

**AN EXPLORATORY STUDY OF QUALITY OF LIFE AND
COPING STRATEGIES OF ORPHANS LIVING IN CHILD-
HEADED HOUSEHOLDS IN THE HIGH HIV/AIDS
PREVALENT CITY OF BULAWAYO, ZIMBABWE**

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I am a Hero



AN EXPLORATORY STUDY OF QUALITY OF LIFE AND COPING STRATEGIES OF ORPHANS LIVING IN CHILD-HEADED HOUSEHOLDS IN THE HIGH HIV/AIDS PREVALENT CITY OF BULAWAYO, ZIMBABWE

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I declare that **AN EXPLORATORY STUDY OF QUALITY OF LIFE AND COPING STRATEGIES OF ORPHANS LIVING IN CHILD-HEADED HOUSEHOLDS IN THE HIGH HIV/AIDS PREVALENT CITY OF BULAWAYO, ZIMBABWE** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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1 June 2005

Summary

An exploratory study of quality of life and coping strategies of orphans living in child-headed households in the high HIV/AIDS prevalent city of Bulawayo, Zimbabwe

A distressing consequence of the HIV/AIDS pandemic and of the increasing numbers of orphans and decreasing numbers of caregivers is the emergence in ever larger numbers of child-headed households (CHHs). The complexity of issues affecting CHHs and the lack of research on this subject means that CHHs are not well understood. This sometimes prompts support agencies to provide emotionally driven recommendations suggesting that it is better for a child to be in an orphanage than to live in a CHH. This exploratory study, involving heads of 105 CHHs over a 12 month period and 142 participants in various focus group discussions (FGD) and interviews, suggests the need for a change in perspective. It addresses the question of CHH quality of life, coping strategies and household functioning and attempts to bring this into a productive dialogue with community child care activities, NGO and statutory support and child care and protection policies.

Research data suggests that the key determining factor contributing towards the creation of a CHH is 'pre-parental illness' family conflict. Another contributing factor is that siblings want to stay together after parental death. Quality of life assessments indicate that despite significant adversities, over 69% of CHHs reported a 'medium' to 'satisfactory' quality of life and demonstrate high levels of resilience. As regards vulnerability to abuse, it is found that while CHH members are more vulnerable to external abuse, they experience little within their household. Contrary to public perceptions about CHHs lacking moral values, CHH behaviour might actually be more responsible than non-CHH peer behaviour as their negative experiences appear to galvanize them into adopting responsible behaviour. Community care and neighbourhood support in older townships are better established compared with newer suburbs. Sufficient community care capacity enables CHHs to function, thus avoiding a situation where households disintegrate and household members end up

as street children. CHH coping responses seem to be mainly influenced by individual and community factors, and by social, spiritual and material support. The interplay between these and the CHH's ability to engage in the required coping task impacts on the coping outcome at household level.

National and international government and non-governmental child service providers in Southern Africa need to recognize that an adequately supported CHH is an acceptable alternative care arrangement for certain children in communities with high adult AIDS mortality and where adult HIV-prevalence exceeds 10%.

Key words:

HIV/AIDS; children; orphans; child-headed households; quality of life; coping strategies; vulnerable children; children affected by AIDS; children's rights; child protection; child welfare policy; community child care capacity; psychosocial support; social safety nets; social policy

Opsomming (Afrikaans Summary)

‘n Onderzoekendestudie van die lewenskwaliteit en hanteringstrategieë van weeskinders, woonagtig in kinderbeheerde huishoudings (KBH) in die stad Bulawayo, Zimbabwe met sy hoë voorkoms van MIV/VIGS.

KBH (huishoudings met kinders aan die hoof), ‘n gevolg van toenemende getalle weeskinders en afnemende getalle volwasse versorgers, is ‘n onrusbarende voortvloeiende van die VIGS pandemie. Die kompleksiteit van kwessies rakende KBH en die leemte in navorsing dra by tot die swak begrip van KBH situasies. Dit spoor steunorganisasies aan tot die bevordering van emosioneel-gedrewe aanbevelings wat die indruk skep dat dit voordeliger vir ‘n kind is om in ‘n weeshuis opgeneem te word as om in ‘n KBH te woon. Hierdie onderzoekendestudie van 105 KBH hoofde, tussen die ouderdom van 15 tot 19 jaar, oor ‘n tydperk van 12 maande asook 142 deelnemers aan verskeie fokus groepsbesprekings en onderhoude, suggereer die noodsaaklikheid vir ‘n verandering in perspektief. Dit het die kwessies aangespreek oor KBH lewenskwaliteit, hul hanteringstrategieë en hoe sulke huishoudings funksioneer en in verband staan met kindersorgaktiwiteite in die gemeenskap, NROs en statutêre ondersteuning en die implikasies van daardie bevindings vir kindersorg en beskermingsbeleide.

Dit blyk uit navorsingsdata dat die sleutel-bepalende faktor, wat tot die skep van ‘n KBH bydra, ‘pre-ouerlike siekte’ familiekonflik is. Nog ‘n bydraende faktor is die feit dat broers en susters nie geskei wil wees na die afsterwe van ouers nie. Evaluasies van lewenskwaliteit dui aan dat, desondanks teenspoed ondervind, 69% van KBH ‘n medium tot bevredigende lewenskwaliteit rapporteer het en hoë vlakke van veerkragtigheid demonstreer. Betreffende kwetsbaarheid vir mishandeling blyk dit dat, alhoewel KBH meer kwetsbaar vir eksterne mishandeling is, hulle min in hul eie huishouding ondervind. Teenstrydig met publieke persepsies dat KBH morele waardes ontbreek, mag KBH gedrag in werklikheid meer verantwoordelik as nie-KBH groepsgedrag wees aangesien hulle uitdagings tot verantwoordelike gedrag bydra. Gemeenskapsorg en buurtondersteuning in ouer woongebiede is sterker gevestig in

vergelyking met jonger voorstede. Voldoende kapasiteit vir gemeenskapsorg maak dit moontlik vir KBH om te funksioneer in plaas daarvan om te disintegreer en die lede van die huishouding in straatkinders te ontlaad.

Klaarblyklik word KBH hanteringswyses hoofsaaklik deur individuele en gemeenskapfaktore, sosiale, geestelike en materiële ondersteuning beïnvloed. Interaksie tussen hierdie en die KBH se vermoë om aan die vereiste hanteringsuitdaging te voldoen, het 'n uitwerking op die hanteringsuitkoms op huishoudelike vlak.

Nasionale en internasionale regering en nie-regering verskaffers van kinderdiens in Suidelike Afrika behoort in te sien dat 'n voldoende ondersteunde KBH 'n aanvaarbare alternatiewe sorgmaatreël vir sekere kinders is in gemeenskappe waar volwasse MIV voorkoms 10 persent oorskry.

Sleutelwoorde:

MIV/VIGS; kinders; weeskinders; kinderbeheerde huishoudings; lewenskwaliteit; hanteringstrategieë; kwetsbare kinders; kinders met VIGS onderlede; kinderregte; kinderbeskerming; kinderswelsynbeleid; gemeenskapkindersorg kapasiteit; psigo-sosiale steun; sosiale veiligheidsnet; sosiale beleid.

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Ad majorem Dei gloriam

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Glossary

Acquired	not inherited in the genes from one's parents, but from the environment
AIDS-related disease	or HIV-related disease; symptoms caused by HIV-infection that do not necessarily indicate full blown AIDS
ARV drugs	drugs that fight retroviruses (such as HIV)
Bereavement	refers to the whole process of grieving (see below) and mourning and is associated with a deep sense of loss and sadness
Child-headed household	a household where both parents or alternative adult caregiver are permanently absent and the person responsible for the day to day management of the entire household is aged 20
Community	Groups in a certain geographical area with which common rules, aspirations, constraints and opportunities can be identified
Coping strategies	to contend with difficulties and act to overcome them
Epidemic	an unusual marked increase in cases in a fairly short period of time
Food security	access by all people all the times to enough food for an active healthy life
Gender	refers to the social relationship between women (girls) and men (boys) as opposed to biological sex differences
Gender equality	equal opportunity and equal enjoyment by women and men, girls and boys, of rights, resources and rewards
Gender equity	means fairness and justice in the distribution of benefits and responsibilities between gender
Grief	intense sorrow caused by loss of a loved one (especially through death)
Gross Domestic Product	basic measure of national economic well-being including the total expenditure by national residents, or goods and services for consumption etc. (over one year)
Guardian / caregiver	any person caring for a non-biological child whose parents cannot do so for one reason or another
Home-based care	care at home for terminally or chronic ill patients, is in Southern Africa often provided by volunteers e.g. Red Cross volunteers
Informed consent	gaining the consent of participants who are fully aware of the process and consequences of the research. Informed consent for children should be sought also from their guardian or programme support staff
Nevirapine	one of the most affordable and widely used ARVs to prevent HIV transmission from parent to child
Orphan	any child below the age of 18 who has lost one or both parents
Pandemic	a global or very wide spread epidemic (see above)
Poverty	living in a state where important human needs (e.g. taxonomy of human needs, Max-Neef) are not adequately met on an ongoing basis
Prevalence	the level of existing infection in a population at one point in time, regardless of when the infection occurred
Protagonism of children	Implies for adults and their institutions to respect and support children as equal and essential partners in the organising of their lives (doctrine of integral support)
Psychosocial support	includes interventions that assist children and families to cope and enable children to experience love and protection that allow them to have a sense of self-worth and belonging
Quality of life	individuals' perception of their position in life in the context of the culture and value system in which they live and in relation to their goals, expectations and concerns
Redd Barna	Save the Children, Norway

Resilience	ability to bounce back and learn from adverse situations
Seropositive	having antibodies to HIV, being HIV positive
Social safety nets	formal, informal and traditional social security systems
Stake-holders	persons, groups or institutions with interests in a programme or activity because it will affect them in some way
Triangulation	is the use of a mix of methods, sources, information and/or researchers to acquire different perspectives on a situation. This increases the trustworthiness of information generated in research.
Values	a set of ideas that are normatively shared by members of a community (see above). These are shaped by several key influencing factors including ideology, religion, culture, history and political systems
Vulnerable children	a child who is below the age of 18 who has been, is in, or is likely to be in a risky situation, where he/she is likely to suffer significant physical, emotional or mental harm

Abbreviations

10MMP	Ten Million Memory Project
ACC	African charter of the rights and welfare of the child
AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
ASI	Anti-Slavery International
BBC	British Broadcasting Corporation
BCC	Bulawayo City Council
BCCA	Bulawayo City Council Administration
BICC	Brethren in Christ Church
BDJD	Bi-daily journal data sheet
BEAM	Basic education assistance model
CABA	Children affected by AIDS
CBO	Community-based organisation
CD	Compact disk
CEDC	Children in extremely difficult circumstances
CFSEI	Culture free self esteem inventory
CG	Community group study participants
CHH	Child-headed household
CINDI	Children in distress
CNSP	Children in need of special protection
CPS	Child Protection Society
CRC	Convention on the rights of the child
CRS	Catholic Relief Services
CSO	Central Statistic Office
CV	Children village
CWF	Child Welfare Forum
DCOF	Displaced Children and Orphans Fund
DFCI	Defence for Children International
DHS	Demographic health survey
DRC	Democratic Republic of Congo
DSW	Department of Social Welfare
ESAP	Economic structural adjustment programme

FACT	Family AIDS Caring Trust
FBO	Faith-based organisation
FGD	Focus group discussion
FHI	Family Health International
FOCUS	Families Orphans and Children Under Stress
FOST	Family Orphan Support Trust
GDP	Gross domestic product
GNP	Gross national product
GoZ	Government of Zimbabwe
HBC	Home-based care
HDI	Human development index
HEARD	Health Economics and HIV/AIDS Research division University KwaZulu-Natal
HH	Household
HIV	Human immunodeficiency virus
HIV+	HIV seropositive
HOCIC	Hope for a Child in Christ
HSRC	Human Science Research Council
ICDS	Inter-censal demographic survey
ICG	International Crisis Group
IFSW	International Federation of Social Workers
IHHA	International HIV/AIDS Alliance
ILO	International Labour Organisation
IQ	Intelligence quotient
IRP	International Resilience Project
JOL	Journey of life
KOP	Key operating partner
MAC	Matabeleland AIDS Council
MC	Masiye Camp study participants
MCHHC	Masiye CHH camp participants
MDC	Movement for Democratic Change
MMP ZW	Million Memory Project Zimbabwe Trust
MSc	Masters of Science
MSR	Market Research Society
MTCT	Mother-to-child transmission
N	Total number of respondents for response histograms
NAC	National AIDS Council
NACP	National AIDS Control Programme
NASWZ	National Association of Social Workers in Zimbabwe
NGO	Non governmental organisation
NMC	Non masiye camp participants
NMF	Nelson Mandela Foundation
NPA	National plan of action
OCVA	Orphans and children made vulnerable by AIDS
OR	Odd ratio
ORAP	Organisation of rural associations for progress
OVC	Orphans and vulnerable children
PEN-3	Model for cultural analysis using a Venn-diagram
PPTCT	Prevention of parent to child transmission
PSS	Psychosocial support
PVO	Private voluntary organisation
QOL	Quality of life
REPSSI	Regional Psychosocial Support Initiative

RSA	Republic of South Africa
SADC	Southern African Development Community
SAfAIDS	Southern African AIDS Information Dissemination Services
SC UK	Save the Children UK
SCF	Save the Children Fund
SDA	Seven Day Adventist
SDC	Swiss Agency for Development and Cooperation
SIDA	Swedish International Development Agency
SIV	Simian immunodeficiency virus
SRM	Social risk management
SSS	Social support scale
Std. Dev	Standard deviation
STRIVE	Support for Replicable, Innovative Village Level Efforts for Children
SUP	Scale up partner
TB	Tuberculosis
UBH	United Bulawayo Hospitals
UCCSA	United Church of Christ Southern Africa
UCT	University of Cape Town
UDI	Unilateral declaration of independence
UK	United Kingdom
UKZN	University of KwaZulu-Natal
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNISA	University of South Africa
UNRISD	United Nations Research Institute for Social Development
USAID	US Agency of International Development
USD	United States Dollars
VCT	Voluntary counseling and testing
Vol	Volunteer
VSI	Vijana Simama Imara 'youth standing firm'
WCRP	World Conference of Religions for Peace
WFP	World Food Programme
WHO	World Health Organisation
WHOQOL	WHO quality of life assessment psychometric tool
WHOQOL-BY	WHO quality of life assessment - short (bref) version for youth
WPSSI	Wechsler Pre-School and Primary Scale of Intelligence
YOCIC	Youth for a Child in Christ
Zanu-PF	Zimbabwe African National Union - Patriotic Front
ZAPU	Zimbabwe African Peoples Union
ZCTU	Zimbabwe Congress of Trade Unions
ZWD	Zimbabwe Dollars

1 Background to AIDS and children in Southern Africa

*Look what it has done to me
First it was my Papa, then my Mama followed
Both gone for a journey
A journey never to return.*

*Here I stand alone in the world
With nothing to call a family
With nowhere to call home
An orphan I have become, Yet I am so young.*

*Now my future is so uncertain
But I weep for you, I weep for us
Weep for us
Who are busy killing the future
Creating a generation of orphans.*

*Salim Yasin (2001), Poem by 7-year old from Pepo
La Tumaini Jangwani, Isiolo.*

1.1 Introduction

The aim of the first chapter is to provide an overview of the socio-economic and cultural context of the HIV/AIDS pandemic¹ in Southern Africa, and a general understanding of the impact of HIV/AIDS on society and on children in particular,. For this purpose an overview of HIV/AIDS, its history, origin, epidemiology, and its impact regarding, demographic, economic and social consequences is given.

The nature of the research is outlined and relevant underlying assumptions are stated. The chapter then briefly describes how the need for this study arose. The chapter closes with a presentation of the study objectives and its limitations.

1.2 Background to the research

The tragedy of HIV/AIDS is that it is a preventable disease and there was never any inevitability that it become a devastating pandemic. As early as 1985, countries in Southern Africa were aware of the dangers related to AIDS (Whiteside & Sunter 2000:xi). However, complex social, cultural and structural conditions, such as a labour system that encourages the separation of household members (Webb 1997:35), combined with high human mobility of people and a lack of political will, fuelled the spread of HIV/AIDS. The pandemic causes untold suffering at the household level, especially for those living with HIV, those dying from AIDS and their children (Germann 2002b:6).

1.2.1 HIV/AIDS in Southern Africa

The impact of HIV/AIDS is likely to reshape societies in hard hit countries in Africa over the next 30 years (Hunter 2003:41). Since HIV transmission in Africa is primarily through heterosexual contact, HIV/AIDS presents itself as a family disease.

¹ In this study the term HIV/AIDS *pandemic* instead of *epidemic* is used. According to the Merriam-Webster Medical Dictionary (2002) a pandemic is an epidemic (outbreak of contagious, fast spreading disease) 'occurring over a wide geographic area and affecting an exceptionally high proportion of the population.' This is clearly the case with HIV/AIDS in Africa.

Children in particular are severely affected by AIDS in their social context due to parental illness and death (Henry 2000:3). It is crucial to realise that the situation of orphans in Africa is long-term and large scale (UNAIDS, UNICEF & USAID 2004:3, Germann, Madörin & Ncube 2001:4). A proliferation of orphan-headed households (Foster 1997:155) are one key manifestation of social change due to HIV/AIDS and a practical example of how the pandemic is reshaping societies.

Short history of AIDS and the origin of HIV

By 1981, the first public record of a new disease, affecting homosexual men, haemophiliacs and people who had received blood transfusions in the United States appeared in the Morbidity and Mortality Weekly Review (MMWR 1981:305). The new disease was later called the **Acquired Immunodeficiency Syndrome (AIDS)**. Only in 1983, was the virus that causes AIDS identified and named, jointly by French and American scientists, as **Human Immunodeficiency Virus (HIV)**.

Over the years, there has been considerable speculation as to the origin of HIV. A discussion of those speculations does not fall within the scope of this study. Today the majority of scientists believe that HIV crossed the species barrier in the last century, probably in the 1930s (Korber 2000:1789). HIV is closely related to a number of Simian Immunodeficiency Viruses (SIVs) found in African non-human primates (e.g. chimpanzee SIV and macaque SIV) and most likely crossed over from these animals into humans (Cohen 2000b:2164). According to Lucas (2000) an accurate account on how the virus crossed the species barrier does not exist, as there are various conflicting theories that are mostly unconvincing or inconclusive.² We might never learn exactly how it happened. But we know, and are witness to, the result - that HIV/AIDS is causing untold human suffering and devastating communities across Africa (UNAIDS 2000:21).

² See the well-researched book, though controversial in its conclusion, [The River: A journey to the source of HIV and AIDS](#) by Hooper, E. 1999. for an in-depth description of the possible origin of HIV and the history of AIDS.

For some time there has been some questioning, notably and conspicuously in South Africa, of the link between HIV and AIDS, stating that HIV does not exist as a virus and that AIDS is a new name for a combination of old illnesses (Cohen 2000a:590). Obviously such dissident viewpoints cannot be ignored, but there is no debate among the majority of recognized international scientists on this issue. The arguments purporting to show that HIV does not cause AIDS have been carefully dissected and their flaws exposed³. HIV has been isolated in different laboratories contrary to dissident views, and clinical research has proved that there is a direct link between HIV viral loads and the manifestation of AIDS-related illnesses (Barrell 2000:4, Whiteside & Sunter 2000:3, Schechter, Craib, Gelmon, Montaner, Le & O'Shaughnessy 1993).

Epidemiology of HIV/AIDS

The ancient Greeks used the word 'epidemeion' for diseases that 'visit' a community (Mercer 1996:4). Modern epidemiology evolved in the second half of the 20th century and can be defined according to Katzenellenbogen, Joubert and Karim (1997:7) as:

The study of the distribution, frequency and determinants of health problems and disease in human populations, with the objective of prevention and controlling ill health.

In most cases, pandemics start slowly, often with insufficient notice being taken of the early warning signs. Then, at a certain point, a critical number of infected people is reached, and the growth of new infections suddenly accelerates. For this reason, it is not atypical for societies to be caught unawares by such diseases. Several factors peculiar to the epidemiology of HIV/AIDS have aggravated this situation. First among these was the early and then lingering public association of HIV/AIDS with homosexuality and drug use, which served to obscure the unique course that the disease was following in underdeveloped and media-deprived communities across Africa. Second has been the fractured and elongated 'time-line' over which the

³ The US National Institute of Allergy and Infectious Diseases published a paper [The evidence that HIV causes AIDS](#). (2000). This paper argues that HIV fulfils Koch's postulates as the cause for AIDS.

disease unfolds. So while HIV/AIDS is a single disease, within society it has appeared almost as a number of 'pandemics' following one upon the next: first the HIV pandemic, preceding the AIDS pandemic by around five to eight years; then the 'AIDS pandemic,' itself fractured into a host of 'smaller' epidemics taking the form of an array of opportunistic infections and illnesses. Thus both the lengthy incubation period and the diverging individual responses to immune-deficiency have sown confusion, as well as creating ripe conditions for public and private denial of the disease, and for misattributions and wayward social responses. And so, hot on the heels of the actual epidemiological pandemic, there have followed the social 'pandemics' - not only of orphanhood and household and community vulnerability and suffering, but also the social 'pandemics' of fear, denial and stigmatization (Kupp 1995:2).

Global picture

In 2004, the total number of people living with HIV/AIDS was estimated at over 39.4 million people with 3 million people estimated killed by the AIDS pandemic in the same year (UNAIDS 2004:1). The anti-retroviral (ARV) coverage of adults in developing countries in need of ARV treatment in 2003 was only 7% according to the World Health Organisation (WHO 2003), but is likely to rise due to the '3 by 5' (treating 3 million by 2005) WHO global treatment access campaign.

When AIDS was first identified, it was expected that the pandemic would follow a similar course globally. Contrary to expectations the pandemic has taken different paths in different parts of the world (UNAIDS 1999:6, Whiteside et al 2000:37). In some regions, especially Southern Africa, HIV infection rapidly became common among heterosexual populations. In other areas, it initially mainly affected high-risk 'sub-populations' such as intravenous drug users or those engaged in unprotected male-to-male penetrative sex (Trussler & Marchand 1997:74, UNAIDS 1999:10). A short overview of the situation in selected regions of the world follows and fosters an understanding of regional differences within the HIV/AIDS pandemic.

Eastern Europe and Central Asia, especially in the Ukraine, Moldavia and the Russian Federation, is experiencing the fastest growth in new HIV infection, especially among young high risk groups, such as intravenous drug users and commercial sex workers, who are living in economically depressed settings (Khodakevich 1997:2). Though the total numbers of HIV-infected people remains low, the trend is worrying, With over 1.4 million people estimated to be HIV-positive in this region, there has been an over nine-fold increase in infection in less than a decade (UNAIDS 2004:47)

In Western Europe, North America and Australia, the pandemic is largely under control due to well-funded prevention programmes and the availability of ARV therapy. Infection is largely confined to clearly defined high risk groups. But there are indications that new HIV infections among these high risk groups are again on the increase, amid concerns that access to life-prolonging therapies is inducing complacency about the risks of HIV and reviving high risk sexual practices (UNAIDS 2004:69).

This is an important and worrying observation, with direct implications for the Southern African region, where ARV therapy is becoming available on an ever larger scale and at low cost (Bloom 2000:2171). Because, if HIV prevention and education efforts - particularly the encouragement of condom use - are not simultaneously sustained and bolstered, the introduction of such drugs on a large scale poses the 'threat' of a very large pool of HIV-positive people being maintained in relative health for long periods. In the absence of a cure or of sustained and entrenched behavioural change, a large HIV-positive population under ARV treatment but still infectious poses a risk for a second 'wave' of HIV infection within society (Blower, Aschenbach & Khan 2003:10). While people on ARV treatment have a lower viral load, which somewhat reduces the risk of transmission, this is no cause for complacency - particularly since there are already media reports of new forms of the virus, resistant to multiple drug regimens, emerging among high-risk groups in the U.S. And in the African context,

fears have been sounded over drug resistance caused by lack of supportive medical infrastructure to ensure medical compliance (Foreman 2000:9).⁴

In Asia, with its great diversity and huge populations (India and China alone have a combined population of 2.35 billion people), the situation is mixed. Countries like Thailand with well-established HIV-prevention programmes have experienced a drop in HIV prevalence, especially among young women. At the same time HIV/AIDS continues to spread in this country among intravenous drug users (UNAIDS 2000:15). Though HIV prevalence in India and China is still below 1%, it is estimated that over five million Indians are infected (UNAIDS 2004:37). Unless preventative action against the spread of the pandemic in Asia is drastically ramped up, the worst is yet to come, because once infection levels rise to a critical level among the high-risk groups of a population, the disease starts to spread more widely (UNAIDS 2000:15). With over 8 million people already living with HIV in Asia, prevention, treatment, care and support needs to be given more attention (UNAIDS 2004:46).

Latin America and the Caribbean have over 2.2 million people living with HIV. The Caribbean, after Sub-Saharan Africa, is the second most infected region in the world with an average adult HIV prevalence of 2.3% and AIDS was in 2004 the leading cause of death in that region (UNAIDS 2004:31).

Although most countries in Latin America have HIV prevalence below 1%, some countries, notably Brazil, have a localized HIV epidemic especially among men who have sex with men and intravenous drug users. But heterosexual transmission is increasing, and women are being infected with HIV in larger numbers (Marins 2003). In the area of ARV treatment, Brazil remains an example among developing countries as it continues to offer ARV treatment to all people living with HIV through its national health service. As a result AIDS cases and AIDS mortality have declined. Several countries, including Argentina, Panama and Costa Rica are following the example of Brazil.

⁴ For an overview on issues of antiretroviral (ARV) therapy, see the Partners in Health publication (2004) The PIH guide to community-based treatment of HIV in resource-poor settings.

Sub-Saharan Africa is the epicentre of the global HIV/AIDS pandemic. For some time now, it has been the worst affected region, having just over 10% of the world's population, but contributing more than 60% of the global total of people living with HIV/AIDS. It is estimated that in 2004, over 2.3 million people died of AIDS in sub-Saharan Africa (UNAIDS 2004:19). The HIV/AIDS pandemic in this region has a uniquely complex character, as the following quote from Webb (1997:32) suggests:

The variables determining HIV epidemiology in Africa are not just physiological and psychological, but also sociological, economic, spiritual and political and always rooted in historical contexts.

For too long, 'African culture' has been viewed as the single overarching factor favouring 'high risk behaviour'. But this is a reductionist view. It suffices to point out that culture influences but does not necessarily determine domains such as sexuality, marriage and household and community structure, each of which is a key factor for potential HIV transmission (Webb 1997:35). Therefore sociological, economic, political and spiritual factors all need to be taken into account for the ways in which they contribute to the complex problems of HIV/AIDS. Due to higher vulnerability, especially in the 15-24 years age group, women show higher infection level than men. The reason for this situation is not yet fully understood, though studies suggest (Gregson, Nyamukapa & Garnett 2000:17) that the desire to marry and the accompanied search for a potential husband is potentially dangerous in high prevalence areas. And young women are more likely to accept high-risk sexual activity in the hope of securing a husband.

Infection levels are highest in Southern Africa. According to UNDP (2004) Life expectancy has dropped below 40 in the following countries - Botswana, Swaziland, Zimbabwe, Lesotho, Zambia, Malawi and Mozambique. Many of these countries have an estimated HIV prevalence of over 20% (McGeary 2001:49). According to the U.S. Census Bureau (1998) infection levels are projected to stay high for some time in most of these countries. In South Africa, as discussed in the section on the history of HIV, denial of the magnitude of the AIDS pandemic by elements of the political

leadership is contributing to increased levels of HIV infection and AIDS mortality. In February 2005, Statistics South Africa released a report on deaths in South Africa for 1997-2003. A massive increase of 57% in total deaths is recorded. Such a figure far outstrips population growth and cannot be accounted for by possible improvements in death registration data (Bourne & Geffen 2005). It can only be attributed to the HIV/AIDS pandemic.

In contrast, Uganda, where the pandemic first made itself felt, population-based surveys seem to indicate that the high level of HIV prevalence has been reversed (Piot 2000b:2178). This is partly attributed to the strong political commitment on AIDS issues by the president of Uganda.

West African HIV prevalence data seems to have stabilized and remains at an average of 3-4% (UNAIDS 2004:27). But in some countries in the region, especially Nigeria, Cameroon, Central African Republic and Central Africa, serious pandemics are underway with HIV prevalence rates of above 10%. Access to ARV treatment in most countries in West Africa is still low (UNAIDS 2004:28).

Pandemics and social change

Global pandemics have taken place periodically in world history. The HIV/AIDS pandemic has been compared with the bubonic plague pandemic in the 14th century (Hunter 2003). Pandemics are always accompanied by profound social change. The mortality figures from the global HIV/AIDS pandemic is likely to be smaller than from the plague pandemic in the 14th century, which killed two-thirds of the population of China, millions in India and claimed over twenty million lives in Europe. Historians of that era document critical social, economic, political, spiritual and technological changes emerging as a societal reaction to the pervasive death experiences of the 14th century plague (Herlihy 1997:9). Though many social changes are not predictable from quantitative analysis alone, the impact of HIV/AIDS on society is likely to produce far-reaching social changes in Sub-Saharan Africa (see section 2.6).

Such changes include changing child caregiving patterns, sexual behavioural patterns and changes in rural agricultural labour patterns (Hunter 2000:66).

Epidemiology of HIV/AIDS in Zimbabwe

The first cases of AIDS in Zimbabwe were reported as far back as 1984. As a result swift measures were taken by the Blood Transfusion Service to ensure safe blood supply and the Ministry of Health engaged in an AIDS education campaign. Sadly, the international 'pandemic' of blame and counter-blame produced official denial of the pending AIDS pandemic in Zimbabwe. As in many other countries, five precious years were lost, during which large-scale prevention efforts could have made a significant difference to today's tragic situation (Meursing 1997:26).

In 1989, government policy on AIDS again took a progressive turn. But soon, economic stress, linked to the economic structural adjustment programme (ESAP)⁵, began to compete with the AIDS pandemic for attention at government and public level. Partly due to the renewed openness by government on HIV/AIDS issues, testing for HIV-prevalence among antenatal clinic attendees started in 1989 and had been recorded every year up to 2000, when reporting stopped due to HIV test kits becoming unavailable (UNAIDS 1998:5).⁶

In urban areas and along major highways, HIV prevalence among women attending antenatal clinics has risen from 10% to 47 % in some selected cross-border towns (NACP 2000:17). Rural areas still show lower figures. The Joint United Nations Programme on HIV/AIDS in Zimbabwe (UN 1999:6) expects that increased rural-urban migration and high mobility will result in the movement of the pandemic to rural Zimbabwe. The present economic situation with fuel shortages, high costs of living in urban areas and limited mobility due to these factors might slow this trend. There is, however, a need for epidemiological research data to show the impact of the present

⁵ Studies that document the impact of ESAP on health delivery and accessibility began to appear in 1993. See for Example Oxfam: [Paying for health](#), 1993.

⁶ Using antenatal HIV seroprevalence testing is commonly used to establish representative national average date of the healthy adult population (15-49 years old).

harsh economic climate. The present estimate of HIV infection amongst adults appears to be stabilizing at 25% (UNAIDS 2004:24). Overall, nearly 57% of people living with HIV in Zimbabwe were women (Ministry of Health & Child Welfare Zimbabwe 2004). This gender difference is accounted for by higher female HIV infection rates among the 15-24 year old population group - as discussed in the section addressing the epidemiology of the disease in Sub-Saharan Africa.

Epidemiology of loss⁷

Neither statistics nor words can describe the human suffering of children grieving for dying or dead parents, and the situation is often made worse through stigma and economic crisis at the household level (UNICEF 1999:3). Two important 'tools' for assessing the stage of a pandemic and its expected duration, are the prevalence of children orphaned by the disease – that is the number in a given place or time - and the incidence – the number of new children being added to this pool (Levine & Foster 2000: 16).

Demographic impact

Because HIV/AIDS is a new and complex pandemic, it is difficult for demographers to predict its impact accurately (Whiteside 1998:77). Various medium- to long-term projections of the demographic impact show considerable margins of error. Factors such as reduced or increased risk behaviour, reduced fertility and other external factors such as access to ARV treatment influence projections significantly. Data of 'current estimates' are, however, important for social planning and policy makers. It certainly is more useful than no data at all (Gregson, Zeba, Garnett & Anderson 1998:41)

⁷ The term was first used in the White Oak workshop report: The Orphan Project. Florida 1998.

In Southern Africa

It is becoming increasingly clear that the population structures of countries hard hit by HIV/AIDS will be changed. In Southern Africa, as in most developing countries, population structure is often described as a pyramid, with the tradition of men on one side of the axis and women on the other side (UNAIDS 2000:21). Birth and death rates in a given population determine the shape of the pyramid. If both are high, the pyramid has a wide base, but 'thins off' with increasing age. Through human development achievements, health improves and fertility falls. This results in older age groups featuring more prominently. The pyramid then starts to resemble a column.

The demographic impact of HIV/AIDS is reshaping the pyramid into a different shape, called the 'population chimney' (UNAIDS 2000:22). If one takes Botswana's projected population structures as illustrated in Figure 1.1 below for the year 2020, one can see the impact HIV/AIDS will have on populations in fifteen years from now. We see in brown, the population structure, as it would be without the HIV/AIDS pandemic, reflecting a pyramid. In yellow we can see the 'population chimney' reflecting projected populations structures amid the reality of HIV/AIDS. It is significant that by 2020 there will be more old people (60-70 year olds) than adults in their 40s and 50s. To predict what such a scenario will practically mean for society is a difficult task.

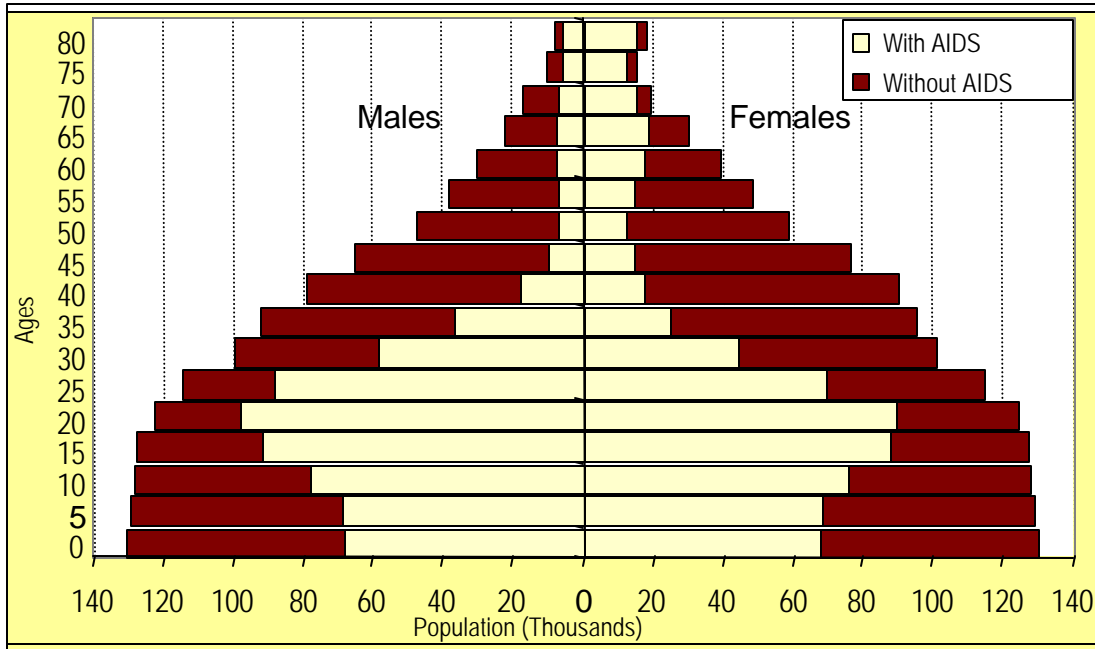


Figure 1.1: Population of Botswana: Pyramid projections with and without AIDS by the year 2020

Source: US Census Bureau, global population profile 2000

Demographers disagree on the effect this will have on the overall dependency ratio⁸. Haldenwang (1994:32), in his projection for South Africa does not expect the dependency ratio to change. UNAIDS (2000:23) on the other hand expects that a small number of young adults will have to support large numbers of young and old people, therefore changing the intergenerational dependency ratio. This researcher concurs with UNAIDS and their scenario projection, because Haldenwang's projections in 1994 were based on infant mortality rates before mother-to-child transmission (MTCT) could be considerably reduced (e.g. in a study in Mumbai from 24% to 4%) with ARV therapies (McIntyre 2000:1, Merchant & Damania 2000:1). At the same time, increased access to ARV treatment, as in the case of Botswana, will eventually alter the projections of the overall dependency ratio, with more adults living with HIV staying alive for a longer time.

⁸ Dependency ratio is the number of available adult caregivers to number of children in society.

Life expectancy, a prime indicator of development gains as reflected by UNDP with the Human Development Index (HDI), is declining (Loewenson & Whiteside 1998:13). Projections in Fig. 1.2 show that life expectancy at birth which rose in Southern Africa on average from 44 years in the late 1950s to 59 in the early 1990 declined to a lower level than in the 1950s by the year 2002 (Wold Bank 2003).

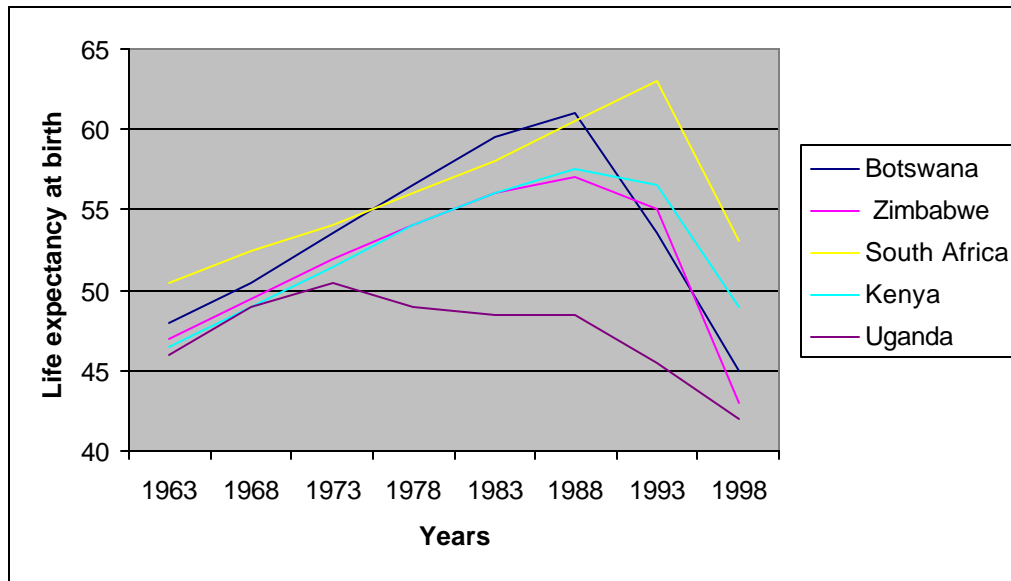


Figure 1.2: Impact of HIV/AIDS on life expectancy in selected Southern African countries

Source: World Bank (2003)

It is likely that the changes in the age structure of the population as a result of HIV/AIDS-related mortality will significantly alter the mean structure of functional family units, which could prove to be the most dramatic effect of the pandemic on the populations in Southern Africa (Daniel 2003).

In Zimbabwe

Zimbabwe, with a HIV prevalence of around 25%, is already experiencing the adverse demographic impact of the HIV/AIDS pandemic. It is expected that Zimbabwe by 2010 will have 4.4 million fewer people than there would have been without the effects of AIDS mortality, affecting the dependency ratio (Ministry of Health & Child

Welfare Zimbabwe 2003). There is a distinct shift taking place in population distribution towards relative increases in the number of children and elderly people as young adult mortality spirals higher.

HIV/AIDS will have a significant impact on population growth rates. Even though Zimbabwe had a relatively successful reproductive health programme, with fertility rates falling from 6 children per women in 1980 to 4.8 in 1994, the population still grew at a rate of 2.3%. Therefore HIV/AIDS is unlikely to cause negative population growth over the next 10 years (NACP 1999:19). The combination, however, of AIDS mortality, reduced fertility and a high level of migration has resulted according to 2002 census data in a low annual average intercensal population growth of 1.1% for the period 1992 to 2002 (CSO 2003).

According to the 1994 Demographic Health survey (GoZ 1994:5), after independence in 1980, life expectancy in Zimbabwe rose. Then from the 61-year life expectancy peak reached in 1994, the trend reversed dramatically in only four years to yield a life expectancy of only 47 years in 1998. And by 2004, life expectancy, due to the impact of AIDS had fallen still further, to 39 years (US Census Bureau 2004).

Economic impact

As we have seen above, solid demographic data show that HIV/AIDS disproportionately kills economically active young adults. According to Kofi Annan (2001):

HIV/AIDS ... takes its biggest toll among young adults ... the age group that normally produces most, and has the main responsibility for rearing the next generation.

It is expected that a substantial increase in illness and death in a population will have negative economic consequences. As Whiteside et al. observe (2000:85), however, 'the effect of AIDS on economic growth is largely unknown at this stage'.

Existing models to predict the macro-economic impact of AIDS are fraught with challenges and are largely not reliable. Especially in the harsh economic climates experienced in most economies in Southern Africa over the past 5 years. At the same time it has been well documented that HIV/AIDS has serious negative economic implications for households and individuals, especially children. A study released by the World Bank (2003) projects a 50% decline in GDP for South Africa over the next 90 years if HIV/AIDS infection and mortality rates are not significantly lowered over the next 10 years. These projections however, were immediately rejected by the South African Treasury Department. Such rejection seems to be rooted in the persistent denial of the impact of AIDS on South Africa by the political leadership, combined with the fear that such research data negatively impacts on investor confidence. It is interesting that the World Bank research acknowledges that it is the first time a long-term HIV/AIDS economic impact study has included impact projections aggravated by large unsupported orphan populations. This may be a signal that orphans issues due to HIV/AIDS, neglected by policy makers for a long time, are finally being acknowledged on the global agenda. It is hoped that this will lead to increased global resource mobilisation for care and support of children affected by AIDS over the next decades.

Macro level

Several studies in Uganda, Zambia and elsewhere (Topouzis 1994, Barnett & Blaikie 1992, Barnett 1994) have shown that HIV/AIDS has an immediate impact at the micro level. But due to the complexity to the HIV/AIDS pandemic, the macro-level impact is difficult to capture. Several models have been developed to predict the effect of the pandemic (Whiteside 1995:10). One of the best-known models is from Over (1992) of the World Bank.

Unfortunately all these models are subject to many complex political and social variables that are difficult to control. A study using such a model for Kenya was based on a GDP growth rate of 4% in the absence of HIV/AIDS for the period 1985 to 2005. Based on this model it projected a 14% decline in GDP due to HIV/AIDS. The reality,

however, is that from 1990-1994 the GDP growth rate was only 0.9%, mainly due to external global economic factors impacting on Kenya. Another example is Zimbabwe, where an economic simulation exercise predicted that the annual GDP growth rate would be 25% less due to HIV/AIDS by 2000. (Kambou, Deveraja & Over 1993:128). Although this scenario had indeed materialized by 2005, the main contributing factor seems to be political and economic policies that have seen Zimbabwe suspended from the Commonwealth and other international bodies such as IMF, and the withdrawal of bilateral funding combined with failed land reform. The result of these policies can best be described as 'political and economic chaos' that are destroying the economy of Zimbabwe. It is therefore not possible to attribute such declining GDP growth rates to HIV/AIDS alone.

At the macro level, although the impact of HIV/AIDS is hidden or cushioned, over the long term, it most likely will become visible in the worst affected countries. Overall effects at the national level will be mainly shaped by complex political and economic variables, including the state of the global economy. Effects caused by HIV/AIDS at the macro level may include: inflation, a decline in aggregated savings and investments at all levels, higher labour costs due to re-training staff, and consequent lower competitiveness in global markets, and finally a long-term decline in consumption caused by large numbers of orphan populations (SIDA 1999:27; Save the Children UK 2002:37).

Because accurate predictions at the macro level are difficult to obtain, the economic impact is best understood by disaggregating the analysis from the macro level to specific sectors. Understanding the impact of the pandemic at sectoral level will help with practical interventions and plans to reduce the possible impact of HIV/AIDS on the sector.⁹ This in turn will help to minimize the negative effects HIV/AIDS may have at the macro level.

⁹ See Barnett, Blas and Whiteside (1996). Understanding the economic impact at the sectoral level for sectoral planners and managers.

Micro level - household

The scenario might arise that GDP per person actually remains stable, or even rises, due to the brute fact that HIV/AIDS cuts into the populations. In strict economic terms, and taken in isolation, this could be interpreted as a 'positive' macro economic indicator (Schoofs 2000:7).

The first and most tangible impact of HIV/AIDS, however, is at the household level and, in the aggregate, on the extent and depth of national poverty (Over 1998:22). The pandemic is expected to drive poor households into deeper poverty or destitution. It is a sad reality that once HIV has entered a household, expenditures on medical care, either formal or traditional rise, just as productivity and income are declining, owing to ill health. This situation is illustrated in Figure 1.3 below. The culmination of this is that after parental death, the economic base of the household is eroded, with children left behind with no savings or productive assets (Germann 1998:23).

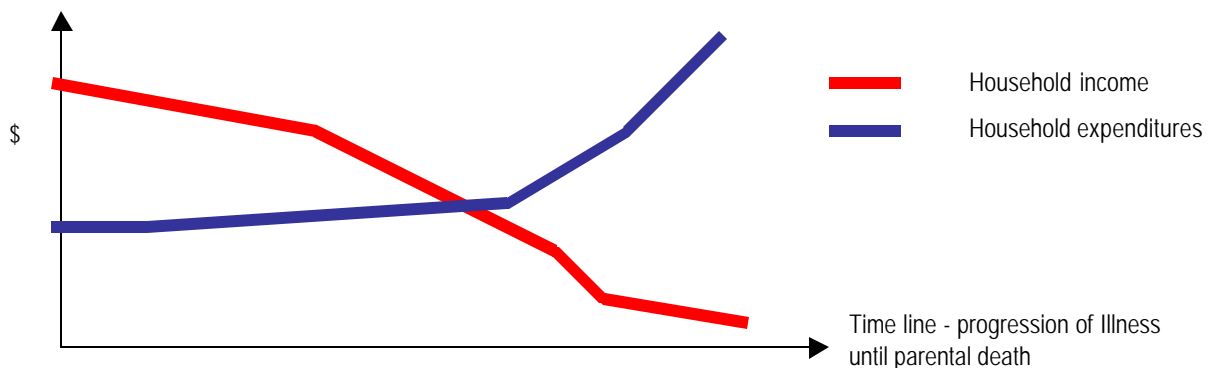


Figure 1.3: Impact of HIV/AIDS on household income and expenditures

Source: Germann (1998)

Households, in order to cope with parental illness or the loss of an adult in the prime of life, often reallocate their resources. This often leads to withdrawing children, especially girls, from school to help at home, or to the selling of household assets. Poorer households, having fewer assets to start with, therefore face proportionally

greater difficulties in coping (SAfAIDS 2001:14). In section 2.3.2 and Chapter 7, economic issues and how they impact households will be discussed in greater detail.

In countries, such as Uganda, Zimbabwe and Malawi, where surveys have been conducted (WHO/UNICEF 1994, Foster, Germann & Sussman 2000, Hunter 1998) it was found that formal social service programmes and government social safety nets are extremely limited. This means that families and communities are carrying the costs and burdens of terminally ill household members and orphans. This means a considerable toll is being exacted from a large number of households in Southern Africa (Hunter & Williamson 2000:5).

Social impact and developmental consequences

If illness and death occur in large numbers within a population, the social fabric of society is affected (Loewenson et al. 1998:23). The social impact of HIV/AIDS often causes family and community paralysis at first; this is linked to the fear of the unknown, particularly where traditional coping patterns cannot address the problem. Fear is followed by stigmatisation of affected individuals and families. Family/household and community patterns undergo change, and traditional social safety nets start to adapt to the new crisis situation in an attempt to mitigate the negative impact (Barnett et al. 1992:90, Baier 1997: 7, Foster 2000b:59).

HIV/AIDS is still too often considered to be mainly a health issue rather than a broad development issue, impacting on all levels of society (Thomas & Howard 1998:95). This was demonstrated in Zimbabwe in August 2000. After years of advocacy by HIV/AIDS NGOs to establish a multi-sectoral AIDS Council to replace the National AIDS Co-ordination Programme in the Ministry of Health, the National AIDS Council (NAC) was formed. But the NAC was again put under the firm control of the Ministry of Health, negating its potential for a broader role. It may be that the introduction of an 'AIDS levy' by the Ministry of Finance presented the Ministry of Health with the prospect of an opportune subsidy to compensate for their declining annual budget. This might then have prompted the Ministry of Health to take control of the NAC to

ensure sufficient funding for the ministry, at the expense of supporting HIV/AIDS activities across the wide spectrum of NGOs and grassroots groups (Mhlanga 2001).

Since 1990, one of the key indicators of development put forward by UNDP is the Human Development Index (HDI). This index is a combination of three basic components of human development: standard of living, knowledge and longevity (Hadjor 1993:140). This indicator was created following the recognition that development transcends mere economic growth indicators (UNDP 1999:1). The impact of HIV/AIDS on the HDI can therefore be seen as perhaps the first clear measurable impact of the pandemic. And the impact is major. AIDS-related mortality, for example, lowered Botswana's standing in the UNDP HDI listing from 71 to 122 between 1996 and 1999. There are, however, many other developmental impacts attributable to AIDS, such as the reduction of human capital, reduction in the quality of life¹⁰, adverse impact on the socially reproductive labour and social cohesion might decline (Barnett 2000:1). These impacts, taken together threaten the existence of civil society (Whiteside et al. 2000:94). These are areas where changes are not easily measured with existing instruments utilized by economics or other social science disciplines. Little is known, for example, about how HIV/AIDS impacts on the social psychology of populations and if and how this affects national development (Germann et al. 2001). There is a growing realisation that the social developmental costs of HIV/AIDS may reverse the hard-won development achievements made over the last 30 years. Based on existing projections it is possible that these negative effects might last for decades. This will be especially true for children and older people in hard-hit countries (Llyod-Sherlock & Barnett 2000:1).

¹⁰ This study uses the WHO (1995:2) definition for quality of life 'as individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns'.

1.2.2 Children affected by AIDS in Southern Africa

Magnitude of the problem

As early as 1988, Beer, Rose and Tout described with remarkable foresight a scenario of the possible impact AIDS might have on children and grandparents. They stated:

As full blown AIDS is fatal, sociologically the main impact will be felt by the survivors (Beer et al. 1988:171).

Rather than to wait until such a tragic problem is fully developed before rousing public and professional concern, we should attempt to plan and prepare adequate responses (Beer et al. 1988:173).

By 2005, the full impact of this predicament is starting to become visible in most communities hard hit by HIV/AIDS. Over the last decade communities across Africa have started to get to grips with the plight of children affected by HIV/AIDS. Responses by local communities to the impact of HIV/AIDS on children have been amazing. This is in stark contrast to how slow policy makers, political leaders and philanthropic agencies have been in putting the issue of children affected by the AIDS pandemic onto their agenda (Levine & Foster 1998:13). Issues of children and HIV/AIDS have for too long been seen by professionals in the context of paediatric AIDS rather than as a long-term key developmental issue (Foster 1998:S18).

It is hard to capture with words or statistics in a satisfactory way, the human tragedy endured by children grieving for dying or dead parents. And the disease is especially cruel as HIV/AIDS is sexually transmitted, and it is therefore often only a matter of time until one infected partner passes it on to the other parent. Therefore children who lost one parent are at considerable risk of losing the second one too (Germann 1996:45). Chapter 5 provides through narrative interviews a better understanding of what children have to endure during parental HIV-related illness and AIDS death.

Africa, due to its high HIV/AIDS prevalence as previously discussed, has more children orphaned by AIDS than anywhere else. Before the HIV/AIDS pandemic, in Africa, approximately 2-5% of the total child population were orphaned; in 2003, rates in some countries were as high as 20% (UNAIDS, UNICEF & USAID 2004:26). In Chapter 2, the demographics of orphan populations will be further discussed.

The negative impact of HIV/AIDS on child development targets

The impact of HIV/AIDS on children reverses the gains in child development¹¹ made over the past two decades. This impact, both current and prospective, makes it very unlikely countries in Southern Africa will achieve set goals regarding child development. UNICEF (1994:2) recognizes that:

the impact of HIV infection and AIDS on the development both of communities and nations and on the well-being of women and children...is widespread, profound, and complex.

Most of the goals set by UNICEF and the governments it works with in the region for the year 2000 were not achieved (UNICEF 1994:6). The following section lists selected goals, and discusses possible factors responsible for the failure to achieve them.

Goal 1: Greater access to various services needed for a healthy environment and good health of women and children.

Structural adjustment programmes aimed at reducing government expenditures in health services (Woodroffe 1993:28) combined with the pressure on governments to fund the care and treatment of HIV/AIDS-related illness on a large scale, results in less money available to spend on promoting services such as family planning and baby/child/youth friendly medical facilities in support of children.

¹¹ Child development in this study means the examination of processes and mechanisms that operate during the physical and mental development of an infant into an adult.

Goal 2: The elimination of deficiencies (e.g. iron, vitamins, malnutrition and low birth weight) and childhood illnesses and maintaining immunization coverage.

Due to HIV/AIDS there has been a shift from preventative child health work to crisis intervention for HIV/AIDS care and treatment. Immunization programmes have been cut back in many countries due to lack of resources for transport etc. Furthermore the physiological interaction between HIV/AIDS and other childhood diseases makes the elimination of these very difficult.

Goal 3: The improved protection of children in especially difficult circumstances.

HIV/AIDS is likely to aggravate difficult circumstance occurring in childhood, such as child abandonment, psychological trauma, discrimination, physical and sexual abuse, poverty and dispossession – which as a result contributes to increasing numbers of children living in especially difficult circumstances. The combination of declining national economies partly due to HIV/AIDS and the increasing numbers of such children mean that there are fewer resources per child available to contribute to improved child protection.

Goal 4: The overall reduction of infant and under-five child mortality and maternal mortality.

With antenatal HIV sero-prevalence reaching 20-45% in some communities in Southern Africa, gains in infant survival are being reversed by paediatric AIDS (UNAIDS 2004:27). South African Census and Demographic Health Survey (DHS) data indicate that infant and child mortality stopped falling in 1992. DHS data suggests that between 1992 and 1997 under-five mortality rose from 53 to 71 per 1000 (Nannan, Bradshaw, Timaeus & Dorrington 2000:1). This increase reflects what can be expected from increasing ante-natal HIV infection rates reported during the same period (Stanecki & Way 2000:1).

Goal 5: The process of 'empowerment' – of women to breastfeed their children and of individuals and families to acquire knowledge, skills, and values required for better living – is increased.

Empowerment is a complex process that does not just happen by itself. It requires time, energy, and resources on the part of those engaged in the process of empowerment (CYP 1998:1). With HIV/AIDS affecting and eroding the ability to participate in such a process within the most productive, most able-bodied age group, the ambition for reaching this goal has been destroyed. Regarding the issue of breastfeeding, there is ample evidence that HIV infection is increased through it, especially when mixed feeding is practiced. Promotion of breastfeeding for all is no longer acceptable once a population group has reached HIV prevalence of 10% (Desclaux 2000:1). After years of public education on breastfeeding, this new situation is causing confusion among women and health professionals. This can be seen in the number of conflicting articles on breastfeeding (Krasovec & Soderlund 2000:1, Sibiyi, Moodley, Moodley & Coovadia 2000:1) that are currently available.

Goal 6: The expansion of basic education (universal access to basic education with a particular emphasis on reducing disparities between girls and boys).

Analysis of data on the impact of AIDS on education systems suggests that the effects of HIV/AIDS exacerbate the existing inequalities and deficiencies in education. This is further aggravated by the high HIV prevalence among teachers. It is estimated that in Zimbabwe, teachers are dying faster than they can be recruited and trained (Foster et al. 2000:15). Schooling is, however, increasingly recognized by policy makers as a strategy for HIV/AIDS prevention and school as a place of safety for orphans and vulnerable children. There are increasing calls for free primary school education for all. Uganda and Kenya as a result of increasing orphans populations have already introduced free access to primary school education and other countries in the region may soon do the same. It is therefore uncertain whether over the long term this particular goal will be as severely undermined by the HIV/AIDS pandemic as the others. Studies have shown that there seems to be a gender bias, with girl

children often first to drop out of school if a household is affected by HIV/AIDS (Müller & Abbas 1990:80, Germann 1998:21).

1.3 Problem definition and research justification

Background to research problem

Over the last five years the number of published studies and agencies reports on children affected by HIV/AIDS has grown. Despite this, there is insufficient quality data available on the subject of children affected by the pandemic in Southern Africa. Most studies and reports concentrate on the issue of scale, the magnitude of the crisis and the importance of community based care. Few studies so far have looked at the impact of being orphaned on individual children, or on children and adults in the household where orphans are absorbed. (Ewing 80:2002). A report by Professor Alan Whiteside from the Health Economics and HIV/AIDS Research Division (HEARD 2001:19) for UNICEF stated 'there is very limited (available) information on child-headed households in Southern Africa.' Serious studies of the phenomenon of large numbers of orphans and child-headed households (CHHs) in particular are recent and only starting to emerge.¹² By 1999 when this study was first conceptualized, only one published piece of research on CHHs existed in Zimbabwe involving 43 CHHs in four rural areas (Foster et al. 1997). This study was followed by a small survey done by the Farm Orphan Support Trust (FOST) involving 17 CHHs in commercial farming communities (Walker 2003). This research is the first in Zimbabwe and likely in Southern Africa that explores the quality of life and coping strategies of a large sample of urban CHHs over an extended period (two years).

Current research in the area of children affected by HIV/AIDS in Southern Africa often lacks a multidisciplinary approach. Studies on children continue to focus on special aspects of childhood, within a specific framework of professionalism, often lacking the analysis of broader social, economic, cultural and political forces (Reynolds 1991:xix). Children's lives and problems are not 'boxed' in professional compartments but are

integrated. HIV/AIDS necessarily affects their entire existence. Children need to be seen as autonomous human beings, and this is not always the case in social research, as stated by Reynolds (1991:159):

All too often children are lumped in that amorphous category 'women and children'. Only recently have they begun to be treated analytically in the social sciences as autonomous beings.

This study aims, in an urban context, to widen the discourse on children affected by HIV/AIDS in Southern Africa, with specific reference to orphans living in CHHs. It does so partly by viewing children as autonomous, interdependent social actors. The broad scope of the discipline of Development Studies enabled the researcher to engage in a research enterprise that could provide an example of how much can be learned through focused multidisciplinary analysis.

AIDS deaths differ in their effect from deaths through other disasters such as floods, drought and famine because of the incremental nature of the pandemic. As the HIV/AIDS pandemic progresses in communities, the adult population decreases. Changes in family and community coping mechanism are taking place (UNAIDS 2000:27), especially in response to the growing number of orphans. Though family and community networks still seem to cope, generalisations that families and communities are coping with their orphans have to be avoided. There are limitations to their care capacity. It is essential to understand these coping mechanisms, how care capacity is expanded in time of crisis, so that support initiatives for children affected by AIDS at local and national level can strengthen, rather than undermine, family and community care capacity (Horizons 2000:7).

¹² Published papers on large numbers of orphans in community care in Southern Africa only started to appear in journals around 1996.

Defining the research problem: The emergence of child-headed households

As adult populations dwindle care-giving patterns for affected children alter and there is a decreased dependency ratio. The proportion of children cared for by the elderly or teenagers has increased significantly over the past few years (Foster et al. 1996, DSW 1999:26, Richter 2004:10). The emergence of CHHs, in extreme situations headed by children as young as 12 years old (Luzze 2002:5; Foster et al. 1997:155) is one of the most distressing consequences of the AIDS pandemic. It is estimated that by the end of 2000, over 40,000 children were living in CHHs in Zimbabwe (USAID 2000:8).

The extended family in Southern Africa continues its traditional care-giving role especially in rural areas. But it must be recognised that the family is under increased stress due to poverty and a sense of despair resulting from the HIV/AIDS pandemic (Rutayuga 1992). Despite these constraints, communities, clans and the extended family system remain the traditional key solutions in coping with the problem of large numbers of orphans. Children growing up in their own extended family environment are culturally rooted and well cared for (Oyemade 1974, Germann 1996). The emergence of CHHs might lead to the conclusion that the extended family care system has broken down. This claim has not been validated as there have been no studies of CHHs before the HIV/AIDS pandemic in Southern Africa (Foster et al. 1997:156). The observation that maternal relatives are stepping in to care for orphans, although this role was previously reserved for paternal relatives, is one symptom of the decline and changes of traditional extended family support (DSW 1999:26). But this also demonstrates that the extended family care systems are adapting to changes taking place in communities (Powell et al. 1994).

Issues related to children affected by HIV/AIDS and CHHs in particular are complex and impact on community life and development at all levels. This complexity and the lack of quality research means that issues related to CHH quality of life and coping strategies are not well understood. Government Social Welfare Departments and NGOs are struggling to apprehend the situation of CHHs. Some interventions by

these agencies even make things worse for children living in such households. Agencies such as the World Bank (Subbarao et al. 2001) and national social welfare departments often provide emotionally-driven, generalized recommendations suggesting that it would be better for a child to be in an orphanage than to live in a CHH. But is this really the case? This study, combined with the researcher's earlier work on community-based orphan care versus institutional care (Germann 1996) suggests the need for a change in perspective.

CHHs potentially represent a group of highly vulnerable children in a community, and community responses in support of such households might be an indicator for community care capacity, a desired outcome of community child care development initiatives. The need for a better understanding of CHHs to inform community child care, protection and development interventions prompted this research.

Against such a background this research will, through an exploratory study, address the questions on CHH quality of life, their coping strategies and how such households function. It attempts to relate this to community child-care activities, NGO and statutory support, and to draw out the implications of its findings for child care and protection policies.

1.4 Objectives of research

As director of a pioneer programme in the area of life skills training and psychosocial support for children affected by HIV/AIDS - one that included the provision of CHH household management training courses - the researcher was made aware of the need to develop better insights into day-to-day life situations faced by CHHs. The researcher had the privilege to be invited¹³ by Nelson Mandela to participate in the African Leaders Consultation: Urgent Action for Children on the Brink (UNICEF 2002). During that meeting, Nelson Mandela made the following statement that made a lasting impression on this researcher:

¹³ The researcher was selected by UNICEF and invited for leaders consultation as a technical expert on children affected by AIDS in Africa.

Of course, we need to do careful planning and deliberation about the actions we shall take, but any moment spent on deliberations that does not lead to decisive action in support of orphans and other children made vulnerable by AIDS is a moment tragically wasted.

This study was informed precisely by this concern. As a result, emerging findings during this four year long research enterprise influenced the programme policy and practice of several organisations the researcher collaborates with, including Salvation Army Masiye Camp, REPSSI, Save the Children UK, UNAIDS, UNICEF and the World Bank.

The primary research objectives of this study are to:

1. Explore the quality of life of CHHs
2. Expand the understanding of CHH coping strategies
3. Identify if CHHs can be an acceptable, 'good enough', alternative child care arrangement

To meet the primary objectives listed above, the following secondary objectives were identified, and came to inform the chapter outlines of this thesis.

- a) Examine the impact of HIV/AIDS on children and CHHs in particular (Chapter 2).
- b) Develop a suitable conceptual framework for the research (Chapter 3).
- c) Identify, adapt and develop appropriate research tools and instruments (Chapter 3).
- d) Conduct an orphans and vulnerable children situation analysis of limited scope in the research area (Chapter 4).
- e) Present through extensive case histories, children's experiences of parental HIV-related illness and AIDS death, and of heading a CHH (Chapter 5).
- f) Examine the emotional impact of HIV/AIDS on CHHs as well as their resilience to foster an understanding of CHH quality of life (Chapter 6).
- g) Develop a suitable coping model and assess CHH coping strategies (Chapter 7).
- h) Analyse community care, programmatic responses, child care policies and legislation and how they impact on CHHs, and provide recommendations for identified gaps (Chapter 8).
- i) Identify on the strength of this study new areas for productive research on children affected by HIV/AIDS and on CHHs in particular (Chapter 9).

It is further anticipated that this research thesis may be used as a 'study support text' for the forthcoming UNISA new sectors B.A. degree in OVC programme management currently under joint development by UNISA with the support from REPSSI and UNICEF (REPSSI 2005).

1.5 Scope of research and limitations

The study deals with the issues of CHHs in Southern Africa in general but is limited in its focus and primary data collection to urban Bulawayo, Southern Zimbabwe. Case studies of CHHs are followed over a 12-month period within this geographical area. Due to the ongoing violent political climate during the study period of 2000 to 2003, the study had to limit itself to urban Bulawayo, because doing research in rural areas as a white male researcher was not advisable as it potentially placed visited families at risk.

The fact that the study group was approached mainly through an orphan support initiative (see Chapter 3) inevitably implied a bias. Ethical concerns for studies involving children, however, would not allow another approach as it would be unethical to deprive CHHs of any form of support just to maintain them as a scientifically 'pure' study group. It needs to be noted, however, that neither the researcher nor any directly affiliated organisations provided any financial or material support to research participants during the primary data collection period.

The main language of communication in the research area is Ndebele. The limited language ability of the researcher required the assistance of translators for data collection activities when English was not suitable. This was especially the case during focus group discussions (FGD) with community members and programme volunteers. Translated data is indicated in the data analysis by providing the original Ndebele version.

As a point of departure, this study acknowledges the following:

- Though much weaker than in rural areas, the majority of urban Zimbabweans still have strong extended family and kinship ties. Traditionally, children belong to the community and children in difficult circumstances are cared for in the community context (O’Gorman 2003, Foster & Makufa 1999).
- It is not in the best interest of orphaned children to grow up in residential care institutions such as orphanages. Children develop better socially, emotionally and mentally within a family, community context, and thus should be cared for in such environments as long as possible (Germann 1996, Tollfree 1995, Dunn, Jareg & Webb 2003).
- Communities in Southern Africa have demonstrated on many occasions that they have a capacity to care, even under great stress. HIV/AIDS is devastating communities and puts a heavy strain on their ability to cope and care. Many examples in the region, however, demonstrate that even under dire stress, communities are taking on the responsibility to care for their children as a means of community survival (Foster 2004, Richter, Manegold & Pather 2004).

The full research design with the conceptual framework, a detailed outline of methodologies used, and development of research instruments, sampling and data collection, analysis and interpretation methods is described in Chapter 3.

1.6 Summary and conclusion

The impact of HIV/AIDS is likely to reshape societies in hard hit countries in Africa over the next 30 years. Since HIV transmission in Africa is primarily through heterosexual contact, HIV/AIDS presents itself as a family disease. Children in particular are severely affected by AIDS in their social context due to parental illness

and death. It is crucial to realise that the situation of orphans in Africa is long-term and large scale. This chapter provided a brief overview of the history of HIV/AIDS and its impact on society, first on a global level, followed by short regional accounts with a focus on the impact of HIV/AIDS on Southern Africa in terms of demographic, economic and social development impact.

Reviewing UNICEF child development goals in the context of HIV/AIDS demonstrated that the impact of HIV/AIDS on children in Southern Africa is severely undermining many child development achievements made in the past.

In defining the research problem the observation was made that 'there is very limited (available) information on child-headed households in Southern Africa.' Serious studies of the phenomenon of large numbers of orphans and CHHs in particular are recent and therefore still in the process of emerging. By 1999 when this study was first conceptualized, only one published piece of research on CHHs existed in Zimbabwe, involving 43 CHHs in four rural areas. This research is the first of its kind in Zimbabwe and most likely in Southern Africa as it explores the quality of life and coping strategies of a large sample of urban CHHs over an extended, two year, period.

Some interventions by external agencies are not benefiting children living in CHHs, sometimes even making things worse. For example external agencies presently provide emotionally-driven, generalized recommendations suggesting that it would be better for a child to be in an orphanage than to live in a CHH. Against such a background, this research will, through an exploratory study, address the questions on CHH quality of life, their coping strategies and how such households function and relate it to community child care activities, NGO and statutory support. It also examines the implications of those findings for child care and protection policies. The following chapter will examine in detail, as a starting point for this study, the situation of orphans and the impact of HIV/AIDS on children and CHHs in Southern Africa.

Listen I have got a future

Why do you abuse us orphans ?
Who stole the sugar, it is me?
Who stole the money, it is me?
Why do you always put the blame on
The orphan? But Why?

Relatives treat us badly, we are
send to school bare footed and half naked.
We are exposed to horrible things. But why?
Have you lost the sense of parental love,
guidance and support.



We need your love, care and support, like your own children,
because listen – **I have got a future.**

(Poem by Roderick, an 11 year old, in 1998 at Masiye Camp
permission was obtained to use Roderick's poem and picture)

2 Orphans and child-headed households in Africa

(Literature review)

But it is the effects on children that are probably the most heart-rending and that pose the greatest challenge to our sense of compassion and caring. They are affected by actions over which they had no control and in which they had no part. It is that cruel reality that keeps one awake at night when pondering all the aspects and implications of the pandemic.

Nelson Mandela, September 2002

2.1 Introduction

Based on the magnitude and impact of AIDS to date, it is likely that countries in Southern Africa will have to deal with at least two generations of children severely affected by AIDS (Gregson 2003). This chapter provides a review of the literature pertaining to orphans and children affected by AIDS in Southern Africa. Furthermore, it examines coping strategies used by these children in dealing with their change of role from being primarily a child to being a caregiver. The chapter concludes with an elucidation of CHHs. The researcher provides a working definition of this term.

2.2 Orphans in Africa

AIDS-related mortality is resulting in a growing number of widows and widowers (Ntozi 1997:4). However, probably the worst consequence of the AIDS pandemic is the creation of large numbers of orphans (Barnett & Whiteside 2002a:177). The 'Children on the Brink' report (USAID, UNICEF & UNAIDS 2004:3) states that more than 12.3 million children¹⁴ had lost one or both parents to AIDS by the end of 2003 in Sub-Saharan Africa, with this number expected to rise to 25 million children by 2005. This unprecedented crisis requires radically scaled-up community, national and regional responses for the next few decades to mitigate the impact of orphanhood on society (Germann 2002b: 2).

2.2.1 Historical overview

Orphans have been a part of communities since mankind began. It is a sad reality that there will always be children with us who have had the misfortune of losing parents. There are references to orphanhood in many ancient texts. A review of holy texts by Germann (2002:1) for the World Conference of Religions for Peace shows that the societies documented by the Old and New Testaments, the Qur`an and the holy book of Buddha were concerned with widow and orphan issues and

implemented social policies geared towards the protection, care and support of orphans and widows. Two text examples follow in Box 2.1:

<p>Deuteronomy 10:17-18</p> <p><i>'The LORD your God is God of gods and Lord of lords, the great God, mighty and awesome, who shows no partiality and accepts no bribes. He defends the cause of the fatherless and the widow.'</i></p>	<p>Qur'an, Sura Al-ma'un 107:1-7</p> <p><i>'Seest thou one who denies the judgment to come? Then such is the one who repulses the orphan, and encourages not the feeding the indigent. So woe to the worshippers who are neglectful of their prayers, those who want but to be seen, but refuse to supply even the neighbourly needs.'</i></p>
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Box 2.1: Comments on orphanhood in holy texts (Source: Germann 2002a:1)

The African saying that 'it takes a whole village to raise a child' is significant when looking at the history of orphans in Africa.¹⁵ When compared to Europe (Pullan 1988:16; Dewar 1968:96) literature on the history of African childhood is scarce, with literature on the history of orphans in Africa virtually non-existent (Dube 2003). This is a consequence of the strength of oral history in Africa, resulting in much of such history being undocumented. In the past, the sense of duty and responsibility among extended families in Africa was almost without limit (Foster & Germann 2002:664). This was the basic premise for the traditional notion that 'there was no such thing as an orphan in Africa' (Foster 2000a:55). Traditionally, orphans were absorbed by the extended family or the village community when care in the extended family was unavailable (Foster 2002:34). However, modernisation, linked with the urbanisation of societies, has impacted on the extended family structure and changed the social fabric of societies in the region (Boyden 1991:2) As was shown in Chapter 1, HIV/AIDS is eating into the middle generation of society (Barnett & Whiteside

¹⁴ Children on the brink (2004) defines orphan as a child under age 18 who has lost one or both parents

¹⁵ African saying 'it takes a whole village to raise a child' – Children's Choir 1998 Music CD

2002b:196) altering the demographic structure of many societies, especially in Southern Africa. This has led to a breakdown of intergenerational dependency and support. Such a breakdown is not unique to the HIV/AIDS pandemic, and has been commented on in many countries in Europe (Carmichael & Charles, 1999:3). However, in economically strong countries, provisions to compensate for the absence of such social support can be made through either the market or the state (Barnett & Whiteside 2002b:220). In poor countries social safety nets are largely unaffordable. This further jeopardizes the African historical practice of 'every one's child'. The emergence of CHHs is a sign of such change.

2.2.2 Terminology and definitions

The following section provides definitions related to children, orphans and vulnerability that are used in this thesis. These definitions are in line with definitions used in the strategic framework for the protection, care and support of orphans and other children made vulnerable by HIV/AIDS (UNICEF & UNAIDS 2003).

Definition of a child

Although there are some differences in definitions at local and even national level, in most international and national instruments, children are defined as boys and girls up to the age of 18 years old (Smart 2003:3). This age refers mainly to the age of majority. Most countries, however, make legal exceptions; for example, a child in South Africa may consent to an HIV/AIDS test without parental consent from the age of 14.¹⁶

In the context of CHHs, the definition of a child has special relevance because of their legal incapacity to inherit property and to legally represent the household, in relation to marriage among other things. Chapter 9 will look at these complex issues in more detail. A working definition for CHHs is provided under section 2.5.2 in this chapter.

¹⁶ Based on Section 39 of the South African Child Care Act, No. 74 of 1983.

Definition of an orphan

Countries in the region (see Table 2.1) differ in the ways they chose to define an orphan. The main variables relate to the age of the child and the exact nature of parental loss – i.e. whether the mother, father, or both parents are deceased.

Definitions of orphans in some selected SADC countries	
Zimbabwe	A child who has lost either one, or both parents. ¹⁷
Botswana	A child below 18 years who has lost one (single parent), or two (married couples) biological or adoptive parents. ¹⁸
Namibia	A child under the age of 18 who has lost a mother, a father, or both (or a primary caregiver) due to death, or a child who is in need of care. ¹⁹
WHO	A child under the age of 15 who has lost a mother, a father, or both.
Children	Children do not like to be called orphans and labelled. 'Some people call us AIDS orphans – but you can call us Nelson, Ncobile and James' (Tsongirirai 2001).

Table 2.1: Definitions of orphans in selected countries in the region

Definition of a child orphaned by HIV/AIDS

In the early stage of the HIV/AIDS pandemic, children who had lost parents to HIV/AIDS were referred to as 'AIDS orphans' (Mukoyogo & Williams 1991:4, UNICEF 1991:3). This term is unfortunately still often used in the media or among the general public. The researcher intentionally avoids using that term because it may contribute to further stigmatisation and inappropriate categorization of a child orphaned by AIDS, since uninformed people take the term 'AIDS orphans' to mean that such children are HIV-infected themselves, which is mostly not the case.

The 'Children on the Brink' reports of 2000, 2002 and 2004 (UNAIDS, UNICEF & USAID) have become the standard reference for definitions and estimates related to children orphaned by HIV/AIDS (Smart 2003:3).

¹⁷ From the UNICEF report: Children in especially difficult circumstances in Zimbabwe 1998:21.

¹⁸ Definition used by the Department of Social Welfare in Botswana to qualify for orphan benefits.

¹⁹ Working definition for the multi sectoral OVC committee in Namibia.

Vulnerability

The concept of vulnerability is complex and local-context specific. Therefore, it is not easy to provide a universal definition. It is more useful to define vulnerability at two levels: a national level definition for purposes of policy, and a local or community definition for support and service provisions. Smart (2003:6) provides an overview of children defined as vulnerable in some selected countries in Southern Africa at national level. Based on her findings, for purposes of national policy and service provision, vulnerable children are best understood as children ‘whose probability of suffering has been exacerbated by unusual individual or societal circumstances’ (GoZ 1992:61). For local or community level definitions of vulnerability among children, participatory methodologies such as FGDs, that include children, should be utilized.

Other definitions

Given the complexity and contextual variations surrounding HIV/AIDS and vulnerability in children in Africa, it is not surprising that multiple terms are used in an attempt to capture the phenomenon of orphans and other children made vulnerable by HIV/AIDS. Table 2.2 below is an attempt to capture these terms,²⁰ their abbreviations, their uses and meanings.

²⁰ The terms described in the table are not comprehensive, some of the terms are used more widely than the country to which they are categorized.

Terms used to define vulnerable children in eastern and southern Africa			
Term	Short	Use	Meaning
Children in Extremely Difficult Circumstances	CEDC	Zimbabwe	This term is used for abused children, working children, street children, children affected by AIDS etc. and defines children whose probability of suffering has been further increased by unusual individual or societal circumstances.
Children in Need of Special Protection	CNSP	Kenya	This term is used in the children's act of Kenya and includes street children, abused children, traumatized children and children without adult care.
Children in Distress	CINDI	South Africa, Zambia	Similar meaning as above.
Orphans and Vulnerable Children	OVC	Global	This term refers to maternal, paternal or double orphans of all causes and other vulnerable children. Given the complex concept of vulnerability described above this is a very broad term with significant variations in local / community definitions
Children Affected by HIV/AIDS	CABA	Global	A broad term for children whose lives have been impacted by HIV/AIDS. For example by death of a parent or caregiver, or through living with an HIV positive parent. In high prevalence countries, (above 15% prevalence) most children's lives are in some way affected by HIV/AIDS. Therefore using the term for programmatic targeting in such areas is not useful.
Orphans and Children made Vulnerable by HIV/AIDS	OCVA	Int. technical consultation on indicators	Due to the limitations of CABA (above), this term focuses on vulnerability occurring as a result of HIV/AIDS. Consequently, it targets a narrower group of children than CABA. This term was first used during the UNICEF / UNAIDS International Technical Conference on Indicators OCVA responses for national monitoring purposes. It includes children who are not orphaned but made vulnerable by HIV/AIDS. The full term would therefore be: children orphaned and / or made vulnerable by HIV/AIDS.

Table 2.2: Summary list of terms used in the field of vulnerable children literature

Source: Adapted from Smart (2003)

For the purpose of this research the preferred terms used are 'Children affected by AIDS' (CABA) and 'Orphans and vulnerable children' (OVC). These abbreviations are sometimes used in the text. The researcher, however, would like to point out, that although these 'labels' are used it always refers first and foremost to valuable, wonderful, and individual children, each one with his or her own dreams and aspirations for life.

There is danger in applying these definitions rigidly, especially considering that the age variable is problematic. Most existing orphan projections limit their age to 15 years old, using WHO and UNAIDS guidelines (Grassly & Timaeus 2003). This

exclusion not only underestimates orphan numbers, as discussed below, but often also results in the exclusion from programmes of adolescent orphans. Orphans aged 15 to 22 years old, especially if they are heading households, are likely to be very vulnerable. This exclusion might have potential negative long-term consequences for children falling into this age group.

2.2.3 Demographics of orphan populations²¹

In section 1.2.1 the demographic impact of AIDS was illustrated. A direct result of these demographic changes in the adult population is the demographic change in orphan populations. Besides the 'Children on the Brink' reports (UNAIDS et al. 2000, 2002 & 2004) and a qualitative analysis by the Centre for Actuarial Research (Johnson & Dorrington 2001), there are still relatively few published reports on the demographics of orphan populations resulting from the HIV pandemic in sub-Saharan Africa. It is important to note that the lack of such reports is mainly caused by the shortage of reliable data on mortality (Bradshaw et al. 2001:3). Hunter (1990:681), as early as 1989, was the first one to predict that due to AIDS there would be 14 million orphans in Africa by 2000. She was using epidemiological and demographic data from Uganda for her initial projections. It is a challenging reality that her projection, which did not sufficiently galvanize policy makers and planners into action, proved to be accurate (UNAIDS 2002:5). In 1995 Gregson (1995:62) conducted research on the demographic consequences of HIV by undertaking a case study in rural areas of Zimbabwe. His study includes a prediction of the number of people who would be orphaned during the course of the expanding pandemic.

Figure 2.1 below illustrates the impact of the HIV pandemic on orphanhood in Zimbabwe with a parallel fertility decline resulting from changes in sexual behaviour and the positive impact of family planning programmes. Series 1 (blue line) shows the projected trend of orphanhood based on fertility decline in the absence of an HIV

²¹ Part of this section is based on a revised version from Germann, S. 1996. Community-based orphan care in Southern Africa: a vital alternative for institutional care? Focus on Zimbabwe. MSc Thesis. Swansea: University of Wales.

pandemic over a 30-year period. Series 2 (red line) projects a parallel scenario with a fertility decline, but accounts for the impact of the HIV pandemic.

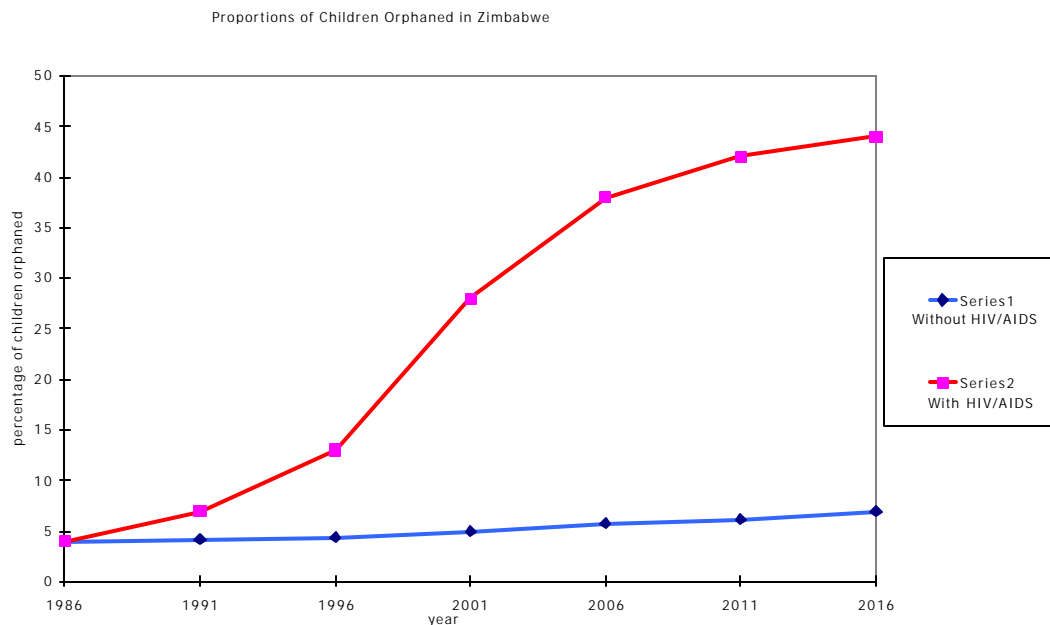


Figure 2.1: Demographic projections of orphan populations

Source : Gregson et al. (1995) Draft article: 'The early socio - demographic impact of the AIDS pandemic in Africa'

This scenario shows that a dramatic increase in orphanhood must be expected fifteen years into the pandemic. Between Gregson's research done in 1995 and 2004 when the 'Children on the Brink' report was published, advances were made in models used to estimate orphan populations due to HIV/AIDS (Timaeus & Grassly 2001, Dorrington & Schneider 2001).²² Further these estimates take into consideration expanding access to ARV treatment promoted under the WHO 3 by 5 (3 million people on treatment by 2005) which reduces AIDS related parental mortality and therefore slows down orphaning. Compared with Gregson's estimates, new estimate models reduce the expected percentage of orphans, as part of the total child population - in the case of Zimbabwe from 38% to 22%. (USAID et al. 2002:28) Estimates for 26 African countries suggest that the number of children losing a father (parental orphans) or mother (maternal orphans) from any cause will more than double between 1990 and 2010. Within the same period, the number of children who

²² For detailed information on algebraic development models used to calculate numbers of orphans see Appendix A in CARE Monograph No. 4 in 2001, UCT.

will have lost both mother and father (double orphans) will increase eight-fold throughout all of Africa, with a staggering seventeen fold increase (from 0.2 to 3.4 million) in Southern Africa, which is the worst affected region in the world (Figure 2.2). This trend has significant implications for care arrangements and partly explains the increasing numbers of CHHs in the region.

