

**AN EXPLORATION OF THE PSYCHOSOCIAL NEEDS OF ORPHANS AND  
VULNERABLE CHILDREN AFFECTED BY HIV AND AIDS IN GOKOMERE,  
MASVINGO PROVINCE, ZIMBABWE**

by

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## DECLARATION

I declare that the study on **AN EXPLORATION OF THE PSYCHOSOCIAL NEEDS OF ORPHANS AND VULNERABLE CHILDREN AFFECTED BY HIV AND AIDS IN GOKOMERE, MASVINGO PROVINCE, ZIMBABWE** is my own work and that all the sources consulted, used or quoted are reliable sources and that this work has not been previously submitted at any other institution.



Handwritten signature of Evidence Bande.

28 February 2015

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SIGNATURE

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## **SUMMARY**

The study explored the psychosocial needs of Orphans and Vulnerable Children (OVCs) affected by HIV and AIDS in Gokomere, a rural area of Masvingo Province, Zimbabwe. The participants of the study included OVCs, caregivers and members of non-governmental organisations (NGOs) and faith-based organisations (FBOs). The data was gathered using semi-structured in-depth interviews and a focus group discussion. The audio-taped data was transcribed, coded and interpreted to generate themes, categories and sub-categories. The main psychosocial needs of OVCs affected by HIV and AIDS were found to be the need for relationships, succession planning, social protection and emotional and spiritual support. Kinship care emerged to be the most important form of care for OVCs while Home-based care and child-headed households emerged as new forms of care for OVCs. This study recommends that coordinated efforts by the government, NGOs/FBOs/CBO and the community at large is needed to address the challenges facing OVCs affected by HIV and AIDS.

**KEYWORDS: Psychosocial needs, psychosocial support, OVCs, caregivers, social protection, home-based care, kinship care**

## **DEDICATION**

The study is dedicated to all the OVCs who have lost one or both parents due to HIV/AIDS epidemics and who find themselves without a proper adult caregiver. May the communities in which they live and their extended families find it in themselves to be in solidarity and empathise with them, instead of judging, discriminating and isolating them.

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## LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BEAM	Basic Education Assistance Module
BHASO	Batanai HIV/AIDS Service Organisation
CBO	Community-based organizations
CHHs	Child-headed households
ZCSO	Zimbabwe Central Statistical Office
ESPP	Enhanced Social Protection Project
FBO	Faith-based organisations
FGD	Focus-group discussion
HBC	Home-based care
HIV	Human Immuno-deficiency Virus
NGO	Non-governmental organisations
NOCP	National Orphan Care Policy
NPA	National Plan of Action
OVC	Orphans and Vulnerable Children
PLWHA	Person Living With HIV/AIDS
RCC	Roman Catholic Church
RUDO	Rural-development Organisation
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

WHO

World Health Organization

ZNAC

Zimbabwe National AIDS Council

## CHAPTER 1

### SITUATING THE RESEARCH PROBLEM

#### 1.1. INTRODUCTION

One of the consequences of the HIV and AIDS epidemics is the proliferation of orphans and vulnerable children (OVCs), with the vast majority of these children (12 million by 2009) in sub-Saharan Africa (Chitiyo, Changara & Chitiyo 2010:112). The proliferation of OVCs affected by HIV and AIDS poses a major crisis with regards to meeting their needs. With the death of a parent, these children often experience a lack of social protection, bereavement support, and love and nurturing from their remaining caregivers.

The HIV and AIDS epidemics pose dire consequences for OVCs and their families and communities. This can lead to family disintegration, the erosion of the extended family safety net and the corrosion of culture as children at times are separated from their relatives and sent to orphanages, where they may grow up divorced from the local culture (Garcia, Pence & Evans 2008:102). UNICEF (2006:6) asserts that a person's cultural heritage acts to build up a sense of identity and community. Without this legacy, tradition and oral history may fade and customs and rituals dissipate. OVCs affected by HIV and AIDS may not lose only the economic and social stability provided by the family, but also a sense of family memory, community heritage and social responsibility (UNICEF 2006:6; Kinyua 2013:329).

Sub-Saharan Africa has been particularly hard hit by HIV and AIDS with Southern Africa, of which Zimbabwe is a part, being at the epicenter of the HIV and AIDS epidemics. Countries in this region have registered the highest HIV and AIDS prevalence rates in the world (UNAIDS 2013:7). By 2012, an estimated 17.4 million people were living with HIV in the nine countries that constitute Southern Africa, namely Zimbabwe, South Africa, Ethiopia, Tanzania, Uganda, Kenya, Zambia, Mozambique and Nigeria (UNAIDS 2013:7). This represents almost 30 per cent of

the global number of people living with HIV in an area where only two per cent of the world's population resides (UNAIDS 2013:8).

This study focuses on the psychosocial, survival and developmental needs of OVCs aged 12 to 15 years and who are affected by HIV and AIDS in Gokomere, a rural area of the Masvingo Province, Zimbabwe. The study further explores the ways in which the community attempts to address the needs of OVCs affected by HIV and AIDS in Gokomere.

This chapter sets out the background of the study, states the research problem, describes the purpose of the study and the conceptual framework that guided it and discusses the research setting, the research objectives and the rationale (motivation) for the study. The methodology employed in the study is also summarised and the key concepts used are discussed and defined.

## **1.2. THE RESEARCH PROBLEM**

### **1.2.1. Background of the study**

The psychosocial problems of OVCs are so great that they have serious negative impacts on African countries characterised by high numbers of OVCs. These problems therefore demand immediate intervention. According to Rusakaniko, Chingono, Mahati, Mupambireyi and Chandiwana (2006:1), AIDS-related deaths have left many children under 15 years of age in the Southern African Development Community (SADC) region without a mother or a father or without both of them. Despite posing a threat to the demographic profile of a country like Zimbabwe, HIV infections have in this way also severely contributed to challenges in attempts to meet the psychosocial needs of OVCs affected by HIV and AIDS.

Meeting the psychosocial needs of OVCs requires having relationships with stable caregivers that support their psychosocial wellbeing (Richter, Foster & Sherr 2006:16; Kinyua 2013:334). In most cases, it is grandparents, particularly grandmothers, who come forward to provide care for OVCs affected by HIV and

AIDS. The strains imposed on elderly people as a result of caring for OVCs are severe as they often need care themselves and have an expectation that their family will look after them.

It is estimated that an average of 34 million [with approximates ranging between 31.4 million to 35.9 million] people globally were living with HIV by the end of 2011 (WHO/UNAIDS/UNICEF 2011:12; UNAIDS 2013:6). In 2015, the number is expected to be approximately 36 million (UNAIDS 2013:7). By region, sub-Saharan Africa is the worst affected, with approximately 23.5 million people living with HIV by 2012 (UNAIDS 2013:7). Sub-Saharan Africa has experienced steep declines in the number of new HIV infections from 2.3 million in 2000 to 2.1 million in 2011 (UNAIDS 2012:11). The number of new infections was 20 per cent lower than in 2001 (2.4 million [with approximates ranging between 2.2 million and 2.5 million]) (UNAIDS 2012:11).

Although there is a decline in the HIV adult prevalence rate from 14 million people in 2011 to 12.6 million by 2012 and increasing access to anti-retroviral treatment, the total number of children aged 0 to 17 years who have lost their parents due to AIDS-related deaths has not yet stabilised or declined (UNAIDS 2013:15). It has, however, increased due to lagged response to AIDS-related mortality from 14.6 million [with estimates ranging between 12.4 million and 17.1 million] in 2005 to 16.6 million [with estimates ranging between 14.4 million and 18.8 million] in 2011 (UNAIDS 2012:42; WHO/UNAIDS/UNICEF 2011:12). An estimated 90 per cent of these OVCs live in sub-Saharan Africa (UNAIDS 2013:15).

The number of children orphaned and made vulnerable due to AIDS living in six countries by 2010 – Kenya, Nigeria, South Africa, Uganda, the United Republic of Tanzania, and Zimbabwe – is more than 9 million. Nigeria counts 2.5 million and Zimbabwe 1.6 million OVCs due to AIDS-related deaths (UNAIDS 2013:8; ZNAC 2011:42). According to Cluver, Garder and Operario (2007:758) and the UNAIDS's (2012:48) global report, by 2011 more than 10 per cent of all children aged 0 to 17 years had lost one or both parents due to AIDS-related deaths in Zimbabwe (17 per cent), South Africa (16 per cent), Lesotho (12 per cent), Botswana (11 per cent) and

Swaziland (12 per cent). It is evident from these estimates that the HIV and AIDS epidemics are producing OVCs on an unrivalled scale, especially in Zimbabwe, compared to the other countries in sub-Saharan Africa. Zimbabwe has 5 per cent more OVCs than Lesotho and Swaziland, 6 per cent more OVCs than Botswana and 1 per cent more than South Africa (UNAIDS 2012:42).

According to the Zimbabwean National AIDS Council (ZNAC) (2005-2009), the rapid increase in the number of OVCs from 1 million in 2009 to 1.2 million by 2011 due to AIDS-related deaths, led the government of Zimbabwe to develop a National Plan of Action for Orphans and other Vulnerable Children for 2011-2015 (NAP for OVC 2011-2015). This seeks to address the urgent issues facing OVCs, their extended families and communities (ZNAC 2011:15). These issues include: stigma and discrimination; social exclusion and experiences of grief and loss; stress; trauma; and depression. According to the ZNAC (2011:42), if these issues are not addressed, OVCs could experience and develop low self-esteem and confidence, poor goal-setting skills, identity crises and experience distress and social isolation. This could eventually result in these children requiring psychosocial support in order to deal with emerging psychosocial problems. The government of Zimbabwe has endorsed the urgent need for coordinated and expanded interventions to strengthen existing work that is done to provide psychosocial support to OVCs by government ministries, NGOs, CBOs, FBOs and UN agencies (ZNAC 2011:42-43).

### **1.2.2 Problem statement**

The increasing numbers of OVCs affected by HIV and AIDS in Africa is a reality and this is mostly the result of the death of one or both parents due to AIDS-related illnesses (Moime 2009:8). The literature reviewed in Chapter 2 shows that limited attention has been paid specifically by researchers to the psychosocial needs of OVCs affected by HIV and AIDS and especially in resource-poor communities such as Gokomere in the Masvingo Province of Zimbabwe (Li, Naar-King, Barnett, Stanton, Fang & Thurston 2008:147).

Much of the research undertaken so far pertains to the nutritional, material and health needs of OVCs affected by HIV and AIDS. For example, Wakhweya, Dirks and Yeboah (2008) investigated the nutritional needs of OVCs affected by HIV and AIDS, while Stover, Bollinger, Walker and Monasch (2007) mostly concentrated on the material and health needs of OVCs in their study. But as yet the researcher is not aware of any studies that have been done that focus mainly on understanding the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere. A study of the psychosocial needs (such as the needs for social protection, bereavement support, love and nurturance) of OVCs affected by HIV and AIDS in Gokomere is required to strengthen service provision for OVCs in this area.

OVCs affected by HIV and AIDS are often viewed as a single homogeneous group, but in reality there is great diversity with regard to their ages, circumstances and degrees of vulnerability (Garcia *et al* 2008: 94; Weinreich & Benn 2004:33). UNICEF (2006:18) agree that all initiatives to address the psychosocial needs of OVCs affected by HIV and AIDS must: be guided by child development theories; address the needs of children at different ages; and plan for their long-term development. The psychosocial needs of OVCs at the age of four, for example, are different from those of OVCs at the age of 13. To avoid stigmatisation and discrimination, OVCs affected by HIV and AIDS should not be singled out and provided with separate services, but rather have their needs met like all other children.

As stated above, when the psychosocial needs of OVCs affected by HIV and AIDS are not met, they can suffer from multiple problems that can include social exclusion, grief and loss, stigma and discrimination, stress, trauma and depression (Cluver *et al* 2007:755; Foster, Levine & Williamson 2005). Accompanying depression among OVCs are often symptoms of general anxiety, which include: excessive worry; fear of going to new places or meeting new people; clinging to caregivers; unusual dependency on, and fear of, separation from a caregiver (Cluver *et al* 2007:758; Dalen, Nakitende & Musisi 2009:8).

The need for the social protection of OVCs affected by HIV and AIDS demands stigma reduction, which could enhance the social status and the rights of marginalised OVCs affected by HIV and AIDS (Madekunye 2007:2; Dalen *et al* 2009:6-8). Studies focusing on this type of social protection are not widespread. OVCs affected by HIV and AIDS also require legal assistance to protect them from abuse, exploitation and discrimination and to secure property rights (Zagheni 2011:763; Foster *et al* 2005:118). OVCs should also be protected from hostility and ostracism from their peers at school or in any other social environment (Foster *et al* 2005:96).

With regards to the psychosocial needs of OVCs affected by HIV and AIDS, the issue of bereavement support appears to be inadequately addressed in Zimbabwe based on a review of the available literature. While many OVCs affected by HIV and AIDS feel the need to communicate with adults about parental illness and death, adults themselves are often unable to identify and manage OVCs' distress constructively and positively (Van der Heijden 2010:42). This is because with the spread of HIV infections and AIDS-related deaths, elders face the serial traumas of losing several of their children due to AIDS-related illnesses and are then left to take care of their orphaned grandchildren on their own.

It appears that much of the research undertaken so far pertains to studying the stages of the grieving process through which OVCs go. Researchers have focused on how OVCs go through the grieving process related to their deceased parents (Van der Heijden & Swarts 2010:43). But as yet the researcher is aware of only a few studies that focus on the bereavement support of OVCs affected by HIV and AIDS in resource-poor communities like Gokomere. Related to this, Cook, Ali and Munthali (2000) focused on Malawian children's exclusion from death rituals. Mangoma, Chimbari and Dhlomo (2008) and Wood, Chase and Aggleton (2006) considered the grieving processes of children and adolescents in Zimbabwe and De Baets, Sifovo, Parsons and Pazvakavambwa (2008) investigated the role of adult caregivers in shaping children's grieving processes in Zimbabwe. These studies noted that OVCs are usually not informed about the circumstances around the death of their parents and are excluded from death rituals such as viewing the body of the

deceased and going to the graveside (USAID 2011:11). This poses a potential danger to the psychosocial adjustment of these OVCs as the children might have a lot of difficulties understanding death (Van der Heijden and Swarts 2010:44).

After their parents' death, OVCs affected by HIV and AIDS need consistency and stability, a caregiver who will nurture and love them (Foster *et al* 2005:120). Caregivers should be in a good state of health in order for them to provide love and nurturing to OVCs. Most OVCs in Africa are fostered or taken care of by their grandparents who, in most situations, are too old to care for them and who are not in good health themselves (Kinyua 2013:335; Foster *et al* 2005:121). On the other hand, adults may reject OVCs affected by HIV and AIDS since these adults often need care themselves due to old age. This can cause OVCs to feel unworthy or unloved. OVCs may then become demoralised and depressed, and the experience of a lack of affection may result in social isolation, withdrawal, despair, and aggressive behavior (Foster *et al* 2005:96).

To provide effective assistance to OVCs, it is important to understand how African communities are attempting to address the needs of these children. This study therefore also explores ways in which the community attempts to address the psychosocial needs of OVCs affected by HIV and AIDS.

The African family structure that is composed of extended kinship networks has in many respects been destroyed due to migration for both political and economic reasons. In addition, there are the devastating socio-demographic effects of the HIV and AIDS epidemics. However, extended kinship networks are still the most important "safety nets" for OVCs. Members of the extended family usually assume responsibility for OVCs when their parents have died. These extended family members comprise the uncles, aunts, cousins or grandparents of both the mother and father (Foster *et al* 2005:17; Zagheni 2011:765).

As stated above, migration has become an important agent in the breaking down of traditional African kinship networks in Zimbabwe. (Chigwenya, Chuma & Nyanga 2008: 265; Foster 2000:57). Due to the socio-political situation in Zimbabwe whereby

many families fled from political violence, the extended family has become fragmented as important family members might be searching for better living conditions in other countries. According to research done by the World Bank (2006) in a report entitled: *Status of social protection in Zimbabwe with a special focus on Orphans and Vulnerable Children and health shocks affecting the Very Poor*, the fragmentation of the extended family has led to a growing number of child-headed households as there are no relatives available to take care of OVCs.

OVCs affected by HIV and AIDS who are not absorbed into the extended family are either adopted or fostered by non-relatives. According to UNICEF (2006:43), adoption is the legal transfer of parental responsibility to a single adult or couple. However, adoption is not a common form of care for OVCs affected by HIV and AIDS in Zimbabwe although some will argue that it is the most appropriate way of providing OVCs with long-term care and protection (UNICEF 2006:34). Jackson (2002:284) argues that African individuals or couples who are childless are usually not willing to adopt OVCs affected by HIV and AIDS due to the stigma associated with the AIDS-related deaths of their parents.

Fostering is another form of care that could be provided to OVCs affected by HIV and AIDS. Foster care “implies a shared responsibility among the biological family (if it exists), foster parents, the local community and the agency administering foster care, and it is generally regarded as temporary” (UNICEF 2006:34). Foster care is not a common practice in Zimbabwe due to the lack of appropriate legal structures that allow OVCs to be fostered by non-relatives. This has led to informal foster care whereby OVCs are “pushed” into a household rather than being “pulled” into a household. The fostering of OVCs can be regarded as “pushed” or “crisis fostering” when OVCs are taken in in a family out of obligation and not willingly (Deters 2008:9). On the other hand, fostering of OVCs can be regarded as “pulled” when the extended family is ready to accept the OVC. Pushed fostering could lead to discrimination against, exploitation of and the experience of deprivation among OVCs affected by HIV and AIDS while pulled fostering could enhance the psychosocial care of OVCs (Deters 2008:9).

According to Foster *et al* (2005), USAID (2011) and UNICEF (2006), institutional care is regarded as the last resort in providing for the psychosocial and material needs of OVCs affected by HIV and AIDS – that is, all other options have failed. Much research has been undertaken around the topic of institutional care of OVCs, but the need exists that specific consideration is given to the situation of OVCs in Gokomere. Most of the studies on OVCs affected by HIV and AIDS have been undertaken in more established and resourced communities in Zimbabwe such as Bulawayo, Kariba and Harare (Germann 2005; Mangoma *et al* 2008; SAfAIDS 2010 respectively), yet there is little written about the plight of OVCs in small communities like Gokomere.

Although institutional care could guarantee to the OVCs affected by HIV and AIDS, the provision of clothing, food, education, companionship and induction into the moral or religious code of the institution, OVCs may not know the most important aspects of their cultural background. This is because as children, they are separated from their families and sent to orphanages (Garcia *et al* 2008, Foster *et al* 2005; Van den Berg 2006). Foster *et al* (2005:12) and Van Den Berg (2006:40) argue that by the age of 18, OVCs need to leave an institution and start fending for themselves. Under these circumstances they normally lose a substantial part of their sense of belonging to a community or area. These children might not have the psychological resilience, let alone skills, to cope effectively with life outside the orphanage and could turn to crime or substance abuse and/or engage in sex work or other actions that would marginalise them further (Jackson 2002:287; Garcia *et al* 2008:106).

### **1.2.3. Focus of the study**

The focus of the study is on the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe, with particular reference to children between the ages of 12 and 15. The study explored the psychosocial needs of these children with regards to social protection, bereavement support, love and nurturing. However, it was noted during data collection that understanding the psychosocial needs of OVCs cannot be understood separately from their survival and developmental needs. The study therefore also explored the survival and developmental needs of OVCs, as

well as the ways in which the Gokomere community attempted to address these needs of OVCs affected by HIV and AIDS.

### **1.3. THE RESEARCH SETTING**

The geographical demarcation of the study was confined to Gokomere in the province of Masvingo in Zimbabwe. Gokomere is a rural area situated in the Masvingo North District, which is located 20 km north of Masvingo city along the Masvingo–Harare road. The people who first settled in Gokomere are believed to be Catholic missionaries; hence most of the people in the area are members of the Roman Catholic Church. The area is dominated by Shona- (one of the official languages in Zimbabwe) speaking people.

There is one mission hospital and one clinic (Gokomere Hospital and St Stancilous Clinic respectively), which service the community. There are also three primary schools and three secondary schools in the community. These include Gokomere Primary, Matova Primary, St Stancilous Primary and Gokomere High School, Matova Secondary School and St Stancilous Secondary School.

The people of Gokomere rely mainly on subsistence agriculture, although the area is located in “region five” of the climatic regions of Zimbabwe, which is characterised by low rainfall. Due to the low rainfall received in the area, drought is a dominant feature, which means most of the families are living in poverty (Zimbabwe Central Statistics Office (ZCSO) 2005). The adverse effects of climatic change present a significant challenge to the already vulnerable community in Gokomere with regards to food security and shortages in water supply (Zimbabwe Red Cross Society (ZRCS) 2008).

#### **1.4. OBJECTIVES OF THE STUDY**

The broader purpose of this study was to gain an understanding of the needs of OVCs affected by HIV and AIDS.

The specific objectives of the study were to:

1. Explore the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.
2. Explore the survival and developmental needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe
3. Explore the ways in which the community attempts to address the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.

#### **1.5. RESEARCH QUESTIONS**

The research questions and problems researched in this study were formulated as follows:

1. What are the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe?
2. What are the survival and developmental needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe?
3. In what ways does the community attempt to address the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe?

## **1.6. RATIONALE FOR THE STUDY**

This study could prove very valuable to the Gokomere community, the Zimbabwean government and the Zimbabwean NGO sector as it could provide recommendations concerning the psychosocial needs of OVCs affected by HIV and AIDS in this area. It could further provide insight to the community, the government, NGOs and other stakeholders as to whether the psychosocial needs of OVCs in Gokomere are being adequately addressed.

It could also highlight some of the best practices in the field of psychosocial support for OVCs affected by HIV and AIDS. In so doing, the community, NGOs and other stakeholders could use the findings of this study in the implementation of psychosocial support interventions to assist OVCs affected by HIV and AIDS. The study's findings could also assist individual community members with regard to finding more effective ways to respond to the psychosocial needs of OVCs.

Furthermore, the relevant policy frameworks such as ZNAC and NPA for OVCs could find usefulness and meaning in this study. This is because it explores the strengths and weaknesses in the provision of services to meet the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, presenting on the basis of the study's findings, local-level recommendations to address the psychosocial needs of OVCs. It also provides recommendations with regard to other areas that need to be researched with regards to the psychosocial needs of OVCs affected by HIV and AIDS.

To place the study in context, the African patriarchal system that characterises Zimbabwe has marginalised women and children. The growth of the AIDS epidemic has seen the further marginalisation of women and children in Zimbabwe. The HIV and AIDS pandemic have come to be regarded as “women's diseases” as society believes they are spread by women. Furthermore, OVCs' identities are negatively framed through the stigmatisation and labeling processes attached to HIV and AIDS.

The study could also assist community members in dealing with the stigmatisation and labeling of OVCs affected by HIV and AIDS by giving local-level recommendations to deal with such matters.

South Africa has the most progressive constitution in Africa with section 28(1) of the constitution clearly stipulate the rights of children. The Constitution (1996) emphasises that, “a child’s best interests are of paramount importance in every matter concerning the child” and has articulated into other acts and policies for implementation. Although the Zimbabwean Constitution, Act 19 of 2013 also emphasises that “a child’s best interests are paramount”, the implementation of the “child’s best interests” is weaker than in South Africa. Zimbabwe’s Child Protection and Adoption Act (5 of 2006) is silent on the rights of children to express themselves.

It is important to note that the psychosocial needs of OVCs affected by HIV and AIDS forms part of the “best interests of the child.” In section 28(1) of the Interim Constitution, Act 200 of 1993 of South Africa sets out specific child best interests in the form of rights. Just like other children OVCs affected by HIV and AIDS should have the right to parental care, family care or alternative care and the right to be protected against abuse and ill-treatment. They are also entitled to other socio-economic rights: shelter, healthcare, nutrition and legal practitioners assigned to them under circumstances that their rights have been violated. This has not been successfully done in Zimbabwe and thus the reason for conducting this study. Involving OVCs who are affected by HIV and AIDS in the study could assist the government and relevant policy stakeholders such as the ZNAC and NAP for OVCs to align their policies according to the findings of the study. This is because it has conducted research using input from the OVCs themselves.

## **1.7. CONCEPTUAL FRAMEWORK**

To understand the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, the psychosocial theory of human development pioneered by Erikson is firstly used to guide this study (Wait, Meyer & Loxton 2005:32). According to Wait *et al* (2005:33), Erikson’s psychosocial theory provides a comprehensive framework

combining features that explain growth across the entire life span, from infancy to old age. It emphasises the determinants of development and posits a series of eight psychosocial conflicts that people must resolve successfully to display healthy psychosocial adjustment (Shaffer & Kipp 2007:134). In an attempt to explore the psychosocial needs of OVCs affected by HIV and AIDS, this study focuses on the early adolescence stage (12 to 15 years), which Erikson referred to as the “stage of identity versus role confusion” (Gouws, Kruger & Burger 2008:78).

However, the role played by the community is also paramount to understand the psychosocial needs of OVCs affected by HIV and AIDS. Therefore Bronfenbrenner’s (1976) ecological model for understanding social influences is also used to guide the study. Bronfenbrenner’s (1976) theory explains the child’s development within the context of a system of relationships that form his or her social environment. In Bronfenbrenner’s (1976) theory, the innermost social environment and the most important circles of care are the family and community who primarily respond to the psychosocial needs of OVCs affected by HIV and AIDS. In his theory, Bronfenbrenner (1994) identified five types of social environments, which can affect the psychosocial needs of children. These include: the microsystem, mesosystem, exosystem, macrosystem and chronosystem.

Erikson’s and Bronfenbrenner’s theories will be discussed in more detail in Chapter 2.

## **1.8. RESEARCH DESIGN AND METHODOLOGY**

Polit and Beck (2008:765) define “research design” as a technique used to structure a study and analyse information in a systematic fashion. In an attempt to understand and explore the psychosocial needs of OVCs affected by HIV and AIDS, a qualitative research design was employed. A qualitative research design aims mainly to understand the daily life and the meanings people give to their lives. This was relevant to the study as it is set out to uncover the subjective experiences and interpretation of the social actors (Fouché & Delport 2002:79). Furthermore, an exploratory approach was used to generate the empirical data for this study. An

exploratory approach contributes to the process of expanding knowledge as the researcher “observes, interviews, records, describes, interprets and appraises settings as they are” (Human Science Research Council (HSRC) 2007:6).

This study utilised semi-structured in-depth interviews and a focus-group discussion to understand the psychosocial, survival and developmental needs of OVCs affected by HIV and AIDS and how the community could attempt to address these needs. Both the interviews and focus-group discussion were tape-recorded. A total number of eight OVCs between the ages of 12 and 15 were interviewed as well as eight caregivers. Six key informants (representatives from NGOs, FBOs and church leaders) participated in a focus-group discussion. Furthermore, purposive sampling was used to ensure that the researcher selected specific participants that are knowledgeable about the psychosocial needs of OVCs affected by HIV and AIDS (Maree 2010:112).

Once the data were gathered, they were coded to identify emerging themes and also to establish how the data relate to the objectives of the study. Chapter 3 of this dissertation further sets out the research design and methodology.

## **1.9. DEFINITION OF KEY CONCEPTS**

The definition and elucidation of key concepts is not only very useful but also necessary as this avoids ambiguity, misinterpretation and enhances a common understanding of concepts (Maree 2010: 31). In so doing, the researcher attempts to remove any misunderstandings of ideas and meaning that might exist and to provide clarity.

### **1.9.1. Psychosocial needs**

“Psychosocial needs” are embedded in features and qualities of life and social relationships that from the viewpoint of OVCs and caregivers, meeting these needs

are necessary, important and critical to their psycho-emotional ability to live with the knowledge and personal and social consequences of HIV and AIDS and thus to the ability to hold themselves and their social worlds together (Kinyua 2013:329). In this study, “psycho” refers to emotions, behaviours, thoughts and attitudes of OVCs affected by HIV and AIDS and “social” refers to the OVCs’ knowledge of values, beliefs, norms and relationships and to the influence of the social environment and social change on the child’s daily life (Dalen *et al* 2009:2).

### **1.9.2. Psychosocial support**

“Psychosocial support” is a process of meeting a person’s emotional, social, mental and spiritual needs (Kinyua 2013:329). It is usually provided through interpersonal interactions that occur in caring relationships in everyday life at home, school and in the community. Psychosocial support includes the love and protection that children experience in family environments, as well as interventions that assist children and families in coping with difficult situations. Psychosocial support enables children to have a sense of self-worth and belonging and is essential for children to learn, develop life skills, participate in society and have faith in the future (UNAIDS & WHO 2004). This study focuses on two elements of support, namely psychological and social support.

### **1.9.3. Orphaned and Vulnerable Children affected by HIV and AIDS**

The concepts, “orphans” and “vulnerable children” are frequently used interchangeably because these children are often exposed to exploitation by the community and are not well cared for and protected (Guest, 2001:5 in Moime 2009: 15). The term “orphans and vulnerable children (OVCs)” as used in Richter *et al* (2006) will be used in the study to focus attention on the increasing number of children affected by the HIV and AIDS epidemics. “Orphaned children” in this study refers to children below the age of 18 years who have lost one or both parents to AIDS-related illnesses (UNAIDS/UNICEF/USAID 2004). “Vulnerable children” is used in this study to refer to those children whose survival, well-being, or

development is threatened by the HIV and AIDS epidemics (UNAIDS/UNICEF/USAID 2004).

