement be established, to provide support and protection to children who absolutely need to work. In this workshop children were heard and they further made a substantial contribution, both in providing information about their situations, and in pointing to areas that need particular attention. The children made an important announcement that they wish to start a movement for working children with the full support (facilitation) of sympathetic adults.

Chapter 7 - Recommendations

Policy/Legislation Level

Clarification of Roles & Responsibilities

- There is need to review current legislation relating to various categories of vulnerable children with a view to clarifying and where necessary, detailing roles and responsibilities of various ministries in implementing and monitoring child care and child protection activities at policy and programmatic levels. At the same time, effective and formalized multi-disciplinary activity by the various ministry personnel, such as their participation in structures such as the Child Welfare Forum, by having these activities form part of their key result areas, should be enabled. This move will assist support organizations and other stakeholders to co-ordinate their activities effectively and to direct specific resources to the appropriate ministries. There is a need for a “champion” to facilitate the process and to oversee all issues relating to children.
- Setting up of Child Welfare Forum throughout the country should be accelerated and the liaison/linkage with the new participatory structures should be developed rapidly.
- Create an enabling economic environment through the arresting of the economic decline and setting the parameters to restore economic growth. This includes the development of an investment climate and the creation of employment.
- Replication of effective programmes and structures should be facilitated, as should scaling up interventions for orphans and vulnerable children.

Co-ordination of Programmes/Interventions

- Policies and programmes need to be multi-sectoral, linking government ministries, religious groups, NGOs, the private sector and the community. Donors should help NGOs and CBOs to engage in longer-term planning and capacity building. Multi-national donors need to be more flexible with their funding in support of local initiatives, preferably by making many small grants rather than one large project one. The emphasis on large-scale grants and projects undermines local initiatives that may be far more effective and appropriate.
- In most programmes in the country, there tends to be a separation by category. For example street children are often treated as not being working children, thus the focus tends to be on the very few children who live on the streets (known specifically as children “of” the streets, in comparison to those who still have a home to go to, often referred to as children “on” the streets). Children “on” the street, are no doubt working children. Children “of” the street are also working children.
- Currently, several organizations have programmes in the field to do with disability in one way or the other. There is no co-ordination of interventions—which may lead to either duplication or omission of important issues. In view of the above, there is need for an audit of the existing programmes by various voluntary service organisations to establish gaps in service provision for children with disabilities.
- Programmes need to focus on family tracing and reunification since this is a best practice. Strategies for intervention need to consider ways of strengthening families’ responsibility for their children. Children should only be placed in homes or foster placements as a last resort.
- There maybe need to re-visit the school time-table in some communities where there are high incidences of school drop-outs so that children can successfully combine work and schooling.
- Provide psychological support for orphans and other vulnerable children
- Devise strategies to deal with harmful practices such as stigmatisation and facilitate access to birth certificates
- Strengthen the training of critical staff in the management of child sexual abuse, strengthening the Child Welfare Forum, Victim Friendly courts, etc., particularly in the rural, farming and mining areas.
- Empower children with critical survival skills to prevent and manage sexual abuse.
- Develop the legal, social, and administrative conditions that support vulnerable children.

Strengthen the Care and Coping Mechanisms of Families and Communities

This involves strategies of increasing the capacity of families to care for vulnerable children and increasing the capacity of communities to support vulnerable children and households through measures such as improving food security and income diversification.

The policy implications for strengthening household coping capacity include:

- Improving agricultural production, which can be done through promotion of existing labour and capital saving technologies such as inter-cropping, promoting the use of high-yielding crop varieties, zero or minimum tillage to reduce the need for expensive ploughs and oxen and, promoting natural pest management.
- Technology development for resource-deprived households in the small-holder farming sector. These include selection of the appropriate variety of crop (e.g. early maturing, disease-resistant, easily threshed or pounded), improvement of existing inter-crops, concentration on high-value food crops that are drought resistant, introduction of farm equipment that can be used by the weak or donkeys (e.g. lighter ploughs and planters and modified hoes), improved indigenous technologies in mulching, inter-cropping, and seed selection, improved technologies of animal husbandry, such as cattle dipping at individual levels.
- Planning to minimize the impact of loss of human resources on labour. These plans must include HIV prevention, prolonging life and reducing morbidity from HIV (particularly for women). There is also need to introduce multi-skill training at all levels to reduce the impact on skills, knowledge and management.
- Improve households' income-generating capacities. A goal is to at least maintain household expenditure patterns and promote savings. One possibility is through micro-projects that tend to be short-term with a rapid turn-over. Another is to expand opportunities for households to own livestock and to protect existing herds through good veterinary care. In this way, the asset buffer of households can be increased. For the poorest, the landless and the urbanites, access to wage employment is crucial.
- Promotion of income diversification. Provision of wage employment has the capacity to provide households with additional sources of income. Another strategy is to encourage crop diversification and promote a reduction in external input requirements. Income generating projects (IGPs) are another possibility. However, these need to be approached with caution and careful planning given the low success rate of IGPs.
- Reducing demands on women's labour. The development of labour-saving methods of food preparation, (through for example more efficient stoves), and improving access to water and fuel supply. Making more water points available reduces the time and distance to fetch water. The development of day care centres where women take it in turns to look after their and their neighbours' children can help also in reducing the demands on women's labour. The potential to participate and benefit from IGPs depends on the extent to which there is the time to undertake these activities. It is also important to consider that the composition and vulnerabilities of households differ and change over time, as do their capacities.
- Facilitate and strengthen the autonomous child-friendly responses among communities. NGOs and CBOs can greatly increase the effects of their resources by facilitating and strengthening the autonomous response of communities, rather than attempting direct provision of services. This can be achieved by supporting activities that are owned by the communities such as child-care, non-formal education and labour sharing, supporting informal societies so that they can expand to bring in new members and building community capacity to undertake responses through the provision of training and technical assistance to community volunteers. Provide relief and mitigation support. Mitigation appears not be given the support that is necessary given the scale of the problem in Zimbabwe and the maturity of the HIV/AIDS epidemic. The emphasis should be helping families avoid jeopardizing long-term survival to meet short-term needs, for example withdrawal of children from school and sale of assets.
- Enable the community to identify needy families, vulnerable children and orphans as they are best placed to identify these categories of people. Communities should be involved in systems of enumerating and assessing the needs of families and communities, to determine the extent of problems, to raise awareness, and to promote informed decision-making. Communities are also best placed to monitor and maintain contact with children, supervise their activities, and prevent child labour abuses.
- Encourage the utilisation of health programmes such as antenatal care by pregnant women and the immunization of children, in view of the fact that many disabilities can be prevented by appropriate health interventions. Creation of support groups for parents of disabled children and sexually abused children should be supported, since such groups assist parents to support each other. Also, counselling services should be made more available for families and victims of child sexual abuse.

Programme Level

Traditional coping mechanisms to child-care are currently weakened by poverty, HIV/AIDS and increasing numbers of households in need of support. This development has resulted in community members losing confidence in their ability to care for their own vulnerable children. GOZ, supported by various stakeholders can ensure sustainable development of programmes by empowering community members to implement and monitor their projects.

Interventions in HIV Prevention

- Urgent steps need to be taken to increase the number of VCT centres, especially in rural areas and vulnerable areas such as the commercial farming settlements. This would require an increase in equipment and supplies for testing, as well as human resources. It is suggested that the National AIDS Fund could be used to partly finance this expansion.
- Information given to mothers and their partners in antenatal care clinics must include emphasis on HIV and AIDS. Specifically as a mandatory and routine practice, all women must be informed regarding their vulnerability to HIV-infection and the consequences of this on their unborn children. There should be an offer to all couples for optional HIV testing, and all women should be given information about feeding options if they are HIV positive. This practice should be incorporated into existing structures of antenatal care services in all public and private health institutions. As far as possible fathers should be encouraged to participate in antenatal clinics to ensure that they are counselled together with partners since men make the decisions.
- Where feasible, modifications to obstetric care should be investigated and adopted and made mandatory in all health institutions. Simple measures such as avoidance of artificial rupture of membranes and suction of new-borns, which are already practised in some institutions should be formalised and made routine practice.
- HIV testing capacities should be gradually expanded in terms of human resources and equipment and should be decentralised to district level institutions.

Management of HIV-Infection in Children

- Children with HIV must be recognised as children with permanently special protection needs and be catered for accordingly in all planning. It is recommended that a holistic approach, offering a continuum of care beginning before pregnancy and up to the care of the teenage child be adopted. This should involve all sectors that have input in the welfare of children, such as social welfare, health and education. The specific recommendations that follow are intended to be integral parts of such holistic care.
- There is need to urgently develop practical national guidelines, including clinical management protocols on the management of childhood HIV disease and management of the pregnant woman in the HIV/AIDS era. The guidelines should be comprehensive in coverage and should include topics such as practice in antenatal clinics, specifically providing information to pregnant mothers, counselling and testing for HIV, and breast-feeding; paediatric procedures in the three common situations namely, where HIV status is known, where status is suspected, where status is not known, prophylaxis against opportunistic infections, psycho-social support, drug use and limits, resuscitation and disclosure of HIV status to older children.
- More than half of the children living with HIV/AIDS are aged five years and above. It is therefore necessary that programmes for HIV-infected children should in future take into account the increasing number of school going and the teenage children who will have different physical and social needs from the younger children.
- Despite an absence of knowledge of street children's HIV sero-prevalence, the study shows that street children are a high-risk group for HIV-infection. Programming for street children must of necessity reflect this risk factor. HIV and AIDS interventions must consider the factors that push children onto the streets, as it is their presence on the streets without support from responsible adults that put them at risk for contracting sexually transmitted infections (STIs), including HIV.
- Consideration should be given to the use of antiretroviral therapy for children who are long-term survivors.