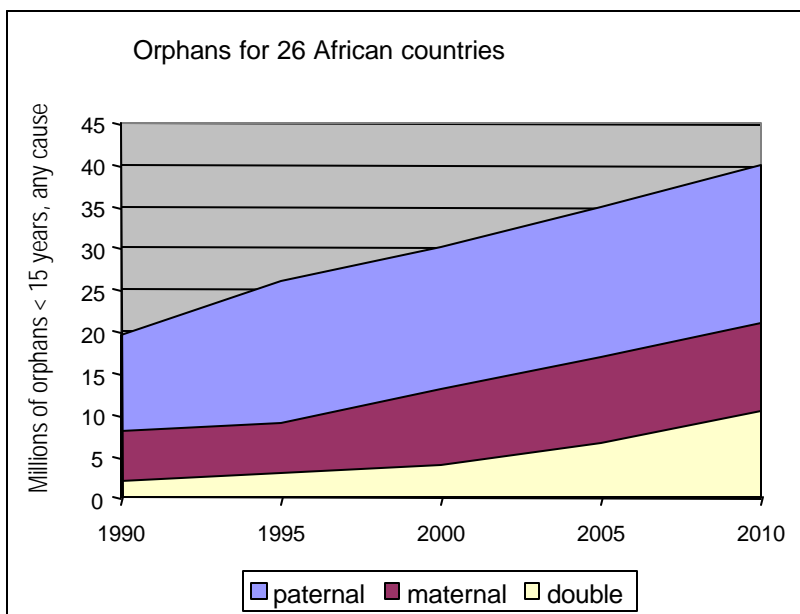


Figure 2.2: Projections of orphan populations in 26 African countries
Source: USAID et al. (2002)

These estimates project a total of 41 million children will be orphaned by all causes in 2010 in 26 African countries. Even if rates of new HIV infection in adults were to fall in the next few years and ARV treatment access is increased, the virus' long incubation period means parental mortality will not plateau until 2020. This situation could only be somewhat ameliorated by the introduction of large-scale access to antiretroviral drugs. But despite some positive developments, this seems unlikely to happen within the next five years. Thus orphanhood can be expected to remain an abnormally prominent feature of the social landscape in Africa through at least the first quarter of the twenty-first century.

Although statistics are important, and vital for policy and planning purposes, it is important not to neglect the personalised impact on children and families if we want a better understanding of the impact of rising orphanhood on society at large. The following section is an attempt to balance statistics with the difficult day-to-day reality of children and families living in a time dominated by economic distress and the HIV pandemic.

2.3 The situation of children orphaned or affected by AIDS²³

A 13-year old, orphaned by AIDS traded her virginity in exchange for a fruit. When asked why, she simply replied, 'no one's ever given me anything before'. (Guest 2001:1).

²³ This section includes material first published by Foster, G. & Germann, S. 2002. *AIDS in Africa*, edited by Max Essex. New York: Kluwer Academic / Plenum Publishers (permission obtained).

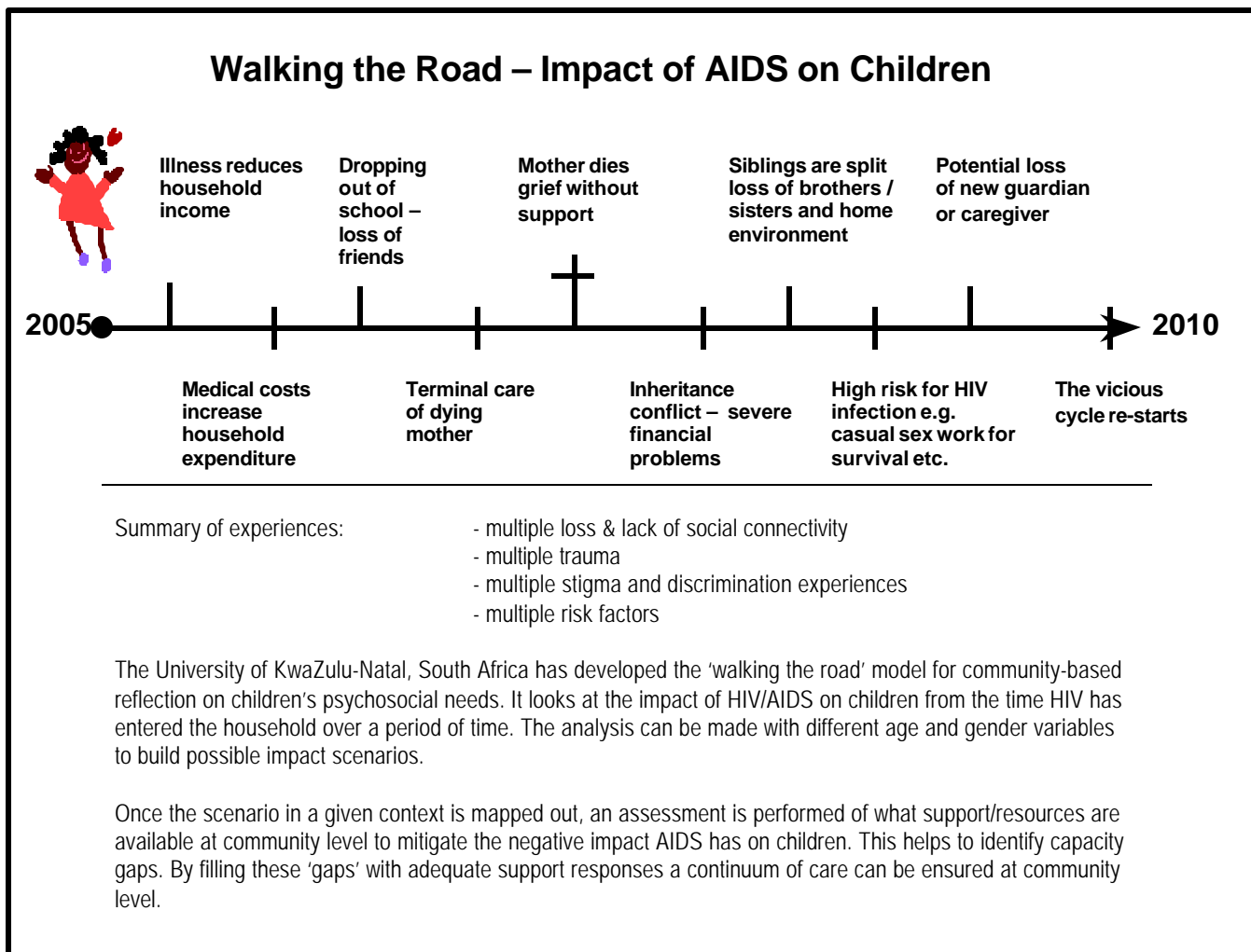


Figure 2.3: Walking the road – impact of AIDS on children

Source: Adapted from Germann (2003:4)

The loss of one or both parents due to AIDS is devastating and may have long lasting negative consequences in a child's life. Figure 2.3 above was developed by the researcher based on a concept called 'walking the road' from the University of KwaZulu-Natal (Schoeman 2000). It illustrates the multiple loss, multiple risk and overall complexity children affected by AIDS may face. Siphon is a 12-year-old girl, whose mother has returned from the clinic because she has not been feeling well recently. Her mother tested HIV+ but fear of stigma and discrimination means she is unable to share the results with her family. Siphon realises that something is not right with her mother as she has become more aggressive and sometimes withdrawn.

Sipho is worried. During the following months, Sipho's mother, who works as a waitress, is unable to go to work on days when she is not feeling well. Since she is paid only for days she works, the family's income is reduced. At the same time, medical expenses to treat her mother's different pains and opportunistic infections start to rise. The new school term has started but there is not enough money to pay for Sipho to go to school any longer. She loses her friends from school and her dream of becoming a car mechanic is shattered. Eventually Sipho's mother loses her job. For Sipho, this means that she must not only look after her dying mother and two younger siblings, but she must also look for ways to earn money for an entire household of four. After a time her mother dies. Sipho has to organize the funeral with limited support from distant relatives she has not seen in years. Subsequent to the funeral, she and her siblings are split and sent to different, distant places. Some other relatives contrive to take possession of the little property that was left to the family. Sipho ends up staying with her caring 30-year-old cousin. After Sipho has stayed there for a year she becomes worried yet again; her older cousin and present caregiver has started to develop similar symptoms to those her mother had before she died. So after four years, the cycle begins again for Sipho.

The complex and interrelated problems among children and families affected by HIV/AIDS, as demonstrated in the practical example above, are illustrated in Figure 2.4 below.

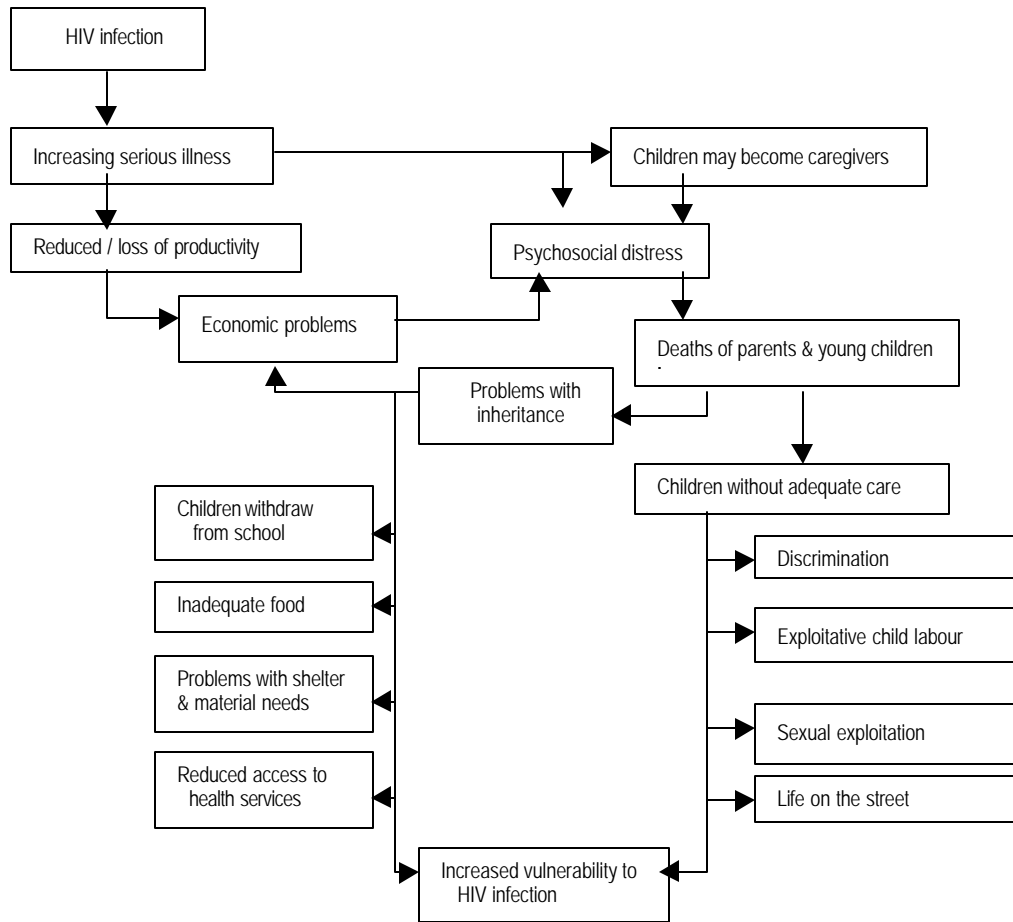


Figure 2.4: Impact of AIDS on children

Source: Adapted from Williamson (2000)

The following section looks in more detail at how HIV/AIDS impacts on children's social, economic and psychosocial well-being as well as their vulnerability to HIV/AIDS infection. It will review the literature on the social changes expected in the region over the next 30 years attributable to prominent orphan populations.

2.3.1 Social and welfare impact

Care for children and social safety nets

As discussed earlier, life expectancy in many countries in the region has declined as a result of AIDS (Piot & Bartos 2002:210; Foster & Germann 2002:666). This results in a reduction in the number of caregivers of optimum age. This shortage of prime-age adults has consequences for the next generation. Increasingly, instead of being cared for by uncles and aunts, some orphans will grow up in households headed by elderly or adolescent caregivers. In most of Africa the extended family system was the traditional social security system. Family members were responsible for the protection and care of the vulnerable. Although the combined impact of urbanisation, HIV/AIDS and poverty has weakened this social safety system, the extended family remains the predominant caregiving unit for orphans in communities with severe epidemics (Ankrah 1993:9; Foster et al. 1995:10; Ntozi 1997:10). But the extended family is not a 'social sponge' (see Figure 2.5) with unlimited capacity to care for an ever-increasing numbers of orphans.

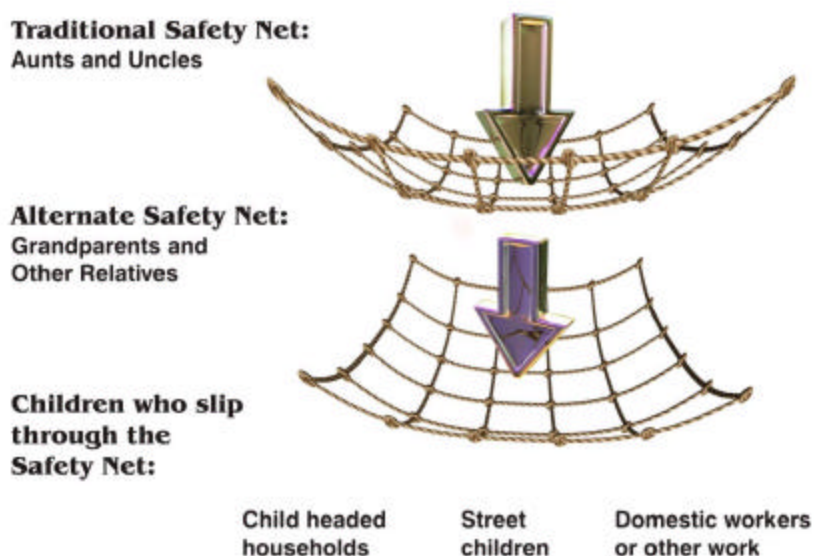


Figure 2.5: Extended family safety net for orphans in Africa

Source: Foster, Germann et al. (2003 :13)

Children who slip through the safety net often end up in a variety of highly vulnerable situations. Increasing numbers of orphaned children living on the street, or working as farm or domestic labourers, or involved in child sex work are all indicators of the growing inelasticity of existing social safety nets (Veale 2000: 235; Foster 2000a:60). In particular, extended family structures that provided for orphaned children in the past are seriously over-extended (Stecker et al. 2000:5), aggravating child poverty and raising its prevalence.

Increased poverty

Many children in Southern Africa already live in poverty amid situations that violate their basic rights. The impact of HIV/AIDS only worsens their situation. Several studies document that households affected by HIV/AIDS or with orphan members are more impoverished than others in the community (Foster & Germann 2002:668; Subbarao et al. 2001:9; K'Oyugi & Muita 2002:11; Barnett & Whiteside 2002b:201). Research further shows that the well-being of orphans within such households is lower compared with non-orphans in the same household (Hunter & Fall 1998:14; Wilkins 2003: 58).

The health of HIV infected and affected children

As briefly discussed in Chapter 1, the impact of HIV/AIDS undermines most of the child development goals set out in 1990 by UNICEF; especially goals related to health and nutrition. Children living in HIV-affected families are more exposed to opportunistic infections, disease-related poverty and psychosocial stressors. These impact on care-giving practices as well as the child's well-being (Piwoz & Preble 2000:20). Infected primary caregivers are sporadically or terminally ill, while other caregivers, such as grandparents, are at times absent to attend funerals or other community functions. Children in such households are therefore less likely to get the medical attention they need and are more likely to suffer repeat infections (Giese 2002:61). Due to the fear of HIV/AIDS-related stigma and discrimination, HIV-affected families are often reluctant to accept the assistance of home-based caregivers who

could see to the health needs of children in the household. In homes run by women, this reluctance is most marked. Women in such situations are often forced, due to social pressure, to continue breastfeeding, which increases chances of mother-to-child HIV transmission. It is estimated that in South Africa there are at least 120,000 children living with HIV due to infection during pregnancy, delivery or through breastfeeding (Shisana & Simbayi 2002:47). Some of these children are abandoned. According to the South African National Council for Child and Family Welfare (1999), there has been a reported 67% increase in the number of HIV-related abandoned children in South Africa between 1997 and 1999. Children infected with HIV who live past infancy experience all the challenges associated with HIV-affected households, but in addition must cope with the illness itself (Bauman & Germann 2005).²⁴

2.3.2 Economic, educational and gender impact

Economic impact

The economic impact of AIDS on the household must be understood within the context of a declining gross domestic product across most of sub-Saharan Africa. In turn, this decline is partly due to the macro-economic impact of AIDS (Caldwell 1997:172). There have been few attempts to model the impact of AIDS on households in a systematic manner (Bechu 1998:343). Save the Children, UK, has developed a model to conduct intra-household surveys to address this issue (Marshland 2002:2). Existing studies tend to focus on individual households and fail to detail how AIDS impacts on households nationally (Barnett & Whiteside 2002a:8). However, there are various themes shared by these individual case studies that can help to assemble the broader picture. First of all, prolonged illness impacts on household income, due to reduced productivity. At the same time, new expenses start to mount up, most notably medical expenses to treat HIV/AIDS-related opportunistic diseases, and the transport costs to access the facilities which offer treatment. By the time a parent dies, there are often few assets left in the household (IHAA 2003:4). As households are steadily sucked dry of funds, the living standards and quality of life of

²⁴ Chapter 3 in A Generation at Risk: The Global Impact of AIDS on Orphans and Vulnerable Children. Germann contributed text boxes in this Chapter. 2005.

all household members are dragged down. Children begin to suffer from food insecurity, malnutrition, poor hygiene and a range of other stressors at household level.

The impact of HIV on education and gender inequity

In most countries in sub-Saharan Africa, insufficient data is obtainable from education ministries, to ascertain the full extent to which HIV/AIDS impacts on education (K'Oyugi & Muita 2002:17; Badcock-Walters 2002:104). However, based on various studies, it appears that the delivery and maintenance of education is already being affected by the illness and premature death of educators and officials at every level of the education system (Badcock-Walters 2002:103; Crouch 2001: 12). Therefore AIDS diminishes the quality of education available to children in countries with high HIV prevalence rates.

An important consequence of HIV/AIDS for orphans and other children made vulnerable by AIDS is exclusion from education. This includes poverty-related exclusion, enforced exclusion (for example enforced by relatives, or voluntary exclusion (Kelly 2000:42). The literature contains some controversy regarding HIV/AIDS-related exclusion from education. Ainsworth and Filmer (2002:4) conclude that 'gaps in enrolment between orphans and non-orphans are distorted by enrolment gaps between poor and non-poor children'. Huber and Gould (2002:28) in research on the effects of orphanhood on primary school attendance in Tanzania concluded that 'there is no sign of the generally assumed universal, negative effect of HIV/AIDS and orphanhood on primary school attendance'. However, in contrast, a recent study by Princeton University for the World Bank (Case, Paxson & Ableidinger 2003:25) using data from 19 countries in Africa, concludes that in at least one important dimension – school enrolment – orphans are significantly more disadvantaged than non-orphans. The Princeton University study suggests that orphans are less likely to be in school than non-orphans with whom they live. Case et al., cited above, further argue that based on Demographic Health Surveys (DHS) data, and contrary to existing literature, female orphans do not appear to be more disadvantaged than male orphans. This finding is in stark contrast to research done in KwaZulu-Natal

(Badcock-Walters et al. 2001:5) showing that the enrolment of orphan girls, especially at secondary school level, is lower compared to boy orphans. These contradictory results are probably due to the use of different methodologies. The Princeton study used national data for children aged 14 and under, in contrast to the KwaZulu-Natal research that included data for secondary school children age 18 and under.

A review of existing literature on the effect of orphanhood and HIV/AIDS on education suggests the following: 1) most data cannot be compared as different methodologies were used and there is need to conduct larger studies in different countries using similar methodologies. 2) Most data is concerned with school enrolment and rarely compares school-going orphans' performance with non-orphans in order to understand the impact of orphanhood and HIV/AIDS on school performance. Research is needed in the field of psychosocial well-being within schools to increase understanding of how HIV/AIDS and orphanhood impacts on children's performance in education over and above the simple fact of attendance.

2.3.3 Psychosocial issues

In the face of visible social and economic hardship due to HIV/AIDS, and with children's rights to basic needs being constantly violated, the psychosocial burden of the HIV/AIDS pandemic may seem less important, less urgent, less compelling. But this is not true for the children themselves. The emotional demands of HIV/AIDS on children's lives are heartbreaking (Bauman & Germann 2004:3). Long before a parent dies, children experience trauma and stress related to caring for terminally ill parents. The impact of HIV/AIDS, linked with fear, economic insecurity and other stress factors frequently result in domestic violence (Giese 2002:62). Children are directly in the line of fire, with little support to make sense of what is happening or to develop the necessary skills to manage such household situations. One can only start to understand the psychosocial impact HIV/AIDS has on children when listening to their own stories:

My mother was very sick and I was very scared because my mom was sleeping on the bed every time. When we go to school, during break I come back to see my mom and I found her screaming in bed and I see the nurses cleaning and washing her. She can't wash herself and she can't walk. I go back to school. I was worried about her. When I write at school I think about her but I tell myself that I will not forget her and when I come back from school she was not at home, she was at hospital. The next day, my friends tell me that my mom, she has got AIDS. I go home, I wash my clothes and at night my brother said to me 'don't worry, it will be alright'. The next day, my mother phoned and said 'you must come to visit me at the hospital'. They discharged her and she was better. I was happy and in the morning I go to school and at school I play with my friends. They asked me about my mom and I said she is well. I go back at home and she was sick again. She goes back to hospital and they said she will be well but she didn't and she passed away and I think that I am lost (Babalo, 12 years old. Children's Institute 2002: 54).

The above story exposes the multiple stresses and risks that children face when HIV/AIDS impacts their household. Fear, worries, observing and caring for ill parents in pain, stigmatisation, hospital visitations, shattered hope and eventual loss are experienced by children affected by HIV/AIDS at various times and often over several years. The effects parental illness and death have on a child's mental health and ability to cope are complex and depend upon the child's development stage, resilience and culture (Bauman & Wiener 1994; Dane & Miller 1992). Consequently, psychological and emotional effects are less obvious and often go unnoticed or neglected. Changed behaviour may be dismissed as a mere transitional stage, a temporary disorder that will pass, rather than as an indicator of psychological trauma with possible long-term implications (Humuliza 1999:10). There is very limited research conducted in sub-Saharan African on psychosocial issues in children in general and less related to HIV/AIDS in particular. Research further suggests (Gelman 2003:177) that existing psychometric tools, mainly developed in Europe or the USA, should not be used in culturally different settings as the results cannot be validated. Only recently have efforts been made to develop culturally appropriate psychometric assessment tools for non-Western cultures (WHO 1999; Horizons & REPSSI 2003:5). Existing research, however, suggests that the impact of AIDS on children at household level may lead to sequential trauma associated with continuous traumatic stress syndrome (Foster & Germann 2002:670; Straker 1992:43). Many children (see Figure 2.3 and 2.4 above) suffer multiple losses – a father, a mother,

siblings, grandparents, uncles, aunts, and other relatives. In addition, they may lose friends, familiar surroundings, schooling, their hope for a future, and their remaining childhoods. Separation of siblings is also a major factor contributing to psychological distress. All of this underlines the importance of providing support to orphans in ways that go beyond traditional support interventions (Nampanya-Serpell 1998:245).

A child's mental health depends strongly upon the well-being of his or her primary caregiver. A child may observe signs of depression, guilt, anger, or fear in a parent without understanding them. Often this results in changed behaviour (Hunter 2000:197). For example, a study in Zambia found that 82% of caregivers noted changes in children's behaviour during parental illness. Caregivers noted that children appeared worried and sad. Children tried to help more in the home and stopped playing, as a result of seeking proximity to their ill parent (Poulter 1997:34). Stigmatisation, discrimination, social isolation, dropping out of school, moving away from friends, and bearing an increased workload in the home all increase the stress and trauma that accompanies the death of a parent (Foster et al. 1997: 395; Naerland 1993:12). In a study in Uganda (Kirya 1996:8), orphans were found to internalise emotional responses to illness such as depression, anxiety, and decreased self-esteem rather than acting out or exhibiting sociopathic behaviour such as stealing, truancy, aggression, and running away from home or school.

It is difficult to predict the long-term consequences of AIDS-related trauma for children in Africa. In section 2.6 of this chapter, a limited attempt is made to sketch some potential long-term impact scenarios.

2.3.4 Vulnerability to HIV/AIDS

Children affected by AIDS have greater vulnerability to a host of negative consequences including illiteracy, increased poverty, child labour, unemployment, sexual abuse, exploitation, and HIV infection. The increased vulnerability to HIV/AIDS itself of orphans and other HIV/AIDS affected children is the subject of this section.

Studies have shown that orphaned children, and children living on the margin of society such as refugees, street children, residents of urban slums or children living in remote rural areas, have an increased risk of contracting HIV (Richter et al. 1995: 33; UNICEF 2002:21). Preventing HIV is not a priority for children and adolescents whose main concern is meeting basic day-to-day survival needs. In a study in Accra, Ghana, most street children were sexually active and had had their first sexual experience on the streets and with commercial sex workers. Most of them had misconceptions about AIDS and were doing little to protect themselves from contracting HIV (Anarfi 1997:293). Children from households affected by AIDS often lack adult protection from sexual exploitation by relatives or by males in their communities. Susceptibility to such exploitation increases during parental illness or after parental death because of the increased frequency of male visitors to affected households. Girl orphans may be taken in by relatives or community members, but then are often exploited through domestic services masquerading as foster care and then subjected to sexual abuse (Hunter 2000:254). Very often, the movement of children out of their parental home reduces community-based child protection mechanisms and increases the children's vulnerability. In a study in Uganda (Sharp et al. 1993:4), 30% of 12-year old orphaned girls and 85% of 18-year old girls were sexually active. The reasons for their becoming sexually active included economic need, peer pressure, discovery, lack of parental guidance and supervision, and rape by relatives, teachers, or strangers in market places. Although most orphans were aware of the existence of AIDS, few knew how to protect themselves from HIV.

Failure to prevent HIV infection in this increasingly large group of vulnerable children has implications for future generations. Orphans represent a pool of at-risk children and youth who have an increased likelihood of contributing to the HIV/AIDS pandemic (see Figure 2.6 below).

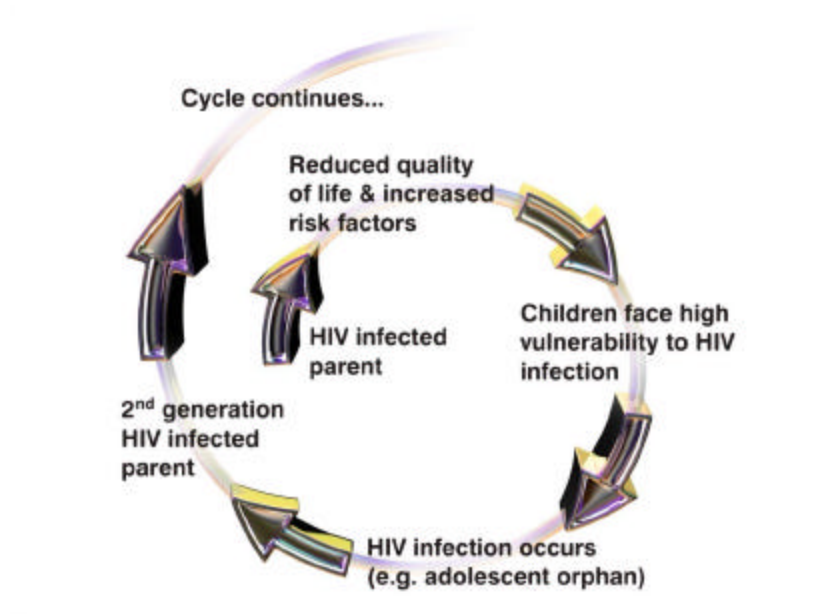


Figure 2.6: The vulnerability cycle to HIV/AIDS for children affected by AIDS

When orphaned adolescents or young adults become ill as a consequence of HIV, they have no mother to nurse them during their terminal illness. When orphaned adults die, there will be no grandmothers alive to care for their children. This second generation of the AIDS pandemic has already begun, with increasing numbers of grandparent-less ‘orphans of orphans’ being left without adult caregivers. The lack of middle-aged grandparents leads to a failure of alternate safety nets, thus increasing the numbers of CHHs and inflating the dimensions of the orphan crisis (Foster & Germann 2002:672).

2.4 Care responses for orphans and children affected by AIDS

The growing demand for care and support of orphans and vulnerable children at the community level has strained traditional coping mechanisms to crisis point in the most affected countries in the Eastern and Southern Africa Region (FHI 2001:2). Over the past 15 years, various care and support mechanisms have been developed to respond to this crisis. These primarily focus on addressing children’s material needs (German et al. 2001:7). The secondary focus of programmes has been to address the need for skills transfer and education. Very few programmes have adequately

addressed the medical, social and psychological needs of children affected by AIDS. Although programmes have responded to some of these needs, they are often fragmented and lack a comprehensive approach (UNICEF 2002:4). This section discusses a strategic framework for protection, care and support of children affected by AIDS. This is aimed at establishing a policy framework for action. Community and other care arrangements are then reviewed, and the section ends with looking at the role of children as caregivers.

2.4.1 Strategic framework for protection, care & support

As discussed above, the crisis of orphans and other children made vulnerable by HIV/AIDS is enormous in scope, complex in impact and lengthy in duration. There is no easy solution to this crisis, but there is an urgent need to increase our collective efforts to generate an adequate response over the long-term. Presently, most responses are still NGO- and community-driven and it almost appears that governments in Eastern and Southern Africa believe that the problem will be adequately addressed by NGOs and community-based organizations (CBOs) (Smart 2003:23). Although some national orphans and vulnerable children's policies have been put in place, there is a need to move beyond rhetoric and towards action. The actual response in most African countries has been, according to Steven Lewis, UN Special Envoy on AIDS in Africa (UNICEF 2002:5), 'limited in scale, fragmented and shamefully short of what is required to halt this preventable tragedy'.

In its concluding session the United Nations General Assembly Special Session on AIDS in June 2001, adopted a declaration which committed its member states to a range of actions to address the HIV/AIDS crisis (UN 2001:28). Articles 65, 66 and 67 of this declaration directly relate to children orphaned and made vulnerable by HIV/AIDS. The content of these articles is as follows:

Children orphaned and affected by HIV/AIDS need special assistance:

Article 65. By 2003, develop and by 2005 implement national policies and strategies to build and strengthen governmental, family and community capacities to provide a supportive environment for orphans and girls and boys infected and affected by HIV/AIDS. This includes providing appropriate counselling and psychosocial support, ensuring enrolment in school, access to shelter, good nutrition, health and social services on an equal basis with other children; and protect orphans and vulnerable children from all forms of abuse, violence, exploitation, discrimination, trafficking and loss of inheritance;

66. Ensure non-discrimination and full and equal enjoyment of all human rights through the promotion of an active and visible policy of de-stigmatization of children orphaned and made vulnerable by HIV/AIDS;

67. Urge the international community, particularly donor countries, civil society, as well as private sector, to complement effectively national Programmes to support Programmes for children orphaned or made vulnerable by HIV/AIDS in affected regions and in countries at high risk and to direct special assistance to sub-Saharan Africa.

Most leaders of Southern Africa countries declared, through signing the UNGASS declaration, their commitment to accelerate action aimed at addressing the orphan crisis. UNICEF and UNAIDS have facilitated, over the past few years, a process among key stakeholders towards establishing a 'strategic framework for the protection, care and support of orphans and other children made vulnerable by HIV/AIDS' (UNICEF & UNAIDS 2003:1). Smart (2003:13) compiled a short historical overview of key events and processes that form the background for this strategic framework. Box 2.2 provides an overview of over a decade of orphans and vulnerable children related events.

A decade of orphans and vulnerable children-related events

In **1994**, at a workshop in Zambia on support to children and families affected by HIV/AIDS, the Lusaka declaration was adopted.

In **1998**, a UN General discussion on 'Children living in a world with AIDS' was held. The committee stressed the relevance of the rights contained in the Convention of the Rights of the Child to prevention and care efforts.

In November **2000**, an African regional meeting on OVC was held in Lusaka Zambia, at which countries made commitments and plans to address the issue of the growing numbers of OVC in their countries.

In June **2001**, the UN General Assembly Special Session met to review and address the problem of HIV/AIDS in all its aspects. The declaration of commitment on HIV/AIDS includes a set of policy and strategy actions on OVC.

In **2002**, a United Nations Special Session on children resulted in the world fit for children declaration. This declaration reaffirmed the goals set in June 2001.

In April **2002**, a regional workshop on OVC was held in West African. Country representatives committed to setting up task teams in their countries to develop action plans to ensure the realization of the targets pertaining to OVC set for the in the UNGASS declaration.

In September **2002**, an Africa leadership consultation entitled 'Urgent action for children on the brink' aimed at developing consensus on priorities for a scaled-up response to the OVC crisis.

In November **2002**, an Eastern and Southern Africa workshop on OVC (with representation from 20 countries) was held in Windhoek, Namibia, to assess the progress of countries toward meeting the UNGASS goals.

During October **2003**, a global partners forum for children orphaned and made vulnerable by HIV/AIDS assembled in Geneva to agree on the draft strategic framework discussed above.

In September **2004**, the final document of the Geneva partners meeting was released setting the global framework for OVC responses.

Box 2.2: A decade of OVC related events

Source: Adapted from Smart (2003:13)

The aim of this strategic framework is to provide more operational guidance and support for approaches to help attain the goals set out and agreed on by leaders during UNGASS in 2001. The following section is a short discussion of the key issues addressed in this strategic framework. This strategic framework was developed over the last four years by the researcher, in collaboration with UNICEF and others.

Fundamental to this framework is that all actions in support of children are guided by the Convention on the Rights of the Child. The Convention on the Rights of the Child includes the following fundamental principles (Byrne 1998:28): 1) to fulfil children's right to survival, well-being and development; 2) ensure non-discrimination; 3) take into account the best interest of the child; and 4) encourage their participation in activities aimed at promoting their well-being. These four principles provide direction for all actions outlined in the framework. Based on these principles, the following five key strategies have been identified for an upscaled and accelerated response to the growing orphan crisis:²⁵

1. To strengthen the capacity of families to protect and care for orphans and other children made vulnerable by HIV/AIDS.
2. To strengthen and support community based responses.
3. To ensure access for such children to essential services.
4. To ensure that governments protect the most vulnerable children.
5. To raise awareness, through advocacy, of the need for creating a supportive environment for children affected by HIV/AIDS.

Based on years of experience in protecting the rights of vulnerable children, the framework also puts forward the following guidelines for programmes:

- Not only focusing on children orphaned by AIDS but targeting the most vulnerable children and communities
- Through participatory processes, defining community specific vulnerabilities and pursuing community owned, locally determined responses
- Ensuring the active participation of children and young people at all stages
- Urgently addressing gender discrimination
- Strengthening partners and partnerships at all levels
- Ensuring that care and support activities are strategically linked with HIV/AIDS prevention efforts
- Using external support to strengthen, not undermine, community initiative and motivation

²⁵ For more detail see 'Children on the brink' (USAID, UNICEF & UNAIDS 2004).

The goals set by the United Nations General Assembly Special Session on HIV/AIDS for orphans and other children made vulnerable by HIV/AIDS are ambitious in scope and time frame. National governments will need the support of international agencies to achieve these goals. Also, it is important for international agencies to recognize that the impact of AIDS on children will continue for decades without short-term solutions. Long-term commitment in partnerships and funding are needed (UNICEF et al. 2003:26). The example of Uganda demonstrates the importance of mainstreaming strategies for protection, care and support into the National Poverty Eradication Action Plan (Okemo 2002:12) towards achieving that long-term commitment.

Through various processes, notably the Eastern and Southern Africa Regional Workshop on Orphans and other children made vulnerable by HIV/AIDS, there is further consensus among Governments, UN Agencies and civil society on the following practical action points:²⁶

- **To strengthen the engagement of parliamentarians and religious leaders.** There is need for parliamentary debates on orphans and vulnerable children in order to sensitise and engage national leadership to shift OVC issues into the centre of public policy and action. Religious leaders need to be engaged to achieve large-scale social mobilization in support of the African traditional concept of 'everyone's child'.
- **Documenting, monitoring and reporting country progress.** Governments in the region committed themselves through signing the UNGASS declaration (United Nations 2001) to acting on the OVC goals (paragraph 65-67 stated above). Part of this commitment is to document and monitor progress made in achieving these goals. In April 2003 an international technical consultation on OVC national programme indicators was held in Gaborone. This technical consultation agreed on ten basic indicators²⁷ for national OVC progress reporting (UNICEF et al. 2003). Over the next two years countries in the region will be expected to use these indicators to collect data through DHS (Demographic Health Surveys) and other data collection process to report to the UN Secretary General on progress made to achieve these OVC goals.

²⁶ Action points are based on a Chapter by Germann (2004) in Institute of Security Studies Monograph.

²⁷ See UNICEF (2003) indicators report from Gabarone meeting for details on all indicators for national response measurement

- **Universal Access to Education.** To secure the future of orphans and other vulnerable children, education is fundamental. The call for 'free primary school education' is more needed than ever. The HIV/AIDS pandemic and its impact on children is a humanitarian crisis and requires bold crisis responses. Collectively we need to advocate channelling funds from debt relief initiatives directly to schools towards universal access to primary education.
- **Children and Young people's participation.** Presently most responses to OVC are reactive and treat children as 'helpless victims' in need of our help. This approach has potential long-term negative consequences as it creates a new generation of adults dependent on 'hand-outs' and unable to contribute to society and national development. Young people must participate both at local and national level in policy formulation, programme planning and implementation. This will promote in them a belief in their own ability to help themselves as well as contributing towards national development.
- **Resource mobilization.** There is need for resource requirement frameworks at national and regional level. Through this, unnecessary competition for resources can be reduced. First, there is need at national level to cost out national plans of action for OVC support. Second, there is need to strengthen or establish effective mechanisms to support community based response on a large scale.
- **Strengthening partnerships, coordination and cooperation.** The magnitude of the OVC challenge is so great that no single response will be adequate. A unified effort is required that promotes synergies and complementarities.
- **Capacity building at all levels.** There is no 'quick fix' to the orphan crisis. We need a critical analysis of capacity gaps and opportunities for strengthening our capacity at national and local level. For example, what is required to support teachers, and who can strengthen their capacity to respond?

The following key steps for government, international agencies and other key stakeholders are aimed at achieving global goals and an accelerated rate of response.

- The acceleration and support of national government efforts aimed at conducting situational analyses, implementing national policy, action plans and legislation. Coordination and monitoring mechanisms are also required.
- All governments, especially those of donor countries, need to assess their resource commitments, to urgently increase and sustain long-term financial support. But there is need for a word of caution. In Congo there is a proverb that goes 'when you call for rain, remember to protect the banana trees'. In other words, the provision of external resources can, if we are not careful, actually make matters worse by flattening local responses.
- Jointly develop and implement a research agenda, including studies of the potential long-term consequences large numbers of orphans may have on society.
- Assess national level progress towards achieving goals using agreed indicators and monitoring guidelines (UNICEF 2003:3)

Effective implementation of this 'normative strategic framework' of programme action and policy at local, national and regional levels will lead to an improved quality of life for children affected by AIDS in the region. Regrettably, to date the response to the current situation has been on too small a scale to reverse the negative impact on countries in the region. Community care initiatives (discussed below) are currently few and far between. They must be brought to scale that adequately ensures the protection, care and support of all children made vulnerable by HIV/AIDS in highly affected countries. In the words of Graça Machel (1996:189) 'we must do anything and everything to protect children, to give them priority and a better future. This is a call to action and a call to embrace a new morality that puts children where they belong – at the heart of all agendas.'

2.4.2 Community care

The effectiveness of extended family and community care responses in absorbing millions of children made vulnerable by HIV/AIDS has contributed to the slow response by national and international agencies to the orphan crisis (Foster & Germann 2002:672). According to Hunter and Williamson (1998:4) 'the first response to the problems caused by HIV/AIDS comes from the affected children, families and communities themselves, not from government agencies, NGOs or donors.' There are

many examples of community coping strategies to meet special needs during times of crisis (UNAIDS 1999:20). Coping in this study is used as a general term that includes defence mechanisms, 'as active ways of solving problems and methods for handling crisis events and stress' (Murphy & Moriarty 1976:7). It is important to note that most response strategies to crisis events are in fact extensions of practices used to a certain degree during 'normal' times (Watts 1988).

Crisis events occur from time to time in people's lives and in the lives of whole communities and societies. Such events call for the mobilisation and co-ordination of resources to cope with the impact (Barton 1969). In situations where people know an event will occur because it has happened in the past, such as drought, they develop ways of coping with it in advance (Fleuret 1986:226). The assumptions upon which people make their decisions therefore rest on the knowledge of subjective estimates and past experiences of how to cope. It is important, however, to be cautious using the term 'community coping mechanisms'. In a paper prepared for UNRISD, Collins and Rau (2000:4) note that 'caution is in order when talking about household and community coping mechanisms. Inventiveness in the face of adversity is now widely recognized and cited by many agencies. However, in too many instances, the rhetoric about coping mechanisms has become an excuse for doing little or nothing to reduce the pressure on communities.' Present policy shifts described above clearly promote community care but there is a danger, unless closely monitored, that governments will not allocate the needed resources to communities to enhance and sustain local care mechanisms (Foster, Lorey & Williamson 2001:3).

There is a wealth of agency reports available describing community care programmes for orphans and children affected by AIDS in Eastern and Southern Africa (Phiri & Webb 2002; Axios 2002; USAID 1999; UNICEF Zimbabwe 1998). Many of these reports are descriptive or evaluation reports. Unfortunately only a small number of reports, e.g. an operations research report by Gilborn et al. (2001), are of high research standards and analytical in their approach towards fostering a better understanding of community care programmes in the region. Foster (2000:4) described a good practical example of a community care programme called Families,

Orphans and Children under Stress (FOCUS) a summary of which is shown in Box 2.3 below.

Families, Orphans and Children under Stress (FOCUS)

FOCUS started in 1995 in the town of Mutare in the Eastern Highlands of Zimbabwe. The program involves volunteers, mainly from local churches. Communities were mobilized by an NGO called Family AIDS Caring Trust (FACT) and communities 'appointed' these volunteers as 'child protection' workers. They identified needy children in the community using a locally determined vulnerability criteria, to support them with basic material, practical and psychosocial support. Initially, instances of nepotism arose, with the volunteers supporting children of relatives; but over time, the group as a whole resolved the problems, and focused on genuine cases. The fears that money and resources would be misappropriated lessened, and the community was able to support a large number of children in the community, including child headed households.

In 1999, the FOCUS community program was operating in one urban community and eight rural sites in the province. In 1998, the volunteers reported almost 60,000 visits to over 6000 orphans in 2174 households at a total cost of USD 20,000. The cost per household visit in 1998 was USD 0.34 and the total support cost per family was USD 9.20. This case program demonstrates that community based care is highly cost effective but that it is imperative that resources are allocated to communities for such responses.

Box 2.3: Community care programme

Source: Adapted from Jackson (2000:281)

Many communities in Southern Africa have a long tradition of 'social support groups' organised by community members. Such organisations include local 'burial societies', which operate like community savings schemes, and groups supporting each other in times of sickness with help in cultivating one another's field (Mukoyogo & Williams 1991:12). A similar scheme used in Zimbabwe involves local chiefs setting aside a certain area of land to be cultivated communally. The produce is then distributed to those in need. This scheme is called 'zunde ramambo'.

Many studies suggest that communities are organising themselves in response to increased numbers of orphaned children in their communities (Phiri & Webb 2002; UNICEF Namibia 1999; NACP 1997; Donahue & Williamson 1996). Community leaders have been seen exercising moral persuasion, encouraging relatives to fulfil their family responsibilities and becoming involved in protecting the inheritance of widows and orphans (Dhlembeu 1996). Teachers have been identified as voluntarily providing direct material support to children affected by HIV/AIDS. Communities are

making adjustments to cope with the impact of AIDS but support is still limited and there is an urgent need for further mobilisation of community support (Germann et al. 1996). It is of vital importance that those bodies and institutions seeking to establish community coping support programmes first analyse community coping mechanisms in a participatory way and use this knowledge to guide them in programme development.

A recent study commissioned by UNICEF and the World Conference of Religions for Peace (Foster 2003) demonstrates the importance of faith-based organizations in supporting orphans and vulnerable children. The historical overview presented in 2.1.1 shows how faith-based communities are all encouraged by their respective holy texts to be engaged in the protection and support of orphans. This six-country study established that most local congregations are key agents in facilitating and promoting community care of orphans. However, to date, most Faith Based Organizations receive little or no external support. Consequently they are forced to rely on their own resources. A key recommendation in this study is that donor organizations support such faith based organizations in setting up small grant making mechanisms for community based orphan care programmes (Foster 2003:3). A direct result of this study is that UNICEF and other large international agencies are forging partnerships with religious organizations. This is based on the recognition that to date no other institutions have been so effective in penetrating communities across Africa. Such partnerships are essential for scaling up community based support responses for children affected by AIDS.

2.4.3 Other care arrangements

Reviewing existing strategies and best practice generates level-of-care hierarchies as illustrated in Figure 2.7, which summarizes care arrangements and their level of priority in most countries in Eastern and Southern Africa.

Level of care

1. Extended family

before

2. Adoption and fostering

before

3. Household type homes

before

4. Orphanages

Figure 2.7: Level of care for orphans and other vulnerable children

Source: Germann (1996)

The following section will give a brief overview of other care arrangements such as community fostering, formal fostering, adoption and institutional care. Existing alternatives based on community care capacity are a viable solution to challenge the crisis. These alternatives are discussed within the socio-cultural context of Southern Africa.

Fostering and adoption

At present, adoption and formal fostering are problematic due to their lack of popularity in Southern Africa. For example, in 1998, only three formal adoptions and ten fostering placements were arranged by the Department of Social Welfare in Zimbabwe (DSW 1998:35). Based on cultural beliefs it is uncommon to care for a child coming from outside one's own clan. Thus, if plans are made to utilize adoption and fostering, as an alternative to orphanages to deal with rising numbers of orphans who slip through the community safety net, national campaigning is required to change attitudes (Powell et al. 1994; Tolfree 1995). However, it has to be recognised that changing cultural beliefs is a difficult undertaking (Webner 1991:11). Although

informal fostering is a common coping practice in the extended family system in most societies in Africa (Jackson 2002:283), formal fostering outside the extended family tends to be problematic. Often there are cultural taboos, related to family totems and fear of upsetting ancestral spirits, which militate against taking in children from outside the clan (CPS 1998:9; Jackson 2002:284). Other relatives may in the future blame any misfortune in the family on the presence of children with the 'wrong' totem or from the 'wrong' clan. Some innovative programmes in Zimbabwe and South Africa appear to have overcome such cultural barriers.²⁸

Parents, predominantly with a strong religious (often Christian) faith, have started to overcome such cultural barriers and increasing numbers of women and couples are willing to foster or adopt young orphaned children from orphanages. This was reported in a study in the Highfield community care programme in Zimbabwe (Powell 2002). In Zambia, formal fostering and adoption is often in conflict with civil and customary law (Siamwiza 1998:15) and there is need for legal and administrative reform in most countries to make formal fostering an option for larger numbers of children in need of care and support. In most countries, existing authorities cannot cope with the present administrative demand for such formal fostering placements. If close monitoring mechanisms are in place at community level, normalising informal fostering may be more workable and adaptive than trying to apply rigorous legislation to formal fostering and adoption.

Orphanages

As discussed earlier, in pre-colonial Africa production and livelihood were communal. There was an extended family system where children belonged to the entire clan. Furthermore, the status of a child was not necessarily defined by the marital status of the parents (Egunyu & Parry 1989: 1). A child did not have to depend, as in early

²⁸ See Farm Orphan Support Trust (FOST) in Zimbabwe. Dube, L. and Thembo, F. 2002. FOST Evaluation. To avoid the problem regarding different totems, FOST arranged that the 'responsible' person for the child is the owner of the commercial farm; the farm worker family where the child stays only provides the care and support but is culturally not linked to the family.

modern Europe, on a particular individual/parent for their livelihood. The welfare and upbringing of the child was the concern of the entire community.

With colonialism came the partial breakdown of the traditional social and economic set up. Through urbanisation the nuclear family often becomes the basic unit of production, progressively alienated from the clan and responsible for its own livelihood. As a result urban children have come to depend almost entirely on their biological parents for their livelihood. This process resulted, for the first time in African history, in a situation where children were found without extended family support. In response to this situation, western missionaries started to build orphanages for such children (Rogers 1991:8). This, although well intended, was culturally inappropriate. Humanitarian zeal and the fact that a visible orphanage with an infrastructure offered 'proof' that one was helping disadvantaged children, helped popularize the construction of orphanages in Africa from the beginning of last century. Imported laws by colonial rulers, focusing on the nuclear family (Egunyu & Parry 1989:24), justified the need for institutions to place children in statutory care.

Today, increasing numbers of orphans due to the HIV pandemic are the motivating force behind new orphanages,

Although not in the overall best interests of the child, there are some advantages to orphanages. The researcher visited orphanages in Uganda, Zimbabwe, Zambia, Tanzania and South Africa, and was able to support the findings of Rogers (1991). He identified correctly that often orphanages have better accommodation and sanitation than family homes in the villages. Diet and nutrition are often more balanced, and thus health records of children are generally good. Education for children in orphanages is in most cases good compared with the education children would receive in their home communities (Tollfree 1989). Furthermore basic education in children's homes is often complemented by vocational training or support for further studies.

However, over the past years, many institutional defects have been identified in orphanages, especially in the African socio-cultural context. Institutions undermine the traditional system of orphan care by removing the child, and the responsibility of care, away from the extended family. In most institutions, no effort is made to instil an understanding of traditional culture. One major problem experienced by adults having grown up in an institution is the dependency syndrome and lack of social networks (Tollfree 1995:230). Socialisation of children in institutions is often delayed, though this observation is challenged by a comparative study in Eritrea (Wolff & Fesseha 1998). His findings are that children in the orphanage were better socialised than the comparative control group of non-orphans. However, Wolff and Fesseha (1998) failed to recognise that his study operated in a specific situation given the war of liberation and the fact that most children knew that their parents were alive but engaged in the war (Teklu 1995). Therefore, these findings on socialisation cannot be generalised and certainly do not apply to most of Southern Africa's institutions. One of the biggest problems of all orphanages is the high per-child running cost and the resulting donor dependency. The annual cost per child tends to be from USD 500 upwards in Africa (UNICEF et al. 2003:30) compared to USD 9.30 for family care using the FOCUS model described above. Such costs are therefore not sustainable. Most orphanages in Africa depend to a large extent on expatriate staff and their links to donor funds overseas. This fact alone, besides all the other institutional defects, should discourage any new plans for such institutions. A working group of an international child welfare organisation (DFCI 1985:i) made the following statement 'When we place a child in an institution, it is our problem (societies) [sic] we are solving, not that of the child'.

Orphanages for more than 14 million orphans simply cannot be built and sustained. Existing institutions should, therefore, forge partnerships with community care programmes to provide places of short-term safety and as a last resort if all other care arrangements fail.

2.4.4 Children as caregivers

It is a common practice in most African countries that older siblings provide a certain level of day care for younger siblings (Bledsoe & Isiugo-Abanihe 1989:447). A study among the Kikuyu people in Kenya found that mothers were the primary care givers of infants for the first 5 months; after this period, the primary caregiver is a female child or adolescent of the same clan (Leiderman & Leiderman 1974:243). The age of the caregiver in that study proved to be particularly interesting. Particularly, the poorest households, unable to afford school fees, had older siblings at home to help in infant care. The average age of caregivers in these families was 13.9 years. The poor, who managed to send their children to school but were unable to hire a nursemaid, pressed their own younger pre-school children to provide day care for infants. This reduced the average age of primary caregivers to 10.6 years. The families with the highest economic level, hired older girls from outside the family but mostly from the same clan to nurse the infants, at an average age of 20.2 years. A second Kenyan study, conducted by Sigman et al. (1988:1255) reported that for infants aged 2-3 years, social interaction was almost always with other children rather than adults. The authors of this study conclude:

The influence of siblings and peers appeared to be quite important for the Embu toddlers' development. Older sisters were frequently the caregivers who listened to and talked to their younger siblings. Furthermore, those toddlers most involved in sustained social interactions developed most rapidly, and social interaction almost always involved other children rather than adults (Sigman et al. 1988:1259).

Reviewing literature on children as caregivers in Africa before the onset of HIV/AIDS (LeVine et al. 1996:152; Sigman et al. 1988; Weisner 1989; Winton 2002) the following summary can be made: 1) Most girl children provide care to younger siblings. 2) Boy children are less likely to provide sibling care although they socially interact with their younger siblings through play. 3) Providing care and social interaction is most often done by older siblings and not by adults.

A result of the AIDS pandemic

As discussed in previous sections, HIV/AIDS mortality among primary caregivers over the past 10 years has resulted in a shortage of adults in highly affected communities. Combined with the partial breakdown of extended family care and safety nets, children are increasingly seen as caregivers, not only for their younger siblings, but also for their own terminally-ill parents (Foster & Germann 2002:673). Even in communities where there are operational home-based care (HBC) programmes, children in families affected by HIV/AIDS are involved in the care of their parents. At best, home-based care volunteers visit a household 2-4 times per week (Jackson 2002:321). Caring for terminally ill people often requires support during the night. In many cases children have to help parents with chronic diarrhoea to get up and go to the toilet, and must clean them and assist them in many other ways. Currently, little attention has been given to the role of children as caregivers in the context of HIV/AIDS. During the South African National Conference on children affected by HIV/AIDS in June 2002, children as caregivers was not a topic (Department of Social Development 2002). The issue of children as caregivers is an urgent topic for research and programmatic interventions. Such children need support, and skills training to assist them in their nursing of ill parents. In addition, research is required on how nursing terminally ill parents affects children psychologically and impacts on their own long-term development (Dawes & Donald 1994:21).

High vulnerability to HIV/AIDS infection

Most children orphaned by AIDS are not HIV infected themselves. Based on an analysis by Hunter (2000), Foster (2000:3) estimates that only 1 in 24 orphans is HIV infected. It is believed that the main route of such infection is through parent to child transmission. Through prevention of parent to child transmission (PPTCT) programmes, the rate of such transmission is significantly reduced. (Jackson 2002:268). However, as discussed in section 2.3.4, orphans often lack protection, care and support, which increases their vulnerability to HIV infection. A recent study, jointly commissioned by the Human Science Research Council and the Nelson Mandela Foundation (Shisana 2002:47), indicates that the rate of HIV/AIDS infection

in 2-14 years olds is higher than would be expected (5,6 %). This age group is not highly sexually active, and most children infected by vertical transmission through the mother have died before the age of 2 years. Although there is some controversy on the methodology applied by Shisana,²⁹ the data strongly suggests that cross parent-child transmission, is a major cause of HIV/AIDS infection in 2-12 year olds.

This is explicable in terms of the conditions under which many children care for their terminally ill parents. Children nursing parents with a high viral load often lack the necessary skills or equipment to avoid infection. Their risk of contracting HIV is further increased by overcrowding and a lack of sanitation. There is urgent need to train children in good home-based care practices and to supply them with the necessary home-based care equipment to avoid contracting HIV through caregiving. The Human Science Research Council is presently engaged in further research to foster a better understanding of children's vulnerability to HIV infection through their role as caregivers in unsafe home-based care situations (Shisana 2003).³⁰

2.5 Child- headed households

The appearance of CHHs is a new phenomenon. The first cases of CHHs were reported in the late 1980s in the Rakai district in Uganda (WHO 1990, Alden, Salole & Williamson 1991) and in the Kagera district in Tanzania (Mukoyogo & Williams 1991:12). In Zambia, such households were first observed in 1991 (Ham 1992) and in 1992 in Manicaland, Zimbabwe (Foster et al. 1995). And in Swaziland, for example, an estimated 10% of vulnerable children are living in family and community supported CHHs, a consequence of traditional extended family living arrangements in that country (Brody 2002). An interesting cross-cultural example of this is several cases of teenagers caring for younger siblings after AIDS-related parental deaths were reported in the United States in 1994 (Levine 1995:194).

²⁹ AF-AIDS discussion forum in March 2003 had several postings where the methodology of Shisana and her team was questioned.

³⁰ Personal discussion with Dr. O. Shisana in July 2003.

2.5.1 Overview of child-headed households

As discussed earlier, grandparents care for many orphans. Households where grandparents have no ties with extended families are especially vulnerable to becoming CHHs after the grandparents have died. In addition to such households, single mother households are vulnerable to becoming CHHs.

In Zimbabwe alone, based on census data (CSO 1993) nearly 1 million children were born to widowed, divorced, separated or never married women; a trend that is seen in many developing countries in Africa (Huber & Gould 2002:18). This combination of factors leads to increasing numbers of CHHs in communities that have high HIV prevalence rates.

Research on CHHs is scarce. Foster et al. (1995) in Manicaland, Zimbabwe, conducted one of the first studies, which involved 43 child and adolescent-headed households. The focus of the study was on determining factors leading to the establishment of such households. Key findings in this small study were: 1) the appearance of CHHs does not necessarily mean that extended families do not care for such children; 2) In a minority of cases it seemed that the extended family support had broken down with children receiving no support from relatives. Such unsupported child-headed households appeared to be especially vulnerable to exploitation as a result of destitution and lack of adult supervision; 3) The number of such households is likely to increase considerably in the face of poverty as the number of new orphans increases and as caregiving grandparents, aunts and uncles become sick and die; 4) Households headed by children or adolescents represent a new coping mechanism in response to the AIDS pandemic in communities; 5) Community groups through voluntary based home visitation programmes can support extended families to cope with the burden of orphans and help to prevent the breakdown of the extended family safety net.

Two masters' degree studies (Hess 2002, Luzze 2002) were written in 2002 focusing on aspects of CHHs. Hess (2002) provides a general overview of children affected by

AIDS and does not add much knowledge to foster a better understanding of CHHs but rightly concludes that 'child-headed households should be seen as part of the solution to the problem of orphan care, rather than part of the problem itself'. The study from Luzze (2002) is of particular interest as it studies the impact of World Vision as an external agent on coping strategies in CHHs in Kakuuto county in Rakai district, Uganda. Luzze observed (2002:62) that NGOs targeting CHHs, were partly, though indirectly, responsible for the emergence of such households. Such households were heavily dependent on World Vision for their existence and survival. It was reported that in such communities where high level of NGO direct support to vulnerable children was available, there existed an 'inversely proportionate relationship between World Vision entry/support to child-headed households and community care initiatives/vigilance towards child-headed households' (Luzze 2003:13). In the context of rural or urban poverty, such NGO support may well elevate such households to relative affluence. As a result, communities cease to perceive NGO-supported CHHs as vulnerable, but rather as being privileged. Such research findings have far reaching programme policy implications; as argued by Foster, Lorey & Williamson (2001:2) international NGOs and large national NGOs should not provide direct service delivery to orphans and other vulnerable children. Their role should be to facilitate and strengthen local capacity for community-based organizations to support community safety nets through a human capacity development framework (Campbell 2002:4). This requires that agencies, such as World Vision, Care, Plan International and others, embark on some major programme policy shifts from a direct service provider to a facilitator and capacity builder of local responses. In Section 8.3.2 the role of external agencies in regards to community care capacity will be further discussed.

During the regional UNCEF and partners' conference on orphans and vulnerable children in Namibia in November 2002, a working group looked at strengths and weaknesses of CHHs. It was probably the first time during a regional conference that special attention was directed towards CHHs. The researcher co-facilitated the session. A summary of the discussion is presented in Table 2.3 below.

Strengths	Weaknesses
Siblings stay together, which reduces loss experiences.	Development of older children is hampered by the new 'parent' role they have to take.
Children do not have to move away from their home and neighbourhood. They remain with their friends.	Heads of such households often drop out of school due to having to provide an income and care for the household. This leaves them with inadequate time and resources for school.
Households can be supported by their community and neighbourhood. In comparison to orphanages they maintain their social connections and community relations.	Such households lack protection.
Children receive cultural guidance and mentoring by elders from the community.	Children in such households often lack parental guidance and there is lack of intergenerational skills transfer.
Property (e.g. land or house) is protected and remains an asset for the children.	Life can be a daily struggle in such households.

Table 2.3: Strengths and weaknesses of child-headed households

Source: UNICEF regional conference satellite in November 2002 in Windhoek

Another form of child and adolescent-headed households that has been identified is found in countries with high rates of economically or politically driven migrations such as Zimbabwe or Ecuador (Germann 2003a:3). Large numbers of 'middle class' professionals in such countries, leave to work in the United Kingdom, the United States or in the case of Ecuador in Spain. They often leave behind their adolescent children, without adult supervision in their houses. Such parents, often out of guilt, provide a high level of financial support to such children but no parental guidance. This combination can have rather negative impact on adolescent behaviour. Some focus groups conducted by the researcher identified a growing trend of 'unprotected sex parties' reported to take place in such adolescent headed households. Friends from school, often prestigious private schools, are invited for all night parties. They purchase expensive liquors, lots of beer and often 'hire' young females for sex. These are teenage girls, often from the same or neighbouring schools, but from poorer family backgrounds who are selling occasional sex to maintain the highly competitive fashion level reported in such schools. The combination of drunken adolescents and sex often leads to unprotected sex, making 'night partners' highly vulnerable to HIV

infection (UNAIDS 2000:16). This research does not examine this form of CHH in Zimbabwe further, as the reasons for their existence are different from that of children affected by AIDS and furthermore, such analysis lies outside the scope of this research. HIV prevention programmes, however, need to provide prevention and life skills programmes to such households.

2.5.2 Forming a working definition

Drawing from the literature as well as workshop findings and focus groups, an attempt is made to form a working definition of CHHs. However, a single definition of CHH cannot accommodate the many variations of such households. Thus for the purposes of this research a matrix was designed which attempts to incorporate the variety of different contextual features that characterise CHHs. This matrix is presented in Table 2.4 below.

Household and household head	<ul style="list-style-type: none"> - A household is one or more persons who share cooking and eating arrangements together - The household head is the person primarily responsible for the day to day management of the household, including child care, breadwinning and household supervision 		
Adolescent-headed household	<ul style="list-style-type: none"> - Is a household headed by a 16-20 year old who is not the biological parent of children in the household. In the event of the adolescent leaving the household (labour migration, marriage etc.) the household becomes a child-headed household 		
Child-headed Household	<ul style="list-style-type: none"> - Is a household headed by a person younger than 16 years old. Once such a head turns over 16 the household becomes an adolescent headed household. (Zimbabwe Children's Protection and Adoption Act; Chapter 5:06 defines as child as below 16 years 		
Accompanied household		Unaccompanied household	
<ul style="list-style-type: none"> A child or adolescent headed household which includes an adult in need of care such as: - An aged grandparent or guardian in need of care and unable to provide child care, income or household supervision - An adult who is mentally unstable and in need of care - Any other adult in need of care and unable to provide childcare, income or supervision 		<ul style="list-style-type: none"> A child or adolescent-headed household where there is no adult residing in the household 	
supported	unsupported	supported	unsupported
<ul style="list-style-type: none"> - Extended family regularly visits the household - Neighbours support and supervise the household - A community care programme for orphans provides monitoring and support visits to the household - Household receives ongoing support from local church or philanthropic groups or from NGOs 	<ul style="list-style-type: none"> - Household has no links with extended family - Household at most receives sporadic support from neighbours, local support groups or NGOs 	<ul style="list-style-type: none"> - Extended family regularly visits the household - Neighbours support and supervise the household - A community care programme for orphans provides monitoring and support visits to the household - The household receives ongoing support from local church or philanthropic groups or from NGOs 	<ul style="list-style-type: none"> - The household has no links with extended family - The household at most receives sporadic support from neighbours, local support groups or NGOs

Table 2.4: Matrix to define child and adolescent-headed households in various contextual situations

A summary definition is made based on the above matrix as following:

A child-headed household (CHH) is a household where both parents or alternative adult caregivers are permanently absent and the person responsible for the day to day management of the entire household is aged 20.

The above matrix and summary definition are based on the researcher's own experience and expertise at local community level programmes. They are intended to take into account the many different nuances of child or adolescent-headed households. The above definitions are used throughout this research.

2.6 Orphans and social change

In 2000, the UN Security Council debated the impact of HIV/AIDS on peace and security in Africa. Secretary General, Kofi Annan, stated that the disease is leading to social and economic crises that threaten the political stability of African countries (United Nations SC/6781). In history, large scale orphaning has been a short-term, sporadic problem mainly caused by war, famine or short-term disease. AIDS has transformed orphaning into a large scale and long-term 'chronic' problem that will extend at least through the first half of the twenty-first century (REPSSI & ISS 2002:5). As shown under section 2.3.3, the death of parents due to AIDS can lead to serious psychosocial consequences for children as they lose nurturing family stability, social connectivity and often their economic income base. Many orphaned children in Southern African who grow up under extreme levels of poverty will be sorely tempted – or even obliged for the sake of physical survival – to commit a range of property related crimes. For example the theft of food and clothing by shoplifting and residential burglary, or the theft of other items that can be sold or traded for food, clothing or other necessities. Older orphans, in their early teenage years, might resort to mugging and robbery to make ends meet.

The migration of children to urban centres has long been observed in developing countries – including Southern Africa – because of high rural unemployment and poverty levels. This trend is likely to increase as the pandemic escalates leaving large numbers of orphans in its wake. Some children affected by AIDS migrate from rural areas to towns and cities. Urban environments are often associated with social ills, such as:

- Higher crime rates
- Emotional, physical, and sexual abuse of children
- Financial exploitation
- Children taking on adult responsibilities
- Higher risks of developing dependency on substances and drugs
- Prejudice, social exclusion, and stigmatization.
- Higher risks of children developing psychological disturbances.
- Psychological trauma and delinquency

High rates of child migrants flocking to the city will increase the already high number of street children in many Southern Africa cities. Street children are both the causes and victims of a range of crimes. Petty thefts, muggings, burglaries and theft out of motor vehicles are crimes commonly associated with street children. Many such children are assaulted, abused, raped, kidnapped and drawn into prostitution rings. Children affected by AIDS are often exposed to multiple traumatic experiences that may lead to continuous traumatic stress. Such experiences are argued to contribute towards the creation of dangerous violent criminals (Zwane 200:17, Streeck-Fischer 1998:1).

Large influxes of orphaned children into the urban slums that surround most larger Southern African cities will exacerbate socio-economic problems. This will result in a vibrant breeding ground for a variety of social ills such as crime. Certain types of crime – such as gang related crimes, vehicle thefts, robberies and burglaries – are higher in cities than in rural areas, with the rate generally increasing according to city size. These consequences not only jeopardize personal development but also undermine years of investment in national development (see Figure 2.8 below).

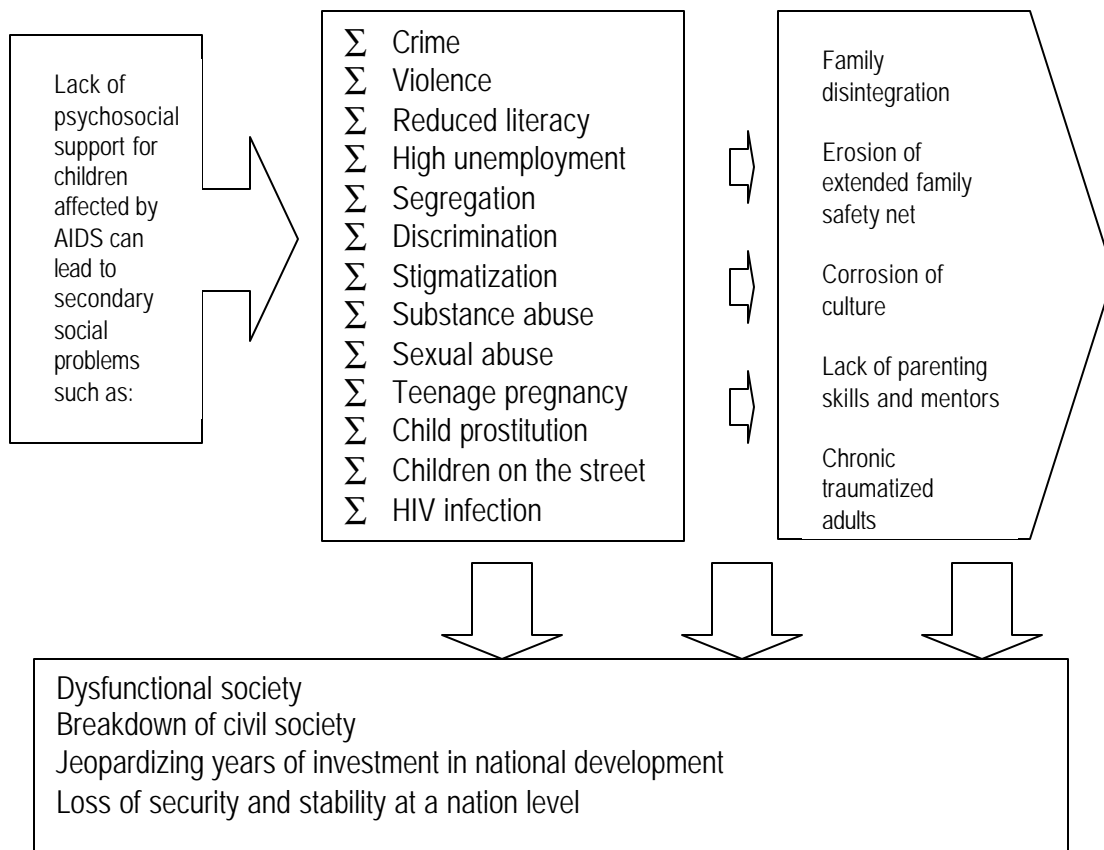


Figure 2.8: Potential long-term impact AIDS has on societies

Source: REPSSI & ISS (2002)

It is therefore imperative that psychosocial support is strategically integrated into programmes for children affected by AIDS. A number of low cost, culturally appropriate responses have shown to improve the resilience and coping capacity of affected children (Foster & Jiwli 2001:5). Some of these practical responses are discussed later (see section 6.3.2).

Impact scenarios of orphan populations on society

In contrast to the field of social development, scenario building is widely used in business. Whiteside (2002:7) is probably the first to use this method to map out different scenarios concerning the impact of AIDS on society. Figure 2.9 below illustrates how scenario planning works. The picture shown is the ‘cone of uncertainty’ (Sunter 1987) opening up wider as one progresses on the time line into the future. For example, if we’re asked what the price for a particular ‘state of the art’ antiretroviral drug will be in a week’s time, we would get answers covering a range of

a few cents. If we're asked what it would be in ten years we might get a range of a hundred dollars. This is true of any time bound parameter: the further one looks into the future, the less certainty there is.

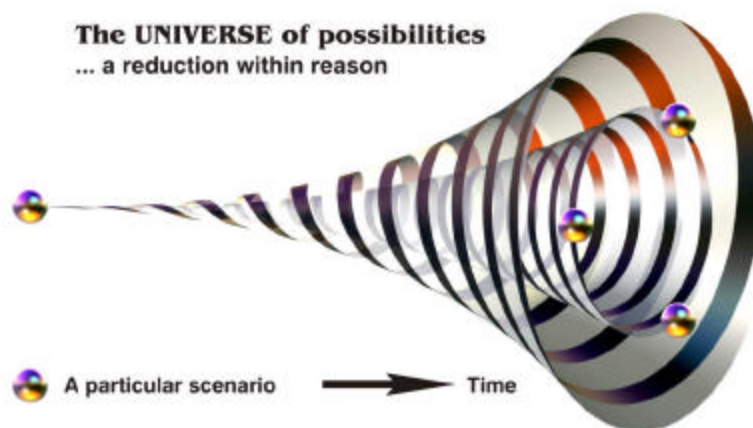


Figure 2.9: The universe of possibilities

Source: Sunter (1987)

Scenario planners aim to reduce the number of reasonable possibilities. The inner cone reflects the dimension of what is most likely to happen. Finally the scenario planner, by analysis, concludes the interdependency between 'key uncertainties' and suggests the most plausible scenario. In 2001, Shell South Africa engaged a team of consultants and specialists to develop a scenario on 'What will be the impact of AIDS on Shell's markets in Southern Africa during the next twenty years?'³¹

Using some of these scenario-planning methods, an attempt is made to project some potential impact scenarios for the future, using the 'tower of stability' illustration (see Figure 2.10 below).

³¹ For more detail see the report by Whiteside, A. and Erskine, S. 2002. The impact of HIV/AIDS on Southern African's children: Poverty of planning and planning of poverty. Report is based on the Shell AIDS impact Scenario for Southern Africa.

'Tower of Stability'

In the past, major disease pandemics have sometimes resulted in social upheaval. (Hunter 2000:278). For example, when Athens was affected by a smallpox epidemic in 430 B.C, a Greek historian described the demoralization, and breakdown of law and order that occurred as a result:

The catastrophe was so overwhelming that men, not knowing what would happen to them next, became indifferent to every rule of religion or law. Athens owed to the plague the beginnings of a state of unprecedented lawlessness. As for the offences against human law, no one expected to live long enough to be brought to trial and punished.³²

There is increasing recognition that the HIV/AIDS pandemic will cause profound social changes in Southern Africa (Pharaoh & Schoenteich 2003:7). The pandemic harms children through its impact at all levels of society. The situation is made worse as the impacts are bi-directional, leading to a vicious cycle; as societies are destabilized, the situation for individuals and communities deteriorates further (Fourier & Schoenteich 2001:41). Table 2.5 below, describes the impact of AIDS on children at individual, household, community, national and global level and the mitigation responses that contribute to societal stability.

³² Quote from Thucydides, History of the Peloponnesian War, 430 B.C.

Level	Impacts	Responses
Individual (Child)	Child having to take on the role of parent. School drop out Child labour Malnutrition Stigmatisation Physical and sexual abuse Psychological trauma	Children become heads of households Children raise money for school fees
Household	Dispossession of property Selling assets Lack of inter-generation knowledge transfer	Extended family assume fostering responsibilities Memory Books support the documentation of family history, gives a platform for disclosure and succession planning
Level	Impacts	Responses
Community	Increased crime Increased abuse of children Weakened community safety nets Increased gender inequalities	Communities use their resources to strengthen safety nets Faith-based orphan support initiatives Young farmer field days for children Waiving of requirements for school uniforms and fees Vocational training through attachment to local artisans Community nutrition gardens
National	Poverty gap widening Unemployment Corruption Weakening of education, health, law enforcement and criminal justice systems Lack of leadership Increasing street children	Child welfare policy development National Plans of Action to support children Networking to support community-based orphan initiatives Reduction or abolition of school fees Improving access to birth certificates Improving access, quality and resources of schools
Global	Migration Increased tension between neighbours Donor apathy Regional food shortages	Increased donor support for orphan and vulnerable children programmes Inter-country consultations to share lessons learnt Regional cooperation in food security

Table 2.5: Impacts of AIDS affecting children and responses which influence societal stability

Source: REPSSI & ISS (2002)

The level of active responses at national, regional and international level to mitigate the impact AIDS has on children will determine the degree to which AIDS will impact negatively on society over the next 50 years. Despite the bleak predictions concerning future scenarios, societal dysfunction is not inevitable. Although current responses are inadequate and weak, others are strong and innovative. At every level those affected by the pandemic are responding in various degrees. Figure 2.10 is an illustration of the stability and security consequences of HIV/AIDS.

**LONG TERM STABILITY & SECURITY CONSEQUENCES OF
THE IMPACT OF HIV / AIDS**



Figure 2.10: 'The Tower of stability' – impact scenarios of HIV/AIDS and mitigation responses

Source: REPSSI & ISS (2002:5)

Following is a short explanation of the 'tower of stability':

- *Scenario 1: The Tower of Stability:* The foundation for individual and household well-being is a healthy community and a stable nation within a secure world.
- *Scenario 2: The Tower of Relative Stability:* Even though AIDS undermines stability, societal collapse is not inevitable. With adequate mitigation responses to the impact of AIDS at every level, societal instability can be minimized.
- *Scenario 3: The Tower of Instability:* In the absence of effective mitigation responses, HIV/AIDS threatens national and global stability. The more unstable the structure becomes at the top – the larger the number of individuals and households impacted by HIV/AIDS with no mitigating support – the greater the threat to national and global security.

Whether AIDS eventually leads to the breakdown of society or not will be determined by the balance between the severity of the consequences and results of AIDS and the scale as well as strength of responses discussed below at all levels.

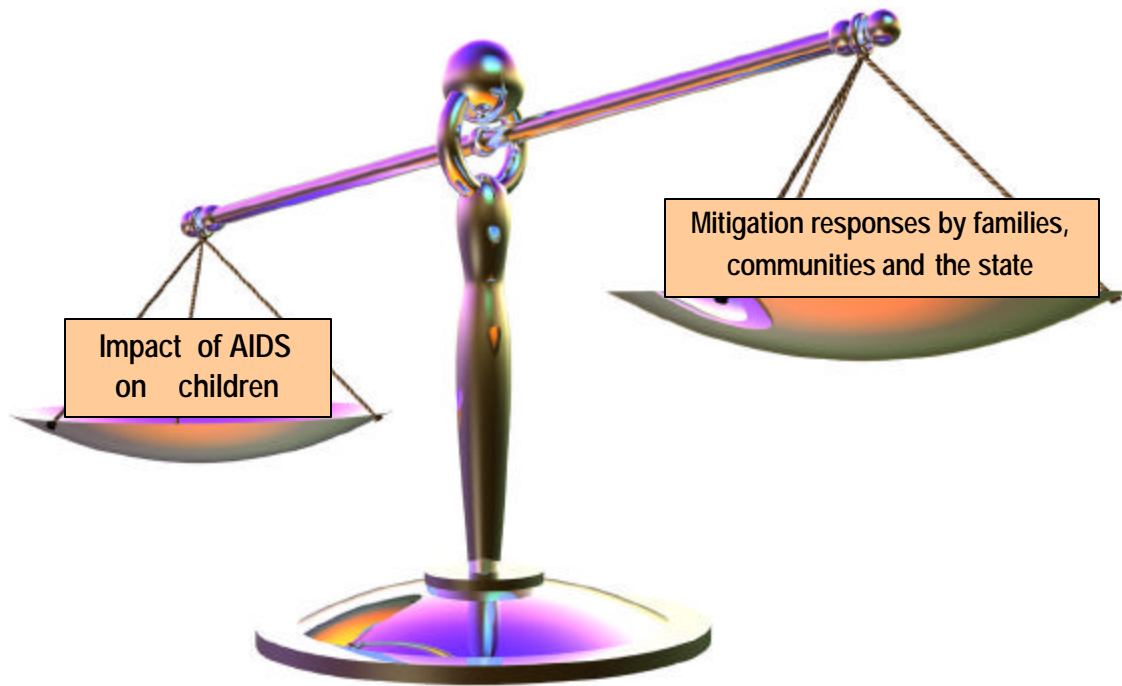


Figure 2.11: Impact of large numbers of Orphans on society – Balancing impact and response

The long-term impact of large numbers of orphans on society depends largely on the differences between the magnitude of the impact AIDS has on children, on the one side, as discussed under 2.4, and, on one side, the mitigating responses discussed above under 2.5. Figure 2.11 illustrates this balancing situation.

2.7 Summary and conclusions

The impact of AIDS on children is multifaceted and affects all aspects of a child's life. Traditional safety nets such as the extended family and community support mechanisms are under increasing stress due to the impact of HIV/AIDS and poverty. Children's roles are changing in response to these circumstances. Children are having to take on caregiving roles, often at an early age, not just for younger siblings but also for terminally ill parents. Girl children are especially vulnerable. Often they

are the first to drop out of school due to reduced household income and the need to provide care and support to parents.

Demographic changes, due to HIV/AIDS have resulted in reduced numbers of primary caregivers. Consequently, child and adolescent headed households are on the increase. If children are not supported, these experiences may have long-term negative consequences on their development. This in turn could affect the stability of societies in countries with high HIV prevalence rates in Southern Africa. Communities across Africa have started to respond in order to support orphans and other children made vulnerable by HIV/AIDS at the community level. Community-based care is in the best interests of the child and is also highly cost effective. Institutional care is an indicator that society has failed to support children in their own community context and should only be used as a last resort preferably as a place of temporary safety. The greatest challenge over the next few years will be to scale up existing community responses across Africa to ensure that millions of children orphaned and made vulnerable by HIV/AIDS receive love, care and support. The long-term negative impact of large numbers of orphans on society depends on the balance between the impact of AIDS and support responses.

This research aims to provide a better understanding of CHHs and how they function and cope. This is intended to facilitate the provision of better support to such households through community care over the next decade.

3 Research design and methods

*All theory is grey, but the golden tree of actual life
springs ever green.*

Johann Wolfgang Von Goethe, 1808

3.1 Introduction

Chapter 1 presented the research problem dealt with in this study and an outline of research objectives. Assumptions underlying this research as well as limitations of the research were also dealt with. Chapter 2 consisted of a literature review in which key issues pertaining to children affected by HIV and AIDS in Southern Africa were identified. A focal area of this review was the growing presence of CHHs in high prevalence countries. Based on this research as well as reviewing the literature, working definitions related to CHHs were developed.

This chapter begins by discussing ethical concerns in research with children. It then provides a conceptual framework for the research presented in this study. This includes methodology such as sampling procedures and the tools developed for data collection. The chapter concludes by discussing the data analysis and interpretation methods.

3.2 Ethical issues in research with children

Over the past twenty years, there has been a growing recognition of the importance of listening to children's views and wishes. This is partly attributable to changes in attitudes towards children (Hill 1997:176). There is increasing acknowledgement that children are experts on their own lives and adults should take what children say seriously (Dunn 2004:4). For example, the UN Convention on the Rights of the Child, ratified by the government of Zimbabwe in 1990 (UNICEF 1999:2), states that 'state parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child' (UNICEF 1990, Article 12). Changes in the importance attached to children's perspectives have led to changes in research concerning children (Esds 2004:2).

3.2.1 Ethical principles and confidentiality in research with children

There is an increasing movement towards actively involving children in research that concerns them. That is, children are regarded as participants in the research rather than merely subjects. So to speak, research is conducted *with* children rather than *on* children (Woodhead & Faulkner 2000:12). In accordance with this approach, a participatory paradigm was integral to the research being presented. An attempt was made to include participants in all aspects of the research including the research design, data collection and interpretation of findings. This posed a variety of methodological and epistemological challenges (Alderson 2000:143). These included adults' level of tolerance towards being interviewed by youths and youths' knowledge and perceptions regarding social phenomena potentially differing from adults.

Human rights abuses in research were common during World War Two. Human crimes were committed in the name of research on Jewish children and children with disabilities, particularly in the field of biomedical research (Grieg & Taylor 1999:37). The Nuremberg Trials resulted in an exposure of human rights abuses in the name of research. Consequently the Nuremberg Code was formed. This led to the Declaration of Helsinki on research ethics which was adopted during the World Medical Assembly in 1964. This declaration was amended in 1989 and 1996 and now includes items pertaining to children's involvement in research (Grieg & Taylor 1999:148).