#### **1.9.4. Caregiver**

In this study the South African Children's Act (38 of 2005) definition of a caregiver was used and it is "any person, other than a parent or guardian, who actually cares for a child and includes amongst others the foster parent, the person who cares for the child whilst the child is in temporary safe care, the manager of the child and youth care centre, the person at the head of a shelter, or child and youth care worker who cares for the child within the community" (Department of Social Development 2009:4). No formal definition was found within the legislation of Zimbabwe which better describes caregivers for the purpose of this study.

In this study, a "caregiver" refers to a person who regularly voluntarily assists a household whose members are related or not related to him/her in offering advice and giving spiritual, psychological and material support (Rusakaniko *et al* 2006). It is one of the assumptions of this study that all OVCs affected by HIV and AIDS must have at least one person who loves them and has a deep-vested, future-oriented interest in their wellbeing. "Where these conditions are missing, every effort must be made to encourage, support or establish them as they are the *sine qua non* [prerequisite] of optimal human development" (Richter *et al* 2006:13).

### **1.10.CHAPTER OUTLINE**

This study comprises of the following chapters:

#### **Chapter 1**

Chapter 1 introduced the study. It then stated the research problem, the aims and objectives of the study, the research questions, the research setting, the rationale for the study, and briefly introduced the conceptual framework that guided the study.

Chapter 1 also introduced the study's research design and methodology, defined key concepts and provided an outline of the dissertation chapters.

## **Chapter 2**

This chapter focuses on: a literature review of the psychosocial needs of OVCs affected by HIV and AIDS; the literature related to attempts by communities to address these needs; and the theoretical framework that guides the study.

## **Chapter 3**

This chapter sets out the research design, sampling procedures, data collection process and data-collection instruments. The pilot testing of the research instruments, data analysis, the research setting, measures to ensure trustworthiness of the study and ethical considerations were discussed in detail.

## **Chapter 4**

This chapter focuses on the analysis and discussion of the results of the study. The biographic information of the participants was given in order to give a picture of their demographic characteristics. Furthermore, chapter 4 focused on presenting and interpreting the findings of this study using thematic content analysis.

## **Chapter 5**

This chapter summarises the main findings of the study. The chapter also focused on providing recommendations for the provision of psychosocial support for OVCs affected by HIV and AIDS and gave suggestions for future research. It also outlined the limitations of the study.

## **1.11.CONCLUSION**

This chapter highlights the proliferation of OVCs as a result of HIV and AIDS epidemics in sub-Saharan Africa of which Zimbabwe is part. It also further highlights that OVC affected by HIV and AIDS have psychosocial needs that are unique to their situation. Although many studies done thus far focused on the material, nutritional and health needs of OVCs affected by HIV/AIDS, this study focuses on the psychosocial, survival and developmental needs of OVCs affected by HIV and AIDS. It also seeks to explore the ways in which the community attempts to address these needs in Gokomere, a rural area of the Masvingo Province in Zimbabwe.

This chapter highlights: the statement of the research problem; the aims and objectives of the study; the research questions; the research setting; and the rationale for the study. It introduces the conceptual framework that guided the study and describes the study's research design and methodology. Definitions of key concepts and an outline of the dissertation chapters are given.

## CHAPTER 2

### LITERATURE REVIEW: PSYCHOSOCIAL NEEDS OF OVCs AFFECTED BY HIV AND AIDS

#### 2.1 INTRODUCTION

This chapter discusses the literature relating to the research problem. In order to execute this task with a larger measure of efficacy, the researcher addressed the psychosocial needs of social protection, bereavement support, and love and nurturing for OVCs affected by HIV and AIDS. The chapter also addresses the traditional forms of care for OVCs. These include the extended family safety nets, foster care, adoption and institutional care. Understanding the psychosocial needs of OVCs affected by HIV and AIDS will also briefly be discussed from Erikson's psychosocial theory of human development and Bronfenbrenner's ecological perspective.

#### 2.2 PSYCHOSOCIAL NEEDS OF OVCs AFFECTED BY HIV AND AIDS

Much research undertaken on the needs of OVCs so far has considered a combination of both material and psychological needs (Mkhonta 2008; Dalen *et al* 2009; Wakhweya *et al* 2008). OVCs affected by HIV and AIDS have similar needs to other children. However, expectations about the fulfilment of these needs are potentially in jeopardy when a parent or caregiver becomes ill and eventually dies (Chitiyo *et al* 2008:385-388). OVCs affected by HIV and AIDS normally find themselves in these circumstances with no one to fulfil their needs. These needs include love and affection, stable care that involves the provision of food and shelter, a stimulating environment, access to health services and protection from both physical and emotional harm (Richter *et al* 2006:23).

Although organisations in sub-Saharan Africa are starting to address both the material (such as food, clothing and shelter) and psychosocial needs of OVCs,

meeting the psychosocial needs still remains an important requirement for OVCs' ability to cope with the death of their parents (UNAIDS 2001; Chitiyo *et al* 2008:384). Meeting these needs as well as the material and psychosocial ones is important for the growth and ability of a child to succeed in life.

The discussion in this chapter will firstly focus on the psychosocial needs for protection, bereavement support, and love and nurturing for OVCs affected by HIV and AIDS.

### **2.2.1. Need for social protection**

Masuka, Banda, Mabvurira and Frank (2012:60) defined social protection as “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of the marginalized.” In many studies a focus on social protection that entails addressing stigma and discrimination, encouraging peer relationships, meeting educational needs of OVCs and facilitating legal protection for OVCs affected by HIV and AIDS is missing.

In his report of the *International Meeting on Social Protection for Children Affected by AIDS*, Van Dijk (2007) focuses on social cash transfers provided to vulnerable households or child headed households by governments. These include child benefits, child support or a family allowance. Littrell, Murphy, Kumwenda and Macintyre (2012:335-355) focused on the role of caregivers in providing care and protection for OVCs affected by HIV and AIDS. It is evident in these studies that the psychosocial needs of OVCs affected by HIV and AIDS did not receive any attention.

### **2.2.2. Need for stigma and discrimination reduction**

The literature on OVCs affected by HIV and AIDS is extensive, as is the literature on HIV and AIDS-related stigma, but specific research on the need for stigma reduction in the case of OVCs affected by HIV and AIDS is relatively sparse. Other studies suggest that stigma and discrimination can exacerbate psychosocial problems OVCs

already face in the context of the HIV and AIDS epidemics (Deacon & Stepheny 2007:1). Stigma can prevent proper access to education, and affect well-being, treatment and care both directly (through abuse, denial of care, forced child labour and loss of inheritance, for example) and indirectly (if OVCs avoid potential stigmatising situations such as social interaction, healthcare and educational opportunities because they expect or internalise stigma) (Campbell, Skodval, Mupambireyi, & Gregson 2010:973; Deacon & Stepheny 2007:2).

The social stigma that has been attached to AIDS is perhaps the most frequently cited factor complicating the psychosocial adjustment of OVCs affected by HIV and AIDS. OVCs affected by HIV and AIDS often face hostility and ostracism rather than support from their peers at school or any other social grouping (Campbell *et al* 2010:975; Dalen *et al* 2009:8; Moime 2009:65; Foster *et al* 2005:96; Madekunye 2007:2). Stigma has terrible negative effects, such as destroying social networks when OVCs are alienated from peers, yet it is so rampant that it has been considered an epidemic in itself - “the silent killer of AIDS” (Campbell *et al* 2010:976; Chitiyo *et al* 2008:385).

In most cases, secrecy around HIV-related illness tends to exist. Moime (2009:65) argues that OVCs’ secrecy around AIDS-related illness is motivated by both shame and by a fear of the social consequences when their parent’s HIV status becomes known. In the case of AIDS-related deaths, family members may feel particular anger at the deceased for having a self-destructive lifestyle and for the potential shame he or she has brought upon the family (Chitiyo *et al* 2008:388; Foster *et al* 2005:97; Moime 2009: 65; Campbell *et al* 2010:977).

### **2.2.3. Educational needs**

The Education Act of 1987 of Zimbabwe makes school education a fundamental right for every child (Chitiyo *et al* 2008:386). However, OVCs affected by HIV and AIDS often do not get adequate education due to financial constraints, which make it impossible for OVCs to further their education after the death of their parents (Masuka *et al* 2012:61; Schenk *et al* 2008:50). Zimbabwe’s Basic Education

Assistance Module (BEAM) have become one component of the Enhanced Social Protection Project (ESPP) that assists OVCs with the payment of levies, tuition and examination fees (Masuka *et al* 2012:61; ZNAC 2011:13). The primary objective of BEAM is to reduce the number of OVCs dropping out of school, and to reach out to OVCs who have never been to school due to economic hardships (Masuka *et al* 2012:61).

A number of studies note that OVCs affected by HIV and AIDS drop out of school soon after the death of their parents due to poverty, stigma and discrimination, lack of adequate care by caregivers and financial constraints (Li *et al* 2008:152; Chitiyo *et al* 2008:386; Zagheni 2011:763). Studies done in Zimbabwe argue that the AIDS epidemic tends to put strain on the few resources of the household as families buy medicine and proper nutritious food for the affected family member living with HIV and AIDS (Zagheni 2011:763; WHO 2008:117). Due to reduced resources available for the household, insufficient funds may be available for OVCs to attend school. Other scholars have found that OVCs who make it to school tend to face rejection and are stigmatised by their own peers (Campbell *et al* 2010:975; Chitiyo *et al* 2008:384; Kinyua 2013:9).

Chitiyo *et al* (2008:386) therefore suggest that OVCs affected by HIV and AIDS need a special education curriculum, which is different from the mainstream educational curriculum. This assertion is supported by Pridmore & Yates (2005:506) who argue that OVCs affected by HIV and AIDS form one group of children that the formal education system has failed. In their study, Chitiyo *et al* (2008:387) further suggest that there is a need to develop a special curriculum for OVCs to address their educational needs.

#### **2.2.4. Need for legal protection**

Zimbabwe has made considerable strides in ratifying most conventions and international children rights instruments that guarantee fundamental human rights as well as the protection of OVCs. The legislation pertinent to OVCs includes the Children's Act, the Guardianship of Minors Act, the Maintenance Act and the Child

Abduction Act (Masuka *et al* 2012:60; ZNAC 2011:14). National policy of the Zimbabwean Government includes the National Orphan Care Policy (NOCP), which was adopted in 1999. According to Masuka *et al* (2012:60), these policies were developed using a broad-based consultative approach, reflecting Zimbabwe's strengths in protecting OVCs, and promoting collaboration between Government and civil society in protecting OVCs. The NOCP identifies opportunities to provide care and support for vulnerable children in the country that are inherent in its legislative framework, its cultural tradition of caring and the collaborative approach that exists between Government and the civic society (ZNAC 2011:14).

The NOCP established a partnership between government ministries and private voluntary organisations, the community, faith-based organizations, traditional institutions and non-governmental organisations (both national and international) (ZNAC 2011:14). The partners collaborate and network to monitor the needs of children, advocate on their behalf, and respond to their needs under consortiums now known as Child Protection Committees (CPCs), which have been established in all tiers of the country, from the village to the national level. The CPCs recognise the traditional leaders' role in the care of orphans and they support these traditional leaders in their initiatives. Programmes include the *Zunde raMambo and Dura raMambo*, which literally mean "chief's granary" (ZNAC 2011:14; ZNAC 2006:18).

However, despite these successes, OVCs affected by HIV and AIDS continue to lack legal representation and forums through which they can communicate their needs. OVCs are at risk of losing their deceased parents' property to relatives and instances of property grabbing is very common in most regions in Africa (Zagheni 2011:763; Littrell *et al* 2012:334; Lund & Agyei-Mensah 2008:94). Scholars who studied kinship care in Zimbabwe assert that OVCs in most cases are the responsibility of the father's family and the father's family may seize the OVCs' possessions, leaving them without anything left by the deceased parent/s (Zagheni 2011; WHO 2008; Lund & Agyei-Mensah 2008; Ritcher *et al* 2004). Therefore, OVCs affected by HIV and AIDS need legal assistance to protect them from such kind of abuse and to secure property rights.

The legislative issues that AIDS-affected countries such as Zimbabwe are beginning to face are often complex and interlinked. For example, the single issue of inheritance rights may require governments to ensure that each OVC has a birth certificate and national identification (which many OVC affected by HIV and AIDS in developing countries do not have) (Zagheni 2011:777; ZNAC 2011:16; Muronda 2009:118). Therefore, to strengthen the coordination and administration of protection services provided to OVCs, social services departments offering alternative care for OVCs need to revisit property and trustee laws, and to reconsider who may legally represent minors (ZNAC 2011:15; Zagheni 2011:768; Ritcher *et al* 2004).

Studies done in Zimbabwe assert that the law is ignored and instead cultural practices are followed (Masuka *et al* 2012:61; Zagheni 2011:767; Foster *et al* 2005). Many rural areas of Zimbabwe follow traditional cultural practices, which are based on the extended family structure in which OVCs are cared for by relatives. The extended family ensures that OVCs grow up with their extended family members and learn about their culture. Hence, in the wake of the HIV and AIDS epidemics, when parents die, OVCs can be left in a precarious situation, as they may be forced to rely on distant relatives, who may be unknown to them. In many cases OVCs are left with their grandmothers, women who often have little legal power to protect the inheritance rights of OVCs (Littrell *et al* 2012:337; Kinyua 2013:8).

Other scholars argue that child-supportive policies should be in place to protect OVCs affected by HIV and AIDS against neglect, harsh treatment, labour exploitation and sexual abuse (Richter *et al* 2006:32; Schenk *et al* 2008:132). The Convention on the Rights of the Child developed by the UN in 1989 to safeguard the rights of children, places a duty on governments, NGOs and members of the community to protect OVCs. To protect OVCs affected by HIV and AIDS from any kind of abuse, there is still a need for supportive relationships between OVCs and the community at large.

### **2.2.5. Need for strong, supportive relationships**

In a study done in South Africa, orphanhood as a result of AIDS-related deaths was significantly associated with peer relationship problems (Cluver *et al* 2007:758). It was evident from this study that OVCs affected by HIV and AIDS have problems in socialising with their peers with whom they identify. Dalen *et al* (2009:13) argue that with the death of parents, OVCs face rejection from their peers due to AIDS-related stigma. Although OVCs continue to engage in social relationships, greater responsibilities at home reduce the possibilities of “nursing” friendships (Dalen *et al* 2009:13). In a study done in Uganda, one of the children said that when his parents died, he lost friends because he was always looking for jobs to fend for himself (Dalen *et al* 2009:13).

Further, it was shown that instances of stigma and discrimination among peers cannot be ruled out (Dalen *et al* 2009:8; Foster *et al* 2005:96). As already noted, OVCs affected by HIV and AIDS often face hostility and ostracism rather than support from their peers at school or any other social gatherings such as in schools, at church or in the community (Dalen *et al* 2009:3). There is a need to create an environment where OVCs have open interaction with their peers or other members of the community. An example of such an intervention is the Masiye Camp’s psychosocial programme in Zimbabwe. Established in 1998, it seeks to enhance psychosocial support through building confidence in OVCs, strengthening the relationships between them, and building links with the communities.

Due to increased stigma and discrimination among peer relationships, it is important for OVCs affected by HIV and AIDS to form friendships among themselves (Morgan & Roberts 2010:206; Dalen *et al* 2009:8). The study done by Dalen *et al* (2009: 8) indicated that OVCs feel more comfortable sharing their personal thoughts and feelings about their deceased parents with peers who have the same psychosocial problems as they do. OVCs affected by HIV and AIDS tend to get more help from their peers than from adults or other community members.

OVCs also need to form relationships with elderly people and relatives. Most often, relatives are a link between the past and the present. They help children to understand the history of the family (Gouws *et al* 2008:89). Gouws *et al* (2008:89) further argue that relatives transmit cultural and familial knowledge and they have a positive effect on the OVCs' search for identity. In a study done in Uganda, Dalen *et al* (2009:7) note that OVCs relied on relatives and the community chairman of the village for guidance and counselling. Therefore the existence of strong, supportive relations, both relatives and non-relatives, can enhance the coping mechanisms of OVCs as they seek guidance from such people (Zagheni 2011:772).

### **2.2.6. Need for bereavement support**

The majority of studies done on childhood grief have come from the fields of psychiatry and psychology. This has included a heavy emphasis on trauma pathology, which focuses more on the general body of literature exploring the nature of an individual's physical, emotional and psychological suffering (Van der Heijden & Swartz 2010:44). In addition, since much of the research concerning childhood bereavement originates in Western and European contexts, the literature tends to focus on manual-based "diagnosis" criteria addressing "trauma" or quantifying the stage of grief for OVCs affected by HIV and AIDS (Van der Heijden & Swartz 2010:44-45; Van Den Berg 2006:28). It deals with how OVCs cope with a parent's death. The *Vhutshilo* programme in the Eastern Cape in South Africa is one example of where manual-based diagnosis is practised. Its aim is to build resilience in OVCs who have lost parents (Van der Heijden & Swartz 2010:44). In so doing, other aspects of the psychosocial needs of OVCs, such as reassurance, respect, and love and nurturing are not addressed.

Cultural expressions of mourning and associated death rituals in many parts of Africa de-emphasise mourning aloud (Zhao, Li, Fang, Zhao, Yang & Stanton 2007:1078; Cluver *et al* 2007:755-756; Van der Heijden & Swartz 2010:46). In China, children are taught to control emotions that are considered adverse or disruptive to harmonious social interaction, hence children's needs to express their emotions during bereavement are largely ignored or misunderstood in Chinese culture (Zhao

*et al* 2007:1078). In South Africa the practice of whispering into the child's ear about the death of a family member, often while the child is asleep, is common. In the Xhosa culture it is not acceptable to speak of anything connected to death; OVCs are therefore cautioned not to mention the names of someone who has recently died (Van der Heijden & Swartz 2010:46).

In Zimbabwe, secrecy around a parent's death due to an AIDS-related illness is common. This leaves OVCs to be solitary, miserable or distressed and to be fearful of new situations (Foster 2002:53). According to a study done in both Zimbabwe and Malawi, OVCs are often not informed about the circumstances surrounding the death of their parents and they are also excluded from death rituals (Cook *et al* 2000; Van der Heijden & Swartz 2010:46; Barrera, Alam, Nicholas, D'agostino & Schneiderman 2013:29).

It is essential to provide OVCs affected by HIV and AIDS and their caregivers with bereavement and grief counseling (Zhao *et al* 2007:1080; Wood *et al* 2006). In a study done in Zimbabwe, De Baets *et al* (2008) emphasised that caregivers should play an active role in shaping OVCs' grieving processes. Caregivers should protect, nurture, and care for the OVCs during bereavement. Li *et al* (2009:150) further argue that without empathic caregivers (attachment figures) to help OVCs recognise and express grief, normal reactions to loss can go unrecognised and persist into emotional and behavioural problems. OVCs are therefore at risk of growing up with unrecognised and unaddressed grief and prolonged negative emotions that are often expressed through anger and depression.

Nevertheless the practice of *kurova guva* whereby the family members brew beer to appease the ancestors is an important ritual that provides psychosocial support to OVCs who have lost their parents to HIV-related illness in Zimbabwe. Zagheni (2011:776) notes that this practice dramatises the common bond between the living and the deceased. The study done by Mangoma *et al* (2008) explains that through this ritual, the deceased and the living are reunited.

### **2.2.7. Need for love and nurturance**

The “ideal” image of childhood, “one where children have love, time and a safe place to play, nurturing, schooling” and connections to their cultural traditions is applicable for many OVCs affected by HIV and AIDS (Van der Heijden & Swarts 2010:41). When these OVCs’ parents die, they do not only suffer the loss of material provision, but also lose important nurturers, role models and family bonds (Van der Heijden & Swarts 2010:41).

Meeting the needs of love and nurturance require providing OVCs affected by HIV and AIDS with proper emotional sustenance; a caregiver or parental figure must be able to care for the child without arousing undue anxiety in the child (Van der Heijden & Swarts 2010:44; Moime 2009:44; Mkhonta 2008:99). To succeed on this level, the caregiver must be sensitive to the child’s needs (Moime 2009:43). Moime (2009:44) further argues that the criteria for love include: genuine expressions of warmth, a smile or a friendly look that communicate empathy and good humour; physical affection; respectful, considerate treatment; tenderness; sensitivity to children’s wants and needs; companionship; and a willingness to be a “real person” with the child rather than simply act the role of “mother” or “father”.

Caregivers need to be sensitive to the fact that OVCs affected by HIV and AIDS need additional love and reassurance, and that they as caregivers may require assistance with other aspects of caregiving such as monitoring of OVCs, especially under conditions of great stress (Richter *et al* 2006:30).

In Zimbabwean communities that are deeply affected by HIV and AIDS, care of OVCs falls heavily on the elderly, especially on women. In a study in Kenya and South Africa, it was found that grandparents often lack adequate knowledge, skills, and resources to act as caregivers, and feel significant stress about their own mortality and the future of the children in their care (Schenk *et al* 2010:331). OVCs are normally insecure when left with grandparents to care for them (UNAIDS 2004:32, Foster *et al* 2005:121; Ssenogzi 2009:309; Kinyua 2013). This kind of insecurity was noted by one of the children at the Farm Orphan Support Trust

(FOST) programme, which responds to the problems of children who had been orphaned in Zimbabwe. She said:

*“We are four staying with our uncle. He is old. Our father died in 1998 and our mother died last year. I am the oldest girl. I am afraid what will happen to us if we all have to leave. Where will we go? Will we still be able to stay together? Will I have to care for my sisters and brothers? I don’t want to be a prostitute (UNAIDS 2004:32).”*

It is on this note that Foster *et al* (2005:120-122) emphasise the need for proper succession planning and security after the death of parents. It is this kind of succession planning that will contribute to fulfilling the psychosocial needs of love and nurturing of the OVCs affected by HIV and AIDS. It is therefore important to look at this aspect of succession planning in more detail as presented below.

#### **2.2.8. Need for succession planning**

Planning and executing long-term guardianship for children is complicated due to socio-economic pressures foster care parents experience (Foster *et al* 2005:121). OVCs affected by HIV and AIDS need to feel secure about who they are going to stay with when their parents become ill or eventually die of AIDS-related illnesses (Foster *et al* 2005:121; Van Dijk 2007). In resource-poor communities, OVCs especially deserve well-considered, carefully evaluated, realistic answers to the poignant question, *“Who will take care of me?”* (Bauman *et al* in Foster *et al* 2005:120). The implementation of legislation that protects OVCs is often weak, especially in resource-poor communities (Foster *et al* 2005:122). Families and communities therefore have important roles to play in caring for OVCs. Schenk *et al* (2010:333) argue that there is a need to make informed decisions regarding the long-term care of OVCs.

Succession planning should aim to reduce uncertainty and fear among adults and OVCs about the OVCs’ future well-being (Schenk *et al* 2010:332). Both Foster *et al* (2005) and Schenk *et al* (2010) agree that parents should disclose their HIV-positive

status to children and help their children in appointing standby guardians to enhance their succession plans.

### **2.3. TRADITIONAL FORMS OF CARE FOR OVCs**

The most common traditional forms of care of OVCs affected by HIV and AIDS in Africa include extended family safety nets, foster care, adoption and institutional care.

#### **2.3.2. Extended family safety nets in Zimbabwe**

Historically in Africa, OVCs affected by HIV and AIDS have been absorbed by the extended family. Even with the rapid increase in the number of OVCs affected by HIV and AIDS on the African continent, institutional care is still viewed as the worst of all possible alternatives and recommendations for OVC-care policies strongly favour strengthening the capacity of the extended family (Heymann, Earle, Rajaraman, Miller & Bogen 2007:337; Zagheni 2011:763). Studies in Southern Africa show that the remaining parent, aunts and uncles and grandparents of OVCs affected by HIV and AIDS are their main caregivers (Dalen *et al* 2009:2, Garcia *et al* 2008:102; Heymann *et al* 2007:337).

The extended family safety net remains the most common form of care for OVCs affected by HIV and AIDS in Zimbabwe (Jackson 2002; Foster *et al* 2005:16; Zhao *et al* 2007:1077). It provides a holistic form of care to OVCs affected by HIV and AIDS that includes meeting the material, nutritional, physical and psychosocial needs of OVCs. The prevailing sociocultural values in Zimbabwe made it “natural” that OVCs affected by HIV and AIDS should be primarily cared for within their extended families (Dalen *et al* 2009:2). Social protection provided by Government is very limited or nonexistent in most settings in Zimbabwe (Zagheni 2011:765). It therefore becomes the responsibility of family members to take care of their OVCs.

Most traditional African cultures are built around patrilineal kinship systems whereby individuals belong to their father’s line of descent (Nyamukapa, Gregson, Lopman,

Saito, Watts, Monasch & Jukes 2008:134). According to Zagheni (2011:765), members of the same patrilineal line live together in multigenerational residential groups, have a strong sense of belonging to a large extended family and provide mutual assistance and share resources. Writing about the Shona kinship system of Zimbabwe, Foster (2000:56) and Nyamukapa *et al* (2008:134) state that, “It used to be, and still is the ambition of a man to gather around him a growing lineage of descendants and dependents who would act as a corporate body for economic purposes and also a united body in times of crisis or tension within the community”.

It is, however, agreed by many writers that the extended family safety net is not a “social sponge” with an infinite capacity to “soak up” OVCs, although extended families remain the principle care unit for OVCs (Foster 2000:55, Garcia *et al* 2008; Dalen *et al* 2009:2). Dalen *et al* (2009:2), Schenk *et al* (2008:895) and Li *et al* (2010:152) argue that the ability of extended families to care for OVCs has reached the maximum absorption. This is especially within the context of the devastating socio-demographic effects of the HIV and AIDS epidemics where grandparents are taking on increased childcare responsibilities. As a result, this has led to the growth of sibling-headed households, also referred to as child-headed households. Child-headed households are commonly defined as households where all members are younger than 18 years.

Garcia *et al* (2008) saw the responsibility of the extended families as being replaced by exploitative economic transactions with strangers for survival, including transactional sexual relationships as a last resort for girls who are desperate to provide for their families. Labour migration from Zimbabwe to neighbouring countries such as South Africa, Botswana and Namibia, together with routinely hyperinflation – which ultimately led to the suspension of Zimbabwean dollar in 2009 – exacerbates the weakened ability of the extended family to care for OVCs (Zagheni 2011:769).

Although OVCs affected by HIV and AIDS are still commonly absorbed into the extended family safety net in many parts of the world (Zhao *et al* 2007:1076 and Foster *et al* 2005:16), the very ubiquity of this phenomenon must not blind us to the potential for discrimination against OVCs by their relatives. In a study in Malawi,

OVCs reported being discriminated against in decision making and also being abused both physically and sexually by their extended family members (Mann 2003 in Foster *et al* 2005:16).

However, while these findings are important, they do not override the central importance of the extended family to provide care to OVCs. Foster *et al* (2005:16) therefore argue that some OVCs affected by HIV and AIDS have particular problems, such as poor school performance, forced kinship care, lack of food, clothing and shelter, abuse and discrimination, that require monitoring and support by members of kin if their psychosocial needs are to be met adequately.

### **2.3.2. Foster care**

The ideal of foster-care placement is to provide foster homes in the community on a temporary or long-term basis, registered with Social Welfare and available to OVCs (Van den Berg 2006:38-39). Fostering by relatives is the most common form of foster care for OVCs affected by HIV and AIDS. This has also been the most recommended form of fostering by governments and NGOs. Budlender, Proudlock and Jamieson (2008:38) argue that in South Africa, the use of the foster-care system and the provision of social grants to children orphaned by AIDS-related deaths has been openly encouraged by government actors, including the South African Minister of Social Development. This is because it provides financial stability to the fostering family.

The foster-care grant has been existence for many years in South Africa. Its original intention was to provide financial assistance to non-relatives who took responsibility for the care of a child in need of alternative care as a result of orphanhood, neglect, abuse or abandonment (Budlender *et al* 2008:37).

Due to the lack of legal placement of children in fosterage in Zimbabwe, informal fostering is occurring whereby OVCs are “pushed” into households, rather than being “pulled”, and this makes them very vulnerable since “push” fosterage does not entail caregivers willing to care for an OVC (Zagheni 2011:766). He further noted that most

fostering takes place within the kinship network and is largely motivated by the need to reallocate resources within the extended family or clan, in order to maximise the survival probabilities of the kinship unit and to strengthen kinship ties. Fostering practices are strongly motivated by factors such as kinship obligations, alliance building, domestic labour and a need to educate an OVC (Jackson 2002:288; Zagheni 2011:766).

### **2.3.3. Adoption**

Dhlembeu (2010:15) defined “child adoption” as “a permanent arrangement whereby adoptive parents and the adopted child acquire the same rights, duties and privileges towards each other as if the child had been their biological child born in lawful wedlock”. Many writers (Jackson 2002: 284; Masuka *et al* 2012:62; Dhlembeu 2010:16) argue that in Zimbabwe taboos about adoption, such as inheritance totems and fear of avenging spirits (*ngozi*), pose a barrier to effective adoption processes in the community. Masuka *et al* (2012:62) argues that relatives may in future blame any misfortune in the family on the presence of a child with a different totem or from a different clan. In some cultures in Zimbabwe, the value attached to blood ties has resulted in the lack or underdevelopment of adoption services. Therefore Foster *et al* (2005:29) argue that if the idea of adoption is to be accepted, cultural values will have to change in many African countries.

In cases where successful adoption takes place, many adoption agencies only consider the placement of very young OVCs, especially when decisions have been guided by the “best interests of the child”. Some fostering programmes have assumed that older OVCs cannot be successfully adopted because it is difficult to establish a new identity concurrent with that of the adoptive family in an older child, hence many adopters prefer very young children (Foster *et al* 2005:32; Masuka *et al* 2012:63).