Training

- All medical staff should undergo training in counselling. This should take place on a continuous basis. All organisations engaged in approved counselling training activities should be brought in as partners by the Ministry of Health and Child Welfare. It is quite obvious from discussions with health workers that the majority are not informed about recent and important developments such as the use of AZT and nevirapine in preventing mother-to-child transmission of HIV. In some cases negative aspects have been picked up and exaggerated and this has created hostile attitudes towards the use of these drugs. It is recommended that an awareness campaign among health workers be started immediately and sustained for some time to appraise staff of developments in the field and to disseminate correct technical information.
- In-service courses for health workers on childhood HIV should be introduced. These courses should, as far as is possible, be conducted at local district or provincial levels. Topics to be covered can be determined through a quick survey of nurses and doctors.
- There is no programme for preventive nutritional support. Children get attention when they come in with clinical malnutrition. This situation compromises their prognosis. A special child supplementary feeding programme for these children should be established.

Awareness Raising, Information Provision, and Education

- There is need to sensitize children on their rights. This would enable children engaged as a group, such as on tea estates and farms, to be able to bargain collectively for reduction of working hours per day, to have access to protective clothing, etc., for the betterment of their working conditions. At the same time this is in line with creating a future workforce/society that often seeks to be aware of its rights in given circumstances.
- Children are becoming disabled in some cases due to diseases that can be prevented (e.g. polio, measles, tuberculosis). There is need for awareness raising, education and provision of information on good health practices, nutrition and the importance of immunization for parents and specific religious groups that advocate against these practices.
- A multi-prolonged approach to public awareness is required, empowering people with disabilities to be their own advocates. Public awareness campaigns are necessary as a continuous exercise. People with disabilities themselves can be at the forefront of these campaigns.
- There is need to mobilise parents of disabled children that they form support groups to help each other. In some disability areas, such groups exist and they need consolidation, utilizing rehabilitation technicians who exist in each district.

Children's Participation

- Children must lead the process of gathering information and analysis in partnership with parents/guardians and other sympathetic adults.
- The working children sub-committee of the national child welfare forum and the pool of experts should facilitate carrying out sector-wide situational assessments and analyses on the phenomenon of working children with a view to establishing areas of concern around which children can be involved in determining solutions to those problems, and establishing plans of action (be it in sector/area within sector) after completion of situational assessments and analyses.
- National frameworks of child self-expression and participation (though tokenistic at the moment) such as the child parliament, the junior mayors and the junior chambers, should be strengthened, in order to establish a solid and true democratic representation of children into national structures of governance.

Measuring the Effectiveness of Community Responses

- Undertake cost/benefit analysis, so the actual costs of community and household responses are estimated. This would assist in selecting and strengthening cost-effective responses that will give the greatest benefits to communities. Given the limited and declining resources, it is crucial that mitigation responses by communities are carefully monitored and evaluated so that the greatest impact is achieved with the limited resources available.

Research and Knowledge Generation

- There is need to monitor the impact of HIV and AIDS and poverty on children and families, through the development of a comprehensive system of monitoring and evaluation, as well as a system of regularly updating the information. It is important to involve the community as a matter of principle, and through participatory methods of data collection.
- The Registrar General's Office should be required to include in the census form a section on disability so that whenever a National Census exercise is undertaken, the number of people with disabilities in the country is known.
- There is need to conduct a best practices survey or study of responses to all categories of vulnerable children which should be shared with all stakeholders.
- There is need for research to be conducted to fill the information gap on the effects of street environments on child development.
- Many of the organisations working in the area of street children have been in existence for a couple of years. In the long-term it could be beneficial for these to have a capacity assessment in order for intervening around NGO, CBO or organisational capacity-building.
- Longitudinal study of the outcome of the HIV exposed child.

- Costing of strategies for prevention of MTCT versus treatment of the HIV-infected
- Child versus the use of HAART
- Psychological effects of prolonged parents illnesses on children
- Psychological effects on other children of having HIV-infected child in the family
- Psychological effects of disclosure of HIV status to children
- Further studies on the efficacy and feasibility of exclusive breast-feeding and replacement feeding in reducing mother-to-child transmission of HIV
- Factors associated with poor utilisation of the VCT centres
- Examine factors associated with stigma and its impact on children