The following principles are included in the declaration: 1) Adequate information must be provided to research participants about the research and their role in the research. 2) Participants in the research must have a clear understanding that their participation is voluntary and that they can withdraw at any time. 3) Informed consent must be obtained from participants in research projects. 4) The section that refers to children specifically states that 'when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation. Whenever the minor child is in fact able to give consent, the minor's consent must be obtained in addition to the minor's legal guardian (World Medical Association 1996: Paras I.9, 11).

Confidentiality and anonymity are complex issues in research with children, especially in the context of HIV and AIDS (Hausermann 1991:71). It is crucial that confidentiality and anonymity are explained to children in a way they can understand (Durrheim & Wassenaar 2002:61). This includes conveying to children that there are several people involved in the research such as research assistants, and data entry clerks. It must be made clear to children i) who will have access to the data and ii) what will happen to the data once the research is completed. Methods of ensuring confidentiality, such as removing names and other identifying information from reports, need to be explained in advance (MRS 2000:4). Difficulties regarding confidentiality arise when there is a conflict between confidentiality and the child's exposure to risk. For example, if a researcher encountered a case of a child being sexually abused there would be both a legal and ethical obligation to take the necessary steps to protect the child. This would require the release of confidential information about the child. Releasing confidential information to protect a child from abuse conforms to the United Nations Convention of the Right of the Child's basic concept of 'the best interest of the child.' The best interests of the child is an ethical requirement at all times in research concerning children, and it is crucial to convey this to children prior to obtaining their consent to participate in research.

Presently, there are no specific guidelines regarding research involving orphans and other vulnerable children affected by HIV and AIDS. Such guidelines are under development by the Horizons Programme of the Population Council (Horizons 2004). The researcher has contributed towards this process, based on experiences and findings resulting from this research.

3.2.2 Specific ethical issues related to child-headed households

Research on CHHs poses the difficulty that often there is no known legal guardian for the household. For the purpose of this research, consent in such situations was obtained from staff or volunteers involved in community care programmes in the vicinity of the CHH. In addition, informed consent was obtained from the head of the household. See section 3.5.3 for more detail on informed consent in the context of this research. Another complex issue, pertaining to this research is the particularly

sensitive nature of information concerning HIV/AIDS. Being identified as a participant in research pertaining to the field of HIV/AIDS may result in harm, such as community stigmatisation, especially if confidentiality is breached (Gray & Lyons 1994:7).

3.3 Selection and training of research assistants

The researcher was fortunate in managing to obtain a small research grant from 'Hope HIV' a British based charity. This made it possible to hire six youths as research assistants and to expand on the fieldwork to pursue ongoing primary data collection over a twelve-month period.

One of the key orphans support programmes operating in Bulawayo is the Salvation Army Masiye Camp. This programme has demonstrated leadership in youth development and participation and was selected by UNIADS and UNICEF in 2000 as a 'best practice' programme (UNAIDS 2000:33). For more information on Masiye Camp visit www.masiye.com. Through Masiye Camp, six suitable unemployed school leavers, aged 18-22, were selected and trained as research assistants. After the initial training, they were engaged for a fourteen-month contract as research assistants. All these youth were orphans themselves and had been volunteers at Masiye Camp for at least two years. They all had experience in working with hundreds of other orphans by providing psychosocial support and life skills education through holiday camps and kids clubs in urban Bulawayo. These youth had an excellent understanding of day-to-day issues faced by orphans at community level. Furthermore, they had excellent peer networks through which to gather information and gain access to CHHs.

The researcher conducted three training sessions, with these research assistants, each lasting three days, and covered the following topics:

- What is social science research?
- Research ethics, especially when working with children
- Varieties of research (qualitative and quantitative)
- Data collection methods, quality and supervision
- Interviewing techniques and practice
- Gaining access and getting informed consent
- Data entry, analysis and interpretation – basics of SPSS program use
- Reporting and dissemination

This process was highly valued by the youth and appreciated as a capacity building process for their future careers. The team was greatly motivated throughout the research. Although there was need for ongoing and close supervision to ensure quality data, the research assistants were a valuable help. Without them it would not have been possible to collect, over a twelve-month period, over 37,000 daily journal questionnaires with over two million single answers provided by the participating CHHs.

The process of youth involvement has confirmed the researcher's experience that youth participation and empowerment is extremely valuable at all levels of development planning and programming, including the research process. This in itself was an informative finding obtained from this research.

3.4 Conceptual framework

Exploratory research was conducted in the geographical area in October and November 2000. This was aimed at refining study objectives and identifying relevant domains and manifestations of CHHs and community care networks. Chapter 2 demonstrated that issues related to households affected by HIV/AIDS, and CHHs in particular, are complex. Before research methods and tools were finalized, FGDs were used in developing a conceptual framework for this research.

3.4.1 Focus group discussions

Focus group discussions (FGDs) are a useful method for exploratory research (Mahr 1995:112). FGDs were employed in this study for a variety of purposes. This included exploratory research aimed at finalizing the framework of this study (McQuarrie 1996). FGDs were also held with key stakeholders at the onset of the research to refine definitions on CHHs and to decide on key factors and contexts influencing the research. FGDs were also used towards the end of the research to identify how communities and organisations respond and support CHHs.

Selection of respondents

Respondents were selected using a non-probability purposive sampling method (Fisher & Foreit 2002:68). Based on this method 8-20 respondents were selected for each of the four planned pre-research focus group discussions. In order to achieve some homogeneity in each of the groups, the following selection criteria were made for each group (see Table 3.1). Similar groups were used again during, and at the end of, the research process.

Group type	Participants had to fulfil at least one criterion	Age range
Guardian & neighbour	<ul style="list-style-type: none"> - Guardian of household with orphans (at least one orphan of teenage age) - Guardian of CHH but not living with them - Neighbours of a CHH 	25-70
Sibling & friend of heads of CHH	<ul style="list-style-type: none"> - Siblings from CHH other than head of household - Friends of heads of CHH 	10-22
Social worker, teacher, police, pastor, NGO staff	<ul style="list-style-type: none"> - Professionals interacting with CHH who are based at community level 	23-65
Heads of CHH and teenage orphans	<ul style="list-style-type: none"> - Heads of CHH - Teenage orphans staying with guardians 	13-19

Table 3.1: Types of focus group discussions

Based on the above criteria, the team of research assistants identified, within the targeted research area, the respondents for each of the FGDs.

Facilitation and recording of FGDs

The researcher developed instructions and guidelines for the facilitators of the FGDs. Appendix 1 shows the sample FGD guidelines and instructions. Since the researcher engaged two isiNdebele speaking FGD facilitators, the interview guide was necessary for ensuring that similar discussion-generating questions were presented to each group in a similar fashion. The guidelines were written in English. During the facilitators' training, agreement on key isiNdebele terms used in the questioning was reached. The FGDs were then held in isiNdebele. Transcripts from these FGDs were translated back into English. To reduce error in reporting and translation, two people were engaged to report each FGD. The reporters were tasked to individually report in isiNdebele and then translate into English. Once both reports were available in English, the researcher, facilitator and reporters reviewed both reports and agreed on one final report. In the initial research design, the use of tape or video recorders for interviews and FGDs were proposed. However, due to the deteriorating political situation in Zimbabwe, this plan was abandoned as people expressed concern and fear over the potential negative consequences of being taped or filmed during group sessions. Detailed findings of these FGDs are provided under Chapters 7 and 8.

3.4.2 Development of conceptual framework

A conceptual framework can serve to clarify complex social situations. By identifying key factors and variables, defining these factors, and analysing the relationships between factors, a conceptual framework is developed.

For the purpose of this research, and based on findings that arose from FGDs and the researcher's own expertise, the following conceptual framework (Figure 3.1) was constructed:

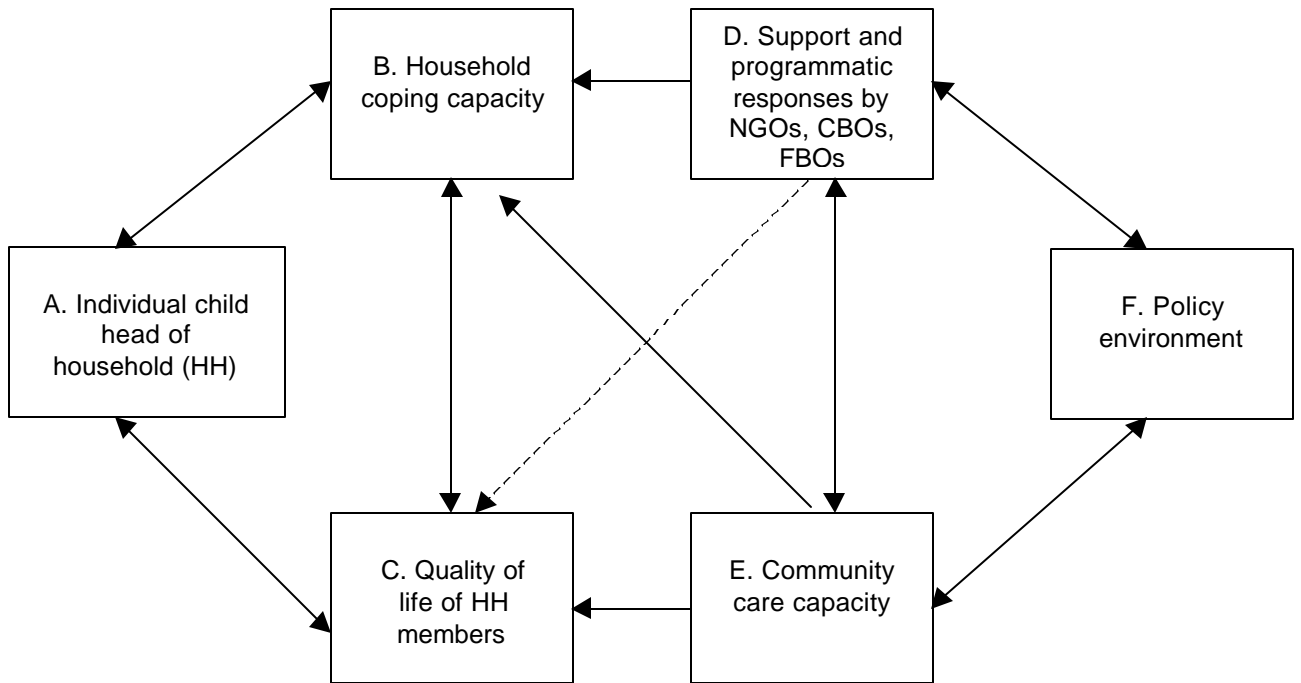


Figure 3.1: Conceptual framework for exploratory CHH study

Based on the conceptual framework following is a description of **key factors** and *variables* (Table 3.2, below):

A. Individual child head of household (HH)	B. Household coping capacity	C. Quality of life of HH members
<i>Age Sex Education Family context Household situation Health status Own strength Resilience Connectedness Self esteem Confidence Self-sufficiency Socio-economic status</i>	<i>Access to basic services and necessities Income opportunities Problem solving skills Community support received Ability to adapting to changing household situations Linkage capacity with extended family</i>	<i>Nutrition Emotional wellbeing Recreation Home environment Extended family support Community support</i>
D. Support and programmatic responses by NGOs, CBOs, FBOs	E. Community care capacity	F. Policy environment
<i>Nature of programmatic support Frequency of support to households Organizational capacity Levels of programmatic funding Programme sustainability</i>	<i>Community support structures Community support provided Leadership involvement Volunteer involvement Perception community has of child-headed households</i>	<i>Policies in place Quality of policies Policies development processes Policies implemented Commitment of key stakeholders to policies Policy gaps</i>

Table 3.2: Key factors and variables of conceptual framework

3.4.3 Explanation of conceptual framework

A – B. Individual factors of head of household influences the household care capacity, and vice versa.

A B. It is anticipated that both individual characteristics and circumstances of heads of CHH influence and affect the household coping capacity. For example, an individual’s self-sufficiency and ability to cope with difficult situations impacts on the overall household coping capacity.

B A. On the other hand, the collective coping capacity of a CHH impacts on individual factors of the head of the household. For example, if four siblings cooperate well together, assist each other in household chores and provide emotional support for each other, this will impact positively on the head of the household - through for example enhancing his or her self-esteem and sense of self-sufficiency.

A – C. Individual factors of head of household influences the quality of life of household members.

A C. This is similar to the A – B relationships but with a focus on quality of life of household members rather than on the overall household coping capacity. For example, exploratory research suggests that members of CHHs headed by a self-employed youth have an improved home environment, good nutritional support and time for recreational activities. Therefore the quality of life for household members is raised.

B – C. Household coping capacity influences the quality of life of household members, and vice versa.

B C. The household's coping capacity may influence the quality of life of individual household members. For example, a CHH that copes well in accessing basic services through various support networks will have increased quality of life for all its members through increased nutritional support, recreation time, etc.

C B. On the other hand, it is expected that the quality of life of household members will impact on the household's coping capacity. For example, if members in a CHH are emotionally well, it is likely to increase their ability to co-operatively manage the household.

D – B (C). Support and programmatic response influences household coping capacity (indirectly influences quality of life of household members).

D B. Programmatic support by NGOs, CBOs and FBOs to CHHs influences their coping capacity. Such support can affect a household's coping capacity either positively or negatively. Some support might undermine a household's long-term independent coping ability by creating 'project' dependencies. For example, ongoing

food handouts to CHHs might undermine the practice of producing food in their own gardens.

D › C (Indirect). It is suggested that programmatic support to CHHs impacts on the quality of life of the members of such households. Increased access to basic services, often delivered by organized programmatic responses, can increase the quality of life of household members.

E – B / E – C. Community care capacity influences household coping capacity and influences the quality of life of household members.

E B. Increased community care capacity results in improved neighbourhood care and protection of CHHs, which influences household coping capacity. For example, CHH households may receive daily visits from a neighbour to check how the children are doing and provide advice and practical assistance to the children on household management issues. Through that community care activity CHH coping capacity is raised.

E C. Community care capacity influences the quality of life of CHH members. For example, a community might have a children's club in place for vulnerable children on Saturday afternoons, where community volunteers assist CHHs with domestic chores on Saturday to free the head of household to attend club meeting. And this could result in CHH members having time for recreational activities which therefore improves their quality of life.

D – E. Support and programmatic responses by NGOs, CBOs or FBOs influences community care capacity, and vice versa.

D E. Programmatic interventions can impact positively or negatively on community care capacity. Some support, for example volunteer allowances, might undermine a community's care capacity by creating unsustainable 'project' dependencies. Other support, for example capacity building through training of community volunteers in the area of psychosocial support, may enhance the community care capacity.

E D. On the other hand, community care capacity may influence programmatic interventions. For example, in a community where voluntarism for community services is common practice responses by NGOs are stronger and more sustainable.

F – D. Policy environment influences support and programmatic responses by NGOs, CBOs and FBOs, and vice versa.

F D. It is anticipated that existing policies, the quality of those policies and policy implementation among other factors, influence support and programmatic responses. Both child-related policies as well as economic and governance policies and practice impact significantly on programmatic interventions.

D F. Support and programmatic interventions by NGOs, CBOs and FBOs may influence the policy environment through advocacy and/or active engagement in the policy development or implementation process.

F – E. Policy environment influences community care capacity, and vice versa.

F E. The policy environment impacts on community care capacity. For example, the absence of a sound policy on orphans and vulnerable children might result in communities engaging in responses that are not in the best interest of the child, such as building orphanages.

E F. Community Care Capacity that leads to grassroots activism may foster a policy environment more responsive to care and protection needs of orphans and CHHs.

Based on the above conceptual framework, singular and combined research tools and methods were developed to analyse, test and improve understanding of the relationships between all the key factors and variables explained above.

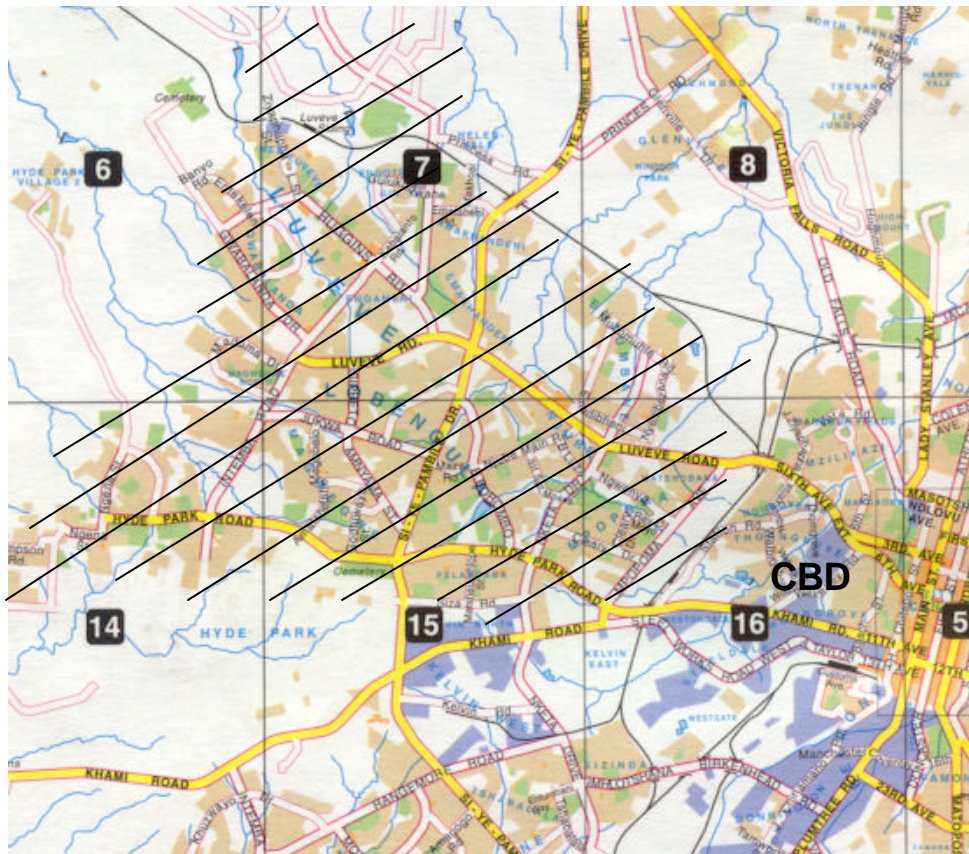
3.5 Research methods

A combination of quantitative and qualitative methods was used. The following section deals with techniques and methods used to collect and analyse data.

3.5.1 Selection of geographical research area

The research being presented was initially going to include rural, urban and peri-urban areas constituting a fully representative study on CHHs in Zimbabwe. However, this was revised to focus exclusively on urban Bulawayo due to security risks involved in travelling in rural areas during 2000 and 2001, as discussed under section 1.4.3.

Bulawayo has a total of twenty-three high-density suburbs (McLean & Philip 1997:2). To ensure that the socio-economic backgrounds of households were similar, only high-density suburbs were included. And to facilitate easier access to the research area for research assistants, the areas used in this research all adjoined one another. Overall, eleven high-density areas were selected. See Map 3.1 below demarcating the area selected with ruled lines.



Map 3.1: Map of Bulawayo – western section

Source: MacLean and Philips (1997:2)

Table 3.3 provides population data for each of the selected high-density suburbs. As there is no ongoing resident registration system in place, all figures are estimates (BCC 2000). The estimated data was gathered from interviewing chief executive officers of the respective Housing Offices and chairpersons of the residents associations from the Bulawayo City Council in each high-density area.

Suburb	Total population estimate	Number of households	Total adult population	Total child population <18
Mpompoma	38,910	5,559	18,288	20,622
Matshobana	12,560	2,093	6,154	6,406
Njube	27,840	4,283	14,198	13,642
Entumbane	34,950	4,369	15,378	19,572
Pelandaba	19,060	3,812	9,339	9,721
Magwegwe (incl. north)	41,090	6,522	19,723	21,367
Pumula	42,560	6,352	23,408	19,152
Gwabalanda	18,560	3,146	9,837	8,723
Luveve (incl. New Luveve)	53,610	7,659	25,197	28,413
Lobengula	33,650	5,608	17,498	16,152
Emakhandeni	28,940	4,823	15,628	13,312
Total for study area	351,730	54,226	174,648	177,082

Table 3.3: Housing and population information from selected study area

Source: BCC (2000)

The only available data on orphans and vulnerable children in Bulawayo comes from a census exercise conducted by the Bulawayo Child Welfare Forum in 1997 (DSW 1997) and is outdated. In addition, that research focused on other high-density areas that are not included in this research. In 1997, the researcher assisted the Child Welfare Forum to conduct this OVC enumeration and registration process.

According to UNICEF (UNICEF 2003:49) Zimbabwe has an orphan population of 1,018,000, which represents 18% of all children living in the country. To estimate the number of orphans in the research area, the researcher and research assistants, in

collaboration with the Masiye CRS Strive operations researcher (Moyo 2001), conducted a survey in selected primary schools in the research areas. Table 3.4 shows the data based on this survey. Unfortunately, due to financial constraints, it was not possible to include all the primary and secondary schools in the study area in this orphans enumeration process. This would have enabled a more accurate estimate of the total orphan population in the study area.

School	Suburb	Enrolment	Orphans	Orphans %
Nkulumane	Mpopoma	2,000	175	9
Mpumelelo	Mpopoma	954	65	7
Lukhanyiso	Mpopoma	1,400	103	7.5
Helemu	Njube	1,600	83	5
Mtshede	Njube	1,783	62	7
Ngubo	Lobengula	1,976	87	4.5
Nyamande	Lobengula	1,774	205	11.5
Induba	Lobengula	1,844	184	10
Pelandaba SDA	Pelandaba	548	67	12
Magwewe primary	Magwegwe	1,899	203	10.5
Babambeni	Pumula old	994	83	8.5
Malindela	Pumula north	1,992	164	8
St Bernard	Pumula east.	750	69	9
Dumezweni	Pumula south	1,500	92	6
Godlwayo	Pumula old	948	164	17.5
Ngwalongwalo	Pumula south	852	104	12
Zulukandaba	Entumbane	2,000	81	4
Ntabeni	Entumbane	1,655	158	9.5
Mthombowesizwe	Entumbane	1,845	193	10.5
Manyewu	Entumbane	2,000	208	10.5
Totals		30314	2550	8.5

Table 3.4: Estimated orphans populations based on selected primary schools

Source: Moyo (2001)

If one extrapolates from this exercise, it might appear that the UNICEF national estimate is too high. Even factoring in an assumption that the majority of children not enrolled in schools on a national level could be orphans, UNICEF's 18% estimate for orphans as a percentage of all children seems high. Recognising that the percentage of orphans who have not enrolled in schools or have dropped out of school is lower in urban than in rural areas, it was estimated for the study area that approximately 14% of all children below the age of 18 years old are orphans. With a total child population of 177,082 (see Table 3.4 above) this percentage would result in a total estimated orphan population of 24,792.

3.5.2 Estimating child-headed household numbers in the study area

The 1992 national census in Zimbabwe did not provide an estimate of child-headed households (CSO 1993). During the 2002 national census this data was gathered, but was still not available for analysis in April 2005 when this research was finalized. For the purpose of this research, in November 2000, research assistants conducted a survey of the numbers of CHHs known to residents living in the area. The survey included 2,382 respondents, all living within the selected study area. Interviewers were posted at shopping centres or busy bus stops on three Saturdays for a period of five hours within a specific high-density area. The only restrictions on sampling were that respondents had to be above twelve years of age and live in the respective geographical area. If a respondent was under that age and/or did not live in the specific geographical area, no record was taken. Respondents were asked the question: 'How many child-headed households do you know in your community?' Interviewers recorded responses by ticking the relevant class interval in the data capturing form (see Appendix 2 for CHH rapid enumeration survey data sheet).

Table 3.5 provides the results for this survey on the number of 'known' CHHs per respondent.

Number of CHH known to responded	Mid point x	Frequency f	Product xf
0	0	4	0
1	1	96	96
2	2	301	602
3	3	232	696
4	4	619	2,476
5-6	5.5	621	3,415.5
7-8	7.5	507	3,802.5
9-10	9.5	2	19
11-13	12	0	0
Above 13, how many	N/A	0	0
		n = 2,382	$\sum(xf) = 11,107$

Table 3.5: Rapid assessment of 'known' CHHs per respondent

Based on this survey, the mean number of 'known' CHHs per respondent in their own community was:

$$\bar{x} = \frac{\sum fx}{n} = \frac{11,107}{2,382} = 4.7$$

This estimate provides a valuable measure of the extent to which CHHs are a part of community life. However, this statistic is unsuitable as a predictor of the overall population of CHHs in the area studied. This is because of a lack of information regarding the extent to which the same CHHs were reported by more than one respondent. A further limitation of this survey is the lack of certainty regarding how informed residents were about the existence of CHHs in their area. The above survey on the number of known CHHs was replicated using community figures as respondents. These included social workers, teachers, police, NGO staff and nurses. Forty-seven community figures were interviewed.

Number of CHH known to responded	Mid point x	Frequency f	Product Xf
2	2	1	2
3	3	3	9
4	4	9	36
4 to 5	4.5	9	40.5
5	5	6	30
5 to 6	5.5	4	22
6	6	4	24
6 to 7	6.5	4	26
7	7	3	21
7 to 8	7.5	1	7.5
9	9	2	18
10	10	1	10
		n = 47	$\sum(xf) = 246$
	Mean (see formula above)	5.23	

Table 3.6: Estimates of 'known' number of CHHs by key informant

These included four to five respondents from each of the eleven suburbs in the study area. The mean number of known CHHs per respondent in this survey was slightly higher, at 5.23 CHHs per respondent (see Table 3.6, above). This differential can possibly be attributed to key informants having a closer understanding of their community. It can be assumed with a reasonable degree of certainty that selected

key people at local level such as team leaders of home-based care task forces, OVC programme volunteers and staff, chairpersons of resident associations, local councillors and social workers have an in-depth understanding of the social context of most vulnerable households in their constituency. In some communities, such as **Njube, Gwabalanda, Magwegwe** and **Matshobana**, CHH figures are taken from the orphan care programme support register, are based on an actual door-to-door assessment and are therefore accurate. It is important to note that the number of households per suburb differs and therefore there are considerable differences in reporting on numbers of CHHs. For the purpose of this research, the estimated number of CHHs in Mpopoma, Entumbane, Pelandaba, Pumula, Luveve, Lobengula and Emakhandeni is taken from these key people at community level (see Table 3.7, below).

Suburb	Position of Key Informant	# of CHH known estimated and actual
Mpopoma	Chairperson Residence Association	11
Matshobana	Staff at Bongani Orphan Care programme, Njube	3
Njube	Staff at Bongani Orphan Care programme, Njube	12
Entumbane	Counsellor at local VCT Centre	15
Pelandaba	Chairperson Residence Association	6
Magwegwe (incl. North)	Staff of JMC Orphan Care programme	8
Pumula (old, South & East)	Social Worker	13
Gwabalanda	Church Leader active in orphan support	9
Luveve (incl. New)	Councillor (Bulawayo City Council)	12
Lobengula	Social worker	16
Emakhandeni	Leader of HBC task Force	13
	Total CHH estimate in study area	118

Table 3.7: Estimated and actual numbers of CHH by key community respondent

3.5.3 Gaining access

Due to ethical considerations, the study population had to be accessed through existing community orphan care programmes. Because of several years of working in the field, the researcher had a good relationship with a number of orphan care programmes in urban Bulawayo. This facilitated good access to community level data on orphans and vulnerable children and enabled easy access to CHHs through research assistants and programme volunteers.

The researcher was the founding director of the Salvation Army Masiye Camp programme. This programme focuses on life skills education and psychosocial support for children affected by AIDS and is complementary to community care programmes. Therefore, Masiye Camp has operational links with all major OVC programmes in the region. In 1998, Masiye Camp began to offer household management and child development training targeting CHHs. Masiye keeps good records of all participating children in the various training camps. Community care programmes and Masiye Camp are discussed in more detail in section 4.4.

While the researcher's close relationship with community programmes enabled good access to the study population, it posed the challenge of how to operate at a meta-cognitive level and resist over-involvement in the phenomena being investigated. As phrased by Sarantakos (1998:110) '[how *to create*] knowledge and explain social phenomena, [*and*] not to reorganise society'. As an inevitable consequence of this tension, while the research being presented is not 'action research', there are elements of action research involved. The researcher in his role as OVC advocate and practitioner utilized research findings throughout the process to influence policy and practice in support of CHHs. This was always predicated on the 'best interests of the child' which is used as a guiding principal throughout this research.

Informed consent

As discussed above under research ethics, it is imperative to respect a 'child's rights and best interest'. Therefore, for all participants in the study, informed consent was obtained.

Based on the Children's Protection and Adoption Act, Chapter 5:06 (GoZ 1996:225) a child is defined as 'a person under the age of 16 years, under the care of an adult guardian' (foster parent, older head of household, caring neighbour or programme staff). The guardian (if traceable) or orphans support programme volunteer/staff were consulted and asked for permission to invite the child to participate. But even with

permission from the adult guardian / caregiver, a child had the right to decline to participate in the study. Youth aged 16 years and older were asked for consent directly. See Appendix 3 for informed consent forms.

Participants were not compensated for their participation. However, Masiye Camp invited all respondents at the end of the research to attend a three day weekend camp to share with them key findings of the research. This was announced to participants only after consent was obtained, so as to avoid placing pressure on eligible youth to participate in the study if they did not wish to do so.

The researcher was responsible for ensuring that informed consent procedures were followed. All participation was voluntary throughout the twelve-month data collection process. Participants were informed of their right to end their participation in the research at any time should they wish so.

3.5.4 Study populations, sample design and size

Based on the conceptual framework discussed in section 3.4.2 above, the following study groups were selected to explore and elucidate relationships between key factors towards developing answers to the posed research questions:

Group 1: Heads of child-headed household (analysing conceptual factors A, B and C)

Group 2: Volunteers and staff of orphan community care programmes (analysing conceptual factors D and E)

Group 3: Neighbours, friends, extended family of CHH and community members (analysing conceptual factor E)

Group 4: Child care professionals and policy makers (analysing conceptual factor F)

Participants for each group were selected through a non-probability purposive sampling method. Non-probability sampling is a sampling method that is not based on known probabilities. Such samples are not valid for obtaining true representations of larger populations. Research with specific groups such as CHHs, however, calls for non-probability sampling (Fisher & Foreit 2002:67). In purposive sampling, a form of

non-probability sampling, researchers purposely choose participants, who in their view are thought to be relevant to the research topic. In such situations, the judgment of the researcher is more important than getting a probability sample (Sarantakos 1998:152).

This sampling method was chosen as it is known to be appropriate, effective and less costly than other techniques and ensures that, based on the researcher's field experience, each dimension of the relevant study population is represented in the sample (Sarantakos 1998:153).

Only Group 1 (Heads of CHH) engaged both in quantitative and qualitative data collection. To ensure accuracy³³ the sample size for this group was determined using a statistically sound table often used in social science research that was developed by Krejcie and Morgan (1970). The following sample size was determined (Table 3.8).

Population size (error margin ±15%)	Minimal sample size	Additional 15% was added to compensate for drop out failure to locate	Ideal total sample size for study
118	92	14	106

Table 3.8: Calculation of sample size for Group 1

As it required the participation of the majority of known CHHs in the community, it took laborious efforts - utilizing the Masiye Camp registry on participants of CHH life skills camps, records from community-based orphan care programmes, and detailed household information provided by key informants at community level - to recruit 105 CHHs into the study. The gender distribution of the participants in this group was 57 female and 48 male. It was not possible within the scope of the study to get more participants, as some did not agree to participate in the study.

³³ The degree of accuracy used by Krejcie and Morgan's table is set at 0,05

For Groups 2, 3 and 4 only qualitative data collection methods were used. Purposive sampling methods ensured that all important views were represented. The sample size was not determined before the study but rather evolved as ‘factors become clear and directive’ and ‘until the study had reached saturation point, until no new data (was) produced’ (Miles & Huberman 1994:27). By the end of the study the following sample sizes existed for each of the study groups (Table 3.9).

Sample group	End of study sample size	Comments
Group 1 Child-headed households	83 CHH (52 Female & 31 Male)	Due to high mobility, 22 CHH dropped out of the study (6 between 1 -8 months; 16 after 8 months)
Group 2 Volunteers and staff of OVC programmes	34 (21 Female & 13 Male)	Including participants of FGD
Group 3 Neighbours, friends, peers and extended family of CHH	61 (29 Female & 32 Male)	Including participants of FGD
Group 4 Child care professional and policy makers	21 (9 Female & 12 Male)	This includes interviews with undersecretary for child welfare and deputy director social welfare and provincial social welfare officer

Table 3.9: Final sample size for each study group

A challenge to the study was the high mobility of CHHs. As a result, during the course of the study twenty-two of the participants dropped out. Since most (sixteen participants) of them dropped out after being involved in the twelve month study for eight months, their data was included in the analysis. Thus a high sample size could be maintained to achieve a higher degree of data accuracy.

3.5.5 Research process time line

Activity	2000				2001				2002				2003				2004 /2005			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4/ Q1/Q2
Research design	xxx																			
Train assistants		xxx	xxx																	
FGD				xx																
Estimate CHH #				xxx																
Sampling					xx															
Design tools				xx	xxx															
Test tools						x														
Data collection						xxx	xxx	xxx	xxx											
Literature review		xx	xx							xx	xx						x	xx	x	
Data capturing										xxx	xxx									
FGD												xx	xx							
Key informant int.														xxx						
Writing part 1													xxx		xxx	x				
Data analysis																	xxx	x		
Data interpretation																		x		
Writing part 2																		xx	xxxx	xx
Editing																				xxxx
Thesis submission																				x 06.2005

3.5.6 Data collection process

What follows is a description of the process of research, subject selection, and data collection. The eleven communities who participated in this study were selected on the basis of having existing community-based orphan care programmes and youth-led clubs for vulnerable children.

Step 1: *Focus group discussion*: Initial FGDs were held with youth, orphans, community volunteers and community leaders to develop the conceptual framework and to determine a local definition of CHHs to be applied in this research.

Step 2: *Pre-test and pilot study*: The instruments developed and translated were first pre-tested with a group of twelve CHH heads from a different geographical area but with a similar socio-economic community profile in Bulawayo's high density areas.

Step 3: *Identifying CHHs*: Utilizing the community formulated definition of CHHs, subject selection was the responsibility of research assistants, who lived in the researched communities, in collaboration with key informants such as social worker, chairpersons of residents associations, leaders of home-based care teams and volunteers of community-based orphan care programmes. After the training in research methods and ethical principles, the research assistants identified CHHs using neighbourhood surveys, Masiye Camp and orphan programme registers and then visited households to verify if the household matched the CHH criteria used for purpose of this research (see 2.5.2).

Step 4: *Gaining informed consent*: Once CHHs had been identified, the research process and timeline was explained to the head of the household and formal or informal guardians if they could be traced. Then permission was sought from guardians and the head of household using a standard informed consent form (Appendix 3).

Step 5: *Baseline data collection*: Utilizing an adapted and pre-tested WHO quality of life assessment tool and a household case description, research assistants interviewed each head of household to establish baseline and basic biographical data on each household. In four communities research assistants opted to call on heads of households to meet them in one location instead of visiting their respective homes to conduct the interview. As the pervasive ethic of this research programme was participation, this suggestion was accepted. Community profiles were established utilizing a community profiling tool that was part of the key informant questionnaire used at community level.

Step 6: *Bi-Daily Journal Data collection*: Each head of household received a folder with 40 bi-daily journal data capturing sheets. Research assistants trained the participants in how to fill in the sheets. At the end of every month, the research assistant visited the respondent and collected the data sheets. Spot visits during the month were made to encourage and ensure research participants adhered to the daily data collection process.

Step 7: *Assess Social Support Network*: An adapted self reporting social support scale (SSS) was used with all research participants after six months once a good relationship between research assistant and respondent had been established. This provided an indication of the head of household's perceptions of the availability of social support within the community and to assess community care capacity available to CHHs.

Step 8: *Focus Group Discussions on CHHs*:

FGDs were held to investigate community perceptions and level of support towards CHHs. Experienced group facilitators were hired and trained in using semi-structured questions to facilitate the discussions held in isiNdebele.

Step 9: Post Daily Journal Data Collection Household case description:

Three months after the twelve month data collection process, each household was again visited with the objective of i) thanking the household members for their participation in the research and ii) updating/reporting changes in the household description data.

Step 10: Feedback on Key Findings to Research Participants: All CHH participants were invited to a three day camp at Masiye Camp to provide them with feedback on key findings. For FGD participants and key informants, a half day dissemination workshop was held once the data was analysed to share key findings and programme/policy recommendations.

3.5.7 Instruments used in data collection

Based on the conceptual framework developed and described above the researcher had to identify, adjust or develop suitable tools to investigate the various relationships between key factors. The instruments to measure these factors and relationships had to be relevant, valid and reliable (Patton 1990; Fisher & Foreit 2002). Cross-cultural issues in research are of utmost importance and make the selection of suitable instruments extremely difficult. Most existing research instruments are not suitable in the context of children affected by AIDS in Southern Africa (Snider 2004; Gelman 2003; Dube, Gilborn, Kluckow & Snider 2005).

Concept interpretation and translation

The Chinese script for the word 'crisis' consists of two characters: one that reflects 'danger' and the other 'opportunity'. The 'danger' of research within cross-cultural settings, requires special attention to the interpretation of concepts, such as childhood, family and community and the translation of research instruments. Most psychometric tools to assess quality of life are culture specific to Western adults (Snider 2004). This 'crisis' therefore created an opportunity for real collaboration and

knowledge development between community members, children, and the researcher towards developing local and youth appropriate research instruments.

The accurate translation and interpretation of concepts and resulting questionnaires provided a challenge. Most research participants were mother tongue isiNdebele speakers. IsiNdebele is very close to isiZulu (Nyathi 2001:10). In a pre-testing phase, it was found that research instruments translated by an experienced adult translator were not fully understood by youth. For example, the Ndebele term 'intombiyani' used for 'girlfriend' was different to the slang word used by young urban youth. The researcher had to ask the research assistants, youth themselves, to adapt the translated version to 'urban youth isiNdebele slang'. At times English words, such as 'girlfriend' which were familiar to urban youth were included in the translated instruments.

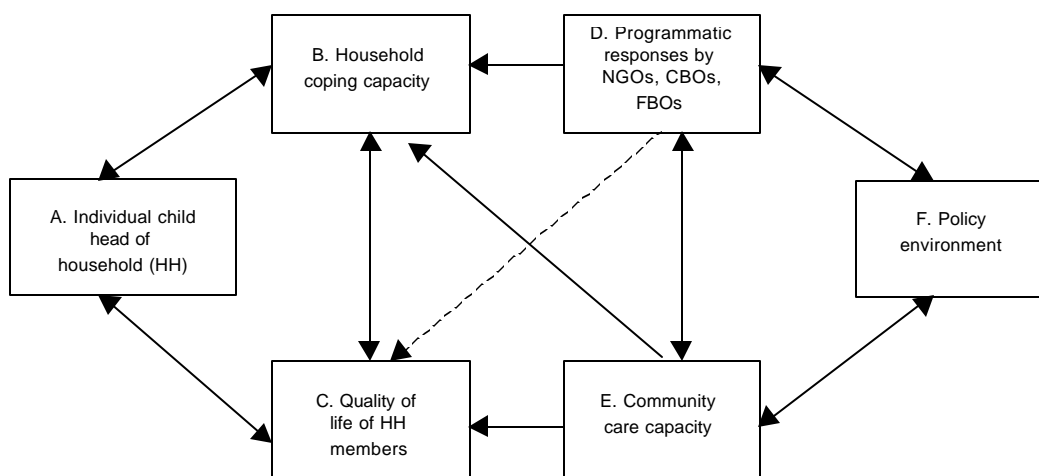
Based on the pre-testing stage of instrument development, the following potential sources of error were identified: (i) isiNdebele like isiZulu is a language that uses many metaphors (Mbiti 1989). This poses the problem of respondents forming their own idiosyncratic interpretations of test items (Tredoux 2002). (ii) Some English terms that have conceptual meaning, are not part of traditional isiNdebele and therefore create challenges in translation. (iii) Young urban people exposed to westernisation, education, media and urban peer processes speak a 'new' isiNdebele 'dialect' that frequently uses terms which are incomprehensible to adults in the same community. A programme evaluation research of psychosocial support programming conducted in KwaZulu-Natal identified similar sources of translation errors (Killian 2004:193).

An important finding in our work on instrument development was the importance of ascertaining respondents' interpretations of test items. Merely focusing on linguistically accurate translations of items proved to be insufficient. Items needed to be translated in concordance with the specific cultural background of respondents. In discussing the translation of instruments for different cultures, Swartz (1998:210) summarizes this point as follows: 'This involves more than accurate translation and back-translation – it requires us to find out, as far as we are able, whether the

meaning we give to any instruments has the same meaning for our respondents'. The translation of instruments used in this study, was laborious. However, it demonstrated in a powerful way, a commitment to bi-directional knowledge sharing, learning and understanding between young community members and the researcher.

Research instruments

For the purpose of this study, the researcher adapted two existing tools (i) WHOQOL the WHO quality of life psychometric assessment tool and (ii) the Social Support Scale (SSS) developed by Beale Spencer, Cole, Jones and Phillips Swanson (1997). Other instruments used were: (iii) a daily journal data sheet, (iv) FGD facilitator's guidelines, and (v) various question sheets for key informants interviews which were developed by the researcher. The Figure 3.2 below shows an overview of instruments used in this study.



Key factor	#	Instrument / method used	Comments
A.	1a	WHO quality of life assessment (WHO, WHOQOL Geneva)	Instrument adjusted for youth and children
C.	1b	WHO quality of life assessment (WHO, WHOQOL Geneva)	Instrument adjusted for youth and children
B.	2	Bi-daily journal data sheet (BDJD) (Germann 2001)	Developed by researcher
D B, E B	3	Social support scale (SSS) (Beale Spencer, Cole, Jones and Phillips Swanson 1997)	Adapted by researcher to local community context
D, E	4,5	Focus group discussions & Key informants (Germann 2001, Germann 2003a)	Developed by researcher
F		Meeting key policy people	Discussions with key people

Figure 3.2: Conceptual framework and research instruments summary

The follow section provides further information about these assessment tools.

WHO quality of life assessment for youth – WHOQOL-BY (#1a & 1b)

The term ‘quality of life’ first appeared in development literature following its use in a UN report in 1962 in the following context:

The problem of the underdeveloped countries is not just growth, but development... Development is growth plus change. Change, in turn is social and cultural as well as economic, and qualitative as well as quantitative... The key concept must be improved **quality of people’s life** (UN 1962:34).

Acknowledgement of the importance of 'quality of life' arose out of disillusionment within the First UN Development Decade. It was found that economic growth was not sufficient to bring significant advancement to underdeveloped countries (Esteva 1995:12). However, it was more than three decades before instruments were developed to measure 'quality of life'. WHO, with the aid of 15 collaborating centres around the world, developed measures for assessing 'quality of life'. These instruments are suited to a variety of cultural settings and allow for comparisons of different populations. The instruments can be used in research, programme audit and policy making (WHO 1995).

In the Constitution of the World Health Organisation (WHO), health is defined as 'A state of complete physical, mental and social well-being not merely the absence of disease'. This informed the following definition of 'quality of life':

As individuals' perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO 1995:2).

WHOQOL-100 and the WHOQOL-BREF are two psychometric instruments developed by WHO for assessing quality of life. The first instrument WHOQOL-100, consists of 100 questions covering the following six domains: (1) Physical health, (2) Psychological, (3) Level of independence, (4) Social relations, (5) Environment and (6) Spirituality / religion / personal beliefs. The second instrument, WHOQOL-BREF, is an abbreviated version of WHOQOL-100. In WHOQOL-BREF, domains 1, 3, 2 and 6 of the full version were merged resulting into the following four major domains: (1) Physical, (2) Psychological, (3) Social relationships and (4) Environment. This shorter version utilizes only twenty-six question items compared with the hundred questions for the full instrument.

For the purposes of this research, the decision was taken to use an adapted form of WHOQOL-BREF, rather than using the longer version. Based on the researcher's experience of working with youth, the shorter version appeared more suited to the concentration span of youth. In support, Fisher and Foreit (2002) found that interview

schedules with youth lasting more than thirty minutes are susceptible to error on account of respondent fatigue.

Adapting the WHOQOL-BREF instrument for use in this research posed a double challenge. First, the instrument was developed for adults and secondly, the instrument was only available in Shona, the majority language spoken in Zimbabwe, and not isiNdebele the main language used in the research area.

To address the problem of adapting the instrument for youth, the researcher visited WHO offices in Geneva and met with the team who coordinated the development of the instruments. They were very supportive and provided valuable guidance on how to proceed. This included linking the researcher with staff at the University of Washington, Centre for Disability Research and Policy, Seattle. Edwards, Patrick and Topolski (2003) adapted and successfully used the WHOQOL-BREF tool for a study on quality of life of adolescents with perceived disabilities.

Information gleaned from this exploratory research, was used in adapting the WHOQOL-BREF tool for this study. This led to the construction of the revised WHOQOL-BY tool (BY standing for Bref-Youth). The development of the WHOQOL-BY included conducting FGDs with youth from urban Bulawayo. Following these FGDs research assistants reviewed the tool, adapting and changing items as necessary. The WHOQOL-BY (see Appendix 4) included biographical data and twenty-six scaled questions. All heads of CHHs used that tool (see 1a in instrument summary Figure 3.2 above). When interviewing household siblings younger than thirteen years old, the tool was adjusted by removing two questions; one on sex life, the other one on capacity to work, as they were seen to be irrelevant to that age group (see 1 b instrument summary Figure 3.2, above).

The issue of translating the tool into IsiNdebele was addressed by contacting the WHOQOL collaborative centre at the University of Zimbabwe's, department of Psychiatry. Professor J. Mutambirwa (2001) provided valuable guidance on adapting the Shona tool into isiNdebele. Translating the tool involved conducting FGDs to

determine local terms for the four major domains. The tool was translated as well as back translated to ensure relevancy and accuracy. Although this process was time consuming, it was critical for the researcher to gain a deeper understanding of the meaning of quality of life for urban African 'township' youth. Once the translated tools were available, research assistants were trained in conducting the interviews. The two instruments were then pre-tested before use with the research respondents. The estimated time to complete the questionnaire was thirty minutes per respondent.

Bi-daily journal data sheet – BDJD (#2)

Measuring coping capacity of individuals and households is a difficult endeavour (Killian 2004; Snider 2003). Despite extensive literature on coping capacity and resilience (Howard & Dryden 1999, Pivnick & Villegas 2000, Lazarus & Folkman 1984, Smith & Carlson 1997, Punamäki & Puhakka 1997), there is still little consensus regarding these concepts (Coutu 2002). For the purpose of this research, coping is considered to be 'constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person' (Lazarus & Folkman 1984:141). It is important to take into account individual and societal variables when attempting to understand coping strategies in children (Brooks 1998:45).

A single interview is insufficient to assess the well-being and coping capacity of CHH's over time (Luzze 2002:29). Thus, for the purposes of this research, a self-reporting questionnaire was designed for ongoing bi-daily assessment. This questionnaire was developed to be used by the head of CHHs on a daily basis over a period of twelve months. The bi-daily journal data sheet (BDJD) was developed using the six domains that were used in the development of the WHOQOL-100 described above. In the BDJD, the six domains were captured through the following nine sections in the questionnaire: (1) Nutritional information, (2) Education information, (3) Health & emotional wellbeing, (4) Recreational activities, (5) Community support, (6) Home environment, (7) Income activities, (8) General issues, (9) Comment of the day. The BDJD consisted of 45 main questions with some selected sub-questions. See

Appendix 5 for the BDJD Sheet. Estimated self-reporting time for the BDJD is six minutes per day.

Social support scale – SSS (#3)

Social support from extended family and the community plays a powerful role in the coping ability of children. Children need to experience the help of concerned, competent adults and peers to meet new challenges and to cope with new stresses (Garbarino 1992:108). Social support has been defined as 'information leading the subject to believe that he / she is cared for and loved ... esteemed and valued... that he / she belongs to a network of communication and mutual obligation' (Cobb, 1976:301). The presence of social support networks mitigates against vulnerability (van der Merwe 2001:86). Social support systems in urban Bulawayo that act as potential protective factors in the lives of CHH members are friends, peers, extended family members, neighbours, teachers, home-based or orphan programme volunteers, grandmothers, and religious workers or ministers (DSW 1997:45). Vulnerable children are especially in need of social support networks, for both material needs and for psychosocial support (Killian 2004:242). This is particularly effective when it provides vulnerable children with a caring, stable, and structured environment. (Werner 1990). Resilient children are children who cope well with their situation. Research has shown that such children demonstrate a pattern of having one or more close friends on whom they can rely on for ongoing emotional support (Garmezy 1981; Kellam 1975). Furthermore, a high degree of social support from one's community has been correlated with less stress and illness, while little social support has been correlated with increased stress and illness (Caplan & Killilea 1976).

Spencer, Cole, Jones and Swanson (1997) developed an 8-item self-report questionnaire (social support scale) for use with children. The scale provides an indication of the child's perception of the availability of social support. The scale uses three contexts: i) family members including extended family, ii) school environment, teachers and counsellors, and iii) peers, including same-aged children as well as

close friends. Given the importance of neighbours, community volunteers, and religious workers or ministers for CHHs in urban Bulawayo, these three categories were added to the scale. See Appendix 6 for the adapted SSS instrument used in this research.

The head of household was asked to respond for each of the contexts dealt with in the scale (i.e. family, school and peers) Children were asked about the availability of particular individuals in the 3 contexts. The scale takes into account the potential absence of important figures such as parents. Children were also asked about the degree of helpfulness of social supports. This included being questioned as to whether an individual provided emotional support, instrumental help, or fun and satisfaction, therefore improving the quality of life through the social support that such interactions represented (Beale Spencer et al. 1997). The SSS instrument was used in Southern Africa effectively by van der Merwe (2001) in her study of the relationship between access to social support and child behaviour outcomes; and by Killian (2004) in her study on psychosocial support to children made vulnerable by HIV/AIDS, poverty and violence in KwaZulu-Natal.

Focus group discussion and key informant interview instruments (# 4-6)

Focus groups seemed the most appropriate method for interviewing various stakeholders about issues of CHH, community-care capacity and programmatic support at community level (Schensul, leCompte, Nastasi & Borgatti 1999, Steward & Shamdasani 1998).

The researcher developed guidelines and semi-structured questions for facilitators of FGDs (instrument # 4 & 5) for the purpose of conducting research related to community care capacity and NGO/CBO/FBO programmatic responses. In addition to the FGD, key informants (teachers, business people, social worker, OVC programme volunteers) were interviewed using an interview schedule that included community profiling data. To assess the policy environment and how that impacts on community capacity and programmatic support, open discussions on policy development and

application with key policy stakeholders were held. This was seen as more useful and respectful than using an interview instrument. These tools and methods were used to validate and enhance the researcher's own extensive professional expertise and observation-based knowledge in these areas.

Initially, focus groups were going to be audio-taped. However, as mentioned in section 3.4.1, this plan was abandoned due to concerns from participants. Given the politically oppressive environment in Zimbabwe, community members were against being electronically recorded for fear of potential future negative consequences. This challenge was resolved by engaging two people for note taking in each of the focus groups. After the meeting the notes were shared. Then the two reporters and the facilitator together compiled the final focus group report and shared it with the researcher.

In Appendix 1 the two focus group guidelines and question schedule are shown and Appendix 7 shows the key informant questionnaire used.

3.5.8 Data analysis techniques

All quantitative data was entered into MSExcel spreadsheets. Data from the daily journals was then exported into the SPSS computer program (Version 11) for analysis (SPSS 2002). Data from FGDs and interviews with key informants was analysed for qualitative data presentation. After all the data had been captured, careful verifying of the accuracy of the data took place. This was a time-consuming exercise as the amount of data collected in the bi-daily journals was overwhelming. The data cleaning process delayed the analysis of the results by about six months. Errors in coding and some incidents of careless entry were identified and corrected.

Some data concerning income and nutrition from bi-daily journals analysed in SPSS had to be inflation-adjusted due to the high inflation rate in Zimbabwe during the entire data collection process. During the data gathering period in 2001 annual inflation was estimated at 115% (Coping with high inflation 2002). The researcher

made use of assistance from a more experienced researcher and frequent user of SPSS for verification of the data analysis utilizing SPSS.

3.6 Summary

This chapter, dealt with the research methodology used in this study. The first area addressed was ethical issues relating to research with children. The discussion on research ethics elucidated how research involving children adds additional challenges to the research process. Only during 2004 were ethical and practical research guidelines developed by Family Health International for doing research with children in the context of HIV and AIDS. Following the section on ethics an outline was provided on the selection and training of research assistants. A crucial focus of this chapter was a clarification of the conceptual framework developed for this study. This conceptual framework involved the identification of relevant domains and manifestations of CHHs as well as community care. This chapter also described sampling techniques, and provided an outline of the research time line. Finally, the development of research instruments was described including how instruments were adapted to the unique cultural context of this study.

The following chapter will provide an analysis and perspective of the contextual situation of children in urban Bulawayo through a situational analysis.

4 Situation analysis – urban Bulawayo

*It is the end of living and the beginning of survival
(Chief Seattle, 1855 in Jeffers 1991:15)*

4.1 Introduction

Bulawayo, often referred to as the 'City of Kings', is the second largest city in Zimbabwe. The geographical focus for this research was, as discussed in the previous chapter, limited to urban Bulawayo. This decision was taken as it was no longer safe to conduct research in rural areas due to the ongoing political violence which dates back to 1999.

The tragedy unfolding in Zimbabwe has plunged the country into its most severe and persistent crisis since independence (Raftopoulos 2002:260). This research was conducted amid a declining socio-economic and political situation, especially during the primary research data gathering period from 2000 to 2003. Bronfenbrenner (1986) argues that meaningful improvements to a child's social ecology require macrosystemic interventions. The corollary to this is that a sustained macrosystemic crisis, as is being experienced in the case of Zimbabwe, impacts negatively on individual children. This chapter provides an analysis of ways in which the Zimbabwean socio-economic and political crisis impacts on individual children and affects their quality of life. This includes an overview of existing child support mechanisms in urban Bulawayo. An analysis is provided of social safety nets including their strengths and limitations.

4.2 Overview of the socio-economic situation

In 1855 settlers in Washington State (USA) began decimating forests to build settlements. In response to this assault on a life-sustaining resource, Chief Seattle made the statement: 'It is the end of living and the beginning of survival' (Jeffers 1991:15). Zimbabwe, over the past five years has seen the decimation of many metaphorical 'trees', such as 'freedom of speech' and 'law and order'. Compounded by the deepening economic misery to which communities are being subjected, this erosion of fundamental rights has indeed resulted in a situation 'where living has ended and survival begins'.

Urban Bulawayo has been subjected to systematic underdevelopment since independence owing to the dominant ethnic group of its inhabitants. This marginalization has more recently been cemented by the related fact of its being viewed as an opposition stronghold by the ruling Zanu-PF party (Ncube 2003). This has resulted in much hardship for people living in urban Bulawayo.

4.2.1 History and culture of Bulawayo

Ndebele history and Bulawayo

Historically, Bulawayo is one of Zimbabwe's most important towns. The area has been inhabited for thousands of years. The earliest inhabitants of Bulawayo were Stone Age people. Later, the area was inhabited by people from the Iron Age. (Mambambo 2004:6, Ranger 1999:2). Khami, near Bulawayo has been identified as the successor of Great Zimbabwe and was established by Kings of the Torwa State in the 15th century. After two hundred years the Torwa state was overthrown by the Mambos of the Rozvi Kingdom. (Iwanowski 1991:212). In 1840 Nguni people from present day KwaZulu-Natal in South Africa, under the leadership of Mzilikazi, the founder of the Ndebele people, settled and established Bulawayo (Palmer & Birch 1992:98). This 'exodus' was triggered by inter-ethnic conflict, Mzilikazi Khumalo, with a group of followers, split from King Shaka in around 1821 and first settled in the former Transvaal region before reaching his final destination in the Matopos Hills and Bulawayo area in present day Zimbabwe (Nyathi 2000:14).

After King Mzilikazi died in 1868 his second son, Lobengula was installed as king. Around 1875 King Lobengula established his new capital, called Gubulawayo five kilometres away from modern day Bulawayo. Escalating conflict arose as a result of Cecil John Rhodes's expansion plans. Rhodes saw 'Matabeleland' as key to his grand design for a British Empire in Africa. King Lobengula expressed his dissatisfaction, concerning these events in a letter to British officials in South Africa: 'the white people... come in here like hyenas without my permission and make roads to my country... today is peace but I don't know what tomorrow may bring' (Amin 1990:52). Only three years later, in July 1893, Rhodes ordered an attack on Ndebele

attachments. Fourteen weeks later, the British South African Company flag fluttered over the smouldering ashes of the royal kraal in Bulawayo. Lobengula fled and died of smallpox in February 1894 (Wills & Collingridge 1894:136, Amin 1990:53). A European settlement arose swiftly from the ashes of the Ndebele capital. Bulawayo was officially declared a town on June 1st 1894 by Leander Starr Jameson, a British Administrator from the Cape Colony. The population of Bulawayo at this time consisted of 1,500 people. Over the past 110 years Bulawayo has grown into a city with a population of over 900,000 (Nyoni 2003).

Bulawayo's urban settlements for Africans (study area)

African areas in urban Bulawayo were governed by the Sanitary Board of Bulawayo under the Town Management Ordinance No. 2 of 1894 (BCCA 1894). Whites lived in 'European' areas and Blacks lived in 'African' areas referred to as 'townships' or collectively as 'The Western Location'. This control of ethnic residence began during colonial rule. It was maintained following the 1965 Unilateral Declaration of Independence (UDI) by white minority ruled Rhodesia. Ethnic segregation was regarded by many whites as natural and by most as unavoidable. Such systems were maintained until Zimbabwean independence in 1980.

The Sanitary Board served to enact local by-laws aimed at establishing and controlling African locations. In the first phase of urban African settlement, people built their own huts from scrap iron sheets in a haphazard fashion (Nyathi 2000:152). Hut owners were made to pay a monthly tax. In return the town council provided sanitary buckets and incinerators for waste removal. By 8.00 p.m. people were required to be in their homes in the location. By 9.00 p.m. lights and cooking fires were supposed to be out. No women were allowed into the locations. A white man who served as municipal location superintendent enforced the town council regulations with the aid of African police. In the first record of African resistance, in Matabeleland's history, African men threatened to withdraw their labour if women were not allowed into the Location. As a result a town pass was introduced for

married women. This also resulted in a culture clash. Some Ndebele men had several wives. However, the law stipulated that they were only allowed to register one wife.

After World War I, the Bulawayo Municipality started to build houses for single men in the Location. In 1923, the Location was surveyed for the first time and proper town planning for future expansion began. The period of the global Great Depression also affected urban Bulawayo (Phimister 1986:67). Many jobs were lost around the country. Agricultural enterprises in Mashonaland (around the present day capital city Harare) retrenched hundreds of workers, who flocked to Bulawayo, an industrial hub, in search of alternative employment. This led, in 1929, to the first urban ethnic clashes between Ndebele and Shona (Nyathi 2000:154). Migration from Mashonaland and later from Malawi and Zambia to Bulawayo continued over the following decades. As a result, Bulawayo today has an ethnic mix of Ndebele, Shona with Zambian and Malawian minorities. This is important when examining socio-cultural issues pertaining to CHH coping and community care capacity.

The houses in the locations of this study (see map on page 119) were mostly built in the 1950s or later. The buildings in these newer locations were designed as small family units in contrast to the single men's units built prior to the 1950s. In the 1950s, changes in housing policies, led to increasing numbers of women and children living in the Locations. These historical facts resonate in unusual but important ways for current CHH coping mechanisms. For example, CHHs living in larger family units often rent out rooms to lodgers. This is an important source of income not available to CHHs living in the older buildings designed for single men's accommodation. Today whole families often live in these single rooms which are generally divided into 2 rooms with a wardrobe. Bulawayo's western locations today have over 120,000 high density housing units (BCC 2003).

4.2.2 Ndebele and Shona culture within study area

There is increasing recognition that to adequately address the HIV/AIDS crisis in Africa, a culture-centred approach is required (Airhihenbuwa & Webster 2004:4).

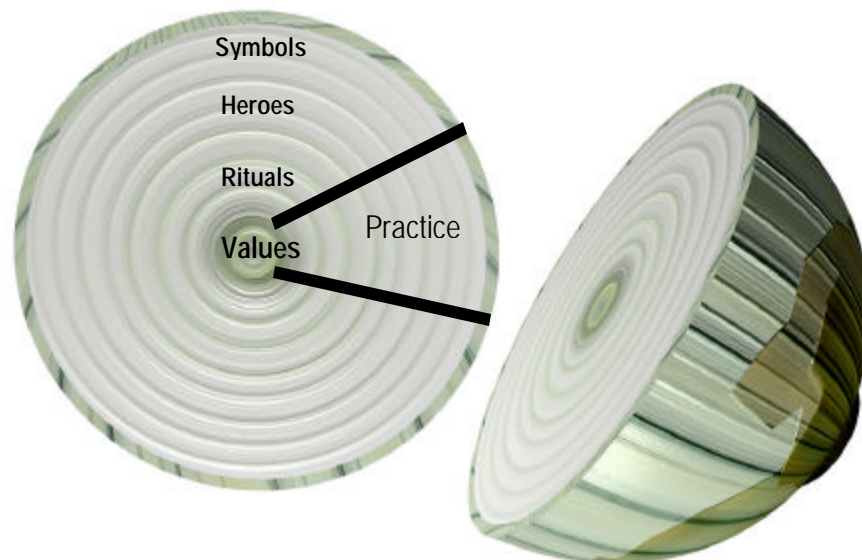
Culture influences how individuals, families and communities cope with stressful situations. In an African context, family and community values are particularly powerful in influencing people's behaviour (Airhihenbuwa, Makinwa & Obregon 2000:102). There is broad consensus that the important role of family and community in African society needs to be taken into account in addressing the HIV/AIDS crisis.

CHHs can only properly be understood with reference to their socio-cultural context. From a Western perspective (setting aside stories such as Pippi Long Stocking, Huckleberry Finn and Bugsy Malone), the idea of children having to fend for themselves is likely to provoke indignation and horror. For example, a South African academic, responded to this study as follows: 'I could not live in a society where CHHs as a model of care are acceptable' (Germann 2001). However, based on their socio-cultural context, CHHs represent a resourceful response to dire circumstances. The role played by community support mechanisms is particularly important in making CHHs a viable coping strategy. The ethic of community support, in African society can be conceived of as a barrier against desolation and loneliness. As stated by Nan Partridge (De Waal 1990:125) in her book *Not Alone*, in contrast with anxieties of people of European origin, black Africans' basic security, despite poverty and adversity, is 'not being alone in the world, in nature, in time, in trouble or in fear.' The findings of this study confirm the invaluable role that extended family and community play in supporting CHHs.

The study of culture dates back to antiquity. However, it is only recently that social scientists have begun to acknowledge the pivotal position of cultural values in attempting to understand social behaviour and health practices (Oyewumi 1997, Airhihenbuwa 1999). Should child development agencies fail to understand the relationship between culture and social security they risk implementing self-reliance programmes that actually weaken the most vulnerable social entities, such as CHHs. (Kaarsholm 1991:7). An impact study by a World Vision CHH support programme in Uganda (Luzze 2002:iii) found that direct service support to CHHs appeared to considerably reduce community philanthropic initiatives towards these CHHs. This suggests that in the long-term dependency on non-sustainable external agency

support reduces the resilience of CHHs. The issue of culture, social security and external agency support to CHH is further discussed in section 8.3.2. Hofstede (1994:5) defines culture as 'the collective programming of the mind which distinguishes the members of one group of people from another'. Mazuri (1986:239) emphasises that values, as the core of culture, 'influence and condition perceptions, judgement, communication, and behaviour in a given society'.

A useful analytical tool to understand culture is the 'onion diagram' developed by Hofstede (1994:9). The following four key manifestation neatly describe culture: symbols, heroes, rituals and at the core, values (see Figure 4.1, below).



- Symbols: gestures, words, objects and pictures that convey similar meaning which is only identified by those who share the culture. E.g. the word 'usharp' with a 'thumbs up' sign is an urban youth expression of 'are you okay today?' Symbols are superficial and change frequently over time.
- Heroes: Persons who hold characteristics which are highly prized in a culture and therefore serve as models for behaviour. E.g. Nelson Mandela with his dignified, calm, firm but gentle personality is seen by most in Southern Africa as a hero.
- Rituals: Burials, weddings, ways of greetings, although technically inessential, are all collective activities that are considered within a culture as socially essential.
- Practices: Symbols, Heroes and Rituals are visible to an outside observer and can be grouped as cultural practices. But their cultural meaning is invisible and subject to interpretation by the insiders.
- Values: They form the core of culture and are some of the first things children learn, mostly implicitly and not conscious. As a result many values we hold remain unconscious to us.

Figure 4.1: The 'onion diagram': Manifestation of culture at different level of depth

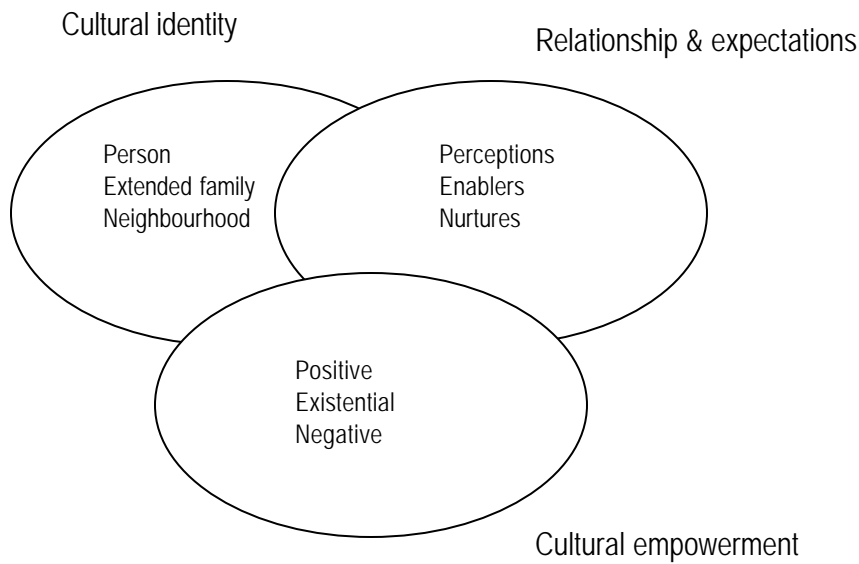
Source: Hofstede (1994:9)

Zimbabwe is populated by a variety of different groups. The Ndebele are the most numerous in urban Bulawayo, closely followed by the Shona people. Over the years, against the backdrop of city life, there has been a mingling of urban Ndebele and Shona culture (Bourdillon 1982:301). This has resulted in these groups forming a new combined cultural identity which is neither western nor traditional Ndebele or Shona.

Although some symbols and rituals differ, the values of modern Ndebele and Shona urban culture are remarkably similar. While interpretations of dreams, application of beliefs and taboos may differ, the religious basis and with it the value systems of Ndebele and Shona people are the same as for most Bantu people (Gelfand 1962, Murphree 1971, Bozongwana 1983). In addition to issues surrounding Ndebele/Shona urban culture the researcher had to foster an understanding of the culture of urban Ndebele/Shona youth. The research assistants provided invaluable aid in this endeavour.

The PEN-3 cultural model developed by Airhihenbuwa (1989, 1993) is used as a guide to cultural approaches to HIV/AIDS interventions in Africa.

Fig. 4.2 shows the PEN-3 model with the three domains that were used to analyse critical cultural factors in relationship to CHHs. Table 4.1 (following Figure 4.2, below), shows key cultural issues that need to be considered in relation to CHHs. This Table is based on the 'onion diagram' and the PEN-3 model, as well as data obtained from FGDs conducted in this study.



Cultural identity

Person: The degree to which a person is dealing with multiple identities (e.g. youth, Ndebele, female) in relation to culture

Extended family: Members of the extended family who have a relationship with the CHH. (e.g. role of grandmother)

Neighbourhood: Core community values regarding neighbourhood support. Communities capacity, power structures etc.

Relationship & expectations

Perceptions: Cultural values and beliefs that influence decision making about family, care and support

Enablers Resources available to support CHH. For example institutional support , and socio-economic status (person, extended family, neighbourhood)

Nurturers Supportive and / or discouraging influences of family, friends and neighbourhood including community events, spirituality and values of friends, and marriage rules etc.

Cultural empowerment

Positive: Cultural beliefs and practices that promote care and support to CHH

Existential: Cultural beliefs and practices that neither threaten nor enhance support and care of CHH

Negative: Cultural beliefs and practices that have a negative impact on CHH.

Figure 4.2: The PEN-3 model

Source: Airhihenbuwa & Webster (2004:7) – Explanatory Table related to CHH developed by Germann (2004b)

Key Cultural Factors affecting CHH in Study Area				
Cultural Identity	Cultural Empowerment and Relationships or expectations			Practice (Rituals / Heroes / Symbols)
Urban Ndebele / Shona Neighbourhood - The culture of 'Ubuntu' or 'umfowethu' in Ndebele (Pachedu in Shona) signifies group solidarity for community survival through brotherly group care rather than individual self-reliance (Mbigi and Maree 1995:1). On going economic hardship in Zimbabwe has placed this value under pressure. - Although less robust than previously, the ethic of 'every one's child' still plays an important role in urban neighbourhoods (MFD 1994)		Positive	Negative	Ndebele / Shona: The traditional all night ceremonies such as 'Pungwe' (Shona) with the purpose of community spiritual celebration and renewal (Mbigi & Maree 1995:30) is adapted to modern urban life in the form of post independence public holidays such as Heroes day and Independence day. Aimed to enhance brotherly group care they are presently used by the ruling party for political propaganda, rather than to enhance e.g. community care capacity for OVC etc.
	Perception	The welfare of the group is an accepted norm. Neighbours have to care for each other	Myths and misconceptions about HIV / AIDS may lead to discrimination against CHHs	
	Enablers	Leaders are guardians of community life. An urban councillors can be the 'guardian' of a CHH.	Political polarization (ruling party versus opposition) causes ongoing tension and distrust in urban communities	
Urban Ndebele / Shona Extended Family - Although in towns the most common household unit is the nuclear family, extended kinship responsibilities are maintained. However, since urban families are economically independent, there is less social control on a person's behaviour from the extended family than in the rural past (Bourdillon 1982:305). The kinship system is patrilineal.	Perception	The spirit of family unity must prevail (Bozongwana 1983:22). A CHH prevents sibling separation.	Death related to HIV / AIDS may be associated with witchcraft. As a result the extended family may not support a CHH	Ndebele / Shona: Burial procedures are extensive and costly often resulting in children being left behind impoverished. Children are often excluded from burials. Ndebele: Bride price (lobola) is modest and more of a symbolic nature and is not always practiced Shona: Bride- prices among Shona families are high. Some couples marry contrary to custom without extended family involvement, or the bride price is never paid resulting in conflict after death of one parent which often disadvantages children
	Enablers	Brothers or patrilineal cousins of a deceased father can take his place with legal and economic responsibility for his children	Often people living with HIV/ AIDS are reluctant to discuss the future of their children. Children are seldom consulted in succession planning	
	Nurturers	Older siblings, working away from home (Harare, RSA or overseas) often provide support to CHH	CHH may experience property dispossession by greedy relatives if they have no 'guardian or protector'	
Urban Head of CHH Female – From an early age, girls are trained in domestic duties and household management. They experience conflict between their culturally expected role of 'mother of the house' and the pressure from urban female peers who expect them to be 'modern, independent women', spending time going out together etc.	Perception	The ethos of womanliness is daily work (Reynolds 1991:106) and the control of her own home (Holleman 1958:65, Mhloyi 1996:63)	The importance attached to young woman getting married and having children (Krige 1977:61) may lead to early marriage as an escape from CHH responsibilities or hope for economic improvement to support siblings	Ndebele / Shona: Traditional ways of reproductive health and sex education that included counseling in the transition from childhood to adulthood are no longer practiced through rituals such as puberty ceremonies for girls (Indunduzelo) and boys (Ukuthomba Komfana). Alternative ways of passing on such critical information are not established. This leaves many children, especially adolescent vulnerable due to ignorance. This is especially the case for CHH
	Enablers	Volunteers in community care programmes encourage and transfer household management skills	Little stigma is attached to casual commercial sex work to earn an income. Thus CHHs are potential targets for high risk sexual behaviour	
	Nurturers	Peers assisting in the care of younger siblings. 'Care for me – I care for you'	Stigma related to the death of parents isolates CHHs and makes them more vulnerable	
Urban Head of CHH Male –Fathers are culturally expected to be providers of food and clothing and are responsible for children's actions and represent them in disputes. The loss of a father often results in young male to struggling with fulfilling their expected role. Male CHH do not have the skills, nor have the opportunities to be the providers for the younger siblings. This leads to role confusion of male CHH. (Germann 2004a:3)	Perception	Be strong in adversity, overcome problems	As head of household I am entitled to authority and I can do what I want.	Ndebele / Shona: See above comment.
	Enablers	See under Female CHH above	Gang up with petty criminals for economic support and group belonging	
	Nurturers	Male role models in the community provide guidance to male CHH. E.g. Camp Counsellors (see 6.4.3)	Stigma related to the death of parents isolates CHH and makes them more vulnerable	

Table 4.1: Key cultural factors affecting CHH in study area

4.2.3 State and political economy in Zimbabwe

Zimbabwe gained its national independence in 1980 after a protracted and bloody struggle. As a post-white settler colonial state Zimbabwe evinces essential structural similarities with other post-colonial states (Mandaza 1986:13). In particular, Zimbabwe has had to deal with the dominant role of international finance capital (De Waal 1990:127). In 1982, two years after independence it was estimated that at least 70% of private sector capital stock was foreign owned (Hawkins 1982:12, Schatzberg 1984:167). What follows is a brief analysis of the political and economic transitions Zimbabwe has undergone. This analysis helps to contextualize this study especially because during the time of primary data gathering, from 2000–2003, significant changes in the political economy of Zimbabwe took place, directly affecting the lives of study respondents.

Pre–independence

As a colony of Britain, Zimbabwe was called Southern Rhodesia (1890s–1965). Following the white settlers' declaration of independence (UDI) from Britain it was renamed Rhodesia (1965-1979). From the time that Zimbabwe was colonized, settlers worked towards developing a state that perpetuated white privilege and control (Stoneman & Cliffe 1989:17). This included domination over all resources, such as land, education, training, the road and rail networks and corporate loans and licences (Palmer & Birch 1992:8). Such inequalities were enforced by settler-controlled parliament, and reinforced by racial segregation. The publication '*Settlers Politician*' summarized this polarization of power and control pointedly in an article from 1922: 'The whole economic system of Rhodesia, on farms as well as on mines, rests on a cheap and plentiful supply of native labour'. During and after the second World War 'import substitution industrialisation' policies contributed to strong economic growth with high foreign direct investment (Bond & Manyanya 2002:5). Such economic growth did not change black workers appalling living conditions. This led to the formation of black trade unions in 1954 that generated leaders like Joshua

Nkomo (former vice president), and started the liberation movement that developed momentum in the 1960s. The subsequent liberation war caused over 40,000 civilian deaths and led to economic depression (Sachikonye 1986). From 1976 until 1979, economic output was cut by 40%. In 1979 the Rhodesians, under internal and external pressure finally surrendered at the 1979 Lancaster House peace talks in London.

Zimbabwe 1980 – 1996

In April 1980, the newly elected, president of Zimbabwe, Robert G. Mugabe, surprised black voters by his willingness to compromise with white-owned business and international capital in the name of national reconciliation. Mugabe apparently aimed to revitalize the economy, using socialist rhetoric but without changing existing pre-independent structures (Bond & Manyanya 2002:9, Herbst 1990:222). Although land reform was a critical campaign issue during the liberation struggle and the first elections, pre-independence economic power relations such as access to productive land remained unchanged, partly due to concessions, such as the 'willing seller, willing buyer' land agreement, that were made during the Lancaster House talks (Kaseke 1993:77, du Toit 1995:120). However, lack of political commitment by the new government combined with the unwillingness of commercial farmers to sell their land resulted in relatively insignificant progress in the process of land redistribution. By 1989 only 45,000 families had been resettled, with 4,000 white commercial farmers still owning over 95% of commercial farmland (Moyo 1997:23). Even after the 1992 Land Acquisition Act, resettlement remained slow due to insufficient resettlement funding support (Scoones 1996:22).

Zimbabwe as a post colonial state has even at the best of times been a 'schizophrenic state', split into, on the one hand, an economically disenfranchised majority, and on the other hand, the interests of a small new Black ruling elite and the international financial oligarchy (Mandaza 1986:14). The struggle between these two groups, with their fundamentally opposing interests has produced ambiguity, contradiction and indecision in several important policy matters ever since independence (Baker 1984:7). Indeed, individual political leaders from the ruling

party, including President Mugabe, sometimes display 'politically schizophrenic' tendencies, as seen in the 1990 elections, when the state promised rural landless people it would take land from white farmers whilst simultaneously reassuring the Commercial Farmers Union (CFU), comprising mainly white farmers and foreign corporations, that land reform would only take place in close consultation with their Union (Sylvester 1991:182).

During the first years of independence, progress was made in areas such as education and health. By distributing resources in such a way as to benefit the majority of people, the state ensured national support for the governing black elite (Copestake 1993:15). However, the legacy of pre-independence financial debt combined with high government spending in key service sectors such as health and education to force the new government to bow to World Bank and IMF pressure and adopt an economic structural adjustment programme (ESAP) from 1990 to 1997 (Dixon & Macarov 1998:11). This resulted in introducing high user fees for formerly free health and education services. The absence of functional mechanisms for social protection of the lower income strata resulted in a surge in poverty levels. In 1997 the structural adjustment programme was terminated. Despite public consensus that the programme was a miserable failure, the World Bank's 'Project Completion Report' registered satisfaction (Bond & Manyanya 2002:32). Thus a combination of 'schizophrenic' state tendencies in key policy areas, oppressive government methods and economic structural adjustment plunged a large portion of Zimbabwe's population into poverty, creating the conditions for Zimbabwe's downward spiral from 1997 onwards.

Zimbabwe 1997 - 2005

Two factors are critical to understanding the crisis that has engulfed Zimbabwe since 1997. First, in 1996 the Zimbabwe Congress for Trade Unions (ZCTU) reported that due to the economic adjustment programme, their average member was 40% poorer than in 1990. Through trade union leadership this rapid decline in the standard of living led to a political re-awakening of Zimbabwe's society from a deep post-independence slumber to demand socio-economic and political reform. This

eventually caused the formation of the first successful labour-led political party, the Movement for Democratic Change (MDC) that nearly won the 2000 parliamentary elections. For the first time in Zimbabwe's history, the ruling party had to face a strong opposition (Stiff 2000:302).

Secondly, the dramatic decline in the standard of living affected the majority of over 50,000 liberation war veterans. Most had never finished their education and had no vocational training since they were fighting the liberation war during their formative time as young adults. After the war, the majority ended up either unemployed, self-employed or in low paid government jobs. Although they were assured access to land during the struggle, such access did not materialize. In early 1997, war veterans began protests in Harare and harassed their 'patron', President Mugabe, for his government's failure to meet even their most basic employment and survival needs (Bond & Manyanya 2002:xi). This situation caused acute embarrassment for Mugabe and the decision to give each war veteran a ZWD 50,000 pension payout plus ZWD 2,000 per month was aimed at quelling their dissent. As there was no budget provision for these payouts, the national budget deficit ballooned far above the agreed level, leading the World Bank to suspend balance of payment support. As a result, on November 14, 1997, international and local financiers caused the Zimbabwe dollar to crash by suddenly transferring large portions of their Zimbabwe dollar capital investments into hard currencies. Within four hours of trading the Zimbabwe dollar lost 74% of its value (Bond & Manyanya 2002:38). Mugabe suddenly announced, partly out of anger at the international finance community, partly to appease war veterans, that the government would at long last begin implementing radical land reforms. Some 1,500 mainly white-owned farms were identified for compulsory redistribution (Stiff 2000:337). November 1997 therefore heralded the start of the downward spiral of political and economic chaos that has subsequently engulfed Zimbabwe. The period since has been characterized by political violence, police brutality, shortages of fuel and other essential supplies, increased corruption, lawlessness, fraudulent elections, and the stifling of civil liberties and freedom of expression. And in the process, the Zimbabwean state has become internationally isolated and reviled as a dictatorial and authoritarian regime. The following Figure 4.3

developed by the researcher gives an illustrated overview of key political and economic events that have impacted on Zimbabwe since independence.

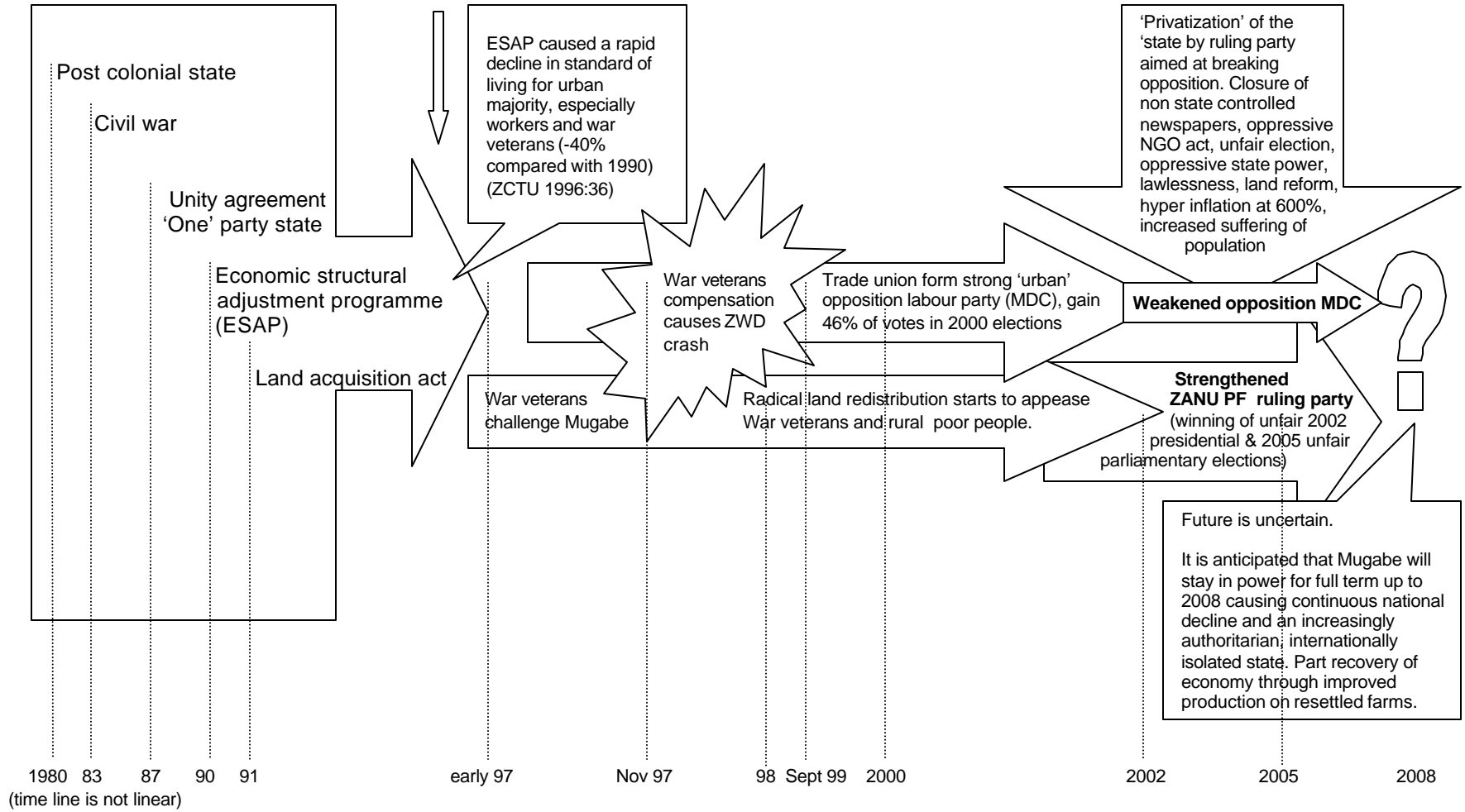


Figure 4.3: Overview of political and economic events in Zimbabwe: 1980 to April 2005

Figure 4.3 illustrates how severe restrictions on civil society have followed the 2002 presidential elections, widely declared as neither 'free' nor 'fair', by among others the MDC opposition party and European Union election monitors. At the time of writing proposed changes in NGO legislation are likely to 'outlaw' all civil society organisations involved in human rights and good governance issues. The closure of 'The Daily News', the main opposition news paper, has considerably weakened the opposition party Movement for Democratic Change (MDC). As a result Zimbabwe's internal situation continues to worsen, producing increasingly destabilizing effects in Southern Africa through economic and political refugees and economic chaos (ICG 2003:1). Although extremely slow, the fact that the Southern Africa region is beginning to engage with Zimbabwe under the leadership of South Africa is a positive sign. If a solution to the Zimbabwe crisis is not found soon, the most likely outcome will be economic and state collapse, increased violence and further suffering for the people of Zimbabwe (ICG 2003:14). As in other conflict situations, the impact of this crisis on the situation of children is severe (Machel 2001:1).