#### **2.3.4. Institutional care**

“Institutional care” refers to “group living arrangements in which care is provided by paid adults who would otherwise not be regarded as traditional caregivers in that particular society” (UNICEF 2006:35). Most of the institutional-care systems in Zimbabwe have been created by governmental and religious organisations (Foster *et al* 2005:12; Masuka *et al* 2012:63). Institutional care has been considered as the last option after all other options have failed. This is because it undermines the traditional modes of care as it alienates children from their families, communities and culture (Masuka *et al* 2012:63). This is also why most of the Western countries have now largely abandoned congregate care in favor of family-based alternatives (Foster *et al* 2005:12).

In countries severely affected by HIV and AIDS such as Zimbabwe, the development of institutional care is sometimes justified on the grounds that both families and communities are so overwhelmed by challenges faced by OVCs that there is no alternative (Masuka *et al* 2012:63). OVCs cared for in an institution usually lack the cultural and practical knowledge and skills needed to allow them to integrate with autonomy and confidence into a community.

Researchers not in favour of this option argue that in institutional care there may be serious violations of OVCs’ rights, whether in the form of systematic sexual abuse or exploitation, malnutrition, inadequate hygiene and healthcare, educational deprivation, strict regimentation and harsh discipline (Masuka *et al* 2012:63; Garcia *et al* 2008:106; Foster *et al* 2005:13). Studies have shown that institutional care results in three main adverse effects for children: emotional and psychosocial disturbance; developmental delays and learning disabilities; and medical problems (Jackson 2002:287; UNICEF 2006:36; Masuka *et al* 2012:63).

Even where physical conditions are good and the standard of education is excellent, a number of OVCs affected by HIV and AIDS are faced with problems, which are almost inevitably associated with residential forms of care (Foster *et al* 2005:13).

These include lack of stimulation and personal care and affection and failing to adjust to the outside world on leaving the institution. According to Jackson (2002:287) and Garcia *et al* (2008:106), OVCs affected by HIV and AIDS might not have the psychological resilience, let alone skills, to cope effectively with their psychosocial problems and could embark on crime, turn to substance abuse, engage in sex work or other actions that could marginalise them further.

## **2.4. THEORETICAL FRAMEWORKS**

Although the psychosocial needs of OVCs affected by HIV and AIDS can be understood from Erikson's psychosocial theory, the social environment plays an important role in understanding the dynamics of the psychosocial needs of children. Bronfenbrenner argued that there is a need to shift from person-focused to environmentally-based and community-orientated approaches since the community has a role to play in meeting the needs of children (Bronfenbrenner 1994). From this perspective, it is important to note that OVCs affected by HIV/AIDS are not merely *tabulae rasae* (clean slates) on which the environment makes its impact, but are rather growing, dynamic entities that progressively move into and restructure their social milieu (Hook, Watts & Cockcroft 2002). OVCs affected by HIV/AIDS are in fact capable of refashioning their environment so that it is more compatible with their abilities, needs and desires.

### **2.4.1. Erikson's psychosocial theory**

Erikson's psychosocial theory provides a comprehensive framework combining features that explain human development and growth across the entire life span, from infancy to old age. The theory is a revision of Freud's theory that emphasises sociocultural (rather than sexual) determinants of development and posits a series of eight psychosocial conflicts that people must resolve successfully to display healthy psychological adjustment (Shaffer & Kipp 2007:48).

In this theory, Erikson argues that human development is a product of interaction between individual (psychological) needs and abilities, and societal (social) expectations and demand (Wait *et al* 2005:48). He further argues that the individual has a need to establish a strong personal identity as the individual is sensitive to social influence (Wait *et al* 2005:49).

#### 2.4.1.1. Stages of development

Erickson produced a chart that explains childhood and society to describe the stages of psychosocial development. For the sake of this study, the researcher will only focus on early adolescence, which is the period from 12 to 15 years and which form the centerpiece of Erikson’s theory (Gouws *at al* 2008:79). During this stage “identity versus role confusion” conflict needs to be resolved as highlighted in Table 1 below (Hook *et al* 2002:279; Gouws *at al* 2008:79)

**Table 1: Stages of psychosocial development**

							Ego integrity vs. despair	Maturity
						Generativity vs. stagnation		Adulthood
					Intimacy vs. isolation			Young adulthood
				Identity vs. role confusion				Puberty & adolescence
			Industry vs. inferiority					Latency
		Initiative vs. guilt						Locomotor-genital
	Autonomy vs. shame, doubt							Muscular anal
Basic trust vs. mistrust								Oral-sensory
1	2	3	4	5	6	7	8	

(Adapted from Wait *et al* 2005:48)

#### **2.4.1.2. Puberty and adolescence**

According to Lorvin (1995:93) most theories view peer relationships as having a positive impact on psychosocial wellbeing. The relationships are important in helping children to form meaningful relationships later in life. Papalia, Olds and Feldman (2006:307) point to the fact that the child of this age “begins to develop a real sensitivity to what matters to another person.” And this is not in the sense of “what should I do to get what I want?” but instead “what should I do to contribute to the happiness or support the prestige and feeling of worth-whileness of my chum?”

##### *2.4.1.2.1. Identity versus role confusion*

The stage of adolescence could be the most exciting period in the cycle of childhood development. This is a period of transition between childhood and early adulthood. Children grapple with the question “*Who am I?*” They must establish basic social and psychological identities, or they will remain confused about the roles they should play as adults (Shaffer & Kipp 2007:64; Gouws *et al* 2008:79). However, the identities gained by children are not permanent because they will still be influenced by their life’s experiences and aspirations (Gouws *et al* 2008:79).

Moime (2009:32) argues that when a child loses a parent, the very basic component that makes up this self-view, that is, appraisals from caretakers early in life are disrupted. A child’s picture of the world as well as of herself is altered if the family system collapses after the death of a parent. The interpersonal support children are able to provide for each other helps them build their sense of self-esteem and lessens` feelings of loneliness and isolation (Moime 2009:32).

##### *2.4.1.2.2. Egocentrism*

Children at an early stage in adolescence are characterised by egocentrism. Santrock (2000) defines egocentrism as the inability to realise others’ viewpoints and to not share another’s ideals. Santrock (2000) further argues that children must continuously learn to adjust to the expectations and needs of relevant others. Social acceptance and emotional support by parents reduce the egocentrism of children at

the adolescence stage. Wait *et al* (2005:52) assert that adolescence's egocentrism has two characteristics.

Firstly, adolescents are very preoccupied with their own distress. Normally they blame themselves, for example in the death of their parents, and have difficulties in coping with these deaths (Zhao *et al* 2011:445; Chitiyo *et al* 2008:385; Chitiyo *et al* 2010:95). They become solitary, appear miserable or distressed and are fearful of new situations (Campbell *et al* 2010:981; Foster *et al* 2005:97). Secondly, adolescents do not realise that others are mostly engrossed in their own considerations and plans and therefore do not share their preoccupations.

The dominant challenge in creating a secure sense of identity among children between 12 to 15 years is to bring together the various facets of their egos (Hook *et al* 2005:48). When this is mastered, children are able to communicate their psychosocial needs. There are many life choices to be made that will have an impact on their identity.

#### *2.4.1.2.3. Emotional development*

Wait *et al* (2005:59) describe the emotional development of children in early adolescence as characterised by emotional intensity and fluctuation. They often have highs and lows, and range from optimistic to pessimistic, from pride to humiliation, from love to hate. An important task for children is to achieve a tolerant perspective on their own emotions, and not to think that they have mental-health problems. Attempts to exercise rigid control over their emotions will probably cause social isolation and maladjustment.

#### *2.4.1.2.4. Relationships*

Gouws *et al* (2008:94) argue that there is a positive relationship between involvement with friends and psychological and social adjustment. Peer conformity increases when adolescents rely on their friends for a sense of self-worth. Erikson argues that every individual should be considered as member of a group (Hook *et al*

2005:68). Gouws *et al* (2008:83-94) further argue that adolescents need relationship with their parents, siblings, other relatives, educators, adults and peer groups. These relationships can help children to search for their individual identities, social acceptance, support and conformity. Peer-group friendships give opportunity for emotional intimacy, support, understanding, companionship and fun.

#### *2.4.1.2.5. Psychosocial crisis*

There is strong pressure on adolescents from three influential sources: their caregivers, peer groups and teachers (Wait *et al* 2005). To identify with a specific peer group, adolescents start spending long hours away from home in the presence of their friends. There is indeed pressure from their peers on whether or not to commit to a peer group, to be loyal to it and to adhere to its norms. At puberty, the task of adolescents is to navigate their “identity crisis” as each individual struggles with a degree of “identity confusion.” The lasting outcome of this stage can be a capacity for fidelity (Wait *et al* 2005).

#### **2.4.2. Application of Erikson’s psychosocial theory to OVCs**

From Erikson’s psychosocial theory of human development, OVCs affected by HIV and AIDS must establish a sense of identity as they grow to be adults. In so doing, they must continuously learn to adjust to the expectations and needs of relevant others (Gouws *et al* 2008:94; Hook *et al* 2005:68; Wait *et al* 2005:59). Peer conformity increases during adolescence and OVCs affected by HIV and AIDS tend to rely on friends for a sense of self-worth (Gouws *et al* 2008:83-94). OVCs affected by HIV and AIDS’s emotions are fluctuating because they often think about their deceased parents.

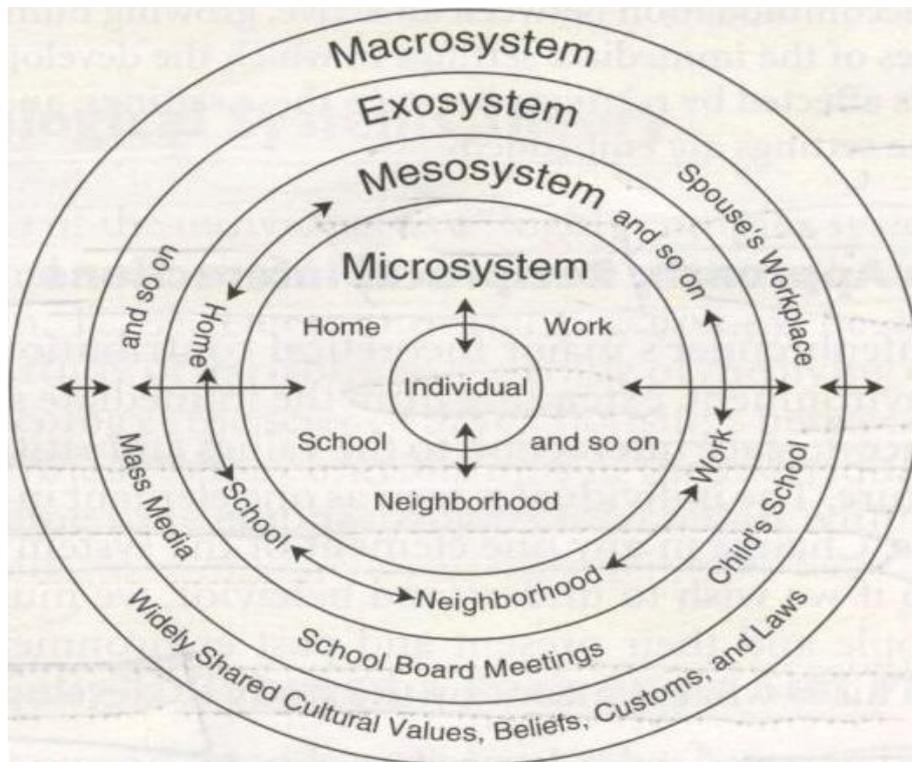
For OVCs affected HIV and AIDS, it becomes very important to have close bonds with boys and girls of their own age and to be popular, loved and respected for who they are and for what they believe (Wait *et al* 2005:88; Zhao *et al* 2011:445; Chitiyo *et al* 2008:386). OVCs affected by HIV and AIDS tend to be stigmatised by their peers who also discriminate against them, hence the capacitating factors of

popularity, love and respect are hindered. OVCs tend, therefore, to be home bound because they are afraid to face their own peers who may expose their situation. They are frequently involved in the process of self-evaluation within the context of their peer group. As such they may be exceptionally sensitive to the opinions others have about them (Wait *et al* 2005).

### **2.4.3. Ecological perspective**

Addressing the psychosocial needs of OVCs is not complete without looking at the circle of care provided to these children. Bronfenbrenner termed this circle of care as *development-in-context*. This is because the individual always remains a proactive feature of the environment as he or she continues to interact with it (Chitiyo *et al* 2008:385; Hook *et al* 2002). Bronfenbrenner (1979) explicates that a child's world consists of four systems of interaction. These are: the microsystem, mesosystem, exosystem and the macrosystem. The diagram below shows the different levels of a child's environment.

**Diagram 1: Topological model of the environment: A schematic diagram of the levels of the environment in Bronfenbrenner's Ecological Systems Theory**



*(Source: Adapted from Bronfenbrenner, 1979)*

The microsystem is the child's most immediate environment (physical, social and psychological). This core entity as depicted by Diagram 1 on the previous page stands as the child's venue for initial learning about the world (Bronfenbrenner 1979). According to Swick and Williams (2006:372), the caring relations between the child and parents (and many other caregivers) can help to influence a healthy personality for the child.

According to Bronfenbrenner (1994), the mesosystem comprises the linkage and processes taking place between two or more settings containing the developing person; a mesosystem is thus a system of microsystems (Bronfenbrenner 1979). For example, the connection between the child's teacher and his parents, between his church and neighbourhood.

The exosystem can be empowering (as a high-quality childcare programme is for the entire family) or it can be degrading (as excessive stress at work is on the total family ecology). In so many cases, exosystems bring about stress in families because we do not attend to them as we should (Swick & Williams 2006:372). The outer layer called the macrosystem contains the attitudes and ideologies, values, laws and customs of a particular culture or sub-culture. The macrosystem, which is the larger systems of cultural beliefs, societal values and political trends can influence the development of a child (Shaffer & Kipp 2007:46; Swick & Williams 2006:372). The point of the ecological model is that each component interacts with other components, making a highly complex context in which the child grows up (Bronfenbrenner 1979).

To OVCs affected by HIV and AIDS, the microsystem forms the important sphere in which their psychosocial needs are first manifested. Further, the connection of the OVCs affected by HIV and AIDS to their teachers, church and neighbourhoods forms the mesosphere. It assists OVCs to build their self-image as it encourages them to communicate their psychosocial needs. Bronfenbrenner (1979) argues that the exosystem does not positively affect children since it is a system external to the child. However, the exosystem can have an impact on OVCs affected by HIV and AIDS as it interacts with some structures in the microsystem.

The macrosystem has a cascading influence throughout the interaction of all other layers. For example, if it is the belief of the culture that caregivers should be solely responsible for raising children, that culture is less likely to provide resources to help caregivers. This, in turn, affects the structures in which the caregivers function.

The effects of the environment also depend the OVCs's age. For example even though the death of parents due to AIDS-related illness hits children of all ages hard, those in late adolescence (15 to 18 years) are less likely than those in early adolescence (12 to 15 years) to experience a sense of guilt that they were to blame

for their parent's death (Bronfenbrenner 1979; Bronfenbrenner 1994; Shaffer & Kipp 2007:46).

## **2.5. CONCLUSION**

This chapter discussed the literature that pertains to the psychosocial needs of OVCs affected by HIV and AIDS. These include the need for: social protection; stigma and discrimination reduction; strong and supportive relationships; bereavement support; love and nurturing; succession planning; education; and legal protection. It also discussed the traditional forms of care for OVCs affected by HIV and AIDS. These were noted as the extended family safety net/s, foster care, adoption and institutional care. Erikson's psychosocial theory of human development and Bronfenbrenner's ecological perspective were discussed as these are used to guide the study theoretically.

The development of the identities of OVCs affected by HIV and AIDS is strongly influenced by the social environment. To deal with group pressure, relationships, egocentrism and the emotional development of OVCs affected by HIV and AIDS, the environment should be supportive. The role played by the school, home and the neighbourhood as shown in Diagram 1 in paragraph 2.4.3.3 has a great influence on the psychosocial adjustment of OVCs affected by HIV and AIDS at an early stage of adolescence, which is characterised by identity versus role confusion.

The next chapter, Chapter 3, is going to discuss the methodology that was used in this study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1. INTRODUCTION**

The aim of this chapter is to describe the research methodology employed in this study and outline the rationale behind the methodology. The previous chapter dealt with the literature review of the psychosocial needs of OVCs affected by HIV and AIDS. In this chapter, the research design, sampling procedure, data-collection instruments, the pretesting of the instruments, data analysis, research setting, measures to ensure trustworthiness of the study and ethical considerations are discussed in detail.

#### **3.2. RESEARCH OBJECTIVES**

The broader purpose of this study was to gain an understanding of the needs of OVCs affected by HIV and AIDS.

The specific objectives of the study were to:

1. Explore the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.
2. Explore the survival and developmental needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe
3. Explore the ways in which the community attempts to address the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.

#### **3.3. RESEARCH DESIGN**

A “research design” is a technique used to structure a study and to gather and analyse information in a systematic fashion (Polit & Beck 2008:765). According to

Babbie and Mouton (2001:73), it is essential for the researcher to formulate the research problem clearly before choosing a research design that will best answer the research questions. The research design chosen for this study was qualitative and exploratory in nature. Given that little is known about the psychosocial needs for OVCs affected by HIV and AIDS in Gokomere, this design was chosen for its potential to explore and describe the research problem.

### **3.3.1. Qualitative research design**

A qualitative research design is used to explore the depth and complexity inherent in a phenomenon in a flexible and holistic manner (Polit & Beck 2008:3). In this study a qualitative research design was used to explore the psychosocial, survival and developmental needs of OVCs affected by HIV and AIDS as well as attempts by the community to address these needs in a systematic and orderly manner. According to Fouché and Delport (2002:79), a qualitative research design aims mainly to understand the people's daily lives and the meaning people give to their lives. Rather than focusing on a quantitative approach, which addresses concerns such as the measurement of, and causal relationship between, variables, qualitative research focuses on qualities, processes and meanings people derive from their experiences.

Qualitative research designs are viewed as naturalistic to the extent that the research takes place in a real-world setting and the researcher attempts to make sense of or interpret phenomena in terms of the meaning people bring to him or her (Patton 2002:39). The following assumptions as stated by Polit and Beck (2008:14) and Streubert Speziale and Carpenter (2003:16), were applied to this study. Firstly, the researcher usually approaches people with the aim of finding out about them. The interaction between the researcher and participants leads to the generation of concepts, which are a product of the "research act". The data gathered themselves generate new theoretical ideas. They help to modify already existing theories or uncover the essence of phenomena.

Polit and Beck (2008:14) and Streubert Speziale and Carpenter (2003:16) also assumed that the meaning of phenomena needs a context, that is what we know has

a meaning only within a given situation or context. The researcher must be sensitive to the context of the research and immerse him/herself in the setting and situation. The conditions in which the researcher gathers the data, the locality, the time and history are all important. If the researcher understands the context, he or she can understand the actions and perceptions of individuals and grasp the meaning that they communicate.

The understanding of phenomena cannot be manipulated. Qualitative research is used where the purpose is to study phenomena as they unfold in the real-world situation without manipulation. Qualitative research designs are linked to the subjective nature of social reality and they provide insights from the perspective of participants enabling the researcher to see things as their informants do. This is called an “emic perspective”. According to Polit and Beck (2008:16), this means that the researcher attempts to examine the experience, feelings and perceptions of the people he/she studies, rather than imposing a framework of his/her own (etic perspective) that might distort the participants’ ideas.

Polit and Beck (2008:14) and Streubert Speziale and Carpenter (2003:16) further assume that qualitative research is more commonly used to explore phenomena inductively and provide a thick/detailed description of events (Terre Blanche, Durrheim & Painter 2006:48). An inductive approach involves moving from the specific to the general. According to Polit and Beck (2008:18), it involves thick description as “deep, dense, detailed account of problematic experiences... It presents detail, context, emotion and the webs of social relationship that join persons to another”. The inductive approach was applicable to this study, since little was known about the psychosocial needs of OVCs affected by HIV and AIDS.

### **3.3.2. Exploratory research design**

Burns and Grove (2005:313) define exploratory research as research conducted to gain new insights, discover new ideas and/or increase knowledge of a phenomenon. Furthermore, Brink, Van de Walt and Van Rensburg (2006:113), Polit and Beck (2008:20) and Rubin and Babbie (2001:123) explain that exploratory research

investigates the full nature of a phenomenon and how it manifests thereby depicting other factors to which it is related. In this instance, little was known about the psychosocial needs of OVCs affected by HIV and AIDS and the attempts by the community to address these needs in Gokomere, Zimbabwe. There was a need to gain knowledge, to discover new ideas and to gain an understanding of the psychosocial needs of OVCs affected by HIV and AIDS. The researcher also sought to discover how the community of Gokomere attempts to address such needs. The research field was therefore approached with curiosity from the point of not knowing and to provide new data regarding the phenomena in context (Burns & Grove 2005:313).

### **3.4. PRETESTING THE RESEARCH INSTRUMENTS**

A pilot study was done to test the research instruments. A pilot study is a small study conducted prior to the larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate (De Vos et al 2005:206). The pilot study was undertaken in Gokomere. This exercise gave an indication of what needed to be modified in order to ensure a successful and a scientific study.

For the purpose of this study, interviews were conducted with two OVCs and two caregivers and an FDG was done with eight key informants. After pretesting of the research instruments, the interview guide and focus-group discussion guide were modified and improved. This took into consideration the feedback on how the participants responded to the questions and the researcher supervisor. Both the interview guides needed to be formulated into English but on a level suitable to OVCs and caregivers. More probing questions were also added to the OVCs' interview guide and caregivers' interview guide so that information to be gathered from these participants would be in more detail. The sample that participated in the pilot study was not included in the main study.

### **3.5. SAMPLING PROCEDURES**

#### **3.5.1. Sampling techniques**

Brink *et al* (2006: 1224) define sampling as the process used by a researcher to select the sample from the population in order to obtain information regarding the phenomena in a way that represents the population of interest. There are two sampling approaches, which are probability and non-probability sampling.

##### **3.5.1.1. Non-probability sampling**

Non-probability sampling was used to select the participants in the study. Non-probability sampling is a process of selecting participants for the study with fewer chances of obtaining a representation sample (Burns & Grove 2005:301). According to Streubert Speziale and Carpenter (2003:24), a non-probability sampling approach is used in qualitative studies as individuals are selected to participate based on their availability and first-hand experience with the phenomena of interest. According to this approach there are various techniques that are used to assist in the selection of the sample. These may include convenience, snowball and purposive sampling.

###### *3.5.1.1.1. Purposive sampling*

Purposive sampling was used to select participants in the study. Purposive sampling is to select the most interesting cases, which will benefit the study by providing rich information (Blaxter, Hughes, Tight 2008; Polit & Beck 2008:354). The researcher approached selected participants personally and also made use of contacts such as social workers, church leaders and school principals to sample out people that could be approached for data collection. The social workers, church leaders and school principal were requested to provide names of OVCs who were willing to participate in the study.

With regard to the caregivers, the researcher approached the management of BHASO, which is a NGO that deals with the treatment and support of people living

with HIV, to provide names of trained caregivers in Gokomere who would be willing to articulate information on the needs of OVCs. Also, the researcher purposively identified the organisations that were dealing with OVCs and asked the programme managers and supervisors to participate in a focus-group discussion, (See Table 5). According to Brink *et al* (2006:134), the advantage of this sampling method is that the most knowledgeable sample about the phenomenon studied is selected to participate in the study.

### **3.5.2. Eligibility criteria**

The participants that were chosen met the eligibility criteria set for the study. Eligibility criteria are the reasons or criteria for including participants in the sample of the study (Polit & Hungler 2004:290). For OVCs to be eligible to participate in the study, the respondents had to be male or female and living in Gokomere and had to be:

- between 12 and 15 years of age
- willing to participate with their parent's, caregiver's, or legal guardian's consent.

To be eligible to participate in the study, key informants (members of NGOs, FBOs and church leaders) had to be male or female and had to be:

- working directly with OVCs affected by HIV and AIDS in Gokomere
- willing to participate and sign the consent forms.

For the caregivers to be eligible to participate in the study, the participants had to be male or female and living in Gokomere and had to be:

- trained in childcare – this category is likely to have knowledge on the needs of OVCs affected by HIV and AIDS
- willing to participate and sign the consent form.

### **3.6. DATA COLLECTION**

Data collection in qualitative research is a process of gathering information from identified participants using methods such as: individual face-to-face in-depth interviews; participant observation; focus group discussion; narratives and case histories (Burns & Grove 2005:733). The researcher's request for permission to conduct the study (see Annexure G) was forwarded to the village headman of Gokomere, Masvingo North District Council, the Ministry of Education, Sport and Culture (MoESC) and NGOS/FBOs and written permission was obtained (See Annexure H).

#### **3.6.1. Data-collecting instruments**

A data-collecting instrument is a tool or device used to gather data (Polit & Beck 2008:755). In this study, a semi-structured in-depth interview guide was used with OVCs and caregivers while a focus-group discussion guide was used with members of NGOS/FBOs, which included BHASO, RUDO and church leaders. The interview guide questions were written in English but they were posed in Shona by the researcher who is an affluent Shona speaking. The researcher further translated and transcribed the tape-recorded interviews into English.

##### **3.6.1.1. In-depth individual interviews**

Bell (2005:159), defined an in-depth interview as a data-collection technique, which the researcher uses to elicit information in order to achieve an understanding of the participants' point of view or situation. In this study, in-depth individual interviews with eight OVCs and eight caregivers were administered using a semi-structured interview guide. Semi-structured interviews have features of both structured and unstructured interviews and therefore use both closed and open-ended questions. In order to be consistent with all the participants, the researcher had a set of pre-planned core questions for guidance to cover the same areas with each participant (see Annexures A and B). The aim of in-depth interviews with OVCs and caregivers

was that they provided more detailed information and a greater knowledge and insight about the needs of OVCs.

The probing questions in the guide were to ensure that the phenomenon under study could be explored in depth and relevant information sourced from participants. Although the questions were written in English, they were posed in Shona which is the mother language for both the researcher and the participants. An example of opening statement that introduced the dialogue with OVCs was “Unonzwa sei kuva mwana ari kukura muZimbabwe” (*What is it like to be a young person growing up in Zimbabwe today?*). A key question or central question that was posed to OVCs was “Ndezvipi zvimwe zvezvinhu zvinodiwa nenherera” (*What do you think are some of your needs as OVCs?*).

The interviews with OVCs were done in the presence of a second person, a qualified female social worker. The presence of a female social worker was to give a relaxed environment to OVCs during interviews. The researcher assumed that some OVCs, especially girls, might not feel comfortable being interviewed by a man and the presence of a female social worker would allow them to freely express their views regarding their needs. Following permission from the participants to conduct interviews, the female social worker also ensured that the audio tape recorder used to capture the information from the interviews worked properly. The advantage of using an audio tape recorder is that all information is captured and the tape recorder provides detailed and accurate information, which cannot be elicited from memory or notes taken during an interview (Bell 2005:159).

However, a tape recorder can intimidate some participants and some may not like the idea of their “stories” being recorded. Therefore the researcher assured participants in in-depth interviews that the tapes would only be accessible to the researcher and the supervisor and that they would be destroyed after the completion of the dissertation.

#### *3.6.1.1.1. Preparing for in-depth interviews*

Appointments for the interviews were made after OVCs and caregivers had agreed to participate. The venue, date and time convenient to the participants were set. The tape recorder was tested to ensure its functionality. The researcher also printed the interview guides so that he could go through all the questions during interviews.

#### *3.6.1.1.2. The in-depth interview procedure*

In most instances the interviews were conducted in the homes of OVCs and caregivers. However, there was only one case where the interview was conducted at the school with a caregiver who was a teacher. The researcher ensured a conducive environment for the interview by selecting a spot or room that was well lit, well ventilated and quiet. A favourable atmosphere was created by greeting and warmly thanking the participants for their willingness to participate in the study. The researcher first introduced himself and also the female social worker in the case of interviews with OVCs. He would then explain the subject of the study. Informed consent and assent (refer to Annexures D and E) were obtained after the purpose of the interview and the objectives of the study were explained to OVCs and caregivers, as well as the reason why they were chosen to participate in the interviews. The participants were able to give written consent and assent (see Annexures D and E).

The interviews with OVCs took place at their homes. The researcher would request a private room or space where other family members could not interfere with the interview. The assistant researcher (female social worker) was requested to ensure that no one disturbs the interviews and to ensure that the tape recorder was functioning properly. OVCs between the ages of 12 and 15 were chosen to participate in the study after getting permission from their parents/guardians (See Annexure D). The researcher would first introduce himself to the OVCs and then introduce the research assistant. The researcher would thank the OVCs for taking part in the study. The researcher would go through the letter requesting their participation with each and every OVC. The researcher would explain all the concepts in the letter before the OVCs gave their assent. The researcher clearly

explained to the OVCs that they were not obliged to participate or remain in the study and that their refusal to participate or withdrawal from the study would not impact negatively on them. Furthermore, the researcher would ask the OVCs if he could tape record the interview and assure them that the tape would be destroyed once the researcher wrote the study report.

One of the OVCs asked whether he would get any financial reward after taking part in the study. The researcher clearly explained that there were no financial rewards for taking part in the study. Most of the interviews with OVCs lasted between 45 minutes to an hour. The shortest interview lasted 30 minutes. During interviews, two OVCs got very emotional as they were relating their stories and started crying. The researcher gave them time to cry before the interview resumed. The researcher would start again by first seeking verbal assent about whether they would be still willing to continue with the interview. Both OVCs expressed their willingness to continue with the interview. Debriefing sessions with counsellors at BHASO were arranged with the two OVCs after the interview during which the OVCs would be able to further express their emotions, allowing healing to take place. The researcher ended the interviews by thanking the OVCs for participating in the study.