4.3 The situation of children in urban Bulawayo

The chapter thus far has dealt with the context in which children in Zimbabwe live today. Results of this research must be analyzed with an understanding of this context in terms of history, culture, socio-economics and the present crisis. The rapidly declining economy manifests itself in poor health delivery systems, poor education standards or no access to education, high cost of living, declining employment and eventually, high levels of poverty leading to a rapid decline in quality of life for all children in Zimbabwe, but most notably for urban children. The situation analysis is divided into two parts 1) a situation analysis of children in urban Bulawayo and 2) analyzing existing child support mechanisms in the research area.

4.3.1 Situation analysis of children in urban Bulawayo

A situation analysis of children can be described as a 'process of gathering and analyzing information about children and child support mechanisms to guide planning

and action' (FHI 2004:3). A situation analysis also provides a synopsis of a given situation at a given point in time. For the purposes of this research, this included identifying priority problems of children living in complex situations as well as considering various dynamics that impact on different groups of children. For example children with disabilities, street children, orphans and other vulnerable children as well as children living in 'functional' families (Williamson, Cox & Johnston 2004:2). A situation analysis was used for this study on account of its capacity to provide a systemic approach to children's situations and areas of vulnerability.

In this research, the situation analysis of children living in urban Bulawayo utilized the following two methods of data gathering.; 1) FGDs held by the researcher at the end of 2002 and in early 2003 and 2) a review of the various reports listed in Table 4.2 below. This situation analysis of children in Bulawayo is the most comprehensive one that has been conducted since 1998.

Table 4.2 shows the key elements included in the situation analysis of children in urban Bulawayo.

Elements of situation analysis for children in urban Bulawayo (for CHH research)				
Activities	Planning	Information gathering		Analysis
		Urban level	Suburb	
	Engage key stakeholders to define: -Scope -Geographical coverage -Process and participation	Review of following key reports and documents: - ILO 2002. HIV/AIDS and child labour in Zimbabwe: A rapid assessment - Khozombah, M. 1999. Highfield community-based foster care: Household survey - UNICEF 2002. Knowledge, attitudes, beliefs and practices: A baseline survey for the Government of Zimbabwe/UNICEF country programme of cooperation 02-04 - UNICEF 2001. A situational analysis of orphans and vulnerable children and adolescent in Zimbabwe - Child and Law Foundation 2002. State of denial, adolescent reproductive rights in Zimbabwe - SCF 2002. Desk study on sexual behaviour and reproductive health of children and young people in Zimbabwe. - GoZ 1999. Zimbabwe national orphan care policy - Wilkins 2003. Re-establishing family structures affected by HIV/AIDS; is there hope? - DSW 1998. Children of the cities, a situation analysis of urban orphans and children in difficult circumstance in Bulawayo - Focus group discussions and interviews with key informants	Focus group discussions Interviews with key informants	Identify: - most urgent problems - vulnerability degrees - causes - key aspects of context - service strength and gaps
Outputs	Process Plan	An overview of: <ul style="list-style-type: none"> • Problems and context of problems • Local responses, coping strategies, and capacities • Relevant laws, policies and services • Mapping of most seriously affected child populations • Service areas of existing programmes (coverage and content) 	- In-depth analysis of local context and support mechanisms - Refined information on coverage of existing services	Refined contextual information for Chapter 4, 6, 7, 8, 9 of this research

Table 4.2: Key elements of situation analysis for children in urban Bulawayo

Source: Adapted from Williamson (2000)

For the purposes of this analysis children were categorized according to types of vulnerability. 'Categorizing' children is potentially problematic, as it can stigmatize children and does not provide for holistic interventions. However, placing children in vulnerability categories was necessary in this research, for the process of systemic analysis. The following categories were used: children living in poverty, children affected or infected by HIV/ AIDS, children with disabilities, children exposed to political violence, 'street-based children', working children and all other children living in 'functional family' circumstances. These categories are not mutually exclusive. Often there are multiple overlaps. For example, a child can be affected by HIV and AIDS, be a working child and have a disability all at the same time.

As outlined in Chapters 1 and 2, children living in communities with a high prevalence of HIV/AIDS such as high density Bulawayo, are particularly at risk. Whilst striving to avoid duplication of the material covered previously, theories associated with specific 'categories' of child vulnerability will be briefly discussed followed by specific data on the situation of children falling within that 'category' in urban Bulawayo. Very limited reliable and current data is available on children living in Bulawayo.

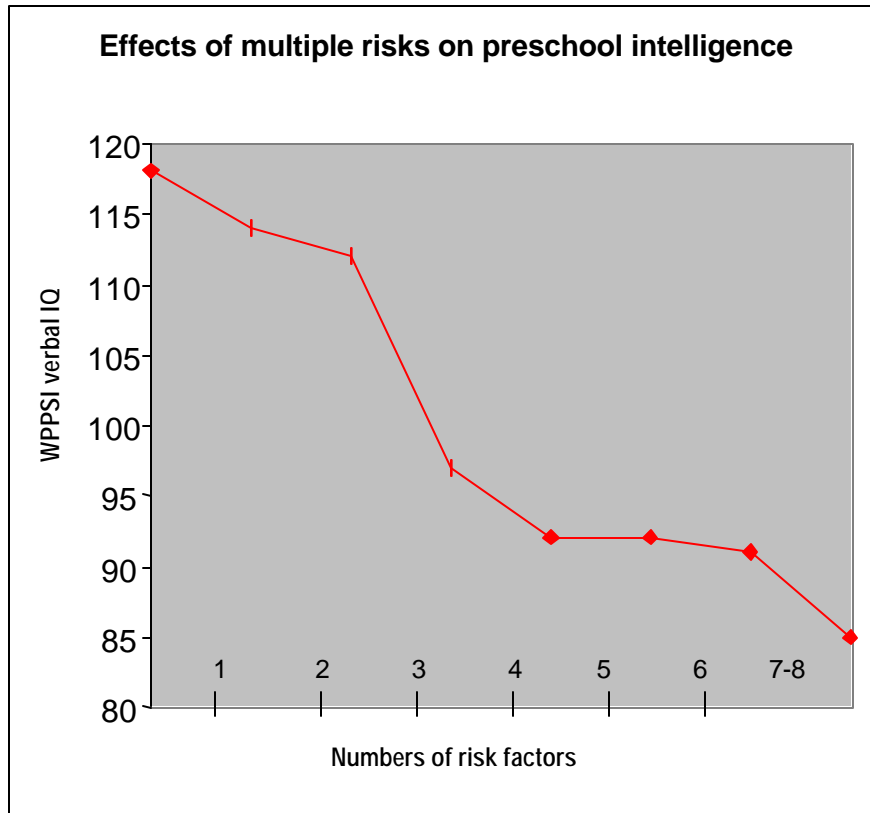
4.3.2 Children and poverty

Children of Bulawayo's urban affluent population, including the researcher's own children, grow up with the advantage of good education, recreation, health and nutrition. They have space, privacy and material well-being. By contrast, poor children experience multiple deprivations. Their health and nutrition are poor. Consequently their physical development is sometimes impaired. They may not attend school, or if they do, their attendance is often sporadic. Often the need for these children to contribute to the basic survival of their household conflicts with time for school, work and play.

'Poverty has been described as the new face of [*global*] *apartheid*: millions of people living in wretched conditions side by side with those who enjoy prosperity' (UNICEF 2000:44). The reasons for inequalities are multiple. There are macro-economic

policies and legislation which protect the interests of the wealthy, leaving poorer communities in abject poverty and deprivation (Montgomery, Burr & Woodhead 2003). World-wide inequalities have increased over the past two decades (Mc Dewitt 1998:5). Economic inequalities in Zimbabwe have escalated over the past four years due to the economic crisis. The standard of living for millions of unemployed or low-paid workers has drastically declined compared to high income groups and the small section in the population with diversified income sources or access to hard currency.

Several studies have shown how poverty and socio-economic problems impact on children's development. (Boyden & Holden 1991; Dodge, Pettit & Bates 1994; Garbarino & Kostelny 1992; Sampson & Laub 1994). The various ramifications of growing up in poverty are well documented. (Holzmann & Jorgensen 2000; Offord & Lipman 1996; Young 2002). Poverty impacts on children directly as well as indirectly (Sherman 1994). By reducing the quality of shelter, food, education, health care and recreation children are directly affected by poverty. Poor children often live in less safe and more hostile physical environments (Killian 2004:94). Indirectly poverty 'brings out the worst in parents who struggle to manage in often impossible circumstances' (Larner & Collins 1996:72). Multiple stress factors, such as financial difficulties, failing to provide for the family, feeling debilitated by the demand of coping with inadequate resources, make it difficult for parents to be sensitive and responsive to children's emotional and social needs (Duncan, Brooks-Gunn & Lebanov 1994; Hart & Risley 1995). Poverty exposes children to multiple risk factors. An accumulation of such risks jeopardizes their development (Sameroff, Siefer, Barocas, Zax & Greenspan 1987:347). Sameroff (1987) and his colleagues studied the relationship between socio-economic risk factors and children's mental development. Sameroff et al. (1987) found that children experiencing multiple risk factors as illustrated in Figure 4.4 below were at risk of mental retardation when more than two major risk factors were present.



Note: The WPPSI³⁴ verbal IQ is an individual administered test of the child's intelligence.

Figure 4.4: Effects of multiple risks on preschool intelligence

Source: Sameroff, Siefer, Barocas, Zax and Greenspan (1987:347)

Results from their research on socio-economic risk factors show that the average intelligence score of children remains good until the third risk factor is added which results in a significant drop of WPPSI Verbal IQ score to a level that may lead to mild mental retardation. It is plausible that this model applies to other domains of child development too. For children, living in poverty with a lack of social support, the loss of one or both parents may well be the last straw that plunges them irrevocably into a state of stunted development. Thus the longer children live in poverty, subjected to multiple risk factors the more severe the impact will be on their lives (Toomey & Christie 1990).

³⁴ Wechsler Pre-School and Primary Scale of Intelligence (WPPSI).

Within development literature in Western countries, as well as some development literature in other parts of the world (Tear Fund 1995:45), Maslow's (1971) hierarchy of human needs has been widely accepted and is consistent with human rights advocacy (Killian 2004:95). This model assumes that the most basic universal human needs are physical subsistence and shelter, followed by security and group support, self-esteem, respect, identity and belonging and finally self actualization (the need for creative involvement in productive activity). One set of needs must be satisfied before one can adequately consider meeting the next set of needs (Eitzen & Zinn 1994:9). For the majority of people living in poverty, it is likely that none of these basic needs are met. Maslow's model is increasingly being challenged (Illich 1992:89, Max-Neef, 1987, Kluckow, 2003). Based on Maslow's model, people living in poverty would be relatively unconcerned with a need for belonging or identity and even less concerned with self actualization, due to struggling to meet basic survival needs. The implication of Maslow's model that poverty inevitably leads to a narrow focus of concern has been found to be problematic.

Max-Neef, a Chilean economist and winner of the alternative Nobel Prize (Fisher 2003), has a radically different view of human needs stating that there is no hierarchy of needs as postulated by Western psychologists such as Maslow, apart from the need for sustenance. He believes that the 'first world's' materialistic view of human beings (Max-Neef 1987, Illich 1992:90) has contributed to increased global poverty. Max-Neef and his colleagues have developed a list of human needs (taxonomy of human needs) and a process by which individuals and communities can identify their 'wealth' and 'poverties' according to how these needs are satisfied. These needs are assumed to be constant across all human cultures and across historical time periods. The following ten human needs are identified: (see Table 4.3) subsistence, protection, affection, understanding, participation, recreation (including time to be idle), creation, identity, freedom and transcendence (spirituality). These needs are further classified according to the existential categories of being, having, doing and interacting.

Fundamental human needs	Existential category of human needs			
	Being (Qualities)	Having (Things)	Doing (Actions)	Interacting (Settings)
Subsistence	Physical and mental health	Food, shelter, work	Feed, cloth, rest, work	Living environment, social setting
Protection	Care, adaptability, autonomy	Social security, health systems, work	Co-operate, plan, take care of, help	Social environment, dwelling
Affection	Respect, sense of humour, sensuality, generosity	Friendships, family, relationships with nature	Share, take care of, make love, express emotions	Privacy, intimate spaces of togetherness
Understanding	Critical thinking capacity, curiosity, intuition	Literature, teachers, policies, education	Analyze, study, meditate, research, investigate,	Schools, families, universities, communities
Participation	Receptiveness, dedication, sense of humour	Responsibilities, duties, work, rights	Cooperate, dissent, express opinions	Associations, parties, places of worship, neighbourhoods
Leisure	Imagination, tranquillity, spontaneity	Games, parties, peace of mind	Day-dream, remember, idle, relax, have fun	Landscapes, intimate spaces, places to be alone
Creation	Imagination, boldness, inventiveness, curiosity	Abilities, skills, work, techniques	Invent, build, design, work, compose, interpret	Spaces for expression, workshops, audiences
Identity	Sense of belonging, self esteem, consistency	Language, religions, work, customs, values, norms	Get to know oneself, grow, commit oneself	Places one belongs to, everyday settings
Freedom	Autonomy, passion, self esteem, open-mindedness	Equal rights	Dissent, choose, run risks, develop awareness	Anywhere
Transcendence	Sense of belonging, spiritual health, communion	Peace of mind	Meditate, celebrate,	Anywhere, places of worship, places to be alone

Table 4.3: Max-Neef's taxonomy of human needs

Source: Adapted from Kluckow 2003:21

Probably, Max-Neef's most significant contribution to understanding human needs is his distinction between needs and satisfiers. Whereas needs are universal and function as an interrelated system, the way these needs are satisfied (satisfiers) can vary greatly over time and across cultures.

Satisfiers have different properties and can be categorized as destroyers, pseudo-satisfiers, inhibiting satisfiers, singular satisfiers, or synergetic satisfiers. Certain

satisfiers that ostensibly satisfy a particular need inhibit or destroy the possibility of satisfying other needs. For example, watching television, whilst satisfying the need for recreation, interferes with and inhibits creativity, understanding and identity. It is possible for needs and satisfiers to be confused. For example food and shelter are often regarded as needs, whereas in this model, they are satisfiers of the need for subsistence. Often there is more than one way in which a particular need can be satisfied. For example an infant's need for subsistence can be satisfied either through breast feeding or through the bottle. Satisfiers can meet a single need or operate synergistically. For example, bottle feeding as singular satisfier may only satisfy the need for subsistence, but breast-feeding can be a synergetic satisfier, simultaneously satisfying the infant's needs for subsistence, affection, understanding, participation, leisure, identity and freedom. Based on this model, resilience becomes internalized through synergetic satisfiers during infancy. This concurs with the work of various developmental theorists. For example, Bowlby (1980), found that the quality of care a child receives as an infant is directly linked with a child's resilience at age five and above.

Max-Neef concludes that each society adopts different methods for the satisfaction of the same fundamental needs. This is integral to the heterogeneity of different cultures. Max-Neef suggests that the types of satisfiers used within a particular group could even be conceived of as a defining factor of culture. For example, he states that 'we may go as far as to say that one of the aspects that define culture is its choice of satisfiers. Whether a person belongs to a consumerist or to an ascetic society, his/her fundamental needs are the same' (Max-Neef 1987:14).

Max-Neef's theory calls for a reinterpretation of the concept of poverty. Instead of defining poverty simply as living below a certain income threshold or Gross National Product (GNP) per capita, any human need that is not sufficiently satisfied is a form of poverty with the potential to generate pathology if left unattended for a prolonged length of time. Prolonged failure to satisfy the need for nutrition will lead to malnutrition; prolonged failure to satisfy the need for affection may lead to a mental

health problem such as depression. Based on this definition of poverty, the often discriminatory and stigmatizing concepts of 'poor people/countries' and 'rich people/countries' fade away. As applied to development, we are left with a view of a global mutual learning process among both 'rich' and 'poor' towards societies where human needs for all are addressed in a holistic manner.

Max-Neef's taxonomy of human needs was used as the framework for this situation analysis of children living in poverty. Based on this framework the summary in Table 4.4 (see below) was developed. Data for this framework was partly obtained from existing situational assessments of children living in poverty. However, these only provided information for the categories 'subsistence', 'protection' and 'understanding' (education). Data for other categories was derived from FGDs and interviews with key informants and applies to all children living in high density urban communities within Bulawayo.

Fundamental human need	Situation analysis of children affected by poverty in urban Bulawayo
Subsistence	<ul style="list-style-type: none"> - Infant Mortality Rate in Bulawayo (IMR) 65 / 1000 (HIV and AIDS accounts for 60% of child deaths (UNICEF 2001) - Family poverty indices based on Central Statistical Office (CSO) data (1998) estimates 52% of all families in Bulawayo as economically poor (42% poor, 10% extremely poor), by 2002 it is estimated that this figure had increased to around 80% of families in high density areas (most families without external remittance support from migrant labourers in RSA, UK etc.) - Main source of support for the child is 63% parent, 37% others (UNICEF 2001) - Weight-for-age malnutrition among children 30 to 35 months is 20% (UNICEF 1999), high levels of inflation in food costs, results in many children having only 1-2 meals per day - Formal unemployment is estimated at 72% but the majority of people are engaged in low income informal sector activities or casual labour - Over 55% of children living in poverty are facing problems with accommodation in the form of overcrowding, water and electricity cut offs and housing evictions due to non payment of rents (DSW 1998).
Protection	<ul style="list-style-type: none"> - Child immunization level estimated at 89% (UNICEF 1999) - Access to social welfare for children living in poverty is less than 8% (UNICEF 2001), social protection mechanisms are not functional due to staff and funding shortages within the Department of Social Welfare
Affection	<ul style="list-style-type: none"> - Corporal punishment is common and is believed to help children behave. It is explicitly allowed under section 15 of the constitution – even though it has been ruled unconstitutional for adults! (UNICEF 1999:48) - It is estimated that about 12% of children are facing physical abuse, including sexual abuse (no disaggregated data available, DSW 1998)
Understanding	<ul style="list-style-type: none"> - Primary school enrolment 91%, completion rate 79% (5% lower for girls) - Literacy rates 86% among males and 75% among female adults (both UNICEF 1999)
Participation	Children's participation in household duties is high. The culture of 'children are seen and not heard' is persistent and excludes most children in decision-taking processes that directly affect their life and future.
Leisure	The less economically stable a family is the more children need to work within or outside the household often resulting in children having no time for leisure.
Creation	Curiosity, creativity and imagination are not generally encouraged at home or within the education sector. However, some encourage children to engage in performing arts such as dance and drama as a leisure activity. Children living in economically disadvantaged households have little time for creativity. Their time is taken up with contributing towards meeting the basic needs of their household.
Identity	<ul style="list-style-type: none"> - Modernization and urbanisation continually impact on children; many children are first generation urban dwellers, living with parents who grew up in rural areas. This causes culture values and norm clashes especially among adolescents. - Many adolescents experience identity crisis related to urban, African, western, modern, traditional and gender roles. There is little support available for adolescents to resolve these conflicts.
Freedom	<ul style="list-style-type: none"> - Oppressive state institutions and legislation greatly impacts on freedom and civil liberties of children and youth. - State controlled media (radio, television and print) with no alternatives is inhibiting expressions of freedom and is undermining open mindedness. Any other opinion than state (ruling party) opinion is seen as enemy of the state
Transcendence	- The majority of children are encouraged by their caregivers and community to be active in religious practice. Often children are expected to choose and participate in the religious practice of their caregiver or guardian.

Table 4.4: Summary on child poverty in Bulawayo high density areas

Most assessments of children living in poverty in urban areas of Bulawayo occurred prior to 2001. Based on the rapid economic and social decline in Zimbabwe, it is likely that over the last 3 years child poverty has increased. Issues of how HIV and AIDS impacts on child poverty were not discussed in this section as they were discussed extensively in section 2.3.1.

4.3.3 Children affected or infected by HIV and AIDS

Broad issues relating to children affected or infected by HIV/AIDS were discussed in Chapter 2. Issues relating to CHHs in the context of HIV/AIDS will be discussed from Chapter 5 onwards. This section focuses on the general situation of children affected or infected by HIV/AIDS within the research area, including some limited data taken from existing assessments (DSW 1998).

Children affected by HIV and AIDS

At present, there are no reliable up-to-date estimates of the number of children affected by HIV/AIDS or orphaned by AIDS in Bulawayo. The last survey was conducted in 1997 (DSW 1998) and indicated that an estimated 77,581 children were living in difficult circumstances of which 18,465 were orphans. As issues around HIV/AIDS are still taboo in many communities, it is difficult to assess how many of the children living in difficult circumstances are affected by HIV/AIDS. However, as discussed in Chapter 2, it is likely that most children living in high HIV/AIDS prevalence communities are impacted at some level by HIV/AIDS. Even children who are not directly impacted (for example by death of a parent) are likely to be impacted by HIV/AIDS in more indirect ways. For example through losing a headmaster or an important community figure. Based on Children on the Brink 2004 data (USAID, UNICEF & UNAIDS 2004) we can do the following rough estimate (Table 4.5) of children directly affected by HIV and AIDS as per end of 2003 and estimates for 2010 for all of urban Bulawayo.

Year	Double Orphans (at least one parent died due to AIDS)	Total Orphans (including paternal and maternal orphans)
2003	33,600	78,400
2010	No data available	87,360

Table 4.5: Estimated number of children affected by AIDS in Bulawayo

Source: Adapted from Children on the Brink (USAID, UNICEF & UNAIDS 2004)

The situation of these children in urban Bulawayo is similar to those discussed in Chapter 2 and is not further discussed here.

Children infected by HIV and AIDS

No comprehensive survey has been conducted to determine the magnitude of the problem of HIV-infected children in Zimbabwe. Nor have longitudinal follow-up studies been done to determine the survival rate of these children. The Ministry of Health and Child Welfare estimated that by end of 1996 the cumulative total of children under five infected with HIV in Zimbabwe (including those who had died since counting started) was 111,000 (GoZ 1999b). For the age group 0-15 years, UNAIDS estimated that there were 57,000 children living with HIV/AIDS in Zimbabwe in 1997 (UNAIDS 1999c).

In August 2000 a count and clinical assessment by a paediatrician of all children in all Hospitals in Bulawayo was done to get data on HIV-infected children in hospitals (Nyathi 2001:39). Table 4.6 below shows that based on this study, it was estimated that 71% of all children admitted to Bulawayo's hospitals were HIV infected.

Facility	Total # of children admitted	Suspected clinically or proven infected	% Infected
Mpilo Children's ward	55	proven 20 suspected 9	53
Mpilo Chest Hospital	7	proven 6	86
Mpilo Nutrition Unit	18	proven 13 suspected 2	83
Mater Dei Hospital	8	proven 3	37.5
United Bulawayo Hospitals	23	proven 8 suspected 3	48
Total	111	proven 50 suspected 14	71

Table 4.6: Estimated children with HIV infection in urban Bulawayo hospitals

Source: Adapted from Nyathi (2001:39) (original table contained an error – corrected above)

It is noteworthy that the 37.5% rate of HIV infection among children in Mater Dei, a private hospital for affluent people is lower than the 48% rate of HIV infection at United Bulawayo Hospitals (UBH), a government hospital located in a low density area, which is itself lower than the 53% infection rate at Mpilo hospital's childrens ward, which caters for the poor in high density areas. This is an indication that HIV vulnerability in children is linked to household poverty levels. Table 4.7 summarizes situational data concerning children infected by HIV and AIDS in Bulawayo.

Issue	Situation analysis of children infected by HIV in urban Bulawayo
Access to antiretroviral (ARV) drugs	<ul style="list-style-type: none"> - The first ARV programme for HIV infected children and adolescents started at Mpilo Chest Hospital and UBH in July 2004. By end of September 2004 a total of 73 children were on the programme showing greatly improved health status (Dixon & Nyathi 2004). - Paediatricians are worried to disclose HIV status to adolescents out of fear of suicide by clients (Dixon & Nyathi 2004).
Use of Nevirapine for prevention of mother to child transmission	<ul style="list-style-type: none"> - Studies in Zimbabwe demonstrate that simple, inexpensive nevirapine treatment given at six month pregnancy and at the onset of labour seems to significantly reduce peri-natal transmission of HIV (Nyathi 2001:36). - When available, government hospitals in Bulawayo utilize nevirapine, but due to frequent drug shortages at government medical stores the programme is not consistent.
Mortality	Mortality in the absence of access to treatment among children infected by HIV is very high. It is estimated that in 20% of children the illness progresses rapidly leading to an early death. In 60-75% the illness has an intermediate or slow course until death and only 5-10% are long term survivors (Nyathi 2001:51).
Disclosure	<ul style="list-style-type: none"> - In most cases only the caregiver (49%) and child's father (21%) know about the child's HIV status. - Very often older children are not told about their status, this is highly problematic as it reduces their capacity to survive (Morgan 2004).
Health staff attitudes	- Although the majority of health staff (76%) report no change in their care attitude, it is of concern that over 19% of staff were identified as having become less friendly, less caring or less interested in HIV infected children. (Nyathi 2001:42).
Socio-economic conditions	<ul style="list-style-type: none"> - The majority of caregivers of HIV-infected children are single parents - Often parents are themselves physically unwell and therefore not able to adequately provide for the needs of the child. - A recent development is that HIV infected babies are abandoned, at present there are about 40 such children at Mpilo hospital (Burrows 2004). - The child may be unable to go to school or access health services due to lack of funds or as a result of being too ill to walk to the clinic or attend school.
Nutrition problems	- Over 45% of children infected with HIV report nutritional problems mainly due to poor appetite, insufficient food or sores in the mouth (Nyathi 2001:43).
Social support	<ul style="list-style-type: none"> - Social support systems are weak. The majority of caregivers (78%) are the main source of sustenance for the infected child. Support groups such as churches and community support groups provide support to 14% of HIV infected children. Only 8% of families with infected children receive social welfare support and such support is inadequate. - Knowledge of community level programme support is very low. 52% of caregivers are unaware of any available support. Only 23% report knowledge of church or community support groups whilst only (13%) of caregivers are informed about the Department of Social Welfare as a potential support (Nyathi 2001:55).
Psychosocial manifestations (Masiye 2004)	<ul style="list-style-type: none"> - Many HIV infected children live with ill parents and do not receive sufficient emotional support from their parents. - HIV infected children are often isolated from other children due to their caregiver's concern of transmission of infection. This isolation means children do not play enough and lose their friends. - Coping with a life threatening illness without adequate parental support can cause sadness and fear

Table 4.7: Situation of children infected by HIV in Bulawayo

Source: Adapted from Nyathi (2002:33-72) and Masiye (2004).

Presently in Bulawayo a comprehensive support network for children living with HIV and AIDS is lacking. Only recently have some groups begun addressing this gap (MMP-ZW Trust 2004:3).

4.3.4 Children with disabilities

The Inter-Censal Demographic Survey (CSO 1997) recorded a total of 57,232 children with disabilities in Zimbabwe (45,228 or 79% were from rural areas while 12,004 or 21% were from urban areas). In 2001 a limited study on children and adolescents with disabilities was conducted. The study included urban Bulawayo (Chimedza 2001:74). Based on this study the following Table (4.8) was developed to provide a summary of the situation of children with disabilities in urban Bulawayo.

Issue	Situation analysis of children with disabilities in urban Bulawayo
Disability prevalence	- It is estimated that over 4500 children and adolescents in Bulawayo have disabilities. The majority of them live in high density areas.
Causes of disability	- Over 60% of disabilities are caused by preventable diseases such as measles, polio, TB and malnutrition (pregnant mother). - 28% of disabilities are attributed to accidents or community or political violence. - Only 7% of children are disabled due to abnormal birth or heredity.
Family support community support	- Disability is still often seen as related to witchcraft, or people see the birth of a child with a disability as a bad omen to the family. As a result only 16% of caregivers receive extended family support, and only 9% receive community support to care for their child. - Most paternal relatives blame the mother for the disability of the child.
Education	- 73% of children with disabilities in urban areas attend school. The percentage of children not attending school is 27% for children with disabilities compared to 12% for other children. - Although many require special assistance, most children with disabilities are integrated into mainstream schools as special schools or support to ordinary schools do not exist. - Although the Zimbabwe Education Act has a non-discriminatory clause (Section 4 paragraph 2), the right of children with disabilities to education is not protected by law. In most countries this is standard practice.
Social support	- People with disabilities in Zimbabwe are not exempted from medical fees, costs for wheelchairs, prosthesis, hearing AIDS or assessment tests. - Only 6% of children with disabilities receive social welfare grants

Table 4.8: Children and disability in urban Bulawayo

Source: Study on child and adolescent disability in Zimbabwe (Chimedza 2001)

4.3.5 Children exposed to political violence

Communities in the research areas were exposed to ongoing political violence during the liberation struggle from 1970 to 1980 (Palmer & Birch 1992:10). They were exposed to further violence from 1981 to 1989 during the ethnic civil war in Matebeleland, with Bulawayo at the heart of it. Political violence only eased off when the unity agreement between the mainly Ndebele represented political party ZAPU and the majority Shona party ZANU was concluded (Stiff 2000:244). From 1989 up to 2000 political violence was low, only re-emerging during election periods. However, with the formation of the powerful opposition party, MDC in 2000, political violence in urban high density areas in Bulawayo intensified and still continues. Bulawayo and Harare are seen by the ruling party as opposition strongholds. State security agencies are utilized to weaken and undermine the opposition (Bond & Manyanya 2002).

Political violence in Zimbabwe has impacted on communities in a variety of ways. These include: through instilling terror, neighbours spying on one another, and the humiliation and degradation of ordinary citizens. Being exposed to such violence is detrimental to children (Garbarino 1992; Killian & Perrot 1994). Furthermore, communities exposed to chronic political violence have reported increases in all forms of violence, including criminal, sexual and domestic violence (Reeler 1994). It is well documented that trauma inflicted by humans, such as is the case of political violence, has more profound psychological consequences, including depression, psychosomatic complaints, excessive aggression and anxiety, than trauma caused by natural disasters (Malmquist 1986, Galante & Foa 1986, Punamäki 1983, Straker 1986).

The number of children that have been exposed to either direct political violence or indirect through witnessing acts of political violence in Bulawayo's high density areas over the past four years of Zimbabwe's internal conflict is unknown (Bischoff 2004). A considerable number of youth, especially males, aged 15 and above are involved in political activism exposing them to the risks of political violence as victims and at

times as perpetrators. Several cases of severe beatings during demonstrations or opposition political rallies by police and other state security agents have been reported by young males. Some young female opposition party political activists have been subjected to beatings as well as rape, including gang rape (Daily News 2002). Although speculative, it has to be assumed that a considerable number of children have witnessed acts of political violence in their communities. Some have had to experience the helplessness, powerlessness and humiliation of their parents being beaten up by security forces, or ruling party youth brigade members in their own homes. Experiencing one's parents as lacking the ability to protect themselves has been linked to origins of aggression and the desire by children for revenge (Gay 1988). Some children as a result may entertain fantasies of obtaining revenge or punishing perpetrators, especially if their mother was threatened (Machel 2001, Killian, Meintjes & Nhlengetwa 2001, Punamäki 2000).

Unfortunately it has to be anticipated that over the next few years the number of children exposed to political violence is likely to increase due to the ongoing volatile situation in Zimbabwe.

4.3.6 Street-based children

A commonly used definition of a 'street child' is 'any girl or boy who has not reached adulthood, for whom the street has become her or his habitual abode and/or source of livelihood, and who is inadequately protected, supervised or directed by responsible adults' (Inter-NGO 1985:2). A distinction can be made between children who are *on* the streets during the day but return home most nights and children *of* the streets who are homeless. For children *on* the streets but with homes to return to, family relationships are still in place although family support is weak. In contrast children *of* the streets are children without functional family linkages, who are homeless and sleep in the street (Taçon 1985:3-4). This distinction is important as in many urban areas in Africa there are large numbers of children *on* the street but the number of children *of* the street is relatively small compared with figures in Latin American cities (Butcher 1996:35).

Since street children are highly visible on streets of the world's cities, this issue has attracted global attention (Richter 1988:11) and remains an ongoing source of pressure for urban authorities. The phenomenon of street children is not new (Connolly 1990). It was already described in Charles Dickens' classic story of *Oliver Twist*, where he depicted life under the shadowy London streetlights of the 1800s. Often adults ignore street children or regard them as a social nuisance (Ennew 1994:13). Among child care professionals there is agreement that the most important and effective response to the phenomenon of street children is prevention (Bartlett, Hart, Satterthwaite, De La Barra, & Missair 1999:212). It has been noted elsewhere that children who slip through the traditional safety nets end up as street children or working children (Foster & Williamson 2000, Subbarao & Coury 2004:45). This research seems to indicate that community support for CHHs is a key preventative measure towards maintaining street children populations at low levels. By contrast, disintegrating CHHs would place children at significant risk for turning to the streets as their last resort for survival.

The situation of street children in Zimbabwe has been extensively described in two studies by the University of Zimbabwe (Muchini & Nyandiy-Bundy 1991, Dube 1998) and will only be briefly covered here in regards to the situation of street children in Bulawayo.

Reliable data on street children does not exist. The last one-off evening time headcount on street children was done in Bulawayo by the Bulawayo Task Force on Street Children in 1997 (Thuthuka 1997). Results of this survey showed that 173 children were found roaming the street. Of these 119 were males and 54 were females. Only 23% reported (self reporting) that they lived permanently on the street. The majority apparently spent time on the street, often accompanied by a disabled parent, begging and returned home late at night after restaurants and cinemas had closed (DSW 1998:45). There are seasonal fluctuations in the number of children

sleeping on the streets. There are fewer children permanently on the streets during the cold season from May to end of July than during the hot season.

The situation of street children in Bulawayo is summarized in the following Table (4.9) and is drawn from a study on street children in 2001 (Muchini 2001).

Issue	Situation analysis of street based children in urban Bulawayo	
Street children prevalence	- 260 children are estimated to be found in the street. The majority of them are boys. Around 25% of them might live off the street. (These are street children programme staff estimates as no count has been made since 1997)	
Reasons for being street children	- Majority are on the street to earn an income for the family (36%) - Abuse or other conflict in the home (26%) - Orphaned children (25%)	
Family community civil society and social service support	- Poverty and domestic conflict is the main factor responsible for street children. Family support is often weak and sporadic. Street children with family links receive better support from family if they are successful in raising a good income in the street during the day - Such children are predominantly perceived by the general public and the law as 'vagrants'. Thus police and social welfare tend to respond to them punitively. There are relatively few social welfare programmes for these children. - The following organisations support street children in Bulawayo: Scripture Union Thuthuka street children project (includes a family re-unification programme), Bulawayo task force on street children, The Shelter, Ethunzini Wethemba, Khayelihle CV, Department of Social Welfare and Zambuko Trust (Micro-finance for street children)	
Education levels of street children	Schooling Level	% of street children
	Never	26
	Grade 1-3	22
	Grade 4-7	38
	Form 1-2	9
	Form 3-4	4.5
Street children's economic activities	Begging	(45%)
	Guarding cars	(22%)
	Washing cars	(13%)
	Selling products	(15%)
	Escorting blind adults	(5%)

Table 4.9: Summary on street-based children in Bulawayo

Over the past four years, the prevalence of street children in Bulawayo has not skyrocketed as has been reported in the capital city, Harare (Dube 2004). Macro-economic factors would normally lead to an expectation of a massive increase, so this might be a sign that Bulawayo's community social safety nets, although fragile are still in place. Another factor could be prevention programmes put in place for

street children coming into Bulawayo from smaller towns. Based on a 1997 survey it was identified that a large number of street children were coming from smaller cities such as Mutare (600km away) and Masvingo (250km away). In response, Scripture Union started street children support and prevention programmes in both those cities (Saxton 2003).

Although they have their own specific problems, street children are a sub-set of working children. Therefore the issue of street children is closely linked with the ‘category’ of working children.

4.3.7 Working children

In most cultures, work is an important part of learning and socialization. As children grow, they have a strong desire for competence, which is satisfied through work as well as through play (Bartlett et al. 1999:189). For millions of economically deprived children around the world, work takes a heavy toll, physically, emotionally and intellectually. However, although many marginalized children are forced by unfavourable conditions to carry out some form of work to survive, such work is not necessarily exploitative (Byrne 1998:15). Anti-Slavery International (ASI 1996) describes the issue of child labour as a continuum, with grey areas in the middle as illustrated in Figure 4.5 below.

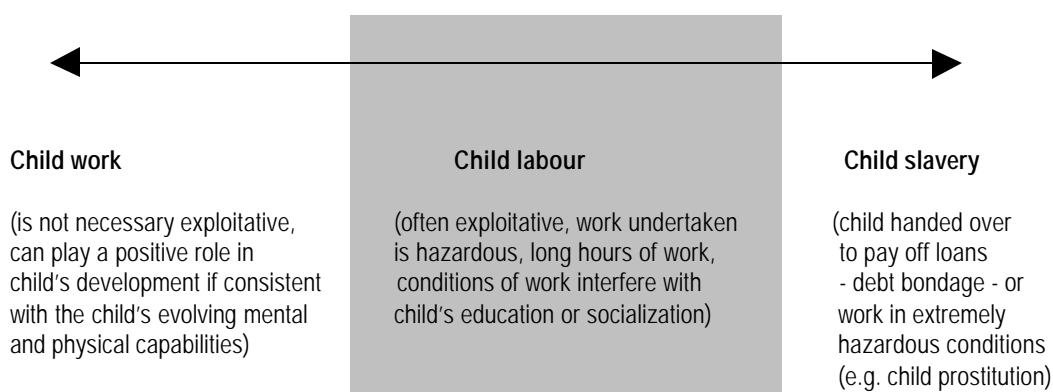


Figure 4.5: Continuum of child labour

The Convention on the Rights of the Child recognizes ‘the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child’s education, or to be harmful to the child’s health or physical, mental, spiritual, moral or social development’ (UNICEF 1990, Article 32.1). A limitation of this article is that it does not provide guidelines on what type of work and conditions are exploitative for children.

The International Labour Organisation (ILO) has developed various regulatory instruments that deal with child labour. Currently there are 27 ILO Conventions and 14 Recommendations concerning child employment (Byrne 1998:16). ‘The Worst Forms of Child Labour Convention’, 1999 (No. 182) provides a useful guide to determine what work and conditions are exploitative, especially in the areas of minimum age, working conditions and remuneration to name a few as summarized in Table 4.10 below.

Issue	Comment	ILO Instrument
Minimum age	<ul style="list-style-type: none"> - The ILO encourages states to develop policies to abolish child labour and to progressively raise the minimum ages when children can legally begin work. - The age should not be less than the age when compulsory schooling ends and in any event should not be less than 15 - Children aged 13-15 are allowed to be employed in ‘light work’ provided it does not affect their schooling 	ILO Convention No. 138, No. 182, Recommendation No. 146, No. 190
Working conditions	<ul style="list-style-type: none"> - The following areas are regarded as hazardous <ul style="list-style-type: none"> • Night-time work • Work requiring regular medical check ups • Occupations that are inherently dangerous - Convention 138 allows states to define what types of work might be dangerous, based upon their own international treaty commitments and current scientific data. 	As above
Remuneration	<ul style="list-style-type: none"> - The principle of equal pay for equal work should be applied, since cheap wages is one of the most significant reasons why people employ children. 	European social Chapter para. 13

Table 4.10: Summary on ILO position - key issues of child labour

Source: Byrne (1998)

Unfortunately ‘working children’ were not consulted and did not participate in the formulation of those conventions, articles and paragraphs. The battle against child labour began almost 150 years ago in Europe and North America. However, only recently have working children begun to participate in this process. Whereas

previously such children were viewed as pitiable and helpless victims, there is increasing acknowledgement of their potential to act as collaborators in the battle for children’s rights (Schibotto 2001:15). Since the 1980s, working children and adolescents of the ‘Third World’, especially Latin America, began paving the way for this new perspective (Liebel 2001:221). These youth powerfully expressed their views in a series of international meetings on working children. These were held by working children from 1996 to 2000. This accorded with The UN Convention on the Right of the Child (CRC). Based on Articles 12-14, children have a right to express their views on issues affecting their lives. Table 4.11 summarizes key statements from these meetings.

Declaration	Key statements made by working children
1 st World meeting of working children, Kundapur, India 1996	<ul style="list-style-type: none"> - We are against the boycott of products made by children. - We want respect and security for ourselves and the work that we do. - We want an education system whose methodology and content are adapted to our reality. - We want to be consulted in all decisions concerning us, at local, national or international level. - We want the root causes of our situation, primarily poverty, to be addressed and tackled.
World meeting of working children, Huampani, Peru 1997	<ul style="list-style-type: none"> - YES to work – NO to exploitation - YES to dignified work – NO to undignified conditions - YES to work – NO to marginalization - YES to work – NO to discrimination
African, Latin American and Asian working children movements meeting, Dakar, Senegal, 1998	<ul style="list-style-type: none"> - We demand a place in ILO conferences that deal with child labour - We are against prostitution, slavery and drug-dealing which involves children. These are CRIMES and not WORK. Policy makers should make a clear distinction between what is work and what is crime. - We fight to improve the standard of living and the work of children throughout the world. - We fight against hazardous work and the exploitation of children throughout the world.
Meeting of the African movement of working children and youth, Bamako, Mali, 2000	<ul style="list-style-type: none"> - We ask authorities and international institutions to listen to us, to encourage us and to support as much as they can. - We fight against child trafficking, because a child is not merchandise. - We fight against poverty that forces children into leaving their villages and families, going to cities seeking for jobs. - We ask African children and youth to join us because the more we are organised, the quicker Children's Rights will progress and be respected.

Table 4.11: Summary statements from international meetings held by working children

Source: Adapted from working children’s protagonism (Liebel, Overwien & Recknagel 2001)

Working children are experts on their own lives. Their views need to be taken seriously. Regrettably this is still not happening. The most recent and gravest

example of failing to ensure working children's participation was the ILO consultation process concerning 'the prohibition and immediate elimination of the worst forms of child labour' in June 1999. Despite intensive efforts of working children's organisations to participate, they were kept from bringing their views into the debate and were hindered in taking part in the final decision taking process (Liebel, Overwien & Recknagel 2001:11). It is therefore not surprising that the final text of this ILO convention is full of paternalistic features, viewing children's work only in its negative aspects. Furthermore, it is not planned that children will take part in the formulation of measures at the implementation (national) level. Liebel et al. (2001:11) pointedly state 'it will require even more persistent power and many small steps, before working children, and with them all children, obtain the respect and the influence they are entitled to'.

After discussing issues of working children in general, the following section will look at the situation of working children in Zimbabwe and in urban Bulawayo in particular. The situation is analysed using an ILO (2002) rapid assessment on the situation of HIV/AIDS and child labour in Zimbabwe and the report on the National Child Labour Survey (1999) and the situation analysis of urban orphans and children in difficult circumstances in Bulawayo (DSW 1998) as they are the most recent studies on the subject of child labour in Zimbabwe.

Zimbabwe, as a full member of the United Nations has signed and ratified various conventions and protocols relating to working children. The Convention on the Rights of the Child (CRC) was signed in 1991. In 2000 Zimbabwe signed two further agreements concerning the rights of children. These were the ILO convention on Minimum Age 1973 (No.138) for which Zimbabwe specified the minimal age for admission to light employment as 14 years; and the Worst Form of Child Labour Convention, 1999 (No. 182).

According to the ILO, a person spending at least one hour a day on any activity for pay or family gain (including unpaid family work, e.g. on a plantation), is described as

economically active. The Ministry of Public Service, Labour and Social Welfare has introduced two major differences to the ILO definition, specifically:

1. A person must be seen for more than 3 hours per day as engaged in income generating activities before being considered 'economically active'.
2. A child engaged in domestic duties must work for more than five hours per day before it is considered 'child labour'.

In assessments on child labour in Zimbabwe it is important to consider changing day time and seasonal patterns. In order to manage with limited national resources, public school sessions are limited to half a day. As a result, there are more children working in the afternoon than in the morning. Secondly, at the beginning of each new school term, the number of children engaged in economic activities is increased as they are forced to work to raise the necessary school fees and levies (Dube 2001:133).

The National Child Labour Survey (1999) reported that over 49% of children aged 5-14 years were economically active using the Ministry's cut-off criteria stated above. Based on ILO criteria this figure would have been even higher. This high number is an indication that the impact of HIV/AIDS and the negative macro-economic environment (discussed under 4.2.2) undermines the primary caregiving capacity of the family to offer material support to children.

In Zimbabwe the following areas where children are found working have been identified (Dube 2001:107):

- In the rural peasant economy as part of the family work force of rural subsistence farming.
- On commercial farms and resettlement farming areas including cattle ranching.
- In middle and high income urban and rural households as domestic workers.

- In the urban informal sector and as street vendors.
- In small scale mining operations working alongside adults.

The particular situation of working children in urban Bulawayo is summarized in the following Table (4.12) based on the researchers own observational data and by analyzing study reports mentioned above.

Issue	Situation analysis of working children in urban Bulawayo
Urban child domestic workers	<ul style="list-style-type: none"> - Majority of non-formal employed domestic workers are children aged 13 and above. - Often they work very long hours (10 – 15 hours), often receiving only boarding in compensation. - Generally girls are preferred for domestic work (90%). Their powerlessness within the household makes them highly vulnerable to sexual abuse, both by males within the household or from visiting males. - Their conditions force these children to lead a marginal and impoverished way of life (Sachikonye 1989:45).
Urban informal sector	<ul style="list-style-type: none"> - Over 40% of vulnerable children are reported as being daily involved in economic activities to support the household. - Economic activities include begging, washing cars, casual labour in construction work and street vending. - The majority of children are engaged in street vending (97%). Merchandize includes vegetables, eggs, sweets, cigarettes etc. - Children are not ashamed of their economic activities and value their work.
Reasons for engagement	<ul style="list-style-type: none"> - To generate economic support for the family. - Caregivers' failure to pay for school fees results in children working for their fees. - To get pocket money to buy things for themselves.
Average age of entry	<ul style="list-style-type: none"> - Most children start with 'economic activities' outside of their household between the ages 7 to 11.
Family and community response as perceived by working children	<ul style="list-style-type: none"> - Children feel that caregivers treat them better when they contribute towards the family income. - The majority of working children (58%) perceive the community as indifferent to them working, 25% feel a positive community response and the rest sees their engagement in work as a nuisance and disturbance.

Table 4.12: The situation of working children in urban Bulawayo - summary

As will be discussed in the following chapters, all CHHs participating in this study fall into the 'category' of working children. All CHHs are forced to work in order to meet their daily needs.

4.3.8 All other children in the community

The ongoing socio-economic decline in Zimbabwe, in which GDP has registered negative growth of 27% over the last 3 years (Zimbabwe's economic woes spread 2003) has had a negative impact on most children in urban Bulawayo's high density areas. The lack of government investment in health, education and social welfare, combined with massive migration of health, education and social work professionals to other countries has caused a significant decline in the quality of life for all children. This includes children living in relatively 'stable' family environments. Circumstances have been made even more difficult on account of high inflation rates for food and other essential products and the loss of employment opportunities for breadwinners.

The following section discusses child support mechanisms, focusing on different agents, roles and their ability to reduce child vulnerability and support those in need for care and support at family, community, civil society and government level.

4.4 Child support mechanisms

To mitigate the negative impact of adversity on children, most societies have developed child support mechanisms. The following section provides a review of such mechanisms. An important purpose of this review is to help identify gaps or weaknesses in social safety nets. Support mechanisms for CHHs are not discussed in this section as they are analysed in the following chapters, especially in Chapter 8.

4.4.1 Family support mechanism

Family support is still the front line response for orphans and vulnerable children. Agencies or the state 'are not a good parent' (Blair 2004) and are unable to replace family and community care and support.

As discussed in Chapter 2, traditionally paternal relatives took care of orphans and other vulnerable children when a father, mother or both were no longer able to

support the child (Chipfakacha 2002:2). However, today in urban Bulawayo, most orphaned or vulnerable children are cared for by relatives on the maternal side (DSW 1998:26). This shift was influenced by modernisation and urbanization processes that have taken place over the past 30 years. Today the primary caregivers for most vulnerable children are a maternal grandparent or relatives.

Family support in the research area is greatly undermined by poverty caused by high levels of unemployment and economic decline. In a study, over 84% of caregivers of OVC were either unemployed or self employed in the informal sector (DSW 1998:26).

4.4.2 Community support mechanisms

Negative reporting in the media, through sensational incidences of lack of community support could give a general impression that community support to orphans and vulnerable children no longer exists in urban communities in Southern Africa.

Although the traditional concept of 'everyone's child', discussed in Chapter 2 does not fully fit into the urban context, this does not mean that community members are not concerned about the welfare of children in their community. On the contrary, it was clearly articulated in various focus group discussions and key informant interviews that the majority of people in urban high density areas are concerned about orphans and vulnerable children. The Bulawayo urban communities seem incredibly resilient and able to form solidarity groups in support of vulnerable children. This is seen by the number of residents associations, home-based care task forces, church groups and burial societies, all of them community support groups who are taking on the additional role of supporting families with vulnerable children. These community organizations play a critical, yet often overlooked, role in addressing the devastating impact of HIV/AIDS and the present crisis on children and families. These responses often have a low profile and are not easily identifiable. Table 4.13 shows the main community support responses in the study area.

Response	Description
Neighbour support	<ul style="list-style-type: none"> - If neighbour relationships are friendly, neighbours often provide informal day care support to families. - Neighbours visit when family members are ill, offering support in child care. - Neighbours support caregivers with limited basic food commodities during times of severe hardship.
Women's groups	<ul style="list-style-type: none"> - Some women's groups run day care or child care services for their members. - A number of groups have started visitation programmes with volunteer women visiting families with OVC to provide care and support on a regular basis.
Residents associations	<ul style="list-style-type: none"> - Identify families with vulnerable children and assist them when such households face housing problems. - Assist in enrolment for social welfare or other form of external assistance.
Church groups	<ul style="list-style-type: none"> - Provide ongoing support to caregivers of OVC (more detail in section 4.4.3 below)
Home-based care task forces	<ul style="list-style-type: none"> - Although linked and supported by city council clinics, the HBC task forces are part of a volunteer community response and support mechanism. Most of these groups have in-depth knowledge on vulnerable families and children. - The HBC task forces have OVC registers in place and visit families with OVC on a regular basis for child monitoring and support.
Burial societies	<ul style="list-style-type: none"> - Members of burial societies support each other in times of difficulties and not only in the context of death and burials. - Such clubs function like credit and savings mechanisms for members with strict rules, enabling members to mitigate short term crisis at the household level. This often helps to mitigate the impact of a crisis on children within the household.
Youth (kids clubs)	<ul style="list-style-type: none"> - Youth within the neighbourhood or street know well which children need support. - Caring youth at community level encourage other youth to be involved in supporting children. - With the support of YOCIC (see section 4.4.3) youth in urban high density communities started and run Kids Clubs in support of vulnerable children. Over 25 such clubs for over 3000 children exist in Bulawayo. 14 of them are located in the study area.

Table 4.13: Community child support mechanisms in study area

Given the importance of religious groups in community responses, the next section focuses entirely on this community group.

4.4.3 Faith-based community responses

A study conducted by Religions for Peace and UNICEF in six African countries showed that over 90% of local faith-based organizations (FBOs) surveyed provide some type of support to vulnerable children (UNICEF & WCRP 2003; Religions for Peace 2004:1). FBO responses are increasingly recognized as key strategies for rapidly expanding support to millions of orphans across Africa. The 650 organisations that were surveyed in the above study, were found to support a combined number of over 150,000 vulnerable children. Furthermore, they had mobilized a combined number of more than 9,200 volunteers to provide care and support. Most of these

groups were working almost entirely without external funds, relying on the contributions and time of their own members and communities.

Table 4.14 below provides an overview of FBO child support responses in Bulawayo. Two key organizations, Hope for a Child in Christ (HOCIC) and Youth for a Child in Christ (YOCIC), will be discussed in greater detail in the following text.

FBO	Description
HOCIC	<ul style="list-style-type: none"> - Umbrella capacity building networking organization with presently 25 participating denominations and programmes to scale up OVC support. - Major denominations (Catholic, Anglican, Lutheran Church, Methodist, Baptist, Salvation Army, Brethren in Christ, Zimbabwe Council of Churches etc.) are represented in HOCIC.
YOCIC	<ul style="list-style-type: none"> - Youth mobilization in support of OVC at community level through Kids Clubs and youth leadership development.
Bongani Orphan Support Trust	<ul style="list-style-type: none"> - Large OVC response from the United Church of Christ Southern Africa (UCCSA) in Njube area in Bulawayo. - The programme is affiliated to HOCIC through UCCSA membership in HOCIC. - Volunteers at congregational level are identified and trained to visit twice per week families with OVC to provide monitoring, care and support. - Integration of material, social and emotional support into programme.
Samekele	<ul style="list-style-type: none"> - A programme of Youth for Christ focuses on abused or abandoned children. - Programme provides teenage pregnant mothers a crisis centre and a short term place of safety for abandoned or abused children (family tracing in place).
The Shelter	<ul style="list-style-type: none"> - A church response for vocational training and skills training for vulnerable school leaving children.
Islamic Aid, Seven Day Adventists, Jewish Women's Society, Latter-day Saints, Sai Baba, Jehovah Witness	<ul style="list-style-type: none"> - Groups who provide at times mainly material support to community OVC programmes. - They have no clear programme plans or strategies in place. - Often target OVC among their own members or work within specific geographical areas. - Raise funds for other community groups who support children.
Salvation Army Masiye Camp	<ul style="list-style-type: none"> - Provision of psychosocial support for children through camps (discussed in 6.4.2 as the organisation is a pioneer in psychosocial support issues).
Scripture Union Thuthuka Project	<ul style="list-style-type: none"> - Work with street children through a contact centre, vocational training centre and a family reunification programme.

Table 4.14: Overview of faith-based child support responses in Bulawayo

In Bulawayo, FBO leaders started in 1994 to coordinate their efforts in support of orphans and other vulnerable children (Germann 1994). Notably the Roman Catholic Church, The Salvation Army and the Brethren in Christ Church, who all had started their own orphan and vulnerable children support programmes, rallied together to form an interdenominational association that networks among church congregations to scale up support to OVC. As a result of that effort, Hope for a Child in Christ

(HOCIC) was established in 1995 and got registered as a Private Voluntary Organization. The researcher was instrumental in the formation of this umbrella organization. Today, 25 denominations are active with in excess of 50,000 children supported in the various church support programmes in Bulawayo and both Matabeleland North and South Provinces. The organization has the following objectives (HOCIC 2004:1):

- To create awareness of the need for community-based orphan care;
- To promote and provide loving care for orphaned children;
- To co-ordinate different approaches for its members so as to maximise the use of limited resources;
- To manage the network of community based care programmes so as to mobilize and share community resources;
- To provide members with technical support and advice in setting up new or strengthening existing support programmes.

This capacity building and networking umbrella organization has made considerable progress over the past six years and has achieved among other things 1) training over 2,600 adult caregivers in psychosocial support and child care to work as programme volunteers; 2) setting up of kids clubs for hundreds of children, and 3) directly strengthening the social safety nets for at least 12,000 OVC in Bulawayo.

In the research areas HOCIC members run church community based orphan care programmes. Some of the participating CHHs in this study are supported by HOCIC member programmes.

Youth for a Child in Christ (YOCIC) is an offspring of HOCIC but since 2000 has operated as an independent organization. At present it has a membership of over 300 young people. It is an interdenominational youth movement that facilitates and provides psychosocial support for orphans and vulnerable children in communities and child institutions in the Bulawayo area (YOCIC 2004:1). YOCIC has been

operating 25 community Kids Clubs for over 3,000 children. This programme seeks to enhance the coping ability of young people, particularly orphans and other children made vulnerable by HIV/AIDS, through life skills training and capacity building. They are further engaged in developing leadership for young people to mobilize support of OVC at a local level. Many CHHs are participating in Kids Club activities and are supported by other youth in managing their households.

4.4.4 Civil society - NGOs and child welfare forum

Compared with the capital city Harare, Bulawayo seems to have a strong civil society response to child support (Dhlembeu 2003). Table 4.15 gives an overview of key stakeholders engaged in child care and support.

Organization	Description and focus
Child Welfare Forum	- Is a coordination platform for all child care and protection stakeholders in Bulawayo to share and network. The Department of Social Welfare is supposed to provide the secretariat function. (Discussed in greater detail under 4.4.5).
Revival of Hope	- Founded by a charismatic woman with a concern for orphans, the organisation focuses on community support and skills training for orphans. - Strong in local fundraising but weak in administration and management. - There is need for organisational development support to improve programme results in support of OVC.
SOS Village and Community outreach	- The international SOS Village group operates one SOS village in Bulawayo for 60 children. - SOS has embarked on a community child care programme focusing on providing support to at least 2000 orphans and vulnerable children in the Makokoba high density area.
CRS Strive	- Catholic Relief Services is a US based welfare organization. Under a USAID supported programme (STRIVE) they set up office in Bulawayo with the aim to support FBOs in care and support of OVC.
Zimbabwe Child Welfare Society	- Has no support programme any longer but uses some of its own trust resources to make small donations to children's homes or community support programmes. - They have indicated interest to re-strategise their activities towards becoming a 'community foundation' for small grant making to community OVC programmes.
Council for the Welfare of Children	- Unclear what their role is as they have no traceable programme on the ground. - Might be part of the other numerous organization that are still registered as child support organizations with the government but are no longer functional or are only 'postal box' organizations.
Family Impact	- Organization that supports and strengthens families with better parenting skills through training and material dissemination for improved parenting.
Bulawayo Legal Project Centre	- Provision of legal support to children and youth, CHHs benefit from their support especially in housing disputes etc. - support with inheritance conflicts - Provide support to OVC community and FBO programmes when they need legal support for children in their programmes.
Western Region Community Foundation	- Manages and implements child care and support programmes on behalf of external donors as an intermediary community foundation. - Attractive option to provide small support grants to many community groups. - Their relatively high management fees are of concern. - innovative community philanthropic approach but lacks local contribution component

Organization	Description and focus (continued)
Zinatha	- The association of traditional healers in Zimbabwe supports community groups who work with infants and children infected by HIV/AIDS with advice on the use of low costs herbal remedies to reduce/treat opportunistic infections.
Samaritan	- Support to children who have alcohol problems.
King George VI	- School and life skills education for children with physical and mental disabilities.
Plan International	- Peri-urban community development support (Hyde Park area) towards an improved community and family environment for all children.
Island Hospice	- Support to bereaved or terminally ill children.
Matabeleland AIDS Council (MAC)	- Support to families and children affected by HIV/AIDS. - Orphan care support through MAC Home Based Care programmes. - Peer education programmes for HIV/AIDS prevention. - Free Voluntary Counselling and Testing for Children and youth.
Jairos Jiri	- Support to children with disabilities. - Skills training centre for children with disabilities.
Contact Family Counselling	- Counselling support to abused children, suicidal children and any other children in need for direct counselling including grief and bereavement counselling.
Specialist organizations	- Various service and support organizations that provide specialist services to adults e.g. council for the blind, offer their services and support to children if they fall within their specialist support criteria.

Table 4.15: Overview of NGO child support responses

The above overview does not claim to be comprehensive but lists all the important agencies providing support services to children within urban Bulawayo. Although weakened due to the non functioning of the child welfare forum, collaboration among child support agencies in Bulawayo is good.

4.4.5 Government responses

Between 1996 and 1998 the Department of Social Welfare with the support of Redd Barna (Norwegian Save the Children Fund) and UNICEF, established national, provincial and, in some districts, child welfare forums (CWF). The CWF are defined as 'a body formed by all/some child related organizations (Private Voluntary Organizations and Government Ministries under the guidance and leadership of the Ministry of Public Service, Labour and Social Welfare). The CWF plays an advisory role to the ministry. It monitors the situation of children at all levels and responds accordingly' (GoZ 1999a:vi).

The CWF created a unique and powerful platform for all child care and protection stakeholders at either national, provincial, district and even village level to be

engaged in monitoring, advocacy, networking, training, responding and joint situation assessment or research.

The role of the CWF is endorsed in the approved Zimbabwe National Orphan Care Policy. Whilst the policy looks at the financial implications of the CWF to the fiscus, this section in the policy document is flawed. The main role of the CWF is coordination and networking, but there has been no budget provision for these two activities. Budget provision for the CWF included only direct service costs to children in the area of education such as costs of uniforms and exam fees (GoZ 1999a:14). It is therefore unsurprising that four years after the policy had been endorsed most CWFs are no longer operational. But lack of funds for coordination was not the only constraint. Most of the social workers that initially were trained as provincial CWF coordinators (financially supported by Redd Barna) have left the country, participating in the professional skills 'exodus'. This has seriously undermined the government's capacity to respond to vulnerable children in their main capacity as coordinator of a collective support response.

Table 4.16 summarizes the role played by different government organizations in supporting children.

Government agency	Function and service
Ministry of Education	- has statutory mandate to provide primary and secondary education for children in Zimbabwe
Ministry of Higher Education	- is responsible for higher education such as vocational training, polytechnic and university education
Ministry of Justice	- established child & victim friendly courts to support children in court proceedings
Ministry of Public Service, Labour and Social Welfare	- provides the Basic Education Assistance Module (BEAM) to over 690,000 vulnerable children. BEAM is strongly criticized as an expensive bureaucratic response. Resources would be better allocated to abolish all primary school fees and levies and introducing a non school specific uniform to cut cost - provides minimal social assistance (approx. USD 2 per month) to 935,000 families (Administrative cost to deliver such assistance is over 100% of actual assistance received!)
Ministry of Health and Child Welfare	- birth and infant health services - immunization services - health services through ordinary clinics and hospitals (2 government Hospitals in Bulawayo have paediatric units) - mental health services for children - AIDS levy (3% on employees tax) to support National HIV/AIDS policy includes some child support to some of the district grant support allocated
Ministry of Home Affairs	- Support to children via Police. Police stations and other public places have suggestion boxes that are frequently used by children in distress. - issuing of birth and other identify documents (is often difficult to obtain, especially for orphans and vulnerable children when some documents are missing)

Table 4.16: Overview of government support to children in Bulawayo

The ongoing crisis in Zimbabwe undermines the government's ability to fulfil its statutory mandates aimed at supporting children and destitute, let alone taking on any new initiatives or provide leadership to improve the quality of life of children in urban areas. At present monthly social support grants for the destitute are ZWD15,000 (approx. 2 USD), whilst the poverty line is calculated at ZWD 750,000 (approx. 100 USD) per month. It is not anticipated that the situation will change within the near future. This has serious consequences for child support mechanisms as the role and leadership of government is critical to make an impact on the required scale. NGO and civil society actors are being forced to upscale their small programmes to reach ever larger numbers of children. This is very challenging as neither internal nor external resources for such expansion are available.

4.5 Summary and conclusions

Macro-and micro-systems impact on the social ecology of an individual child. To understand the social ecology of CHHs in a Southern African, high HIV/AIDS prevalence, urban community various factors need to be considered. These include the socio-economic situation as well as historical and cultural factors. This chapter included an analysis of the history and present socio-economic conditions in Zimbabwe. The role of an ineffective government in Zimbabwe was highlighted. 'Zimbabwe's crisis is not a crisis of land, or a colonial crisis, it is a crisis of governance' (Tsvangirai speaks on 2005 elections 2004). It was argued that the crisis in Zimbabwe impacts negatively on all children. However, already vulnerable children are particularly at risk, in terms of adverse effects of this crisis thereby increasing their vulnerability further.

This chapter provided a brief discussion on the link between culture and social behaviour. This included an elucidation on how cultural and social safety nets are interlinked. Cultural factors affecting CHH research within the study area were identified. The chapter then provided a situation analysis on children and child support mechanisms in urban Bulawayo. This included an analysis on child support mechanisms. The gap in coordination and networking among child agencies, due to governments failure to provide leadership in this area, was highlighted. The issue of the collapse of the government's social welfare system was also addressed. It is critical for civil society to compensate for the absence of government child support mechanisms. This is particularly necessary, since it is unlikely that over the next five years government child support mechanisms will improve significantly.

The following chapter will provide individual case studies of CHHs who participated in this research. These household profiles will give insight into the daily lives of CHHs and provide material for the analysis of their coping mechanisms.

5 Case studies of child-headed households

I am too young to do all those things on my own.

Nompilo, 17 years old, Old Pumula

5.1 Introduction

This chapter presents case histories of three heads of CHHs. The chapter first delineates the methods used for documenting these case histories. This is followed by the actual case histories. The case histories presented in this chapter are intended to provide an in-depth view of how CHHs are formed and what it means to head and live in a CHH. A longitudinal view of approximately three to five years from the onset of parental illness until the end of contact with the research team is taken. This forms a background against which the overall findings of this study are analysed. Chapters 6 to 9 discuss the overall results of the fieldwork component of this study.

Participants who appeared representative of different types of CHH were selected for these three case histories. The first case is Future, a 19-year-old female. At the time of research Future was employed. She also received limited but regular external support from her father's former employer. The second participant is Nompilo, a 17-year-old female living with an elderly grandparent in need of care. The last case history is Bongani, a 17-year-old male. Bongani is HIV positive. At the time of research he was without external household income. His family were depending on his informal sector income-generating activities. These case histories are intended to reveal important factors influencing coping in CHHs. These include social connectedness, financial resources, community and neighbourhood support, siblings' interactions and peer responses to CHHs.

5.2 Methods of documentation

During the course of the study, the researcher met with all participants. The researcher then identified three participants representing different types of CHHs by analysing the biographical data gathered in the initial baseline quality of life assessment WHOQOL-BY (see section 3.5.7). By early 2004, a number of 'narrative

interviews' and 'hero book processes' had been conducted with these selected participants.

Narrative interview

Narrative interviews are mainly used in the context of biographical research (Flick 1999:99). Schütze (Riemann & Schütze 1987) introduced the narrative interviewing method. Hermanns characterizes narrative interviews as follows:

In the narrative interview, the informant is asked to present the history of an area of interest, in which the interviewee participated, in an extempore narrative... The interviewer's task is to make the informant tell the story of the area of interest in question as a consistent story of all relevant events from its beginning to its end (Hermanns 1991:183).

Narratives are powerful as they are responsive to the processes by which the structure and 'gestalt' of experiences are made. They reconstruct the internal logic of participants' perceptions. However, this method does have the following limitations: 1) Narrative and experience are put into an analogous relationship. This is problematic as the story presented in the narrative may be influenced by memories of earlier events or events not related to the area of research interest. 2) This method inevitably results in large amounts of textual material in the transcripts of narrative interviews. This mass of mainly unstructured text is laborious to consolidate and challenging in terms of analysis and interpretation (Flick 1998:106). However, despite these limitations, narratives provide a valid method for obtaining authentic case material.

Hero book

Hero books were developed as a form of narrative therapy by Jonathan Morgan (REPSSI, formerly with University of Cape Town). The method was initially developed as an intervention for children affected by AIDS. It is part of a 'memory work' methodology. Morgan (2004) describes 'memory work' as follows:

The deliberate setting up of a **safe space** in which to contain the telling of a life story. This **space** might be a **room**, the **shade of a tree**, a drawing or a map, or a **memory box, basket or book**. In therapeutic contexts, the scope of memory work is not necessarily restricted to the past, its purpose is often to deal with difficulties in the present, and its main orientation often tends towards planning and the **future** (Morgan 2004:36).

Memory work has been used in the context of supporting children affected by HIV/AIDS primarily as a communication tool between children and parents/caregivers.

The theoretical foundation of hero books is found in narrative therapy and 'externalisation discourses' developed by White and Epston (1990, 1999). Hero books include expressional art, projective drawing and story-telling. They involve a process where the child or youth is invited to be author, illustrator, main character and editor of a book. A story is created where the hero (the child or youth) obtains power over an identified challenge in his or her life. A primary aim of hero books is to promote a sense of power over this identified challenge (Morgan 2004:38). Hero books have been used as a therapeutic strategy or form of psychosocial support to address behavioural, emotional or social problems of children.

The case studies to follow were constructed using the hero book process as well as semi-structured interviews. The hero book process was complementary to the narrative interview described above. The three case histories were based on interpretations of both texts. There do not appear to be any previous studies using this combination of research methods. Based on results from this research, this innovative approach is recommended for qualitative participatory data collection. Besides being an excellent means for collecting authentic case material, the combination of narrative interviews and hero book making appeared to have therapeutic value for participants. It is recommended that further studies are conducted using this approach.

An important step in the hero book process, when used as a research tool, happens after the child has drawn and explained a whole series of drawings based on structured drawing instructions. The researcher then retells the hero story back to the child, preferably in written form. This becomes the introduction to the hero book. This text stands beside the child's own words which are explanations of the series of drawings. This validation process enhances the quality of the case history. The full process takes around 10 to 15 hours depending on the literacy level of the child/youth and is ideally done over a period of a week in two hour sessions. The three participants of the case histories for this chapter enjoyed the process and experienced it as fun and empowering. In Appendix 8 a copy of Nompilo's (Case history number 2) hero book is presented together with the facilitator's instructions.

5.3 Case studies

Participants of the following three case studies gave authorization to have their individual case histories and pictures made public. This was in addition to their written consent to participate in this research.

The case histories were structured as follows: a) time before parental illness; b) experiences during parental illness; c) parental death and funeral; d) post-parental death and living in a CHH; e) individual life reflections. Utilizing the 'walking the road' concept described in section 2.3, participant's life experiences were graphically summarised and presented together with a task time line coping analysis, to assist in identifying coping strategies.

5.3.1 Case history 1

Brief: Future, female CHH, 19 years old, employed, limited support from father's former employer. Source of data: Conveyed by Future through narrative interviews and hero story.

Future was born in November, 1984 in Bulawayo. She is the eldest child in her family and has two younger brothers. Her father was employed as a soldier in the Zimbabwean National Army. Future's mother brought in some money by going to Botswana to purchase goods to sell at the flea market.

Before parental illness

Future's family initially lived in Luveve Township. Her parents had a civil wedding in 1989. Prior to this they were married under African customary law. This involved a process of agreements for the union between the two family clans. Future's father paid the required bride price called 'lobola'. However, there was considerable conflict between the families. Future either did not know or was unwilling to share what the cause of this conflict was. In 1998 her father was deployed to the Democratic Republic of Congo (DRC) as part of a contingent that the Zimbabwean government sent there to provide military support to President Joseph Kabila. Shortly before he left, the family was planning to buy a house in the newly developed township called Pumula South. However, he departed before the purchase could be made. Future's mother did not have access to his bank account to pursue this investment. For nearly two years, Future's family received no messages from her father. They inquired after him on several occasions at the army offices in Bulawayo. However, they received no confirmation of whether he was killed in combat or still alive.

In early 2000, Future's mother began having health problems. Initially these appeared relatively minor. The family was not particularly concerned as they thought these problems were temporary. However, they sent a message from the Army Signal offices notifying Future's father of her mother's illness. There was no response to this message.

During parental illness, death and funerals

From mid-2000, Future's mother became increasingly ill. Eventually she was too weak to continue her informal income generating activities. Future was unable to get her mother to hospital since they could not access the father's bank account. Future described her mother's illness as follows:

For a period of six month I had to take care of my terminally ill mother. During that time we stayed in Luveve. Our neighbours supported us with food and money to pay for our rental bills. Neighbours who were supporting us during my mother's illness were from the Brethren in Christ Church (BICC). The HBC caregivers from the clinic gave us advise on how to care and protect us during the care. They supplied us with gloves and Jik. Once per week the HBC volunteer visited to support us. I had to stop going to school to support my mother, sadly I never managed to complete my secondary school.

My mother never shared with me what she was suffering from. She never talked with me about her illness. I think she was thinking that she is protecting us by not talking about her illness. I did not really want to know from her, but I knew what she was suffering from. Neighbours were 'talking' about her condition and felt pity for us hoping she might tell us children.

On the 11th January 2001 Future's mother's condition became critical. Neighbours insisted she must go to hospital and assisted in getting her there. She was admitted, but since the children could not pay, the mother did not receive good medical care. She spent one night at the hospital and then died.

After Future's mother died, her father's relatives immediately came to see her. Her mother's relatives were supportive. However, apparently, her paternal relatives, including grandparents, tried to disinherit the children. Future attributed this to greed. Future already felt indignant that her father's relatives had not provided her or her siblings with any support during the terminal illness of their mother. Apparently, on arrival, they demanded money from Future. According to Future, they believed that her father had been sending them large sums of money earned through his work as a soldier in the DRC. But there was no money available as her father's bank account was inaccessible. Only her father was able to access his account. Future struggled to

organize materials such as food for the funeral. The army attempted to notify the father in the DRC of his wife's death. However, the message never reached him. This was because his deployment to the DRC had ended. He was already on his way back home to Zimbabwe.



Picture 5.1: Future with one of her brothers at their new house in Cowdry Park

Future's father struggled to accept the news of his wife's death as he'd been unaware that she was seriously ill. Future's father arrived home in time to finalise the funeral arrangements. Future's mother was finally buried two weeks after she'd passed away. After the funeral, the family stayed for four months more in their rented

accommodation in Luveve Township. They then moved to their newly-built (using a building society mortgage) but unfinished two-room house in Pumula South. Shortly before they moved, Future's father began having health problems. His illness progressed rapidly. He was emotionally drained from war in the DRC and the loss of his wife. It is therefore unsurprising that his resistance was poor. Future described her father's illness as follows:

I had to provide care for him for more than four months before he died. He died before our new house was finished. In Pumula South, since it is a new location I did not receive neighbourhood support. No HBC team was available so the entire care burden was on me. At the same time, I had as well to take care of my 13 and 16 year old brothers and I was only just 17 myself. My Dad never talked with me about his illness. I know what he was suffering from. He knew it as well since he knew why my mother had died.

Before he died he went to the rural areas to see his parents, he went there for one week. He felt pity that we as children had to take care of him and was afraid that he might die in our care. Therefore he went to his parent's home. From the rural area he went directly to the Mbizo Barracks Army Hospital. We do not know exactly when he died as relatives tried to hide the truth from us, thinking they could get his Army pension money etc. before we have access to the estate. But the Army chaplain came to inform us about his death saying he died on the 26th February 2002. We were allowed to participate in the funeral that took place in his rural home. The army provided for all the funeral costs. Fortunately my dad made a written will 6 years before he died putting the entire estate into the children's name.

After the burial, before people dispersed, the Army Chaplain realised that there was conflict between the children and the paternal relatives. He gathered the children and all relatives and disclosed the father's will that was written six years before his death. The paternal relatives responded angrily to the will as they were not beneficiaries. In their anger they said that since only the children benefited from their 'son's' estate, they [the children] may as well look after themselves. Thus Future and her siblings were thrust into forming a CHH.

Post parental death and living in a CHH

The funeral was in a rural area. Following the funeral the army drove the children back to their house in Pumula South. They provided the children with food supplies for the first six months, but after that their support was sporadic. The building society facilitated the completion of their new house. However, Future had to sell most of their household property, for example sofa's, a bed and a stove to finish paying the housing mortgage. She also needed money to pay ZESA (Zimbabwe Electricity Supply Authority) for an electricity connection. At the time of research (two years after the father's death), the children still had not managed to access their father's pension from the Army due to bureaucratic problems. The family desperately needed the money. Future was struggling to raise funds to pay her younger brothers school fees. The family were also short of money for household expenses such as food and monthly bills.

Future spoke positively about her new community and described feeling protected. Despite being a good looking and vulnerable young woman, she reported no experiences of sexual harassment from her community. However, Future described her first few months in the newly developed Pumula South Township as challenging. Having to head the household was a major adjustment. Also, because she was a newcomer in the community, there were no trusted adults or neighbours to turn to for advice or help. The family did not receive any support from the Department of Social Welfare. The only government support they received, was from the Luveve Clinic HBC programme during their mother's illness and from the Zimbabwe National Army, their father's employer, to cover funeral costs followed by limited and sporadic food support.

At the time of this research, the younger brothers were not coping well. This was particularly the case for the brother next in line after Future. He was still struggling to accept that both his parents were dead. Dealing with his father's death was particularly difficult for him. He passed his secondary exams well with six O Level

subjects. However, at the time of research, Future was still waiting to access her father's pension, to obtain funds for him to continue with his A-level examinations. Her brother was working part time in the construction industry to help Future pay bills. Future said that her long-term ambition was to train as a nurse.

Future described her siblings as getting on well and supporting each other as much as possible. She pointed out that although they struggle, it is better that they stay together as brothers and sisters rather than being separated and placed with different, and most likely hostile, relatives. Future spoke about how important it was for her to have a close relationship with her younger brothers. She said she wanted them to be happy and free. She conveyed that both brothers respect her and listen to her as they really appreciate how she supports and cares for them. Her overall narrative conveyed that she and her siblings attach a lot of importance to helping and caring for one another. She spoke as though their survival depended upon the principle that only in unity could they succeed.

Personal reflections

As part of her narrative interview Future was asked to reflect on her life during her parents' illness, at the time of their death and as head of household and summarize lessons learnt from those experiences.

It was very hard for me during the time I had to care for my mum and dad, especially for my dad as by then I was fully aware that he was suffering from AIDS. He was the last parent in this earth, who would care for me. It was a great burden. After his death I asked God for boldness and strength to cope with the difficult situation.

Through these adversities I have learnt to be accountable, responsible and caring. You need to be bold in life and cope with adversities. Learn to face the hard times and solve them as they will pass. Pray to God for strength and encouragement. I am drawing strengths from going to the Family of God Church. It gives me spiritual power.

I have three very good, close friends who are supporting me very much. They counsel me and support me in whatever they can share. One friend I met at Masiye Camp, a programme who supports with life skills training people like me, the two others are friends from my neighbourhood. Thinking about a male relationship or marriage. I am really scarred. I do not have the trust, as you never really know how trustworthy a person is. I feel it is very hard to trust a male. Experiencing what has happened to my mother, she quietly blamed my father for her illness, and see my father die and suffer and at the same time observe how men, young and old behave in the community makes me scared to think about marriage. I have no solution how to deal with that, because I would like to get married one day and have children. But I do have no answer to that and how I can solve this.

For me it was helpful to join the splash girls bicycle courier service for young female orphans in the same situation like me. This gives me peer support and some limited but sustainable income to support my family. It gives me as well meaning to life and it is cool. I am a Hero and after having experienced all this I am sure I can handle any problem that will come across my path of life in the future.

Future had to leave school when she was in Form 4, shortly before her final exams. This was because of her mother being seriously ill and needing her care. She expressed regret that she'd had to leave school. At the time of research, she still had not had an opportunity to return to school. However, she expressed hope that soon she would be able to go back to school and finish her exams. Future conveyed that at times she feels as though she's lost hope for her own life. Her energies are focused on helping her two younger brothers. She expressed hope that once they get their father's pension money, they will be able to extend their house so as to obtain an income by renting out part of it. Future said that she would love to do the International Computers Drivers License from Microsoft and work in an internet café.

5.3.2 Case history 2

Brief: Nompilo, female head of CHH, 17 years old, living with grandmother who needs care and support. Source of data: Conveyed by Nompilo through narrative interviews and hero story.

Nompilo, the second child in her family, has two sisters. Her father was employed as a carpenter in the furnishing industry in Bulawayo. Her mother managed the house and was not formally employed. They live in a four-roomed house in Old Pumula, one of the older townships in Bulawayo.

Before parental illness

Nompilo's parents had a conflictual relationship. Conflict would increase at the end of the month after the father's pay day. Nompilo's father would stay away for the entire weekend after payday. Apparently, he spent this time 'enjoying life with his various girlfriends'. Nompilo's mother could not tolerate this situation. As a result, Nompilo's parents often quarrelled. However, there was no physical conflict. Nompilo's father paid some lobola for his marriage, but never the full amount. This caused tension between the two extended families. Her parents ended their traditional marriage in November 1999 for the second time. Her older sister got married shortly before then and moved to a distant place. After that, Nompilo and her younger sister stayed alone with their mother.

During parental illness, death and funerals

Shortly after her parents separated, Nompilo's mother became sick with an HIV-related infection. Her relatives were mostly unsympathetic. Nompilo said that they blamed her mother for having 'enjoyed life too much' whilst living in town. Their attitude was 'now she can suffer for it.' This left Nompilo, as the eldest sister, at home, to care for her mother. As a result she was unable to go to school during that time (Form 1). Her younger sister stayed with their paternal grandmother and

continued attending school. Nompilo's mother became increasingly weak and had sores all over her body and inside her mouth. Nompilo had to bathe her, wash her clothes and feed her as she was unable to do these things for herself. Initially Nompilo cared for her mother with relatively little support. Later, neighbours started to provide limited support, but refused to touch Nompilo's mother's body, as it was full of sores. Her paternal grandmother visited her about three times per week, however, she herself was very frail. She tried to help Nompilo with washing her mother, but lacked the physical strength to do this. Nompilo's grandmother knew that her son was 'going around with too many girls.' She pitied her daughter-in-law for having to suffer with this illness as a consequence of such behaviour.

Initially Nompilo cared for her mother without taking any precautions against HIV infection. Later members of her community trained her in methods of avoiding the transfer of infection. One neighbour, an HBC member of a Seven Day Adventist (SDA) Church group began visiting Nompilo's home once or twice a week. She provided Nompilo with advice on caring for her mother. She instructed Nompilo to use gloves when bathing the mother and supplied them. She also warned Nompilo not to eat her mother's leftover food. She advised Nompilo to wash her mother's pillows with hot water and Jik. The Catholic parish priest supplied this Jik. When Nompilo's mother was near her end, the priest visited them for prayers and sacraments. The priest also provided Nompilo with advice on how to take care of her dying mother and herself. Nompilo recalls these times as follows:

During the time of taking care of my mother, I was worried because I knew I was losing my mother, and soon my father too. I felt like dying myself, because I knew that my future would no longer be good. Full of fear that no one would take any care of us. I feared greatly that I was HIV infected myself as in the beginning I had to care for my mum without gloves, touching at times her blood. I was sure I was HIV infected myself. During that time I was healthy, but a few months after her death I was getting sick myself. I thought I would die of HIV but the doctors said it was Malaria. I believed the doctors, but I still think that I am HIV +. At times I feel like killing myself to end this fear. But some friends are giving me courage. I decided that after I finish my O-level exams. I want to go for an HIV test to Matabeleland AIDS Council (MAC) or

Mpilo Opportunistic Infection Clinic. I want to know my status to start a new life, either as positive or as negative, but I need to know.