The researcher listened attentively during the interviews for the content, sequence of events and emotions, looking for clues for further questions or probes. The researcher did not interrupt the participant while talking. If the researcher had a question during the interview, it was noted down for later reference. This was done to prevent disturbing the participants' line of thought. The participants were allowed time to think and frame their responses without undue pressure. Individual differences were recognised as some people needed time to think about their responses. If facial expression showed confusion or doubt, the researcher was able to rephrase the question while avoiding leading the participants to respond in a particular manner, which would have invalidated the data.

The researcher used probes during the interview to elicit detailed information and to seek clarification from OVCs and caregivers. Where contradictory views were

observed during the interviews, the researcher would probe about these contradictions, in order to seek clarity and to assist the participants on focusing.

#### *3.6.1.1.3. Post-in-depth interviews procedure*

The tape-recorded interviews were replayed by the researcher and checked for audibility and completeness of the information soon after the interviews. This enabled the researcher to identify gaps and ambiguities with the recording and to reconstruct the interview immediately while it was still fresh in his mind (Polit & Beck 2008:401). During this time, the researcher listened to the tapes objectively and got the opportunity to critique his own interviewing style in readiness for subsequent interviews. The researcher then transcribed the tape-recorded interviews verbatim. Caution was taken to ensure that words were not missed and information about pauses, laughter, crying and shouting was adequately captured and noted. The information was translated from Shona to English before the data analysis could begin.

#### **3.6.1.2. Focus-group discussion (FGD)**

This is a qualitative data-collection technique that aims to collect data through group interaction on the topic determined by the researcher (De Vos *et al* 2005). The reasons for using a focus group was the assumption that group dynamics can assist people to express and clarify their views in ways that are less likely to occur in a one-on-one interview. The group dynamic may give a sense of safety in numbers to those who are wary of researchers or those who are anxious (Burns & Grove 2005:542). The focus group is also effective in that the researcher can obtain the viewpoints of many individuals in a short time, and members react to what is being said by others, leading to a richer and deeper expression of opinion (De Vos *et al* 2005:300). The interaction of participants may stimulate a richer response, or new and valuable thoughts, and group pressure will be valuable in challenging the thinking of participants and illuminating conflicting opinions (Polit & Beck 2008:395).

The sample size of the group was six participants. A group of this size allows everyone to participate, while still eliciting a range of responses. In making decisions about size, it is useful to think concretely about how much time each participant will talk in the group. The focus group consisted of two females and four males. The fact that the group had individuals of different genders did not interfere in any way with the quality of the data that was collected.

#### *3.6.1.2.1. Preparing for the FGD*

The executive board and directors of NGO/FBOs and churches purposively sampled were approached and asked to arrange for church leaders, programme managers and/or supervisors in those organisations to become key informants in the study. This was done so that homogeneous participants were selected to maximise disclosure about the needs of OVCs among key informants. Appointments were made with participants after they had agreed to participate. The venue, date and time convenient to the participants were set.

#### *3.6.1.2.2. Procedure in the FGD*

The discussion was conducted in the BHASO board room. The researcher started by greeting the key informants and thanking them for agreeing to be part of the focus group. Consent was obtained after the objectives of the study and purpose of the FGD were explained to key informants. Ground rules were laid down relating to issues of confidentiality and permission to opt out of the group. It was agreed that every member would contribute, that every member would be listened to, and that all ideas would be analysed and every contribution considered vital.

The seating arrangement was circular, so that every member could see each other and the researcher was able to communicate with every member of the group. Since the researcher is a social worker and is familiar with group discussion, it was easier to manage the group. One question was asked at a time, and every member was given a chance to respond to it. The researcher ensured that he paraphrased and summarised long complex or ambiguous comments to demonstrate active listening

and also to clarify comments for everyone in the group. The female social worker acted as a research assistant and she took detailed notes of what every member said, so that “data collection should not interfere with the coordination of the group” (Burns & Grove 2005:544). She also ensured that the tape recorder was working properly. The research assistant was properly orientated as to the process of focus-group data collection. The researcher tactfully dealt with one participant who tried to dominate the discussion by asking him to let others give their comments as well. The discussion was completed in one hour fifty minutes and the researcher thanked all the key informants for participating.

#### *3.6.1.2.3. Post-FGD procedure*

The tape-recorded focus group discussion was replayed by the researcher and checked for audibility and completeness of the information. The detailed notes made by the research assistant were matched to the tape-recorded focus group discussion. Caution was taken to ensure that words were not missed and information was adequately captured and noted. Some responses, which were in Shona were translated to English before the data analysis could begin.

### **3.7. DATA ANALYSIS**

Data analysis is the process of reducing, organising and giving meaning to the data, which involves breaking down massive information into themes (Burns & Grove 2005:733; Brink *et al* 2006:184). Data analysis requires that the researcher become immersed in the data. In qualitative research, data analysis is done to preserve the uniqueness of each participant’s lived experience while permitting an understanding of the phenomenon under study. It begins with listening to the participant’s description and this is then followed by reading and rereading the verbatim transcriptions. It is when the researcher becomes immersed in the data that he/she is able identify the themes, categories and subcategories and extract significant quotations/statements made by the study participants.

### **3.7.1. Method of data analysis**

The researcher used thematic and content analysis in the study of the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere. The researcher translated and transcribed the tape-recorded interviews and the focus-group discussion, then read and reread the focus group discussion and interviews. From the themes that were emerging, categories developed and these categories were divided further into sub-categories. These were then aligned with quotations/statements made by the participants (see Tables 5 and 6). When each category was exhausted and saturation was reached, then the researcher wrote descriptive findings from the quotation/statements made by the participants about the categories and sub-categories and looked for relationships between categories.

#### **3.7.1.1. The data-analysis process**

The researcher used Tesch's proposed eight steps in data analysis (De Vos, Straydom, Fouche & Delport 2002: 340-341). The points below reflect these eight steps:

- 1) The researcher carefully read through all the transcriptions, making notes of ideas that came to the mind.
- 2) The researcher selected one interview and read it to try to get meaning in the information, writing down thoughts coming to mind.
- 3) After going through the transcripts, the researcher arranged similar topics in groups by forming columns labeled major topics; unique topics; and leftovers.
- 4) The researcher then abbreviated the topics as codes and wrote the codes next to the appropriate segments of the text. The researcher then observed the organisation of data to check if new categories or codes emerged.
- 5) The researcher found the most descriptive wording for the topics and converted them into categories. The aim was to reduce the total list of categories by grouping topics together that related to each other. Lines drawn between the categories indicated interrelationships between categories.

- 6) A final decision was then made on the abbreviation of each category and the codes were arranged alphabetically.
- 7) The data belonging to each category was put together in one place and preliminary analysis performed.
- 8) Recoding of the data was done where necessary to ensure that coding was done properly.

#### **3.7.1.2. Description**

Description is the initial phase whereby the researcher becomes familiar with the data (Burns & Groves 2005:378). In this study, the researcher replayed the tape after the interview to listen to voice, tone pause and responses as well as to the entire content (Burns & Grove 2005:380). Codes and coding were used as a way of indexing or identifying categories of data. Several categories or codes could be identified within the data recorded for any given participants (Brink 1999:192). The categories that were sighted more frequently were identified and later compared with those of other participants so as to determine the final theme. Survival needs, psychosocial needs, developmental needs, traditional forms and emerging forms of care for OVCs were the main themes noted.

#### **3.7.1.3. Analysis**

Analysis goes beyond description because data is transformed and extended (Burns & Groves 2005: 382). In this process, there is identification of essential features of data and description of interrelations among them.

The researcher identified themes and patterns from the data. Coding was also used to expand, transform and reconceptualise data, providing opportunities for more diverse analysis.

#### **3.7.1.4. Interpretation**

Interpretation of the findings focused on the usefulness of the findings to the theory that guided the study. The researcher identified any relations between categories that could be used to formulate tentative propositions (Burns & Groves 2005: 382).

### **3.8. RESEARCH SETTING**

Zimbabwe is a landlocked country that covers an area of 390, 757 km<sup>2</sup> with an estimated population of 10.4 million (ZCSO 2005:7). It is bounded on the north and north-west by Zambia, south-west by Botswana, Mozambique on the east, South Africa on the south and Namibia's Caprivi Strip touches its western boarder at the intersection with Zambia. The country is divided into 10 provinces namely: Bulawayo, Harare Province, Manicaland, Mashonaland Central, Mashonaland East, Mashonaland West, Masvingo, Matabeleland North, Matabeleland South and Midlands.

Masvingo North District in Masvingo Province comprises Gurajena, Makoholi, Zimuto and Gokomere. These areas are home to the Karanga people although few other ethnic groups such as Zezuru and Manyika have settled in the area. The study was conducted in Gokomere, a rural area of the Masvingo Province. Gokomere consists of non-affluent people living in the sparsely populated settlements and have traditional leaders who are headmen of the villages. The community comprises four villages: Makandiwa, Chiramba, Chikumbedzi and Mhike.

The community of Gokomere falls in the category of semi-intensive livestock and subsistence agriculture. However, the community is frequently affected by droughts because it is located in region five which is characterised by low rainfalls. People in Gokomere practise animal husbandry to supplement their diet. The status of men in the village is assessed by the number of cattle they possess. These are the most prized possessions in the village. Other people in Gokomere engage in cross-border trading with neighbouring countries such as South Africa, Mozambique, Botswana

and Zambia. Some community members are employed at the Gathes and Shabani mines, which are located 30km south-east of Gokomere.

Most women and children in the community are involved in food gardening and looking after livestock. NGOs in Gokomere focus mainly on poverty-alleviation projects that are aimed at providing food security in the community. BHASO is one of the NGOs offering psychosocial support to families and children affected by HIV and AIDS in the community.

### **3.9. TRUSTWORTHINESS OF THE STUDY**

Trustworthiness exists if the findings of a qualitative study reflect accurately the experiences and the viewpoints of the participants and not the perception of the researcher (Polit & Beck 2008:537; Streubert Speziale & Carpenter 2003:38). Lincoln and Guba's model was used to ensure trustworthiness of the study (1985:294-3331). The model refers to four criteria of trustworthiness, which are credibility, transferability, dependability and conformability.

#### **3.9.1. Credibility**

Hollaway (2005:290) defines credibility as a quality assessment of whether the data convincingly describe the phenomenon under study. The study findings should reflect the context of where the study was conducted. According to Shenton (2004:64), credibility deals with the question: "How congruent are the findings with reality?" In this study, the following measures were used to ensure credibility.

##### **3.9.1.1. Prolonged engagement**

According to Lincoln and Guba (1985:302), prolonged engagement is the investment of sufficient time to achieve a certain purpose: learning the "culture; testing for misinformation introduced by distortions either of the self or of the participants and building trust." It also involves intense interaction with data collected. During the fieldwork phase of this study, there were prolonged interactions with participants

during data collection and the researcher engrossed himself in the data during verbatim transcriptions of audiotapes and during the data-analysis process, reading and re-reading the transcripts.

The researcher was in close contact with participants for four months during data gathering and while verifying themes and categories. The researcher had worked with OVCs at BHASO as an intern field worker for nine months before embarking on the study.

### **3.9.1.2. Member checking**

This is the opportunity for the participants to check the data for adequacy and provide additional information to fill gaps and correct errors in the data where the researcher might have misinterpreted the participants' responses (Babbie & Mouton 2001:277). In this study the researcher referred the analysed data back to the participants for review, validation and comments as well as corrections on the themes and categories. This was done to ensure that the participants who lived the described experiences confirmed that the reported findings represented their experiences. The trustworthiness of the findings was demonstrated in eight OVCs, eight caregivers and six members of NGOs/FBOs and church leaders, who all confirmed the reported research findings as accurately representing their feelings on the psychosocial needs of OVCs.

### **3.9.1.3. Peer debriefing**

Peer debriefing is a process that exposes the researcher to the critique of other researchers who are experienced in qualitative research or the phenomenon being studied or both (Polit & Beck 2008:548). The researcher exposed his work to a colleague for constructive criticism. The colleague acted as "devil's advocate" by critically searching for biases, theme identification and interpretation based on the data analysis and procedure that was followed by the researcher (Lincoln & Guba 1985:315).

The researcher also presented to the supervisor a written data version that had been collected with themes, categories and sub-categories that had emerged. The suggestions that came up from their discussion were incorporated into the study.

### **3.9.2. Transferability**

Transferability refers to the probability that the study findings have meaning to others in similar situations (Polit & Beck 2008:539). The potential user, not the researcher, determines whether or not the findings are transferable (Streubert Speziale & Carpenter 2003:29). These authors further states that the researcher should provide a research methodology and research findings database that makes a potential user able to judge transferability.

According to Krefting (1991:220), it is important that researchers provide dense information about participants, research context and setting to allow others to assess how transferable the findings are.

In this study, the findings were found to be congruent with Erikson's psychosocial theory of human development and other studies on the psychosocial needs of children. The literature review enhanced clarity by discussing what is already known about the needs of OVCs and this will allow other researchers to make judgements about transferability of the findings to other similar contexts. In the discussion of the findings of this study, relevant studies and articles on the needs of, and support provided, to OVC were used to establish commonalities and differences. The comparison was done as a means of strengthening the trustworthiness of the study.

### **3.9.3. Dependability**

Dependability refers to the stability of data over time and over differing conditions (Polit & Beck 2008:539). The study must provide its audience with evidence that if it were to be repeated under similar circumstances or context, it would yield similar results. It is the criterion that is obtained through securing credibility of the findings (Lincoln & Guba 1985:36; Streubert Speziale & Carpenter 2003:38). Shenton

(2004:71) noted that in order to address dependability more directly, the processes within the study should be reported in detail, thereby enabling the future researcher to repeat the work. According to Holloway (2005:289), a qualitative research report should provide a clear description of the path of decision-making process so that the trustworthiness or validity thereof can be established.

An audit trail, which requires that written strategies be developed to show how the researcher made certain decisions so that other researchers exploring similar situations can follow the same logic and arrive at the same conclusions was evident. This can be shown by the proper documentation of the transcribed interviews and data sources, the protocols for data collection and analysis, the findings and interpretations. The research objectives were checked by the research supervisor for clarity and congruency with the research design. The semi-structured interview guides were pretested and modifications were made based on the feedback given before the study was conducted. Findings were validated by the participants who confirmed that these accurately reflected their experiences.

#### **3.9.4. Confirmability**

The fourth criterion to measure the trustworthiness of qualitative research is confirmability. Confirmability is the degree to which the research findings can be confirmed or corroborated by others (Seale 1999). Polit and Beck (2008:539) further state that confirmability is a criterion for evaluating the quality of the data in terms of its objectivity and neutrality.

In this study, the research process was discussed in detail giving a complete picture of how the process was done. Data collection, analysis, interpretation and discussion on how conclusions were drawn for each category were presented. Coding of data by the researcher was checked, and these showed adequate agreement. The findings, conclusions and recommendations were supported by the data collected and analysed. The researcher's interpretation of the data on the psychosocial needs of OVCs was examined by the researcher's supervisor and colleagues.

### **3.10. ETHICAL CONSIDERATIONS**

De Vos (2005: 57) defines ethics as “a set of moral principles which is suggested by an individual or group” and “is widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects...” In the social sciences, ethical decision-making requires complex decisions to be made about the study participants. The study abided by the ethical considerations of privacy, anonymity, confidentiality, informed consent, debriefing and avoidance of harm.

#### **3.10.1. Privacy**

The right to privacy is the individual’s right to decide when, where, to whom and to what extent his/her attitudes, beliefs, and behaviour will be revealed (De Vos 2005:61). The privacy was also maintained by not attaching participants’ real names to the information. Possible identification of participants in the tape-recorded interviews was removed before transcriptions were made. Tapes were locked up in a safe place where only the researcher had access. During interviews, the researcher collected only the necessary information. The rights, interests and the wishes of the participants were considered at all times in this study.

#### **3.10.2. Confidentiality**

Confidentiality means that no personal information that the participants divulge is made public or available to others (Brink *et al* 2006:35). The researcher ensured that confidentiality was maintained and that participants were treated with dignity and respect. The researcher kept in strict confidence the identity of the participants. Even when quoting information in the reporting of findings, there was no linking of the participants with the quotations. The data gathered was kept in a safe place and was only made accessible to the supervisor. To further ensure confidentiality, the names of the places where the interviews were conducted were not mentioned in the report. Participants were given pseudonyms to safe-keep their identities.

### **3.10.3. Informed consent**

The researcher's request for permission to conduct the study was forwarded to the village headman of Gokomere, the Masvingo North District Council, the Ministry of Education, Sport and Culture (MoESC) and NGOS/FBOs (see Annexure G) and written permission was obtained (See Annexure H). Furthermore, participants were provided with information about the purpose, objectives, risk and non-risk aspects of the research to enable them to make informed decisions especially on whether to participate or not (Heath, Charles, Crow & Wiles 2004:2). Participants were assured that they had the right to withdraw from the research at any time. Written informed consent and assent forms were available for the participants to sign for the purpose of data collection (See Annexure D, E and F).

### **3.10.4. Debriefing**

The purpose of debriefing is for the respondents to reflect on the experience of the interview and emotions that resulted from the study. De Vos (2005:66) alludes to the fact that after completion of the study, the researcher has to rectify any misperceptions that may have arisen in the minds of participants. Due to stigma and discrimination associated with HIV and AIDS, participants who were affected were debriefed by the researcher who is a qualified social worker and some were referred to the Department of Social Welfare for such services. The researcher used the offices at BHASO to conduct counselling as a form of debriefing of study participants. Only three OVCs were involved in debriefing sessions with the researcher. One case in which an OVC was in need of material assistance was referred to the Department of Social Welfare in Masvingo.

### **3.10.5. Avoidance of harm**

OVCs affected by HIV and AIDS can be harmed in a physical or emotional manner. An ethical obligation rests with the researcher to protect subjects within reasonable limits from any form of physical, mental or emotional discomfort that may emerge from the study (De Vos 2005:58). Although emotional harm is more difficult to

predict, respondents were thoroughly informed beforehand of the potential impact of the study, for example, secondary bereavement of the OVCs.

The interviews were conducted in a quiet and private place (own homes for OVCs and caregivers) where the participants felt safe and comfortable and where the possibility of the discussions being overheard by others was eliminated. The researcher spent time after the interview with the OVCs and caregivers to ensure that they were emotionally stable and gave each an opportunity to reflect on the interview and to express their feelings. This study did not result in any emotional harm to OVCs who took part in the study.

### **3.11. CONCLUSION**

In this chapter, various methodological steps followed in conducting the study were discussed. The research design was stated as having been exploratory, descriptive and qualitative in nature. Data collection and analysis methods that were followed during fieldwork were discussed. The study utilised individual in-depth interviews with OVCs and caregivers who participated in the study. A focus-group discussion was also conducted with key informants. Before data was collected, the researcher ensured that the objectives of the study were clearly explained to the participants. The data that were gathered were transcribed and coded to identify major themes, categories and sub-categories. Lincoln and Guba's model was used to ensure trustworthiness of the study. The chapter also discussed ethical issues to ensure that the rights of participants in this study were protected.

In the next chapter, Chapter 4, the findings of the study and an outline of the themes that emerged during the data analysis will be discussed.

## CHAPTER 4

### DATA ANALYSIS AND INTERPRETATION

#### 4.1. INTRODUCTION

In the previous chapter, the research design and methodology to conduct this study were discussed. In this chapter, data generated through the fieldwork relating to the psychosocial needs of OVCs affected by HIV and AIDS as expressed by the OVCs, caregivers and members of NGOs/FBOs are analysed and presented in terms of the themes, categories and sub-categories as depicted in Table 2 below:

**Table 2 Schematic presentation of the findings**

<b>THEMES</b>	<b>CATEGORIES</b>
Survival needs	<ul style="list-style-type: none"><li>• Need for clothing</li><li>• Need for food</li><li>• Need for shelter</li><li>• Need for healthcare</li></ul>
Developmental needs	<ul style="list-style-type: none"><li>• Educational needs</li></ul>
Psychosocial needs	<ul style="list-style-type: none"><li>• Need for relationships</li><li>• Emotional needs</li><li>• Spiritual needs</li><li>• Need for succession planning</li><li>• Need for social protection</li></ul>
Traditional forms of care for OVCs	<ul style="list-style-type: none"><li>• Kinship care</li><li>• Non-kinship care</li><li>• Institutional care</li><li>• Adoption</li></ul>
Emerging forms of care for OVCs	<ul style="list-style-type: none"><li>• Home-based care (HBC)</li><li>• Child-headed households (CHHs)</li></ul>

Table 2 indicates that the analysis of the individual interviews and focus-group discussion generated five major themes, namely: psychosocial needs; developmental needs; survival needs; traditional forms of care for OVCs and emerging forms of care for OVCs.

Before the findings of the study can be discussed, it is important to first look at the biographical profile of the participants.

## 4.2 BIOGRAPHICAL PROFILE OF PARTICIPANTS

Tables 3, 4 and 5 depict the biographical profile of the research participants. Please note that pseudonyms have been used as names for the participants.

**Table 3 Biographical profile of key informants**

<b>Name</b>	<b>Gender</b>	<b>Position at work</b>	<b>Educational qualification</b>
Mr S. Runyoka	Male	Programmes Manager	BA. Social Work, MA. Social Work & Diploma in Business Administration
Mrs C. Dehwa	Female	Supervisor	Honours in Social Work
Mr T. Mangu	Male	Supervisor	Honours in Sociology
Mr T. Maruta	Male	Programmes Coordinator	B.A. Development Studies
Ms B. Jena	Female	Priest	B.A. Religious Studies
Mr E. Makandiwa	Male	Priest	Diploma in Pastoral Studies

Four of the key informants who participated in this study were male and only two were female out of the six who participated in the study. Five of the participants had university degrees and one had a diploma as depicted in Table 3 above. The key informants had influential positions in the organisations where they were working.

It is important to note that the OVCs who participated in the study were doing their secondary education. A total number of three OVCs were living with HIV while the other five OVCs were living with caregivers who are living with HIV. Pseudo names were also assigned to the OVC participants as in Table 4.

**Table 4 Biographical profile of OVC participants**

<b>NAME</b>	<b>AGE</b>	<b>GENDER</b>	<b>SCHOOLING</b>
Sipho	15	Male	Form 2
Tom	14	Male	Form 1
Abi	15	Female	Form 3
Sarah	15	Female	Form 2
Danny	13	Male	Form 1
Elly	15	Female	Form 2
Sama	15	Female	Form 2
Eddy	15	Male	Form 1

Table 4 indicates that four female OVCs and four male OVCs participated in the study. Their ages ranged between 13 and 15 years old with six OVCs being 15 years old. All the OVCs were going to school and their grades ranged between Form 1 and Form 3 (which is equivalent to Grade 8 and 10 in South Africa). The three OVCs who were living with HIV were on anti-retro therapy (ART) while the other five OVCs were reported to be in good health.

**Table 5 Biographical profile of caregivers**

<b>NAME</b>	<b>AGE</b>	<b>GENDER</b>	<b>MARITAL STATUS</b>	<b>NO. OF OVCS CARED FOR</b>
Ms Gogo	55	Female	Widowed	1
Mr Blue	52	Male	Married	6
Ms Green	25	Female	Single	1

Ms Red	66	Female	Widowed	1
Ms Black	55	Female	Married	2
Ms Pinky	38	Female	Married	1
Ms Yolanda	53	Female	Widowed	4
Ms Masvo	43	Female	Married	None

Pseudo names were also assigned to each of these participants. Most of the caregivers were staying with their grandchildren. Four of the caregivers depended on subsistence agriculture, two depended on money sent by family members who work in town or other countries while one was a teacher and one was retired. The average children per caregiver were two. One of the caregivers had six OVCs in his care as shown in Table 5 above. One of the caregivers was an HBC volunteer and did not have an OVC in her care.

### **4.3. FINDINGS OF THE STUDY**

As stated above, the findings of this research relate to the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere as discussed with OVCs, caregivers and members of NGOs/FBOs. The themes and categories that emerged during the analysis of the data gathered for this study will be discussed in detail below.

#### **4.3.1 Theme 1: Survival needs**

Although the study seeks to explore the psychosocial needs of OVCs affected by HIV and AIDS, the survival needs (food, clothing, shelter and healthcare) were found to play a crucial role in meeting the psychosocial needs of OVCs. According to caregivers and key informants, the lack of fulfilment of survival needs of OVCs affected by HIV and AIDS proved to have negative effects on the psychosocial adjustment of OVCs.

**Table 6 Survival needs**

Theme	Category
Survival needs	<ul style="list-style-type: none"><li>• Need for clothing</li><li>• Need for food</li><li>• Need for shelter</li><li>• Need for healthcare</li></ul>

#### **4.3.1.1 Category 1: Need for clothing**

The need for clothing was found to have social and health effects on the lives of OVCs affected by HIV and AIDS. The category dealing with the need for clothing has further yielded sub-categories as highlighted in Table 7 below.

**Table 7 Need for clothing**

Category	Sub-category
Need for clothing	<ul style="list-style-type: none"><li>• Social impact</li><li>• Health impact</li></ul>

##### *4.3.1.1.1 Social impact*

OVCs who participated in the study indicated that they need proper clothes in order for them to socialise freely with their peers. Normally when OVCs do not have proper clothes, they withdraw from social environments such as schools, feeling ashamed of their appearance. The researcher observed that OVCs endeavour to be accepted by their peers by conforming to a particular code of dressing. These OVCs expressed the following views:

*“Having nice clothes makes me feel comfortable when I am with my peers”*  
(Danny).

*“Love is the most important thing... But we also need to be well clothed just like our peers and friends at school. Sometimes we feel out of place wearing torn clothes while others are wearing nice clothes” (Tom).*

*“It means that our uncle is now our father and he is the one who will take the place of my father. He will be the one responsible for us. He should make sure that we eat, we are clothed and we go to school” (Elly).*

There were also general sentiments amongst the OVCs who participated in the study that NGOs and the government should be responsible for providing clothing for OVCs in need as expressed by the following statements made by OVCs:

*“I think despite subsidising for our health and educational fees, the government should also provide clothing for orphans” (Sipho).*

*“NGOs should work together with the government so that they can provide clothing and nice houses for us” (Eddy).*

*“NGOs should give us food, clothing and books for school” (Danny).*

*“The community and NGOs should help us by providing us with clothing because we do not have enough clothes” (Eddy).*

#### *4.3.1.1.2 Health impact*

Although it was noted that clothing is important to ensure OVCs are able to socialise freely with their peers by conforming to particular dressing, OVCs who participated in the study indicated to the researcher that they also need to be protected against harsh weather. This is especially in the winter season as expressed by the following statements made by OVCs:

*“They should give us food and nice place to stay. “Pandinogara nagogo vangu tinongori nezvimba zviviri zveuswa” [Where I stay with my grandmother we*

*only have two small thatched houses]. Sometimes when it's raining it will be leaking. Caregivers from organisations should also give us clothing and blankets because it will be very cold in winter” (Sama).*

*“NGOs should provide us with blankets especially in winter when it would be very cold” (Elly).*

*“It's difficult to go to school in winter especially if you don't have a warm jacket to wear. We end up catching flu because it will be very cold” (Eddy).*

#### **4.3.1.2. Category 2: Need for food**

The provision of food for OVCs in the community is hampered by drought year after year as most of the people in the community depend on subsistence farming. The need for food has social and health effects for OVCs and these aspects are depicted in Table 8 below.

**Table 8 Need for food**

<b>Category</b>	<b>Sub-category</b>
Need for food	<ul style="list-style-type: none"><li>• Impact on social integration</li><li>• Impact on health</li></ul>

##### *4.3.1.2.1. Impact on social integration*

One of the OVCs (Sama) who participated in this study indicated that she feels isolated when she goes to school with food that is disregarded by her peers at school. She believes that OVCs do not feel comfortable when they go to school with *“baked maize”* instead of the widely accepted *“bread”*. OVCs feel ashamed when their level of poverty is exposed to their peers at school.

*“We lack food especially when it is close to month end before we go to collect our food parcels. So sometimes the food will be finished before we get to month end and if you explain that to other children they won’t understand. “Saka ndinotoenda kuchikoro nemaputi asi vamwe vana vanenge vane chingwa” [So we go to school with roasted mealies while others take along bread] (Elly).*

*“I can’t be going with groundnuts to school while my friends are having bread. It makes me feel out of place” (Sarah).*

*“I feel so ashamed when I am with my peers at school because I won’t be having proper food to share with them... I want to also come with bread just like my friend not with sadza [pap]” (Abi).*

The care for OVCs is putting a strain on the caregivers as far as food provision is concerned. Caregivers who participated in the study indicated that they do not have enough to provide for OVCs in their care. In this regard, Mr Blue and Ms Gogo expressed the following views respectively:

*“Yes they are getting food but it’s not enough. I also do not have enough capacity to provide for them as far as food is concerned.”*

*“All my children are working in town and they sometime send money so that I can be able to provide but the money they send is not enough for me to be able to fully provide for the OVCs in my care.”*

To supplement nutrition, farming was reported to be the only way caregivers can provide for OVCs. The community has embarked on low-input gardens where they acquire the farming inputs such as fertilisers, pesticides and seed from NGOs to increase their yields. Low-input gardening refers to a system of crop growing that reduces the amount of energy and water one uses for growing crops. In this regard, caregivers and OVCs highlighted the following:

*“Yes they are getting food but it’s not enough. Farming is the main source of food in this community; therefore we have started low-input gardens whereby we give the community farming inputs to increase yields... As you know most of the people here in Gokomere are poor and don’t have money to buy farming inputs; we group people into small cooperatives and give them seeds and fertilisers” (Mr Blue).*

*“Food is never enough for everyone even for children who have both parents. This is mainly because the community relies on subsistence agriculture, which is mostly affected by draughts. As a result, most families will not be able to provide for their children. Therefore OVCs are subjected to the same predicaments as any other children who have parents but for the OVCs it is more difficult because they do not have parents” (Ms Masvo).*

*“I sell the cattle that I got from my father’s inheritance. Sometimes I have to sell surplus of agricultural produce while sometimes I get money from my boyfriend who is working in town [Masvingo]” (Ms Green).*

The need for food has also put strain on individual OVCs. Eddy, an OVC who was heading a household indicated that he had to make sure that after school he maintained the food garden. Eddy noted the following:

*“We are getting some food parcels from BHASO but I think in the next rainy season I will make sure I will plough some crops that can sustain us. Sometimes we also get assistance from the village headman. He gives us 50kg of maize, which we take to the grinding mill for mealie meal. Every day after school I have to maintain our vegetable garden so that we always have a meal” (Eddy).*

However, some participants reported that the *Zunde raMambo* is helping the OVCs as they acquire food from the chief or village headman. The food OVCs acquire from the *Zunde raMambo* is in most cases in the form of maize grains as expressed by the following statements:

*“We have Zunde raMambo whereby the community give a certain percentage of their agricultural produce to the chief of the village. The chief will keep all the received produce in his granary with the purpose of feeding the needy children and other vulnerable groups in the community” (Mr Blue).*

Key informants and caregivers who participated in this study indicated that the *Zunde raMambo* practice is no longer common in the community. The general perception among the key informants was that the *Zunde raMambo* can play a very important role in boosting the food provision for OVCs affected by HIV and AIDS. In regard to this, one caregiver and two key informants expressed the following views:

*“For me Zunde raMambo practice still needs to be reintroduced since it was helpful by ensuring that OVCs are fed” (Mr Runyoka).*

*“I think the other practice that used to be so helpful is called Zunde raMambo whereby the community could contribute farming inputs and their labour to plough the field of the chief. The yields of that field would be used to feed vulnerable people including families with OVCs. In so doing, it lightens the burden of the caregivers” (Mr Runyoka).*

*“We also have Zunde raMambo whereby the community give a certain percentage of their agricultural produce to the chief of the village. The chief will keep all the received produce in his granaries with the purpose of feeding the needy children and other vulnerable groups in the community” (Mr Blue).*

#### *4.3.1.2.2. Impact on health*

OVCs that are living with HIV are encouraged to eat before they take their ARV treatment. Two OVCs who participated in the study are benefiting from the food parcels they are given from the clinic and from NGOs. In regards to this, the OVCs said the following:

*“At the clinic, they encourage us to eat before we take our ART treatment”*  
(Elly).

*“Yes, I am getting enough food because my mother gets food from the clinic and I also get food for OVCs from BHASO. We also get food from our ploughs”* (Elly).

*“My aunt takes us to the clinic when we are sick. We also get some food at the clinic”* (Danny).

The food parcels OVCs get from the clinic and NGOs normally include beans, maize meal and cooking oil. Families with members who are living with HIV are encouraged to eat beans, which are rich in protein. Mr Runyoka, a key informant indicated that in Gokomere the lack of food leads to malnutrition in the case of many OVCs. He expressed the following:

*“Some are even affected by malnutrition, they show signs of kwashiorkor, which means that they are not getting enough food... You see by a protruding abdomen.”*

#### **4.3.1.3. Category 3: Need for shelter**

The researcher observed that the shelter for OVCs in Gokomere is commonly characterised by traditional dwelling units, which are found in the old-style family settlements. Here a number of buildings are made of farm bricks or mud, with thatched roofs. This observation is substantiated by the following remarks from OVCs:

*“The other thing the government should do is to build houses for OVCs especially those who are like me who stay alone without parents. The house I built for myself can collapse any time when it rains because it’s made of mud”*  
(Eddy).

*“The houses OVCs are staying in are not in good condition; they are collapsing because they are not properly thatched and the farm bricks are not of good quality” (Danny).*

*“Patinogara naGogo vangu tinongori nezvimba zviviri zveuswa... Sometimes when it’s raining it will be leaking” [Where we are staying with my grandmother we only have two small thatched houses] (Sipho).*

The above quotations highlight that the conditions of houses where OVCs stay are very poor: Some OVCs mentioned that most of the houses had thatched roofs that were leaking. Deteriorating leaking thatched housing conditions were prevalent especially with regards OVCs in CHH. One caregiver and one key informant noted the following:

*“Those who have relatives who look after them are properly sheltered but those who are staying alone normally live in poor shelter with leaking thatched roofs” (Ms Green).*

*“Normally the shelters for OVCs are not well maintained and are not in good condition... Most of OVCs’ shelter, especially those who are staying alone, are collapsing and have leaking roofs” (Mr Runyoka).*

#### **4.3.1.4 Category 4: Need for healthcare**

One key informant noted that although medical services are available to OVCs and other vulnerable people, the cost of the medicine is in most cases the responsibility of the needy person. Members of the community end up selling their assets such as cattle and goats to afford medical expenses. Ms Dehwa recognised that the health needs of OVCs had to be fulfilled to enable them to develop their potential as expressed by her statement below:

*“Most of the families end up selling their household valuables like goats and cattle so that they can have money to buy medication for the sick family*

*member or so that they can be able to take the member to the doctor. Some use the money to buy nutritious food for the affected person in the family.”*

The study's findings revealed that OVCs' health needs are met through community-established HBC services with the help of NGOs as expressed by the statement of Mr Runyoka below:

*“At BHASO we have so many programmes that support OVCs and other people living with HIV and AIDS (PLWHA). We have a psychosocial support programme whereby we directly deal with OVCs – we normally go camping with children who are orphaned and we talk about issues that affect them. We also do many games that build trust and resilience in OVCs. We also have the New Life department, which deal with HIV tests, pre-and post-test counselling. We also have HBC department, which trains caregivers in home-based care, its advantages and disadvantages.*

There was general consensus among study participants that home-based caregivers also ensure that PLWHA adhere to their treatment as expressed by the following statement by one of key informant:

*Lastly we have positive development, which deals with encouraging the community to adhere to treatment and to take other traditional herbs to boost their immune system” (Mr Runyoka).*

In HBC, caregivers encourage parents who are ill to write wills. The advantage of HBC is that parents get a chance to discuss their wills with their children before they die and children also get to inform their parents about their wishes. In this regard, one OVC and one caregiver noted the following:

*“It was hard, I wanted to see him and tell him that I love him but unfortunately I was not allowed in the wards. However, my father was released from the hospital so that he could be cared for at home and that is when I got a chance to talk to my father” (Tom).*

*“Normally they get support from HBC caregivers who go around visiting sick people at home. They prepare the children for the impending death of their parents and they ensure that children discuss what they want to happen when their parents die. Even after the death of parents, home-based caregivers also support OVCs by ensuring that the arrangements that were made before the parents died are followed” (Ms Yolanda).*

### **4.3.2 Theme 2: Psychosocial needs**

The data gathered on the psychosocial needs of OVCs affected by HIV and AIDS have been categorised as: the need for relationships; emotional needs; spiritual needs; the need for love and nurturing; and the need for social protection. These categories have further yielded sub-categories as indicated and discussed below.

#### **4.3.2.1 Category 1: Need for relationships**

The study has found that the relationships of OVCs with their peers play a positive role in the OVCs’ development. The need for relationships relates to the need for peer association, relationships with older people and communication. Table 9 below depicts the sub-categories for category 1.

**Table 9 Need for relationships**

<b>Category</b>	<b>Sub-category</b>
Need for relationships	<ul style="list-style-type: none"> <li>• Need for peer association</li> <li>• Relationship with older people</li> <li>• Communication</li> </ul>

##### *4.3.2.1.1 Need for peer association*

From the findings, there appears to be a positive relationship between involvement with friends and the psychosocial adjustment of OVCs affected by HIV and AIDS. OVCs seem to rely on friends for a sense of self-worth and they encourage each

other to be patient with their elderly caregivers and infuse a sense of responsibility with regard to their own lives by helping each other to deal with their personal problems. The intimacy, trust and comradeship OVCs seem to have with their peers especially those who find themselves in a similar situation may fill the gap left by their deceased parents. OVCs encourage each other and help each other with schoolwork and household chores, as is evident in the following statements made by OVCs:

*“My friends will be encouraging me to be patient with my grandmother because they know that she is old. Sometimes my friends would come and help me with cleaning and fetching water” (Sama).*

*“It means I have people who like me and who appreciate me as I am despite being an orphan, unlike other people who would not want to be associated with orphans” (Abi).*

*“With Davy, my friend, we talk about our personal problems and he helps me deal with my problems but with other friends of mine we talk about general things” (Tom).*

*“Aah...well one of my friends is orphaned and the other has both parents. So I normally talk to my friend who is in the same situation as me because she would understand most of my problems but when we are together the three of us, we talk about school or any other general things. I only want to be happy and when I am with my friends it’s the only time I would be happy” (Sarah).*

*“My friends are important because there are some things I cannot talk about with my mother that I can talk only to my friends” (Elly).*

*“My friends help me a lot when we are at school to understand some of the school things I won’t be in a position to understand” (Eddy).*

However, the responsibilities OVCs have at home can have an impact on the relationships they have with their peers. OVCs themselves and some caregivers pointed out that some OVCs are made to do work at home such as cleaning, fetching water and cooking. Often they do not have the time to interact with their peers as is expressed by the following OVCs and caregivers:

*“Yoh, you don’t know my aunt!! She will be saying that we are running away from doing household chores. It is boring because you would be seeing other children going to church” (Sarah).*

*“Most of the time I will be helping my aunt with household chores” (Sipho).*

*“They do not have time to play with friends because some OVCs are taken as labourers by relatives who use them to look after their cattle” (Ms Green).*

*“They play with their friends at home as well unless they are doing some chores at home” (Ms Yolanda).*

*“I have to help our housemaid to cook and also to ensure that my young sisters do their homework” (Danny).*

Although OVCs rely on friends for a sense of self-worth, instances of stigma could not be ruled out and this kind of stigma was related to the physical appearance of OVCs. Some of the caregivers who participated in this study informed the researcher that OVCs in most cases will isolate themselves from other children, citing that their peers are unreceptive as evidenced by the statements below:

*“Vanotiseka, hanzi vane chena patinenge tisina kugeza [People laugh at us when saying we are ashen when we are not bathed]” (Tom).*

*“Vane rusarura [They are discriminatory]. In most of the time they do their own things and they run away from me” (Danny).*

*“Therefore OVCs will fail to understand death when there is no one who can talk to them. Eventually OVCs end up isolating themselves from others – they will be feeling unloved and unwanted by their peers and members of the community” (Ms Pinky).*

*“The problem is most of the OVCs do not want to play with other children. They prefer staying at home rather than playing because they are afraid to be called names by their peers” (Ms Green).*

Some of the OVCs are called names like *“nherera”* (orphans) which makes OVCs to become emotionally vulnerable and develop a feeling of self-pity, self-doubt and low self-esteem as expressed by the following OVCs:

*“They call us with names and call us ‘nherera’, which makes me feel very sad” (Sipho).*

*“Hazvirevi kuti kana ndiri nherera vanhu vanditora sebenzi kana kuti vondibata sezai nokuti vanotywa kuunza ndangariro dzekufiwa [It doesn’t mean that because I am an orphan people should take me for a fool or they should treat me in a very special way fearing that they can awaken the memories of my deceased parents]. We are just like any other children and we should be treated just the same. At the same time people should not call us names” (Abi).*

*“I don’t like the comments people give about me and my parents. Some will be calling me names saying, ndosaka uchigara nambuya” [That’s why you are staying with a grandmother] (Sama).*

#### *4.3.2.1.2 Relationships with older people*

Most of the OVCs reported that they need to form relationships with older people who can guide them to make decisions in life. According to the OVCs who participated in this study, their relationships with older people should be nurturing in

nature and be equated to the relationship OVCs used to have with their parents before their death. Although OVCs encourage each other to be patient with their elderly caregivers, the researcher found that OVCs liked to talk to older people such as grandparents, uncles, aunts or church elders when they had problems. OVCs seem to require relationships with elderly people who can be good role models to them in life and who can also help them to deal with their problems. Reflecting on the need for relationships with older people, OVCs mentioned:

*“Elders at church give us guidance. They are older people who are responsible for the church” (Sipho).*

*“We need caregivers who would lead us by example, by doing good things we can follow. Caregivers should show concern, love and care for us” (Abi).*

*“I need someone who will be like a real mother to me. Someone I can open up to and can help me without judging” (Sarah).*

*“He [Danny’s father] supported us by talking to us, I always feel relieved when someone talked to me about what happening when my mother was ill” (Danny).*

*“Yes, I look after my mother and she looks after me as well. However, we are looking up to my uncle since he is the one who is responsible for us. We are looking forward that he should be there for us when we need him” (Elly).*

*“My grandmother was always there; it gave me confidence that whatever was going to happen to my parents, my grandmother would ensure that I was protected, loved and cared for” (Sama).*

*“Since we started to stay alone, she is the only one who is coming to check on us and talk to us. If we have a problem, she [Eddy’s aunt] is the one I can talk to and she shows that she has time to listen and she will help us” (Eddy).*

#### 4.3.2.1.3 Communication

In this study, the researcher noted that communication is important in nurturing the relationship between OVCs and their caregivers. The general feeling among some OVCs who participated in the study was that they needed to communicate with caregivers about their personal problems, parental illness and death, but caregivers themselves are often unable to identify and manage children's distress constructively and positively. In this regard, OVCs stated that:

*"I don't like people who don't believe me when I say something to them, especially adults. It makes me miss my mother because my mother used to listen to me" (Abi).*

*"Sometimes as a young girl you would like a person who treats you like a real child, for instance when you start your menstrual cycles. You need someone like a parent you would talk to. If I had a mother to talk to about such things, it would be better for me instead of asking things from friends who in most cases do not know anything" (Sarah).*

*"He [Danny's father] supported us by talking to us, I always feel relieved when someone talked to me about what happening when my mother was ill" (Danny).*

Caregivers normally assume that *"time will heal"* when OVCs are struggling to come to terms with the death of their parents. In this regard, Ms Yolanda stated that:

*Some take them for counselling but most caregivers just leave it like that...saying "zvichapera hazvo" [time will heal].*

#### 4.3.2.2 Category 2: Emotional needs

Emotional needs have been categorised as the need for bereavement support, the need for guidance and counselling, the need for support groups and the need for

appropriate socialisation. These aspects of emotional needs are depicted in Table 10 below.

**Table 10 Emotional needs**

Category	Sub-category
Emotional needs	<ul style="list-style-type: none"> <li>• Bereavement support</li> <li>• Need for guidance and counselling</li> <li>• Need for support groups</li> <li>• Need for appropriate socialisation</li> </ul>

#### 4.3.2.2.1 Bereavement support

Some caregivers and OVCs who participated in this study indicated to the researcher during the data-collection process that the community of Gokomere normally gathers as religious groups or have traditional beer while consoling the children of the deceased parents. The tradition of brewing beer after the death of a parent was also noted to play a crucial role in easing the emotions of OVCs. This practice is called *kurova guva* and dramatises the common bond between the living and the deceased. The importance of *kurova guva* is therefore to help the OVCs to cope with death and overcome the daily problems they come across, knowing that their deceased parent is among them. Reflecting on bereavement support, OVCs and caregivers said:

*“People do it differently, some do a church memorial service while others brew beer to appease the ancestors and call back the spirit of the deceased”* (Eddy).

*“In most cases the relatives of the deceased brew traditional beer on the day and slaughter a cow. There will be a gathering that will be composed of the relatives. This practice is called “nyaradzo/kurova guva” and by doing this*

*they will be calling the spirit of the deceased to come and look after the children” (Ms Gogo).*

*“Mmhh..., normally people do traditional memorials. By doing this, they believe that they are bringing back the spirit of the deceased parents to look after the children” (Ms. Green).*

*“It depends with families. I know of a tradition whereby a family brew beer and slaughter a cow. There will be a bull in the kraal that will be chosen by the family. That bull will be given the name of the deceased person. The family will pour beer on the bull calling the spirit of the deceased to come into the bull to protect the children” (Ms Black).*

*“Eeemm...I am not sure about the traditional practices people do...there is a tradition whereby the affected family brew beer at the grave... “...and what what...” I don’t know what they really do” (Ms Masvo).*

On the other hand, some of the caregivers indicated that church memorial services are normally done or arranged by the members of the same church of which the deceased was a member. Some would contribute food, money and also help the OVCs with arranging the funeral. The money that is contributed by church members for the funeral is called *chema* and it helps in buying what will be needed at the funeral. Most of the OVC who participated in this study informed the researcher during interviews that members of the church helped them with the funeral arrangements. These sentiments were expressed by OVCs and a caregiver as below:

*“Members of the church helped us a lot. They are the ones who arranged for the burial of both of my parents. They also provided food for people at the funeral” (Sama).*

*“We just do our church memorial services after the death of a person” (Ms Green).*

Affected children would bring flowers that would be put on the grave of the deceased to symbolise their love. In this regard, Ms Pinky noted that:

*“On the other hand, guardians take OVCs to the grave of their parents with flowers, which symbolise love. OVCs will put the flowers on the grave while saying what they wish their parents can do for them.”*

One caregiver indicated to the researcher that OVCs are sometimes marginalised from the experience of death and some are sent to distant relatives so that they are not part of the funeral proceedings. Ms Jena indicated that:

*“The problem we have in coming up with a comprehensive bereavement support is the silence that is associated with death. OVCs are not allowed to talk about the death of their parents. Some are sent away during the time of the funeral, which leads to OVCs feeling confused and depressed about the death of their parents.”*

It appears as if the community believes that when OVCs are distanced from the funeral, they come easily to terms with the death of their loved ones. This was noted by Ms Pinky who informed that:

*“Normally children are taken to stay with a relative for some time. Guardians think that when OVCs are far away from the place where their parents die, it will help them to forget about death.”*

#### *4.3.2.2.2 Need for guidance and counselling*

Caregivers who participated in the study indicated that OVCs need counselling before and after the death of a parent. They pointed out that the counselling that is provided to OVCs in most cases is informal counselling, which is provided by elders in the community who do not have an educational qualification to execute the task. Nevertheless the use of the elderly people who are not qualified for such services

has proven to be very effective in meeting the guidance and counselling needs of OVCs. Caregivers remarked that:

*“Before the death of their parents OVCs get counselling. Immediately after the death of parents, OVCs get bereavement counselling although this form of counselling might not be formal as well. Despite counselling, OVCs are quickly linked to the members of the extended families so that a person who can take care for them is quickly identified”* (Mr Blue).

*“The elders encourage the affected children to have focus in life and ensure that they are counselled on all the issues of grief”* (Ms Black).

*“Yes, the same people [the elderly] provide the support... and normally it’s in the form of adult counselling”* (Ms Masvo).

*“They get support from community elders in the form of counselling and the community can also provide clothing and food to vulnerable children like OVCs”* (Ms Black).

*“There are some individuals here in the community who can talk to the children so that they come to terms with the death of their parents. For example, older people who might not necessarily be relatives but who are gifted in counselling”* (Ms Gogo).

*“It is very effective, we old people have a lot of experience with life and young people can use our experience to make decisions in life”* (Ms Red).

Two key informants, Mr Maruta and Mr Makandiwa, in a FGD suggested that there is a need to utilise the effectiveness of informal counselling done by the elderly in the community by providing training to the elderly to enhance their role. They suggested that:

*“What I can suggest is to use community elders as informal counsellors for OVCs”* (Mr Maruta).

*“I suggest that we need to empower these community elders by offering some training on counselling” (Mr Makandiwa).*

Professional counselling is not readily available for OVCs affected by HIV and AIDS. There were also reports by key informants that some caregivers cannot afford the bus fare to take OVCs for professional counselling in town, while others cannot afford to pay for such services as indicated in the following statements below made by a key informant:

*“What Ms Dehwa is saying is true but we also have to consider the community we are dealing with. Gokomere is an impoverished community and most people cannot afford to send their children to counsellors. Some cannot even afford the bus fare for the child to go to Masvingo where they can find professional counsellors. Although it is a good point that OVCs should be taken for counselling, the viability of this is impeded by financial costs” (Mr Maruta).*

Some of the OVCs who participated in this study indicated that they have used the services of nurses at the clinic for guidance and counselling. The counselling services provided by the clinic emerged as a very important community resource, providing adjunct support in addition to informal counselling by elderly people in the community. This service afforded the opportunity for OVCs affected by HIV and AIDS to talk to nurses about issues such as ART, adherence to treatment and healthy living as expressed by the following OVCs:

*“At the clinic, nurses also encourage me to eat healthy food and also to be consistent in taking my medication. They also encourage me to do exercises so that I keep my body strong and fit” (Sama).*

*“They would also teach us how to prepare herbs that are recommended for HIV-positive people” (Elly).*

*“She would just encourage me to go to the clinic and take my ARVs since I am HIV positive” (Sama).*

*“Nurses at the clinic and people at Red Cross always help me when I have a problem” (Elly).*

#### 4.3.2.2.3 Need for support groups

There are not enough available support groups in the community to cater for the increasing needs of OVCs. The general perception of the study’s participants was that support for OVCs from the community was minimal and hence there was a need for support groups for OVCs. Three OVCs and one caregiver mentioned the following:

*“OVCs should also form their own support group where they can talk about issues affecting them without discrimination” (Sipho).*

*“Sometimes I will be feeling unloved hence it is always important to have support groups with other children or other OVCs so that we can share our experiences” (Abi).*

*“In most cases I get enough food because I get food from the clinic when I go and take my pills and also when I attend the support groups” (Sama).*

*“We have support groups for OVCs. We offer counselling through our New Life department to OVCs and other people infected and affected by HIV and AIDS. We also do capacity-building workshops in the community to ensure that people adhere to treatment and boost their immune system” (Ms Dehwa).*

However, support groups for OVCs are not the only way needs of the OVCs affected by HIV and AIDS are met. Some caregivers who look after OVCs felt that they needed to form support groups for the caregivers of OVCs so that they could deal better with the needs of OVCs. In regard to this, three caregivers noted the following:

*“They [caregivers] need to be taught to have patience which children. They need to form support groups so that they can learn about the needs of OVCs” (Ms Black).*

*“They [religious groups] can also form support groups that helps the OVCs with prayers and any other coping mechanism when faced with difficulties” (Ms Gogo).*

*“Yaah..., I can now say I do have experience because for the past three years I have been involved with Batanai (BHASO) and I have being taking care of the six children I told you I have. I also have the opportunity to meet other caregivers and we shared different experiences we have with OVCs” (Mr Blue).*

It is in these support groups that caregivers should *“learn to be patient”* (Ms Masvo) with OVCs and to provide for their needs. Caregivers would share different experiences about the OVCs they are looking after and in so doing they would be learning to meet their needs adequately, as is evidenced by the following statements made by caregivers:

*“Guardians also share experiences about different situations of OVCs and this enable them to learn more about the needs of OVCs” (Mr Blue).*

*Caregivers need to form their own support groups so that they can learn to be patient with OVCs’ concerns. Caregivers can also learn and share how to deal with different issues of OVCs” (Ms Masvo).*

#### *4.3.2.2.4 Need for appropriate socialisation*

According to the findings of the study, it was emphasised that OVCs need a stable home that instils love, respect and responsibility. In an interview with Ms Green, she informed that:

*“They [OVCs] should learn about the community structure and to be able to respect older people. They should also learn about their family’s background and traditions so that they can keep in line with their family heritage” (Ms Green).*

OVCs who participated in the study indicated that the immediate family environment is crucial in shaping their roles and responsibilities in life and teaches them to be responsible as young people growing up. Three OVCs mentioned the following:

*“We need to have people, elderly people who REALLY take care of us in the real sense of taking care of us. Like being there, helping us, teaching us instead of making us do all the chores. We need to be taught about responsibilities as young people or as children – knowing how to sweep, cook, clean and to do laundry. We should be taught with love.” (Sarah).*

*“It is good as long as those relatives love you and prepare you to be a responsible adult” (Eddy).*

*“Relatives are more patient and will be able give you the love you want. Relatives can also teach you values and norms that are expected of you. They are more considerate and caring knowing that you are HIV positive” (Sama).*

#### **4.3.2.3 Category 3: Spiritual needs**

The spiritual needs category relates to the instilling of religious values that could provide hope and trusting relationships.

##### *4.3.2.3.1 Need for trust and hope*

Caregivers who participated in the study indicated that OVCs should trust in God for the provision of their needs; hence OVCs are encouraged to pray. It was notable that a number of participants reported that OVCs should trust God so that they could achieve their goals in life. Caregivers expressed the following:

*“It [religion] ensures that OVCs pray and believe in God for them to prosper in life” (Ms Pinky).*

*“The church leaders will pray for the affected family and children so that they are able to carry on with their lives...” (Ms Green).*

*“I told you, my son, the community is there to encourage the children to cope with death. The religious groups are offering prayers to affected children and families” (Ms Gogo).*

*“They can get inspiration through prayers and they can also get counselling” (Ms Black).*

It appears that the relationship OVCs have with their God inspired and motivate them to endure the hardships they face in life as expressed by the following statements made by OVCs:

*“I prayed. It was hard at first but I think God gave me the courage to cope with my mother’s death” (Sipho).*

*“At night I would pray. My mother taught us to pray and she always said God listens to prayers and He helps us to reduce our sorrows. I would cry to God and I would feel better knowing that God will comfort me” (Sarah).*

*“It helps me to know God better and to understand that everything happens for a reason” (Elly).*

*“I normally go to church to search for blessings and to ask God to be in my life and help me to overcome the difficulties I face. I pray to God so that I pass my ‘exams’ [examinations] and go to university” (Eddy).*

#### 4.3.2.4 Category 4: Need for succession planning

Succession planning is a two-way process that involves both the child and the adult. In most cases OVCs are not told about who they are going to stay with after the death of their parents. It was quite apparent from the findings of the study that OVCs end up staying with aunts or grandparents, which could be against their will in most cases. Four of the OVCs who participated in the study expressed the following:

*“No one told me. I went with my aunt to her house after the funeral. She was the only person close to my mother when she was sick” (Sipho).*

*“No one told us anything; we just knew we were going to stay with our uncle. He is the one who told us we are going to stay with him” (Sarah).*

*“They were no arrangements. I don’t think there was a relative who wanted to stay with me. I preferred to stay with my grandmother because she was the one who took care of my mother when she was ill and at the same time my grandmother was the one who was closest to me” (Sama).*

*“There were no arrangement but we had to stay with our grandfather since he was the one who used to take care of my mother and us as well” (Eddy).*

One of the OVCs who participated in the study indicated that the community practises rituals to hand over the guardianship to the surviving family member. As a result, OVCs felt that they are not consulted about with whom they would be staying after the death of their parents. As such, they are always uncertain about their future well-being. In an interview with Elly, she said that:

*“Pakafa baba vangu tsvimbo yakapiwa kuna babamudiki...” [The stick was given to my uncle when my father died] “...It means that our uncle is now our father and he is the one who will take the place of my father. He will be the one responsible for us. He should make sure that we eat, we are clothed and we go to school.”*

There was general consensus among the participants that it is always very important to consider the views of OVCs when executing their long-term guardianship. OVCs expressed their fear when their parents died before they made a decision on the people with whom they were going to stay. They expressed how instability they would be if they were to be cared for by grandparents. This was shown by the following statements made by OVCs:

*“It helped because my grandmother showed love to me but on the other hand I am the one who is taking care of my grandmother because she is old”* (Sama).

*“I worry about who will take care of us should our mother die”* (Tom).

*“My grandmother always tells me that she is old and will die one day. I have to do everything because my grandmother can’t see properly. I am afraid that if I let her cook, one day she can burn herself because of her poor sight”* (Sama).

Caregivers and key informants generally concurred that it is not ideal that OVCs should be cared for by the elderly who in most cases lack adequate knowledge, skills, and resources needed by caregivers. They also feel significant stress about their own mortality and the future of the children in their care. They expressed the following views:

*“As you can see, my son, I am old and sometimes I do not have patience with children. Sometimes I cannot even cook for them. I cannot make them happy as much as I like because I do not have the strength to do so. I also need someone who can look after me as well”* (Ms Gogo).

*“Caregivers do not give enough attention to OVCs such as what their parents could have done. In most cases, caregivers are old people who are not patient with children”* (Mr Makandiwa).

#### 4.3.2.5. Category 5: Need for social protection

The data gathered for this category has been sub-categorised as: the need for protection against abuse; the need for protection against stigma and discrimination; and the need for legal representation. Table 11 below reflects these sub-categories.