One month before Nompilo's mother died, she called Nompilo to her room and begged her to take care of her younger sister and herself. Nompilo described this disclosure as follows:

My mum told me, life is not an easy road, and that I have to learn hard at school and run away from boys. She shared that she is suffering from HIV because of my father's behaviour. She was angry, as she was sure that he gave her the disease. If she would have known better she said, she would have run away from my father long before she would have gotten the disease. It was very difficult for my mother to tell me. I already knew about her HIV status a year before she shared with me as she was always coughing and getting thinner. When I was asking my parental grandmother why my mother's relatives are not helping, she told me it was because of family misunderstandings and conflicts, but I knew it was because of HIV/AIDS. At primary school I was a member of an AIDS club that was run by my class teacher. The teacher initiated the club on her own. We were doing dramas on HIV prevention, but did not learn anything about caring for people with HIV.

Whilst my mum was disclosing she was crying, this made me cry as well. My heart broke and I wished that my father would die first as I felt pity for my mum as I too think it was my dad who brought this on our family.

Nompilo's maternal grandmother came a few days before her mother died. However, by then Nompilo's mother was unable to eat because of the sores in her mouth. Also, she was no longer able to go to the toilet; she just slept. The day before she died, she was feeling slightly better. Nompilo was not at home as it was a Sunday and she was in church (Roman Catholic). Nompilo's mother said she was feeling better. She asked where her children were. She wanted to show them that she was feeling better. Nompilo recalls that when she got home that day, her mother even had the strength to sing two church songs. This was a few hours before she died. Nompilo was at home, but not in the bedroom where her mother was. Her maternal grandmother and aunts did not allow her to enter. Nompilo was told that her mother cried a lot and needed some water and that after she drank the water she died.

I wanted to be with my mother during her last time, I felt angry about my relatives, asking myself why are they interested in being with my mother the last few moments, whilst they never came before to assist me when I needed them the most. I felt that they were just interested in the property and that was the reason they came in the end. I felt betrayed as I was caring for my mum for many months and in her last moments I was not allowed to be with her. By that time my younger sister was there but she did not want to go and see mum. I was outside the house when she died. They [the relatives] started to cry and I forced myself into the bedroom. But they got me back out telling me that my mother was gone. I was heartbroken, devastated but relieved for her to have rest at least after that long and painful suffering. But I was very angry with my relatives; I am still angry up to today.

Nompilo's mother died on the 28th February 2000. During the funeral Nompilo began sharing her mother's story about suffering from HIV/AIDS. She also described her experience of having to care for her dying mother on her own. Her close relatives tried to stop her from telling this story. Nompilo thinks they were embarrassed because of her saying that 'no one wanted to see her mother while she was alive, and now they all came.' Her aunt wanted her to lie about the cause of her mother's death. She wanted Nompilo to say that her mother was bewitched. However, Nompilo had already told people the truth.

When Nompilo's father left in 1999, he first moved to his mother's place in Pumula. Later he went to stay with one of his girlfriends. He became ill and then died in April 2003. Nompilo did not have much contact with him. At the time of this research his children had still not managed to access his pension. This is surprising since he had a steady job at National Furnishers. Nompilo said that she and her siblings are unaware of what has happened to their father's pension money.

Post parental death and living in a CHH

After Nompilo's mother's funeral, the relatives said that they should stay in the house and an uncle and aunt should move in. Apparently the children were ill-treated by them. The uncle and aunt were reluctant to provide food for the two children (then 13 years and 12 years old) and did not want to let them go to school. The uncle began selling off household items such as the iron and radio. He claimed that this would benefit the girls as he would pay their school fees with the income, but that did not happen. Nompilo's uncle and aunt even wanted to sell the house, but fortunately, Nompilo's mother made it clear before she died that the house belonged to the children. When the children challenged them [the uncle and aunt] regarding the property disposal, lack of food, and their unwillingness to provide for their schooling, they became angry and moved out of the house leaving them alone. The children then stayed on their own for two months until their paternal grandmother, by then weak and in need of care herself, moved in with the children.

At the time of research, Nompilo was having to care for both her younger sister and elderly grandmother. Her difficulties were exacerbated by lacks of parental and financial support. She said her life was hard, adding that she didn't feel well cared for herself, but thought it important for her grandmother to be with them:

My granny is old. If she dies I am afraid of the uncle as he is cruel. He would chase us out of the house as at present we can stay here because of the mother's last words. Ownership of the house has not yet been transferred into our name. Our uncle thinks we are a nuisance, he tells us we should look for the city council rate money ourselves. I am afraid as well that he might one day sexually abuse me. But I would kick him and run away. Although my granny is old, weak and in need of care, her presence is protection to my life.

Going back to school after her mother's death was a difficult process. Nompilo had to leave school for a year to care for her terminally ill mother. However, school authorities were not helpful in writing her a transfer letter to enrol her in school again. They did not appreciate the fact that she had to care for her mother and therefore

was unable to go to school. The headmaster told Nompilo, ‘it is not my fault, it was your mother’s problem’, and was unwilling to change his mind and to re-admit her into school.



Picture 5.2: Nompilo with the grandmother she cares for in their house in Pumula

Through support from neighbours, she later managed to go to another college much further away, using the lodger’s rent money to pay for her school fees. Nompilo described her neighbours as very supportive and caring. Apparently, they bought exercise books for her as well as lending her textbooks from their own children. Nompilo and her sister are members of the SDA like the neighbour who supported her with HBC materials. Nompilo feels supported by her community and church. She conveyed that if it weren’t for this support she would have committed suicide as she did not want to end up on the street as a street child. She said that at times, she still has suicidal thoughts.

Nompilo linked up with Masiye Camp when youth leaders came to her community to inform them of the starting up of a kids club in Pumula. They wanted her to lead a kids club. As Nompilo was already leading a small group of children, she changed

the name of the group to Masiye Kids Club. She then joined a training workshop at Masiye Camp. Nompilo described this as a life-changing experience. She enjoyed being in a new environment and said it was a great place. She also said the care of group leaders was fantastic.

It made me special, it made me feel like when I was with my mother. The loss and bereavement support was very good, Tsitsi [a camp counsellor] provided great support and care to me. I realized I was not alone.

Nompilo and her CHH have not received any support from the Department of Social Welfare (DSW). She once thought about trying to get support from DSW for school fees but she did not get any information on how to access such support. In 2003, for eight months, they received, on a monthly basis, maize, sugar and beans from Plan International. This was part of an urban supplementary feeding programme. They were enrolled in this scheme by another neighbour who is actively involved in politics (ZANU-PF Women's league). This neighbour was intermittently helping them but then moved away from their neighbourhood.

Nompilo managed to improve relations with her paternal relatives. This was partly due to her caring for her paternal grandmother. Nompilo described her paternal aunt as nice. At the time of research, the aunt was struggling financially. Nevertheless, she would occasionally visit Nompilo's household and provide some support. However, Nompilo spoke of ongoing conflict with her maternal relatives. Nompilo portrayed them as cruel and abusive. She said they wanted to make her and her sister their 'house girls' and 'slaves'. Three weeks before the interview, they forcibly took her younger sister, Talent, to their rural home in Nkayi. Nompilo said that her maternal relatives believed her sister should be working in the homestead and fields of relatives instead of going to school. Nompilo was not able to prevent them from taking her sister away as it happened when the sister visited their house in town. Nompilo went to them the next day to ask what had happened to her sister. The next door neighbours told her that Talent had been beaten up by the relatives and forced

to go with them. After her O-level exams, Nompilo is determined to go to the rural area to rescue her younger sister. She said she wants to stay with her sister, as she is her friend and they need each other.

Personal reflections

In her personal reflections Nompilo spoke a lot about her 'very good friend' who she spends quite a lot of time with. Nompilo met her friend in church. The friend, who is the same age as Nompilo, went through similar experiences to Nompilo when she lost her father to HIV/AIDS. At the time of research, the friend's mother was working in South Africa and healthy. Nompilo expressed a lot of appreciation for this friendship. When Nompilo's mother was ill and dying, her friend visited her regularly and supported her emotionally. Nompilo said that her friend gave her strength to accept the situation and told her that her father had died like this. That helped Nompilo as she realized that she was not alone in such a difficult situation. Nompilo said she knows other people but they are not really her friends.

Nompilo shared thoughts that she and her friend have when discussing relationships, boyfriends and their future. Nompilo said that in these discussions they always reflect on their experiences of losing a parent to AIDS. This makes them feel that staying single is best. Nompilo, said that at times she feels that she would like to become a nun and her friend feels the same. At the time of research, the two girls were attending workshops and training for different nun congregations. The main reason for their wish to become nuns was the fear that they might end up in a bad marriage and might suffer from AIDS one day too. Nompilo, said she did not believe that she could find a loving, faithful partner. After what she had experienced, she does not trust any men. She thinks they are all like her father. She feels that she can only trust women and fully trusts her friend and her granny but not men.

I can trust women but not men. I do not know if I can ever trust a man again.

Nompilo conveyed that she has managed to accept her life situation and thinks that she can cope with the future.

I tell myself that I can cope. I tell myself that I have a future and a plan for life. I want to take an HIV test. If I find myself positive, then I will accept it as I would have been infected by caring for my dear mother. I want to become a journalist, even if I become a nun. I think journalists travel around that will help me to be independent. I do not want to stay in one place and be dependent on a man.

Experiencing all these difficulties, I learnt that even though one has to suffer a lot one has to accept it as it is God's life. Life is not just one sweet song. It leaps with its ups and downs. I need to be fully committed to life and focus, I have to be strong. My belief in God is important, it is giving me strength. One has to fight hard and strive to get my 'territory'. I told myself that since I have no mother and no father I need to try to provide that motherly love to myself. I always make myself happy by trying to deal positively with the problems I encounter. It is difficult but I feel I manage and I am still alive. I am happy, although not that often. I am proud of myself, I am a hero. I coped with the most difficult problems life can offer. The forthcoming problems in life will be smaller and more manageable. Doing the hero's book was very helpful, as it helped me to see that I am a hero. I am an achiever. In the past I had at times a guilty conscious but writing the hero book really helped me. I managed to conquer the greatest problems, some children have even bigger ones. I am not alone and I am still alive and 'kicking'.

Nompilo finished her O-Level examination end of November 2004. She is still on her journey towards becoming a 'travelling' journalist.

5.3.3 Case history 3

Brief : Bongani, male CHH, 17 years old, no sustained external financial support, house owner, self employed, informal sector, HIV positive. Source of data: Conveyed by Bongani through narrative interviews and hero story.

Bongani has a younger brother and one younger sister. His father was working in Hwange, a coal mine 300 km away from Bulawayo. The family has a three-roomed house in Gwabalanda Township. The mother was a housewife.

Before parental illness

Bongani's mother was pregnant with him before her traditional marriage to Bongani's father. Apparently, Bongani's paternal relatives initially rejected the pregnancy stating that it must be due to another man. However, Bongani's father acknowledged that he was the father. Since then, however, there has been conflict between Bongani's mother and her in-laws, as they have never really accepted her. They said that they wanted their son to marry a 'pure' woman and not someone like her who already had a baby from another man in the past. Prior to Bongani's mother's illness his family had a good relationship with his maternal relatives. The distance between the home and the father's work resulted in him only returning home at the end of the month after payday. When he was home for the weekend, he often went to beer-halls to drink. Bongani's parents treated their children fairly. Bongani and his siblings did not witness much conflict between his parents. However, they did not seem to have a close relationship with each other.

During parental illness, death and funerals

Bongani's mother became ill in 1993, during her pregnancy with Bongani's second brother. The brother died at five months. On the death certificate they stated the cause of death as HIV/AIDS. At that time Bongani did not know much about HIV/AIDS and therefore did not understand the consequences.

In 1995 his mother became ill again. After a year of illness, she rapidly became worse. For the last six months, she could not eat or wash on her own. Bongani had to take care of his mother, feeding her and washing her. His younger sister was too small for such work. This was very difficult for him, as he felt too young and inexperienced for such work. At times maternal relatives came to assist them in caring for their mother. There was no HBC in 1996 as at that time Gwabalanda was a relatively new township and neighbourhood support was limited. Bongani did not

have any HBC supplies such as gloves, Jik or other protective supplies but since he did not know much about HIV/AIDS at that time, he did not worry.

Their mother was aware that she was going to die and told the children so. However, although they were concerned about her illness, they did not take the message that seriously. She knew that she was HIV positive as at times, when people asked her how she was feeling, she responded: 'Ah, I am alright but this AIDS thing is going to kill me'. Bongani recalls:

She did not clearly disclose to us but said: 'I am going to die of AIDS' but at that time we did not really understand what this means. She blamed her husband on her condition. Later when we understood what was going on we blamed him as well.

Bongani recounted a memory of an incident that occurred when his mother went for the weekend to his aunt to relieve the children of their difficult care duties. It was the end of the month and their father was home. As usual was he went the beer-hall. Late in the evening they saw him coming home with a woman. The woman was their mother's friend. She often came to socialize with their mother, sitting and chatting with her. They used to go to the same church (Roman Catholic) together. Bongani 'spied' on them and saw them getting into the parent's bedroom. Early in the morning the children saw the woman leaving the house. The children told their terminally ill mother about this incident. When the father heard about the children telling the mother about this affair, he physically punished them. Bongani remembers that this woman died of AIDS in 2003.

During the last week of her life, Bongani's mother was very weak. Neighbours said that she needed to go to the hospital. They felt it was not fair on the children for their mother to be at home in such a condition. The neighbours assisted in getting her into hospital as the father was away for work. After one week, on the 22nd February 1996, she died at the hospital. Bongani was worried when she left for the hospital, although he was hopeful that she might get better since she would get treatment there. One

day when he was coming home from school, he saw a red cloth [symbol of death] outside the gate. He knew it was for his mother. The children were taken to an uncle's home. They were not allowed to participate in the funeral. Bongani said that at the time he did not really know what was going on. However, he said that he now feels it would have been important for him to participate in the funeral and its arrangements.

In April, of the year that Bongani's mother died, his father was on leave at home. He seemed to have taken the death of his wife lightly. During the holiday period, he had a road accident and fractured his leg. He had an operation on his leg. However, following the operation the surgical wound did not heal well. The father slowly became increasingly weak and sick. He had to use crutches to walk around. Again Bongani, as with his mother, had to assist his father to get him to the toilet, to wash him and to provide general day-to-day care. This lasted for over three years. Bongani's father was no longer able to fulfil his duties as a mineworker. Therefore he was forced to stay at home. Luckily, he received a small disability pension from his employers. Apparently, Bongani's father began showing concern for his children whereas previously he'd often regarded them as a nuisance. He also began missing his wife. Bongani said this was because he believed that he would have been better looked after had she been alive.

For a short while during this time, Bongani's father had a 'wife' nearly the same age as Bongani who had a baby from someone else. Apparently she did not treat the children well and did not give them food after they came home from school. Bongani described an incident where she beat up his younger sister for no apparent reason. Bongani said that one day he slapped this 'wife' after which she left the home. The father was angry at first, but later forgave Bongani.

Towards his end, Bongani's father was very sick with full-blown AIDS. He did not receive any visits from his relatives. He complained that his mother did not come to see him. Bongani had to care for him nearly until the end. He did not want to go to

hospital. Some friends eventually came to fetch him with an ambulance and took him to the hospital. The children went to visit him there a few times. Two weeks later, on the 10th of February 1999, he died. Bongani thinks his father knew that he died of HIV/AIDS, but did not acknowledge it. He never spoke to his children about it. He gave them the impression that he died because of the accident and his bad leg.

After the mother had died, the maternal relatives withdrew from the family. The paternal relatives had not cared much for the children since the onset of their mother's illness. So there was nobody to arrange for the father's funeral and Bongani had to arrange it together with some of the father's friends. The burial was in the rural areas and his relatives participated as it was in their home. Only Bongani attended the funeral as the other children stayed at home with some neighbours. After the funeral was over Bongani went home to Gwabalanda.

Post parental death and living in a CHH

There was immediate inheritance conflict between paternal and maternal relatives over the father's estate, especially the house. At first the children stayed with their maternal aunt which was a good arrangement. They stayed there from 1999 to 2001. In 2001 the aunt and her husband were having increasing conflict over the three children staying with them. The aunt's brother in law was ill and eventually died. After that the children were told that they could no longer take care of them, as they had now to take care for the husband's brother's children. The children were 'kicked' out of the house. During that time, Bongani's young brother had to go to jail. He sold some of the late parent's property and some relatives called the police and he was sent to jail. Bongani went to the police to plead for the brother. He succeeded and he was released. From then on the children had to look after themselves, renting a single room in the neighbourhood, as some relatives rented out their family house. Bongani had to drop out of school to start generating some income for the family.

All along he had kept the death certificate of their baby brother, but later destroyed it as he was worried that relatives or friends would see it and laugh at them.

Members of the church supported them during this time. They mainly provided them with food when they had none and encouraged them to be strong. Bongani also has five good, close friends from church.

Some people in the community arranged for Bongani to participate in a CHH camp at Masiye Camp. For the first time Bongani received in-depth HIV/AIDS information at Masiye Camp. He then became worried that in caring for his mother he might have become infected, as he did not have any protection at the time. To overcome the worry of being HIV infected, he was encouraged by Masiye Camp counsellors in 2002 to go to a 'New Start' centre [Voluntary Counselling and Testing Centre] where they had a promotion and offered HIV testing for free. By then his worrying had subsided. The pre-test counselling was most helpful, but it was very difficult when he obtained the results as he had to accept that he was infected with HIV himself. With peer support, however, he managed to pull himself together and develop a positive outlook on life.

I have a purpose in life, I need to support my younger siblings and looking well after myself, I can still have a long life ahead of me.

With the support from the legal department at Masiye Camp he was given the information on how to proceed to find out about his father's estate, especially the house. Bongani went to the High Court to find out about his father's house. They assisted him after he had produced marriage and death certificates for his parents and the children's birth certificates. The High Court helped them to get the house transferred into the children's name. In October 2003, they managed to reclaim their house and move into it. They were told that the father's pension had paid off the building society mortgage. Earlier, relatives had claimed they were collecting the rent to pay off the mortgage, but this turned out to be false, as the mortgage had been paid long ago by the pension fund.

In order to generate family income, Bongani was doing part-time jobs in different informal township hair salons. When they reclaimed their home, he decided to convert one of the three rooms into a 'hair-salon'. The other room is rented out, and they only use one room for themselves. The income from the business is sufficient to cover the school fees for the younger brother and sister, food, and household maintenance.

Personal reflections

Bongani, spoke positively about his sibling relationships. He said they all support one another, although Bongani has faced problems with his younger brother since the time he was in jail. It seems that this experience had a very negative psychological impact on his brother. The siblings talk about household issues, plan what to do and how to manage their household, and how to raise funds for schooling and other issues. Bongani was lucky to receive some support from a Rotary Club member who helped him to establish the hair salon. This will ensure that the three siblings will have a small but sustained income.

Bongani shared the following reflections on his experiences over the past few years:

Although, all these experiences were very hard, especially as I am infected myself, they have helped me to grow, strengthen my resilience to fend for myself. At times I still cry, hidden from others and I cannot really share my feelings with others.

We take each other serious as siblings and help each other. Any opportunity that comes along in life I take serious, as I know that there is no second chance coming. My behaviour has changed as well, I know about HIV/AIDS and how to protect myself to live a long life. I do not trust people in terms of relationship any longer after having seen how my parents died. I am scared of getting into a serious relationship. It is very difficult to think of getting married being HIV positive but I would not want to get married before my younger siblings have established themselves in life. Although at times I thought getting married would solve my problems. A few times I had older business

women trying to take advantage [sexual] of me as they see me as vulnerable and in need for financial support.

It is unclear whether Bongani contracted the HIV infection through caring for his parents or through sexual contact with either an older woman or a young girlfriend. He was not willing to talk about his sex life.

5.3.4 Time line summary of case studies

Table 5.1: Situation and coping strategies of Future, female, 19 years old, employed, limited support from father's former employer

Life time		Before parental illness	During parental illness, death and funerals				Post parental death, living as CHH		End of contact
Social coping	Family relations	Parents married, civil and traditional. Existent unknown family conflict	Father absent as soldier in DRC when mother ill		After mother died, maternal relatives withdraw	Paternal relatives hope to get inheritance	After opening of will, relatives break relationship	No contact	Know where relatives are but no contact
	Peer support	Enjoys school friends		Drops out of school and loses friends	Maintains peer contact in neighbourhood	Participates at Masiye Camp	Establishes support with Masiye youth	Joins Splashgirls	Has 3 good friends, siblings get on well
	Neighbour support	Good neighbourhood interactions in Luveve	Support of HBC, advice, HBC supplies and food	Luveve Clinic supplies gloves and Jik	Assist to get mother to the hospital	Move to new township, no support	New township does not offer support	Slowly developing relationships	No adult support, 2 friends are from area
Economic coping	External support	Not necessary, father employed as soldier		Neighbour support as family is unable to access father's funds in bank		Army provides sporadic food support	Army covered funeral costs for father	Sporadic food support from Army, expected to stop soon	Still have not accessed father's pension
	Income generating	Not engaged in income generating activities	Mother still can work at times at flea market	Future needs to do small jobs for other people to raise income	Fully absorbed in providing nursing and siblings care	Joins Splash Girls for income generating	Splash Girls	Splash Girls	Works with Splash Girls bicycle courier
Emotional coping	Intra personal	Feels happy and well	Mothers illness, though light is worrying her		Mother dies †, troubled and unsupported grief experience	Father dies †, one year after mother, last parent on earth	Feels she is a hero after having to go through all this	Job with Splashgirls gives her meaning to life	Has hope and plans (computer training) for the future
	Inter personal	Use of friends from church and community for emotional support	Gossip about mother's HIV status is troublesome	Mother does not disclose her status, knows what mother is suffering from	Caring for terminally ill mother is emotionally draining	Experiencing greed from relatives was hard to accept	Gaining strengths from siblings support	Brothers respect and listen to her	Is worried about relationships and marriage. Distrust towards men.

Table 5.2: Situation and coping strategies of Nompilo, female, 17 years old, living with grandmother who needs care and support

Life time		Before parental illness	During parental illness, death and funerals				Post parental death, living as CHH		End of contact
Social coping	Family relations	Considerable parental conflict, unfaithful father (beer garden sex)	Parents separate	Mother starts to get	Relatives move in	Staying with	Paternal grandmother lives in but does care from Nompilo	Both want to become nuns when grown up	Maternal side no relationship. Paternal relationship improving
	Peer support	Good friends at school and at church		finds one friend in church who lost her father due to AIDS	This friend is important emotional support during that time		Snared everything with friend		
	Neighbour support	Old township with good neighbourhood support		Good church support from SDA and RC priest	Priest visits for prayers and sacraments	Neighbours help to get mother to hospital	Helped her to get back into school	Can use text books of neighbours	Receives education support
Economic coping	External support	Father works in furniture industries	Father although separated provides limited support		Father provides sporadic support	Support from father stops, start to have lodgers		Lodgers income, aunt provides some support	Renting out one room to lodger, uncle supports at times rates
	Income generating	No need for Nompilo to be engaged in such activities	None	Starts up during holidays to sell fruits	No time, as she needs to provide care for her mother		Starts to manage the lodger in the house	Mainly holiday activities, selling fruits outside the shops	Is interested to become a journalist
Emotional coping	Intra personal	Happy person but concerned by frequent parental arguments			Mother dies †, unsupported grief, but relieved of care burden, anger at relatives	Father dies †, although away it is last parent and main breadwinner	Feels like committing suicide. Low self esteem.	Writes hero book and feels like a hero. Still times of unhappiness.	Is worried about being HIV infected, wants to go for testing
	Inter personal	Has close relationship with her younger sister Talent. Interacts well with other people. Outgoing personality.		Deeply worried about her mother whilst taking care of her.	Worried about herself and her younger sister's future		Feels all alone in this world	Though grandmother is a care burden, appreciates her protection	Is deeply troubled about relatives who took away her younger sister

Table 5.3: Situation and coping strategies of Bongani, male, 17 years old, house owner, self employed informal sector, HIV positive

Life time		Before parental illness	During parental illness, death and funerals				Post parental death, living as CHH		End of contact
Social coping	Family relations	Conflict between mother and in-laws due to child from past relationship	Good relationship with maternal relatives	Father often spends time at beer garden, strains relationship with mother	Mother never accepted by in-laws, told that their son should have married a 'pure' women	Inheritance conflict with relatives	Move to father's sister until uncle's brother dies leaving kids behind	Move to a rented one room on their own, no family linkages	No contact to paternal relatives, maternal relation strained
	Peer Support	Has several friends from school and church			Drops out of school to care for mother	Went to Masiye Camp for CHH camp	Developed good friends at Masiye	Support to cope with HIV status	5 close friends
	Neighbour support	Good support in Luveve an old township	Good social connectedness and community spirit	Family moves to Gwabalanda, new Township	No HBC in community, little support			Neighbours are happy, children are back	Good relationship but no support
Economic coping	External support	Father works in coalmine 300km away. Home every month end.				Some older women offer support for sexual favours	Father's pension paid off the housing mortgage	Received Rotary support to set up hair salon	No external support
	Income generating	Bongani likes selling sweets and other things to make pocket money		Gets training from colleague in cutting hair		Fully absorbed in providing care for ill father	Working in various hair saloons in township	Move into their family house, income from lodgers	Established his in-house hair salon to support family
Emotional coping	Intra personal	Is a happy, active young person	Proud to be able to generate pocket money to buy gift for younger brother and sister	Concerned and worried about future	Has to care for terminally ill mother as father is away for work	Mother dies †, and father ill, causes so much worries	Father dies †, Had to make funeral arrangements alone	Devastated after receiving HIV + test result	Still struggles to adjust to a live with HIV
	Inter personal	Interacts well with younger brother and sister. Has good relationship with mother		Mother starts to be ill, worries Bongani. Mother open about HIV but does not directly disclose	Shattered to see father bringing girlfriend (friend of mother home) whilst mother is very ill	Beaten up by father for spying on him, telling mother about affair	Feels like dying too, emotionally drained seeing both parents wasted by AIDS	Gets good peer support to cope with HIV status	Deeply troubled when thinking about marriage and relationships being HIV +

5.3.5 Key issues and discussion

Based on the three different case studies discussed above, the situation analysis and the literature review, the following important issues are identified. These relate to the formation of, coping with and management of CHHs. The impact of hero books is also dealt with. These key issues are discussed in the following four groups:

1. Emotional coping, resilience and HIV/AIDS vulnerability
2. Household management
3. Community care, extended family linkages, programme support
4. Policy and child rights issues

Some topical terms are highlighted below in **bold**. These issues will be discussed in greater detail in Chapters 6 to 9.

Emotional coping, resilience and HIV/AIDS vulnerability

Social connectedness. The case studies dealt with suggest a relationship between resilience and social connectedness. One or more friends, neighbours or programme volunteers appeared to be critical for emotional coping in CHHs. Generally **siblings' support** in CHHs is good (see section 6.5.2, Figure 6.12). Children help each other in the various daily chores to manage the household according to their age and ability. The social connectedness among siblings is a strength factor in CHHs that is often underestimated. Most children, when asked, prefer to stay together as siblings, even if it means living in a CHH than to be separated and split up into the care of different relatives.

Households where children are the primary caregivers during parental HIV-related illness are very likely to progress into CHHs. Caring for a terminally ill parent is emotionally taxing, especially for a child. The term post-traumatic stress disorder

refers to the negative impact of a particular traumatic experience. Such a term underestimates the extent to which such children are exposed to ongoing and multiple traumas. Possibly a more useful term to describe what these children experience is **continuous traumatic stress** (Straker 1992; Gelman 2003) (see sections 2.3.3, 2.6 & 6.4.1).

Based on findings of the case studies presented in this chapter, hero books (see 5.2) seem to be powerful tools for strengthening children's resilience. When reflecting on their experiences, the participants of these case studies all expressed a feeling of having overcome the most difficult challenge imaginable. They all expressed belief in being **able to cope in life** (see chapter 7) in the future.

The scale and lack of coverage of HBC results in children often being left to care for terminally ill parents without adequate information or material support to ensure basic infection control. This situation puts children at **high risk for contracting HIV infection through the care process** (see section 2.3.4). Children become highly concerned about this after acquiring a basic knowledge of HIV/AIDS transmission. Such psychological stress needs to be addressed, often through pre-test counselling, testing and post-test counselling.

Open **disclosure by parents** regarding their HIV/AIDS status is important to enhance a relationship of trust between the parent and child (see section 6.2.1). The participants in these case studies all knew exactly what their parents were suffering from, either from their own symptomatic observations or from neighbourhood 'gossip'. Therefore, parental disclosure is often not as much about sharing 'new information' but to confirm existing knowledge held by the child. This results in strengthening the relationship and trust between parent and child.

For children who have cared for their terminally ill parent, it seems that **attending the parent's funeral** is important for dealing with the psychological stress caused by the illness and subsequent death of a parent. It appears that children do not want to be excluded from these crucial rituals. Excluding them might result in suppressed anger

for many years. Such suppressed anger against relatives potentially contributes to conflicts with relatives after parental loss. This may escalate to the point where the extended family caregivers feel that they can no longer cope with these children and therefore send them away to care for themselves, thus creating a new CHH.

Many heads of CHH appear to be strong and vocal personalities. They express their views or anger when experiencing abuse, such as dispossession of inheritance by relatives or through other circumstances. Such conflict, and the inability of both parties to amicably find a resolution, due to lack of conflict resolution skills, contributes to the formation of CHHs.

Many CHHs experience parental **relationship conflict**. They frequently see a parent, often male, living a high-risk lifestyle. This profoundly impacts on their ability to develop healthy relationships with the opposite sex. This is especially the case for female-headed CHHs. Such young people are often deeply **afraid of marriage** and its potential consequences. Given the large numbers of children experiencing parental loss in the context of HIV in Southern Africa, the issue of young people being afraid to enter into a relationship or marriage may cause social changes in terms of marriage as a family institution.

Household management (see chapter 7 for more detail)

Generating sufficient **household income** is the most challenging feature of CHHs. Heads of CHHs are deeply concerned and worried about not being able to adequately support their younger siblings in terms of schooling, education, and other provisions. The result is that most CHHs who have little or no external support, either through rental income from lodgers, pension scheme income or sustainable programme support, have members who have to leave school and engage in the highly competitive informal sector to generate household income. This often puts them into vulnerable situations as other people in the informal business sector try to **exploit** them, or offer them 'easy' money for sexual favours. This puts them, especially the girls, at considerable risk for HIV infection. Fortunately, however, CHHs who have

received minimal HIV/AIDS education and know about prevention, do not easily engage in high-risk behaviour, especially if they were the main care provider during the final stages of AIDS of their parent. They are well aware of the consequences of HIV infection. It is therefore imperative that CHH and orphan support programme **integrate effective HIV/AIDS prevention.**

Children in CHH where parental assets such as a house and household property were retained to benefit the children, generally manage better in running a CHH. Selling off assets during parental illness to cover for medical and eventually funeral costs severely undermines the children's household management ability. **Dispossession** attempts by relatives during the inheritance proceedings are frequent in families where pre-parental illness conflict existed. Successful dispossession has a negative impact on children in a CHH as they no longer have the means to cope economically and feel emotionally disempowered by that experience.

Furthermore, it is important for parents during their illness to train the children in **how to manage a household**. Simple instructions from parents regarding rate payments; water and other utility payments; how to solve problems when utilities are disconnected; and how to deal with many other small household management issues have a positive impact on children's ability to manage a household.

Community care, extended family linkages, programme support

Existing **family conflict** before the onset of parental illness appears to increase the likelihood of children ending up in CHHs. Such family conflict can often be identified if, during parental illness, children are the main care providers with little or no extended family support. In low or non-conflict family situations, a relative often moves into the household to provide the primary care during the period of illness as part of the extended family coping strategy. This is still generally the case, in spite of the extended family network being increasingly challenged (this issue was addressed in Chapter 2). However, in families with long-standing conflicts such support is often absent. This has important programming implications for HBC programme. Hardly

any HBC training manual gives attention to the important factor of identifying family conflict and how to **facilitate family reconciliation and conflict resolution**.

Neighbourhood support during parental illness and thereafter, in providing HBC services, care, infection protection advice, material and emotional support, is important in order to mitigate the negative impact of HIV/AIDS on children. Research data suggests that community care capacity is better developed in older townships, where communities have had time to develop such support and social safety net systems. Children in CHHs in newly established townships rarely experienced much neighbourhood support and often struggle more than CHHs in older townships. This is an important issue for programme planning as special consideration needs to be given to families affected by HIV/AIDS in new townships and community capacity development processes may accelerate the establishment of social safety nets in such communities.

As the HIV/AIDS pandemic progresses, within certain communities, demographic patterns are shifting (see section 1.2.1). The age of grandparents providing primary childcare is increasing, and with it the number of grandparents in need of care themselves. This results in increasing numbers of 'accompanied' CHHs: households where, although there is an adult, this adult is no longer able to provide care and support but instead needs care and support. Such grandparental care inability and eventual grandparental death will cause the number of CHHs to increase considerably in Bulawayo over the next decade.

Policy and child rights issues

The situation of CHHs appears considerably worsened by a number of **absent or flawed policies** (for more detail see chapter 8). This is especially the case in the area of education, social welfare, inheritance, and access to parental pension funds.

Many children who are forced to provide **care for terminally ill parents** are unable to attend school regularly during that period. Frequently, children have to stop attending

school altogether. After parental death, when such children wish to continue their education, often education authorities bar them from re-entering. School authorities often do not seem sufficiently aware of the social or family environment such children are coming from. Education policies should take into consideration that a sizeable number of students, especially at secondary school age, may have to provide care and support to ill parents. School authorities need to be supportive to pupils in such situations and show understanding by providing children with **temporary leave of absence or re-entry into the class** after parental death. Furthermore, schools are an invaluable place to identify and provide psychosocial support to help mitigate the negative emotional impact that parental illness can have on such children. There is need for teachers' training to include psychosocial support skills development.

Traditionally, the extended family and community support were the primary social safety nets. After Zimbabwe's independence, a state social welfare system was developed within the Ministry of Public Service, Labour Relations and Social Welfare. The training of social workers was increased and all 57 districts had fully staffed and functional social welfare offices. Monthly social welfare grants, though modest, were just slightly below the monthly national poverty income line. The onset of the politically influenced economic decline and the mass exodus of professionals, including social workers, from 1997 onwards has resulted in a steady decline in the state's social welfare system. Hundreds of social workers, both in government and NGOs, have since left the country³⁵. At one point, the government of the United Kingdom advertised and held interviews for social worker positions in the UK in Zimbabwe. The migration of most qualified social workers, combined with hyperinflation of up to 600 percent has resulted in the collapse of the state social welfare system. Most district social welfare offices have vacant social welfare officer positions, with the majority of offices without qualified social workers at present. As discussed in section 4.4.5, monthly social welfare grants as of September 2004 amounted to less than USD 2. A person who needs to use urban public transport to collect the grant spends approximately one third of the grant just to collect it!

There is urgent need for government to invest in an **appropriate, adequate, and functional social welfare system**. But funds to finance such a turnaround will not be available unless the government of Zimbabwe reinstalls the rule of law and democracy to regain local and foreign investor confidence.

Children frequently face relatives who attempt to dispossess them of parental estates, especially among families where conflict existed. **Accessing a parent's estate and pension poses bureaucratic challenges**. No clear guidelines exist on what process needs to be followed in order to succeed (see sections 8.4.2 & 8.4.3). Although no data exists, it is estimated that billions of Zimbabwean dollars worth of parental estates and pension funds are locked up depriving vulnerable children of critical livelihood support. It is critical that policies are developed and implemented that protect children's inheritance and facilitate speedy access to such resources. This requires that civil society organizations, government ministries, pension funds, and building societies collaborate closely towards developing jointly policies and simple guidelines on what procedures need to be followed to access parental estates and pension funds.

5.4 Conclusion

Conducting detailed narrative interviews and facilitating the production of hero books with research participants is a time consuming process. Analysing results, however, shows the importance of narrative research methods as they provide insight into key reasons for CHH formation, coping conditions, and skills, as well as other important factors impacting on CHHs. Data gained through that process gives valuable information on almost all factor areas within the conceptual research framework (Section 3.4.2). Although fascinating, the time required to conduct a narrative interview (about five hours) and develop a hero book (about 15 hours) made it

³⁵ The National Association of social workers estimated in 1999 that Zimbabwe had about 2500 qualified Social Workers. In 2005 the association estimated to have less than 500 social workers in the country (NASWZ 2005).

prohibitive within the scope of this research to do that process with all 83 CHHs as it would have required almost 12 weeks for such a process, and would have consumed considerable human and financial resources.

Findings established through narrative methods (validated with quantitative data) show that the single most determining factor contributing towards the creation of CHHs are various forms of family conflict, which already existed before the onset of parental illness.

Furthermore, community care and neighbourhood support in older townships is better established compared with newer ones where such support is almost non-existent. Regarding care for terminally ill parents, children are the key care provider often due to family conflict that deters extended family members from participating in the care process. For HBC programme volunteers or staff, identifying households where no extended family members are available to provide terminal care can be an indicator for potential future CHH formation. Family reconciliation support, facilitated by HBC programmes, could be critical in preventing CHH formation. In the absence of HBC support, children providing palliative care to parents are at high risk for HIV infection through care. This finding corresponds to findings from a study by the Human Science Research Council (Shisana & Simbayi 2002), where they raised the concern that considerable numbers of children in South Africa may be HIV infected through unprotected care provision.

State social welfare provision has collapsed in Zimbabwe. First of all bureaucratic hurdles pose obstacles to obtaining support that for many vulnerable families are insurmountable. Furthermore, if a CHH actually succeeds in overcoming these bureaucratic hurdles, the benefit acquired hardly justifies the effort. In September 2004, social welfare benefits amounted to approximately 2 USD per month per child. A key policy and programme concern relates to the difficulties of children accessing the parent's estate, especially pension funds. A number of participants in this research had been trying for over three years to access such entitlements without success. There is no data available, but it is likely that billions of Zimbabwean dollars

each year are not accessed by vulnerable orphans, boosting pension fund companies' bottom lines instead of boosting CHHs' and other orphans' meagre family income.

Finally, life for CHHs is more 'eventful' during the time of parental illness and death than during the time they live as a CHH. As hard as parental loss is for children, it does at times provide them with some respite, especially if they were the primary caregiver during a prolonged terminal parental illness. Although it is difficult to manage a CHH, the new situation can even be a relief.

The following chapters will discuss in greater detail the four core areas listed above, namely: Quality of life, emotional coping, resilience and HIV/AIDS vulnerability, household management and coping, community care and programme support / policy and child rights issues. Each of these core areas has its own chapter.

6 Households, quality of life, emotional coping and resilience

Resilient children are able to manipulate and shape their environment, to deal with its pressure successfully, and to comply with its demands. They are able to adapt quickly to new situations, perceive clearly what is occurring, communicate freely, act flexibly, and view themselves in a positive way. Compared with vulnerable children, they are able to tolerate frustration, handle anxiety, and ask for help when they need it.

(James Garbarino 1992:103)

6.1 Introduction

The case studies in Chapter 5 document the constellation of experiences and emotions that typically impact children affected by HIV/AIDS at one time or another over a period of several years. To attempt to sketch these experiences and emotions in a few strokes is impossible, but we can speak of fear, worries, especially those that accompany caring for parents who are ill and in pain, stigmatization, hospital visitations, shattered hope and eventual loss. The effects parental illness and death have on a child's mental health and ability to cope are complex and depend upon the child's development stage, resilience and culture. Psychological and emotional effects can manifest in ways that often go unnoticed or neglected.

Over the past decade, this researcher has been one of the pioneering advocates for psychosocial support for children affected by HIV/AIDS and for scalable models to enhance such care at community and programme level in East and Southern Africa. Research on psychosocial issues among children in Southern Africa is limited. This chapter therefore relies heavily on the researcher's own data and experience, supported by statements from research participants. Data presented in this chapter has been validated through peer review interviews with Dr. Beven Killian, University of KwaZulu-Natal, Prof. Linda Richter, Human Science Research Council, Dr. Leslie Snider, Tulane University and Sarah Gelman, Tel Aviv University.

Section 2.3.3 provided an introduction to the psychosocial issues of orphans. This chapter discusses the emotional impact of HIV/AIDS on CHH in more detail, focusing on trauma and stress experienced in CHHs during parental illness and in response to loss, stigmatization and compromised self esteem. This is followed by an analysis of how resilience expresses itself in CHHs and a psychosocial discussion of quality of life in such households. The chapter closes by providing information on the specific psychosocial support programmes that are available in the countries and regions covered by the research.

6.2 Emotional impact of HIV/AIDS on CHHs

The emotional impact of HIV/AIDS on children is well documented (Poulter 1997; Foster & Germann 2002; Germann 2002b; Germann & Madörin 2002; Killian 2004; Dube, Gilborn, Kluckow & Snider 2005). Culturally appropriate psychometric methods of assessing emotional impact, however, are still not available and some of the above studies have already identified this lack. There is urgent need for a collective effort to agree on a set of basic psychosocial indicators and to develop appropriate assessment tools to remedy this problem. In the absence of more appropriate tools, the researcher, as mentioned in Chapter 3, has utilized an adapted version of the World Health Organisation's (WHO 1995) quality of life psychometric assessment tool and CHH focus group discussions. Lessons learnt from applying this tool within this study will hopefully contribute to a collective effort within eastern and Southern Africa to develop and validate appropriate, standardized PSS assessment tools.

6.2.1 Trauma and stress during parental illness

All CHHs in the study were exposed to prolonged period of illness of at least one parent. Some 57% experienced this with both parents. Prolonged parental illness creates an emotional roller-coaster for the children. Ailing parents, who are often themselves in emotional turmoil, are less able to provide a stable emotional environment for children. Hudis (1995) and Wild (2001) have documented that such parents become progressively less likely to supervise and discipline their children. Research literature from other socio-cultural settings suggests that children, who are experiencing the sort of disruption to family routine and security that usually follows in the wake of parental HIV infection, tend to suffer a form of chronic trauma whereby disorders are internalized as the children become anxious, depressed and socially alienated (Lutzke et al. 1997, Tremblay & Israel 1998).

Disclosure of parental HIV positive status to children is not the norm as there is no social or cultural sanctioning for speaking about death. In fact, many people in the research area hold to a superstitious belief that speaking about death, 'invites death into the home'. This leaves children confused, scared and anxious as the child

realises that the parent is terminally ill, but no adult attempts to explain what is happening, or why it is happening. This forces children to gather information regarding their own parent's health status among neighbours and friends, and to draw their own conclusions and the implications this has for their own future.

Experience	21 Accompanied CHH	84 Unaccompanied CHH	Total CHH
Exposure to parental illness			
Mother only	5	15	20
Father only	3	14	17
Both	11	48	59
No	2	7	9
Provided care for terminally ill parent			
For father	3	33	36
For mother	7	43	50
Not	11	8	19
Parental disclosure of illness or HIV status			
Father only	7	10	17
Mother only	4	27	31
Both	2	13	15
No	8	34	42
Fear of being HIV infected through care			
Male CHH	5	21	26
Female CH	7	30	37
No	9	33	42
Experienced anxiety, stress during parental illness			
Male CHH	4	42	46
Female CHH	13	41	54
Did not	4	1	5
Relationships with relatives during parental illness			
Paternal side			
Good	2	0	2
Strained	14	15	29
Bad	5	69	74
Maternal side			
Good	3	2	5
Strained	16	16	32
Bad	2	66	68

Table 6.1: CHH experiences during parental illness

Note: Data was collected at onset of study when all 105 CHH were still in the study group

Research data suggests that in a majority of cases (82%) the head of the CHH had been the primary caregiver during parental illness. It is common for boys to care for their terminally ill fathers, but only seldom does a boy provide care for a terminally ill mother. It is, however, not unusual for girls to provide care to terminally-ill fathers. This suggests that the traditional care role of females is maintained within the

households even in the context of male parental illness. The percentage of cases where children care for fathers (34%) is lower than in the case of mothers (48%). This is attributable to the fact that within the study area, female-headed households are unusually common, since many fathers are either unknown, work as migrant labourers in South Africa or live apart (DSW 1998:32).

The following account of Mandla, 18 years old, illustrates how difficult it is to experience terminal parental illness:

I wake up early in the morning tired, because I had to assist my father during the night to go to the toilet several times. Then I had to prepare breakfast for the family and get the two younger children ready for school. My father is too ill to eat with sores in the mouth; the only way he can eat is when I feed him with a spoon some porridge. During school I am still tired and when I come home after school, I have to sell tomato and fruit outside our house to make some money to buy food. After dark, I have to wash my father. I can not afford gloves and at times he has open sores. All is so hard, I often feel lost, not knowing what to do next.

High levels of experienced anxiety, the fear of being infected through the care process and the experience of social alienation and high levels of conflict with relatives exposes CHH members to considerable trauma and stress during parental illness. It is therefore not surprising that 72% of CHH members reported that although parental death was very distressing, it was at the same time a relief and in fact alleviated household stress.

6.2.2 Psychological coping in CHHs upon parental death

The loss of a highly valued person, such as a parent, is one of the most painful of human experiences. Adapting to such a loss, facing it and then finding a way to move on, is one of life's greatest challenges. The term 'bereavement' refers to the state of being deprived of something. Bereavement according to Corr et al. (1994:168) 'identifies the objective situation of individuals who have experienced a loss'.

Most theories of loss and bereavement have their foundation in Bowlby's Theory of Attachment (Bowlby 1980). According to Worden (1991:7), 'before one can fully

comprehend the impact of a loss and the human behavior associated with it, one must have some understanding of the meaning of attachment'. Bowlby (1977), rejecting the claim that attachment between individuals develop only in the interests of meeting biological drives (such as the drives for food or sex), asserts that such bonds are also deeply rooted in a need for safety and security. Forming attachments with significant others is considered normal behavior for both children and adults. When a significant attachment is threatened, such as during terminal parental illness, emotional distress is triggered and every effort is made to restore the bond. 'In such circumstances, all the most powerful forms of attachment behavior become activated – clinging, crying and perhaps angry coercion...when these actions are successful, the bond is restored, the activities cease and the states of stress and distress are alleviated' (Bowlby 1977; in Worden 1991:8). However, in some circumstances, such as death, the bond is not restored. Once it has been understood that an attachment has been irretrievably lost, grieving takes place. Thus attachment theory provides a way of understanding the human tendency to form strong emotional bonds with others and the intense emotional reaction that occurs when these bonds are severed.

In the context of parental HIV (and in the absence of ARV treatment), once children are aware of the inevitable loss, grieving may start before the actual loss takes place. Unlike discussions of mourning (defined as the process of adapting to a significant loss) in childhood (Speece & Brent 1984; Dane & Miller 1992), which tend to be dominated by issues of cognitive capacity, the writing about mourning in adolescence is focused around the interplay between tasks in emotional development and grief-related issues. This is partly because adolescents are considered to have achieved a level of cognitive development that allows for a mature understanding of the concept of death. As noted by Corr et al. (1994:276), 'it is generally accepted that by the beginning of the adolescent era individuals with normal cognitive development are capable of understanding death as final, irreversible and inevitable'.

Adolph and Fleming (1986) suggest that the loss of a significant person during adolescence may delay or arrest the successful completion of the key developmental tasks associated with this period. As they note: 'During adolescence, the loss of a

profound relationship – whether an internalized object or a person in the external world – may interfere in what seems to be the natural progression of intellectual, emotional, psychological ‘growing up’. Changes that are normally expected may be averted, avoided, or may not even take place’ (Adolph & Fleming 1986:101-102).

With the support of a caring adult environment, however, it is anticipated that delayed developmental changes in adolescence as a result of parental death can be overcome without a negative long-term impact (Gelman 2003). Although beyond the scope of this research, it can be assumed that given the frequent absence of a sufficiently caring adult environment, children and adolescents in CHHs will typically find it very challenging to compensate for developmental deficiencies following the trauma of parental death. For this reason, the role of adult neighbours can be critically important and requires further empirical investigation. It is key to our understanding of how parental death affects millions of adolescents in Sub-Saharan Africa as they move into adulthood and to what extent this impact is being mitigated by the presence of surrogate caregivers.

6.2.3 Multiple loss and sibling dispersal

As discussed in section 2.3 (the walking the road concept), children affected by HIV/AIDS often experience multiple losses including sibling dispersal. Loss of a profound relationship as discussed above may have a severe long-term negative developmental impact on a child’s life.

Item	Total CHH
Experienced Loss (5-year prior to CHH formation)	
Both parents (counts for two losses)	83
One parent	22
Infant sibling	69
Grandparent or other close person	146
Average number of losses experienced (5 years prior to CHH formation)	3.8
Importance siblings staying together	
Important	98
Does not matter	7
Not important	0
Experience of sibling dispersal	
Older siblings	23
Younger siblings	31
Frequency of contact with dispersed siblings	
Often	9
Seldom	27
Never	18

Table 6.2: CHH experiencing multiple loss and sibling dispersal

This research shows that heads of CHHs experienced on average nearly 4 deaths of close persons in the five years prior to CHH formation. This includes the death of one or both parents, an infant sibling and other close relative, such as grandparent, or other important adults in the community. As Nomakhosi, a 15 year old research participant noted:

During the time when my mother was terminally ill, I lost my 18 months old baby brother. This was very sad, as I was like a mother to him. A few months later we had to burry our mother. I had to care for her with the assistance of my younger sister. Then my father died, although I was not very close to him as he worked in a distant place from home, it was so sad to realize to be all alone in the world. The worst happened 2 years later when my gogo [granny] with who we stayed suddenly died of sugar [diabetes]. Now we are all alone, I only have my younger sister left.

Comparing this data with other multiple loss data of non CHH orphans suggests that CHHs experience a greater number of losses than other orphans (Dube et al. 2005:15).

As a coping mechanism within families, siblings are often divided out among relatives. The reason for this is that the economic burden on any one family is moderated if they take responsibility for one rather than several children. Nampanya-Serpell (1998) has identified that sibling dispersal is often a source of considerable emotional distress to an HIV/AIDS affected child - not only because the other children in the new household are often perceived as being favoured by the guardian, but also because the separation is itself a threat to the secure and meaningful attachment relationship between siblings. Siblings often feel particularly close to one another because they were united in facing the same adversities, and in attempting to maintain care and support amid the illness of their parents. Siblings also provide a strong link to the family history with its stories, collective memories and sense of belonging (Killian 2004:47). This sense of belonging can be bolstered if siblings stay connected. Results regarding the importance of siblings relationships shown in Table 6.2 indicates that siblings provide essential support within CHHs. And the data suggests that CHH households where most siblings are living together cope better than CHH households where a number of siblings are absent. There is, however, still need for further research into the role that siblings have in providing social and emotional care and support to each other.

6.2.4 Stigma and self esteem

Stigma

Although the situation is beginning to change, the belief that HIV/AIDS only affects 'bad' and 'immoral' people is still widespread and causes considerable stigma (Clacherty & Associates 2001; Mallman 2002). A veil of secrecy is often maintained by individuals and families to the extent that children are not told the truth about a parent's illness or death. The same children, however, will frequently hear the HIV

status of their parents discussed among friends and neighbours, effectively alienating them from such people.

Towards the end my mother told me that she was suffering from this monster called AIDS. I knew it all along, as I heard neighbours talk about my mother and I could see with my own eyes how my mother looked. If someone is HIV positive in the home, children live with stress. Everybody talks about the parents, which is not nice as we love our parents even if they are HIV positive. People should help us and not gossip about us, but I guess that people who are HIV positive should be open about it themselves, then people have nothing to gossip about any more.

Linda (F12), 16 years old

Often such children, especially in poverty-stricken areas, are the victims of incremental discrimination due first of all to the stigma related to HIV/AIDS itself, and then also because of the inevitable effects on afflicted households, such as increased poverty, educational deficits, and social skill deficits due to the absence of parental mentoring. This research only gathered qualitative data on stigma through the short narrative interviews held at the end of the quantitative data collection process. Data from the WHOQOL, however, suggests that many CHHs (62%) experience stigma, especially from within the extended family. This data is derived from the question on satisfaction with personal relationships and the quality of relationships with relatives.

The full extent of how stigmatization impacts children affected by AIDS - particularly when they are orphaned and live in CHHs - remains unknown and requires further investigation. Stigmatization experienced by children in other contexts contributes to delinquent behaviour, and with millions of children affected by HIV/AIDS in Africa, it is important to know how stigmatization will impact on their long term socialization within their own communities.

Self esteem

Grotberg (1995) notes in the report of the International Resilience Project (IRP)³⁶ that 'resilient children have positive self esteem and a sense of their own competency and efficacy'. Children develop self esteem when people in their close environment provide them with positive encouragement and feedback and when they have ample opportunity to develop skills in various areas of human functioning (Killian 2004:120). To measure self esteem within the cultural context of Southern Africa, however seems to be problematic. Killian (2004) utilized the Culture Free Self Esteem Inventory (CFSEI) (Battle 1992) in a study to measure self esteem before and after a community-based psychosocial support intervention in KwaZulu-Natal, South Africa. Although the CFSEI seemed to be a promising tool, reliability coefficients were extremely low. A Cronbach Alpha of 0.46 for general self esteem, whilst other subscales such as social/peer issues had Cronbach Alphas of 0.12, demonstrates test instability. Killian (2004:239) notes,

although the name of this inventory [CFSEI] suggests that it includes 'culture free' items, it is questionable whether this is the ideal type of measure to quantify self esteem within a collectivistic culture, in which individual perceptions of oneself are more likely to be interlinked with perceptions of others. [and on page 390] ...the concept of self-esteem has little meaning in collectivistic African cultures. The concept of evaluating self without valuing and acknowledging the critical role of others is contrary to their cosmology and to the concept of Ubuntu (Mkhize 2004).

It is, however, unclear if Killian's (2004) results were due to the test being inadequate or the inability of the psychosocial support intervention to enhance self esteem. Especially since an impact assessment on another psychosocial supporting programme, Masiye Camp (further discussed in section 6.5.2) has shown that one of the main programme impact indicators was enhanced self esteem. Dube et al. (2005)

³⁶ The International Resilience Project (IRP) is an international research project that is using different types of research methods to examine what helps children and youth cope with the many challenges that they face in life. It looks at this from the perspective of youth, elders and others in each community that participates. The project is working with children, youth, and elders in twelve countries and on five continents around the world. It was a 3-year pilot study funded by the government of Canada through Dalhousie University in Halifax, Nova Scotia Canada.

developed for that research their own tools, using initial exploratory research to develop these tools. These techniques were extensively used in Rwanda and documented by Bolton (2001). Tests of reliability such as test-retest reliability, and validity were conducted at the time of the cross-sectional survey. Data from that research show that compared to their comparison group of boys who did not participate in camps at Masiye (CG), boys who participated in Masiye Camp (MC) were more likely to report 'feeling confident in themselves sometimes or always in the last month' (MC 87.2% vs. CG 77.5%. See Table 6.3 below). It is interesting to note that the adjusted odds ratio is significant (adjusted OR 2.27, 1.14-4.45, $p < 0.05$) suggesting that, controlling for other factors, MC boys are more than twice as likely than CG to report good self esteem. MC boys were also more likely to report being able to cope with life's problems (73.7% vs. 66.7%), although this was a non-significant trend (adjusted OR 1.40, 0.88-2.22). Similar data for girls was not significant.

Item (boys)	Response: MC vs. CG	Adjusted OR	Confidence Interval	p value
Self esteem	87.2 vs. 77.5%	2.27 significant	1.14-4.45	$p < 0.05$
Ability to cope with life's problems	73.7 vs. 66.7%	1.40 non-significant	0.88-2.22	$p < 0.05$

Table 6.3: Self esteem measure in Masiye Camp PSS impact assessment

Source: Dube et al. (2005)

Analysing data from this research by using the two questions (F6.3: How satisfied are you with yourself? and F7.1: Are you able to accept your bodily appearance?) from the adjusted WHOQOL, suggests that children in CHHs have a high level of self esteem (see Table 6.4 below). This research has found that one of the important reasons children within CHHs cope is their resilience, which is partly reflected in their high level of self esteem. This despite an array of experienced adversities. This corresponds with findings from the international resilience project (Grotberg 1995).

Question	57	48
F6.3 How satisfied are you with yourself?	Female CHH	Male CHH
Very dissatisfied	0	0
Dissatisfied	2	0
Medium	14	2
Satisfied	26	30
Very satisfied	15	16
F7.1 Are you able to accept your bodily appearance?		
Not at all	0	0
A little	1	0
Moderately	6	3
Mostly	32	30
Completely	18	15

Table 6.4: CHH self esteem results from adjusted WHOQOL

This research corresponds with the Masiye Camp PSS impact study. The lower levels of reported self esteem among females may partly be attributed to the cultural status women have within the research area and possibly the fact that they have more often been involved in traumatic care experiences during parental illnesses, as shown in Table 6.1 above.

6.3 Resilient children

Resilience in the context of CHHs is a key concept in relation to individual and household coping as discussed before. While the developmental consequences of living in families affected by HIV/AIDS and caring for terminally ill parents can be devastating for some children, and all children pay a price, not all children experience developmental harm or psychological damage. This is clearly illustrated through the case studies in Chapter 5. CHH children like Future and Nompilo, who experienced and often still experience very difficult life circumstances, still see themselves as heroes, demonstrating this resilience in practice.

6.3.1 Concept of resilience

According to Coutu (2002:46), despite an improved understanding of the concept over the past three decades, resilience remains one of the ‘great puzzles’ of human nature. Various models have been developed (Rutter 1987; Grotberg 1995; Masten 2002; Baylis 2002) to explain the diverse empirical findings. Various child development experts have estimated that around 80% of all children (Garbarino 1992) exposed to highly stressful situations and conditions do not sustain developmental damage; it even seems that some children even make use of such difficult circumstances to grow stronger (Rutter 1979; Werner 1990; Fish-Murray 1990). Resilience therefore could be defined as the ‘the process of, or capacity for, successful adaptation’ (Killian 2004:112) of a person to challenging and extremely threatening life circumstances. Resilience is very important, especially for vulnerable children, as it is the ‘human capacity to face, overcome and be strengthened by or even transformed by the adversities of life’ (Grotberg 1999:3). The international resilience project, a 30-country study, facilitated by the Bernard van Leer Foundation, found that every country has a common set of sources of resilience from which children draw. These sources can be labelled as: I HAVE, I AM, I CAN. Table 6.5 below describes what children draw from each of the three sources.

Source	Practical application / description
I HAVE (external support and resources)	<ul style="list-style-type: none"> • People around me I trust and who love me, no matter what • People who set limits for me so I know when to stop before there is danger or trouble • People who show me how to do things right by the way they do things • People who want me to learn to do things on my own • People who help when I am sick, in danger or need to learn
I AM (Internal make up, beliefs, attitudes)	<ul style="list-style-type: none"> • A person people can like and love • Glad to do nice things for others and show my concern • Respectful of myself and others • Willing to be responsible for what I do • Sure things will be all right
I CAN (Interpersonal Skills)	<ul style="list-style-type: none"> • Talk to others about things that frighten me or bother me • Find ways to solve problems that I face • Control myself when I feel like doing something not right or dangerous • Figure out when it is a good time to talk to someone or to take action • Find someone to help me when I need it

Table 6.5: Three sources of resilience; Source: International Resilience Project
Source: Grotberg (1999)

There is no doubt that further research is required towards refining theoretical models of resilience, especially when taking into considerations cultural aspects of Southern Africa. Based on the above sources of resilience (Table 6.5) and various resilience models, the researcher developed Figure 6.1 below to demonstrate what key protective factors contribute to resilience in children living in CHHs.

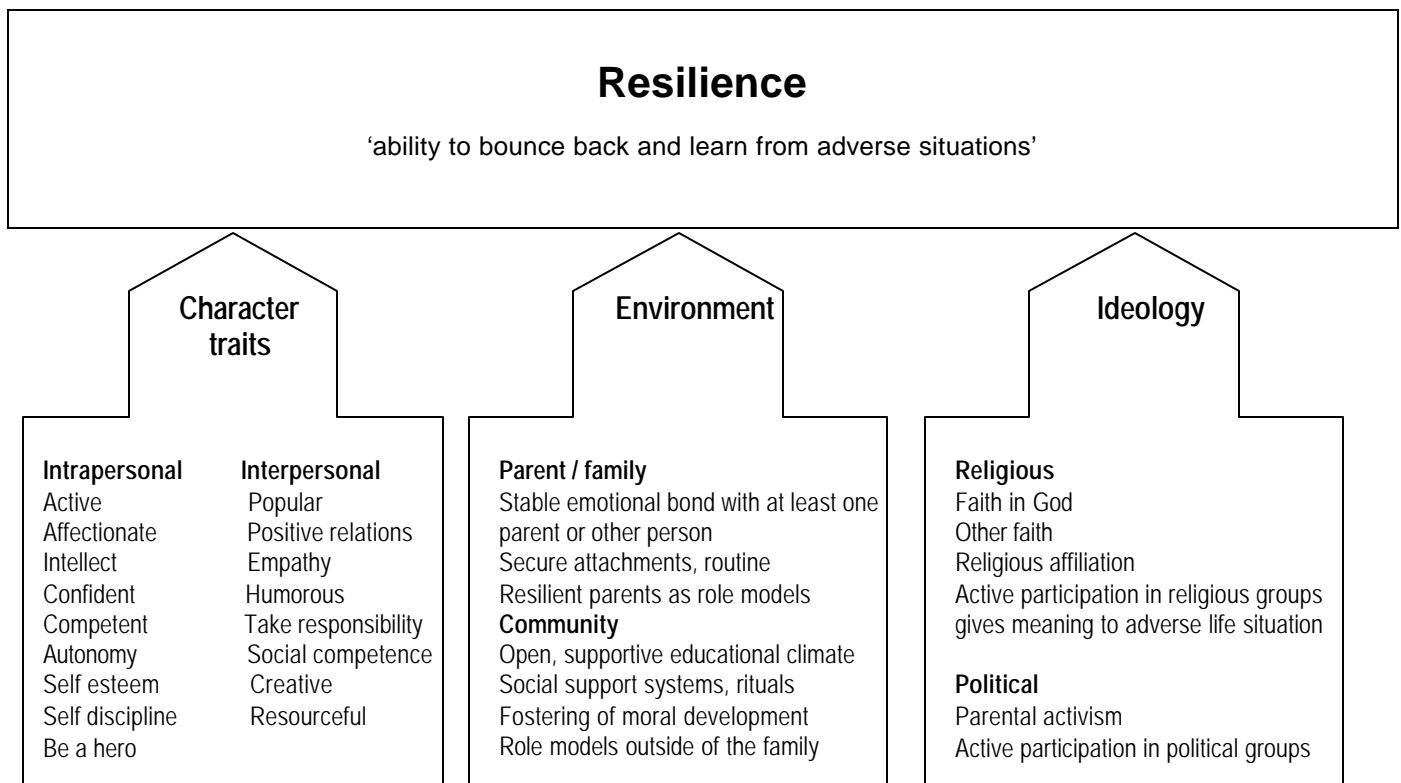


Figure 6.1: Key factors contributing to resilience in children

It has been noted (Masten et al. 1990) that resilient children have 'a sense of purpose and future orientation' which is combined with a sense of usefulness. The conclusion can be made therefore that age-appropriate responsibilities and tasks in the home, community and school contribute towards strengthening resilience. 'Required helpfulness' was identified by Werner (1984) as a resilience factor. So in the case of children who take care of siblings, relatives or even parents, while such experience is often traumatic, it may also boost resilience. Within the context of HIV/AIDS and poverty, however, it is important to carefully assess what constitutes age-appropriate tasks for children, as 'children need time to be children' (Killian 2004:122).

Reflecting on Future Ncube, the first case history presented in Chapter 5, the question can be asked: Why and how did she make it? She experienced several years of family instability and parental illness. She experienced high vulnerability and multiple losses. Yet she is a success story and sees herself as a hero.

First, Future possesses individual character traits that correlate with resilience, such as intelligence, popularity with peers and adults, and being affectionate, self disciplined and socially competent.

Second, several key factors in her environment served as protective factors. While Future had a stable emotional relationship with her father, her relationship with her mother was primary. Her mother provided, despite her illness, a supportive emotional environment for Future. Her mother was also a role model of resilience during her illness, because although she suffered greatly at times, she never complained and never gave up. Also, Future managed to access community social support systems by liaising with neighbours to provide limited support to the household during the mother's illness.

Third, when Future moved to the newly developed Cowdry park location, where her father built a two-roomed house after the mother died, she managed to make new friends and again establish strong peer support.

Fourth, Future has a strong faith in God, stating:

(I)...pray to God for strength and encouragement. I am drawing strengths from going to the Family of God Church. It gives me spiritual power.

Her active participation in a faith-based community further increases her potential emotional support bases and enlarges her social support system.

Thus in spite of multiple risks in Future's environment, including heading a CHH, there are several protective factors that help her prevail against all the odds. Given

the magnitude of the HIV/AIDS pandemic and the resulting large numbers of children who have to endure horrible circumstances, finding ways to enhance their resilience makes a lot of practical sense. Although they are changed by these difficult life experiences, and despite the enormous energy they must invest in survival and coping, given the right protective factors in their lives, they do bounce back rather than break.

I coped with the most difficult problems life can offer. The forthcoming problems in life will be smaller and more manageable (Nompilo, CH 2).

It therefore seems clear that 'enhancing resilience' should be a key focus for child support programme.

6.4 Quality of life and emotional well-being of CHHs

In section 3.5.7 the concept of 'quality of life' (QOL) was introduced and defined as the 'personal perception of an individual, regarding his/her position in life within the context of culture and value systems in correlation to his/her goals, expectations and standards regarding life.'

Utilizing an adjusted WHO psychometric tool called WHOQOL – BY the researcher aimed to assess the quality of life of CHHs within the study population. The results of this 'one-off' quality of life assessment conducted at the onset of the study are discussed below.

6.4.1 Quality of life of CHHs in study group

Many research participants felt it a challenge to answer questions when using a 5-point scale. Although the WHOQOL – BY questionnaire was translated, back translated and pilot tested, many participants struggled for example to distinguish the difference between 'dissatisfied' and 'medium' or 'medium' and 'satisfied'. For further research with adolescents it is recommended that face picture codes be utilized for each point to assist in choosing the question when using questions with a 5-point

scale. This could range from a bright smiley face for ‘very satisfied’ or ‘completely’ responses to a sad, distressed face for ‘very dissatisfied’ or ‘not at all’ responses (see Figure 6.2).



Figure 6.2: Symbols to use for 5-point scales

Given the constraints experienced in this research with the 5-point scale, the researcher decided to collapse the 5-point scale into a 3-point scale for the data analysis. Results are then presented as positive responses, medium responses and negative responses. In the following scale (Table 6.6), collapsing and weighting was allocated as shown:

Survey Scale	Descriptive Terms	Analysis Scale	Response Reported as	Weighting
1	Not at all, very poor, very dissatisfied	1	Negative	40%
2	Not much, poor, a little, dissatisfied	1	Negative	
3	Moderately, medium, neither poor nor good, quite often	2	Medium	20%
4	Good, satisfied, very much, mostly	3	Positive	40%
5	Completely, very good, very satisfied, an extreme amount	3	Positive	

Table 6.6: Scale survey and analysis weighting allocation

For the purpose of analysis, some responses (F1.4, F11.3, F8.1) were converted into reversed score. E.g. Question F8.1 asks 'How often do you have negative feelings such as bad mood, despair, anxiety and depression? The survey tool scale value for 'never' was 1. For the analysis, this was converted into scale value 5 (3) as the answer 'never' is positive.

The WHOQOL – BY tool was applied to 105 CHH members (57 female/48 male) and 26 siblings (14 female/ 2 male) within CHH. The WHOQOL – BY consisted of a cover page with general questions and the psychometric question page (see Appendix 4). Test questions needed to be answered in relationship to the respondent's life over the last two weeks prior to the test. Quality of life results are analysed and presented (see Table 6.7) in the following domains:

Domain	Q#	Questions
Physical life	B5 F1.4 F11.3 F22.1 F16.1 F7.1 F18.1 F10.3 F12.4 F19.3	Currently healthy Physical pain prevents day to day functioning (reversed score for analysis) Medical attention needed for day to day functioning (reversed score for analysis) Healthy physical environment Safe in daily life Accept bodily appearance Enough money Ability to perform daily living activities Capacity to work Access to health services
Psychological life	F4.1 F24.2 F5.3 F2.1 F21.1 F3.3 F6.3 F15.3 F8.1	Enjoy life Life is meaningful Ability to concentrate Energy for everyday life Opportunity for leisure activities Satisfied with sleep Satisfied with self Satisfied with sex life Negative feelings (despair, anxiety etc.)
Social relationships (see SSS under 8.3.1)	B16.1 F14.3 F13.3 F14.4	Relations with relatives Support from others Personal relationships Support from friends
Environment	F20.1 F9.1 F17.3 F23.3	Availability of needed information to take decisions Ability to get around Conditions of living place Transport situation
General QOL	G1 G2	Self rating – quality of life Satisfied with life

Table 6.7: Summary of quality of life domain / question allocation for analysis

Physical domain of CHH quality of life

Not surprisingly under the economic and political circumstances, not having enough money (96%) is a key negative factor impacting on the CHH physical domain of QOL. Of considerable concern is that a relative high number of CHH members (32%) do not see themselves as healthy, with (16%) feeling that physical pain prevents them from doing on a day-to-day basis what they need to do. It seems that the inability to access health services (24%), most likely due to a lack of money for clinic fees, contributes to the high number of CHH members not feeling healthy.

Although only the minority (15%) feel themselves unsafe in their community, there is a considerable gender difference, with (73%) of such respondents being females (Table 6.8 below). This has programming implications, such as integrating self defence training for females into CHH support programmes. Masiye Camp (see section 6.5.2) integrated into its CHH Household Management camps self defence lessons for female CHH members.

Physical domain QOL question	Positive ¹ responses %	Medium ¹ responses %	Negative ¹ responses %
Currently healthy (only yes – no option)	68	-	32
Physical pain doesn't prevent day to day functioning ²	71	12	16
Medical attention not needed for day to day functioning ²	87	8	5
Healthy physical environment	73	14	13
Safe in daily life ³	62	23	15
Accept bodily appearance	57	21	22
Enough money ⁴	4	15	81
Ability to perform daily living activities	67	23	10
Capacity to work ⁵	-	-	-
Access to health services	45	31	24
Compounded physical domain	60	16	24
Notes ¹ 5-point scale was collapsed into 3 for results presentation – weight distribution: Positive 40%, Medium 20% Negative 40% ² Questions from survey tool are negated for the analysis (see comment above on conversion of scales, use of reverse scores) ³ Within negative responses more females (73%) compared with males (27%) reported as feeling not safe in daily life ⁴ As discussed in Chapter 4, Zimbabwe has been experiencing an economic collapse with hyper inflation ⁵ The data from this question was deleted as it appears that the majority of respondents referred to 'having the opportunity for work' rather than the 'capacity to work' and therefore mostly (93%) reported negatively which was not consistent with the other QOL data pattern			

Table 6.8: Results from physical domain of WHOQOL – BY

Combining the results from the various physical domain questions gives a compounded result shown in Figure 6.3 below. Despite many negative experiences, the majority (60%) of CHH members seem to cope within the physical domain regarding their quality of life. The lack of financial resources at household level, however, is of concern as it impacts on the quality of life of the overall household; the youngest siblings, especially, are made very vulnerable as they are unable to generate income themselves.

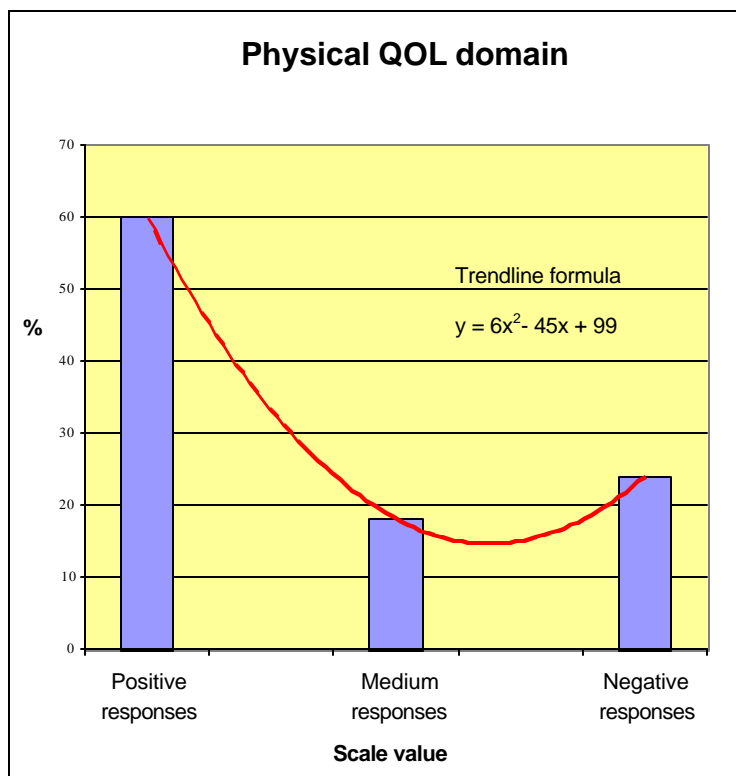


Figure 6.3: Graphical compound result of physical QOL domain

Psychological domain of CHH quality of life

Resilience is manifested in the following responses: Nearly 78% of CHH members responded that they are 'satisfied / very satisfied' with themselves, and for 63%, despite the trauma associated with parental illness and death due to AIDS, life continues to be seen as meaningful. At the same time, however, a high number either often (53%) or very often/always (10%) experience negative feelings such as bad

mood, despair, anxiety and depression. They therefore seem psychologically vulnerable but in some strange way invincible. Although psychological issues are often less visible in the day to day struggle of CHH members, they must invest enormous energy in the sphere of survival and coping in order to remain 'invincible'.

It is therefore not surprising that a considerable number of CHH members experience insufficient energy for everyday life - reported as mostly (14%) and moderately (27%) not having energy. This is further aggravated by a lack of food. When analysing the bi-daily journal nutritional information, it appears that most of those who reported lack of energy in the WHOQOL - BY had the lowest level of food security over the research period and may well have experienced chronic malnutrition within their CHH.

A disturbingly high number (50%) are not satisfied with their sex life, with 24% reporting themselves as dissatisfied or very dissatisfied. Lack of adult guidance in the area of sexuality, and the general inability to obtain important life information (73%) (see Table 6.12) seems to contribute to this dissatisfaction. It appears, that although there are lots of messages in the context of HIV/AIDS prevention on what not to do, there is little in-depth guidance for adolescents on how to manage / live out their sexuality in a satisfactory manner. Such counselling for CHH members seems to be missing regardless of whether such members are sexually active or live in abstinence.

Furthermore, only 49% of CHH members feel that they have adequate time or opportunity for leisure activities. For the majority, their tasks and responsibilities deny them the right to play and enjoy recreation. They do, however, seem to have time to meet with peers (Figure 6.11). Both are important developmental factors and if not satisfied (Max-Neef 1987) represent poverty in their lives. Children in CHH still need time to be children: to play with peers and engage in fun child activities (Table 6.9).

Psychological domain QOL question	Positive ¹ responses %	Medium ¹ responses %	Negative ¹ responses %
Enjoy life	40	34	27
Life is meaningful	63	21	16
Ability to concentrate	54	30	16
Energy for everyday life	59	27	14
Opportunity for leisure activities	49	24	27
Satisfied with sleep	73	22	5
Satisfied with self	78	12	10
Satisfied with sex life	50	26	24
Negative feelings (despair, anxiety etc.) ²	37	53 ³	10 ³
Compounded psychological domain	56	27	17
Notes ¹ 5-point scale was collapsed into 3 for results presentation – weight distribution: Positive 40%, Medium 20% Negative 40% ² reversed score, <i>Never / Seldom</i> gave positive response ³ medium stands for 'quite often' and negative for 'very often or always', therefore over 63% of CHH experience more than seldom negative feelings			

Table 6.9: Summary results of psychological QOL domain

As discussed in Chapter 4, during data collection there were serious shortages of stable food, fuel, transportation and even cash at the bank. Thus, in addition to the usual struggles of adolescence, youth in Zimbabwe confront added stresses due to the political and economic context. This is especially true of CHH members who have the additional burden of managing a household, often with insufficient support from others as discussed below.

As identified in the case studies (Chapter 5) most CHH members experience conflict with relatives or have no relationship with them. According to the QOL assessment (Table 6.10 below) a staggering 93% of CHH members have 'no / not a good' relationship with their relatives. Many CHH members (60%) perceive that they do not get much support from others. That changes, however, when asked about support received from friends, where 61% report being satisfied with such support. Although it is anticipated that the term 'friend' among adolescents is associated with peers, it is unclear from the WHOQOL – BY assessment if neighbours are regarded as friends or not. Data from the Social Support Scale (SSS) and BJDJ suggested that respondents in the WHOQOL – BY regard neighbours as friends. The data on support from others was disaggregated into 'old' and 'new' townships, as support differs between the two,

as seen in the case studies (Chapter 5). This disaggregated data is discussed in section 8.3.4.

Social relationships domain of CHH quality of life

Social relationships domain QOL question	Positive ¹ responses %	Medium ¹ responses %	Negative ¹ responses %
Relations with relatives (only yes – no option)	7	-	93
Support from others ²	19	21	60
Personal relationships	27	38	35
Support from friends	61	26	13
Compounded social relationship domain	29	21	50
Notes ¹ 5-point scale was collapsed into 3 for results presentation – weight distribution: Positive 40%, Medium 20% Negative 40% ² Needs to be disaggregated regarding 'new' – 'old' township location (see Chapter 8)			

Table 6.10: Summary results of social relationships QOL domain

Combing the psychological domain and the social relationships QOL domain provides data on the psychosocial wellbeing of CHH. In Figure 6.4 below, trend-lines within the chart show that the majority (58%) of CHHs experience psychosocial distress.

This data corresponds with research results on OVC psychosocial well-being from Dube et al. (2005) that included results from over 1,258 respondents in Matabeleland. Respondents reported high levels of psychosocial distress, with psychosocial distress among OVC consistently increasing with age (Table 6.11).

Some/Most of the time	Age	14-15	16-18	19-20
Feel sad		57	67	68
Trouble concentrating		56	65	74
Feel nothing in life interests me		44	53	54
Feel alone in the world		35	43	48
Feel overwhelmed by problems		55	65	71
Cannot control my emotions		41	49	51
Feel hopeless about the future		51	59	66
Feel worried or stressed		64	74	81
Feel irritable		62	65	74
Note: For each item, there was a significant difference, $p < 0.05$, between contiguous age groups. Other items followed the same trend but were not statistically significant.				

Table 6.11: Proportion reporting indications of psychosocial distress by age

Source: Dube et al. (2005)

It appears that respondents in that study more exposed to trauma were also more likely to report that they could ‘cope with the difficulties in life’. This suggests, as discussed above that resilience is gained, rather than lost, as a result of moving through traumatic experiences – a phenomenon known as ‘post-traumatic growth’ (Tedeschi & Calhoun 1996).

The concept of ‘post-traumatic growth’, however, has only limited application in the context of CHHs. For children affected by HIV/AIDS, and CHH in particular, there may be the need to introduce a new term such as - ‘chronic-traumatic growth’. Although this concept cannot be found in the literature along the lines of Straker’s (1987) concept of ‘continuous traumatic stress symptom’, it may be useful in capturing what many children affected by AIDS are experiencing and how it impacts on their resilience over sustained periods of adversity.

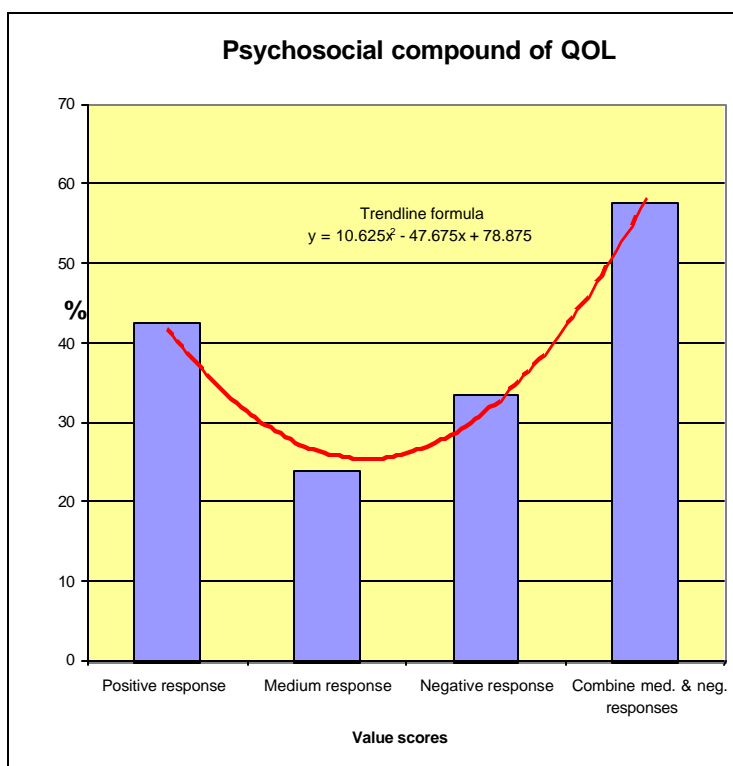


Figure 6.4: Graphical compound results of psychosocial issues in QOL

Environmental domain of CHH quality of life

As mentioned above, access to and availability of needed information to take good decisions is not adequate for over 92% of CHHs. They struggle to obtain information on issues such as household management, sexuality, alcohol use, legal issues to run a household, care of younger siblings, etc. Facilitating access to information for CHHs seems to be a primary gap in the social safety network for vulnerable children at community level.

Part of the Quality of Life questionnaire includes the question on access to transport. It appears that the high costs of transport impacts on CHH members' ability to make use of existing transport infrastructure in urban Bulawayo and therefore has a negative impact on the environmental domain of the quality of life (Table 6.12).

Environment domain QOL question	Positive ¹ responses %	Medium ¹ responses %	Negative ¹ responses %
Availability of needed information to take decisions	8	19	73
Ability to get around	36	40	24
Conditions of living place	57	14	29
Transport situation ²	12	67	21
Compounded environment QOL domain	28	35	37
Notes ¹ 5-point scale was collapsed into 3 for results presentation – weight distribution: Positive 40%, Medium 20% Negative 40% ² Main reason is affordability and not availability			

Table 6.12: Summary results environment QOL domain

Quality of life CHH self assessment

Two questions in the WHOQOL – BY tool are a self assessment of the respondents perceived quality of life and general life satisfaction. A majority of CHH members (55%) report 'medium' on their self assessed quality of life which is consistent with results from the BJDJ (Figure 6.8). Not surprisingly, for 22% the quality of life experienced is viewed as 'poor / very poor' (Table 6.13).

QOL self assessment questions	Positive ¹ responses %	Medium ¹ responses %	Negative ¹ responses %
Self Rating – Quality of Life	19	53	28
Satisfied with life	27	57	16
Compounded QOL Self Assessment	23	55	22
Notes ¹ 5-point scale was collapsed into 3 for results presentation – weight distribution: Positive 40%, Medium 20% Negative 40%			

Table 6.13: Summary results QOL self assessment

The overall assessment of the quality of life for CHHs in Figure 6.4 below shows that despite all the adversities experienced by CHHs, over 37% reported a satisfactory quality of life. This is in stark contrast to public opinion as expressed in FGDs with community members. It is of concern, however, that almost 30% of CHHs do not

appear to cope well, lacking good relationships with relatives and receiving inadequate support from their community.