**Table 11 Need for social protection**

Category	Sub-category
Need for social protection	<ul style="list-style-type: none"><li>• Need for protection against abuse</li><li>• Need for legal protection</li></ul>

##### 4.3.2.5.1. Need for protection against abuse

The data gathered from the key informants emphasised that OVCs need to be protected from all forms of abuse, as expressed by Mr Makandiwa and Mr Runyoka respectively:

*“OVCs need to be protected from all forms of abuse: physical and sexual abuse, abandonment and neglect. As we said before, OVCs are more vulnerable compared to other groups, hence more care should be directed to them.”*

*“It is also important to note that a vulnerable child is exposed to exploitation and abuse, which include sexual or physical abuse.”*

Furthermore, it was apparent from one key informant and one caregiver who participated in the study that OVCs tend to be abused because they are vulnerable and they do not have a parent who is available to protect them. They expressed the following sentiments:

*“They are not given enough food to eat – they are shouted at and normally they are given harder chores compared to other children” (Mr Mangu).*

*“Some are raped by caregivers while some are given hard tasks to do” (Ms Green).*

Some OVCs are either abused sexually, emotionally or physically by their caregivers or members of the community. Emotional abuse usually comes in the form of name calling as stated by some OVCs. These forms of abuse were noted by the following statements made by OVCs who participated in the study:

*“Most of children are abused and raped while women suffer domestic violence and all these are happening while everyone sees. Nothing is being done by the government to address this” (Abi).*

*“Every time we ran to our uncle to hug him when he came back from work, my aunt always said...zvihure zvevanhu, munoda kupa murume wangu AIDS yakauraya amai venyu” [...you prostitutes, you want to infect my husband with AIDS, which killed your mother] (Sarah).*

*“In a children’s home OVCs will be protected from abuse like being raped unlike children who are not in a children’s home” (Elly).*

As a result of name calling, one of the OVCs indicated that he felt depressed, angry and unloved by the members of the community and that he ended up isolating himself from the community. Siphon stated the following:

*“They call us names and they call us orphans, which makes me feel very sad.”*

*“They call us fools, stupid, nherera [orphan].”*

Furthermore, one caregiver felt that death due to an AIDS-related illness carries a lot of shame and OVCs end up opting to stay indoors, fearing to be called names. In regard to this, Ms Green reported the following:

*“The problem is most of the OVCs do not want to play with other children. They prefer staying at home rather than playing because they are afraid to be called names by their peers.”*

Due to the shame associated with HIV-related illness, OVCs stated that their peers at school did not want to play with them because they thought they might be HIV positive. The following was noted by two OVCs who participated in the study:

*“They run away from me when they go to play cricket. They are my friends, I love them but they are jealous that I play cricket better than them. I sometimes wish my mother was alive and I was in Harare with my friends who understand me. I prefer being with my siblings all the time than being with Alex and Tobias because they are hypocrites” (Danny).*

*“I think they should build schools for OVCs so that OVCs can be alone and no one will look down upon them. In the class where I am at the moment we are mixed and other children do not want to play with us” (Tom).*

As noted before, OVCs are in many cases exploited by their caregivers. Some caregivers who participated in the study indicated that OVCs are made to work the whole day in the fields or to look after the relatives' cattle and consequently the educational needs of OVCs are neglected. With regard to exploitation, the following was expressed by the caregivers:

*“Others are taken as labourers by relatives whereby relatives use them to look after their cattle” (Ms Green).*

*“They end up looking for jobs in nearby towns while others opt to look after their relative's cattle or any other person who will pay them. In such cases children will end up being abused and exploited – they will be used as cheap labour and they will go for months without being paid by their employees” (Ms Pinky).*

*“Those who work in town are normally abused by their employers. We also see a phenomenon whereby children are dropping out of school due to lack of money for them to continue with their education” (Mr Makandiwa).*

*“It is not only children who have left their families who are abused. Even those who are cared for by the extended families are abused and ill-treated by their relatives” (Mr Mangu).*

One caregiver who participated in the study noted that OVCs tend to be given jobs that cannot be done by children of their ages. In this regard, Ms Black noted the following:

*“They give them hard jobs to do that do not match their ages, spending the whole day in the field or looking after the cattle. The treatment OVCs get is not the same as these relatives give to their own children” (Ms Black).*

*“They come to school with dirty clothes. Some also show signs of physical abuse with bruises on the buttocks and around the stomach” (Ms Pinky).*

It is important to note that one OVC interviewee (Sarah) brought up the issue of secrecy around abuse, which leaves OVCs appearing miserable and becoming fearful. She indicated that she does not want to report abuse because she does not want to get involved in her caregiver’s marital issues.

*“I do not want to cause any problems at home so I prefer keeping quiet. I do not want to be involved in my uncle’s marriage” (Sarah).*

#### *4.3.2.5.2 Need for legal representation*

General sentiments about legal representation among the study participants were that the lack of proper legal structures in Gokomere poses a problem for OVCs with regards to reporting the matter of their inheritances being taken by relatives. Lack of legal representation can result in OVCs losing the inheritance their parents left them

before they died and as a result they become more vulnerable. The inheritance that is left by OVCs' parents is important to build a sense of identity for OVCs, as is expressed by the following statements made by key informants and caregivers:

*"The courts should be accessible to everyone. Each community should have its own court because people only go to Masvingo when they need to go to court, which is far from Gokomere"* (Ms Jena).

*"They do not have any legal representation since our community is located far away from courts"* (Ms Red).

*"Of course, it is difficult for OVCs to come to terms with death. However, OVCs inability to cope with death comes when their inheritance is taken away from them by relatives"* (Ms Black).

*"It [inheritance] helps to keep the family memories. Also remember that we defined psychosocial needs as needs that help OVCs to keep their ethnic identity, hence, it is around the parents' inheritance that OVCs can build their identity"* (Mr Mangu).

Although there are traditional courts in Gokomere, the rulings in these courts do not always seem to address the best interests of the children. In an interview with Eddy, one of the OVCs, he reported that the village headman finally gave him a piece of land to build a house after an inheritance dispute. He said that:

*"I went and reported it to the village headman... He called a family meeting and we discussed the issue. There were no agreements so he ended up giving us the land where I built a small mud house where we are staying now."*

It was evident from the findings that OVCs are generally not informed about their rights to have legal representation when it comes to claiming the property that their parents have left to them before they die. In this regard, the following was expressed by OVCs:

*We were left with all the furniture but my uncles took all his cattle. Hapana muhnu akasitsanangurira kuti sei vana babamudiki vakatora mombe dzababa wangu* [No one explained to us why my uncles took my father's cattle] (Tom).

*“My uncle started to sell the cattle my mother left for us claiming they were his and it's not ours. So in December he wanted to sell other cattle again and that is when I refused and he chased me out of the house”* (Eddy).

Financial constraints were another impediment for OVCs preventing them from going to the nearby town to access legal services as noted by the following statement made by Elly in her interview:

*“My mother also tried to go to court but she didn't have money to travel to court time and again and she ended up thinking of saving the little money she had rather than wasting it by going to court.”*

### **4.3.3 Theme 3: Developmental needs**

This theme only yielded one category, which is educational needs. The category of educational needs further yielded sub-categories as highlighted in Table 4.8 below.

#### **4.3.3.1 Category 1: Educational needs**

Not meeting the educational needs of OVCs affected by HIV and AIDS has a negative impact on their psychosocial wellbeing. In Zimbabwe, a number of OVCs do not pay school fees but caregivers have to buy books, school uniforms and other school materials that might be required by educators. Therefore some finances are required to ensure that the educational needs of OVCs are met.

**Table 12 Educational needs**

<b>Category</b>	<b>Sub-category</b>

Educational needs	<ul style="list-style-type: none"> <li>• Lack of monitoring and supervision</li> <li>• Impact of level of income on education</li> </ul>
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#### 4.3.3.1.1 Lack of monitoring and supervision

OVCs need to have caregivers who always check on their educational progress. This is to prevent them from dropping out of school and resorting to other means of earning a living, such as living on the streets. In this regard, caregivers stated the following:

*“Some OVCs drop out of school and go to nearby towns and live as street kids” (Ms Masvo).*

*“We have a number of homeless OVCs in town [Masvingo] who run away from schools here in Gokomere because they were not supervised by their caregivers” (Pinky).*

Other caregivers who participated in the study indicated that when OVCs are denied their education, they enter the labour market. Here they are exploited by their employers because of their age, immaturity and lack of knowledge about the job they will be doing. This was expressed by the following statements made by the caregivers who participated in the study:

*“Some children are left without caregivers or anyone who ensures that they go to school. So they end up dropping out of school and look for jobs” (Ms Gogo).*

*“They lack support from the family. Some are those who are left with none of their parents’ possessions to support them. As a result they drop out of school. Others are taken as labourers by relatives whereby relatives use them to look after their cattle” (Ms Green).*

*“...the problem comes when the OVCs are staying alone without adult supervision. In such cases children end up dropping out of school to help each other to come up with some means to sustain themselves. They end up looking for jobs in nearby towns while others opt to look after their neighbours’ cattle or work for any other person who will pay them. In such cases children will end up being abused and exploited – they will be used as cheap labour and they will go for months without being paid by their employers” (Pinky).*

Therefore, caregivers and key informants who participated in this study felt that meeting OVCs’ educational needs ought to be monitored and supervised so that they do not drop out of school. In this regard, they expressed the following sentiments:

*“They should act like real parents for OVCs, checking their progress at school and attending parents meetings at school” (Ms Black).*

*“The other problem OVCs are facing is the lack of monitoring at school and even of their medical care. Caregivers do not look at the children’s progress at school or even ask OVCs about their problems. As a result OVCs end up feeling that their education is not a concern and they drop out of school as said by Mr Dehwa” (Mr Mangu).*

*“OVCs need to be cared for by a person who loves them. The person should ensure that OVCs continue going to school and their education should be monitored on a regular basis” (Ms Black).*

#### *4.3.3.1.2 Impact of level of income on education*

Low household income can have a negative impact on the education of OVCs affected by HIV and AIDS. This was cited by caregivers who participated in the study as one of the reasons why OVCs drop out of school. Caregivers who are left to care for OVCs are in most cases not in a position to provide financially for OVCs as is expressed by the following views:

*“They will be concerned about the death of their parents and at the same time they will be concerned about the possessions of their parents which have been taken by the relatives. This is the reason why some will drop out of school because they won’t be having any source of money to buy all the school materials.”* (Ms Green).

*“We see most of the OVCs in the community are not going to school due to lack of money and support from the family members. You know who they are because they are wearing dirty and torn clothes”* (Mr Mangu).

*“We also see a phenomenon whereby OVC are dropping out of school due to lack of money for them to continue with their education”* (Mr Makandiwa).

*“Most OVCs drop out of school due to difficulties in acquiring school materials like books and school uniforms. Some of them are discouraged by relatives to drop out of school saying they should look for a means to support themselves”* (Ms Masvo).

During data collection, the researcher observed that the HIV epidemic can put financial strain on households and there may be insufficient funds for OVCs to attend school. Caregivers may also not be interested in the children’s welfare due to financial constraints as expressed by the following statement by Ms Gogo:

*“I didn’t want to look after these children, but I was the only option available. I am not working and I don’t have money so how will I be able to provide for these children. It’s better for the government to take these children because I am not coping.”*

Interviews with key informants indicated that some OVCs are assisted by the government’s model (BEAM) with the payment of school fees. BEAM is one of the five components of the Enhance Social Protection Project (ESPP), which again forms part of the Government of Zimbabwe’s wider social-protection strategy. BEAM is administered by the Ministry of Education, Sport and Culture (MoESC) in

collaboration with the Department of Social Services (DSS) under the Ministry of Labour and Social Services (Masuka *et al* 2012:61). This notable programme has remained the only hope for some OVCs to complete their education. The primary objective of this programme is to reduce the number of OVCs dropping out of school and to reach out to OVCs who have never been to school due to economic hardships (ibid). Key informants noted the following with regards to the role BEAM plays in fulfilling the educational needs of OVCs:

*“Normally, it [educational needs] is the responsibility of relatives. Some, they depend on the parents’ inheritance, like cattle, to go to school and others are assisted by the government schemes like BEAM” (Ms Jena).*

*“I know of the National HIV/AIDS Policy, which supports PLWHA including OVCs. All the taxable population contribute 3 per cent. This 3 per cent AIDS levy is contributed to the National AIDS Trust Fund, which is administered by the National AIDS Council. We also have BEAM which helps vulnerable children with school fees” (Mr Runyoka).*

OVCs also felt that the BEAM programme is important in ensuring that they continue going to school. Abi and Eddy expressed the following views respectively:

*“Since I was I Grade 7, I was registered under BEAM.”*

*“I don’t know. I have been registering as an orphan with the social welfare so that the government can help me with school fees but up to now I am still waiting for my fees.”*

#### **4.3.4 Theme 4: Traditional forms of care for OVCs**

The data gathered relating to traditional forms of care for OVCs affected by HIV and AIDS have been categorised by the researcher as kinship care, non-kinship care, institutional care and adoption. The categories that relates to traditional forms of care

for OVCs are depicted by Table 13 below. Some of these categories have further yielded sub-categories as discussed below.

**Table 13 Traditional forms of care for OVCs**

Theme	Category
Traditional forms of care for OVCs	<ul style="list-style-type: none"> <li>• Kinship care</li> <li>• Non-kinship care</li> <li>• Institutional care</li> <li>• Adoption</li> </ul>

#### **4.3.4.1 Category 1: Kinship care**

The care of OVCs by their members of kin is provided through single parenting, sibling care, a widow remarrying, purposive fostering and crisis fostering. The aspects of kinship care are depicted in Table 14 below.

**Table 14 Kinship care**

Category	Sub-category
Kinship care	<ul style="list-style-type: none"> <li>• Kinship foster care</li> <li>• Sibling care</li> <li>• Widow remarrying</li> </ul>

##### *4.3.4.1.1 Kinship foster care*

Kinship foster care of OVCs in a formal or legal sense through recognised national laws and policies is not common in Gokomere. This study found that extended families informally assume the responsibility for the care of OVCs with no court order and that kinship safety nets remain the major form of care for OVCs in the community as expressed by the following statements made by caregivers:

*“I think OVCs should be cared for by willing relatives who are prepared to meet their needs... I mean relatives who are not forced to take care of OVCs – those who voluntary come to the fore and take care of OVCs” (Ms Green).*

*“OVCs are pushed to stay with relatives without a court order because they do not have options. The only option will be to stay with relatives” (Ms Black).*

*“The matters do not go to court, OVCs are taken care of by relatives especially grandparents” (Ms Yolanda).*

OVCs indicated that they wanted to be cared for by the members of their paternal family so that they could identify with their tradition and history. OVCs do not want to stay with their mothers because they do not identify them with their paternal family. In this regard, Tom and Abi noted the following:

*“One thing that bothers me a lot is that my mother doesn’t know much about our family history and culture. I need to know my family and my mother is not in a position to inform me” (Tom).*

*“I need to be proud of my history like other children. Ndinopedzisira ndatizwa neshamwari dzangu kana vakutaura nezvemhuri dzako [I end up running away from my friends when they start talking about their families] (Tom).*

*“I’m not sure, I don’t understand how adoption work but for me I feel OVCs should be cared for by relatives “kuti vana vakwanisa kudzidza tsika nemangariro emuri” [...so that children can learn more about their culture and heritage]...OVCs should understand the culture and religion that their family practise, izvi zvinoita kuti nherera dzizive kwadzakabva uye dzidzidza tsika dzavo” [...this ensures OVCs learn about their culture and background] (Abi).*

Caregivers and key informants unanimously agreed, however, that members of kin normally assist OVCs by providing for their basic needs such shelter, food and clothing. They expressed the following views:

*“It is important that OVCs grow up in their families so that they will be able to learn the family culture and tradition. This will help OVCs to build their identities around their own families. Therefore when OVCs’ caregivers are relatives, it is easy for the OVCs to form their own identities and to know who they are... I mean that OVCs will be able to know where they come from and to be able to reflect their own history. Unlike children who are being raised by non-relatives who in most cases tend to trace their identities along the families they were raised” (Ms Masvo).*

*“It helps to keep the family memories. Also remember that we defined psychosocial needs as needs that help OVCs to keep the ethnic identity, hence it is around the parents’ inheritance that OVCs can build their identity” (Mr Mangu).*

The general sentiments of the participants in the study were that the extended family is no longer providing care as it used to in the olden days. Changes in the economy such as hyperinflation, labour migration and shortages of basic commodities were noted as reasons that are causing the further weakening of the extended kinship care. Ms Jena noted the following:

*“In most cases, OVCs are being cared for by members of the extended family but their capacity to take care of OVCs is now faced with a lot of challenges like inflation and lack of support from Government and NGOs.”*

One caregiver who participated in the study reported that money given by relatives who are working in town or in other countries is inadequate to cater for the increasing needs of OVCs. In this regard, Ms Gogo state the following:

*“I am not working as well my son and money is my major problem. Although some of my children who are working help me it is not enough for me and my grandchildren” (Ms Gogo).*

It was further reported by key informants that some extended family members only want the inheritance of the deceased parents of OVCs and they do not intend to care for the children. Once the member acquires the inheritance, OVCs are abused, exploited and left to fend for themselves. Two key informants noted the following:

*“Relatives are in most cases after the inheritance of OVCs and they tend to abuse OVCs. It is not only children who have left their families who are abused. Even those who are cared for by the extended families are abused and ill-treated by their relatives”* (Mr Mangu).

*“OVCs lack support from the community and relatives and they end up not going to school. Relatives in most cases take OVCs’ possessions that were left by their parents that could have helped them in purchasing school material and paying school fees”* (Ms Dehwa).

Most of the OVCs reported that when their possessions are claimed by relatives, they are left impoverished and without any income to acquire food or clothing and funds to pay for their education. The researcher observed that the property that was lost to relatives included both household items and livestock. In this regard, two OVCs expressed the following:

*“My father had six cattle and three goats but after his death, my uncle and aunt took everything. My uncle who is my father at the moment took all the cattle, and goats were given to my aunt who is my father’s sister.”* (Elly).

*“Everyone took everything he/she wanted... Lots of people, some I have never seen before, other were my mother’s cousins. All those relatives who were there were the ones who were saying ndipe mapoto aamai vako, ndipe chakati chakati [...give me your mother’s pots, give me this and that]... I now don’t have anything my mother left for me. I had a watch but my aunt took it... It was the only thing I had that my mother left for me and I loved it. It was the only connection I had with my mother. It makes me feel sad and angry with my aunt”* (Sarah).

It was noted by one OVC that challenges arose when the legal system could not even ensure that OVCs received what actually belonged to them. Eddy expressed this sentiment by the following statement:

*“I reported the matter to the village headman who failed to give us a solution. The only thing he did was to give me the land to build a house. My uncle kept on demanding all the things my mother left. The village headman took us to court in Masvingo and I lost the case. My uncle was being helped by a lawyer and I didn’t have one.”*

#### 4.3.4.1.2 Sibling caregivers

Siblings can take care of each other after the death of a parent whereby the older sibling takes care of the younger ones. Some of the caregivers who participated in this study indicated that sibling caregiving is the better form of care for OVCs who have lost both parents. One caregiver said that siblings who are working should look after the younger ones. In this regard, caregivers expressed the following sentiments:

*“The immediate family siblings who are old enough and working should take care of their other siblings.”* (Ms Gogo).

*“Siblings should take care of each other; older siblings should be responsible for the younger ones. These older siblings should be working in order to give support to young ones”* (Ms Black).

*“Normally it is the immediate family members – especially siblings who will continue to take care of their brothers and sisters. So yes, OVCs have someone who loves them. These people also ensure that children go to school, take them to clinic and give them food”* (Ms Pinky).

*“OVCs should be cared for by relatives especially immediate relatives, which include grandparents, uncles, aunts or older siblings. It is these people who*

*should ensure that OVCs are loved and they should love them. They should listen to the OVCs needs and they should ensure that OVCs feel safe and happy when they are around” (Ms Yolanda).*

#### 4.3.4.1.3 Widow remarrying

The key informants explained the practice of “widow remarrying” as a practice whereby the brother of the deceased takes over the family responsibility by marrying the widowed wife or where the younger sister takes over family responsibilities by marrying the widowed husband. The key informants further reported that widow remarrying ensures continuity in the provision of care to OVCs as expressed by the following statement made by Mr Mangu:

*“Just to add to what Mr Runyoka is saying, there was also a practice of widow remarrying, whereby the brother of the deceased used to marry the wife of the deceased and continue to take care of the children. Same applies when the mother died, the younger sister would be married by the husband of the deceased and continue to care for OVCs. In those days the OVC phenomenon was not common.”*

However, one OVC indicated that when the remaining parent remarries, he or she tends to give less attention to the children, attending more to his or her new partner. Abi expressed the following views:

*“When my mom died, I had to deal with my father remarrying, which left me vulnerable. I was relying on my father for my future care but that turned out to be different.”*

*“My father went on to marry another wife who didn’t like me and since then my father stopped supporting me. My grandmother stood a place [represented] for my father while he was alive.”*

Key informants indicated to the researcher that the prevalence of HIV and AIDS epidemics had a negative impact on the practice of widow remarrying. Two key informants further indicated to the researcher that people are no longer encouraged to remarry due to high HIV mortality. Instead key informants recommended that the support provided by extended family to OVCs needs to be strengthened as expressed by the following statements:

*I think the extended family system is still a common practice. Due to widespread HIV, families are no longer practising the system of widow remarrying. Although the extended family still exists, it is faced with many challenges as we mentioned before (Mr Mangu).*

*“It is difficult to reintroduce widow remarrying due to HIV and AIDS – it is not even encouraged although it was helpful in assuring care for OVCs. However I think the extended family needs to be strengthened in order to be able to care for OVCs” (Mr Makandiwa).*

#### **4.3.4.2 Category 2: Non-kinship care**

The researcher observed that some nurturing roles in Gokomere are the responsibility of non-biological parents and non-relatives through non-kinship foster care and community parenting. These aspects of non-kinship care are highlighted in Table 15 below.

**Table 15 Non-kinship care**

<b>Category</b>	<b>Sub-category</b>
Non-kinship care	<ul style="list-style-type: none"> <li>• Non-kinship foster care</li> <li>• Community parenting</li> </ul>

#### 4.3.4.2.1 Non-kinship foster care

Non-kinship care of OVCs in a formal legal sense through recognised national laws and policies is not common in Gokomere.

OVCs have a mixed reaction with regards to non-kinship foster care. A considerable number of OVCs indicated to the researcher that non-relatives are in a position to provide love to OVCs compared to relatives, who, in most cases seek to possess the inheritance of OVCs' deceased parents. This was expressed by the following statements made by one OVC and a caregiver:

*“It’s better to be cared by non-relatives. It’s the caregivers who are looking after us at the moment. Our uncle doesn’t care. Caregivers would make sure that we have food and how I am coping with my mother’s illness. They would come twice a week on Monday and Friday”* (Elly).

*“In most cases parents do not make any arrangement with regards to their possessions before they die. We are therefore normally faced with the problem whereby the extended family take all the inheritance that was left by OVCs’ parents. Which means the extended family is benefiting from this inheritance and not the OVCs.”* (Mr Blue).

On the other hand, one OVC indicated to the researcher that relatives in most cases are jealous of the positive progress that OVCs might be making in life and that this might jeopardise their well-being. In this regards, Danny stated the following:

*“Munhu asiri hama yako anokuda nemoyo wake wese, hama dzinonetsa nekuti kana wava kubudirira vanotanga kuita godo”* [A person who is not your relative loves you with all his/her heart; relatives are jealous] (Danny).

Non-kinship care can be voluntary whereby members of the community or members of a religious group willingly decide to take care of OVCs. These members do not

necessarily have to stay with OVCs in order to provide care to them. This was expressed by the views below:

*“Some individuals help with food and clothing while a few are prepared to take OVCs into their homes, especially members of religious groups.”* (Ms Pinky).

*“The community is trying a lot to help OVCs. They are taking care of OVCs who have lost both parents. A number of people are volunteering to be community caregivers and they are involved in a number of programmes that are helping OVCs, for example, the home-based care [HBC] programme.”* (Ms Dehwa).

*“Members from NGOs, churches and other individuals in the community are more considerate of OVCs. Some members of the community love OVCs, they give them food, clothing and some even absorb OVCs into their families.”* (Mr Makandiwa).

A key informant who participated in the study indicated to the researcher that individual members and organisations should not attach monetary value when providing voluntary services as this can have a negative impact on the care of OVCs. Mr Makandiwa noted that:

*“Voluntary services should be done out of the willingness of the person without any monetary award expected. Once we start paying people, it will reduce productivity as people will be doing their work only for money and not the willingness to assist OVCs”* (Mr Makandiwa).

#### 4.3.4.2.2 Community parenting

The general perception among the respondents was that the care of OVCs is the responsibility of everyone – *“...it takes a village to raise a child”* (Mr Blue). Some caregivers and key informants who participated in the study felt that the community should take responsibility for the care of their OVCs. They expressed the following:

*“They are there, people like us, us volunteers who go around the community to ensure that OVCs are cared for. We also encouraged community parenting – every child is everybody’s responsibility” (Mr Blue).*

*“All members of the community should have a collective action to ensure that OVCs are supported and protected.” (Mr Makandiwa).*

*“It is everyone’s responsibility and that is why we talk about community parenting. However, at schools we expect that teachers should be responsible and if OVCs are in the community, volunteers and the entire community should be responsible” (Mr Blue).*

Caregivers who participated in the study felt that the community helps OVCs before and after the death of their parents in a number of ways that include helping with cooking for the funeral and contributing money for the burial of OVCs’ deceased parent/s. Some caregivers stated that some members of the community, including religious groups, provide food, clothing and shelter during bereavement time to the affected children. These views were expressed by statements made by caregivers below:

*“The community members can come and help by fetching water from the boreholes, sweeping the yard and also cooking. They also bring food to the affected families. Some are also there to talk to the children and cheer them up so that they don’t always think about their sick or deceased parents” (Ms Green).*

*“Yes they do get support from relatives, the community and even from the church in the case of those who are affiliated to a certain church” (Ms Gogo).*

*“Some individuals help with food and clothing while a few are prepared to take OVCs into their homes, especially members of religious groups” (Ms Pinky).*

#### 4.3.4.3 Category 3: Institutional care

The researcher noted that placing children in a children's home or institution is not a common practice in Gokomere. The general sentiments expressed by caregivers were that the care of OVCs in a children's home is not common. In this regard, caregivers noted the following:

*"It is not common to see a child going to a children's home here in Gokomere but I understand that some OVCs in the country are cared for in a children's home"* (Ms Masvo).

*"I have never heard of an OVC from Gokomere who ended up in children's home"* (Ms Green).

*"Yes but here in Gokomere we do not have those cases since we do not have children's homes"* (Ms Yolanda).

On the other hand, some OVCs felt that they needed to be cared for in an institution, especially those who are double orphaned while others preferred to be cared for by their relatives instead of in children's home. This was expressed by the following statements made by OVCs:

*"It is a good idea for OVCs to be cared for in a children's home, especially OVCs like me who do not have a parent"* (Eddy).

*I don't want to be at the children's home. Children at the children's home do not get everything they want* (Sipho).

*"Institutional care is good for those who do not have family relatives but it is best that OVCs should be looked after by family relatives"* (Sama).

There was also an indication by one of the OVCs who participated in this study that although they can be placed in children's home, they should also have time to visit

their families in order for them to keep in touch with their family traditions. In this regard, Eddy expressed the following:

*“It is a good idea for OVCs to be for cared in a children’s home especially OVCs like me who do not have a parent. If I knew of any children’s home around the time my uncle chased me away, I could have went and stayed there. I even wanted and go and stay in the streets but I thought twice because I have to go to school and at the same time I have to look after my young brother. However when children stay in a children’s home, they should have time to visit their families so that they won’t forget where they belong.”*

Isolated cases of ill-treatment of children in children’s homes were noted by OVCs who participated in this study. Tom said the following:

*I hear a lot of bad things about children’s homes, I wouldn’t want to be cared for in a children’s home... Children are not properly fed at children’s homes and some children beat others.”*

However, there were mixed feelings among other OVCs who preferred to be cared for in a children’s home because they felt that cases of discrimination would be minimal. In this regard, Sarah and Elly expressed the following views respectively:

*“Eish..., I don’t know. I don’t know how it is in a children’s home but I think it will help because when you are there, there will be other children who are like you and there won’t be certain children who are favoured over the others.”*

*“I think it’s a good idea that OVCs should be cared for in a children’s home. In a children’s home, OVCs will be protected from abuse like being raped unlike children who are not in a children’s home.”*

#### 4.3.4.4 Category 4: Adoption

There was general consensus among the study participants that adoption is not the best form of placement for OVCs affected by HIV and AIDS. Although the Protection and Adoption Act (20 of 1994) of Zimbabwe makes provision for vulnerable children to be adopted, the practice of adopting OVCs is not common in the community of Gokomere to the extent that some OVCs are not even aware of the practice. In this regard, Mr Mangu and Abi noted the following respectively:

*“Children who are in need of care are protected by the Protection and Adoption Act. This act ensures that children who are abandoned, OVCs or children with untraceable parents are adopted or placed in alternative care.”*

*“I’m not sure, I don’t understand how adoption works but for me I feel OVC’s should be cared for by relatives kuti vana vakwanisa kudzidza tsika nemangariro emuri [...so that children can learn more about their culture and heritage].*

Some OVCs felt, nevertheless, that being cared for by a non-relative is similar to adoption since there are no family ties in being cared for by a non-relative. However, the researcher noted that most OVCs preferred to remain with their families rather than being adopted. This was expressed by the following statement made an OVC:

*“I don’t want; I prefer being cared by my grandmother... She loves me. Being adopted is as good as you are being cared by someone who is not your relative” (Sama).*

Some OVCs who participated in this study felt that adoption is a good practice especially those who are double orphaned. However, OVCs mentioned that one challenge associated with being adopted is that the community regards children who are adopted as bringing misfortune to the family. These views were expressed in the following statements made by OVCs:

*“I have a friend of mine called Mandy, I think you should help her to have a parent. Both of her parents passed on and she stays alone at home. So in that case adoption is a better idea” (Elly).*

*“OVCs should be cared by their family members so that they can understand their family better. Vamwe vanhu vanoti mwana akaadotiwa anozoita ngozi [Other people say a child who is adopted can be avenging spirit]” (Eddy).*

*“So adoption is a good thing. I would like to be adopted as well so that I will have someone who will take me as a child and who loves me... Sometimes as a young girl you would like a person who treats you like a real child... You need someone like a parent you can talk to. If I had a mother to talk to about such things, it will be better for me instead of asking things from friends who in most cases do not know anything” (Sarah).*

#### **4.3.5 Theme 5: Emerging forms of care for OVCs**

The data gathered for this study indicated some emerging forms of care. The emerging form of care for OVCs were identified as home-based care (HBC) whereby the community caregivers trained by the health professionals are responsible for meeting the needs of OVCs and their families. However, some OVCs keep on living on their own in their parents’ houses after the death of their parents – these households become child-headed households (CHHs) as discussed below.

The categories that relate to emerging forms of care for OVCs are depicted by Table 16 below.

**Table 16 Emerging forms of care for OVCs**

<b>Theme</b>	<b>Category</b>
Emerging forms of care for OVCs	<ul style="list-style-type: none"> <li>• Home-based care (HBC)</li> <li>• Child-headed households</li> </ul>

#### 4.3.5.1 Category 1: Home-based care

It was noted by one caregiver that the HBC programmes that are available in Gokomere are mostly offered by religious organisations like BHASO. In this regard, Ms Gogo noted the following:

*“Most religious organisations like BHASO have HBC programmes whereby caregivers go to households where a sick person is being cared for and talk to children together with the sick person.”*

It was apparent from the study’s findings that HBC volunteers from BHASO were assisting households affected by HIV and AIDS with writing wills, ART adherence and also providing counselling to the affected children. Some caregivers who participated in the study indicated to the researcher that the HBC programmes ensure that OVCs, parents and HBC volunteers decide on what will happen to the possessions of the parent/s after death. This was expressed by the following statements made by a caregiver and a key informant:

*“They come to the house of the sick parent and help the children to take care of the sick parent and help the sick with the writing of a will” (Ms Green).*

*“It is important to come up with a HBC programme in order to assist the sick parents of OVCs with adherence to ART and to provide counselling to the affected children” (Mr Makandiwa).*

There was general consensus among the study participants that the advantage of HBC is that it allows the sick parent/s and their children to discuss their wills before they die while they are at home. This was expressed by the following statements made by caregivers and key informants:

*“It also encourages the sick parent to write a will that will be used when he/she dies” (Ms Gogo).*

*“However, as BHASO, we have a home-based care (HBC) programme that encourages parents to write wills while they are still sick so that OVCs will get what rightfully belong to them” (Mr Mangu).*

*“The caregivers go around all the households that have a sick person and encourage the person/parent to talk about his/her illness to the children. They encourage the sick parent to disclose their status to the children so they understand why their parent is sick. HBC caregivers also encourage children to talk about what should happen to their parent/s’ possessions when they die. They also encourage parents to write wills before they die” (Mr Dehwa).*

In most cases, the care of sick parent/s at hospitals makes it difficult for the children to visit and to talk to them. Visitation in hospitals is controlled and limited hence OVCs might not have the opportunity to discuss their parents’ wills with their parents before they die. OVCs preferred to be present when their parents were dying so that they could tell them how they felt about them. In this regard, Eddy expressed the following:

*“The moment she was released from the hospital so that she could be part of BHASO HBC programme I already knew that her death was coming soon... I could hear from the way caregivers who used to come to help us were speaking. They were speaking like they were preparing us for the death of my mother” (Eddy).*

Tom, an OVC who participated in this study, further indicated that the HBC programmes that are done by community caregivers helped him to accept death and to be prepared for the death of his parent. He noted the following:

*Children are not allowed in the admission wards so I had to stay behind at home with my younger brother while my mom visited my father at the hospital*

*and brought him some food... It was hard, I wanted to see him and tell him that I loved him but unfortunately I was not allowed in the wards. However, my father was released from the hospital so that he would be cared for at home and that is when I got a chance to talk to my father (Tom).*

#### **4.3.5.2 Category 2: Child-headed households**

Although CHHs are not a form of care for OVCs affected by HIV and AIDS, most OVCs eventually head households due to lack of family support. Caregivers who participated in this study noted that in most cases there is no relative who is willing to take care of these OVCs and they eventually stay alone without any adult supervising them. This is reflected by the following statements made by two caregivers who participated in the study:

*“Some OVCs in Gokomere do not have relatives who are willing to take care of them. These OVCs in most cases do not have food and they do not have an elderly person to supervise their education” (Ms Green).*

*“However the problem comes when the OVCs are staying alone without adult supervision. In such cases, children end up dropping out of school to help each other to come up with a means to sustain themselves” (Ms Pinky).*

A key informant who participated in the study indicated to the researcher that there is an increasing number of CHHs due to lack of community and Government support. This increase of CHHs has been caused by a lack of formal non-kinship foster care through recognised national laws and policies. In this regard, Mr Makandiwa noted the following:

*“The growing number of OVCs has led to the increasing number of child-headed families, which in most cases lack support from the community and Government... I mean support for food, living conditions of OVCs and also schooling. Child-headed families are not fully supported with regard to these things by the community” (Mr Makandiwa).*

One OVC who participated in this study indicated that the conflict over inheritance has resulted in the growing number of CHHs. In this regard, Eddy felt that:

*“My mother died in June last year and we stayed with our maternal grandfather. Our grandfather also died in November last year and we continued staying at our grandfather’s but our uncle was now responsible for our well-being. My uncle started to sell the cattle my mother left for us claiming they were his and not ours. So in December he wanted to sell other cattle again and that is when I refused and he chased me out of the house.”*

*“Staying with my grandfather was the only option I had but the subsequent chasing away that my uncle did to me after the death of my grandfather taught me that I should grow up and be independent at a young age.”*

Mr Blue in his interview indicated that some OVCs preferred to continue staying at their parents’ house. He stated that:

*“Some just keep on staying at their parents’ house and these normally become child-headed households.”*

They were mixed feelings among the participants on the challenges of OVCs who are in CHHs. Caregivers felt that the deteriorating living conditions of OVCs in CHHs has led to a number of OVCs dropping out of school and looking for jobs to fend for themselves. This was reflected by the following statement made by a caregiver:

*“Some children are left without caregivers or anyone who ensures that they go to school. So they end up dropping out of school and look for jobs” (Ms Gogo).*

One OVC who participated in the study also mentioned housing as the main challenge CHHs are facing. Eddy said that OVCs’ houses are in most cases not in good condition. He noted that:

*“The other thing the Government should do is to build houses for OVCs especially those who are like me who stay alone without parents. The house I built for myself can collapse at any time when it rains because it’s made of mud.”*

*“He [uncle] called a family meeting and we discussed the issue. There were no agreement so the village headmen end up giving us the land where I built a small mud house where I am staying now”*

#### **4.4 CONCLUSION**

This chapter discussed the research findings on the survival, developmental and psychosocial needs of OVCs affected by HIV and AIDS as reflected by interviews with OVCs, caregivers and key informants who were members of NGOs and FBOs. The biographical profiles of participants were discussed and also explained in the form of tables (see Tables 3, 4 and 5). From the research findings, five themes that related to the needs of OVCs affected by HIV and AIDS were generated. These themes were: psychosocial needs; developmental needs; survival needs; traditional forms of care for OVCs; and emerging forms of care for OVCs (see Table 2). The themes yielded categories and further sub-categories, which were discussed backed up by quotations from the study participants.

The next chapter, Chapter 5 contains a summary of the findings of this study. The limitations of the study and recommendations for policy and research are also discussed in this chapter.

## **CHAPTER 5**

### **CONCLUSION, RECOMMENDATIONS AND LIMITATIONS**

#### **5.1. INTRODUCTION**

The previous chapter presented the findings of this study in detail. The purpose of this chapter is to provide the conclusions of the study by summarising its findings. Chapter 5 also mentions recommendations for policy and for future research and explains the limitations of this study.

#### **5.2. SUMMARY OF THE RESEARCH FINDINGS**

The broader purpose of this study was to gain an understanding of the needs of OVCs affected by HIV and AIDS.

The specific objectives of the study were to:

1. Explore the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.
2. Explore the survival and developmental needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.
3. Explore the ways in which the community attempts to address the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere, Zimbabwe.

In this qualitative study, purposive sampling was used to select the research participants namely OVCs, caregivers and key informants. The main data-collection methods that were used to gather information from the OVCs and caregivers were in-depth individual face-to-face interviews, which were guided by a semi-structured interview schedule. A focus-group discussion was also done with key informants to

gather information. In this study, the interviews and focus-group discussion was tape recorded and the tape-recorded interviews were transcribed by the researcher and translated from Shona into English. Data saturation was reached when no new themes emerged from the data collected.

The findings of this study will be summarised in terms of five main themes that emerged. These are: survival needs; psychosocial needs; developmental needs; traditional forms of care for OVCs and emerging forms of care for OVCs (see Table 2).

The psychosocial needs of OVCs affected by HIV and AIDS were identified in terms of five themes namely: the need for relationships; emotional support; spiritual needs; the need for succession planning; and the need for social protection. It is important to note from the findings of the study that OVCs affected by HIV and AIDS did not only have psychosocial needs. Survival and developmental needs were also found to be very important in meeting OVCs psychosocial needs.

### **5.2.1 Theme 1: Survival needs**

The conclusions for research objective 2 of the study pertain to the survival needs of OVCs affected by HIV and AIDS in Gokomere (see Table 2). Unfulfilled survival needs have social and health effects on the psychosocial needs of OVCs affected by HIV and AIDS.

#### **5.2.1.1 Category 1: Need for clothing**

The study findings revealed that a lack of clothing was viewed as a barrier for OVCs to be involved in social activities like going to school and to church while other OVCs needed clothing to protect themselves from harsh weather conditions. The provision of clothes was seen as the responsibility of the families. However, according to some studies, provision of clothes for OVCs largely relies on donor organisations (Mkhonta 2009:156).

According to the findings of the study, OVCs affected by HIV and AIDS in Gokomere tend to try to be accepted by their peers by conforming to a particular code of dressing. School uniforms were also found to be instrumental in keeping children at school because school children without school uniforms dropped out of school regardless of adequate provision of school fees and other supplies.

The study done by Mkhonta (2009:157) shows that clothing has an aesthetic value. They also complement feelings of self-esteem. Children tend to feel good depending on the clothes they wear, that is, the style, the make and the fit. However, in this study, the OVCs' clothes did not fit them properly. These children had to be content with any type of clothes they had.

#### **5.2.1.2 Category 2: Need for food**

A lack of food also had social and health effects on OVCs affected by HIV and AIDS. The findings of this study revealed that OVCs were often malnourished, which had a negative impact on their physical development. These findings were congruent with the study done by Wakhweya *et al* (2008) who comment that there is need for nutritious food to ensure physical development of OVCs affected by HIV and AIDS.

Caregivers supplemented the provision of food through subsistence farming while some OVCs were also involved in food gardening. According to the study by Stover *et al* (2007), the provision of food rations through donor organisations is important in meeting the nutritional needs of OVCs. The rations normally consisted of mealie meal, vegetable oil and beans. However, in this study, OVCs who were in need of food were assisted by the *Zunde raMambo* scheme, which provides basic necessities for vulnerable groups in the community.

Some OVCs received food from the clinics and NGOs in the community. The responsibility of OVCs to provide for themselves and their families puts a lot of strain on their ability to focus on their schooling as they were always endeavouring to ensure that they had food.

The findings of the study further revealed that the need for food had discriminatory effects on OVCs affected by HIV and AIDS. The researcher found that OVCs tried to be accepted by their peers by bringing to school the food that is socially accepted. OVCs who cannot manage to do so end up isolating themselves from their peers at school for fear of stigmatisation. Research done by Mkhonta (2009:157) finds out that the stigmatisation of OVCs as a result of having food that is not widely accepted has led to children dropping out of school in the rural communities of Botswana.

#### **5.2.1.3 Category 3: Need for shelter**

The findings of the study revealed that some OVCs were staying in thatched houses that were leaking, especially in the rainy season. Mkhonta (2009:160) argues that poor living conditions compromised the health of OVCs affected by HIV and AIDS. Therefore key informants cited that there was need for Government and NGOs to intervene in order to provide proper shelter for OVCs. Similar findings were noted in a situational analysis of OVCs done in the provinces of Zimbabwe. This stated that organisations should build houses for OVCs who lived in dilapidated houses (HSRC 2008:205).

However, even though it was believed that Government and NGOs should take responsibility in ensuring that OVCs are properly sheltered, it was also felt that community members should also take responsibility of the OVCs in the community. A study done in Mutare, Zimbabwe revealed that the community members were able to contribute in order to repair dilapidated houses of OVCs (HSRC 2008).

#### **5.2.1.4 Category 4: Need for healthcare**

It was apparent from the study's findings that OVCs affected by HIV and AIDS in Gokomere also were in need of healthcare. OVCs normally visited the local clinic to get treatment for any medical problem. In most cases treatment of OVCs in clinics or hospitals in Gokomere is free. The findings of this study were congruent with those by Masuka *et al* (2012:64) who note that OVCs in Zimbabwe are one group of

people who get free treatment in hospitals through free treatment orders from the government of Zimbabwe.

They are some instances where some OVCs do not get free treatment even if they qualify. The findings revealed that some community members had to sell their livestock (such as goats and cattle) to meet the medical expenses of OVCs. Findings of the study further revealed that there is increased access to ART for OVCs living with AIDS due to increased awareness of ART in the community. Contrary findings are noted in the study by HSRC (2008) in Nyanga, Zimbabwe where access to ART for OVCs living with HIV was low due to the unavailability of ARVs at the clinics and hospitals.

Home-based care (HBC) was the main service available for the care of OVCs and their families. It was noted from the study's findings that HBC was provided by trained caregivers from various NGOs in Gokomere. However, there was apparently an insufficient number of properly trained personnel across the board of HBC programmes. These findings are congruent with a study by Masuka *et al* (2012) who noted that HBC programmes are becoming less of a priority due to: insufficient resources to conduct training; the lack of expertise to carry out training; and problems in recruitment and the retention of HBC personnel.

## **5.2.2. Theme 2: Psychosocial needs**

The first objective of the study was to explore the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere. These needs were found to be: the need for relationships; emotional needs; spiritual needs; and the need for succession planning.

### **5.2.2.1 Category 1: Need for relationships**

The findings of this study reveal that OVCs need to have relationships with their peers and older people who can guide them to make life choices. They should have an open atmosphere of love and trust for communication between them and their

caregivers. The findings of this study further revealed that the OVCs struggled for identity as they were often abandoned and neglected by their other immediate relatives and were left in the care of grandparents. This study highlighted that the need for love and belonging had led to some children to drop out of school and to become street children. This is an indication that children need to be loved and to have a relationship with caregivers who belong to their own family.

These findings are congruent with the study done by Van der Heijden & Swarts (2010:42) who notes that caregivers should attempt to address the questions OVCs may have about the death of their parents. However, it was noted from the findings of this study that OVCs tend to be stigmatised and discriminated against by their peers. This makes OVCs become emotionally vulnerable and as a result, they draw back in self-pity, self-doubt and low self-esteem. This was supported by Dalen *et al* (2009:9) and Foster *et al* (2005:96) who note that OVCs affected by HIV and AIDS often face hostility and ostracism rather than support from their peers.

#### **5.2.2.2 Category 2: Emotional support**

The study's findings revealed that OVCs should be allowed to be part of the funeral arrangements of their deceased parents, rather than being marginalised from the experience of their parents' death. OVCs are often sent away to stay with distant relatives after the death of their parents. These findings are congruent with the study done by Van der Heijden and Swartz (2010:46), Madekunye (2007:20) and Dalen *et al* (2009:8) who noted that OVCs are often marginalised from the experience of death and this can affect their expression of the emotions of grief and loss.

According to the findings of this study, OVCs who are marginalised by their peers expressed the need to form their own support system, such as support groups, in order to share experiences and to talk about their own needs. This is supported by Morgan and Roberts (2010:210), who state that one way of assisting bereaved children and adolescents is to give them the opportunity to come together with other grieving young people and help them to learn about and share their grief.

This study further found that there was a need for OVCs affected by HIV and AIDS to be provided with guidance and counselling before and after the death of their parents. This could be provided by qualified professionals or alternatively by the elderly people in the community. However, these findings seem to be contrary to Stover *et al* (2007:48) who find that many OVCs who had lost both parents lived with their grandparents who were no longer capable of giving the guidance and counselling required because of the generation gap.

### **5.2.2.3 Category 3: Spiritual needs**

It also emerged from the findings of this study that OVCs affected by HIV and AIDS have spiritual needs to be met. This study revealed that OVCs need to have an intimate relationship with God so that they can still have hope despite the trials and tribulations of their lives. This study showed that OVCs get some degree of consolation from a belief in God. It was noted from the findings of the study that religious organisations give hope to the children that their future is in God's hands. Caregivers and key informants who participated in the study believed that these children would be able to make good decisions if their lives were based on faith in Jesus Christ.

### **5.2.2.4 Category 4: Need for succession planning**

The findings of the study also revealed that families need to have succession planning in consultation with OVCs before and/or after the death of their parents. This includes the writing of wills and planning regarding with whom the OVCs will stay in the event of the death of their sick parent/s. OVCs expressed their fears about who they would be staying with after the death of their parent/s. In this regard, Schenk *et al* (2010:332) note that succession planning should be aimed to reduce these OVCs' fear and uncertainty about their future well-being.

OVCs who participated in the study felt that they needed to be consulted when adults were discussing with whom they would be staying after their parents died. They felt that they should not be cared for by the elderly since their grandparents

often lacked adequate knowledge, skills, and the resources needed. Grandparents also experienced significant stress about their own mortality and the future of the children in their care (Schenk *et al* 2010:331). These findings were congruent with the study by Zagheni (2011:767) who reveals that the caregivers of OVCs are more likely to be from the extended family and are likely to be poor old women who typically have reduced access to property, housing and employment.

#### **5.2.2.5 Category 5: Need for social protection**

Social protection can broadly be defined as the protection that a society provides to its vulnerable members (Masuka *et al* 2012:60). This study's findings revealed that the need for social protection encompasses the need for protection against abuse and the need for legal representation.

It was apparent from the study's findings that OVCs needed to be protected against all forms of abuse that ranged from physical abuse, to sexual abuse, abandonment and neglect. It is because of their vulnerability that OVCs affected by HIV and AIDS need to be protected from abuse. The findings of this study are congruent with those by Masuka *et al* (2012:60) who argue that social protection aims at protecting the vulnerable against livelihood risks, and enhancing their social status.

Some of the OVCs who participated in the study informed the researcher that they were abused by their caregivers and they found it difficult to report such abuse. The same findings were reported in the study by Chitiyo *et al* (2008:388) who argue that OVCs in most cases do not talk about abuse because they are afraid of being further abused. This kind of secrecy around abuse has caused it to be considered an epidemic itself – “the silent killer of AIDS” (Campbell *et al* 2010:976; Chitiyo *et al* 2008:385).

As stated earlier in Chapter 2 of this study, OVCs lack proper legal structures protecting the property and possessions their parents left for them from property-grabbing by relatives. This study's findings revealed that OVCs are at risk of losing their deceased parents' property to relatives. Similar findings also noted that

instances of property-grabbing is very common in most regions in Africa (Zagheni 2011:763; Littrell *et al* 2012:334; Lund & Agyei-Mensah 2008:94).

The findings of this study revealed that OVCs tend to be more vulnerable when all that belongs to them is taken by relatives. Consequently, they do not afford legal protection against property-grabbing by relatives. This study further showed that OVCs' access to legal services is normally impeded by financial constraints preventing them from seeking legal services at a nearby town. Although the key informants were aware of the laws (the Children's Act, the Guardianship of Minors Act, the Maintenance Act and the Child Abduction Act) that protect OVCs, the majority of general community members seem to be unaware of such laws. However, regardless of the community members' lack of knowledge about the laws protecting OVCs, Masuka *et al* (2012:61) argue that Zimbabwe does have a legislative foundation, which could be used as a base to improve child protection.

### **5.2.3. Theme 3: Developmental needs**

The conclusions for objective 2 of the study pertain to the developmental needs of OVCs affected by HIV and AIDS in Gokomere (see Table 2). The need for education was cited as being important for the development of OVCs affected by HIV and AIDS. A lack of monitoring and supervision of the educational progress of OVCs and the impact of low levels of household income have detrimental effects on the education of OVCs.

#### **5.2.3.1 Category 1: Need for education**

It was apparent from the findings of this study that HIV and AIDS have put a lot of financial strain on the limited resources of the affected families. As a result, OVCs might not be able to attend school. These findings are congruent with those of Zagheni (2011:763) who notes that the HIV epidemic can put financial strain on households and there may be insufficient funds for OVCs to attend school.

The BEAM programme that is administered by the Ministry of Education Sport and Culture (MoESC) in collaboration with the Department of Social Service (DSS) has remained an important financial security programme for OVCs to get their rights to education (Masuka *et al* 2012:61). This study found that some OVCs were assisted by the BEAM programme to ensure that they continued going to school after the death of their parents. However, the study done in Bindura District, Zimbabwe by Chitiyo *et al* (2008:332) points out that the BEAM scheme negatively affected the poor due to bias in the selection of beneficiaries, during which some needy OVCs were left out. Furthermore, the study done in Mutare District, Zimbabwe by the HSRC (2008:147) reveals that an increasing number of OVCs could not be catered for by the BEAM programme, especially those at secondary-school level.

The findings of this study further revealed that unsupervised OVCs end up dropping out of school. They resort to looking for jobs and end up being exploited due to their lack of knowledge about the work they are doing. Others drop out of school due to financial constraints. It was apparent from the findings that there is a need for caregivers to monitor and supervise OVCs when they are in school to prevent them from dropping out. These findings were congruent with those of Chitiyo *et al* (2008:387) who find that caregivers should strive to ensure that OVCs schoolwork is always supervised to reduce school dropout rates. It was apparent from the findings of this study that caregivers should make the time to check the educational progress of OVCs to prevent OVCs from dropping out of school due to a lack of supervision.

#### **5.2.4. Theme 4: Traditional forms of care for OVCs**

The conclusions for objective 3 of the study pertain to community attempts to provide for the needs of OVCs affected by HIV and AIDS (see Table 13). The major community attempts to care for OVCs affected by HIV and AIDS were considered to be kinship care, non-kinship care, institutional care and adoption.

#### **5.2.4.1 Category 1: Kinship care**

This study's findings reveal that OVCs who were cared for in kinship care were those who stayed with their older siblings or parents who remarried. Those in kinship foster care stayed with aunts, uncles and grandparents. This study found that kinship care through recognised national laws is not common in Zimbabwe. This can be confirmed by the study done by Masuka *et al* (2012:66) who argue that although Zimbabwe may have legislation pertinent to children that includes the Children's Act, the Guardianship of Minors Act, the Maintenance Act, and the Child Abduction Act, it does not have a legislative foundation, which could be used as a base to improve child protection.

This study's findings revealed that OVCs preferred to remain with their extended families after the death of their parents in order to be able to identify with their family traditions and history. UNICEF (2006:6) and Garcia *et al* (2008:102) assert that OVCs need to grow up within their families to build their identities around their family history and customs. However, the care of OVCs in the extended family in this study was cited to be weakening due to inflation and migration making it difficult for the extended family to absorb OVCs.

Although the practice of widow remarrying was cited as a form of care for OVCs, key informants who participated in the study felt that widow remarrying should not be recommended due to high HIV infection rates. This study's findings further revealed that in these circumstances OVCs are in most cases neglected as the parent/s will be more concerned with their new partners and children. The findings from the study by Zagheni (2011:767) reveal that the prevalence of widow remarrying, which is still accepted in the rural areas, is very low among young men and women.

This study's findings confirmed that older siblings could take responsibility for younger ones after the death of parents. Sibling care was cited as the best form of caring for OVCs affected by HIV and AIDS. It ensures that OVCs remain in the homes of their parents. The study by Morgan and Roberts (2010:206) confirms that older siblings, especially females, are committed to caring for their younger brothers

and sisters after the death of a parent. As noted above, this form of care can enhance the identity of OVCs since they remain within the same family continuing with the same family traditions.

#### **5.2.4.2 Category 2: Non-kinship care**

In South Africa, OVCs are normally placed in non-kinship care in cases where the family or relatives of the child are not available (Budlender *et al* 2008:37). This study found that the placement of OVCs in non-kinship care through recognised national laws is not common in Gokomere. This study's findings identified two forms of non-kinship care for OVCs which are non-kinship foster care and community parenting.

From the findings of the study, OVCs felt that it is difficult to find a non-relative who can provide much needed care. They felt that non-relatives are not in a position to love OVCs compared to relatives because in most cases they are not after the money or inheritance of the deceased. However, contrary findings by Budlender *et al* (2008:37) suggest that non-kinship foster care through national laws (for example in South Africa) is a form of income-generation for non-kinship foster parent/s and there is a need for supervision and monitoring to ensure that the needs of OVCs are met.

The general views of the research participants in this study were that the care for OVCs should be the responsibility of everyone in the community. This study's findings revealed the research participants were of the opinion that members of the community should assist OVCs with food, clothing and shelter while others should offer bereavement support to the affected children. These findings are congruent with those in the study done in the Mutasa District, Zimbabwe by the HSRC (2008:156), which reveals that the communities of the Mutasa District play a key role in the provision of shelter for OVCs.

#### **5.2.4.3 Category 3: Institutional care**

Masuka *et al* (2012:63) define institutional care as the care for OVCs in a children's home. The findings of this study reveal that this form of care is not common in Gokomere. Garcia *et al* (2008:102) argue that institutional care tends to destroy the traditional forms of care for OVCs as children grow up divorced from their local culture. Key informants who participated in the study felt that for institutional care to be effective, OVCs should be allowed to visit their families while they are being cared for in children's home.

This study further revealed that the perception exists that OVCs who happen to be in children's homes are often abused by the caregivers. In Chapter 2 of the study, similar findings in other studies noted that there are often serious violations of OVCs rights in the form of systematic sexual abuse or exploitation, malnutrition, inadequate hygiene and healthcare, educational deprivation, strict regimentation and harsh discipline (Masuka *et al* 2012:63; Garcia *et al* 2008:106; Foster *et al* 2005:13).

#### **5.2.4.4 Category 4: Adoption**

This study's findings reveal that most of the community members in Gokomere are unaware of the practice of adoption and that they confuse "adoption" with "foster care." Key informants who were aware of the practice of adoption highlighted that members of the community are not in favour of adoption because they believe that an adopted child can bring misfortune to the family. Masuka *et al* (2012:62) in their study also note that in the event that a child is adopted, relatives may in future blame any misfortune in the family on the presence of a child with a totem from another family.

Key informants who participated in the study expressed the opinion that OVCs who have lost both parents should be adopted as a permanent plan in the care for OVCs. Adoption of children is not a common practice and legally documented in Zimbabwe. Section 157(b) (v) of the South African Children's Act (No. 38 of 2010) makes provision that every measure in securing stability of the child's life should be taken to

maintain the permanency care of the child. However, few individuals are interested in adopting a child who is HIV positive. Masuka *et al* (2012:62) argue that although adoption has been widely utilised in Western countries, it is not widely accepted in Africa.

### **5.2.5. Theme 5: Emerging forms of care for OVCs**

The conclusions for objective 3 of the study pertain to community attempts to provide for the needs of OVCs affected by HIV and AIDS (see Table 17). Two emerging forms of care for OVCs affected by HIV and AIDS were noted by research participants as being care in CHHs and HBC.

#### **5.2.5.1 Category 1: Home-based care**

HBC is the care given to an individual in his/her own natural environment by his/her family and supported by skilled social welfare officers and communities to meet not only his/her physical and health needs, but also his/her spiritual, material, and psychosocial needs (Masuka *et al* 2012:59). The findings of this study revealed that HBC programmes in the community were important in providing counselling and ensuring that parents write wills before they die. This type of care for OVCs was also provided by members of religious groups and other concerned community members.

It was apparent from the findings of this study that HBC programmes give OVCs the opportunity to talk to their parents before they die rather than if they were to be cared for in hospitals. OVCs further stated that they preferred seeing their parents dying at home rather than having to incur the travelling expenses of going to see their parents in a hospital. These findings were congruent with a study done by Zagheni (2011:777) who argues that the advantage of HBC is that it reduces medical expenses that would have to be paid if somebody was cared for in a hospital.

### **5.2.5.2 Category 2: Child-headed households**

The research findings revealed that some relatives might not be willing to take care of OVCs, leading to them staying alone without any adult supervision. In most cases, OVCs inherited their parents' home and continued to provide for themselves. Similar findings were also noted by Muronda (2009:111) who noted that children often continue to stay on in their parents' homes and they assume parental responsibility over younger siblings.

Lack of Government support and strong kinship ties were reported to be the leading cause of the increased number of OVCs heading the households. The research participants felt that there is a need for Government to intervene in order to ensure that OVCs do not eventually head their own households. Contrary to this view, Muronda (2009) notes that the government should help to sustain and support CHHs by providing them with food, clothing and water. This assertion is further supported by Masuka *et al* (2012) who mention that the role of the government is to ensure that vulnerable children in CHHs are properly clothed and fed.

## **5.3. RECOMMENDATIONS**

The recommendations of the study are made based on the findings made. These include: recommendations for future research; policy recommendations in terms of how to meet the psychosocial needs of OVCs affected by HIV and AIDS; and community attempts to meet the psychosocial needs of OVCs affected by HIV and AIDS.

### **5.3.1. Recommendations for future research**

There is need to investigate the experiences of caregivers who are providing for the psychosocial needs of OVCs affected by HIV and AIDS. The psychosocial well-being of caregivers can improve the psychosocial support provided to OVCs affected by HIV and AIDS. Future research should concentrate on caregivers and could include information on how the HIV and AIDS epidemics affect them, most importantly with

regard to the fact that they are a population caring for OVCs affected by HIV and AIDS.

A focus on the experience of the OVCs cared for by their grandparents in rural communities could bring insight and understanding concerning grandparents' experiences, which would ensure that support provided to these children would meet their needs in a holistic way.