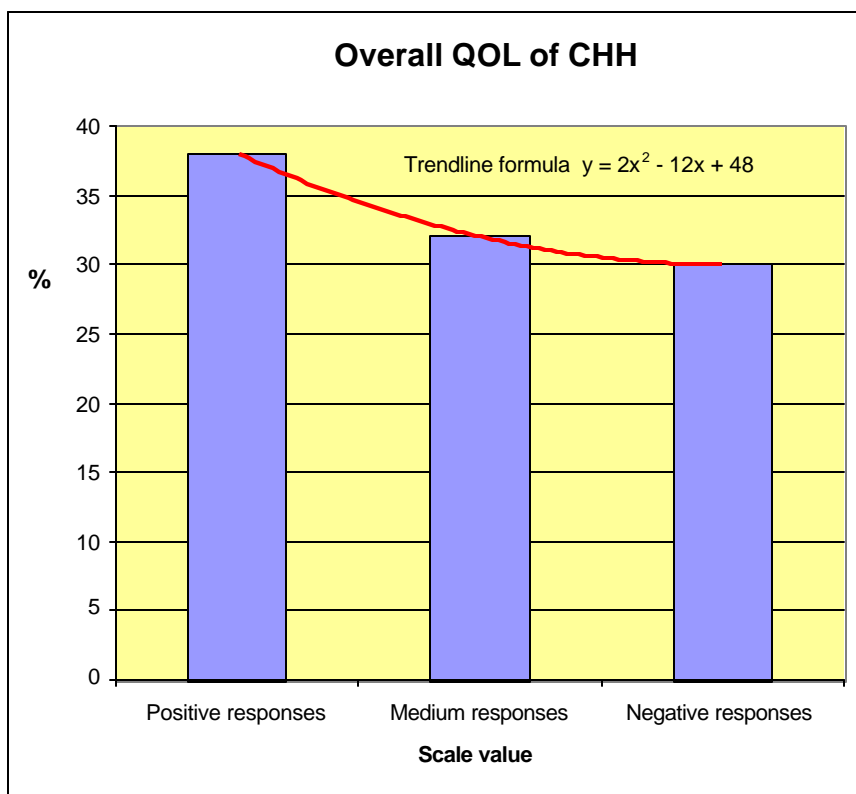


Figure 6.5: Overall QOL assessment of CHH

Whereas assessing the quality of life in the physical and environmental domain does not raise many methodological questions, assessing psychological or social issues is more complex and problematic. The following section provides some analysis on psychosocial issues and highlights some of the difficulties in assessing those domains in an age- and culture-appropriate manner.

6.5 Psychosocial issues of CHH

Although psychosocial support for children as a concept has a long tradition, essentially integrating good child-rearing practices over the child's developmental stages, it has a short formal documented and researched past. While it remains a

difficult concept to define accurately, it aims at contributing towards increased resilience in children.

6.5.1 Psychosocial support and care

Only as recently as November 2004, the first stakeholder consultation in Southern Africa aimed at 'defining psychosocial support' in the African context took place (Laugharn 2004:1). This consultation produced the following working definition for psychosocial care and support (Box 6.1).

Psychosocial support and care

Psychosocial wellbeing is essential for children's survival and development, especially in enduringly difficult circumstances.

Children affected by HIV/AIDS endure the loss of caregivers, livelihoods, and health. Many suffer deprivation, overwhelming loss and grief, upheaval, discrimination and social exclusion.

Psychosocial care and support includes interventions that assist children and families to cope. They enable children to experience love, protection and support that allow them to have a sense of self-worth and belonging. These are essential in order for children to learn, to develop life skills, to participate fully, and to have faith for the future.

Support for children's psychosocial well-being is a key investment in human capital because it underpins all other processes for the long-term development and stability of societies.

Box 6.1: Working definition on psychosocial support

Source: Laugharn (2004)

As discussed in Chapter 2, HIV/AIDS at household level causes children to face complex and devastating adversities, increasing their vulnerability. It further exposes them to profound and prolonged emotional and social suffering (see section 2.3.3). Psychosocial support (PSS) has been advocated as the strategy through which ongoing psychological and social problems of individuals, families and communities can be identified and addressed at a micro-systemic level (Germann & Madörin 2002; WHO 2003b; Levine & Foster 1998). Although the practical application of PSS is at

the micro-systemic level, PSS needs to be the overarching paradigm, operative at all systemic spheres of influence, that is: as micro-systemic, exo-systemic, meso-systemic and macro-systemic (Figure 6.6) (Bronfenbrenner 1997).

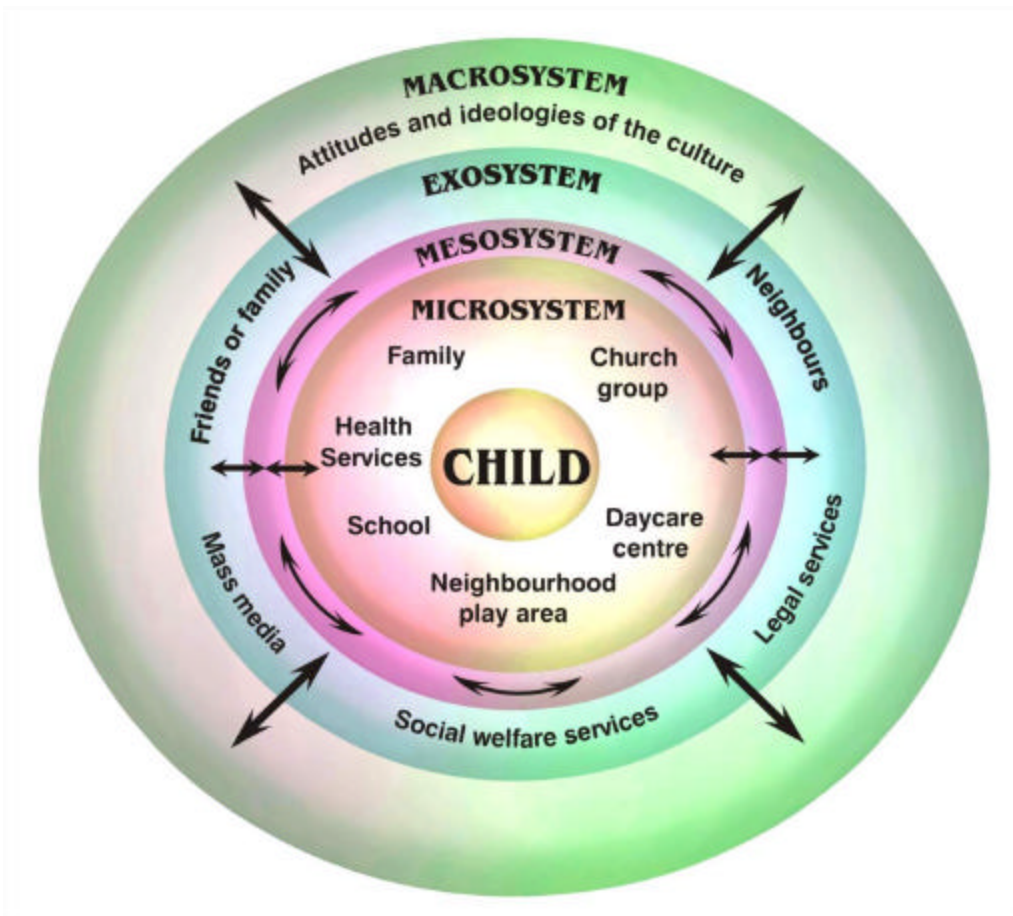


Figure 6.6: Bronfenbrenner's four ecological settings for developmental change
Source: Adapted from Kluckow (2003)

The researcher's own PSS advocacy involvement helped PSS to become an integral paradigmatic approach in the global OVC programming framework that was finalized by the United Nations in February 2004 (UNICEF & UNAIDS 2004). However, for the purpose of this research, PSS was largely considered as micro-systemic, as the data collection and analysis from the WHOQOL – BY and bi-daily journal data sheets (BDJD) is primarily concerned with person-to-person interactions, emotional well-being of CHHs, as well as assessing the caring capacity of the immediate environment in which children live.

To foster a better understanding of the practical application of PSS at local programmatic level, REPSSI (2002) with the involvement of this researcher, developed a set of basic assessment indicators to assist programmes to identify whether they address all aspects of PSS within their programme (Table 6.14). It is acknowledged that many child-support programmes often only cover one or two of the three programme areas outlined below. They therefore do not provide full psychosocial support.

Domain	Description	Possible form of programmatic application
Psychological	When an organization or community group provides / organizes / stimulates etc. and therefore creates a platform that makes it possible for an individual child to disclose feelings, realities etc. and provides some form of counselling.	<ul style="list-style-type: none"> • Group processes / group counselling • Debriefing in experiential learning, plays • Home visits of OVC with quality time spend with children • Drop in centre • Etc.
Social	When an organization or community group actively influences the social environment in direction of reintegration of affected children into 'normality' and creates comprehensive understanding of the specific situation of children i.e. create somehow durable social structures	<ul style="list-style-type: none"> • Training of care takers and guardians • Community sensitization of PSS issues for CABA • Orphans organization (orphans organize themselves in interest groups) • Kids Clubs • OVC community committees • Etc.
Support	When an organization or community group explores and builds up systematically the internal / own resources of children in order to enhance their resilience	<ul style="list-style-type: none"> • Training of kids in life skills or camps • Positive feedbacks to children about their performance • Solution focused approaches / participatory methods / creative self expression / drama and dance etc.

Table 6.14: Basic PSS programme self assessment indicators

Source: REPSSI (2002)

As the rather abstract term ‘psychosocial support’ is not suitable at community level it is important that communities adopt or choose a word or phrase in their own language that relates to ‘building a child’ along the lines of basic PSS programme indicators and the working definitions described above. The following section looks at community perceptions of PSS issues within CHHs, based on FGDs. It also examines the psychosocial status of CHHs through analysing the twelve-month use of the bi-daily journal data sheets (BDJD) of research participants.

6.5.2 Psychosocial results from bi-daily journals (BDJD) and FGD

A majority of FGD participants reported that they were not too worried about children’s emotional well-being in CHHs, but wanted to be able to help in some way with their material needs. Several of the respondents claimed that they felt that the community did not care about the children’s psychosocial well-being and said that ‘people have too many problems of their own’. Some people said that CHHs were seen as a problem by the community because of their anti-social behaviour (such as aggression, withdrawn, uncommunicative behaviour, and alcohol abuse), stating:

They [CHHs] are not ready to face life's challenges i.e. they have no moral values therefore a lot of problems may arise (FGD 5.11).

There was a general feeling amongst community members that more should and could be done to help orphaned children, particularly CHH members, especially in the area of moral support and 'teaching them about life'.

Most FGD participants suggest that CHH members' emotional well-being is better catered for if they are not sent to orphanages, because

children in orphanages are not happy. They yearn for a life with relatives and siblings. I think orphanages are not good because children brought up in the orphanages turn out to be different from those who grow up in their homes (FGD 1.11).

Although issues of emotional and social well-being were mentioned during the FGD, there was not much depth in these discussions. This seems to confirm that for many communities, psychosocial issues, since they are not visible, are not seen as important. For CHH themselves, however, these are important issues affecting their quality of life.

As discussed in section 3.5.7, a one-off interview using the WHOQOL - BY instrument is not sufficient to assess the well-being and coping capacity of CHHs. In order to obtain an understanding of how a CHH copes and fits into society over time, ongoing assessment is required (Luzze 2002:29). Therefore, for this research, the BDJD was developed using the six domains that were used in the development of the WHOQOL-100 described in section 3.5.7. To analyse the psychosocial status of CHHs the following highlighted questions were used from the BDJD instrument (Table 6.15).

Domain	Q#	Question	Comment
Psychological	HE2	Are you very tired?	Although this series of questions has not been validated for use in clinical psychiatric diagnosis (e.g., diagnosing depression or anxiety disorders), they are useful in eliciting a picture of emotional well-being and distress among respondents.
	HE3	Did you sleep well last night?	
	HE6	Are you happy?	
	HE7	Can you concentrate well today?	
	R5	Did you pray today?	
	G2	Did you enjoy the day?	
	G9	Did you experience abuse?	
Social	R1	Did you play today?	
	R3	Did you spend time with friends?	
	C3	Did you visit someone today?	
	H1	Did you cope with your sisters / brothers?	
	H5	Did you have a conflict at home?	
	G7	Are you satisfied about your friends?	

Table 6.15: BJDJ set of questions for CHH psychosocial status analysis

Note: (Non market data sets contained irreversible errors or non significant)

Although there are considerable individual differences related to psychosocial well-being of CHHs, it is of interest to analyse the data from the BJDJ on a summary reporting basis to examine the overall psychosocial status of CHHs within the research area. Examining individual psychosocial well-being is beyond the scope of this research and falls into the area of psychological research.

Data was therefore analyzed using histograms on total reported incidences from the 13,055 available BDJD sheets for significant results on the selected psychosocial issue questions.

On the question: Are you happy today? It was surprising to find the majority of bi-daily reporting CHH members reported 'yes' (Figure 6.7).

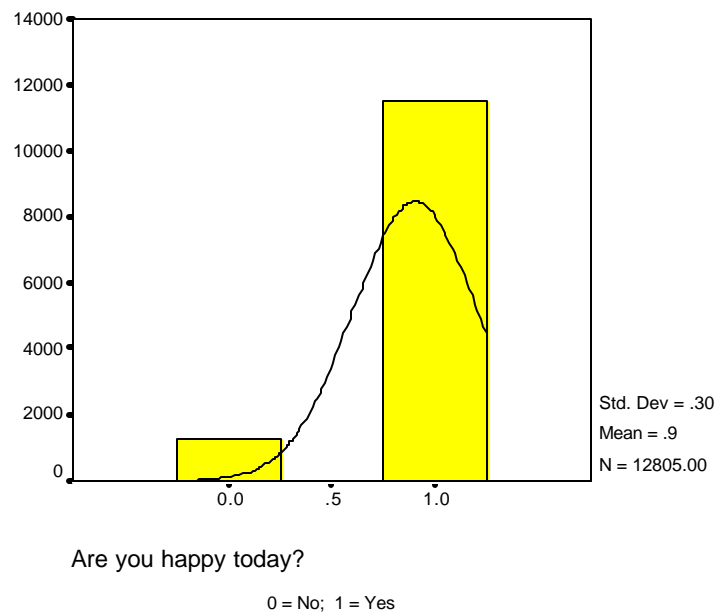


Figure 6.7: Are you happy? Response histogram

However, when respondents were probed to answer the question, 'Did you enjoy the day?' with a 5-point scale ranging from 'no' to 'a great deal,' the results tended to be clustered around 'medium' (Figure 6.8).

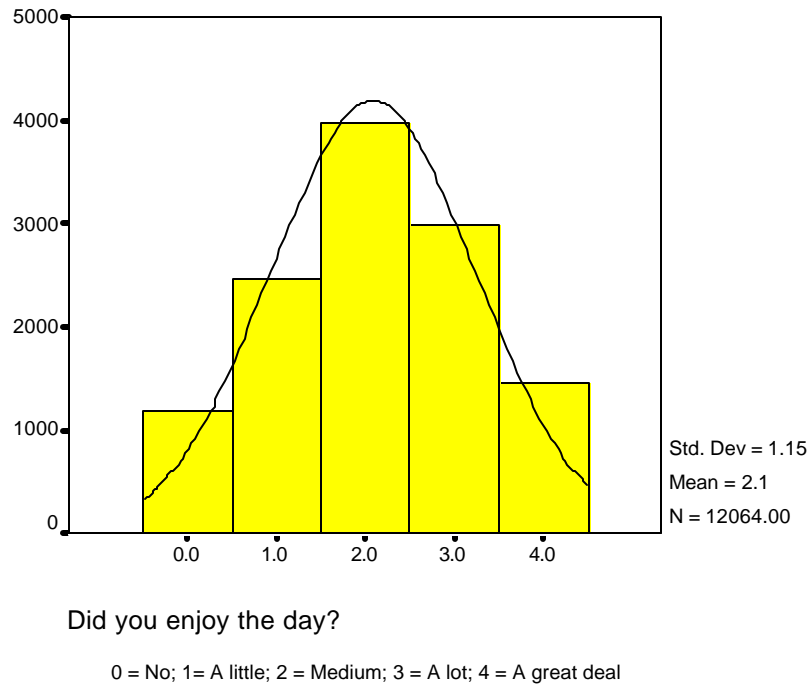


Figure 6.8: Did you enjoy today? Response histogram

It was surprising that despite the daily hardship experienced, CHH members experience 'medium' day-to-day enjoyment, even with a slightly positive trend (Mean 2.1). This corresponds with the data from the quality of life assessment described in section 6.4.1 above.

Spirituality seems to be an important resilience factor for CHHs as the majority are engaged in daily prayers as shown in Figure 6.9.

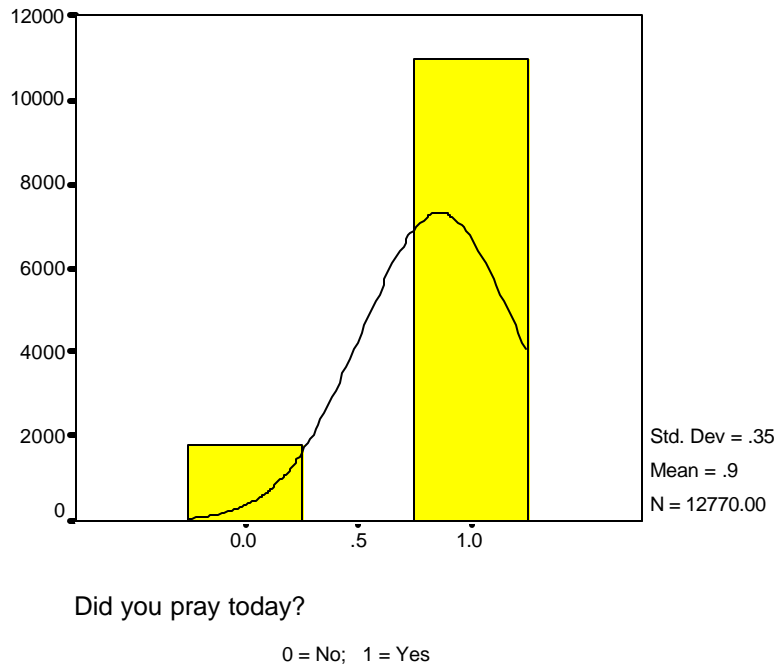


Figure 6.9: Did you pray today? Response histogram

Narrative interviews further showed that participating in spiritual activities, friends from their faith based group, and neighbours who are church members are all sources of support to the CHH.

It is of considerable concern that over 975 abuse incidences, ranging from verbal to physical and even sexual abuse, were reported (Figure 6.10). Twelve percent of such reported abuse incidences were sexual abuse. In two situations, both involving females, the respondents had to be referred to Contact Family Counselling for support as they told the research assistant that they had been raped. Using individual analysis from the total CHH sample, some 9% experienced abuse on one or more occasions during the 12 months data collection period.



Figure 6.10: Abuse incidences response histogram

Related to social connectedness it appears that on most days CHH members in urban Bulawayo are able to maintain and draw strength from interacting on a daily basis with friends (Figure 6.11).

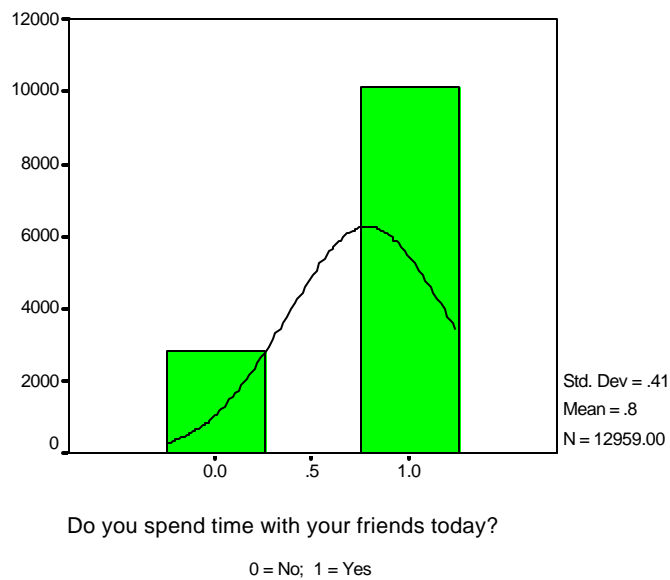


Figure 6.11: Meet with friends response histogram

Individual CHH data show that 6% of members were not able to meet with their friends at least once per week. This might be an indicator of considerable household distress. Unfortunately the BJD questionnaire did not capture the actual time spent with friends. It is therefore not possible to make a qualitative analysis of CHH members' interaction with friends.

Sibling relationships within CHHs are generally good although there were over 1,398 reported conflict incidences. Based on data presented in Figure 6.12 below, it appears that most of these conflicts tend to centre on incidences of disobeying the head of the household. Drawing from narrative interview data presented in Chapter 5, the conclusion can be drawn that in most CHHs, siblings get on well together and are a source of strength for each other. Good sibling relationships seem to be a factor that strengthens CHH resilience and coping capacity. Siphso (F32) expresses the importance of siblings as follows:

Since both my parents died, my two younger brothers are the most important persons in my life. Although we quarrel at times, especially if I ask them to wash and clean the floor, we are getting on well together and need each other.
Siphso (F32)

Therefore, for extended families and OVC support programmes, keeping siblings together after parental death should be a high priority. Although there is no supporting qualitative data available, the researcher's own empirical assessment of the living conditions among orphans suggests that siblings staying together, even if it means the formation of a CHH, are not worse off than orphans who have been split up and live separately in relatives' households.

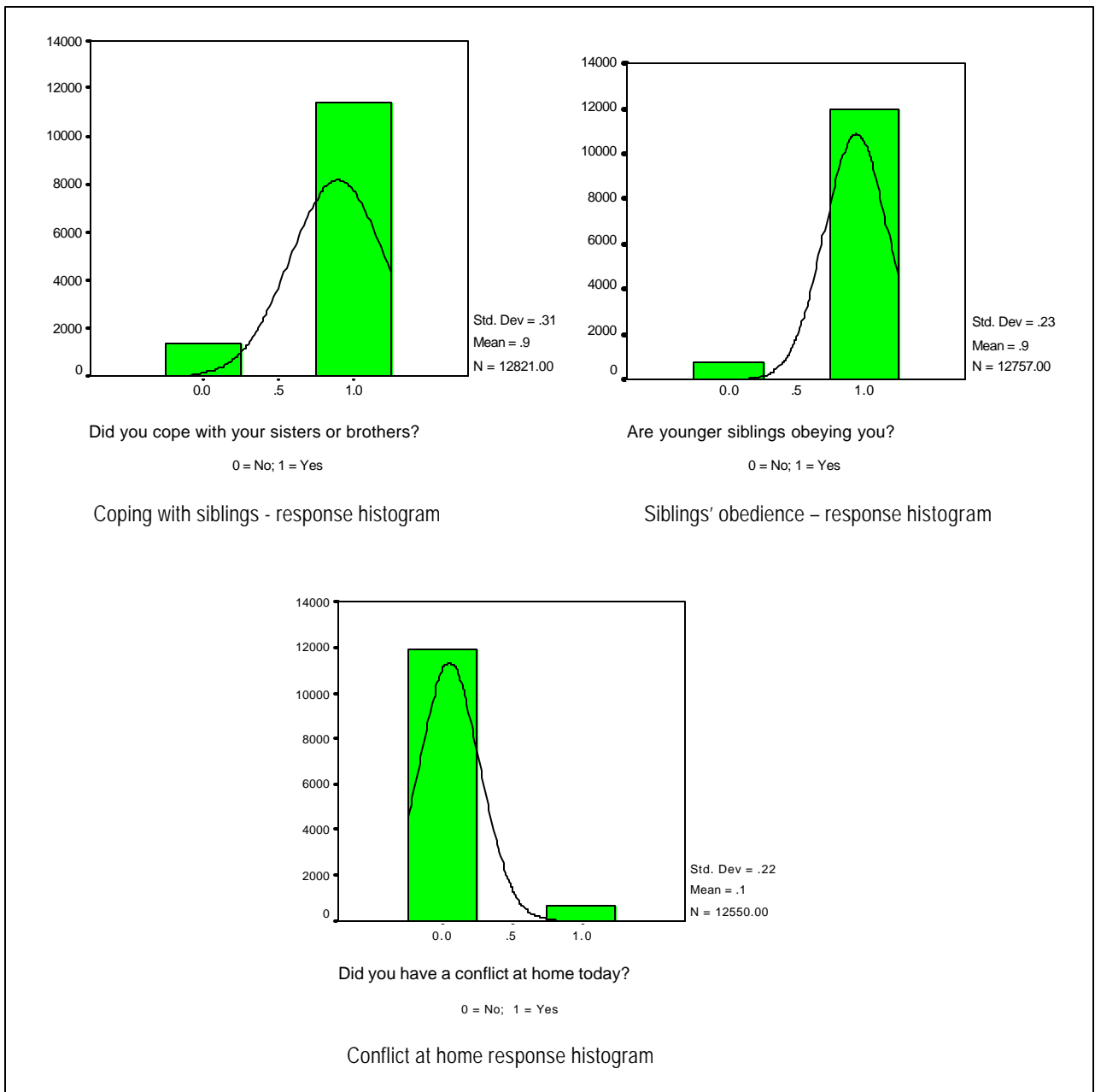


Figure 6.12: Conflict, siblings coping and obedience histogram

Although there were over 2010 reported incidences of dissatisfaction with friends, most of the time CHH members enjoy good relationships with their friends. The level of dissatisfaction with friends reported is not unusual among adolescents. Therefore the conclusion can be drawn that CHHs in urban Bulawayo have peer relationships as healthy as adolescents in the broader community (Figure 6.13).

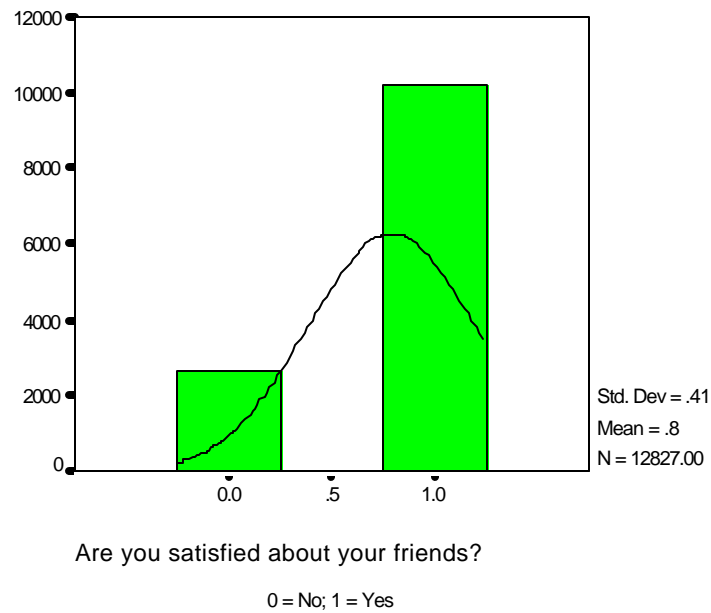


Figure 6.13: Relationship with friends response histogram

In summary, contrary to public perception as expressed in the FGD above, quantitative research suggests that although CHHs face many adverse life situations, they often as a result demonstrate high resilience. CHHs do not, as stated in the FGDs have *'no moral values,'* but stand up amazingly to life's challenges. However, neighbourhood adult guidance and peer and sibling support are essential components for their resilience and coping capacity.

6.5.3 Difficulties in assessing psychosocial wellbeing

The measuring and assessment of the psychosocial wellbeing of children and adolescents in the cultural context of eastern and Southern Africa is an emerging field, and will remain a challenge over the next few years. A good deal of recent research (Killian 2004, Dube et al. 2005, Gelman 2003) including this research, highlights the following research constraints:

- Existing psychosocial research has concentrated principally on developed countries, and even there, research has mainly focused on sick children and their families (Levine & Foster 1998, WHO 2003).

- Methods to measure psychosocial wellbeing have not yet been thoroughly evaluated for validity and reliability.
- Researchers, often from different cultural and socio-economic backgrounds, do not fully understand or capture vulnerable children's attitudes towards death, grieving processes, and the signs and symptoms thereof.
- Often researchers speak a different language and this creates enormous challenges with translating complex psychological and social concepts.
- Issues of self-esteem within collectivist cultures need further research as Western tools are too focused on the category of the individual.
- Researchers noted that when questions on emotions are worded positively, respondents generally reported more positively. This could reflect differences in how youths perceive questions depending on how they are phrased. It could also simply capture the ordinary range of adolescents' emotions.
- Gender issues related to psychosocial wellbeing within the cultural context of this research are not fully understood. Findings in some research (Dube et al. 2005) suggest that there are higher levels of psychosocial distress in girl respondents, lower confidence in their own coping abilities and less faith in others. It is unclear whether this is because girl respondents tend to more readily express and describe their emotions or because girls simply suffer more stressful and traumatic experiences than boys.
- Literacy levels in vulnerable child populations are often very low, impacting negatively on the use of existing self-reporting tools.
- Many children and adolescents have a limited vocabulary, even in their mother tongue, of words to describe different feelings, often labelling all bad feelings as 'pain' and all good feelings as 'happiness'. This low level of 'emotional literacy' hinders research.
- Questionnaires using scales seem to be problematic and picture codes to scale a response might need to be developed and tested for validity and reliability.

Research bodies, notably the Human Science Research Council, Children's Institute of the University of Cape Town and the University of KwaZulu-Natal, are increasingly engaged in the area of psychosocial support for vulnerable children, and this will

hopefully accelerate the development of urgently needed, culturally appropriate, psychometric tools and reliable outcome measures for psychosocial support.

6.5.4 Psychosocial support programmes in Bulawayo

When reviewing the data from this research, it is important to contextualize it amid a relatively well established psychosocial and community response to OVC. As discussed in Chapter 4, collective efforts for OVC support started as early as 1993 within the research area. In response to the rapidly growing number of children affected by AIDS in Bulawayo, and the recognized need for psychosocial support as a micro-systemic intervention, several important psychosocial support programmes emerged. Table 6.16 does not claim to be conclusive, but lists key organisations in the research area that strengthen capacity or provide PSS for children affected by AIDS.

Type of organisation	Name of organisation	Methodological Approach /Tools	Geographical Focus
Technical capacity building	REPSSI	Partner capacity building in PSS methods, training, resource material development, Journey of life tools, PSS knowledge management, advocacy and documentation	SADC regional / Secretariat in Bulawayo
	CRS STRIVE	Partner capacity building to increase child focused activities to improve PSS	Zimbabwe national / office in Bulawayo
FBO umbrella	HOCIC	Training of FBO grassroots programme volunteers in PSS. PSS community mobilisation	Bulawayo and south- western Zimbabwe
Child Service delivery	Masiye Camp	Adventure based outdoor learning, Life skills camps for orphans, CHH household management camps, PSS for children under 6 years	Camps for children from Bulawayo. Training in PSS at national / regional level
	YOCIC	PSS through kids clubs, training of kids club leaders in group therapy processes	Bulawayo urban
	MMP Zw Trust	PSS through memory work approaches such as body maps, memory books, hero books, memory boxes, tracing books etc.	Bulawayo urban with national training activities
	Contact Family Counselling	Systemic family and individual counselling, counselling training programme	Bulawayo urban

Table 6.16: PSS Programme response summary in urban Bulawayo

From his position as a 'social entrepreneur,' this researcher was a founding director of four of the above organisations (REPSSI, HOCIC, Masiye Camp, MMP Zw Trust).

The PSS programme initiatives of each of these organisations are set out below, with a focus on their impact on CHH psychosocial well-being. Although the research on support programmes did not include programme evaluations, some suggestions on possible programme improvements are made. These suggestions were shared with each organization after the assessment visit was done.

REPSSI (www.repssi.org)

The idea of REPSSI (Regional Psychosocial Support Initiative) as a regional initiative to scale up psychosocial support for children affected by AIDS was conceived during a regional Think Tank. In August 2001, a diverse group of practitioners, children, youth, managers and academics from organisations responding to the OVC crisis participated in this Think Tank so as to identify gaps in psychosocial support within the region. In January 2002, REPSSI - by then a collaborative NGO venture with four lead agencies - invited donors to participate in this regional initiative as partners. By March 2002, a donor consortium including the Swiss Agency for Development and Cooperation (SDC), SIDA (Swedish) and the Novartis Foundation for Sustainable Development agreed to fund REPSSI in addressing OVC needs. REPSSI launched its capacity building programme for regional technical psychosocial support in May 2002.

REPSSI's major objective is to build partners' technical capacity to conduct appropriate and cost-effective psychosocial interventions in the lives of children affected by AIDS, poverty and violence. These interventions aid emotional healing and strengthen community connectedness, through intentional emotional, behavioural, and psychological support. Psychosocial support thereby enhances the resilience of children and their families in the context of HIV/AIDS. The result chain

below (Figure 6.14) outlines REPSSI's results-based management framework, instituted to assist organizations in providing psychosocial support for CABA.

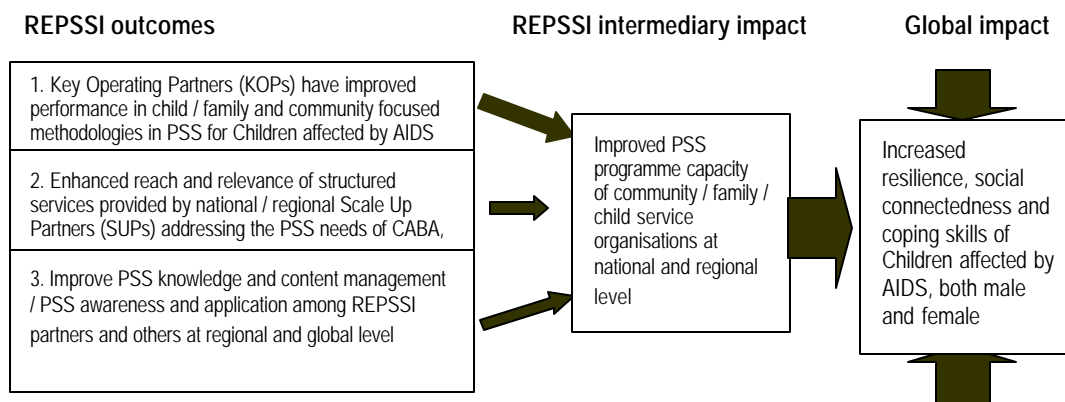


Figure 6.14: REPSSI results chain

Source: Germann (2005)

After a short time in operation, REPSSI established itself among key stakeholders in the region as a leader and centre of expertise in the area of PSS issues for children in eastern and Southern Africa. REPSSI was registered as an independent organisation in early 2005.

Although REPSSI does not work directly with children, its work impacts on CHHs. Within the research area, REPSSI partners with Masiye Camp, HOCIC, YOCIC and CRS Strive programme and supports them with technical capacity building and programme support to improve and scale up PSS interventions for children. REPSSI helped Masiye Camp to introduce a life skills camp programme for CHHs and to develop a CHH manual. The development of this 'child-headed household guide' (Smith 2004), was prompted by the results from this research, which showed that 92% of CHHs (discussed under section 6.4.1) did not have adequate access to appropriate information for taking informed decisions in their daily lives.

REPSSI further facilitated the development of a PSS community care capacity building tool called 'Journey of Life' (JOL). The Journey of Life is a workshop designed to help youth and adults to become more aware of the needs and problems of children who live in difficult circumstances within their own community. This

community resource is widely used by REPSSI partner organizations to facilitate community mobilization processes aimed at increasing community care and support for vulnerable children.

Reflecting on the work of REPSSI it is suggested that REPSSI increases its documentation work as many important PSS programme responses at local level are not adequately documented. Through increased knowledge and content management, REPSSI would be able to further upscale PSS within the SADC region.

CRS STRIVE

In 2000, USAID/Zimbabwe conducted a situation analysis of orphans and vulnerable children (Foster, Germann & Sussman 2000). Based on this situation analysis USAID/Zimbabwe sought applications for funding to address the crisis. After a competitive selection process Catholic Relief Services' (CRS) STRIVE project (Support for Replicable, Innovative Village level Efforts for children affected by AIDS) was chosen. In addition to its Harare head office, a CRS STRIVE project office was set up in Bulawayo from 2002 to 2004.

Psychosocial support interventions were included among the five key strategic areas for the STRIVE programme. The aim was to support CRS STRIVE partners with child-focused activities to improve the psychosocial condition of orphans and other children at risk, as well as their caregivers (CRS/USAID 2003:5).

By March 2003 a total of 35,000 children within eight STRIVE partnerships had received ongoing PSS through the following activities:

- Raising awareness within communities to support programming to meet the emotional, physical, spiritual, mental and social needs of vulnerable children
- Capacity building of network organizations (e.g. HOCIC) and community volunteers in integrating PSS into child support programmes

- Setting up of community-based group counselling services for orphans and other vulnerable children
- Establishing of support systems and widening of social networks of trusted people to which vulnerable children could turn for safety and counselling
- Organising and supporting OVC life skills camps and galas for peer socialisation, self-esteem development and confidence building among vulnerable children

While CRS STRIVE and its partners have assembled a sizeable database for their operational research, they have no data on CHHs within partner communities. CHHs within STRIVE partner communities are integrated into the programme, benefiting from the same support as all the other vulnerable children, including educational support, PSS, food security and household economic strengthening.

Many of the communities where CRS STRIVE partners work have not taken 'ownership' of the PSS programme, and have not fully understood their role (Brakarsh 2003:A42). There is an urgent need for CRS STRIVE to develop strong community PSS mobilization elements, utilizing tools such as the Journey of Life.

HOCIC (Hope for a Child in Christ)

As HOCIC was already introduced in section 4.4.3, this recapitulation will only look at the PSS interventions of HOCIC within their FBO community responses. As a CRS STRIVE implementation partner, HOCIC, with the support of Masiye Camp, piloted community PSS activities in selected communities.

Most notable among these were the Bongani Orphan Support Trust and the Bulawayo Archdiocese Orphan programme. Both of these HOCIC partners initiated interesting community PSS programmes with HOCIC support in their operational areas. Both programmes started as home-based care (HBC) programmes to support sick community members who were mostly terminally ill. Realizing the need to support children within such households and after parental death, these programmes started to integrate orphan and vulnerable children support into their programmes.

Initially they focused on providing material and educational support. Through the influence of Masiye Camp, programme volunteers were increasingly sensitized to the PSS needs of children within their programmes. In response they started community dialogues on how caregivers, grandparents, neighbours and community members could best provide PSS to their own vulnerable children. The community mobilization efforts of HOCIC were supported by CRS STRIVE, and selected sites were included in the PSS impact assessment by Dube et al. (2005). Results from that study indicate that although there is a positive correlation between participation in community PSS and confidence among males, the same does not apply to females. There seems to have been no further association between community PSS exposure and positive psychosocial outcomes for vulnerable children in the participating research communities. The study concluded that community PSS programmes need to be strengthened.

As indicated earlier some of the participating CHHs are supported by HOCIC partner programmes. The majority of CHHs who participated in the Masiye Camp CHH management camps were referred to those camps by HOCIC member programmes. It does not appear that HOCIC partner programmes will be providing any additional PSS to CHHs.

To strengthen the PSS programme activities of HOCIC partners at community level, they need to be trained to facilitate, not teach, psychosocial capacity building at community level. Tools like the Journey of Life (REPSSI 2004) or the PSS community sensitization programme (Killian 2004) need to be utilized more often to create a sustainable community 'dialogue of discovery' (Brakarsh 2003) on how communities can 'build a child' and take ownership of psychosocial outcomes.

Masiye Camp (www.masiye.com)

Masiye Camp is a Christian development organization that facilitates and provides psychosocial support to orphans, vulnerable children and youth in sub-Saharan Africa through building coping capacity building and training in life skills. Masiye Camp is

situated on the border of Matopos National Park in an area of outstanding beauty. The organization has developed a 30 acre site to cater for its work.

Utilizing experiential learning methods, camps for 6-11 year olds and 12-15 year olds affected by AIDS are run. The course concentrates on targeted outdoor activities and games, and the facilitation of positive grief and bereavement processes through building relationships with camp counsellors. The courses also educate attendees on HIV/AIDS prevention and care, first aid, and nutrition. It also includes practical sessions in arts and crafts. In recognition of the fact that increasing numbers of children and youth are already parenting younger siblings, with many more - currently living with elderly grandparents or sick parents - potentially facing the same challenges, a training course was also designed to help older children to cope with managing a household. Key aspects of the Camps include (Foster & Jwili 2001):

- Morning talks & training sessions - lectures are presented on the following topics: *Drugs and alcohol; Loss and bereavement; Household management; Safe sexual practices and AIDS; Food and nutrition; Child abuse; First aid, Self defence courses for girls.*
- Physically challenging activities - abseiling, canoeing, hiking and ziplining
- Campwide activities - organized games (e.g. scavenger hunt, staff hunt, tug-of-war) run for the whole camp in the afternoons,
- Evening activities - entertainment programmes including marimba music, traditional dance, skits and a bonfire
- Meeting other young people who have lost parents - getting to know other young people with similar life experiences in an informal setting.
- Sharing experiences of adversity through hero books - Campers develop a hero book (see section 5.2)
- Personal interview - a one-on-one interview with a psychologist, covering many of the different aspects of the experience of losing one's parent/s.

Every year, over 1,200 children and adolescents participate in various life skills camps. According to Masiye Camp records, since 1998, over 4,750 orphans and

other vulnerable children from within the research area have participated in camps at Masiye.

As a Key Operating Partner of REPSSI, Masiye Camp helps to spread lessons learnt at the camp to others in the SADC region. Every year, Masiye runs several regional PSS programme management courses and provides apprenticeships for other programmes in camp leadership and outdoor learning processes. Since the programme started in 1998, over 800 adults have been trained in PSS, some coming from as far as Jamaica and Haiti.

By pioneering CHH management camps, Masiye has significantly strengthened CHH life skills within the research area. Through targeting adolescent double orphans, who are living with aged grandparents or guardians who are ill, the CHH camps bolster coping skills in households that may become headed by children. Over 43% of CHH heads interviewed for this research participated in the past in Masiye life-skills camps. Comparative results for the two groups in terms of household management and coping are set out in section 7.2.2. For reasons of research ethics, all CHH research participants who had not participated in Masiye CHH camps were enabled to participate in such camps after the primary data collection phase was completed.

Critical areas of programme improvements for Masiye Camp include the introduction of programme monitoring and evaluation systems and expanding their PSS interventions to include guardian and community members. Presently Masiye Camp has no systematic approach for programme monitoring and evaluation. This inhibits ongoing organisational learning and programme improvement. To date, Masiye Camp has relied on three external evaluations to enhance and strengthen its programme. It is recommended that Masiye Camp establishes simple, daily programme monitoring systems to inform its programming on an ongoing basis. Masiye Camp in the past has primarily focused on the child, often in isolation from the guardian and the community. To ensure a continuum of care and support, it is important for Masiye Camp to engage and support guardians and communities in PSS through methods such as the Journey of Life (JOL) described above.

YOCIC

YOCIC, introduced in section 4.4.3, could be an important PSS provider in urban Bulawayo. YOCIC's main activity is to help youth to establish Kids Clubs for vulnerable children. The aim of these Kids Clubs is to provide ongoing PSS to children affected by AIDS at community level. However, severe organisational development constraints experienced in 2004 due to unclear governing roles and responsibilities have prevented YOCIC from delivering on many of its planned PSS activities. As a youth-led initiative YOCIC has great potential to be a key PSS service provider for OVC and CHH in particular. Through the Kids Club network, new CHHs and their PSS needs can be brought to light.

It is suggested that YOCIC should cooperate more closely with Masiye Camp and HOCIC to receive organisational development support to solve the present governance crisis. After this consolidation phase, YOCIC should engage in a strategic framework development process to re-focus their work on supporting children affected by AIDS in the Bulawayo community.

MMP Zw Trust (www.10mmp.org)

The MMP Zimbabwe Trust was formed in 2004 with the aim of scaling up, locally appropriate, quality memory work in Zimbabwe. Memory work might be defined as the creation of a safe space for the sharing of life stories. The scope of memory work is not only restricted to the past. Its purpose is often to deal with difficulties in the present, and its main orientation often tends towards planning and the future (Morgan 2004:7).

MMP – Zimbabwe Trust works in close collaboration with the Ten Million Memory Project (www.10mmp.org) and is a REPSSI Scale-up Partner (www.repssi.org).

The MMP – Zimbabwe Trust has the following goals:

- Establishing a training and capacity building unit to respond to memory work training requests in Zimbabwe
- In one programme site, to provide direct memory work services to children and adults living with HIV and AIDS in the context of ARVs in Bulawayo
- Implementing longitudinal operational research to assess the impact of memory work in improving quality of life for people living with HIV and AIDS

Within the research area the MMP Zimbabwe Trust is mainly active in training volunteers and staff of AIDS and OVC service organisations in memory work. They also directly provide PSS through offering memory work to HIV infected children and adolescents who have started the Ministry of Health / Medicine sans Frontier supported ARV treatment programme at Mpilo Hospital in Bulawayo. Two HIV-infected CHH members who were identified in this research were referred by this researcher to the Mpilo ARV treatment programme at the start of the ARV treatment programme for adolescents in July 2004.

It is suggested that the MMP Zimbabwe Trust accelerates its plans to set up support groups for HIV-infected adolescents. There is a pressing need for this, because young people can only be encouraged to undergo HIV testing if they are aware of support programmes for them. The visibility of adolescent peer support groups for youth on ARV treatment programmes is therefore essential. The MMP Zimbabwe Trust plans in August 2005 to invite a group of HIV-infected youth from an active peer support programme in Cape Town, RSA, to assist youth in Bulawayo to set up such support groups. This development is very welcome. It is further suggested that MMP Zimbabwe Trust collaborate closely with YOCIC to establish a referral system enabling HIV-infected YOCIC Kids Club members to access ARV treatment and join peer support groups.

Contact Family Counselling

Contact Family Counselling was established in Bulawayo in 1993 to provide affordable (free) quality counselling services using a systemic counselling approach. Presently the organisation is providing the following services:

- Family counselling
- Marriage counselling
- Abuse / Sexual Abuse Child Counselling
- Counselling in the context of domestic violence
- Counselling in the context of political violence
- HIV / AIDS counselling
- Counselling for suicide survivors and families
- Training in systemic counselling

Although their model is primarily individual counselling, they do cater for group therapy processes. Being the only organization with a broad range of counselling services in Bulawayo they are overwhelmed with requests for support and are unable to cope with counselling requests. Contact therefore trains staff and volunteers from various community social development programmes in general systemic counselling skills and provides training in specific areas to organizations upon request.

It is suggested that Contact Family Counselling increases its collaboration with organisations such as HOCIC, utilizing community PSS facilitation tools as suggested above. Contact also has an important back-up role for referring cases where there is need for professional counselling support. They are encouraged to improve their linkages with OVC and AIDS service organizations to make them aware of this referral role and expand their existing team of professional counsellors, seconding them into some of the larger organisations such as Masiye Camp and HOCIC in Bulawayo.

Coordination and referral among PSS programme organization

Although a considerable number of PSS service providers operate in Bulawayo, there is an obvious lack of co-ordination, and no referrals system is in place among key organizations. The collapse of the provincial child welfare forum has aggravated this lack of collaboration and coordination.

To ensure a systemic approach to PSS for vulnerable children it is imperative that agencies collaborate closely. Based on the brief organisational assessment of this research, combined with the researcher's own experience in urban Bulawayo, it is recommended that HOCIC as an umbrella organization should take a leading role in enhancing collaboration and establishing a systemic referral system to ensure a continuum of quality child care despite the difficult operational environment.

6.6 Summary and conclusions

Psychosocial and emotional well-being is still often not recognized as an important area of concern when children face parental HIV-related illness and death. Caring for terminally ill parents is a taxing, stressful and traumatic process. The majority of CHHs are mired in adverse circumstances and have been exposed to very traumatic experiences. To understand how the head of CHHs as well as younger siblings within a household manage to cope, the concept of resilience is useful. Resilience - the ability to bounce back and even find strength from adverse life experiences - seems to be a critical factor in CHH coping. Research data suggest that CHHs in the research area demonstrate high levels of resilience, without which they would not be able to function and sustain themselves.

Such resilience also shows in the quality of life experienced by CHH members. The overall quality of life assessments within CHHs shows that despite all the adversities experienced by such households, over 69% of CHH members reported a satisfactory to medium quality of life.

It is important to acknowledge that measuring and assessing psychosocial well-being of children and adolescents in the cultural context of eastern and southern Africa is an emerging field of endeavour, and one that will continue to pose challenges for years to come. To address these challenges, culturally appropriate psychometric tools and reliable outcome measures for psychosocial support initiatives will need to be developed.

Organisations working with vulnerable children in the research area started to respond to psychosocial issues presented by children in their programmes. Although a number of organisations provide support to children in Bulawayo, coordination among these initiatives is poor, with, for example, no clear referrals system in place. For a systemic approach to child welfare, child protection and child development, it is imperative that agencies should collaborate far more closely.

Quality of life and psychosocial issues in CHH and how support agencies enhance those are key to CHH coping. The following chapter examines CHH household management and coping strategies, and develops a specially tailored coping model that addresses the CHH phenomenon.

7 Child-headed households & household coping

Dear Mama,

I'm writing this letter to tell you what has happened after you left us. The baby is troublesome; our brother acts like our father but fails to provide for us. You left us alone. We no longer go to school. Life is no longer the same without you. I have to look after the kids myself. I will not forget you Mama, because you left us in a bad situation.

Elizabeth, Entumbane

7.1 Introduction

Household coping in the context of HIV/AIDS is well documented (Gow & Desmond 2002; Vermaak, Mavimbela, Chege & Esu-Williams 2004; Whiteside & Sunter 2000). Ewing (2002), however, points out that there is very limited information available on CHH coping.

The period leading up to the formation of a CHH heavily taxes the coping resources of CHH members. Chapter 6 provided insight into how this period impacts on psychosocial wellbeing and resilience in these households. Most notably, household coping has been shown to be closely linked to the resilience of individual household members.

In order to improve our understanding of how CHHs cope with adverse circumstances, and what is required to improve their coping, this chapter begins by looking at the concept of coping in general, and at CHH coping in particular. A coping model suitable for the analysis of CHH coping is constructed by adapting existing task models of coping (Taylor 1986). Through the use of research data, a task list for CHH coping in urban Bulawayo is developed. For the sake of comprehensiveness, emotional and social aspects discussed in Chapter 6 are included in this task list for CHH coping.

Research data is used to raise understanding of how CHHs cope in areas such as nutrition, health, education and child protection. The chapter closes by looking at CHH economic coping, and looks at risk and loss management behaviour at the household level.

7.2 Household coping strategies

The conceptual framework of this study was developed to gain a better understanding of how various factors influence coping in CHHs, and how such factors impact on the quality of life of CHHs. In addition, it is observed that community or external support

responses influence household coping capacity (see 3.4.3). To analyse CHH coping the following coping model and task list for CHH coping was developed.

7.2.1 The concept of coping

It is important to note that the ability to cope with adverse circumstances or stressors is clearly linked to resilience, as discussed in Chapter 6 (Howard & Dryden 1999). Stressful events are part of everyday life. Stressors may be of an internal nature (for example, fearful memories, and painful emotions) or external events (for example, a quarrel with a relative). The impact of such stressful experiences on a person depends, in the main, on how the individual copes with them. Coping can be defined as 'the process through which a person manages demands (internal or external) that are appraised as taxing or exceeding the available resources' (Lazarus & Folkman 1984:141). This concept of coping can be expanded to the household level and, as such, can be defined as the ability of household members to manage internal or external demands that are experienced as taxing or exceeding their available resources.

Coping is not static. Rather, it is a dynamic process. It involves a series of reciprocal responses between the individual/family and the environment (Meursing 1997:43). Therefore, coping is systemic rather than mechanistic. It is characterised by systems of interactions and feedback loops that take place over time. Thus, it is not surprising that a single or 'once off' quality of life assessment of CHHs is not advisable. This is due to the fact that coping consists of ongoing, dynamic and changing behavioural efforts to manage, master, minimise or tolerate stressors or demands.

General coping theories

There are various methods of categorizing coping strategies, such as active/passive (Lazarus 1991); approach/avoidance (Horowitz 1992); or conscious/automatic (Aldwin 1994). These can be termed general coping theories. However, with regard to the functions of these coping strategies, current research suggests they are best

understood as either problem-focused³⁷ or emotion-focused. The former is an active coping style that arises when individuals or families feel 'in charge' of a problem. The latter is a coping style that arises when individuals or families feel that stressors are 'too monstrous to handle' (Folkman & Lazarus 1991; Taylor 1986; Horowitz 1992). Problem-focused coping entails dealing with the problematic situation itself. For example, by seeking help, additional information or taking direct action. However, if the individual or family, after assessing the stressful situation, judges that at present they have insufficient internal or external resources to control or deal successfully with the stressor, a sense of powerlessness may cause them to turn to emotion-focused coping. Such coping does not attempt to deal with the stressor/situation itself, but with the emotional pressure it causes. This can lead to the stressor being re-interpreted in a more positive light, the expression of negative emotions, or denial of the stressor (for example, children believing, after parental death, that their parents are on a journey and will return one day).

Many stressors cause coping responses of both types. But, in most situations one or the other coping style is dominant. For successful long-term resolution of distressing events, it is critical for individuals / families to utilize both these coping strategies. The choice of coping styles is not only determined by the nature of the problem. It is also strongly influenced by relevant intra-personal / family variables such as resilience factors, vulnerability, self-efficacy³⁸ and important context / time bound variables, such as the availability of social and material support for coping (Bandura 1995).

Although often not mentioned in existing research, the availability of practical and material resources, such as information, services or finances, is of prime importance for coping with adverse life situations. Billings and Moos (1981) found that families with access to savings use more active, problem-focused coping strategies in dealing with problems than families without access to savings. Similarly, Helman (1990) and Lewis (1966) link poverty to a low sense of control over life-stressors. This often results in short-term perspectives and short-term problem-solving skills. Although

³⁷ Some authors (Wolf et al. 1991) call this 'active-behavioral coping'.

³⁸ Self-efficacy in this research is defined as 'a person's own effectiveness / successfulness in self-management, summarized in the belief 'I can'.

studies from these authors relate to other contexts, they are relevant for this research on CHH coping in urban Zimbabwe.

A further important environmental influence on coping is the availability of social support. Practical, material, informational, spiritual and emotional support from friends and neighbours boosts the ability to deal with a problem, and can act as a buffer to avoid emotion-focused coping. Therefore, social and material support can stimulate active, problem-focused coping strategies. At the same time, lack of social support may result in the use of emotion-focused strategies.

Some means of coping are not positive (Luzze 2002:20). Ainsworth & Over (1992) observed that after cumulative crisis experiences, poor people develop a 'culture' of hopelessness and helplessness, and accept their condition and situation as final and a result of God's wish. Such attitudes do not result in coping responses that improve dire conditions. This amounts to a kind of fatalism, in which people 'just accept, there is nothing I / we can do'. (This shares some characteristics with what Galbraith in 1979 called the 'culture of poverty'.)

Task models of coping

General coping theories are not easily adaptable to specific problem categories such as CHHs. In recent years, task-based models have gained popularity among researchers and service providers as they have a number of advantages. Instead of conceptualizing coping in a reductionist manner (as a set of responses to stressors), task models understand coping in terms of a system of various efforts to achieve certain goals or 'tasks'. According to Meursing (1997:48)

task models of coping demand specification of multiple challenging aspects of a problem situation, and a formulation of goals to be striven after in coping. Task models can be constructed to fit various problem situations.

There are at least four major advantages for using task-based models to study coping (Doka 1996:116). Firstly, they adopt an active perspective, focusing on coping

activities or work. Other models often view a person as passively reacting to a crisis, whereas a task model emphasizes that an individual / family has to generate ways of coping with the problems at hand. Secondly, the task model allows a more individualized approach, and confirms that each person copes with tasks in a unique way. Thirdly, task-based approaches allow a self-determining, empowering perspective as individuals have the liberty to decide what tasks they choose to cope with at any given time. Lastly, the concept of tasks provides a framework for individuals / families and researchers or care providers to understand and cope more effectively with challenges posed by certain crises, such as forming or living within a CHH. As seen in previous chapters, these challenges are multifaceted. Individuals in CHHs must cope with the physical, psychological, social, and spiritual implications of living in such a context.

Over the last three decades task lists have been formulated for the following problem situations:

- Chronic illness (Cohen & Lazarus 1979)
- Cancer (Taylor 1983)
- Bereavement (Cleiren 1991; Kastenbaum 1991; Corr 1992)
- Work stress (Diekstra 1991)
- Living with HIV in developed countries (Siegel & Krauss 1991)
- Living with HIV in developing countries (Meursing 1997)

Tasks for coping with various life stressors in particular problem situations are formulated on the basis of goals that the researcher or therapist considers desirable. Although task lists have a normative format, it does not mean that a person/family must achieve every task on the list in order to be shown 'to be coping well'. Taylor (1986) suggests, that 'coping tasks should be seen as "themes" around which coping efforts are structured, and which may continue on a long-term basis without having been completely resolved'. In complex situations, such as living in a CHH, it is often more about 'easing' the situation than finding a 'solution'.

In summary, task models have advantages over general coping theories in that: they can be adapted to the specific, complex problem at hand; they can clearly state desired outcomes of coping; and they can factor in contextual as well as intrapersonal factors (Meursing 1997:49).

Figure 7.1, presents a model, developed by Taylor (1986) and Diekstra (1991) that combines both ‘general coping theory’ and ‘task models’. This integrated model specifies stressful life aspects and desired outcomes of coping, presenting an awareness of the internal and external factors that influence the coping process.

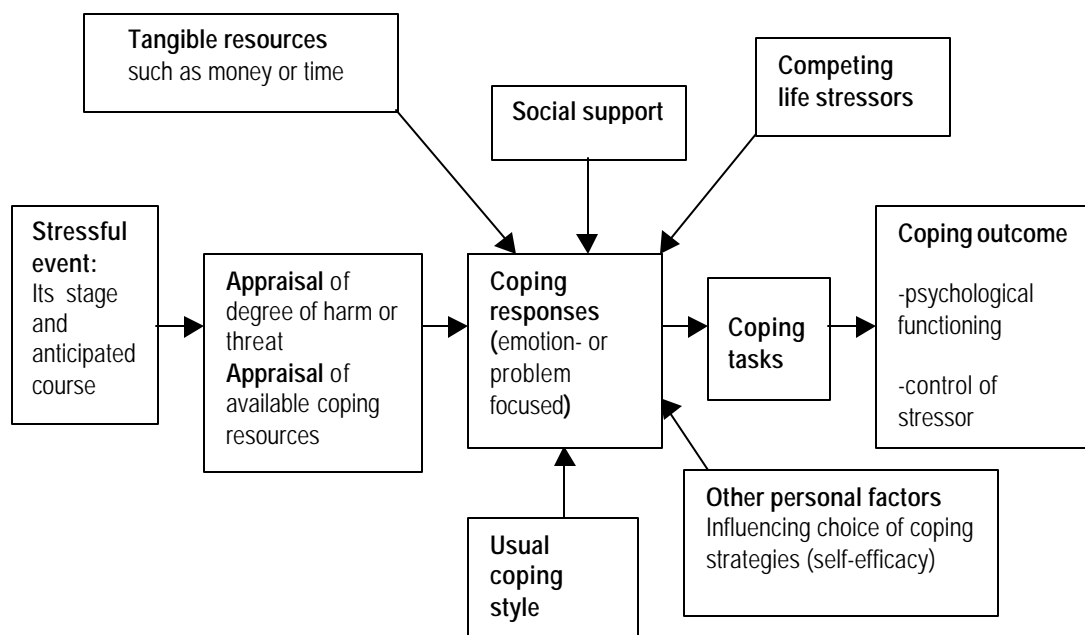


Figure 7.1: Integrated coping process model

Source: Taylor (1986) and Diekstra (1991)

For a number of reasons, as discussed above, the general coping theories are not satisfactory for dealing with CHH coping. The integrated model is also deficient for studying how CHHs cope. Firstly, the model does not mention the influence of culture and community factors in the coping process. Secondly, it does not take into account that some stressors – like the consequences of the household head or a younger sibling being HIV-positive – are likely to change over time and under the influence of coping. Thirdly, spiritual factors - an important source of support identified in this study - are not included. Thus, using the existing model in the context of CHH does

not do justice to the fact that CHH coping is an iterative process. That is, it is a process in which the self-efficacy beliefs of the individual or the household affect coping strategies and outcomes, which in turn may affect the stressor itself, as well as self-efficacy beliefs with regard to the stressor. Therefore, given the complexity surrounding the coping of children affected by AIDS in the CHH context in particular, a more dynamic model is required.

Figure 7.2 shows a new version of Taylor's integrated task model, adjusted for the purpose of studying CHH coping. Meursing (1997) in her study on adults living with HIV in Matabeleland, Zimbabwe, successfully adapted Taylor's integrated coping model. For the purpose of this study, the researcher adjusted Meursing's model to apply to the context of CHHs. This model depicts the outcome variables of emotional or physical well-being, quality of life, and being responsible in the CHH context. These variables are products of the discrepancy between task demands on one hand, and social connectedness and support, spiritual support, material resources, cultural and community influence, and individual CHH factors on the other hand.

In this model, the coping process starts with the onset of HIV-related parental illness as the initiating stressor, followed by the main stressor of CHH formation. This main stressor is of an ongoing nature, and may vary in nature and strength over time. It may, for example depend on the amount of neighbourhood/external support, or HIV-infection of the head of the household or siblings, to mention just a few.

The self-efficacy beliefs developed by the CHH to cope with the main stressor are influenced by a number of factors that are represented as five interrelated blocks in the upper part of the model: i) cultural and community factors, ii) spiritual factors, iii) the availability and nature of relevant social support/connectedness, iv) material resources and v) individual and personality factors of the head of household. This last group includes general self-efficacy beliefs and existing coping skills, which can be mobilized in dealing with the stressor. This model differs from Meursing's (1997) model in its addition of the block of spiritual support (identified as important for CHHs).

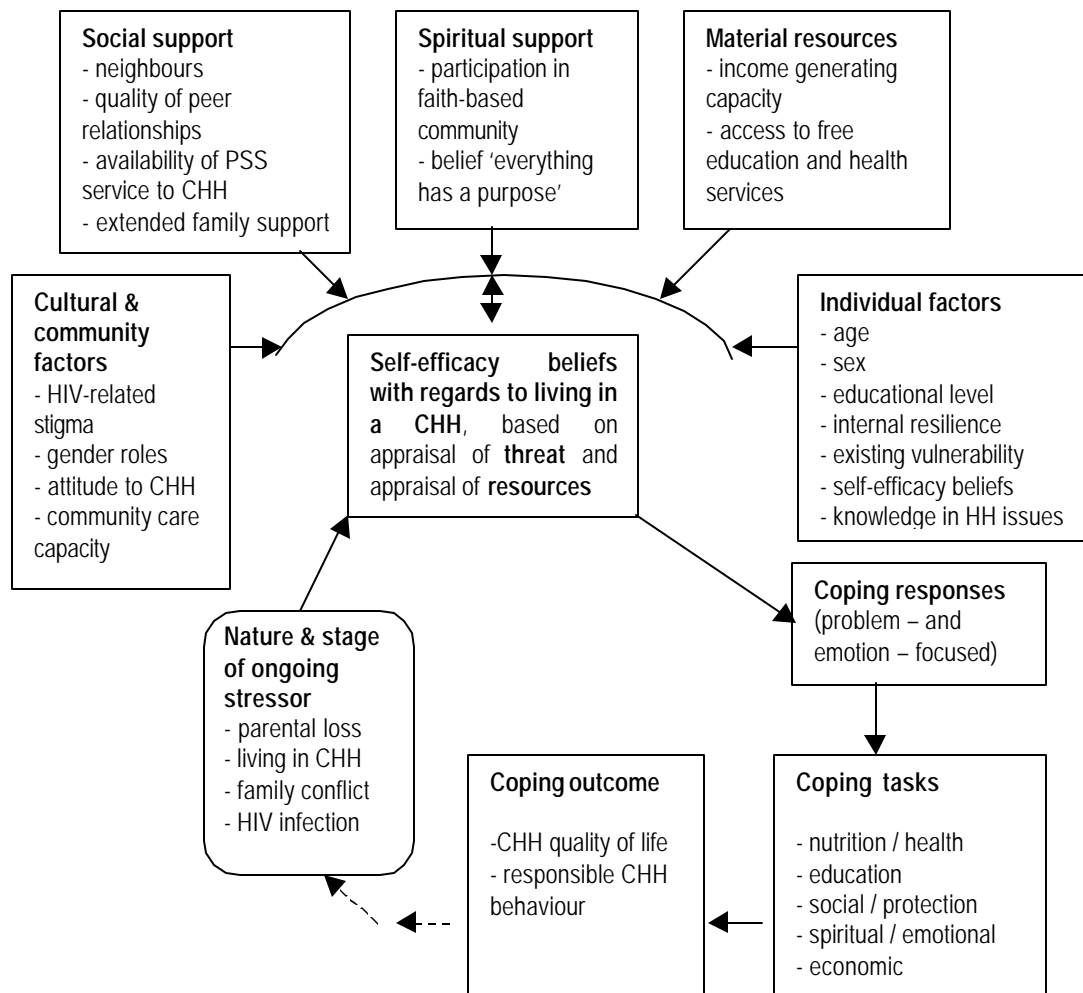


Figure 7.2: Coping model applied to CHH coping

Source: Adapted from Meursing (1997)

In contrast with Taylor’s original model (Figure 7.1), a dual relationship exists between these five ‘external’³⁹ factors in the upper half of the model and the coping process in the lower half. Therefore, this adjusted model assumes that all five ‘external’ factors, especially social support, spiritual factors and material resources, considerably influence self-efficacy beliefs and enhance problem-focused household coping. At the same time, effective coping generates (more) social support and/or better or more material resources. The effectiveness of coping also feeds back into CHH self-efficacy beliefs. Someone who is able to deal effectively with aspects of the

³⁹ ‘External’ in relationship to individual CHH self-efficacy beliefs.

main stressor (living in a CHH) may consequently begin to feel more self-efficacious (expressed by CHHs in hero books as 'I am a hero') with regard to the challenges of managing or living within a CHH. This, in turn, can positively affect future coping. Finally, coping outcomes – defined as CHH emotional/physical well-being (quality of life) and being a responsible household – follow from CHH coping responses and the task demands that come with the stressor. The broken arrow line shows that coping responses and coping outcomes only influence the nature of stressors to a certain extent. Being a responsible household (a coping outcome) can influence risk factors siblings in the CHH are exposed to. For example, a household may decide not to engage in casual commercial sex as a means of economic coping. This would impact on the magnitude of the main stressor, but at the same time it would not change the fact of living in a CHH.

This model is used in the following sections to demonstrate CHH coping in specific situations, such as nutrition/food security, health, education, child protection and economic coping.

Based on this adjusted model, a task list (see Table 7.1 below) for CHH coping is constructed, taking into account socio-cultural factors (Chapter 4), FGD results, issues faced by children affected by AIDS (Chapter 2) and data from narrative CHH interviews (Chapter 5). This task list is presented below and represents the detailed 'Coping tasks' in Figure 7.2 above. It is important to remember that while this or any model can be useful, it is at best a general description of a complicated and highly individual CHH coping process. Not every CHH experiences the situations and reactions as described in this adjusted task model. Nor will every CHH proceed along the same lines as this model suggests, given their complexity. Yet the model can be a useful tool for better understanding CHH coping and to improve assistance to such households.

Table 7.1: Task list for CHH coping in the context of urban Zimbabwe

Task demands	Required coping behaviour	Required resources
COPING WITH NUTRITIONAL ASPECTS		
Improving knowledge / understanding on low cost nutrition	Seeking information	Elderly women in family or community
Optimizing food storage and preservation	Seeking information, experiment new storage methods	Informal information sources in community
COPING WITH HEALTH ASPECTS		
Optimizing general health status	Eating a healthy diet, engage in fitness	Nutritious food, information on fitness
Accessing health care early	Attain fee exemption, build relationship with local clinic staff	Exemption process information, communication skills, clinic nearby
COPING WITH EDUCATIONAL ASPECTS		
Accessing school	Access support from BEAM ⁴⁰	Information on how to access, communication skills, linking adult person
Improving school performance	Create study time	Time and household management skills, practical support in household chores
COPING WITH SOCIAL ASPECTS		
I. COPING WITH SIBLINGS		
Improving parenting skills	Seeking information, try different approaches	Advice and / or role models, parenting training programmes
Increase siblings participation in household management	Planning and task allocation	Household management skills, relationship skills, relevant skills

⁴⁰ BEAM (Basic Education Assistance Model) introduced by Ministry of Education in 2001 to assist vulnerable children accessing school

Task demands	Required coping behaviour	Required resources
II. COPING WITH EXTENDED FAMILY		
Improving satisfactory relationships	Dealing with conflict and blame	Communication and conflict resolution skills
III. COPING WITH NEIGHBORS		
Respectful and appreciative interaction	Deciding who to approach in the family to maximise the chance of support and minimize chance of rejection	Social and communications skills, appreciative behaviour
IV. COPING WITH COMMUNITY		
Develop strategies to contribute to community ⁴¹	Practical engagement in community building processes	Time and skills to assist in community projects or care
COPING WITH PROTECTION ISSUES		
Develop preventative behaviour patterns	Assertive behaviour, avoidance of risk situations	Assertive behaviour training, self defence training
Improving child protection knowledge / understanding	Seeking information, establish protective support	Information, advice, practical protection availability
COPING WITH SPIRITUAL ASPECTS		
Addressing spiritual concern related to parental loss	Seeking spiritual support	Sources of spiritual support, faith community
COPING WITH ECONOMIC ASPECTS		
Maintaining an economic survival basis	Planning and implementing economic survival strategies	Relevant skills and material / social support
Optimizing expenditure pattern	Reduce / substitute unnecessary expenditures	Household budget skills
COPING WITH EMOTIONAL ASPECTS		
Developing strategies to maintain emotional health	Development of adaptive emotion-focused strategies	Sources of social-emotional support, peer groups

⁴¹ Community solidarity increases when CHHs are not experienced as a burden but actively participate in community building processes (Madörin 2004)

Although the task list includes inputs from CHHs through FGDs and face-to-face review processes, it mainly represents the researcher's expert view on how to cope and live in a CHH, rather than the self-experienced views of persons living in CHHs. Though this 'normative' approach is common in studies, it raises the important question as to what extent discrepancies exist between these two points of view. This was a creative tension experienced throughout this study. Adherence to research ethics, and the desire to ensure meaningful participation at all stages, reduced this tension. The researcher holds strongly to the belief that 'children are experts in their own lives, and we need to take seriously what they are telling us' (Lancaster & Broadbent 2003). For this reason it, was important to share the constructed CHH coping task list with CHHs on four occasions (at the Masiye Camp), and have them reflect and critically appraise the lists and improve them on the basis of their own experiences.

In conclusion, striking similarities, in terms of key factors, between the adjusted model applied to CHH coping (Figure 7.2) and the conceptual framework outlined in Chapter 3, seem to demonstrate that the conceptual framework and chosen research methodology are well suited to fostering an understanding of CHH coping.

7.2.2 CHH coping skills training

The task-list on CHH coping (Table 7.1) shows that key resources required for coping are i) access to information, ii) parenting skills, iii) household management skills and iv) emotional peer group support. Masiye Camp, discussed under 6.5.4 above, is offering life skills camps targeting CHHs, with the main aim of:

- restoring and strengthening of self esteem
- allowing and supporting grief processes to overcome trauma
- developing goal setting, decision making, communication and negotiation skills
- developing conflict resolution skills
- establishing linkages to after-camp peer support follow-up groups
- encouraging empowerment and a healthy sense of responsibility for one's life

- developing parenting and household management skills
- (re-) instilling values and hope for the future, peer emotional support and spiritual support

Although this research was not designed as a Masiye CHH camp programme evaluation, some useful comparative analysis can be made since 43% of CHH participants in this study had been to a Masiye CHH Camp before the primary data collection started. By comparing household coping of the Masiye CHH Camp participants (MCHHC) with the non-Masiye CHH Camp participants (NMC), the following interesting findings (Table 7.2) were made. These findings correspond with Dube et al. (2005) and their PSS study involving youth attending Masiye Camps. Although their study included participants of camps other than just CHH Camps (labelled MC in Table 7.2), it is still worth sharing these findings here.

Item	MCHHC	NMC
CHH who have Information to take decisions at hand ¹	83 %	17 %
Coping with siblings ²	92%	89%
Peer relationships ²	94%	78%
<i>Data from study Dube et al. (2005)</i>	MC	NMC
Ability to cope with life's problems (males)	73.7 %	66.7 %
Ability to cope with life's problems (females)	72.2 %	63.4 %
Do things to help themselves (females)	81.7 %	76.3 %
¹ It is important to note that only 9% respondents felt to have sufficient information and 19% medium sufficient whereas the majority felt not to have sufficient information. Above data uses both groups (sufficient / medium sufficient) as 100% for analysis. Data source WHOQOL – BY tool. ² Using BDJD as data source, reporting on % reported frequencies, ration of MCHHC research participants to NMC research participants is 0.78.		

Table 7.2: Comparing CHH coping between CHH participating in Masiye CHH camps and non-participants
Source: Dube et al. (2005)

Participation in Masiye CHH camps seems to contribute to increased information at hand for day-to-day living. Of those who reported sufficient or medium-sufficient

information available to them, 83% had attended a Masiye CHH camp. However, as the majority (72%) of respondents, both MCHHC and NMC participants, do not have sufficient information at hand there is a need to address this within the camp programme. During the time research participants attended the camp, the child-headed household guide (Smith 2004) was not yet available for campers. It is anticipated that, were a similar assessment conducted today, the CHH campers would have more information at hand as they would be able to take copies of the CHH guide back to their households as parenting and household management resources to enhance their coping skills. Results on improved coping with siblings are not significant (MCHHC 92% vs. NMC 89%) when considering the ratio of 0.78 for MCHHC and NMC research participants. It seems, however, that the participation in MCHHC has a positive outcome (94% MCHHC vs. 78% NMC) in terms of improved peer relationships and peer support as coping resources.

7.3 Nutrition, health, education and protection in CHH

Utilizing selected BJD SPSS database histogram data presentations, the following section looks at CHH coping in areas such as nutrition, health, education and child protection. To enhance understanding of coping systems in each of these four areas, the coping model as illustrated in Figure 7.2 is put to use.

7.3.1 Nutrition and food security

According to the SADC Food, Agriculture and Natural Resources Vulnerability Assessment Committee (SADC 2002), the number of Zimbabweans in need of assistance at the end of 2002 was nearly 7.2 million people. In more than two-thirds of all districts, people experienced either moderate or extreme food insecurity for the period 2000-2004. The food crisis, caused by drought, land policy and deteriorating economic conditions, highlighted the inter-relationship between food insecurity and household vulnerability due to HIV/AIDS and other factors, and the impact this has on orphans and other vulnerable children (McDermott 2003:A53). CHHs are especially affected by widespread community food insecurity as they frequently depend on food

support from neighbours, or supplementary food programmes. A study by CRS STRIVE (CRS 2002), comparing CHHs and OVC with other children showed that most children, regardless of their parental or household status, had two meals a day. There was, however, a significant difference in self-reporting on adequacy of food, with 23% of vulnerable children reporting they had adequate food, and 50% of non-vulnerable children reporting so.

There is no doubt that the political, economic, food and HIV/AIDS crisis in Zimbabwe is having a significant negative impact on children, families and communities. Over 37 percent of CHH in this study reported as ‘feeling hungry’ most of the time (Figure 7.3), with 89 percent reporting to have on average only 1-2 meals per day with lunch being the primary meal.



Figure 7.3: Self-reported CHH feeling of hunger

It is of concern to note that the majority (73%) reported not having regular protein intake (meat, egg, kapenta fish etc.), nor fruit-based vitamin intake. Most CHHs have a carbohydrate diet in the form of maize meal and green vegetables, with cooking oil

to prepare the vegetables being the main fat source. All CHHs in the study were food-insecure. Most of them had food reserves for less than 3 days on average. Only 27% are making attempts to grow their own food, either in a municipality-allocated urban field for dry land crop production during the rainy season, or in their own vegetable gardens at their houses. High City Council water charges and seed input costs make urban food production expensive. Household siblings are often anxious about getting enough to eat or taking a 'lunch pack' to school. Working to raise money for food, or organizing food from neighbours, is a constant struggle for CHHs, and must be seen as a key stressor affecting household coping. Figure 7.4 (below) summarizes this study's findings on how CHHs cope with the stressor of hunger, lack of food and malnutrition.

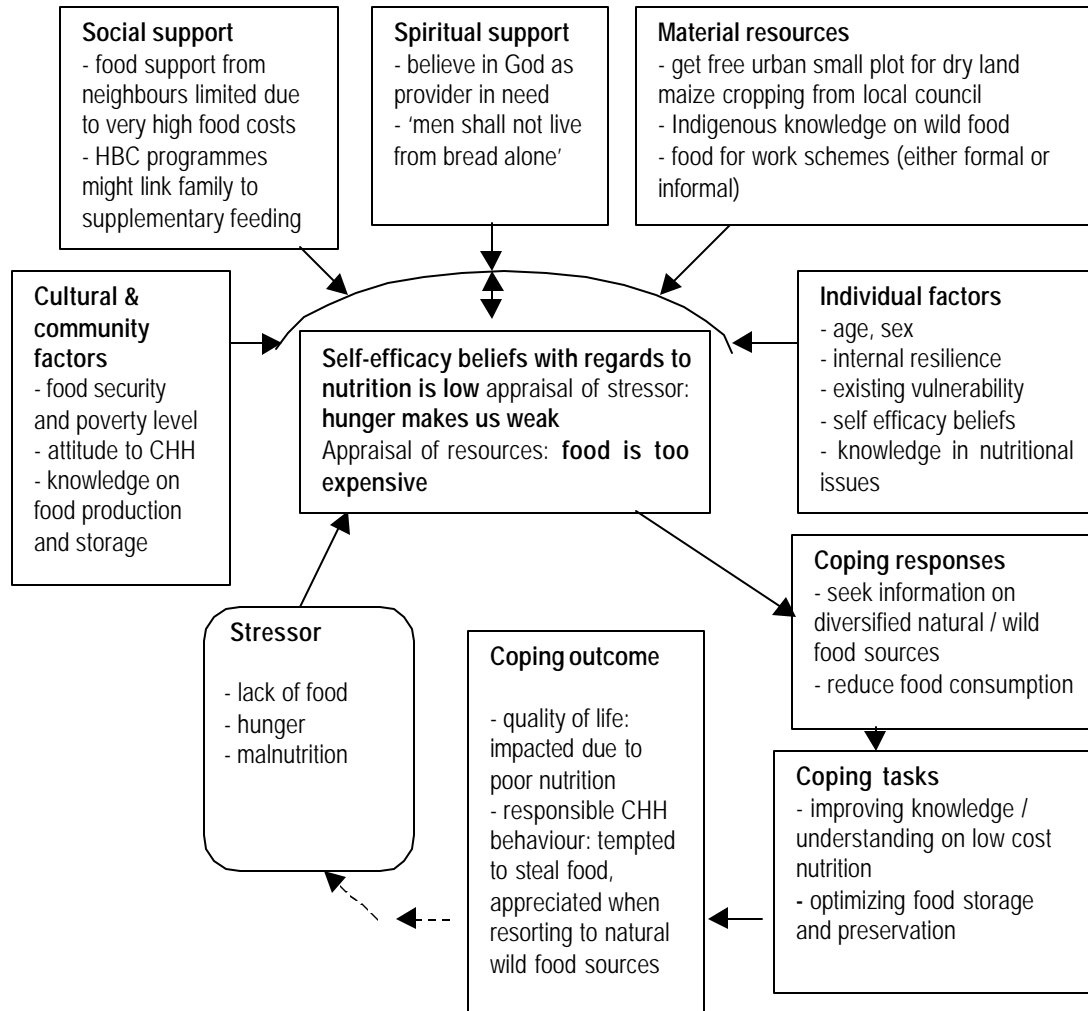


Figure 7.4: Coping with nutritional and food security aspects of living in a CHH

CHH self-efficacy beliefs with regard to nutrition are generally low. Their appraisal of the stressors is that 'hunger makes us weak and, as a result, we are not able to work, or perform at school'. When appraising their resources, all CHHs see 'food as too expensive, and many other people in the community have not enough food in their households'. Important coping tasks for CHHs are to improve their knowledge and understanding on low cost and 'wild' nutrition, food storage and preservation techniques. Elderly volunteers in community-based support programmes are an important source of information for CHHs in these matters. Accessing 'wild' food sources, such as wild vegetables (e.g. delele), roots, berries and other wild fruits (e.g. sweet apples) is possible for urban CHHs. Town planning in Bulawayo ensures that there are natural 'wild' green spaces that contain such natural food sources. These food sources, however, are seasonal, and food storage and conservation methods such as drying vegetables etc. are important knowledge fields that contribute towards improved CHH nutrition. A key coping response to food insecurity is to reduce food consumption. This, however, has consequences regarding school performance, or a CHH's ability to work and generate income. Neighbourhood support in CHH food-crisis situations is critical. Most CHHs reported that in times of severe food shortage, or when they have run out of a basic commodity and have no money at home to purchase food, neighbours have assisted them in overcoming the crisis. Those CHHs who are registered in support programmes have at times received food support from supplementary feeding programmes run by the urban World Food Programme (WFP) and distributed by World Vision, Christian Care or ORAP. Such supplementary food support includes mainly maize meal and cooking oil.

7.3.2 Health status and access to health services

General health in CHHs seems to be good, and comparable to other children within the community. An area of concern to heads of households in CHHs is younger siblings that are either suspected or known to be HIV-infected. During the data collection period, CHH members reported themselves, on most occasions, to be healthy (see Figure 7.5). When comparing days of a reported illness and access to a clinic on that day, less than 45% of CHH members actually accessed the clinic.

Unfortunately, the collected data did not provide reasons for this failure to access such service. It is, therefore, not possible to determine whether a CHH member did not access the clinic because they felt it was not necessary, or because they did not have money to pay for service fees. Data from FGD and from WHOQOL-BY, however, indicate that accessing health services is problematic due to service fees. Furthermore, negative attitudes of health service staff towards children who come to the clinic without adult caregivers makes CHH members uneasy about visiting the clinic at the onset of illness, often leading them to wait too long.

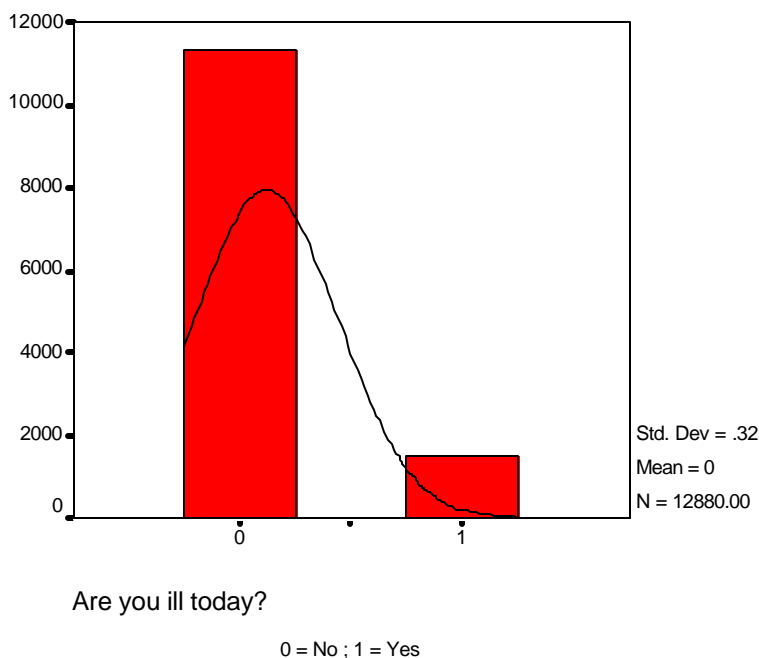


Figure 7.5: Health of CHH members

Such health staff attitudes work contrary to one of the key health coping tasks of CHHs: accessing health services early (Figure 7.6), before an illness progresses and makes treatment more costly and complicated. CHHs that are part of support programmes can ask programme volunteers to accompany them to clinics. Some 42% of CHHs received a health user fee exemption letter from the local counsellors. In most instances, this letter was facilitated by members of the HBC task team during the time of parental illness.