The challenges faced by families in the provision of adequate support to OVCs and lasting solutions to address these should also be a focus for future research. The provision of psychosocial support to OVCs affected by HIV and AIDS can be hampered when families are facing challenges in providing adequate support to these children. Insights regarding the challenges facing families will ensure that OVCs' needs are viewed within the family context.

### **5.3.2. Policy recommendations to provide for the psychosocial needs of OVCs**

To instill good values so that OVCs make the right choices in life and relate well to other people, different religious groups should be encouraged to do home visits to the families of OVCs. They could provide spiritual, material and psychosocial support and assist caregivers in their activities to take care of OVCs. The government should make the laws less stringent by allowing FBOs, CBOs and NGOs to visit OVCs and provide humanitarian help. The laws in Zimbabwe restricts group of people providing humanitarian services to the community since this is linked to some political activities. Coordinating mechanisms for the support of OVCs should be put in place and fully supported by organisations including Government. All organisations that support OVCs should be aware of these mechanisms. Organisations should work together to strengthen the care and support provided to OVCs affected by HIV and AIDS.

It is also recommended that families should be educated and encouraged to include OVCs as part of their parents' funerals arrangements. They should, in addition, ensure that succession planning is done in consultation with OVCs. To guarantee

the well-being of OVCs, there is a need to strengthen the OVCs' grandparents' and community elder's ability to provide psychosocial support. This can be done through awareness campaigns explaining to the grandparents the psychosocial needs of OVCs affected by HIV and AIDS.

There is a need to protect OVCs affected by HIV and AIDS from all forms of abuse. To ensure that OVCs are protected from abuse, stigma, discrimination, exploitation and dispossession of property, communities should establish legal structures for child protection in the rural communities to look into the rights of OVCs including rights to inheritance and land, and protection from all form of abuse, exploitation and discrimination.

It is also recommended that OVCs affected by HIV and AIDS should access education and acquire life skills for their future sustainability. School legislation should be revisited whereby exemption from fees for vulnerable children could be legislated and enforced to enable the OVCs to benefit from the education system. There is a need to cut the red tape associated with the disbursement of the BEAM funds. This will result in predictability, consistency, and improvement in the quality of this programme.

### **5.3.3. Recommendations regarding community attempts to care for OVCs**

The community should be encouraged to assist in the building and repairing of dilapidated houses especially those housing OVCs affected by HIV and AIDS. The community should contribute resources so that they can build housing structures for OVCs affected by HIV and AIDS. The NGOs and Government could also engage the community in income-generating projects geared towards improving the lives of OVCs affected by HIV and AIDS.

The government and NGOs should provide OVCs with clothing to protect them from adverse weather conditions. The HBC practice should encompass the holistic survival needs of OVCs affected by HIV and AIDS. These include food, clothing,

shelter and healthcare. All the themes that were covered in this study should form part of HBC practice in Gokomere.

Lastly, there is a need to strengthen the capacity of the extended families to absorb OVCs affected by HIV and AIDS. There should be coordinated efforts between the government and NGOs to ensure that laws are put in place that allow the caregivers of OVCs to get social grants that will help them to meet the needs of OVCs affected by HIV and AIDS. This good practice model could be copied from South Africa where needy children and their caregivers are entitled to a social grant that can sustain them.

#### **5.4. LIMITATIONS OF THE STUDY**

The study was conducted within the qualitative research paradigm and therefore findings cannot be generalised to the whole population. The relatively small sample in the study provided a convenient way of conducting the research, taking limited finances and transport problems due to the socioeconomic deprivation in the country into account. The psychosocial needs of OVCs affected by HIV and AIDS may vary from one location to other due to socioeconomic factors. However, generalisation was not the aim of the study, but rather an understanding of the phenomenon from the perspective of the participants.

The research quality is heavily dependent on the skills of the researcher and more easily influenced by the researcher's personal biases and idiosyncrasies. Bias in the data gathering and interpretation may have resulted from the fact that the researcher once worked in the community as a field officer before embarking on the study. The fact that the researcher grew up as an OVC himself could also have contributed to bias towards the feelings and needs of OVCs. In order to ensure that the study can be as objective as possible, a research assistant who was qualified as a social worker, assisted with data collection. Data-analysis notes were also given to colleagues for their input.

The researcher must acknowledge that the socioeconomic situation in Zimbabwe had a negative impact on the study. This was manifested in the way certain gatekeepers mistook the study for a type of charity. Some gatekeepers thought that the study will result in providing material needs to vulnerable households.

## **5.5. CONCLUSION**

The proliferation of OVCs affected by HIV and AIDS is an issue that continues to face Zimbabwe and other African countries. It is clear that OVCs affected by HIV and AIDS need psychosocial support in order to cope with the negative effects of the death of their parents. This study showed that OVCs in Gokomere have critical relationship, emotional and spiritual needs. They also need proper succession planning and social protection. It further highlighted that meeting the developmental and survival needs of OVCs also plays a crucial role in the provision of psychosocial support to OVCs affected by HIV and AIDS in Gokomere.

This study further highlighted that the local community cannot continue to absorb OVCs affected by HIV and AIDS. The traditional extended family is also no longer able to absorb OVCs. HBC emerged as a contemporary way to deal with the increasing proliferation of OVCs affected by HIV and AIDS in Gokomere. Some OVCs have resorted to staying alone in CHHs due to the failure of the extended family to absorb them. Adoption is not commonly practised due to the belief that adopted children bring misfortune to the family and institutional care is not widely accepted in the community.

As the researcher reflects on the study journey, he admits that interacting with OVCs affected by HIV and AIDS as they related their life stories was the hardest part of the study. The researcher discovered that the wounds of growing up as an OVC were still fresh and conducting the interviews with these was like ripping open a scab, leading to more bleeding. This was manifested by the way OVCs wept during the interviews.

The researcher recognises that the intimate details of OVCs' ill parents and their subsequent death were topics rarely discussed between OVCs and their caregivers. Consequently, probing the OVCs and caregivers to provide greater detail made the researcher feel uncomfortable in the beginning. However, the research participants' uncompromising nature actually made the researcher to realise how much they valued his study. From the researcher's observations, the OVCs seemed not to have previously spoken so deeply about their situation to other people, because they seemed socially withdrawn.

The most appropriate way to conclude the study is to mention that through coordinated efforts by the government, the NGOs/CBOs/FBOs and the community at large the problems facing OVCs affected by HIV and AIDS could be made better. It is critical that the government, NGOs/CBOs/FBOs and the community address the needs of OVCs. The battle against the AIDS pandemic will only be won by the involvement of all community members.

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### **Legislation – Acts, statutes and laws referred to in the text**

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*South Africa's Children's Act*. No 38 of 2005.

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*Zimbabwe Child Protection and Adoption Act*. Act 5 of 2005.

*Zimbabwe Constitution Act*. Act 19 of 2013.

*Zimbabwe Education Act*, Act 5 of 1987

## **ANNEXURE A: OVCs INTERVIEW GUIDE**

### **Introduction**

My name is Evidence Bande. I am studying at the University of South Africa and I am gathering information on the psychosocial needs of Orphans and Vulnerable Children (OVCs) affected by HIV and AIDS as part of the partial fulfillment of my degree. I would like to find out from you about the needs of OVCs. The information you give me will only be used for the purpose of this study.

1. What is it like to be a young person growing up in Zimbabwe today?

Probe:

- What are some things you like about being a young person today?
- What are some things you do not like about being a young person today?
- How do you feel about life in general?

2. Tell me what has changed for you since the death of your parent(s)?

Probe:

- How long has it been since your parent(s) died?

3. Did anyone tell you who you were going to stay with after the death of your parent(s)?

Probe:

- What were the arrangements made regarding the person you were going to stay with after the death of your parents?
- Did you like those arrangements?
- If there were no such arrangements, what would you have wanted to see happening?
- Do you have siblings?
- Where do your siblings stay/live?

4. What do you think are some of your needs as OVCs?

Probe:

- Do you have any person who loves you and take care of you? Who is that person? In what way does the person love and cares for you?
- Did you get any support before your parents died? Who supported you? In what way?
- Did you get any support after your parents died? Who supported you? In what way?
- Do you have friends? How often do you see your friends?
- What happened with your parents' possession when they died?
- Do you get medical attention when you are sick? Who fulfill this need? In what way?
- Do you go to school? Who fulfill this need? In what way?
- Do you have a place to stay? Who do you stay with?
- Do you get enough food? Who provide you with food?

5. What do you think the community or your caregivers can do to help you meet your needs?

Probe:

- What are your views about being cared for by your family relatives?
- What are your views about being cared for by a person who is not your relative or you being adopted?

6. What do you think the government can do to help you meet your needs?

Probe:

- What are your views if you were to be cared for at a children's home?
- What do you think NGOs can do to help you meet your needs?

7. How your father/mother's illness does affect you?

Probe:

- How did you deal with these effects?
- What new roles did you have to take up during your mother/father's illness?
- Who took care of your mother/father during their illness? Probe (Paternal or

maternal grandmother, aunty, brother/sister, no one)

- What helped to reduce the pain you were going through?

8. What are your interests?

Probe:

- at school
- at church
- in meeting with friends
- other interests

9. How does your involvement in the above activities mean to you?

10. What do you do when you have a problem?

11. Who do you talk to?

Probe:

- What problems do you talk about?

12. How do you feel after you have talked to these people?

13. What is AIDS and how is it transmitted? What is the source of your information?

14. What role do you see yourself playing in improving your own life? What do you think can be done to improve the lives of OVCs? (Expected answers: supporting each other and caregivers; surveillance of other children in the community for the early identification of vulnerable children)

15. How did you see your life in future when you have grown up?

**THANK YOU VERY MUCH FOR YOUR PARTICIPATION**

## **ANNEXURE B: CAREGIVERS INTERVIEW GUIDE**

### **Introduction**

My name is Evidence Bande. I am studying at the University of South Africa and I am gathering information on the psychosocial needs of Orphans and Vulnerable Children (OVC) affected by HIV and AIDS as part of the partial fulfillment of my degree. I would like to find out from you about the needs of OVCs. The information you give me will only be used for the purpose of this study.

1. How are you involved in the care of OVCs?

Probe:

- What is your role in the care of OVCs in Gokomere?
- 2. Who in your community is regarded as a vulnerable child? (Explore child's age, deceased parent's sex)
- 3. What are the difficulties that OVCs face in this community?

Probe:

- stigma
- lack of friends
- bereaving of the lost parents
- lack of representation in legal issues
- health/medical care
- education
- shelter
- food

4. What do you think are the needs of OVCs?

Probe:

- Do OVCs have someone who loves and take care of them? Who is the person? In what way are they loved and taken care of?
- Did OVCs get emotional support before parents die? Who provided emotional support? In what way?
- Did OVCs get emotional support after parents die? Who provided emotional

support? In what way?

- Do OVCs have friends? Do they get enough time to spend with friends?
  - Did OVCs get their parents' possessions when they died?
  - Do OVCs get health/medical care? Who fulfills this need? In what way?
  - Do OVCs go to school? Who makes sure that they go to school?
  - Do OVCs have proper shelter? Who makes sure they are sheltered? In what way?
  - Do OVCs get enough food? Who fulfill this need? In what way?
5. What are the traditional practices that are there to help OVCs to deal with their grief when parent(s) dies?
  6. What do guardians do to alleviate the emotional pain OVCs experience soon after the death of parent(s)?
  7. What type of psychosocial support can OVCs get?

Probe:

- From the community
  - From the government
  - From religious bodies
8. Who takes care of OVCs who have lost their parent(s) in your community?  
Probe if necessary (e.g., grandparents, relatives, neighbors, community, institutions)
  9. What type of care do you have in mind for OVCs?

Probe:

- Issues regarding permanent care, psychosocial support, educational support
  - Who should be responsible? (Immediate or extended family; adoption group; foster care family; institution - specify what kind of institution)
10. Where do most OVCs live here in Gokomere?

Probe:

- With one surviving parent in the community?
- With extended family [paternal] members?
- With extended family [maternal] members?
- Living and fending for themselves?

- Left the community going to unknown places?
- In an institution, such as orphanage, abandoned children's home, or live on the streets?

11. Does the extended family provide any kind of care/support for OVCs?

( ) Yes ( ) No

- If yes, probe for type of support. If no, ask why?
- Do you suspect that there have been any changes in the extended families' abilities to take care of their relatives' OVCs? Briefly describe.

12. In what way do you think the number of OVCs in this community has changed in the last two years? Probe for estimated number and direction of change.

13. Please tell me what are the support needs of people like you who care for OVCs?

Probe:

- Elderly people, such as 80-year-old grandparents
- Child heads of household
- Loans as opposed to grants

14. What are the training needs for psychosocial support of OVCs do you have?

Probe:

- Child heads of households (Example: skills in childcare, hygiene, skills in managing a home and budgeting).
- Caregivers who have never had children of their own/little or no experience in raising a child.

15. What is the community doing to address OVCs needs?

16. What do you think are the most important things you would like to be done for OVCs?

**THANK YOU FOR YOUR PARTICIPATION**

## **ANNEXURE C: KEY INFORMANT INTERVIEW GUIDE**

The key areas to be covered in the focus group discussion are numbered. Below these are prompts that may be used to elicit discussion, plus the particular areas that need to be covered in the focus group discussion. The prompts are only used when the respondent is finding it difficult to talk about the area. Responses are sought beyond the immediate prompts as long as the discussion stays within the broad subject.

### **Methodology**

The researcher will be taking notes of the discussion and the discussion will be tape recorded by an audio cassette.

1. What is the background of your organization?

Probe:

- How does your organization assist OVCs?
2. Who in your community is regarded as a vulnerable child? (Explore child's age, dead parent's sex)
  3. What do you think is the size of the problem in relation to psychosocial needs of OVCs?
  4. What impact is it having on this community?
  5. How did families and communities take care of each other, especially OVCs and children in need, during your grandparent's time?

Probe:

- Which of these practices are still in place?
6. Among the practices that are no longer in place, which would be helpful if they were reintroduced?
  7. What are the major problems facing OVCs in this community now?
  8. Have you noticed more OVCs in need of support/assistance (e.g., education, shelter, food, clothing) in this community in recent years? If so, what gave you this impression and what do you think are the underlying causes?
  9. How do you understand "psychosocial needs"?
  10. What are the psychosocial needs of OVCs affected by HIV and AIDS?

Probe:

- What are their needs for social protection?
- What are their needs for bereavement support?
- What are their needs for love and nurture?

11. What contributions is your organization making towards the care and support of OVCs?

Probe:

- How can you increase and sustain the capacity of your organization to do so?

12. What contributions is Gokomere community making towards the care and support of OVCs?

- How can you NGOs/FBOs and church leaders increase and sustain the capacity of the community to do so?

13. What do you feel is the attitudes of the community toward OVCs affected by HIV and AIDS?

14. What are the attitudes of people in Gokomere towards OVCs?

Probe:

- What are the perceptions of OVCs by people of Gokomere?
- What kind of psychosocial support services offered to OVCs?

15. Are there any government policy and legislation for the protection of OVCs?

Probe:

- Do OVCs have knowledge of law, policies or pre-established practice to protect them?
- Do OVCs aware that are protected by such laws?

16. Do you have any suggestions on how to help in the meeting of psychosocial needs of OVCs in the community?

Probe:

- What is the role of individuals, NGOs, FBOs, the church and state structures?
- What is needed to facilitate these contributions?

## **ANNEXURE D: OVCs ASSENT FORM**

Dear Participant

### **PARTICIPATION IN AN INTERVIEW**

This letter serves to invite you to participate in an interview in partial fulfillment of the requirements to complete a Dissertation of Limited Scope towards a MA degree in Social Behaviour Studies in HIV and AIDS in the Department of Sociology, UNISA. The dissertation seeks to understand the psychosocial needs of orphans and vulnerable children affected by HIV and AIDS in a rural area of Masvingo Province, Zimbabwe. The dissertation is being supervised by Ms Elize Koen (+27124296600) from UNISA's Department of Sociology

### **Purpose of the study**

The purpose of this study is to understand the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere.

### **Selection of the participants**

The children who will answer my questions are those between the age of 12 and 15 years who have lost one or both parents and who lives in Gokomere. You have therefore been selected to be part of this study because your age is between 12 and 15 years, you have lost one or both parents and you stay in Gokomere.

### **Voluntary Participation**

Be informed that you are not forced to take part in the study. Even if the guardian/caregiver allowed you to take part in the study, the final decision rests on you and you are allowed to choose not to take part. There is no penalty for pulling out of the study at any stage. You are also free to raise any questions, concerning the study before, during and after the undertaking of the study. Your questions will get a response from the researcher.

### **Procedure**

The researcher will ask you questions that you are requested to answer and in order

for the researcher to remember what you would have said, the researcher will use a tape-recorder. Do not be afraid to tell the researcher the questions that you are not comfortable to answer. The interview will take place at Batanai HIV/AIDS Service Organization and will be in the form of a conversation in which you will be asked questions relating to the psychosocial needs of OVCs affected by HIV and AIDS. As a result, you are kindly requested to be as honest as possible reflecting your own personal opinion.

### **Risks and Discomforts**

The questions the researcher is going to ask you may require you to share some personal, confidential and sensitive information. In doing so, you may feel uncomfortable talking about some of the topics. You are therefore free to refuse to answer any questions which you may deem too personal.

### **Benefits**

There are no direct benefits from this study. Recommendations will be made to the local government on what can be done to address the identified psychosocial needs of OVCs.

### **Incentives**

There is no reward for your participation in this study.

### **Confidentiality**

The information the researcher obtain from you about you identity shall be between the researcher, yourself and his supervisor. The researcher will not share this information with anyone else. The tape recordings will be destroyed after the researcher has finished using it. If the researcher happens to give the tape to the supervisor as proof that you took part in the research, the supervisor will destroy the tape after checking it.

Please find attached an assent form that you are required to sign and return to the researcher as a matter of priority.

Thank you for agreeing to participate in this research project.

Kind regards

A handwritten signature in black ink, appearing to read 'Ujjwal', enclosed within a faint rectangular border.

EVIDENCE BANDE

Student Number: 46541500

ID 54-083974C-54 Cell: +27718694913

Email: [bande92@gmail.com](mailto:bande92@gmail.com)

ASSENT FORM FOR PARTICIPATION IN AN IN-DEPTH INTERVIEW

I \_\_\_\_\_ have been told about this research being conducted at *Batanai HIV and AIDS Service Organization (BHASO)*. I have been told about my role in the study and the role of the researcher and how this might affect me. I have been encouraged to ask questions and have had my questions answered. I have also been informed that participation in this study is voluntary and I may refuse to be in the study or I may withdraw from the study at any time. By signing below, I agree to participate voluntarily in this research study. I will receive a copy of this signed assent form.

-----  
SIGNATURE OF CHILD

-----  
DATE

*The undersigned researcher hereby declares that he had the opportunity to discuss the research project with the concerned child participant. He has explained the details of the information contained in the assent form document.*

-----  
SIGNATURE OF RESEARCHER

-----  
DATE

Dear Parent/Guardian

PARENT/GUARDIAN INFORMED CONSENT FOR CHILD TO BE RESEARCH PARTICIPANT

*This serves as a request to allow your child to participate in an in-depth interview as part of my research towards the completion of my Dissertation of Limited Scope towards a MA degree in Social Behaviour Studies in HIV and AIDS in the Department of Sociology, UNISA. The Dissertation seeks to understand the psychosocial needs of orphans and vulnerable children affected by HIV and AIDS in a rural area of Masvingo Province, Zimbabwe. The dissertation is being supervised by Ms Elize Koen (+27124296600) from UNISA's Department of Sociology.*

*The study will be conducted in Gokomere, a rural area of Masvingo Province in Zimbabwe. The researcher will ensure that the child will not be emotionally harmed. If so, debriefing will be provided whether by the researcher who is a qualified social worker or your child will be referred to another organisation for counselling. Please note that participation is voluntary and the child can withdraw at any stage during the study.*

*The information that is going to be gathered from your child will be coded in order to identify emerging themes and their subsequent relationships to the main objective of the study. Every attempt will be made by the researcher, to keep the identity of all research participants strictly confidential.*

*Please indicate that you permit your child to participate in this study by signing below.*

-----  
PARENT/GUARDIAN'S SIGNATURE

-----  
DATE:

## **ANNEXURE E: CAREGIVER CONSENT FORM**

Dear Participant

### **PARTICIPATION IN AN INTERVIEW**

This letter serves to invite you to participate in an interview as part of the partial fulfillment of the requirements to complete a Dissertation of Limited Scope towards a MA degree in Social Behaviour Studies in HIV and AIDS in the Department of Sociology, UNISA. The Dissertation seeks to understand the psychosocial needs of orphans and vulnerable children affected by HIV and AIDS in a rural area of Masvingo Province, Zimbabwe. The dissertation is being supervised by Ms Elize Koen (+27124296600) from UNISA's Department of Sociology.

### **Purpose of the study**

The general purpose of this study is to obtain a detailed insight and understanding of the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere.

### **Voluntary Participation**

Be informed that the decision to participate in this study entirely rest on you. There is no penalty for pulling out of the study at any stage. You are also free to raise any questions, pertaining to the study before, during and after the undertaking of the study. Subsequently, you will get a response from the researcher.

### **Selection of participants**

You have been selected to participate in the study because you are a caregiver of an OVC and have some knowledge and experience on child care.

### **Procedure**

The researcher will ask you questions that you are requested to answer and in order for the researcher to remember what you would have said, the researcher will use a tape-recorder. Do not be afraid to inform the researcher about the questions that you are not comfortable to answer. The interview will take place at Batanai HIV/AIDS Service Organization and will consist of a conversation in which you will be asked

questions relating to the psychosocial needs of OVCs affected by HIV and AIDS. As a result, you are kindly requested to be as honest as possible reflecting your own personal opinion.

### **Risks and Discomforts**

The questions the researcher is going to ask you may require you to share some personal, confidential and sensitive information. In doing so, you may feel uncomfortable talking about some of the topics. You are therefore free to refuse to answer any questions which you may deem too personal. Some of the questions that you will be asked may touch on sensitive areas, hence to minimize your discomfort, the researcher is going to give counselling or refer you to an appropriate organisation for such service.

### **Benefits**

There are no direct benefits from this study. Recommendations will be made to the local government on what can be done to address the identified psychosocial needs of OVCs.

### **Incentives**

There is no reward for your participation in this study.

### **Confidentiality**

The information the researcher obtain from you about your identity shall be between the researcher, yourself and his supervisor. The researcher will not share this information with anyone else. The tape recordings will be destroyed after the researcher has finished using it. If the researcher happens to give the tape to the supervisor as prove that you took part in the research, the supervisor will destroy the tape after checking it.

Please find attached a consent form you are requested to sign and return to the researcher as a matter of priority.

Thank you for agreeing to participate in this research project.

Kind regards

A handwritten signature in black ink, appearing to read 'Ujjwal', written in a cursive style.

EVIDENCE BANDE

Student Number: 46541500

ID 54-083974C-54 Cell: +27718694913

Email: [bande92@gmail.com](mailto:bande92@gmail.com)

CAREGIVER CONSENT FOR PARTICIPATION IN AN IN-DEPTH INTERVIEW

I \_\_\_\_\_ have been told about this research being conducted at *Batanai HIV and AIDS Service Organization*. I have been told about my role in the study and the role of the researcher and how this might affect me. I have been encouraged to ask questions and have my questions answered. I have also been informed that participation in this study is voluntary and I may refuse to be in the study or I may withdraw from the study at any time. By signing below, I agree to participate in this research study. I will receive a copy of this signed consent form.

-----  
SIGNATURE OF CAREGIVER

-----  
DATE

*The undersigned researcher hereby declares that he had the opportunity to discuss the research project with the concerned caregiver. He has explained the details of the information contained in the consent form document.*

-----  
SIGNATURE OF RESEARCHER

-----  
DATE

## **ANNEXURE F: KEY INFORMANT CONSENT**

Dear Informant

### **PARTICIPATION IN A KEY INFORMANT FOCUS GROUP DISCUSSION**

This letter serves as an invitation for you to participate in a key informant focus group discussion as part of my research towards the completion of my Dissertation of Limited Scope towards a MA degree in Social Behaviour Studies in HIV and AIDS in the Department of Sociology, UNISA. The Dissertation seeks to understand the psychosocial needs of orphans and vulnerable children affected by HIV and AIDS in a rural area of Masvingo Province, Zimbabwe. The dissertation is being supervised by Ms Elize Koen (+27124296600) from UNISA's Department of Sociology

#### **Purpose**

The general purpose of this study is to obtain a detailed insight and understanding of the psychosocial needs of OVCs affected by HIV and AIDS in Gokomere.

#### **Voluntary Participation**

Be informed that the decision to participate in this study entirely rest on you. There is no penalty for pulling out of the study at any stage. You are also free to raise any question, pertaining to the study before, during and after the undertaking of the study. Subsequently, you are assured of a response by the researcher.

#### **Procedures**

As a key informant participant, you will be invited to participate in a focus group discussion that will be facilitated by the researcher. A tape recorder is going to be used for the benefit of the researcher to remember what will be raised during focus group discussions.

#### **Risks**

Some of the questions that you will be asked may touch on sensitive areas, hence to minimize your discomfort, the researcher is going to give counselling or refer you to an appropriate organisation for such service. You are encouraged to discuss with the

researcher any negative feelings of discomfort you experience as a result of participating in this research project. You are free to pull out of the research at any time you feel to do so.

### **Compensation**

There are no financial benefits or any other compensation directly associated with participation in this research project. However, the researcher believes that it is likely that participants will benefit from attending the group interventions as participants will be sharing ideas on the psychosocial needs of OVCs affected by HIV and AIDS.

### **Confidentiality**

Every attempt will be made by the researcher to keep the names of all participants in this study strictly confidential, except as may be required by court order or by law. If any publication results from this research, you will not be identified by name.

Please find attached a consent form you are requested to sign and return to the researcher as a matter of priority.

Thank you for agreeing to participate in this research project.

Kind regards



EVIDENCE BANDE

Student Number: 46541500

ID 54-083974C-54 Cell: +27718694913

Email: [bande92@gmail.com](mailto:bande92@gmail.com)

**CONSENT FOR PARTICIPATION IN A KEY INFORMANT FOCUS GROUP  
DISCUSSION**

KEY INFORMANT CONSENT FOR PARTICIPATION IN A FOCUS GROUP  
DISCUSSION

I \_\_\_\_\_ have been told about this research being conducted at Batanai HIV and AIDS Service Organization. I have been told about my role in the study and the role of the researcher and how this might affect me. I have been encouraged to ask questions and have my questions answered. I have also been informed that participation in this study is voluntary and I may refuse to be in the study or I may withdraw from the study at any time. By signing below, I agree to participate in this research study. I will receive a copy of this signed consent form.

-----  
SIGNATURE OF KEY INFORMANT

-----  
DATE

*The undersigned researcher hereby declares that he had the opportunity to discuss the research project with the concerned caregiver. He has explained the details of the information contained in the consent form document.*

-----  
SIGNATURE OF RESEARCHER

-----  
DATE

## **ANNEXURE G: LETTER REQUESTING PERMISSION TO CONDUCT THE STUDY**

### **RE: REQUESTING PERMISSION TO CONDUCT A STUDY**

This letter serves to request permission to conduct a study as part of my research towards the completion of my Dissertation of Limited Scope towards a MA degree in Social Behaviour Studies in HIV and AIDS in the Department of Sociology, UNISA. The study seeks to understand the psychosocial needs of orphans and vulnerable children (OVCs) affected by HIV and AIDS in Gokomere.

The data is going to be gathered from OVCs, caregivers and representatives of NGOs/FBOs and church leaders. As an NGO/FBO or church, your organization will be requested to participate in a focus group discussion about the psychosocial needs of OVCs affected by HIV and AIDS. Once the data is gathered, it will be coded in order to identify emerging themes and their relationships to the objectives of the study. Every attempt will be made by the researcher to keep identity of the research participants strictly confidential.

With your permission to conduct this study, local level recommendations will be made on what needs to be done to address the identified psychosocial needs of OVCs. Please note that this study is being supervised by Ms Elize Koen (+27124296600) from UNISA's Department of Sociology

Your permission to undertake this study will be highly appreciated

Kind regards



EVIDENCE BANDE

Student Number: 46541500

ID 54-083974C-54 Cell: +27718694913

Email: [bande92@gmail.com](mailto:bande92@gmail.com)

# ANNEXURE H: LETTERS GRANTING PERMISSION TO CONDUCT THE STUDY



# BHASO

Batanai HIV & AIDS Service Organisation

PVO-16/96

6 Rekayi Tangwena Ave, P.O Box 1707, Masvingo, Zimbabwe

Tel/Fax+263 39 264960 Cell: +263 912 405 790/913 415 292

Email: batanai@bhaso.org Web: www.bhaso.org



01-11-2012

Programme Convener  
Department of Sociology  
UNISA  
P. O. Box 392  
UNISA, 0003

**RE: Letter of access for research for Mr. E. Bande**

Following your request on the above matter, this letter serves to inform you that Mr E. Bande has been granted access to conduct his research at our institution. He will be working on his research under the Positive Development Department for the purpose of his research. The department has a project which works with the Children, Families and Communities affected by poverty, Conflict, HIV and AIDS.

Batanai HIV and AIDS Service Organization (BHASO) in Zimbabwe works to empower the people infected and affected by HIV. It works and partners with communities in Masvingo province covering 1 urban and 6 rural districts in the province. We hope that he will have a conducive environment to conduct his research for the partial fulfillment of his studies.

Yours Sincerely

F. P Mahaso  
BHASO- Coordinator



care

support

PVO 16/96