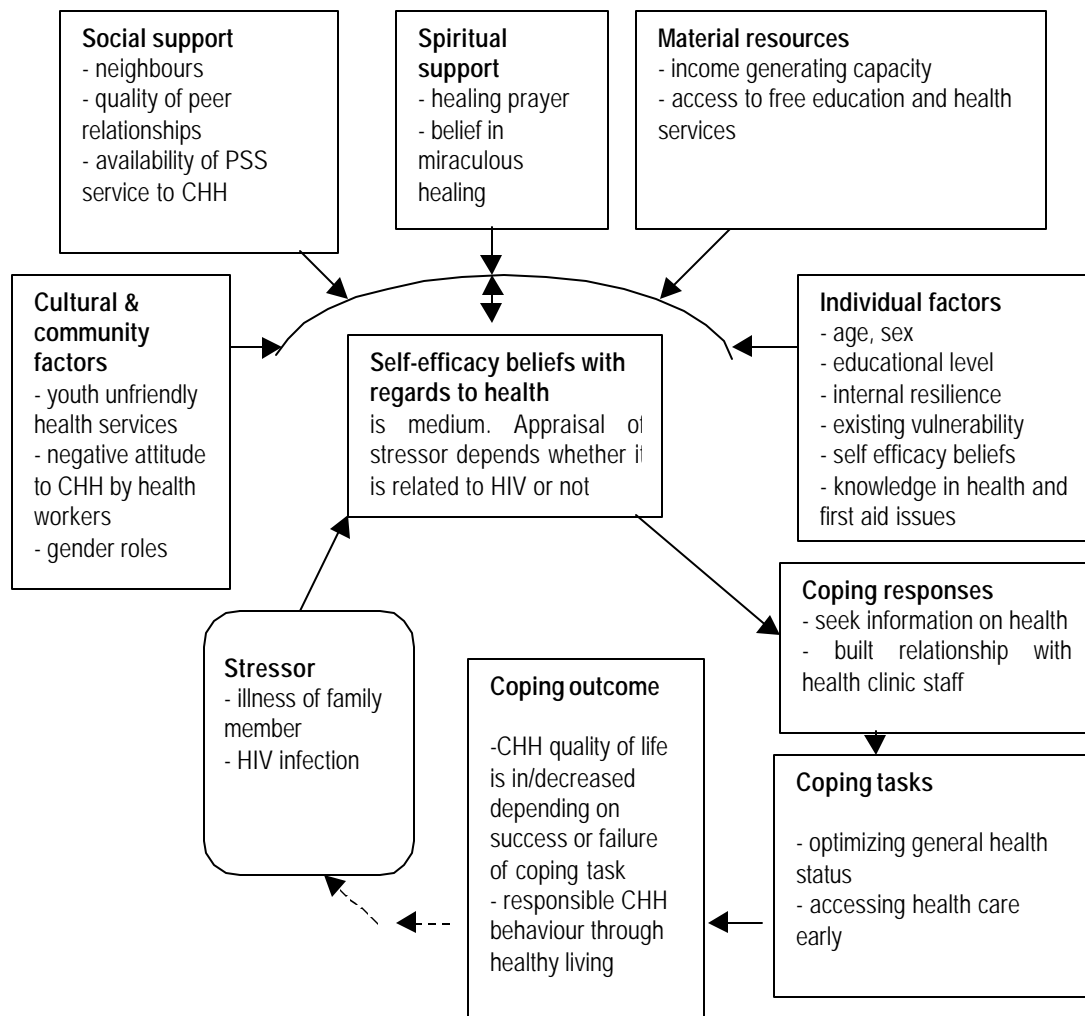


Figure 7.6: Coping with health issues of living in a CHH

Although many health workers have negative attitudes towards CHHs, mainly because they come for clinic visits without adult guardians, an important coping response from CHHs seems to be to build good relationships with health clinic staff in the hope that, as a result, accessing health services in times of need will be easier. Furthermore, programmes such as Masiye CHH camps, HBC teams and OVC support programme volunteers and staff, seem to contribute towards improved information on health issues among CHHs. As coping tasks, CHHs optimize their general health through fitness and balanced nutrition, as well as through gaining access to health services before an illness progresses. As coping outcomes in the

health domain, CHHs either increase or decrease their quality of life, depending on how well they apply the required health coping tasks.

7.3.3 Education status and access

Issues concerning education and children affected by HIV/AIDS were discussed under 2.3.2. The following section discusses how CHHs cope with education and access thereto. It is well known that dropping out of school prematurely impacts on the developmental potential of a young person (Kelly 2002:23). Over 87% of CHH members in the study did not attend school, of which 37% should still be at school according to their age (Figure 7.7).

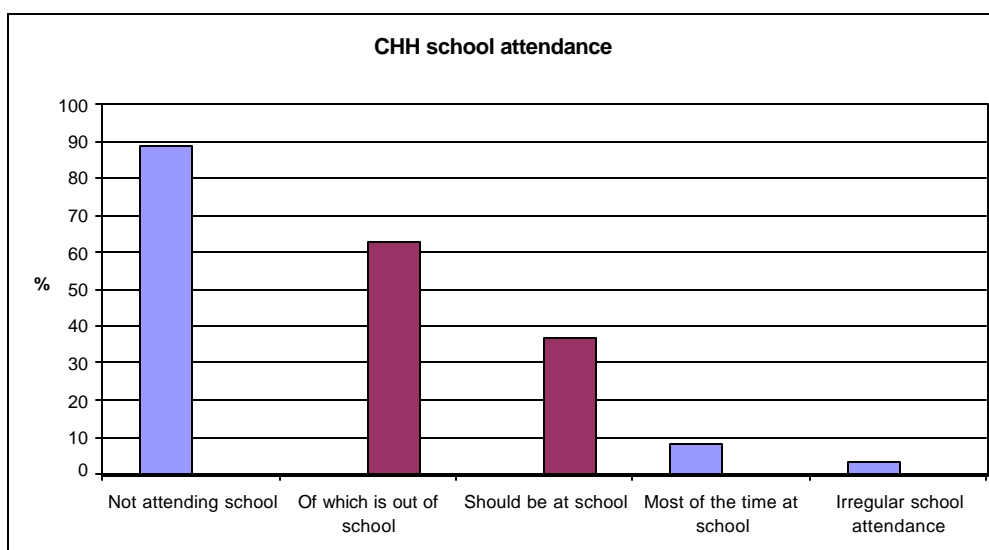


Figure 7.7: CHH school attendance

In addition, 3% of those going to school have irregular school attendance, and 8% attend school most of the time. Only 2% attend school all the time. Using data from FGD, it appears that many of those attending school struggle with performance due to either i) hunger, ii) lack of time to study, iii) irregular attendance, or iv) thinking about other things whilst at school. This is not surprising, considering the major adult-caring roles CHH members have to take charge of on a daily basis.

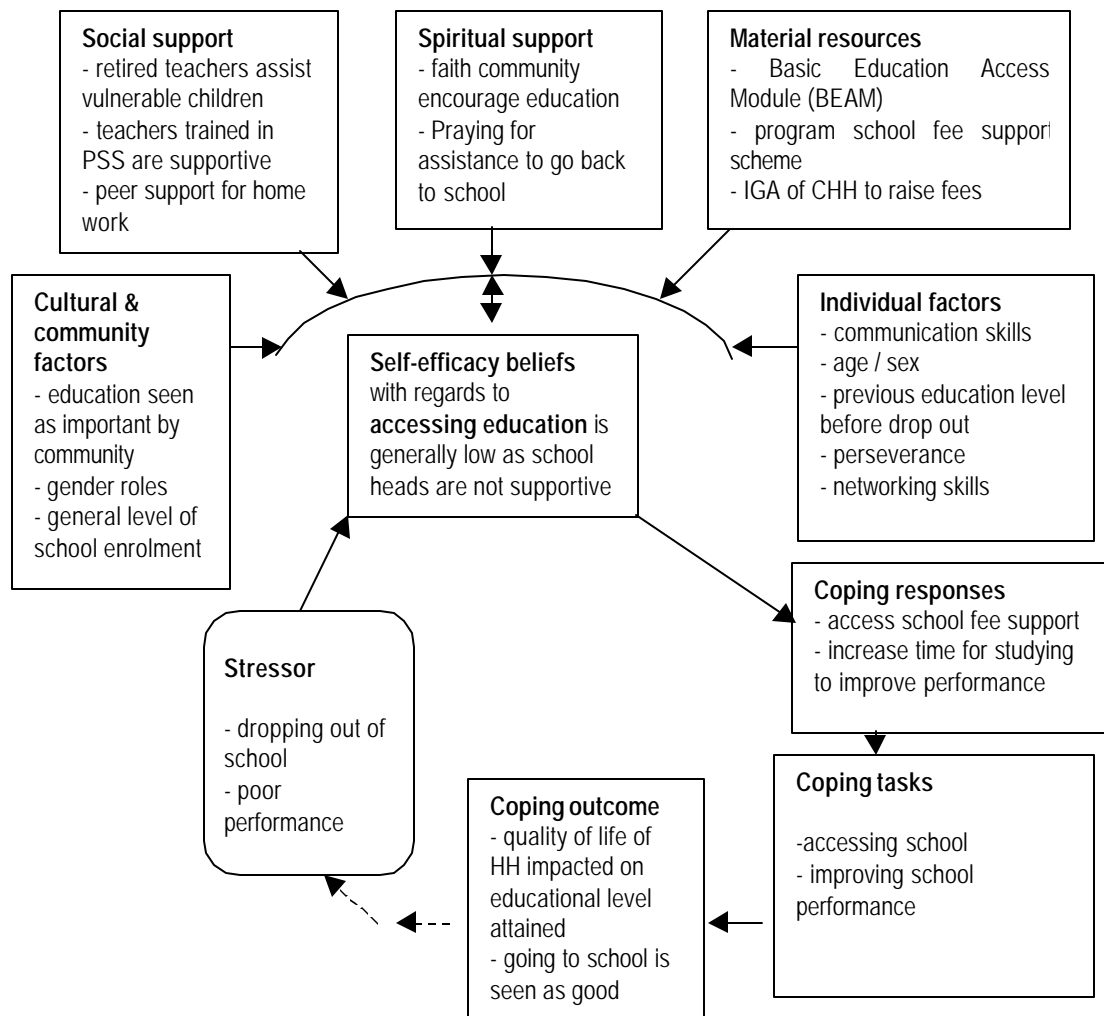


Figure 7.8: Coping with educational issues in CHH

The majority of CHH members who dropped out of school did so during parental illness, with the accompanying need for them to provide terminal care. School authorities did not seem to be helpful at re-integrating such CHH members back into school after parental death. Unwillingness was shown to re-admit them, or even to write transfer letters for them to access other schools. As a result, most CHH members are no longer at school. Those who managed to stay in school either negotiated successfully with school authorities, or had support programme volunteers to help them. Furthermore, many support programmes have, although on an irregular basis, school fees support components. In some instances (12% of CHHs) younger siblings were registered with the Basic Education Access Module (BEAM) - a

government education support programme. But this programme does not offer adequate support at the secondary school level. Due to the higher costs of secondary school education, often 2-3 times more expensive (Coombe 2003:A57), CHH members are unduly disadvantaged as they do not benefit from the higher level of skills development as will be required in the future by Zimbabwe's economy.

A coping response (Figure 7.8) to poor school performance is to increase study time. This can be achieved by improved household management, and by training younger siblings to share day-to-day chores. Household management and parenting skills, as provided by Masiye Camp, assist in creating study time towards improving school performance. Peer support for certain household chores can contribute towards more free time for study. As discussed under 6.5.2, support from friends with household chores, taking care of younger siblings, and other support activities are key resources for CHHs.

7.3.4 Child protection

It is generally accepted that CHHs 'are especially vulnerable to abuse and exploitation' (UNICEF 2004:5). This, however, should not be generalised as research data seems not to support such a view. Figure 7.9 shows that although CHHs do experience abuse in various forms, and over 1000 instances of abuse among 105 CHHs over a 12 month period were reported, there is no indication that CHH members experience more abuse than other vulnerable children in the community. The study on urban orphans and vulnerable children in Bulawayo (DSW 1998) reported that it is not unusual for orphans living in extended family settings to be abused by relatives. A frequent form of abuse of orphans living with relatives is actual or perceived discrimination between the caregivers' children and themselves. A considerable number - 36% of CHHs - established themselves after experiencing abuse in various forms from extended family caregivers. Therefore, although CHHs are at higher risk of experiencing abuse from people **outside** the household, they experience less abuse **within** the household.



Figure 7.9: CHH experience abuse

Coping with abuse (Figure 7.10) is an important task for CHHs. This research shows that in most cases neighbours are key protective agents to prevent abuse committed by external community members. It appears that years of investment by various stakeholders in community sensitisation, and community training on OVC care and support, is bearing fruit. Although, according to FGD, community members often have negative attitudes towards CHHs, the notion ‘these are our children’ is deeply rooted. Neighbours and other community members close to CHHs are often impressed by the responsibilities and burdens these members carry as they manage their households.

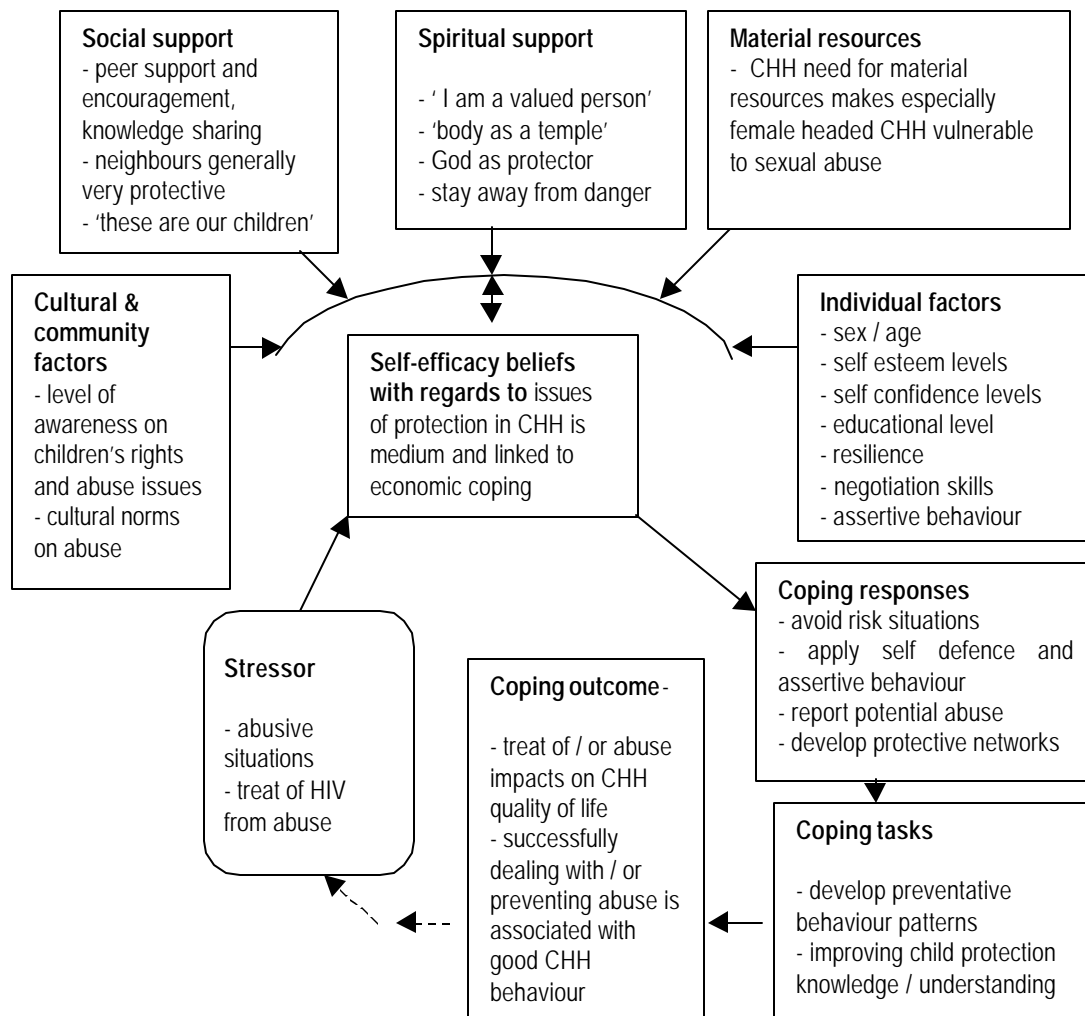


Figure 7.10: Coping with protection issues in a CHH

Such appreciation may be related to the Ndebele and Shona belief system that links caring for others to gaining an 'eternal spirit'. In terms of this belief system, a woman only gains an eternal spirit if she has children, or if she is engaged in caring for other children (CPS 1998:35). Therefore, since the heads of CHHs are taking care of themselves and other siblings, this may be seen as evidence of an important 'traditional spiritual value'.

Coping responses that deal with protection issues include avoidance of risk situations, as well as assertive and self-defensive behaviour. These behaviours are

reinforced by the development of protective networks within the community. It is especially the female heads of CHHs that develop protective networks through other females in the community, notably through neighbours. Through building good relationships with people within the community, they have a place to go in order to report perceived danger or to report experiences of abuse.

Those CHH heads who participated in a CHH camp at Masiye reported appreciation of the self-defence course. The avoidance of potentially abusive situations along with assertive behaviour and self-defence are skills that can be learnt, and that serve to reduce vulnerability to abuse. It is therefore critical that CHHs are supported with such skills development through training courses. It is important to understand that coping with abusive situations and economic coping are closely linked. When a CHH does not cope economically, such a household is more vulnerable to abuse.

7.4 Economic coping at household level

When HIV/AIDS and parental illness strike a household, the stress of disease, terminal care, death and uncertainty about the future can be enormous. Household resources erode quickly due to parental illness, followed by funeral costs and inheritance conflicts, such that a household can slide with frightening speed from relative comfort to destitution. The following section will discuss the economic situation of CHHs and their attempts to cope through the use risk and loss management methods. The section concludes by looking briefly at how targeted micro-credit schemes could mitigate negative economic impact on CHHs.

7.4.1 Economic situation and coping at household level

A CHH's ability to mitigate the economic impact of HIV/AIDS and parental loss depends on their capacity to stabilize the internal household economy, as well as its access to existing internal resources or external ones from community members in order to provide temporary relief. Although seeking relief from the extended family is

an important mitigation strategy, a high level of conflict between CHHs and extended families often prevents CHHs from making use of this strategy.

Another way CHHs cope with economic strain is through income generation, a strategy long used by families in response to crisis and economic stress from many causes (Donahue 1998:11). A considerable number (71%) of CHHs in urban Bulawayo turned to informal sector-self employment, ranging from selling apples outside shops, to running a hair salon out of the family home, to manufacturing and selling fruit jam. Around 19% of the heads of CHHs managed to engage in part-time employment in butcheries, shops and domestic work. The time spent by CHHs on income-generating activities varies greatly. Although some heads of CHHs spend considerable time (in some cases up to 11 hours per day) generating income, income from these activities is generally very low. In this study the daily average income of CHHs involved in income-generating activities was only ZWD 320 (USD 0.5; utilizing the parallel mid market rate from July 2001). When considering that most such CHH heads only work an average of four days per week, that makes for a monthly income of less than ZWD 5200 (USD 9 in July 2001) for the average CHH in this study. It is, therefore, not surprising that when using the WHOQOL – BY to assess the quality of life, 96% of respondents reported not having sufficient money for day-to-day living expenses (see section 6.4.1).

An important additional source of household income is utilizing part of the house left by the parents to rent out to lodgers. Some 67 of a total of 105 households made use of this income-generating strategy as their parents owned the house they were living in. Parental house ownership might be a contributing factor for CHHs being established, as house ownership not only provides them with a place to stay together, but is also an income source. Many CHHs, however, have great difficulties due to the bureaucracy involved in transferring the parental estate, especially with regard to housing deeds, into joint ownership for the children. This will be further discussed under section 8.4.3.

Unfortunately the BJDJ did not take account of casual commercial sex as an income-generating strategy for CHHs. Other studies (Donahue 1998:3) suggest that as HIV/AIDS erodes household income, girls are more likely to engage in casual commercial sex-work to earn an income. This research is unable to support or disprove such findings in the context of CHHs. It is suggested that some CHH members, especially female heads, engage in casual commercial sex to provide household income. The self-reporting research tool would not have captured this, as it would be highly unlikely for a respondent to write 'prostitution' or 'sex for income' under the category 'type of work' in the BJDJ answer sheet. This is especially the case as such behaviour carries considerable stigma within the prevailing culture.

The economic consequences of living in a CHH are undoubtedly severe. This is seen in the areas of nutrition/food security and accessing schools as discussed above under 7.3. However, CHHs show remarkable resilience, even in the area of economic coping, as seen when looking at their risk and loss management strategies

Risk and loss management of CHHs

An important element of the dynamics affecting CHHs' coping decisions with regard to their household economy is their perceptions of, and attitudes towards, their risk environment. Risk environments for CHHs include the probability of further economic loss, and the size of the potential or actual loss. CHHs also consider the likely impact of loss on their existing economic security. As a result of this mostly unconscious appraisal process, CHHs manage their household economies by developing strategies to either reduce economic risk (by reducing their exposure to it), or to manage loss (by reducing the negative consequences of an actual or potential loss).

CHHs in the study seem to reduce their exposure to economic risk by:

- choosing income-generating activities that have lower risks. Such informal sector activities are associated with lower, but steady returns.

- diversifying and expanding household income-generating activities. Most CHH members aged above nine are involved in some form of income-generating activities. In many CHHs each member is engaged in different activities e.g. hair braiding, selling boiled eggs, washing clothes for lodgers, rent from lodgers, selling sweets etc.
- strengthening, maintaining or rebuilding 'insurance' mechanisms. Preserving, strengthening or rehabilitating extended family and community relationships are important 'insurance mechanisms' because such ties allow families to share risk and access additional resources. A few CHHs benefit from parental pension schemes and are able to access these savings during crises.

In addition to **mitigating risk**, another CHH coping mechanism is **managing economic loss**. During periods of crisis CHHs employ a predictable set of loss-management techniques to alleviate the worst effects on their well-being during such times. Donahue (1998), Over (1998) and Barnett and Blaikie (1992), in various economic household coping studies, identified three stages of household loss-management techniques. The magnitude and gravity of the experienced economic loss, as well as the initial economic stability of the household, determines the technique used to manage such loss. The following three-stage loss-management model is used in this research:

- **Stage I:** The loss management strategies used are reversible and have little to no impact on the household's future income-earning or production capacity.
- **Stage II:** The strategies are difficult to reverse because they involve the sale of productive assets – often at less than their full market value – which undermines the households' future capacity to generate income. Most families will reduce their expenditures and tolerate considerable hardship and hunger before they endanger their prospects in such a way. (This is unfortunately not always the case in CHHs as they may lack understanding of the potential long-term consequences of selling certain assets. Advice and guidance to CHHs in such matters is important as some ill-meaning relatives or community

members might take advantage of CHHs by offering them, in times of crisis, easy cash for important assets.)

- **Stage III:** When the household becomes destitute, few, if any, economic coping mechanisms remain available. In the context of CHHs this may result in the household breaking up, with children ending up as street children.

Table 7.3 (below) illustrates the types of economic coping strategies employed by CHHs to manage loss at these three stages.

The three stages of CHH economic loss management	
Stage	Loss-management strategies
I. Reversible mechanisms and disposal of self-insuring assets	<ul style="list-style-type: none"> • Reduce household consumption • Switch food consumption to natural food sources, berries, roots, wild vegetables, wild fruits • Borrow from neighbours and willing extended family members • Seek temporary support from neighbours and / or willing extended family members • Migrate temporarily in search for short-term jobs • Access burial society funds through an adult neighbour • Liquidate savings or valuables (parental wedding rings etc, although such have irreversible impact on positive memories) • Dispose non-productive assets such as television, radio • Decreasing spending on education (temporary drop-out of siblings) or non-urgent health / body care
II. Disposal of productive assets / investments	<ul style="list-style-type: none"> • Selling equipment, furniture, household goods • Purchasing food and other goods on account with often high interest rates • Dropping out of school of younger siblings to reduce costs and increase income-generating labour • Further reducing consumption, health and other expenditures • Selling of family home
III. Destitution¹	<ul style="list-style-type: none"> • Depending on handouts from neighbours or support programmes • Begging in street or petty food-related criminal behaviour • Distressed illegal migration to Botswana or South Africa • Household breaks up, resulting in household members becoming street children
¹ Some of the stage III loss-management strategies may be used by some CHHs at earlier stages, such as food theft or illegal migration	

Table 7.3: The three stages of CHH economic loss management

Source: Adapted from Donahue (1998:13)

Adult guidance and household management skills training (including loss-management training) are important support interventions for CHHs. Unless CHHs are advised or trained in these matters, they struggle to employ sustainable, reversible loss-management strategies. CHHs that were involved in parental care, and received parental and neighbours' guidance and advice in such matters, tend to cope better with economic crises.

Figure 7.11 illustrates in summary CHHs with economic stressors such as financial crisis or chronic insufficient income levels.

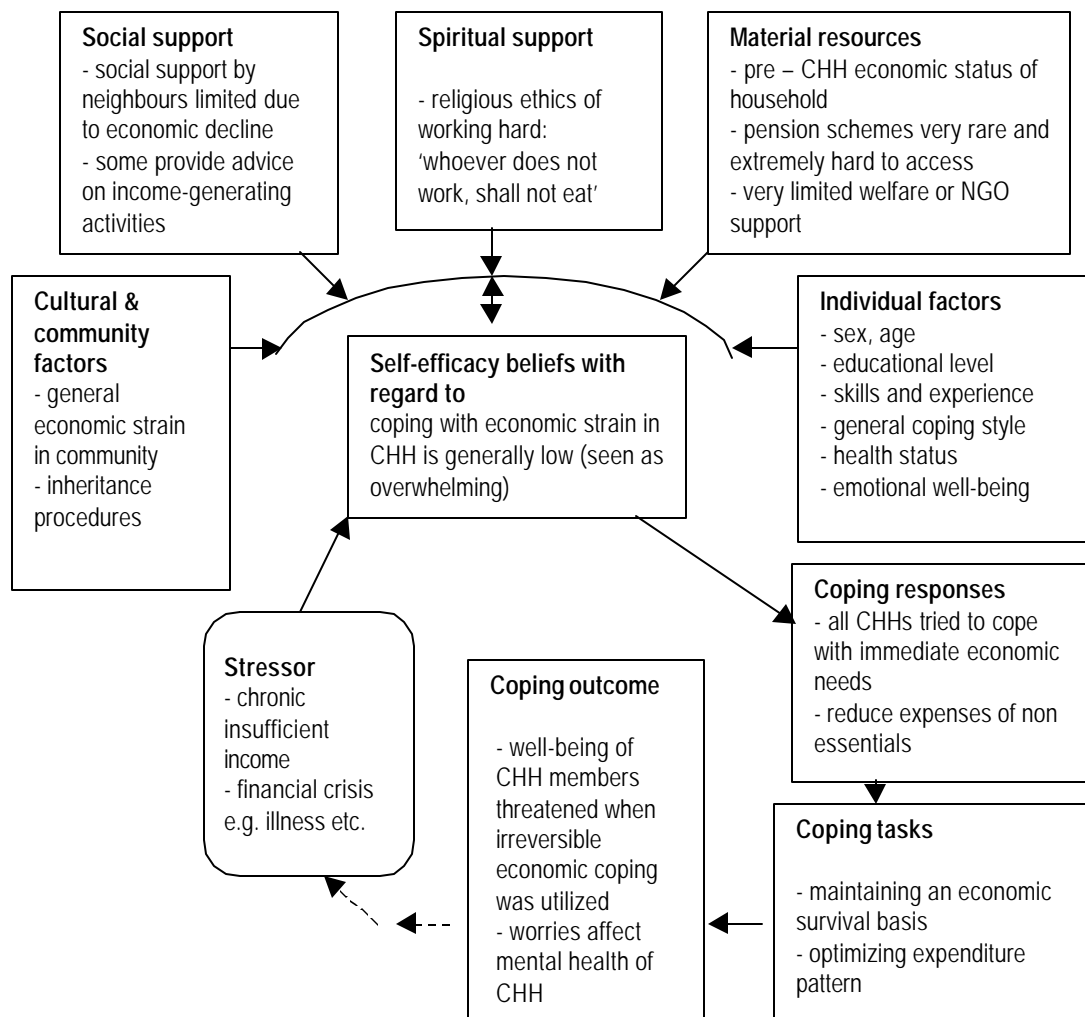


Figure 7.11: Coping with economic aspects of CHH

For policy and programme planners it is important to understand that only by strengthening and building the economic resources of CHHs, and strengthening community or neighbourhood safety nets, can such households function in a sustainable manner. Well-planned micro-credit programmes, working with CHHs and other households with vulnerable adolescents, can be an important mitigation strategy. Unfortunately only few such programmes exist.

7.4.2 Micro-credit⁴² programmes and household support

Within the research area no micro-credit scheme was identified that could be accessed by CHHs or other vulnerable youths. In most urban communities in Bulawayo, adults have organized themselves into 'burial societies' that function along the lines of microcredit / insurance schemes. Members pay either weekly or monthly subscriptions. They meet once per week and requests for financial support from members are assessed using strict guidelines endorsed by all members. Only when it is the burial of a member's close relative, or a severe crisis, does the 'society' make a 'pay-out' to a member (Chirwa 2003). Non-burial related 'pay-outs' take the form of a credit that needs to be re-paid within an agreed time-frame. Failure to repay will compromise a member's 'savings' in the future, and will be deducted from any burial-related payout at a later stage. Some CHHs benefited from such 'burial societies' for funeral costs when a parent, who was a member, died. However, because of their age they are not allowed by these societies to become members.

As micro-credit programmes can be an effective tool for strengthening the economic resources of CHHs they are briefly discussed here, despite the fact that none of the CHHs in the present study benefited from such programmes. A case study from a microcredit programme response in Tanzania is used to illustrate the importance of such interventions for orphans' economic and household coping.

⁴² Such programmes are at times confused with 'micro-finance' programmes. Micro-finance programmes offer credit and demand-deposit savings, intended to create financial service institutions. Micro-credit schemes do not make savings available on demand. If savings are part of such a programme, they mainly serve as collateral in case of loan of credit.

Vijana Simama Imara – Youth standing firm⁴³

The Humuliza programme in Tanzania is addressing coping capacity and psychosocial support needs for orphans and vulnerable children in rural Kagera District. In March 2000, during a workshop with teenage orphans, some participants agreed that they want to start their own orphans' organization. Youths asked two programme staff from Humuliza to support them in their endeavour as facilitators. Objectives of the 'orphans' organization' were: 1) to assist members in schooling; 2) to work collectively in the community to increase the image of orphans in the community; 3) to start up a youth-bank for micro-credit and savings; 4) to ensure mutual assistance in cases of illness and death of family members. They chose the name 'Vijana Simama Imara (VSI)', meaning 'Youth standing firm'. Contrary to the common view that organized orphans would become more stigmatized, interviewed adult community members have shown a positive reaction. People appreciate the orphans' active self-reliance, and praise their willingness to contribute to community development (Butler 2002:9). Without their organization, orphans would still be called orphans, but would be more ignored and marginalized. VSI frees them from their roles of being victims, giving them a stronger position in the community. 'Orphanhood can be cured', children from Bindura in Zimbabwe said (UNAIDS 2001:31). VSI is such a cure.

The micro-credit scheme is especially important as it empowers CHHs and other vulnerable households in the community. Participating children provide certain community services, e.g. fetching water for elderly people, assisting in the reconstruction of burned / damaged houses of community members, and other communal tasks. In return they receive from the programme a weekly payment into their 'bank account'. The bank is managed by older children of the programme. These savings can then be used as collateral to apply for micro-credit. It is up to the children to decide to either purchase a new school uniform, or use funds to buy dried fish for

⁴³ VSI case study is based on a publication by the researcher in the journal, Commonwealth Youth and Development (Germann 2003a).

re-selling etc. Children regularly meet and discuss how they are using credits and savings. This encourages - through peer support - good use of finances, and discourages expenditures on sweets or other non-essentials. In times of economic household crisis, this scheme enables participants to access savings and microcredit. As a result, a household's ability to stay within stage I of the loss management model is far greater. In such instances a household's resilience in times of economic crisis is enhanced.

Therefore, programmes working with CHHs should ensure that such households have access to micro-credit to mitigate the impact of short-term economic crises at the household level.

7.5 Summary and conclusion

Although coping strategies and abilities seem critical for CHH functioning and their experienced quality of life, there has to date been very limited understanding of CHH coping.

Household coping and individual household members' resilience are closely linked. Stressful events are part of everyone's everyday life. Through research, several coping theories have been developed that take into consideration the fact that coping is not static, but a highly dynamic process. For the study of specific situations, such as CHHs, general coping theories are limited by their lack of adaptability. Therefore, a task based model was adapted from Taylor (1986) and Meursing (1997) to suit the context of CHHs. Based on the researcher's experience, and in line with Max-Neef's human taxonomy of needs (discussed under 4.3.2), FGD results, and narrative interviews, spirituality was added to the coping model.

In this research the coping task model was adjusted for the purpose of understanding CHHs in areas such as nutrition, health, education, child protection and economic issues. CHH household coping responses and tasks seem mainly to be influenced by individual factors, community factors, social, spiritual and material support. Interplay

between these factors and the CHH's ability to achieve the required coping tasks impacts on coping outcomes at the household level.

Research data suggests that in the area of nutrition and food security CHHs have low self-efficacy beliefs, as the often-experienced chronic food shortage is overpowering. The same applies relation to education, where a lack of understanding from school authorities makes re-accessing school after parental death very difficult. At the same time, however, CHHs show remarkable coping strategies in mitigating the negative impact of stressors related to food security and education. Through accessing information (often from elderly female community members on reducing costs, traditional diets, and improved food storage), nutrition at the household level can be improved, even when neighbourhood food support is low, due to the prevailing economic situation. With regard to education, peer support helps CHH members to take more time for studying and to improve their performance.

It appears that CHH members, although more vulnerable to 'outside' abuse, are not more abused than other OVCs in the community, largely because CHH members seldom experience abuse within the household. When child protection coping tasks, such as assertive behaviour and self-defence, are effectively applied the prevention and reduction of abuse seem possible.

In a rapidly deteriorating macro-economic environment, economic coping for CHHs is very difficult, as most households within the community struggle to cope. Some economic coping tasks for CHHs were identified. These include optimizing expenditure patterns, and utilizing economic risk and loss management strategies. To mitigate the negative impact of economic stressors on CHHs, micro-credit schemes for such households should be introduced. The example of VSI in Tanzania demonstrates that such programmes have positive effects on economic CHH coping. This suggests that policy issues and CHH programme support issues are critical for improving and sustaining quality of life in CHHs.

8 Child-headed households, community child care capacity, programmatic responses and policy / child rights implications

The National Orphan Care Policy recognizes the Zimbabwean cultural adage that the child belongs not only to his immediate family but also to the community at large... The policy provides room for stakeholders, including children themselves to continuously review the country's response to children at all levels through research and training.

Chitauo (2002:i) (Minister of Public Service, Labour and Social Welfare, Zimbabwe)

8.1 Introduction

Children's lives are impacted by communities in which they live, national policies and legislation. This chapter first discusses the differences between community perceptions of CHH circumstances and research findings derived from CHH questionnaires and interviews. This is followed looking at CHH in relationship to child safety nets and community coping. The chapter closes with an analysis of rights, law and policies and with their implications on CHH.

8.2 Community perceptions of CHH circumstances

In the course of this research, community stakeholders' perceptions concerning the circumstances of CHHs in urban Bulawayo were documented. Community stakeholders' perceptions were captured using two FGDs, and through interviews with key informants. Participants included community members, and guardians as well as child care professionals. A total of 78 participants were included in this investigation. Results obtained from these FGDs on CHH perceptions differed from results collected from CHH questionnaires and interviews. This could relate to the fact that discussions of CHH issues are often emotionally charged, as is often the case with emerging issues that do not fit into the traditional pattern of 'how things should be'.

8.2.1 Community stakeholder perceptions of CHHs

FGDs were used to investigate community stakeholders perceptions of:

- positive aspects of CHHs
- negative aspects of CHHs
- risks of CHHs
- possible support to CHHs
- existing community, FBO, NGO and government support to CHHs
- putting CHH members into orphanages
- siblings staying together after parental death
- future of children in CHHs in the absence of adequate community support
- future of children in CHHs receiving adequate community support

Positive aspects of CHHs

A small number of positive aspects were reported. Most that were reported related to issues concerning the benefits of siblings staying together.

They stay together as a family (Teacher).

Some of these households are united (Neighbour of CHH).

It teaches children to be responsible – they learn to work hard and to help each other (Community leader).

Another positive aspect mentioned was children being better positioned to benefit from the parental estate when they are on their own.

They can keep their parents' property together so that no one grabs it from them (Neighbour).

At times children inherit property left behind by parents more easily (Businessperson).

Most FGD participants were able to identify some positive aspects about living in a CHH. However, some were unable to identify any positive aspects as reflected in the following statement.

There is nothing good about child-headed households (Social Worker).

Negative aspects of CHHs

This question concerning negative aspects of CHHs generated a lengthy and more lively discussion than the one above. One participant simply put it as:

They don't enjoy life (Community member).

The following Table 8.1 summarizes the responses given concerning negative aspects of CHHs.

Aspect	Statements / community perspectives
Abuse	'Neighbours may take advantage of these children, e.g. men may sexually abuse girls in return for material provisions' 'They become vulnerable to all sorts of abuse' 'Relatives may grab property instead of helping them' 'Neighbours may exploit them' 'Property grabbing by relatives'
Lack of material support	'Such children may not have money to buy food, clothes, pay rentals and school fees' 'People do not want to help because they think that children are helped through the AIDS levy' 'Lack of basic necessities like food, clothes school fees'
Health concerns	'Such children may fall sick and there may be no one to take them for treatment' 'Health problems – when they are sick there are no adults to care for them' 'Health of the children deteriorates due to lack of cleanliness. They may suffer from diseases such as TB and diarrhoea'
Conflict among siblings	'Older children may ill treat the younger ones' 'The children may lack respect for one another, leading to disharmony in households'
Lack of adult guidance	'Adults do not understand the behaviour of these children. They judge them, but do not give them advice' 'They lack guidance from an adult about their future' 'They are not ready to face life's challenges i.e. they have no moral values, therefore a lot of problems may arise'
Bad behaviour	'Some children may engage in delinquent behaviour such as stealing' 'Girls may become promiscuous in return for food, clothes and money'
Experience stigma and discrimination	'People may shun the children because they feel the death of their parents was as a result of promiscuity, therefore the children also may be promiscuous' 'They are stigmatised by the society' 'They may lose their identity in terms of registration and a person may lose confidence as a result'

Table 8.1: Community perception on negative aspects of CHH

Risks of CHHs

The discussion on risks attached to CHHs overlapped with the discussion on negative aspects. Key risks areas were identified, such as higher vulnerability to HIV infection:

Girls may get infected with HIV as a result of promiscuity (Police officer).

Another risk area identified, concerned children’s education:

They may lose their education either due to failure to pay school fees or school refusal since there are no adults who ensure that they attend school (Neighbour).

Socialization issues were of concern to community stakeholders. Concern was expressed about CHHs being at risk for not developing appropriate social skills due to stigma and lack of adult guidance:

They may be stigmatised by the society. As a result they may always be suspected of wrongdoing, e.g. where a theft occurs, they may be the first suspect (Health clinic staff).

May develop a habit of fighting in order to defend themselves (Pastor).

Possible support to CHHs

Table 8.2 summarizes the FGDs results regarding possible support that communities could provide to CHHs.

Area of support	FGD responses
Economic & material support	<ul style="list-style-type: none"> Help them to get employment Give them material support Provide children with material provisions such as food, clothes, blankets Equip them with practical skills that will help them generate income to sustain themselves
Life skills	<ul style="list-style-type: none"> Teach them to respect themselves and others so that people may like them Build confidence in them Help them in legal matters – act as their guardians Teach them skills necessary for daily living such as cooking, washing, cleaning
Guidance and protection	<ul style="list-style-type: none"> Advise them like your own children Provide them with spiritual support Encourage them that even though they have lost parents, they I have a future – we should stand in for them as parents Connect the children to organisations that offer support Provide counselling to the children The police are communicating with children via victim friendly office, use of suggestion boxes Inform communities about child abuse and other issues that concern children
Care arrangements and support	<ul style="list-style-type: none"> One relative can become the guardian of the children. The guardian should be chosen soon after the burial of the parent Children can be separated so that relatives care for the younger ones and the older ones remain on their own. This will prevent a situation where younger children are ill-treated by their older siblings Helping children can be a problem as relatives can block a neighbour who is trying to help Neighbours should work closely with children’s relatives when helping them Relatives should visit these children

Table 8.2: Community perception on CHH support needs

Putting CHH members into orphanages and siblings staying together after parental death

During the FGDs the following questions were raised by the facilitator: 1) Is placing children living in CHHs into orphanages a good thing or not?; and 2) In case your relative should die would you want his children to be split up among relatives or possibly stay in a supported CHH? Results from the discussions show that communities face an unresolved dilemma. On the one hand, they identify many negative aspects and risks associated with CHHs, and are against the idea of CHHs being an alternative care arrangement. On the other hand, they strongly believe that children should not stay in institutions, and siblings should not be split up, but preferably staying together in the children's parental home.

Mina ngokwami ngibona angani asizo ndawo ezihle zokuthi abantwana bakhulele kwenza umuntu akhule etshiyene lomuntu okhulele ekhaya ngoba sebesuswe bayahlala bodwa njenge zinthandane. (Home-based care volunteer)

Translation: I think orphanages are not good because children brought up in the orphanages turn out to be different from those who grow up in their homes. (Home-based care volunteer)

Placing children living in CHHs into orphanages, is still a common response by social workers and the Department of Social Welfare should they identify CHHs. However, most FGD participants rejected this approach, offering the following reasons:

Some children might have property, when they go to orphanages what happens to their property?

Taking children to orphanages may result in sibling's separation which is not good.

Children will feel isolated and do not socialize well.

Children will have no roots and loose cultural values.

Abuse takes place in institutions as well.

Reintegrating children from orphanages into society is difficult.

Some participants suggested that if children in a CHH are too young, it might be good to have them in an orphanage, but only as a temporary measure.

Strong feelings were expressed regarding the importance of siblings staying together. Although it is common practice to separate siblings and share the 'burden' of care among various relatives, participants felt that this is not a good practice. Many would prefer to have siblings stay together in their parental household as long as they are supported, ideally by an adult relative staying with them.

Children should not be separated, but an adult should come and stay with them. (Teacher)

It depends on how the children treat each other. If they treat each other well they should stay together, but if they don't live in harmony then they can be separated. (Grandparent)

Separating children would weaken family ties and children might lose their identity. (OVC programme volunteer)

Acceptable age to head a household

There were a range of responses to the question, 'at what age do you think and feel a young person should be able to head a household, looking after younger siblings when their parents have died? Ages suggested by participants ranged from 14 years to 18 years. A key concern was not so much the age, but maturity of the particular head of household.

Umntwana ongacina omunye ngumntwana ongazibhekela yena ngokwakhe. Umntwana oseqede isikolo njalo osesebenza. Ngingeke ngithi ngingasebenzi ngigcine omunye ngizamuphani nxa sekufuze aye eclinic. Ngizamuphni nxa esekhlela isinkwa. Kumele ngibe ngilenzuzo besenngigcina abanawami? (Community member)

Translation: A child who can head a household is the one who is able to look after himself; that is a child who has completed school and has a source of income. One cannot care for other children without income. What will happen if the child needs to go to the clinic or wants bread? (Community member)

Opinions about the desirable age of household heads also related to the availability of community support. One FGD felt that:

We agreed as a group as 14 being the earliest age. However only if the child gets the necessary support.

Future of children in CHHs in relationship to adequate / inadequate community support

In both FGDs, it was agreed that given adequate community support - the developmental outcomes for children in CHHs would not necessarily be bleak.

Their future will be the same as those of other children in the community (Teacher).

They will help other people to take up life's challenges (Community leader).

They will live like everybody else in the community (OVC programme volunteer).

They will lead good lives – crisis encouraged creativity on their part (Pastor).

The tough life they have to endure will make them strong people (Police officer).

However, participants stressed that such positive predictions were dependent communities providing support to such households. The groups concluded that failure to provide such support could result in children:

- having bleak futures;
- becoming street kids;
- dropping - out of school;
- becoming criminals;
- developing poor self-esteem;
- being vulnerable to abuse;
- dying of AIDS;
- ending up as prostitutes;
- becoming suicidal and
- becoming depressed.

These views echo the discussion in section 2.6 regarding the impact a large number of orphans may have on society. They serve to reinforce the observation that whether HIV/AIDS eventually leads to the breakdown of society, or not, will largely be determined by the nature and extent of remedial or compensatory actions and responses (section 2.5) and whether these are proportionate to the magnitude of the impact AIDS has on children (as discussed under section 2.4).

Community stakeholders seem to realize the importance of community support in mitigating the impact of the HIV/AIDS crisis on children. They acknowledge that such support is not, at present, adequately forthcoming.

8.2.2 Comparing community responses and CHH responses

'Child participation' has existed in different ways over thousands of years in family and community life. However, there has always been significant opposition to including children's active voices in community decisions (SC UK 2004:1). Only recently, has it been acknowledged that children may express concerns, needs and perspectives that differ from those of their caregivers. This recognition necessarily leads to the an important question: - 'whose knowledge counts?', This question can be posed as a 'challenge' because adults invariably hold more social power than children. Adult caregivers and the decisions they take do not necessarily serve children's best interests. It is, therefore, important to have children participate in child-care arrangements and activities, while at the same time ensuring that caregivers are not disempowered in the eyes of the children (Dominelli 1999:183).

Children are experts on their own lives, and adults should take what children say seriously. Therefore, it is important to compare the community perceptions on CHHs with the perceptions that were expressed in the two other FGDs, one for CHHs and the other for CHH siblings and friends. In most domains dealt with, there was considerable overlap between the groups. However, there were striking differences regarding the questions on positive and negative aspects of CHHs and community / organisational support to CHHs. Table 8.3 summarizes those differences.

Issue	Adult CHH perceptions	Child CHH perceptions
Negative aspects of CHH	Community members identified more negative aspects of CHH and the key negative aspect was around issues of being more vulnerable and the potential for delinquent behaviour as expressed in: 'Neighbours may take advantage of these children, e.g. men may sexually abuse girls in return for material provisions.' 'They are not ready to face life's challenges i.e. they have no moral values therefore a lot of problems may arise'	Children identified similar negative aspects but fewer, key negative aspect for them was: 'It is a hard life and CHH members have little time for friends and time to play'
Positive aspects of CHH	One group stated: 'there is nothing good with CHHs' but the other group acknowledge that siblings staying together is a positive aspect.	Children had a longer list of positive aspects, with the key issue being able to stay together and being united as a 'family'.
Community / organisational support to CHH	Community responses to that issue mainly focused on providing for children in the following areas: <ul style="list-style-type: none"> - economic and material support - life skills - guidance and protection - care arrangements and support 	'Community should appoint, in consultation with the children, a trusted adult as 'guardian' to monitor the CHH' 'Community leaders should encourage relatives to regularly visit CHHs' 'Organisations should provide loans to orphans so that they can start projects' 'Day care and pre-schools for orphans should be established where they should also be fed. This would greatly help CHHs' 'Places of temporary safety should be established for children from CHHs to go if they experience danger'

Table 8.3: Differences between adult vs. children's perceptions on CHH issues

This short comparison shows that it is important for children to participate in the planning and implementation of support activities, as they can help prioritise strategies of assistance. Furthermore, it is vital to see children's participation as a '*means for improving care, as well as promoting self-empowerment and psychosocial development*' (SC UK 2004:5).

8.2.3 Comparing community perceptions with research data

It has been observed that community members face the unresolved dilemma of not accepting the idea of the CHH as an alternative care arrangement, while at the same time - in line with international child care and protection policies - not wanting to place children in institutions. Although this study was not designed as 'action research', it is hoped that its findings may contribute to a better understanding among policy-makers and communities of how to deal with CHHs in the 'best interests of the child'. To that effect, the researcher recorded key differences between findings based on community FGDs on CHHs and research findings. These findings were shared in a research dissemination meeting with FGD participants. It is anticipated that these findings will contribute towards a better understanding of CHH circumstances and the acceptance of supported CHHs as alternative care arrangements. In short, these may contribute towards resolving this existing dilemma.

Table 8.4 below presents the above-mentioned findings. Areas that are not listed reflected similarities between community perceptions and research data. It is of great interest that in some important areas, research data and children's perceptions are more in accord than research data and adult community perceptions. This reinforces the importance of child participation in support programme planning and implementation.

Issue		Adult community perception on CHH circumstances	Research CHH data
Negative aspects	Abuse	<p>'They become vulnerable to all sorts of abuse'</p> <p>'Relatives may grab property instead of helping them'</p>	Although CHHs are at higher risk of experiencing abuse from people outside the household, they experience less abuse from within the household. 36 % of CHHs established such a household after they experienced abuse, including property 'grabbing' from extended family caregivers. (see 7.3.4 for details)
	Conflict among siblings	<p>'Older children may ill treat the younger ones'</p> <p>'The children may lack respect for one another, leading to disharmony in households'</p>	Sibling's relationships are mainly good, although there were over 1398 reported conflict incidences. It appears that most of these conflicts were caused by incidences of disobedience with the sibling's head of household, and seemed not to differ from sibling conflict in non-CHHs. Good sibling relationships seem to be a factor that strengthens CHH resilience and coping capacity. (see 6.5.2 for details)
	Lack of adult guidance	'They are not ready to face life's challenges i.e. they have no moral values therefore a lot of problems may arise'	Although lack of adult guidance and the resulting lack of basic information to take good day-to-day decisions has been identified in this study, research data does not suggest that 'they have no moral values'. Through their intense engagement in care, initially for terminally ill parents and not for themselves and siblings, members in CHHs seem to have developed high degrees of responsibility, and are able to take decisions based on accepted moral values in the community.
	Bad behaviour	<p>'Some children may engage in delinquent behaviour such as stealing'</p> <p>'Girls may become promiscuous in return for food, clothes and money'</p>	<p>Economic coping data does not support the perception that children in CHHs would engage in delinquent behaviour more frequently than others in the community.</p> <p>Collected data is insufficient to determine if and how girls may be involved in 'casual commercial sex activities' for basic subsistence. However, the low reported frequency of sexual activity suggests that such behaviour is not common.</p>
Risks	'May develop a habit of violence and fighting in order to defend themselves'	There is no data that would support the claim that CHHs are violent and fight to defend themselves. But data suggests that CHHs, as a coping mechanism, have developed assertive behaviour that could be seen by others in the community as very challenging.	
Community support	'Neighbours may exploit them'	Research data suggests that neighbours are the most important coping support source for CHHs. In older townships where neighbourhood networks are more established, community support of CHHs seems to be better. See Chapters 5, 7 and 8.3.3 for details.	

Table 8.4: Comparison between adult community perception and research data

8.3 CHH and safety nets

The following section considers the interplay between informal CHH support mechanisms provided by the household and the community, and the formal support mechanisms provided by the FBO, NGO sector and the state. This approach is used

by the World Bank (2004) for analyzing social protection issues, and is called social risk management (SRM). First of all, community approaches to supporting CHHs are discussed. Based on this discussion, it is suggested that we need to change the ways we perceive CHHs. This is followed by revealing results from the Social Support Scale that assisted in identifying who the key social support stakeholders for CHHs are. Thereafter, the discussion concerns itself with the extended family and the role of grandparents as frontline response, support for CHHs provided by community safety nets and external agencies, and the importance of community care capacity building efforts. Lastly, and possibly least importantly in the case of Zimbabwe, statutory safety nets for children, and their impact on CHHs are discussed.

8.3.1 Community approaches to support CHHs

Community perceptions as shared above (8.1.3) influence power balances in relation to children. Many of the perceptions expressed by community stakeholders are shared by child-care professionals in Zimbabwe and, most likely, throughout Southern Africa. Agencies such as the World Bank and national social welfare departments provide emotionally-driven recommendations, suggesting that it would be better for a child to be in an orphanage than to live in a CHH (Subbarao et al. 2001). This study suggests the need for a change in perspective.

A helpful analogy to illustrate the use of changing perspectives is the familiar 'Introductory Psychology' illustration of 'vase – double face profiles'. This optical 'thought exercise' demonstrates that if you focus on the figure you see a vase. If, however, you focus on the background, you see face-to-face profiles (Richter 2004:20). We can learn from this that we respond in our lives to what we see, but it is possible to see things differently. For example, if we perceive CHHs as a negative, even 'ugly' part of our society, we respond to them in a negative way. If, however, we see CHHs as groups of 'resilient heroes' in a united struggle to overcome the impact of a devastating human tragedy, we will collectively support such households in a positive way, acknowledging these children as partners.

Community approaches to child-care, include the African tradition of ‘everyone’s child’ and ‘every child has rights’ and these call for exactly the type of shift in perspective outlined above. It provides significant opportunities for programme innovation and developments that have potential to shift the balance of power in communities in favour of children support. According to Dominelli (1999:186):

pursuing the objective of empowering children because these can make caring for children a responsibility that can be discharged by a large group of people which are not necessarily related to children through kinship ties, but who, nonetheless, accept that they have a duty of care towards them. These people are those living in the same community as them and who share with them a number of attributes and social links rooted in interdependence, reciprocity and citizenship. For adults to share a reciprocated interdependent citizenship with children requires the empowerment of children, that is, their being treated as citizens from birth.

Citizenship in this context is not the ‘status that is acquired as one grows up’ that is limited to the boundaries of a nation-state. It is more along the lines of a ‘portable citizenship right’ that starts from birth, regardless of place of abode (Dominelli 1999:192).

As a result, children’s upbringing should focus on them realising their rights as citizens, with the assistance of adults, from the day they are born until they are able to fend for themselves. This process varies for each child, but should be conducted as a publicly accountable process whereby the child should never lose citizenship rights and entitlements. Treating children as equal citizens does not mean that they are ‘little’ adults, and childhood needs to be given a special status. However, it is critical to accept that children are people in the process of becoming adults from the day that they are born, and do not only embark on this process when they turn a certain age.

These insights have the following important implications for CHH support: 1) children do not ‘belong’ to their parents or guardians in a proprietorial sense. They are ‘citizens’ in their own right and therefore have a right to choose to live in a CHH; 2) child-care workers and professionals have to ensure that the rights of children in CHHs are maintained, and that their voices are heard; 3) each adult in the community

is required to put some effort into the growth and development of all children in their community; all community members have a collective responsibility to care for children in the community in a reciprocal and reciprocated manner, especially for CHHs.

The empowerment of children could, in this way, contribute to the empowerment of the entire community, as the strength of a community can be judged in terms of the ways in which it empowers its own perceived weakest members.

8.3.2 Results from social support scale analysis

After six months of primary data collection, there were 99 CHH participants left in the study. Of those 84 completed the self-reporting social support scale described in 3.5.7 (see Appendix 6).

Person is in my life			Helpful when personal problem			Helpful when I need money / other things			I have fun with this person				
Domain			Psychological			Material			Social				
	N	Y	NAA	SO	V	NAA	SO	V	NAA	SO	V		
Local Counsellor ¹			61	23	20	2	1	1	4	18	21	2	-
Total	Score		46	-	2	2	-	4	36	-	2	-	
Teacher			72	12	3	7	2	6	4	2	10	2	-
Total	Score		21	-	7	4	-	4	4	-	2	-	
Relatives			27	57	36	14	7	32	16	9	49	8	-
Total	Score		73	-	14	14	-	19	18	-	8	-	
Grandparent			52	32	10	15	7	21	11	-	23	7	2
Total	Score		51	-	15	14	-	11	-	-	7	4	
Brothers & Sisters			5	79	4	34	41	27	43	9	6	33	40
Total	Score		290	-	34	82	-	43	18	-	33	80	
Close friend			3	81	12	37	32	46	30	5	-	15	66
Total	Score		288	-	37	64	-	30	10	-	15	132	
Youths your age			0	84	49	31	4	55	27	2	14	61	9
Total	Score		149	-	31	8	-	27	4	-	61	18	
Neighbours			13	71	32	27	12	26	33	12	37	24	10
Total	Score		152	-	27	24	-	33	24	-	24	20	
Programme volunteers / staff			47	37	14	19	4	-	17	20	21	13	3
Total	Score		103	-	19	8	-	17	40	-	13	6	
Social Worker			79	5	5	-	-	-	4	1	5	-	-
Total	Score		6	-	-	-	-	4	2	-	-	-	
Church Worker			12	72	28	32	12	16	38	18	53	17	2
Total	Score		151	-	32	24	-	38	36	-	17	4	
Other people			59	25	19	4	2	16	5	4	17	6	2
Total	Score		31	-	4	4	-	5	8	-	6	4	
Score: NAA: Not at all = 0 SO: Sort of = 1 V: Very = 2 Score = Frequency multiplied by above score Total Score = Total of score in row					¹ The figures in the row is the reported frequency - if a respondent agreed to have the 'person in my life' but stated then 3 x Not at all, the person was counted as not in the child's life.								

Table 8.5: Summary results of social support scale from 84 CHH members

Discussion of social support scale results

By using the social support scale, external support to CHH can be assessed with respect to the psychological, social and material domains that impact on CHH coping strategies, as discussed in Chapter 7.

Figure 8.1 below, a summary of Table 8.5, presents the importance of the various persons in the lives of CHH members. It has to be noted that there was scope for double reporting with regard to OVC programme volunteer / staff and church workers since some churches run OVC support programmes. Therefore, the figures regarding church workers and OVC programme volunteers / staff need to be read with caution.

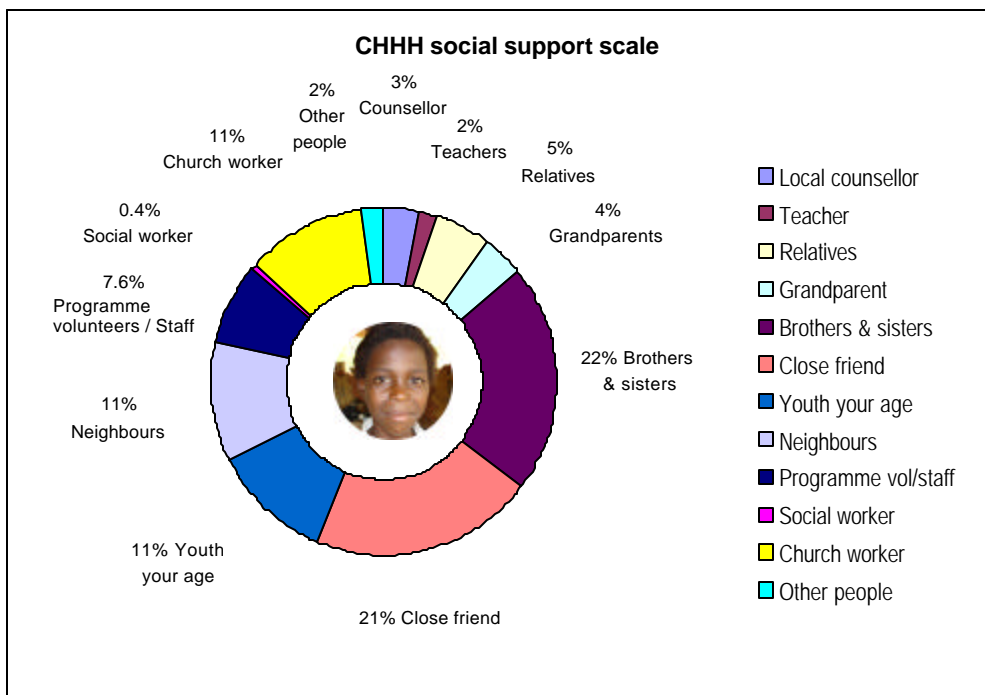


Figure 8.1: Overview of CHH social support scale results

First level of support

Data from the Social Support Scale suggests that siblings (22%), followed by close friends (21%), and other youth (11%) are the key support structures for CHHs. This indicates that, in total, over 54% of perceived CHH support comes from youth and children. This has important policy and programme implications, and calls for allocating more resources to enhance child-to-child and peer group support.

Second level of support

Neighbours (11%), Church Workers (11%) and OVC Programme Volunteers / Staff (7.6%) account for almost 30% of social support to CHHs.

Third level of support

Consistent with data from narrative interviews and WHOQOL-BY assessments, due to the high level of extended family conflicts experienced by CHHs, support from relatives (5%) is low. For those CHHs who still have a grandparent in their lives, such a relationship is an important support source. However, as only a small number of CHHs in the study still had a grandparent, the overall social support provided by grandparents was only 4%. In total relatives and grandparents account for a total of 9% of support.

Local councillors (3%), teachers (2%) and other people are additional, though not significant, CHH support sources. Studies focusing on the general OVC population and the importance teachers have in their lives (World Bank / UNICEF 2002:53), suggest that for school-going OVC members, teachers are a critical support source. An investment in teachers, enhancing their understanding and skills to address OVCs' psychosocial needs, is probably the most scalable psychosocial support intervention available (REPSSI 2005:2). This, however, will not directly benefit CHHs as the majority are out of school, or have dropped out prematurely. But it might benefit younger siblings in the household.

Data regarding social workers in the lives of CHH members (0.4%) seems to confirm that in Zimbabwe state social and child welfare provision has almost collapsed. For

CHHs, social workers are not seen as a source of support. This data has serious implications for national social policy formulation, and is discussed under 8.2.6.

8.3.3 Extended family support

As discussed in 2.3.1, it is acknowledged that the extended family safety net is still by far the most effective response to individual and household crisis in Zimbabwe. Yet the extended family in Zimbabwe is becoming stressed as a result of a combination of factors, such as a rapidly declining economy, a drastic increase in the number of orphans, and reduction in the number of available primary caregivers, such as uncles and aunts.

Even prior to the HIV/AIDS pandemic, the strength of the extended family was in decline due to labour migration, urbanization, the cash economy, formal education and reduced family sizes. Similarly, some extended families have always experienced conflict among themselves. Unresolved family conflict is strongly associated with a weaker social safety net. As discussed in section 5.3.5, existing family conflict prior to the onset of parental illness is a key determining factor or indicator for the increased possibility of children ending up as members of a CHH. In the past, however, the number of available primary caregivers, such as uncles and aunts, should parents not be available, were numerous. Even when family conflict existed, it was almost always possible to find a willing and caring primary caregiver within the extended family. This situation has, however, dramatically changed. In high HIV/AIDS prevalent communities, the combined impact of AIDS, economic decline and changes in kinship support systems has resulted in the harsh fact that, at times, especially in households with existing pre-parental illness conflicts, no suitable or willing primary caregiver is found after parental death. This creates CHHs with little extended family support.

The role of grandparents in accompanied CHHs

Stephen Lewis (2002), UN Special Envoy for HIV/AIDS in Africa pointedly stated 'Grandmothers are emerging as the unheralded heroes of the continent. They live with the inconsolable anguish of having buried their adult children, yet are the true, resilient hearts of the struggle against the pandemic'.

From a total of 105 CHHs that initially participated in this study, 21 were termed 'accompanied CHHs' in that the CHH members were living with an aged grandparent in need of care. The members of only four stayed with a grandfather, while the others lived with their grandmothers. In addition to these, 18 CHHs had a living grandparent, but did not stay with them. The social support scale shows that, for both groups, grandparents are an important support source.

An important role played by a grandparent is that, even though the head of the CHH needs to provide care, the grandparent provides household legitimacy. As Sibongile (15 years old) states:

If she [80 year old grandmother] were not here, we would be scattered around other families, treated badly. I hope she stays alive until I am old enough to ensure that we can stay together here (Sibongile 15 years old).

For others, grandparents play the key role of providing advice and moral guidance.

She brings us up properly, and tells us stories about our traditions and the past (Peter, 17 years old).

A grandmother participating in FGD expressed her experience as following:

Although it was not supposed to be that way, what can you do? If the parents leave the children, you just carry on, you have no choice but do what you can. Fortunately, the older one is good and works hard, providing even food for me (MaTshuma 79 years old).

Reduced mobility of aged grandparents, often due to illness or age can result in grandparents in accompanied CHHs being isolated from their own peers, as one expressed:

The children are good; all I need is someone of my age to listen to me, to encourage me. I am too old to visit my friends and relatives seldom visit (Mrs. Ngwenya 74 years old).

Some organisations, such as Help Age Zimbabwe, facilitated the formation of support groups for elderly people. In one of the suburbs such a support group has 48 members and together they support over 80 vulnerable children who are living with them. They meet on a weekly basis to share experiences, and to sing and dance together for mutual encouragement.

Some grandparents seem to struggle with teenage CHH members, especially males. Room for conflict is provided when the head of the CHH realizes that he/she is the 'primary caregiver' of the household, but the grandparent still feels the need to 'boss' him/her. There is a need to support such households to overcome such conflict.

Help Age International has recently identified that aged persons staying in households of orphans are the most vulnerable group of aged people. The following recommendations are made to assist grandparents in such households (Help Age International 2004:24):

1. Provide direct income support to address the financial needs of older carers
2. Provide older people with information and training on HIV/AIDS, and the rights of the children and older people
3. Develop policies and programmes that address the psychosocial needs of older carers and orphans and vulnerable children
4. All actors should ensure the involvement and participation of older carers and orphans and vulnerable children, in community structures, as well as in the formulation of national policy for poverty reduction and supporting families affected by HIV/AIDS.

As discussed in section 2.3.3, as the HIV/AIDS pandemic progresses in a given country, the average age of grandparents taking care of orphans increases. This is due to the fact that the mortality rate in the 20-50 year old group is highest, resulting in fewer younger grandparents. The higher average age of grandparents means increased mortality, and results in households requiring new caregivers. In the absence of such caregivers, CHH formation is likely to accelerate over the next decade. It would be prudent, therefore, to improve geriatric health programmes so as to promote longevity of these important role-players, thereby ensuring that orphans can stay with grandparents for as long as possible.

8.3.4 Community coping with CHH and support

All FGD participants confirmed that they were aware that CHHs exist in their community. But how do communities cope with CHHs and support such households? As discussed earlier, communities face an unresolved dilemma regarding CHHs. Divergent views are encountered, such as 'CHHs should not exist', and 'CHHs are good to keep siblings together'. Those members in the community who personally know CHHs, such as neighbours, seem to resolve this dilemma once they realize that such households can function responsibly with the help of neighbours and community, and may well be the best available option for these children at that particular time. Data from the BDJD sheets indicates that the majority of CHHs receive support from neighbours (Figure 8.2)

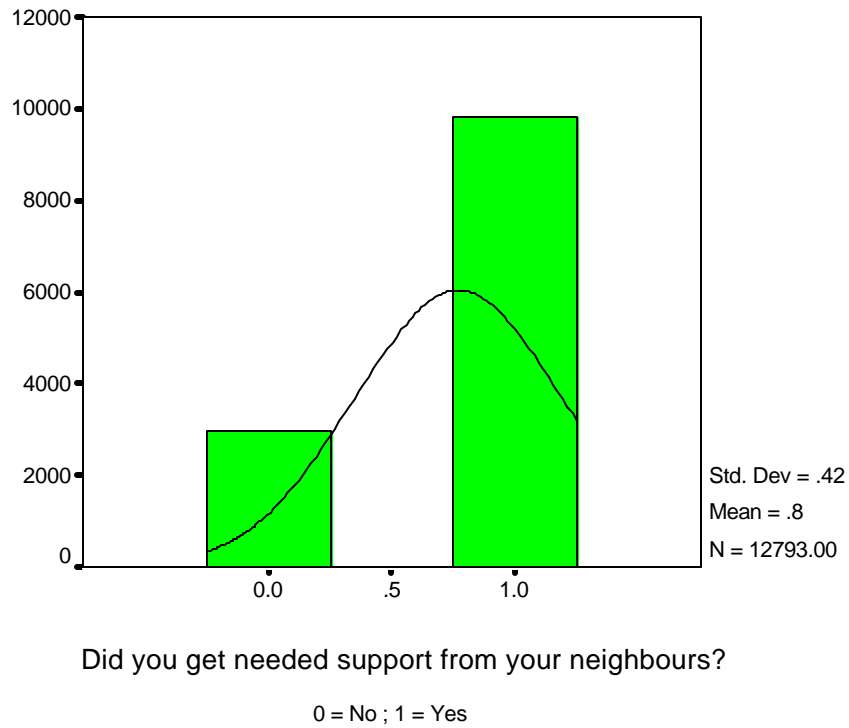


Figure 8.2: Neighbour support response histogram

It is interesting to note that there were differences reported in both tools (BDJD and SSS) with regard to neighbour support in old, well established locations, and newly established neighbourhoods (see Table 8.6 below), probably because of a lack of a sense of community and belonging.

Suburb	Age of suburb ¹	Number of households	CHH perceived neighbour support ²
Mpompoma	Old	5,559	5
Matshobana	Old	2,093	7
Cowdry Park	New	7,945	1
Njube	Old	4,283	5
Entumbane	Old	4,369	8
Pelandaba	Old	3,812	5
Magwegwe (incl. North)	Medium	6,522	4
Pumula Old	Old	6,352	6
Pumula South	New	4,569	2
Gwalabanda	Medium	3,146	3
Luveve (old)	Old	4,659	6
Luveve (new)	New	3,023	3
Lobengula	Medium	5,608	4
Emakhandeni	Medium	4,823	8
Note: ¹ Age of Suburb: Old (21+ years) Medium (8 – 20 years) New (1 – 7 years) ² The highest possible score for CHH perceived neighbour support for each area was 10. Since not all suburbs had equal numbers of CHH study participants, there was need to adjust the response score in relationship to the numbers of respondents in the suburb to ensure representative results.			

Table 8.6: CHH perceived neighbourhood support in various suburbs

Data from the above Table further suggests that the number of households, and resulting suburb size, do not seem to matter in terms of neighbours' support for CHHs. The single determining factor for such support is the 'age' of the neighbourhood. Newly established suburbs seem not yet to have built sufficient community capacity to adequately care for CHHs. It may be that neighbours in new suburbs have not yet had sufficient time to establish the trusting relationships that are necessary for reciprocal neighbourhood support. For OVC programmes, it is important to pay special attention to newly established suburbs and build their capacity to support CHHs. Although the age of the suburb is a key determining factor

for neighbourhood support, the case of Emakhandeni, a relatively new Suburb with an active local councillor in OVC issues (his wife is the chairperson of the HBC task force), signals that active leadership in social development issues accelerates community care capacity building processes.

Using FGD and the task model for coping developed in Chapter 7, Figure 8.3 was developed to show how communities cope with CHHs in Bulawayo.

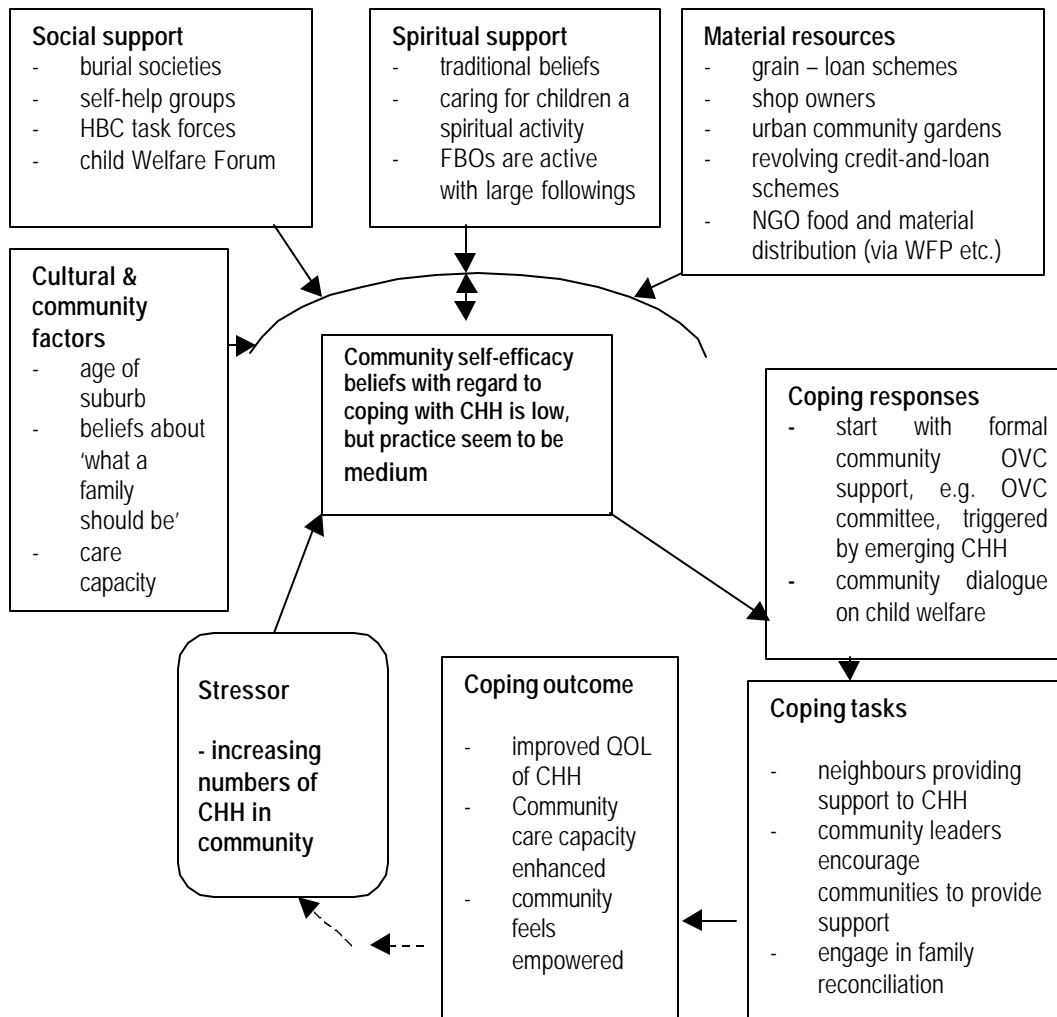


Figure 8.3: Coping of communities with CHH

Positive coping outcomes take place when communities make effective use of required coping tasks. This, however, will not necessarily result in reduced numbers of CHHs. On the contrary, it may actually increase the number of CHHs in a

community if these are seen by community members as an acceptable alternative form of care arrangement for children. This may not necessarily be bad. However, should CHH numbers increase due to community care being unintentionally undermined by an external agency, such as an NGO (reported in Luzze 2002), then this is certainly a cause for concern.

8.3.5 External agencies CHH support

A number of CHHs are part of OVC support programmes controlled by external agencies. In this context external means organisations that have their 'head office' outside the community, although staff from the organisations might live within the community. FBO and most NGO interventions are of such an 'external' kind. As noted above, support from such agencies should never undermine local caregiving, but should contribute towards increased community care capacity. External agencies supporting OVC and CHH were discussed in section 4.4.4 and 6.5.4, and are not repeated here.

As numbers of CHHs increase, due to the shifting dependency ratios of children in need of care and available primary caregivers, (see 1.2.1 under demographic changes), external support agencies might be encouraged to start up programmes directly supporting CHHs. This research, and research from Luzze (2002), discourages such an approach, as it might undermine existing community efforts to support CHHs. The support for CHHs should be integrated with OVC support that is rooted in community care. Unfortunately, many external agencies that support OVCs continue to use direct service delivery approaches. Often such approaches not only disempower caregiver-child relationships, but at times they alienate community self-help efforts for the care and support of vulnerable children. Interventions from external agencies should help community members to realize that their existing responses - using their local resources, abilities and ideas - are important to address child-care capacity issues, but that their responses can be more effective if they enhance collaboration. Most importantly, external agencies' interventions need to assist communities to take ownership of support activities, while becoming effective

advocates for their own needs and priorities, thereby experiencing empowerment (IHHA 2003).

Through community mobilization and community care capacity building, partnerships between various stakeholders are created that enhance community support for CHHs. Some OVC support programmes have created partnerships with the private sector. At present Barclays Bank and the Bulawayo Rainbow Hotel assist CHHs with shelter, clothing and food via local programmes (STRIVE 2004:5). Archer Clothing, one of the largest textile firms in Bulawayo, with over 1000 employees, engaged in a partnership with Masiye Camp enabling Masiye to recruit CHH members, aged 18 and above, into the permanent labour force of this company. Through that partnership, Archer significantly contributes towards social development in the community in which they operate. The company hopes that CHH members who participated in Salvation Army Masiye Camp programmes are less vulnerable to HIV infection due to increased awareness and behavioural change. This is seen to contribute to a reduced HIV prevalence in their workforce, thereby reducing labour replacement costs (Germann 2004c:3).

8.3.6 Child care focused community capacity building

As discussed in Chapter 2, the HIV/AIDS pandemic is creating a child welfare and child rights crisis of unprecedented magnitude. Increasingly, it is recognized that the most sustainable and cost-effective efforts to support, protect, and assist orphans and other children made vulnerable by HIV/AIDS, are those started and managed by grassroots community groups (Foster, Lorey & Williamson 2001:2). International advocacy efforts have highlighted the magnitude of the problem and, as a result, international agencies and donors have started to find ways to support such community level efforts. There is, however, according to Foster (2002), great danger that such support might, if not channelled through appropriate mechanisms, undermine local efforts. This is especially important for responses supporting CHHs, as efforts to support CHHs can easily undermine community care, as shown in a study of CHHs in Uganda, briefly discussed in the previous section (Luzze 2002).

In their desire to support community initiatives, external organizations must be careful to avoid undermining community coping. There is a proverb from the Congo that goes 'When you call for rain, remember to protect the banana trees'. In other words, the provision of external resources can, if we are not careful, actually make matters worse by flattening local responses. External agencies would do well to remember that community initiatives are the frontline response to orphans and vulnerable children and plan their responses accordingly (Foster 2002).

This, therefore, calls for a community child-care capacity building response. But what is capacity building? Eade & Williams (1995:9) state that 'strengthening people's capacity to determine their own values and priorities, and to organize themselves to act on these, is the basis of development'. Thus, capacity building is an approach to development, not something separate from it. Eade (1997), in an Oxfam development guide on capacity building, provides a thorough account of capacity building as an approach to people-centred development.

For the purpose of this study, community child care capacity building is best understood as a process whereby external agencies, rather than providing direct child services, strengthen local NGOs, CBOs and community groups through organizational development, training, provision of key resources and, often, provision of small grants through local grant-making mechanisms. For some international agencies, this requires a fundamental shift in their programming, a shift from the role of direct service provider to facilitator of community responses. Many of the local organisations discussed in sections 4.4.4 and 6.5.4 are organizations that provide both direct services and community child care capacity building. For regional or international agencies, however, their role should be strictly of a capacity building nature.

Involving the community as a whole, and working in partnership with its members to enhance child-care, is also empowering for child-care practitioners at the organisational level. Such efforts help child-care workers not to feel isolated in their work, but supported by the community. REPSSI, discussed under 6.5.4, in collaboration with its many partners, developed from 2002 to 2004 a participative community tool to enhance community care capacity in the context of HIV/AIDS,

conflict, and family disintegration. Using the concept that ‘to grow from a child into an adult is a journey of life’, the Journey of Life community child-care capacity workshop manual was developed. Its objective is to assist the community in identifying for themselves children in need of social, emotional, intellectual, spiritual, and physical support. It also seeks to find solutions to the problems that children encounter using the resources available in the community, and assists communities to strengthen the resilience of their own children (REPSSI 2004:5). When children are overwhelmed by life’s problems, the community can use its strength to support the child.

In summary, community child care capacity building requires that each adult in the community puts some personal effort into sustaining the growth and development of all children, especially CHHs, in their community.

8.3.7 The state and statutory approaches to CHH

The last, but possibly least significant, stakeholder within the existing CHH safety net in Bulawayo is the state, represented by the Department of Social Welfare, with its statutory role of child protection and welfare. As discussed in the results from the social support scale, the social worker did not appear to exist in the lives of CHHs.

International conventions, national legislation and policies discussed in section 8.3 below, mandate the state with responsibilities for child welfare. The rationale of such statutory welfare structures is that the state is responsible for ensuring the ‘best possible’ care for children, if necessary, through alternative placement by professional social workers. Although adapted since independence in 1980, most existing legislation and the child welfare system in Zimbabwe are, in essence, still based on old Western and colonial models of child welfare and protection. The legally endorsed system of support for children in need of care is mainly based on legal adoption or formal fostering through child maintenance grants, under the supervision of professional child welfare officers. In reality, the use of these statutory child welfare options, with only a handful of adoptions and formal foster arrangements processed in Zimbabwe each year, do not impact on the lives of the majority of children in need of alternative care.

Such case-oriented systems, involving placement of children by government-employed social workers in carefully selected and monitored settings, may have been feasible in a well resourced setting, and before the current orphan crisis unfolded. But in the present context these strategies are utterly inappropriate to support the large number of children in need for care. Thus, there is need for statutory systems to recognize *formally* the role played by extended families, neighbours, and communities in supporting children. According to Foster (2004:87), the concept of ‘good enough’ standards – appropriate to the norms of the community in which the child lives – is worth considering in settings where the number of children who have lost both parents exceeds 10% of the total childhood population.

The concept of ‘good enough’ is often in the best interests of the child. For social welfare policy and practice this may well include acknowledging ‘supported CHHs’ as viable alternative care arrangements. This is presently not the case, as illustrated in the following short case study from one CHH participating in the study (Box 8.1).

Talent, a 17 year old girl, headed an accompanied CHH. Her 86 year old grandmother was blind and in need of care. Mandla, the older 18 year old brother, did not cope well with the loss of their parents, especially his father. As a result he was not contributing much to the household management duties. They had two younger siblings, Tandi an active 12 year old girl and Nkosi, the two year old chronically ill brother (suspected to be HIV infected).

The household was supported by the local HBC task force, with the local councilor taking on a ‘guardian’ role for the CHH. Whenever they had a problem they could not cope with themselves as a household, Talent would go to the local councilor, where she would get support and assistance. The wife of the councilor was the team leader of the local HBC task force. According to the councilor and the community, this accompanied CHH was a functioning household.

One day, when the researcher visited the household, all the children were gone, and the grandmother was on her own with two adult males, who, it turned out, were lodgers. After contacting the local councilor, he stated that without their knowledge, an officer of the department of social welfare visited the household and decided to remove the children. Talent and Tandi were put into a girls’ orphanage, Mandla in a boys’ orphanage and Nkosi was put into hospital (where he shortly thereafter died).

Neither the grandmother nor any of the community volunteers of the local HBC and OVC support group agreed with that action of removing the children. When the researcher later followed up on Talent and visited her in the girls’ orphanage, she was very unhappy with her new situation and expressed ‘I would want to run away from this place with my sister and go home to my granny and brother’.

Box 8.1: CHH and Department of Social Welfare intervention case study

Unfortunately, such actions by child welfare professionals result from a lack of understanding of CHHs and their coping strategies. It is, however, encouraging to note that the International Federation of Social Workers (IFSW) is taking the challenges posed by the impact of HIV/AIDS on social welfare systems and practices seriously. Some of the key recommendations made by IFSW for Ministries and Departments of Social Welfare include (IFSW 2002:23):

1. Departmental social welfare activities should be decentralized from the national to the provincial or district level. An explicit focus on children is needed that would reinforce and support formal and informal care arrangements in the community.
2. Welfare departments need to transform from 'welfare' service delivery towards 'development' activities in bringing about an attitude change more oriented towards empowering communities. The department of social welfare should develop strong links with the community, providing inputs such as technical expertise, administrative support and financial assistance.
3. Registers of orphans and children in need should be maintained at district and provincial levels, and monitoring of activities of communities participating in programmes is encouraged. Institutional care should be a last resort, due to the harmful effects of institutionalisation and inadequate available resources for this option.
4. Department of social welfare should take a proactive role in supporting community coping strategies, by encouraging and supporting child care arrangements in the community. Such may include recruiting, training and supervising support persons in the community to assist with caring for children in formal and informal care.
5. A clearer understanding of the changing professional role of social workers in the context of the HIV/AIDS pandemic needs to be developed.

These recommendations are a significant shift away from case-oriented child welfare practices towards a facilitatory role. To put such welcome changes in policies into practice, however, requires a considerable change in attitude among many child-care

professionals, who may resist such change. It further requires vital changes in existing legislation.

8.4 Rights, laws, policies and CHHs in Zimbabwe

In line with the conceptual framework of this study, it is important to analyse international and national obligations and rights, laws and policies to understand and appreciate how they impact on alternative care arrangements, and CHHs in particular.

8.4.1 International and national obligations and CHH

The rights of children living in Zimbabwe are encompassed in The United Nations Convention on the Rights of the Child (CRC) - ratified by Zimbabwe in 1990 - the African Charter on the Rights and Welfare of the Child (ACC) - ratified by Zimbabwe in 1995 - , and by the Zimbabwean Constitution.

Since all these instruments were developed in an era before the HIV/AIDS pandemic and resulting CHHs, it is worth observing how these instruments, especially the CRC and the ACC, positively or conflictingly impact on CHHs. Table 8.7 is an attempt to give an overview of these instruments in relationship to CHHs within selected key areas.

Issue	Instrument	Impact on CHH
Age	CRC Art. 1 ACC Art. 2	Both CRC and ACC state that a child is a person below the age of 18 although the CRC gives provision that, should the law applicable to the child have an earlier age of majority, this would apply as the cut-off point. To ensure that CHHs are covered under the various legal instruments it is sound to keep the age of 18. This, however, poses challenges, as some rights that CHHs need to access, e.g. property ownership, accessing welfare grants etc. can not be accessed as a minor. There is need within national legislation to ensure CHHs have access to such without removing their protection under the CRC and ACC.
Discrimination	CRC Art. 2 ACC Art. 3	There is need to prohibit discrimination based on real or perceived HIV status of children. Statutory agencies should not discriminate against CHHs, but see them as a 'new form' of family unit.
Best interest of the child	CRC Art. 3 ACC Art. 4	May positively impact on CHHs, but the challenge is: who decides what the 'best interest of the child' is? As an overarching principle, this instrument is powerful to support CHHs if the right to be heard and participate by the children is guaranteed.
Participation and free expression	CRC Art. 12, 13 ACC Art. 7	Instruments give provision that CHH voices should be considered regarding care arrangements etc., and they should participate in planning future care arrangements. This, however, is often not the reality as competent statutory child agencies are given authority in certain cases 'to know what is in the best interests of the child', even if it is against the child's will. This provision is needed, but may negatively affect CHHs in situations where child-care professionals do not accept CHHs as a possible form of alternative care. The right to be heard, and of participation by the children, is not guaranteed in the constitution, which results in CHHs having no existing legal instrument to ensure that their opinion is taken seriously regarding their care arrangements.
Identity	CRC Art. 8 ACC Art. 6	Many OVCs and CHHs have their right for identify violated by a bureaucratic registration authority
Education, social security, health and leisure	CRC Art. 24, 26, 28, 31 ACC Art. 11, 12, 14	All CHHs would have the right to access education, health and time for leisure. Further, CRC Art. 26 gives every child the right to benefit from social security, including social insurance. CHH rights in that regard are greatly violated, as they are not even able to access the meagre existing social welfare support grants on their own.
Alternative care arrangements, review of placements	CRC Art. 10, 18, 20, 25 ACC Art. 18, 19, 20, 24, 25	Article 20(3) is problematic as it only provides for foster placement, adoption or placement in suitable institutions for children who are deprived of their family environment. The problem, however, is that no definition of family is given in the CRC and ACC. This provides an opportunity for CHHs as they can claim they represent a 'family environment', and therefore not be in need of alternative placements, as called for in article 20.
Notes: CRC (UN Convention on the Rights of the Child) ACC (African Charter on the Rights and Welfare of the Child)		

Table 8.7: Child rights instruments and their impact on CHH

In light of the unprecedented HIV/AIDS pandemic, and resulting changes in childhood, family and child-care patterns, there is need to review and revise certain elements of The United Nations Convention on the Rights of the Child (CRC)

(especially Article 20), the African Charter on the Rights and Welfare of the Child (ACC), and the national Constitution.

8.4.2 National legislation affecting children and CHH

In addition to signing international conventions, the Zimbabwean legal system has further demonstrated its commitment to children by putting in place relevant statutes such as the Children's Protection and Adoption Act (Chap 5:06), the Children's Protection and Adoption Amendment Act, the Education Act (Chap 5:04) the Guardianship of Minors Act 9 Chap 5:08), the Sexual Offences Act and the Deceased Person's Family Maintenance Act (O'Gorman 2003).

The **Child Protection and Adoption Act** mandates the department of social welfare to deal with the care and protection of children. It stipulates that probation (social welfare) and police officers have the authority and responsibility to remove children in danger to places of safety. Measures to be taken include placement in foster care, adoption or institutionalization.

The second safety net for children is the **Guardianship of Minors Act**, which deals mainly with the custody of children in cases of divorce, or separation, or deceased parents. The best interests of the child, decided by a professional, is the basis for decision making. The **Deceased Person's Family Maintenance Act** was recently introduced to ensure that widows and their children are not disinherited by the husband's/father's relatives. **The Maintenance Act** asserts that all children have the right to be maintained by their parents. **The Education Act** provides the right to education for every child. The responsibility to ensure child attendance is placed on the parents.

The Birth and Deaths Registration Act mandates parents to register a child's birth with the Registrar of Births within 42 days of birth. There are certain obstacles to this; such: as the uncertain marital status of parents, births outside of a medical facility, and transport costs/time needed to effect the registration process. The lack of registration impacts on every aspect of a child's life, including access to education,

health care, inheritance, employment and identity. Many orphans face great difficulties to acquire a birth certificate if their parents did not get one for them at birth or whilst they were still alive.

The recently enacted **Children's Act** allows the Ministry of Labour and Social Welfare to outsource services to child-related organisations, giving provision that Church and NGO-employed social workers have statutory powers if registered with the Ministry.

All of these Acts, except the **Children's Act**, were put in place at a time when family structures were still intact and no CHHs existed. They rest, thus, on the supposition that children have two living parents. These Acts are based on the idea that the nuclear family provides the best protection for the child, and that intervention is mainly necessary in cases of divorce or separation. Thus, they do not address the range of issues presented by a society in which large numbers of parents have died. They fall short of providing the range of protection that many children in Zimbabwe need today.

There is urgent need for statutory systems to give formal recognition to the role played by extended families, neighbours and communities in the support of orphans and vulnerable children. Existing fostering procedures need to be reviewed and simplified, focusing on community monitoring of households with foster children. Furthermore, the present foster grant system needs to be revised from only making grants to formal adult foster parents, to providing grants to informal foster parents, and direct support grants to CHHs. This will require heavy investments in training community volunteers for care programmes, in family assessment and supervision, and in setting up referral structures by equipping social workers with community care supervisory skills so that they can address household issues that community volunteers are unable to address.

8.4.3 Current child-related policies in Zimbabwe

The Zimbabwean government's acknowledgement of the problem of orphans and vulnerable children lies, in particular, in the National Orphans Care Policy, and the National HIV/AIDS Policy 1999.

The National HIV/AIDS Policy was developed in 1999 and guides present and future responses to the pandemic in Zimbabwe by all stakeholders. The Policy encourages a multi-sectoral approach and contains guiding principles and strategies for many aspects of the fight against HIV/AIDS. Children issues are only partly addressed in this policy with regard to HIV testing and treatment.

The National Orphan Care Policy was adopted by Cabinet in 1999 and is a response to recognition that the available legislation was not 'orphan-specific', that many orphans had fallen through the safety nets put in place by the Child Protection and Adoption Act, and that many orphans were failing to access the 'protection of the law' in respect of benefiting from deceased parents' estates. It recognizes the concepts of children's rights and general ignorance with regard to these, and the negative impact of this ignorance. It further recognizes the failure of safety nets to cope with current numbers of children, in terms of available resources, poor targeting mechanisms and uncoordinated approaches. A further set of recognitions is the problem of excessive red tape, lack of information on how to access services, weakened traditional leadership, and the impact of increasing poverty on the ability of the extended family to cope.

The objectives of the new orphan policy are summarized in Table 8.8.

Zimbabwe national orphans policy - key issues:
Reorient the Child Welfare Forum to address the particular needs of orphans
Support existing family and community structures to develop orphan care strategies
Promote accessibility to services
Include orphans in all activities for children, particularly health care and education
Develop an awareness of children's rights
Promote protection of orphans from all forms of abuse
Coordination for monitoring and information sharing in the Child Welfare Forum to be implemented at national, provincial, district and village levels
The policies orientation was mainly towards the access of education to all orphans

Table 8.8: Zimbabwe national orphans policy – Key issues

The Zimbabwe National Plan of Action (NPA) for Orphans and Vulnerable Children was developed in 2003 at the National Stakeholders' Consultative Conference. The document outlines commitments made by the Zimbabwe government and international organizations to OVC, ensuring them access to education, food and health services, birth registration, and protection from abuse and exploitation (Futures Group 2004).

Despite these international instruments and many policy choices, the lack of consistent revisions to align legislation with such instruments and policies, as well as lack of commitment from the fiscus for financial resources, has prevented the realization of many of the commitments outlined in these documents.

8.4.4 CHH – gaps and conflicts in policy and law

In terms of a child rights framework for understanding gaps and conflicts in existing policy and law in Zimbabwe, it can be said that CHHs suffer all the responsibilities of duty-bearers without any of the benefits of rights-holders.

Children's laws in Zimbabwe are based primarily on a welfare approach. They do not recognize children's rights in relation to parents and the state and, as a result, do not support CHH needs. Prior to the adoption of the CRC there was little interest in

children's rights, and most child-related legislation was formulated before Zimbabwe signed the CRC.

None of the existing Acts discussed above are specific to orphans and vulnerable children. Thus they provide no guidance or special provision for CHHs. The Department of Social Welfare - which is mandated, under the Child Protection and Adoption Act, with the care and protection of children - admits that its services are not orphan-friendly (Dhlembeu 2004). One example of this is that the Department of Social Welfare depends on referrals from adults and, therefore, CHHs in need cannot self-refer. The biggest impediment, however, to the Department's functioning is the fact that it no longer has sufficient human or financial resources to deal with the unprecedented numbers of orphans.

There is an excess of bureaucracy involved in the implementation of the National Orphans Care Policy, since the process of assisting orphans is based on referral. Once again, this excludes CHHs from referring themselves.

Furthermore, due to the existence of a dual legal system of customary law and codified general laws, a plethora of contradictory laws have been enacted that impact negatively on children's full enjoyment of their rights (O'Gorman 2003:6). One example of this is the issue of the definition of a child, which varies from one statute to another and increases the vulnerability of orphans and vulnerable children. According to one statute children below 18 are allowed to engage in consensual sex through marriage. But, on the other hand, common law prescribes sex with a 16 year old as rape, since the child is not considered legally capable of consenting.

Table 8.9 is a summary of gaps and conflicts in existing policy and law in Zimbabwe for comprehensive support of orphans and vulnerable children, especially CHH members.

Issue	Existing gap / conflict	Recommendation
Consistency	Existing policies and laws are not consistent with the CRC and the African Charter of the Rights and Welfare of the Child.	Up to date Zimbabwe only engaged in 'piecemeal' child law reform. There is need to engage in a well-planned, fully funded child law review and reform process.
Dual law system	Presently there exists a dual law system of customary and codified laws	There is need as part of the above recommended review and reform process to harmonize contradictory laws within the two systems
Human and child rights	Constitution does not reflect sufficiently a human rights and child rights framework	Zimbabwe faces a constitutional crisis. The constitution does not uphold in all aspects human rights, and certainly not children's rights. The constitution needs to change issues regarding civil registration and majority and minority status in favour of CHHs. Gender vulnerability, created by section 23(2)(b), needs to be amended. A new constitution is needed that complies with all human rights treaties Zimbabwe has signed.
Restrictive interpretation	Statutory mandated agencies seem to have very limited and restrictive interpretation procedures of policy and law	Differences between policy and law require that the responsible line ministry needs to give application guidelines. E.g. Social Workers need to have national guidelines on how to deal with / support CHHs. Such guidelines need to be made public to ensure professional accountability of child welfare officers.
Recognize informal and alternative care	Extended family care and other informal fostering or alternative care arrangements such as CHH are not recognized under the law	The recognition of the primary duty of the extended family network should be supported by the state in terms of Article 18 of CRC and 22(2) of ACC. Neighbours and other community vetted/appointed 'caregivers' should be able to be formal guardians. CHHs should be recognized as an alternative care arrangement.
Social security grants	Direct social support through grants are inadequate and CHHs cannot benefit	Support grants to families should be managed by transparent community support groups, and not the state. CHHs should be able to benefit from such community-awarded social support grants, and self-reporting by vulnerable children should be acceptable.
Age	Various age definitions cause problems and conflicts	There is a need to have a consistent definition of a child as below 18. But the Legal Age of Majority Act No 6 of 1997 should be amended to include a provision that allows certain minors (e.g. the heads of CHHs) to be recognized as majors in relation to certain specified areas, because of the roles they playing as heads of households at tender ages, while still enjoying the special protection of childhood.
Recognition of specific roles and status	Presently children taking on caregiving roles are neither supported nor assisted in many instances	A publicly identifiable status should be conferred to CHHs to enable them to assist their brothers and sisters with civil registration and other legal requirements. The same recognition of roles should enable them to accompany their brothers and sisters to hospital for treatment / or meet with school authorities without requiring someone to act as guardian.

Table 8.9: Gaps and conflicts in policy / law regarding OVC and CHHs in Zimbabwe

Source: Adapted from O'Gorman (2003)

Gender-specific issues to policy, law and CHHs

It must be recognized that a higher value is placed on boys than girls in Zimbabwean culture. Decisions about the future of girls are over-prescribed by tradition, and lack the influence of the mother. A slight majority of heads of CHHs seem to be females, and the impact of HIV/AIDS places the girl head in triple jeopardy, namely as an individual, care-giver to siblings and, at times, already being a mother herself. Existing legislation does not provide for special protection of vulnerable girls. On the contrary, as indicated above, section 23(2)(b) of the present constitution increases gender vulnerability.

While acknowledgment must be given to the range of laws and policies in place, it is necessary to acknowledge that they were fashioned in a different era, and that most of the current policies and laws are not responsive to the emerging issues and lived realities of contemporary children. The lack of linkages between policies and emerging issues creates programming gaps that result in increased vulnerability of certain children. This is evident in the fact that CHHs, though an increasing phenomenon in Zimbabwe, have not yet been tackled systematically at any level of national policy or law.

Unfortunately, policy and implementation are two different processes. It is the application, not formulation, of policies that presents the real challenges. Zimbabwe would need considerable investment and political commitment to significantly improve the present gap between policies and practice reflected in law reforms. The present political chaos and economic collapse greatly reduces professional human capacity, and depletes financial resources for such processes. The researcher anticipates that it will take at least a decade to 'normalize' the situation to the extent that children's issues, especially those pertaining to vulnerable children, might be addressed in a full and comprehensive manner. This does not mean that no efforts need be made in the interim to improve the conditions of orphans and vulnerable children in Zimbabwe. But it may mean that no fundamental structural policy and law reforms will be

undertaken to ensure the sustained improvement in the living conditions of vulnerable children in Zimbabwe.

8.5 Summary and conclusions

Through FGDs, community perceptions on CHHs and their circumstances were examined. Communities are struggling with the dilemma of not wanting to have children in CHHs, but at the same time not wanting to have them in orphanages. Communities seem not to have solved this dilemma. They identify that the key strengths of the CHH is that siblings can stay together and, in the case of parental property, houses can be an important asset for the children. Negative elements of CHHs include vulnerability to abuse, bad behaviour due to lack of adult guidance, and high conflict among siblings.

Research findings support the fact that communities have positive perceptions of CHHs, especially regarding the importance of siblings staying together. However, many negative issues regarding the way CHHs are perceived by the community do not hold up in the light of the research data. There is no indication that siblings have more conflict than any other children in the community. Indeed, CHH member behaviour might be more responsible than non-CHH peer behaviour as CHH members have to work hard to manage the household. On the issue of vulnerability to abuse, it seems that, although CHHs are more vulnerable to external abuse, they experience less abuse within the household, whereas other studies suggest that OVC in extended families may frequently experience abuse and discrimination.

The discussion on safety nets called, firstly, for the need to change the ways we perceive CHHs. Community approaches to CHHs and vulnerable children are powerful, as they see children as equal partners on a journey to adulthood from the day they are born. They have 'full citizenship rights', and all adults in the community have an obligation to contribute positively to the growth and development of all children in their community. All community members, therefore, have a collective

responsibility to care for all children in the community in a reciprocal and reciprocated manner, especially for CHHs.

An assessment of the roles of the key stakeholders in support of CHHs was made via the Social Support Scale (SSS). These findings, supporting those of BDDJ, showed that siblings are the most important source of support, and suggests that friends and neighbours are important too. Neighbours in old suburbs, where community care capacity seems to be higher, scored higher than neighbours in newly developed suburbs. An important safety net for OVC is the extended family. This, due to family conflict, does not seem to apply to CHHs. Grandparents, however, are important to those CHHs who still have them in their lives, whether they stay with them or not.

Communities are finding ways to cope with CHHs and the dilemmas they face with them. Task demands of the community in support of CHHs include neighbourhood support, mobilization of community support through leaders, and community members engaging in family reconciliation work. The discussion on the role of external agencies in supporting OVC, and CHHs in particular, shows that no separate, vertical CHH programming should be done, but CHHs should be included in OVC programme responses, giving attention to some of the special situations CHHs face. External agencies should not engage in direct child service activities. They need to use a community child-care capacity building development approach towards sustained and empowered community child care responses.

By reflecting on the situation of existing statutory child safety nets, it is apparent that the Department of Social Welfare's child support mechanisms, due to lack of human and financial resources, has collapsed and bears little relevance to community needs. It is necessary to change social welfare practice from a case-oriented approach to a community care capacity building and facilitation approach. The fiscus needs to allocate sufficient resources to reform and revitalize statutory child safety instruments.

While acknowledgment must be given to the laws and policies in place, it is also necessary to acknowledge that they were fashioned in a different era and that most of

the current policies and laws are not responsive to the emerging issues and lived realities of contemporary children. The lack of linkage between policies and emerging issues creates programming gaps that result in the increased vulnerability of children. Furthermore, the yawning gap between policy and implementation, law and enforcement, negatively affect Zimbabwe's ability to adequately and appropriately respond to vulnerable child populations, such as those found in CHHs. Due to the present chaotic political and economic context, it is not likely that, over the next decade, important legal reforms or financial investments will be made to support sustained efforts at improving the livelihood of vulnerable children in Zimbabwe.

9 Discussion, conclusions and recommendations

Of course, we need to do careful planning and deliberation about the actions we shall take, but any moment spent on deliberations that does not lead to decisive action in support of orphans and other children made vulnerable by AIDS is a moment tragically wasted.

Nelson R. Mandela, September 2002

9.1 Introduction

The complexity of issues affecting CHHs, and the lack of research on this topic, contribute to the fact that CHHs are not well understood. This lack of understanding prompts support agencies to provide emotionally-driven recommendations that suggest it is better for a child to be in an orphanage than to live in a CHH. This exploratory study, involving 105 CHHs over a twelve month period and 142 participants in various FGDs and interviews, set out to explore quality of life and coping strategies of orphans living in CHHs in Bulawayo, Zimbabwe (a city in which HIV/AIDS has a high prevalence). The primary aim of the study was to contribute to the body of knowledge that would assist researchers and practitioners alike to arrive at an improved understanding of CHHs. The following research objectives were set to achieve such improved understanding: i) exploring the quality of life in CHHs; ii) expanding understanding of CHH coping strategies and, finally iii) deciding whether CHHs could represent acceptable, 'good enough', alternative child-care arrangements.

This final chapter will demonstrate how these objectives were met. After a short discussion of the conceptual framework and its usefulness, summary results are discussed. This is followed by an account of the negative and positive aspects of living in a CHH. Following the discussion of the limits of this study, recommendations for further research are made. The chapter closes by providing some recommendations for changes in perspective, on CHH support interventions, social policy and practice, and, finally, on CHHs as alternative child-care arrangements.

9.2 Conceptual framework

Borrowing from systems theory, we can say that the situation of children affected by HIV/AIDS, and that of CHH children in particular, is, using Ackoff's (1974) terminology, a 'mess'. This is because of the scale of the problem, its considerable complexity, and the absence of any clear solutions. The only way forward therefore is to find ways of improving the situation and our understanding thereof. The conceptual framework developed for this study is rooted in the systems thinking approach. That is, it is a framework that seeks to understand the context of CHHs, as well as the relationships between the different key elements that affect CHHs. FGDs were utilized to develop the following comprehensive conceptual framework for this study -

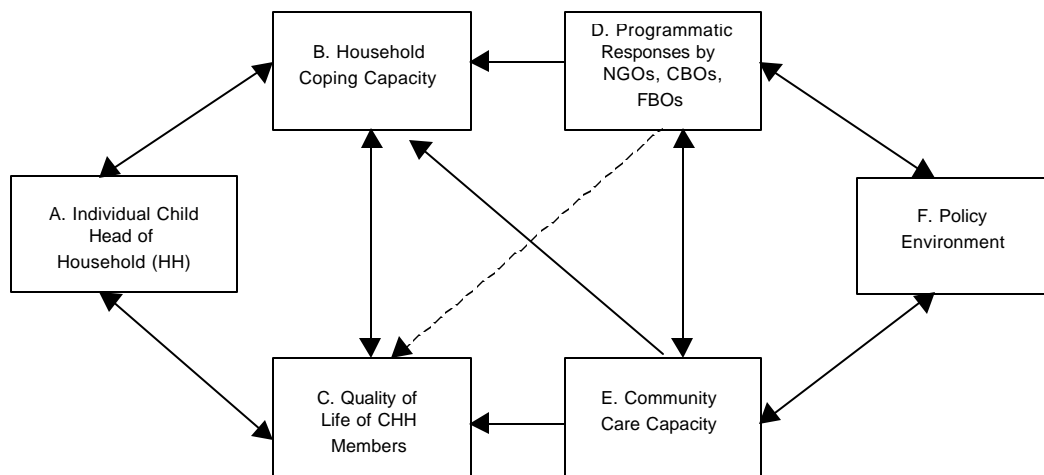


Figure 9.1: Conceptual framework for exploratory study of CHHs

This strong conceptual framework proved to be a powerful tool for remaining focused throughout this research, despite the complexity of the issues under research. In conclusion, striking similarities between the adjusted coping model applied to CHH coping strategies in Chapter 7 and the conceptual framework announced at the onset of this research, seem to demonstrate that this framework, and its chosen research methodologies, are well suited to fostering a better understanding of CHH quality of life and coping strategies.

The following discussion of research results makes use of the conceptual framework's discussion of relationships and interactions among key elements, as explored in section 3.4.3.

9.3 Limitations of the study

The conceptual framework developed for this study presents useful tools for exploring CHH quality of life and coping strategies, and how external issues affect them.

Limitations of study

This study set out to explore a domain about which relatively little was known. Though other studies have generated some information on specific aspects of CHHs – for example, on factors leading to the establishment of CHHs (Foster et al. 1997), or the impact of programme support on CHHs (Luzze 2002) – they did not result in an in-depth understanding of CHH functioning, quality of life, and coping strategies. Nor did these studies present a comprehensive overview of what it means to live in a CHH, and of the wide array of coping strategies CHH heads and their siblings embark upon in dealing with their lives.

The present study is an effective attempt to increase understanding of the quality of life experienced in CHHs, their household functioning, and the coping strategies they use. The limited available research data on CHHs prompted this exploratory study. This study aimed to arrive at a concrete understanding of CHHs, instead of using comparative research methods into the lives of children living under various care arrangements.

Due to ethical concerns with regard to conducting research with children, CHHs had to be identified through community child-care support programmes. This meant that all children in the study either already had a relationship with a support initiative, or had just entered such a relationship. It would not have been ethically acceptable to deprive CHHs of any form of programme support in order to study 'non-programme

supported CHHs. It has to be noted, however, that such support is generally very limited and sporadic. It can further be argued that, with the level of community support networking that exists in Bulawayo, one would fortunately not be able to identify a 'pure non-supported CHH'.

Because of the security situation during primary data collection, as discussed in Chapter 3, the focus of the study was limited to urban areas.

Research respondents had difficulties answering questions in the quality of life assessment (WHOQOL-BY) in which 5-point scales were used. They struggled, for example, to distinguish the difference between 'dissatisfied' and 'medium', or 'medium' and 'satisfied'. For further research, especially with adolescents, it is recommended that face picture codes be utilized to assist in choosing answers when using questions with a 5-point scale. This could range from a bright smiley face for 'very satisfied' or 'completely', to a sad, distressed face for 'very dissatisfied' or 'not at all'.

9.4 Summary of results

Key relationships and interactions that contributed to key research results areas are as follows -

Relationship	Research result area
A – C: Individual factors of head of household influences the quality of life of household Members.	Quality of life
B – C: Household coping capacity influences the quality of life, and vice versa	Quality of life, coping strategies
D - - C: Support and programmatic influences <u>indirectly</u> influences quality of life of household members	Quality of life
A – B: Individual factors of head of household influences the household coping capacity, and vice versa.	Coping strategies
D – B: Support and programmatic responses influences the household coping capacity	Coping strategies
E – B: Community care capacity influences household coping capacity	Coping strategies, community care
E – C: Community care capacity influences the quality of life of household members	Quality of life, community care
D – E: Support and programmatic responses influences community care capacity, and vice versa	Community care
F – D: Policy environment influences support and programmatic responses, and vice versa	Agency support, policy issues
F – E: Policy environment influences community care capacity, and vice versa	Policy issues and community care

Table 9.1: Link between conceptual framework and research result areas

9.4.1 Quality of life

Using the WHO (1995:2) definition of quality of life as individuals’ perceptions of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns, the quality of life of CHHs was assessed. It is important to note that the assessment is rooted in an individual’s perceptions.

Quality of life appears to be better in older established townships with better-developed community child-care capacities. Results from the Social Support Scale support the findings that neighbours in older townships are more supportive, and this contributes to increased quality of life through community child-care capacity.

The lack of sustained economic support is a source of considerable concern for all CHHs. It is imperative that programmatic responses make micro-credit schemes available to CHHs to improve the quality of life in the material domain. No such support mechanisms were identified in the study, and it is therefore not surprising that economic factors in the quality of life assessment scored lowest among all CHHs.

The quality of life experienced in CHHs is directly linked to the sibling, peer and neighbourhood support the household receives. All households in the study have experienced considerable adversities. Despite these, the majority of households (69%) reported a medium to satisfactory quality of life. Most of these households demonstrated an effective application of required coping tasks to positively influence coping outcomes. There is, therefore, a direct link between quality of life and successful application of required CHH coping tasks within each of the measured domains of CHH life.

9.4.2 Coping strategies

One of the reassuring findings of this research has been the remarkable resilience and resourcefulness of children. Children in CHHs demonstrate extraordinary coping strategies. It has been heartening to find many CHHs who, rather than allowing themselves to be passive victims of unsatisfactory care arrangements, have taken active steps to help to shape and change their experience. Many children have managed to make their CHHs 'good-enough' places of care by creating - through effective social networking among siblings, neighbours and peers - an atmosphere of support, affection, acceptance and solidarity. This has gone some way to compensate for what would otherwise be a deeply depriving experience.

By using an adjusted coping task model, coping tasks, responses and possible coping outcomes for CHHs were identified and discussed. As shown in Appendix 9, CHHs apply a wide range of coping strategies, and show a high degree of adaptability and flexibility that positively influence neighbourhood and community care and support.

But such remarkable application of coping strategies, and the resilience shown by many CHHs, should never be an excuse for failing to provide such vulnerable children with the best that society can offer them. It is important to acknowledge existing community support for vulnerable children. However, there is no doubt that much more can and needs to be done to support vulnerable children. Each adult in the community is required to put some effort into the growth and development of all children in their community. All community members have a collective responsibility to care for children in a reciprocal and reciprocated manner, especially for those children in CHHs.

9.4.3 Community care capacity, agency support, law and policy

Community support, especially neighbourhood support, is critical in terms of how well CHHs cope and what quality of life they enjoy. In the absence of community and programme support, it is unlikely that CHHs can exist in a sustained way, and it is anticipated that such unsupported households will disintegrate quickly, with siblings splitting up, going to various relatives, or ending up as street children.

Research identified the key determining factor that contributed to the establishment of CHHs as family conflict prior to parental illness. Unfortunately, there have been no community care, NGO, FBO or statutory child support initiatives to work at resolving family conflict with the aim of re-connecting CHHs to their extended family support structures.

Some external agencies are tempted to identify CHHs and to provide direct support to them. Such approaches need to be strongly discouraged, as they contribute towards undermining and reducing local community support and care. Interventions from

external agencies can only be meaningful and sustainable if they assist communities through a capacity building and facilitation approach to realize that their existing care efforts can be enhanced through effective multi- stakeholder collaboration.

Statutory support for CHHs is nearly non-existent, and the small number of identified situations in which Social Welfare intervened in CHHs had negative consequences for all household members. Case-oriented child welfare systems are not suitable for situations in which large numbers of vulnerable children exist.

While it is acknowledged that Zimbabwe has in place a wide range of laws and policies in support of children, it needs to be accepted that these laws were fashioned and developed on the basis of a case-oriented welfare approach. Present legislation is inappropriate for dealing with large numbers of children without parental care, and is not responsive to the emerging issues and realities of the majority of today's children. Zimbabwe has an orphan care policy in place, and a remarkable national plan of action in support of orphans and vulnerable children. Unfortunately however, policy and implementation are distinct processes. It is the application, not formulation, of policies that presents the real challenges. The lack of linkage between policies and existing legislation creates gaps that increase the vulnerability of certain children. CHH issues have not been tackled in existing policies or legislation. One of the major flaws of existing law and policy in relationship to CHHs is that statutory assistance to children is based on referral by adults. This excludes CHHs from the option of self-referral.

Due to the existing, persistent, and difficult political and economic climate in Zimbabwe, it is not anticipated that, over the next decade, substantial advances will be made to reconcile law and policy gaps in order to adequately support large numbers of vulnerable children in Zimbabwe.

9.5 Recommendations

The overall picture of CHH quality of life and coping strategies emerging from this study is cautiously encouraging, with the caveat that adequate community support is a key determining factor for CHH sustainability and functioning. Based on this research, the following recommendations for further research, required changes in perspective, support interventions for CHHs, social policy issues, and alternative care arrangements are made.

9.5.1 Recommendations for further research

In broad terms, this was a highly ambitious research enterprise that explored quality of life and coping strategies of orphans living in CHHs within an urban community in which HIV/AIDS was prevalent. Based on the strength of this study, with its comprehensive conceptual framework and wealth of analyzed primary data, the following further research programmes can use this research as their starting point.

Although awareness of the extended families of CHHs was gathered via one FGD, further studies should engage in family tracing, followed by the use of qualitative and quantitative interviews to improve understanding of extended families' relations to, and conflicts with, CHHs.

Study results were derived from a particular socio-economic and cultural context. Similar research projects in other geographical areas, especially rural areas and with groups with different ethnic and/or socio-cultural backgrounds, are needed in order to assemble a more comprehensive understanding of CHH issues. This will increase the body of knowledge that will allow future researchers to generalize and start developing theories on quality of life and coping in CHHs. Such knowledge will assist policy makers in making decisions about the conditions and contexts that are necessary for CHHs to become acceptable alternative child-care arrangements.

This exploratory research did not attempt to compare CHHs with orphans in other care arrangements. To draw more final, generalized conclusions regarding CHHs as

alternative care arrangements, there is need for a comparative study with the following sample groups: CHHs, orphans in extended family care; orphans in non-extended family informal fostering arrangements, and other children in the community. This study has laid the foundation for effectively conducting such further research by expanding the conceptual framework to include these other sample groups.

This study identified that siblings are a key social support factor for CHHs. There is need for further in-depth psycho-social research to better understand the role of siblings in providing attachment security, as well as social and emotional care and support for each other. Furthermore, as stated earlier, one of the limitations of this study was its focus on heads of CHHs. Although a considerable overlap between the quality of life of the head of household and that of members can be observed, there is need for further research into the quality of life of siblings in CHHs. This study did not aim to capture this in depth.

The conceptual framework helped to delimit the scope of investigations to an exploratory study of quality of life and coping strategies in CHHs. At the same time, it helped to identify a distinct need for a study that would focus on the legal and policy environment, and the ways in which this environment influences capacities for community child care.

9.5.2 Challenging existing perspectives

During the course of this research it became evident to the researcher that some major social narratives need to be challenged, as they may negatively impact on children affected by HIV/AIDS. These challenges are only listed below, as discussion around each issue is necessarily extensive, and is beyond the scope of this research.

- *Children as objects of charity.* This attitude regards children affected by HIV/AIDS as helpless victims. Such people or organisations often use the discriminatory term ‘AIDS orphans’. Supporting children by using a victim-approach often results in increased dependencies that persist into adulthood, and decrease children's belief in self-efficacy.

This research suggests that children need to be seen as 'citizens' with rights. Adults need to take seriously what children are saying about their needs and aspirations. Political will is needed to translate these values and understandings into practical measures to address the rights of these young 'citizens'. The existence of CHHs establishes children as active social actors, coping in the best way possible. One needs to recognise and support this coping. Such children need to be seen as 'heroes'.

- *Fixed perceptions of childhood and family structure.* Many adults, including child-care professionals or child support service volunteers, mainly use their own childhood and family experiences to create a fixed sense of 'how childhood and families should be'. Childhood and family concepts are social constructs. They are, therefore, dynamic. Children can thrive within a wide range of family forms. No one kind of family can be considered 'best' for their needs, and it is a mistake to view single parent, or child-headed households as deviant family forms. It is suggested that CHHs are an early indicator of the profound social change that the HIV/AIDS pandemic is bringing to Southern Africa, changes that impact particularly heavily on concepts of childhood and family.
- *Exclusive emphasis on HIV/AIDS,* with specific focus on orphans and children affected by HIV/AIDS. Such emphases, often applied by support programmes, necessitate a focus on individuals and may discriminate against other non-HIV related vulnerable children. By contrast, an emphasis on the larger group of children made vulnerable by poverty serves to focus on all vulnerable children in a community. Acknowledging that the living conditions of children is likely to be considerably worsened by HIV/AIDS will reduce 'positive discrimination' that may, especially in poverty-stricken regions, undermine community care.
- *Agency child service delivery and case-oriented child welfare approaches.* These are rooted in traditional, reactive and direct service child welfare practice, such as foster care, institutional placement, adoptions, social assistance payments, and the like. However, the scale of existing poverty, exasperated by the HIV/AIDS pandemic, renders such measures impractical and ineffective. The role of external agencies should be to strengthen community child-care capacity, instead of providing direct child care support services. Statutory child welfare bodies need to shift from case-oriented approaches

toward being facilitators / mentors and monitors in order to strengthen and support the existing traditional welfare systems of the extended family and community.

This thesis does not provide solutions. Instead, it provides suggestions as to how to alleviate the above-mentioned problems, as well as pointing to the need for changes in perspective. Further debate is required so that, over time, solutions can be constructively sought and developed for transforming the dominant social narratives. In light of the above, the following section discusses conditions and factors that contribute towards improved quality of life for CHHs.

9.5.3 Support interventions for CHHs

Even with existing constraints in community care capacity, law and policy, a number of options exist that could help to improve care and support for CHHs at present, and lay the foundation for a gradual improvement in quality of life and coping in CHHs in the more distant future. Figure 9.2 outlines favourable conditions for improved self-efficacy beliefs within CHHs, and the resulting improvement in quality of life.

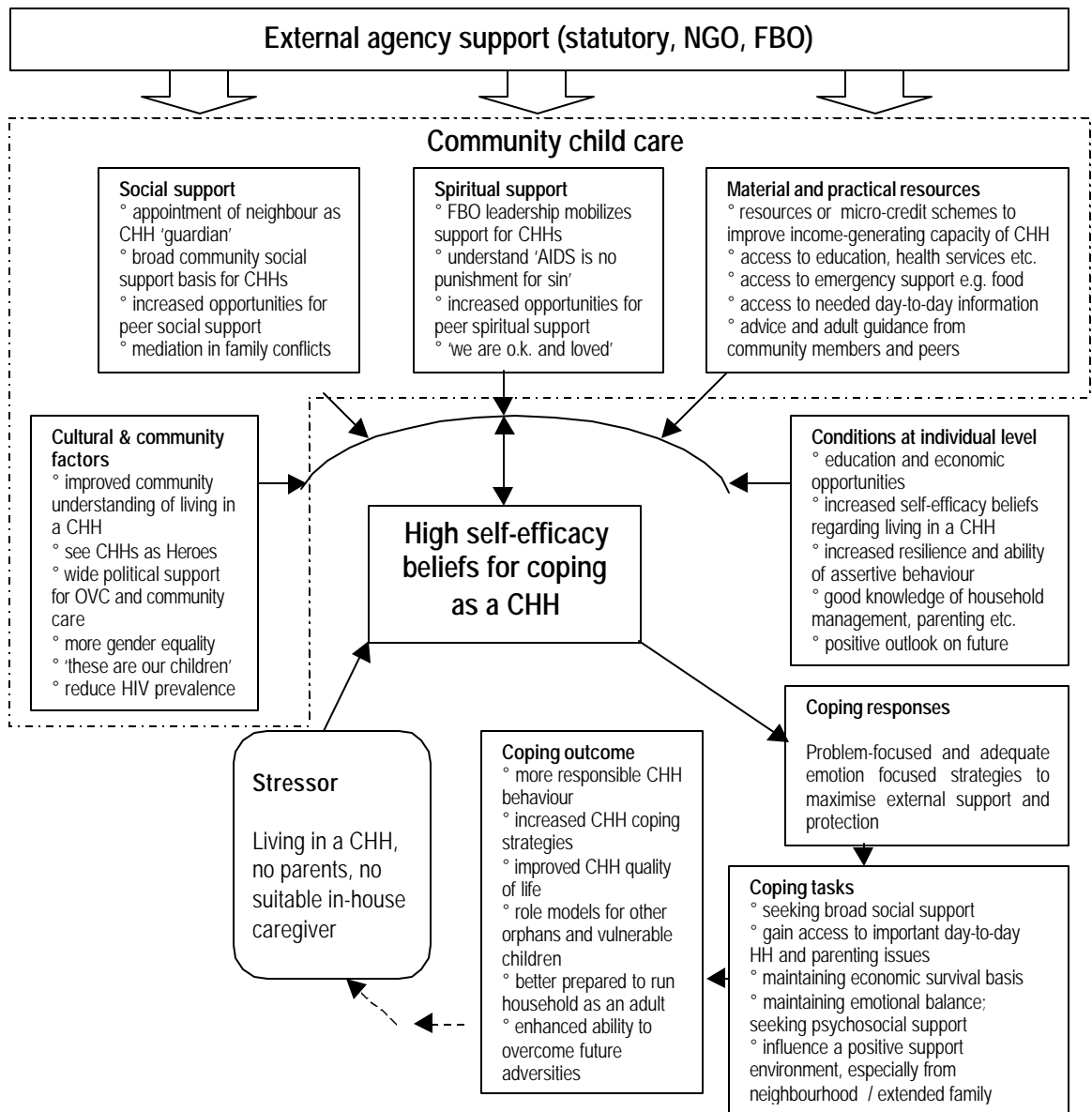


Figure 9.2: Conditions supporting CHH coping towards improved CHH quality of life

Table 9.2 below provides an overview of preventative and supportive measures necessary for effective community care. These measures would aim to improve the community's beliefs in its capacity to care for vulnerable children, as well as to enhance self-efficacy beliefs and coping responses within CHHs.

	Individual	Family	Community	State
Prevent CHH formation	Maintain good family relationships	Maintain good relationship with extended family members Address and resolve 'old' family conflict	Engage as mediator in family conflicts	Reduce AIDS mortality through improved health services and access to ARV treatment
	Prepare good care arrangements prior to parental death, e.g. using memory work	Encourage pre-parental death succession planning and involve the children in this important planning process. Address issues that may hinder good care.	Assist vulnerable households to access economic support, e.g. micro-credit schemes	Provide adequate support to vulnerable families with universal child support grants in resource-poor communities
	HIV prevention to reduce HIV prevalence and AIDS mortality rates	Encourage shared confidentiality and provide good care to increase life span of ill family members	Breaking the barriers between 'them' and 'us' to reduce stigma	Promote policies that aim to decrease conditions which promote the spread of HIV/AIDS
CHH care and support	Engage in family reconciliation	Recognize the extended families' role and responsibility to support the CHH and overcome old family feuds	Challenge non-supportive extended family members.	Provide policies that encourage extended family responsibilities, and support them
	Utilize appropriate coping tasks to enhance care and support	Develop supportive relationship with CHH members. Show understanding and establish good relationship	Mediate to reconcile families	Provide a legal framework that protects and supports CHHs
	Gain access to important information	To protect CHHs, ensure regular monitoring visits	Provide day-care to relieve CHHs of day infant care	Accept child self-referral to access social services and other support
	Ensure economic survival	Provide economic support to CHH	Facilitate access to micro-credit	Provide supportive economic environment
	Maintain psychosocial balance	Provide adult guidance, affection and love to CHH	Provide adult guidance	Ensure access to education for all

Table 9.2: Some elements towards comprehensive CHH prevention, care and support responses

It must be noted that the above Table is not conclusive. It provides a sense of many different elements that contribute towards a comprehensive response. Comprehensive community approaches to child-care combine the African tradition of

'everyone's child' with the modern approach of 'every child has rights'. It provides significant opportunities for programme innovation and developments that have the potential to shift the balance of power in communities in favour of children, especially children in CHHs. With such comprehensive CHH support, innovative and alternative child-care arrangements become possible.

9.5.4 CHHs as alternative child-care arrangements

Although the number of CHHs throughout Southern Africa is unknown, in countries with severe HIV/AIDS epidemics it may be anticipated that the number of CHHs will increase significantly over the next decade. The appearance of CHHs, as discussed in this thesis, does not necessarily mean that community safety nets have failed. Indeed, CHHs can be viewed as a new mechanism to cope with the impact of HIV/AIDS and resulting high numbers of children without parental care. As discussed in Chapter 2, in Swaziland, for example, an estimated 10% of vulnerable children are living in family- and community-supported CHHs. This is a consequence of the tradition of extended family living arrangements in that country.

As unsupported CHHs are particularly vulnerable to abuse and exploitation due to poverty and a lack of adult supervision, the issue of neighbourhood, community and programme support is critical for quality of life and sustained functioning in CHHs. This research shows that communities with developed community child-care capacities, operating in a supportive policy environment, can and do support CHHs.

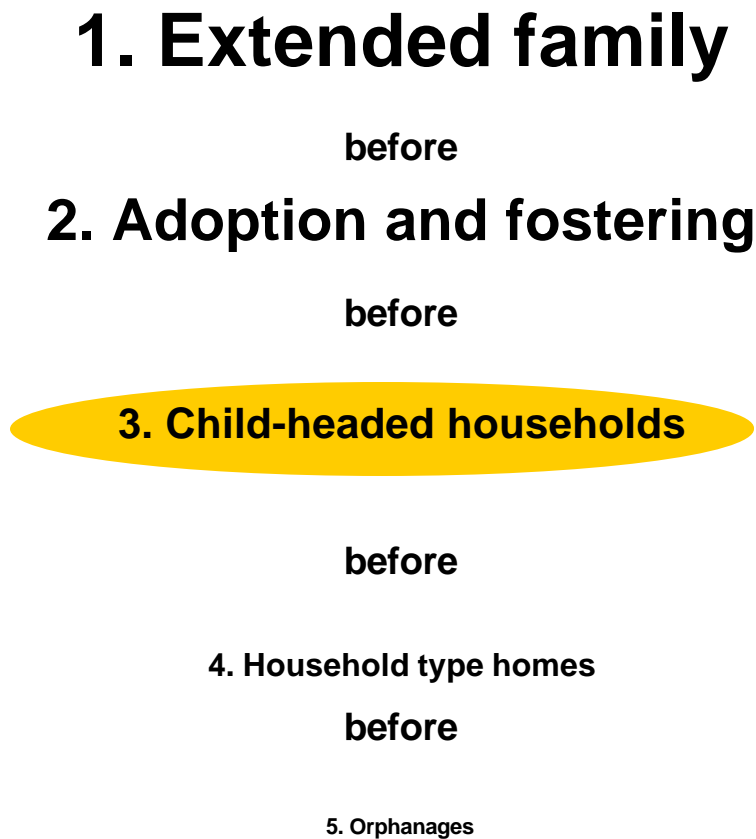


Figure 9.3: Proposed new levels of care for orphans and other vulnerable children

This study concludes with a cautious final recommendation (see Figure 9.3, above) that suggests for national and international governments, NGO child support service providers in Southern Africa, to recognize that urban CHHs that receive adequate, planned and resourced community support (as discussed in section 9.6.3 above) is an acceptable alternative care arrangement for children without parental care in communities with high HIV/AIDS-related adult mortality, and in which prevalence of HIV/AIDS exceeds 10%.



Through these adversities I have learnt to be accountable, responsible and caring. You need to be bold in life and cope with adversities. Learn to face the hard times and solve them as they will pass ... **I am a Hero** and after having experienced all this I am sure I can handle any problem that will come across my path of life in the future (Future, 19 years old, Head of supported CHH).

Appendices



Appendix 1: Focus group discussion guides and instructions

Process: (Warm up, confrontation, relaxation / being strange, orientation, adjustment, intimacy, conformity and fading out)

Facilitators Names: _____ Name of 2 Reporters: _____

Participants: _____ male: _____ female: _____

Introduction:

Welcome, provide overview of next 3 hours

We are all aware of the impact HIV/AIDS is causing in our community. Over the past few years we have all witnessed increased numbers of funerals of people aged in the best years some of them relatives, others neighbours and friends. The consequences of these deaths are that we are having increasing numbers of children to care for in our families and communities. Some extended families are no longer able to cope. As a result we have seen that in some places new households have started that could be called 'child-headed households'. This morning we would like to have a discussion that is focusing around issues of child headed households. We thank you for your participation, the discussion is, if the group agrees recorded electronically and names of participants are taken for reference purposes and there is full confidentiality. This will ensure that you are all free to discuss openly.

After this introduction ask participants if they have questions for clarification

Starting questions:

1. How would you personally define a 'child-headed Household'?
2. What definition would be acceptable to most in the group?

Follow on questions:

3. Do you know of such or similar households in your community?
4. What are the good things about such households?
5. What are the problems faced by such households?
6. What are the main risks of such households?
7. How could such households be supported by the extended family and by the community?
8. Do child-headed households you know in your community receive that support?
9. If yes, how and by whom? 9a. If no, why do they not receive the support?
10. What support do child-headed households receive from church groups and other NGOs?
11. Do you think such groups, especially churches could do more?

12. If so, what should they be doing?
13. How is the department of social welfare and other government agencies presently supporting child-headed households?
14. How should the department of Social Welfare and other government department deal with child-headed household?
15. Do you think putting them into orphanages or Luveve remnant home would be a good thing?
16. If yes, why? 16a. If, no why?
17. If someone in your family died, would you preferred that Children would be all split up and moved to different relatives, or would you see it possible that they could stay at the same place and manage the household themselves with support from you and community members?
18. At what age do you think and feel a young person would be able to head a household, looking after younger siblings when their parent had died?
19. What will be the future for children in child-headed households if they receive good community support?
20. What will be the future for children in child-headed households if they do not receive neighborhood and community support?

Fading out questions:

21. How many CHH do you know exist in your community?
22. Are there any other issues regarding the topic of child-headed households that you feel you would like to discuss?

Thank them for their time spend and their active involvement and then invite them for lunch. Ask one participant to bless the meal. De-brief with 3 reporters to agree on discussion content. Finalize the report by end of day.

Instructions for facilitators:

- The group size should ideally be 12 participants, but no larger than 20 and not smaller than 8
- As facilitator you need to encourage participation of all participants, motivate and encourage non-talkers and facilitate through soft restrictions those domineering the group
- The discussion needs to be controlled by the leader as required by the situation. Taking a reserved and non-directive position and being encouraging to focus the discussion content on the topic
- Guide the discussion but never control it. Be careful that you do not bias the discussion by your own statements. You are there to ask questions and not to contribute to the discussion
- If the discussion goes off topic, you might need to create additional linking questions to bring the discussion back in line before asking the next standardized question.
- Ensure that the main and two assistant reporters cope well in the recording process, get periodic feedback from them and their progress
- Make sure that you stick to the agreed translated keywords in the set of guidance questions
- The physical environment needs to be conducive to encourage debate, there should be no external noise and the room should not be too hot. Participants should sit in a circle that all respondents can see each others and communicate freely
- Although the introductions and facilitation questions are standardized, the discussion itself is not
- As facilitator you need to create a warm atmosphere among members in the group, some ice breakers in the introduction appropriate to the group composition is encouraged. Do a time breaker in-between if you feel the group is tired or tensed. This will help the group to loosen up.
- Evaluate at the end of the discussion with a short de-brief the content with the groups. Your co-facilitator and main reporter should assist you in that process. Give a short 5 minute break at the end of the discussion. Have the key reporter list a brief summary of the discussion on a flip chart and then have the group back to hear the reported summary and give them opportunity for feedback and validation.
- Close the Focus Group discussion and dismiss with a word of thanks the participants
- Take time with the co-facilitator and the 2 reporters to agree on the report, comparing notes between the 2 reporters. Once the content is agreed, the key reporter will finalize the report on the same day and hand it over the principal researcher. The principal researcher is an observer of all the focus group discussions to monitor quality of facilitation and recording for validation purpose. He will not participate in the discussions nor support the facilitators.

Appendix 2: CHH rapid enumeration survey data sheet

Instructions: 1) Ask each person if they are willing to stop and answer two questions. If agreeable ask 2) Do you live in this high density suburb and are you above 12 years old? If the answer has **one no**, thank the person and no record is taken. If the answer is **two yes**; ask 3) How many child-headed households do you know personally living within your neighbourhood / community? Please tick the relevant box below.

#	0	1	2	3	4	5-6	7-8	9-10	11-13	Above #
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
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23										
24										
25										
26										
27										
28										
29										
29										
30										
31										

Thank you. Hand in all sheets end of the day to researcher. Sheet number _____
 Name of research assistant _____ Date: _____ Location: _____

Appendix 3: Informed consent

Child-headed households in urban Bulawayo

Purpose of the study: You are being asked to participate in a research study. We are assessing lives of teenage orphans and vulnerable children. We are trying to better understand the lives and feelings of these young people, especially if they are heading households. This research is being done by Stefan Germann as part of his doctoral studies under the auspice of Salvation Army Masiye Camp with financial support from hope hiv.

Procedures: If you agree to participate, you will be asked to participate in an initial interview that will take about 40 minutes. After this you will be asked to maintain a bi-daily journal questionnaire for the next 12 months.

Discomforts and risks: It is possible that some of the questions may make you feel uncomfortable or cause you to think about things that are upsetting. You do not have to answer any question that makes you uncomfortable. You can choose to stop responding to a given question or end to be part of the research at any time. The research assistant will visit you once per month to collect the bi-daily data sheets. If you want, you talk privately to the research assistant about how you are feeling.

Compensation and benefits: You will not be paid or compensated for the interview. However, you may enjoy the experience of talking to someone about the most important issues in your life. And the answers you provide will help to improve programmes for young people with similar experiences.

Confidentiality: If you decide to participate, the interviewer will write down and record your answers in the initial interview. The bi-daily journal questionnaire you will fill in on your own. This information we will use to learn about young people like you. Records will not have your name on it. We record your name on a separate list. This record will be kept in a locked place, accessible only to the researcher. No one else will be given your name or told that you participated in the study. Views of research participants may appear in a report on this research but will not be linked to individuals.

If you have a question or problem with the research, you can stop and ask your question to the research assistant.

Right to withdraw: It is your decision whether or not to participate in this study. You may refuse to participate and can end the interview or the compilation of the bi-daily journal questionnaire at any time if you wish. You will not be penalized in any way for this decision.

Informed consent: I have been read or read to myself this entire form in my own language. All of my questions have been answered. I agree to participate in the study.

Signature of interviewee _____ Age _____
Signature of guardian if interviewee is under 16 _____
Relationship to interviewee _____
Signature of researcher _____
Date _____

Appendix 4: WHOQOL – BY psychometric instrument for quality of life

Quality of life assessment

ID #

What is your date of birth? Day____ month____ year____

What is the current /highest education you have received? none primary secondary vocational

Are you currently at school? yes no If no, why? _____

Do you have a boy / girl friend? yes no don't tell

Are you currently healthy? yes no If no, why? _____

Name of referring organization: _____ Church denomination: _____

Father alive? yes no don't know

Mother alive? yes no don't know

I live with:

Parents grandparents younger sibling older sibling relatives

What age are your grandparents: _____

Is your grandparent healthy: yes no

If no, what is the problem? _____

Ages and health status of other relatives living with you? _____

Is your guardian working? yes no

If yes, what?

Self employed government industry domestic unemployed

Are you working? yes no

If yes, what and how many hours per week?

Less than 5 5-10 10-20 more than 20

Your monthly income average ZWD? _____

Have you good relations with your relatives? yes no

If no, why?

Inheritance problem lobola problem other

The following questions relate to your life in the last 2 weeks.

F3.7	Do you get the kind of support from others that you need?	Not at all 1	Not much 2	Moderately 3	Good 4	Completely 5
G1	How would you rate your quality of life?	1 Very poor	2 Poor	3 Medium	4 Good	5 very good
G2	How satisfied are you with your life?	1 Very dissatisfied	2 Dissatisfied	3 Medium	4 Satisfied	5 very satisfied
F1.4	To what extent do you feel that physical pain prevents you from doing what you need to do?	Not at all 1	A little 2	A moderate amount 3	Very much 4	An extreme amount 5
F11.3	How much do you need any medical attention to function in daily life?	1	2	3	4	5
F4.1	How much do you enjoy life?	1	2	3	4	5
F24.2	To what extent do you feel your life to be meaningful?	1	2	3	4	5
F5.3	How well are you able to concentrate?	1	2	3	4	5
F16.1	How safe do you feel in your daily life?	1	2	3	4	5
F22.1	How healthy is your physical environment?	1	2	3	4	5
		Not at all	A little	Moderately	Mostly	Completely
F2.1	Do you have enough energy for everyday life?	1	2	3	4	5
F7.1	Are you able to accept your bodily appearance?	1	2	3	4	5
F18.1	Have you enough money to meet your needs?	1	2	3	4	5
F20.1	How available to you is the information that you need in your day to day life?	1	2	3	4	5
F21.1	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
		Very poor	Poor	Neither poor nor good	Good	Very good
F9.1	How well are you able to get around	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Medium	Satisfied	Very satisfied
F3.3	How satisfied are you with your sleep?	1	2	3	4	5
F10.3	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
F12.4	How satisfied are you with your capacity for work?	1	2	3	4	5
F6.3	How satisfied are you with yourself?	1	2	3	4	5
F13.3	How satisfied are you with your personal relationships?	1	2	3	4	5
F15.3	How satisfied are you with your sex life?	1	2	3	4	5
F14.4	How satisfied are you with the support you get from friends?	1	2	3	4	5
F17.3	How satisfied are you with the conditions of your living place?	1	2	3	4	5
F19.3	How satisfied are you with your access to health services?	1	2	3	4	5
F23.3	How satisfied are you with your transport situation?	1	2	3	4	5
		Never	Seldom	Quite often	Very often	Always
F8.1	How often do you have negative feelings such as bad mood, despair, anxiety and depression?	1	2	3	4	5

Appendix 5: Bi-daily journal data sheet (BDJD)

#	Name or Number		#	Date			
	Nutrition	Y	N		Social support & assistance	Y	N
N1	Did you have breakfast?			C1	Did you get any assistance?		
N2	Did you have Lunch?			C1.1	If yes, what kind?		
N3	Did you have supper?			C2	Did you get needed neighbours support?		
N4	Did you feel hungry?			C2.1	If not why?		
N5	Did you eat any meat, egg or kapenta?			C3	Did you visit someone today?		
N6	Did you eat any fruit?			C3.1	If yes, who?		
N7	How much did you spend on food?				Siblings and family situation		
	Education			H1	Did you cope with your sisters or brothers?		
E1	Did you go to school?			H2	Are they healthy?		
E1.1	If no, why?			H2.1	If no, what is it?		
E2	Did you have time for homework			H3	Are they obeying you?		
E3	Did you feel good?			H4	Is your guardian well?		
E3.1	If no, why?			H4.1	If no why?		
E4	Are you improving at school?			H5	Did you have a conflict at home?		
E4.1	If no, why?			H5.1	If yes why?		
	Health			H6	Did you clean your house?		
HE1	Are you ill?			H7	Did you do washing?		
HE1.2	If yes, what is wrong?				Economic situation		
HE2	Are you very tired			I1	Did you work today for ZWD ?		
HE3	Did you sleep well last night			I1.1	If yes, what and how long?		
HE3.1	If no, why?			I2	How much ZWD did you make?		
HE4	Did you go to the clinic			I3	Was it difficult?		
HE5	Did you have any pain?			I3.1	If yes, why?		
HE5.1	If yes, where?			I4	Did you enjoy the work?		
	Psychosocial			I4.1	Why, yes or no?		
HE6	Are you happy?				General		
HE6.1	If no, why?			G1	What did you miss most today?		
HE7	Can you concentrate well?			G2	Did you enjoy the day?		
HE7.1	If no, why?			G3	Did you have enough money?		
R1	Did you play today?			G4	Did you smoke?		
R1.1	If yes, how long?			G5	Did you drink alcohol?		
R2	What did you play?			G6	Did you feel safe?		
R3	Did you spend time with friends?			G6.1	If no, why?		
R3.1	If no, why?			G7	Are you satisfied about your friends?		
R4	Did you dream today?			G8	Did you have sex?		
R5	Did you pray today?			G8.1	If yes, with condom?		
				G9	Did you experience abuse?		
				G9.1	If yes, what kind?		
				G10	Any additional comments:		

Appendix 6: Adapted social support scale (SSS)

Person is in my life (Ngulomuntu osempilweni yami)			Helpful when personal problem (Ngomuntu ongisiza nxa ngilohlupho)			Helpful when I need money / other things (Ngomuntu ongisiza nxa ngingela mali lezinye izinto)			I have fun with this person (Ngiyathaba nxa ngilalomuntu)		
Domain			Psychological			Material			Social		
No	Yes		Not at all	Some times	Very often	Not at all	Some times	Very often	Not at all	Some times	Very often
Local counsellor (ukhansila)											
Teacher (umbalisi)											
Relatives (izihlobo)											
Grandparent (ugogo lo khulu)											
Brothers & sisters (ubhudi lo sisi)											
Close friend (umgane)											
Youths your age (Intanga yakho)											
Neighbours (umakhelwane)											
Programme volunteers / staff (iVolunteer / isisebenzi)											
Social worker											
Church worker (umfundisi)											
Other people (Abanye abantu)											

Appendix 7: Key informant interview schedule on CHH in Bulawayo

Interview guides: _____ Interviewed by:

_____ & _____

Respondent – Age _____ Sex M F Job: _____

Introduction:

Thank you for making 10 minutes time to participate in this research

We are all aware of the impact HIV/AIDS is causing in our community. Over the past few years we have all witnessed increased numbers of funerals of people aged in the best years some of them relatives, others neighbours and friends. The consequences of these deaths are that we are having increasing numbers of children to care for in our families and communities. Some extended families are no longer able to cope. As a result we have seen that in some places new households have started that could be called 'child headed households'. Over the next few minutes I would like to ask you a few questions concerning Child Headed Households in our community

Starting questions:

1. How would you personally define a 'child-headed household'?

Follow on questions:

2. Do you know of such or similar households in your community?
3. What are the good things about such households?
4. What are the problems faced by such households?
5. What are the main risks of such households?
6. How could such households be supported by the extended family and by the community?
7. Do CHH you know in your community receive that support?
8. If yes, how and by whom? If no, why do they not receive support?

1.	
2. Yes	No
3.	
4.	
5.	
6.	
7. Yes	No
8.	

9. What support do CHH receive from church groups and other NGOs?

10. Do you think such groups, especially churches could do more?

11. If so, what should they be doing?

12. How is the department of social welfare and other government agencies presently supporting Child Headed Households?

13. How should the department of Social Welfare and other government departments deal with child headed household?

14. Do you think putting them into orphanages or Luveve remnant home would be a good thing?

15. If yes, why? 15a. If, no why?

16. If someone in your family died, would you preferred that Children would be all split up and moved to different relatives, or would you see it possible that they could stay at the same place and manage the household themselves with support from you and community members?

17. At what age do you think and feel a young person would be able to head a household, looking after younger siblings when their parent died?

18. What will be the future for children in child headed households if they receive good community support?

19. What will be the future for children in child headed households if they do not receive neighborhood and community support?

Fading out questions:

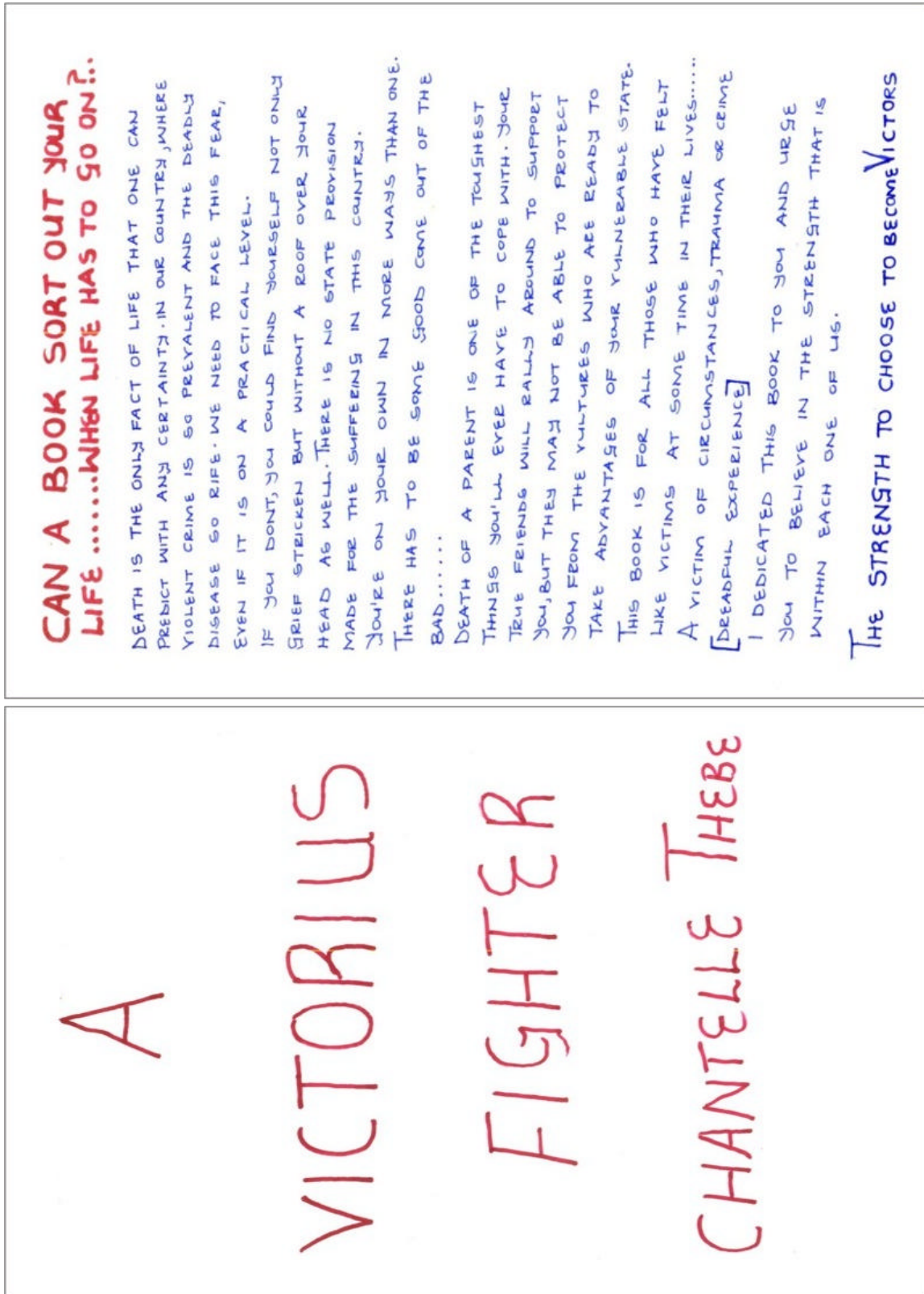
20. How many CHH do you know exist in your community?

21. Are there any other issues regarding the topic of child headed households that you feel you would like to discuss?

Thank you for participating.

9.	
10. Yes	No
11.	
12.	
13.	
14. Yes	No
15.	
16. Yes	No
17. Age:	
18.	
19.	
20. Number estimated:	
21.	

Appendix 8: Nompilo's⁴⁴ hero book (Case history 2)



⁴⁴ A participant making a hero book can choose a fictive name; Nompilo decided to use her 'dream name' Chantelle.

I SPEAK AND SMILE ONLY TO HIDE MY
JAUNDICED EYES FILLED WITH TEARS.....

ACT 1
HELLO WORLD!



In 1986 both my parents were blessed with a baby girl that being their second child. It was me Chantelle Thebe on the 7th of June at Mpilo Hospital in Bulawayo. I'd suppose I was very muchly alike my dad by then for mum used to tell me people used to call me his perfect duplicate. I stay in Pumula old with my grandmam

I'm a friendly little girl who is always smiling. I love people in general not those who talk behind other people's backs and those who bear grudges.

PRAYER IS ALWAYS MY WEAPON
AND WILL NEVER SURRENDER
NO MATTER WHAT HAPPENS....

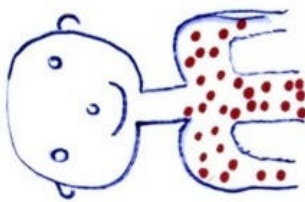
GUYS THERE ARE THINGS THAT I'VE COME ACROSS IN LIFE THAT HAVE MADE ME TO BE WHAT I AM TODAY. THUS I WISH YOU COULD FULLY APPRECIATE ALL THAT I'VE DECIDED TO SHARE WITH YOU THROUGH WRITING COZ I HAVEN'T BEEN ABLE TO SAY THAT ALL FACE TO FACE.

SO KEEP ON TUNED FOR MUCH ARE STILL UNDERWAY.....

I WROTE THIS BOOK MYSELF. THE STORY IT TELLS IS UNFORGETTABLE & THE HOPE THAT IT GIVES IS INVALUABLE.

WINDOW 1 MY BIRTH	WINDOW 2 MY HERO	WINDOW 3 EARLY MEMORIES	WINDOW 4 FAMILY TREE	WINDOW 5 MY COMMUNITIES
WINDOW 6 DARK USLY MONSTER	WINDOW 7 FEELING CHART	WINDOW 8 STRESS & COPING	WINDOW 9 STAINING MONUMENT	WINDOW 10 LAST FAMOUS IMPRES

...1
 PLOT / LIFE CAN BE TOUGH & REALLY CHALLENGING
 BUT I'LL FIRMLY STAND FOR WHAT I BELIEVE
 IN & WANT I'LL KEEP ON FIGHTING FOR MY
 TERRITORY.



q e i o u } This I saw through my
 } first year at primary. I did
 } my primary education at St
 } Bernard's Prg in Bulawayo

ENGLISH 1
 NDEBELE 1
 CONTENT 2
 MATHS 2

This I got when I finished my grade 7 heading now for form 4. I did my secondary education at Foundation College in Bulawayo. I'm now doing form four and am looking forward in passing my O level exams because if I fail then that will be the end of my formal education for nobody will be willing to pay my fees.

ACT 2:




My hero was my mum. She was my role model, and is always going to be. She was the most loving and caring person in my life. She was always there for me but death ceased and took away her life. I was called somebody on earth because of her. She was always there for me but now I'm lost. Mama was a beautiful lady who was always smart in her way. She had a caring heart. She was so special to me. She was my eyes when I couldn't see, my ears when I couldn't hear & my legs when I couldn't walk. But sadly I lost her. I will always love and cherish my days with her. Turning back time remembering the way I dressed, the kind of clothes I wore, Really I'm missing that. My life has timed the other way round. I now wear clothes given by other people and even go for some days without eating but during my days with my parents, things were more than good. I was living a golden life. Everything they did/provided satisfied me but now it's more than HECTIC.....

MAY HER SOUL REST IN PEACE TILL WE MEET AGAIN!

ACT:3

LOVING MEMORIES KEEPS YOU NEARER ALL THE TIME.

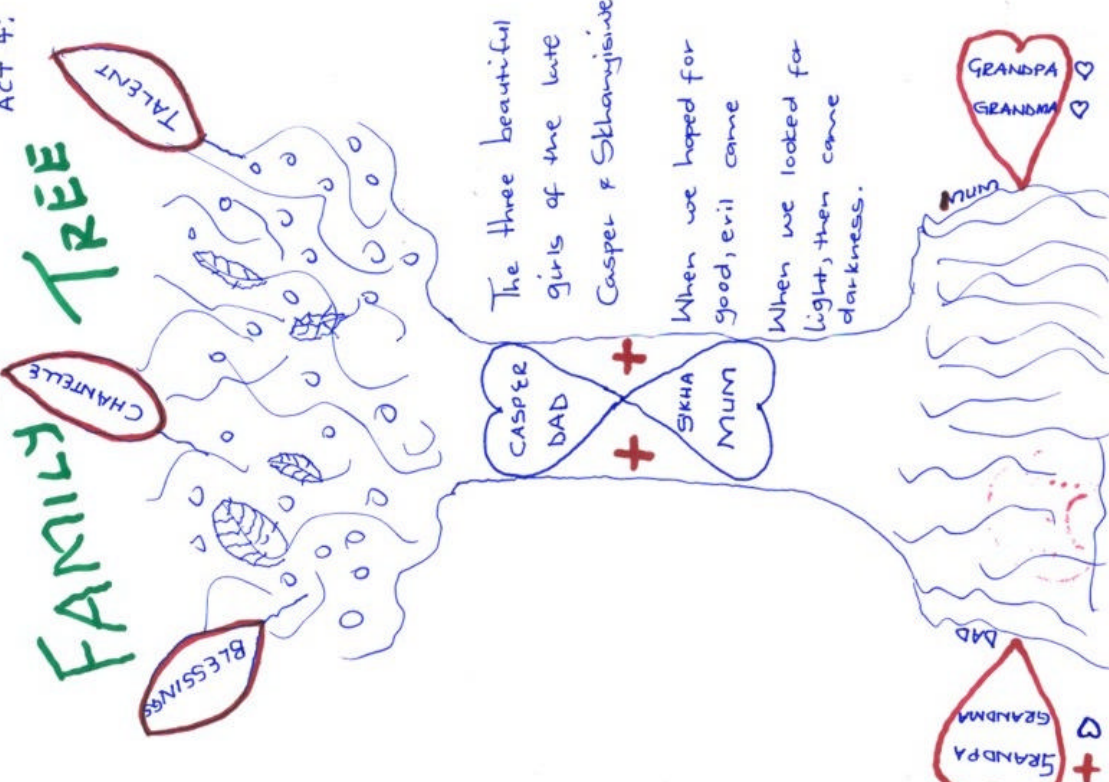


LIFE WAS SO HECTIC AT FIRST THEN IT TURNED SOCIALLY THE TIME I BEGAN TO LOOK AT IT NEGATIVELY...

I remember my life when things were normal. I used to go to town on weekends with my mum and dad. I lived a very happy life. My parents were a very loving couple who planned for their future but sadly one unexpected day something terrible happened. My parents broke up for unknown reasons. I had a guilty conscience thinking maybe mum left because of me. I just thought myself as dirty as I was living with one parent. I denied myself ~~my~~ neither did not like myself at that time.

ACT 4:

FAMILY TREE



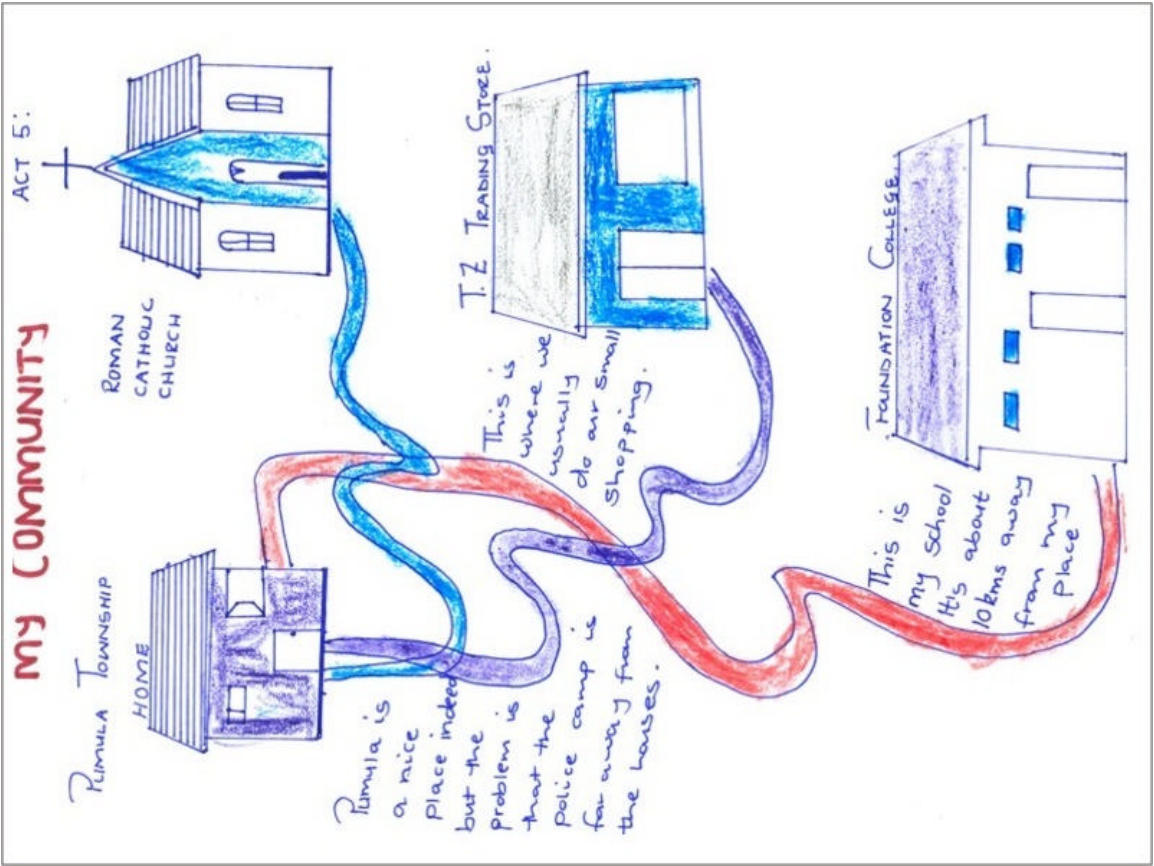
The three beautiful girls of the late Casper & Skhangiside

When we hoped for good, evil came

When we looked for light, then came darkness.

GRANDPA
GRANDMA

GRANDPA
GRANDMA



ACT 6:

MIZWANGEDWA.

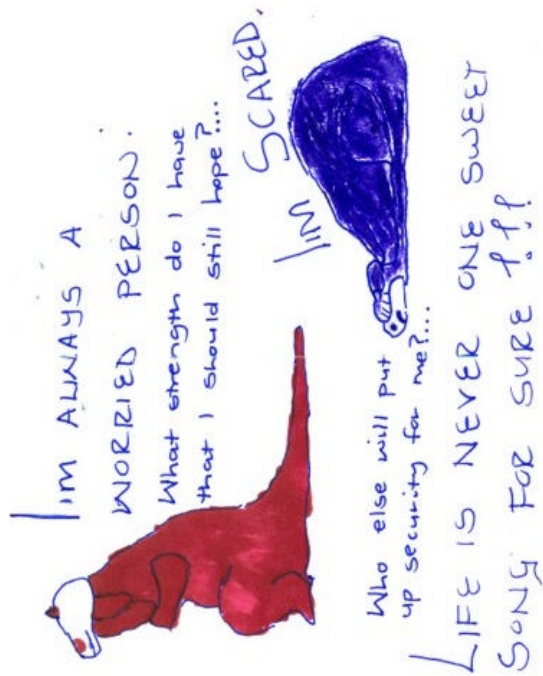
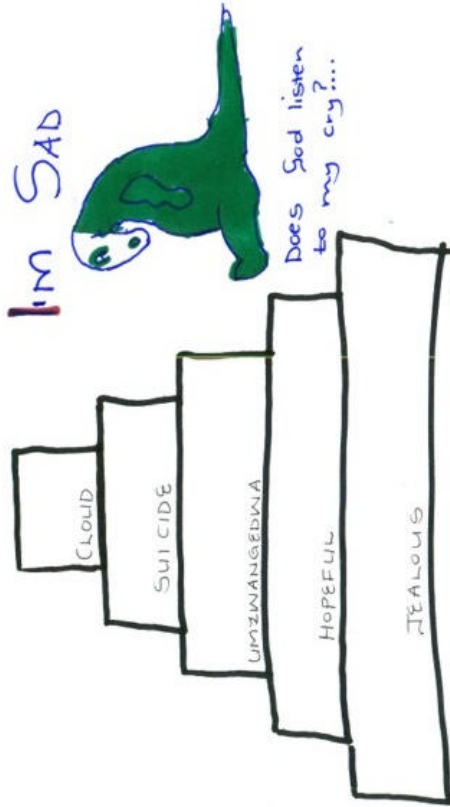
A dark ugly monster which comes in a form of a cloud. This visits especially when I'm

- angry
- guilty
- lonely
- hopeless
- ill
- sad

I hate this monster which I have badly named MZwangedwa. When it comes, I get mad like a demon possessed person & I think of destroying my life.

WIKI I EVER BE AT PEACE. ?

ACT 7



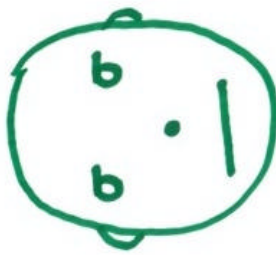
ACT 6:

Sometimes think of killing myself. This actually happens when I get sick. I may take this thing as a demon coz I can't really explain how I will be reacting at that specific time. Being sick shocks me a lot because the time I get sick, my mind flashes to the deadly disease that killed my mum. I do believe I'm HIV positive as well coz I'm the one who was nursing my mum. I haven't done the test before but I have the feeling that I'm positive. Imagine, washing blood stains, cleansing one's body full of sores and seeing that person dies of AIDS. Really if I think of this, suicide seems the only way out. I may take this reaction as a demon for I'll be allowing myself getting into something terrible. This also happened when my uncle threatened to chase us out of the house if we didn't help in paying the rent bills. I thought of my late mum, the way she suffered and how I struggled during her illness and by this I took the rat poison & told my young sister I'm DEPARTING. I also phoned my friend Tsitsi & before I could drink it my uncle came and threw that cup away. I was given a thorough beating but still the thing doesn't leave me. It visits me almost everyday. I just have the feeling of destroying my life, each time I remember the past & compare it with that of today.



.....BUT WHY IS THERE SUCH SUFFERING?
WHY ME THEN?

ACT 7:



JEALOUS

I sometimes feel jealousy of children with parents. I compare my life with theirs, then jealousy exist. I just wish they might loose both parents one time then we suffer together.



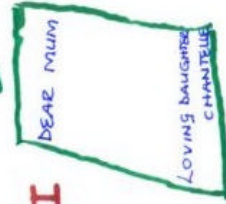
HOPEFUL

I then feel hopeful when I think of my future. I believe someday I will be smiling after having achieved all from my sweat.....

THERE HAS TO BE SOME GOOD COME OUT OF THE BAD !!



I'm with the kids in our club. We're rejoicing, dancing and singing. The Mzwangedwa has no space now. He's getting shy & runs away from me.



I'm writing a short letter to my mum asking why she left us without saying good bye. I also tell her about Mzwangedwa and the way I react when he visits. I put that letter under my pillow and wait for the reply.



I'm going to my friend's place and on my way Mzwangedwa tries to visit me. The time I reach my friend's place he quickly runs away. I forget everything about him & deal with my friend. I



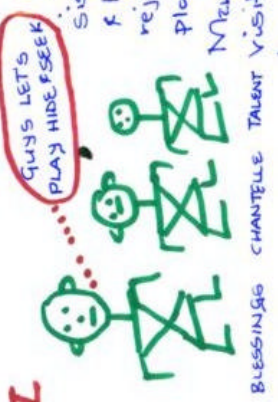
Stay there for a long time and Mzwangedwa gets angry and goes back to his place

A DAY IN MY LIFE ACT 9:



My shining moment was on April 24 2008 at 2pm when I tried to commit suicide. It was after my daddy's burial by then. I thought myself as dirty as I had no shoulder to lean on. I looked at myself and compared my life with other kids then suicide seemt the only way out. Mzwangedwa was about to talce his chances. The rat poison was near me but before I could use it, the claud broke into two pieces. I thought about my sisters & how it will affect them & also I asked myself am I the only orphan?, then that thought vanished. I gave myself hope that one day I'll conquer all the difficulties I encounter in my life only patience and perseverance is needed.

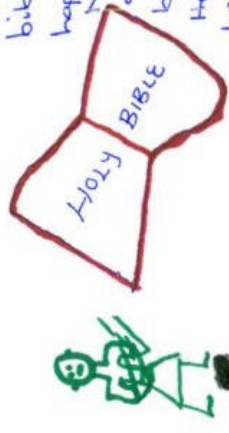
IV I'm with my loving sisters cracking jokes & laughing. We're rejoicing, singing & playing games together. Mzwangedwa tries to visit but he quickly turns away and goes out forever.



V I'm singing loudly my gospel songs. Mzwangedwa doesn't love noise so he jess ignore me and goes somewhere else.



VI I'm busy reading my bible. It gives a lot of hope for my future. Mzwangedwa gets angry and goes back to his place. He's crying because he's tired by all means to get me down but all in vain I've CONQUERED.



SHINING MOMENT.

ACT: 9:2

 2005

Wow!! What a day in my life. Monday the 10th of January is one of my days I will never forget. I will always love and keep this day as treasure. A special day I will always remember. It's a day I was born again not in body but in mind and heart. All my dirty thoughts vanished on this day. At first it was like a dream to me. I couldn't believe that was actually said to me.

HIV positive was always my answer but to my surprise 2005 brought its correct and unbelievable answer. My RESULTS CAME.....

NEGATIVE ✓

1
It was on the 10th of January when I and Mrs Gemann went for the HIV TEST. I couldn't sleep the previous day. Prayer was on the tip of my tongue. I was shivering. Of coz I had already told myself that I'm positive, but I didn't want to be told by somebody. I only wanted my status to be known by few people who I knew, will help me & will always be with me till the end. We drove to Matebeleland Aids Council where I did my testing and counseling. I was told to change my name which I was going to use for that day & also paid my testing fee. The counselors came immediately & I was taken to a room where I was alone. What I said & what I heard was only for me and the counselor. I gave the whole of my heart and told myself that I will accept either POSITIVE or NEGATIVE answer coz I knew that it's natural. Testing positive is not a death sentence & also being positive is not my fault. It happened due to some circumstances I also told myself that if I'm found positive, that will not be the end of my world or what. I can live for more than my expected days of living as long as I expected symptoms are not shown....

CONT.....

2

I also told the counselor that if I'm tested positive, firstly I'd like him to deepen his counseling before he gives me the results. And I also told him that, I don't want anyone to know my status except for Mrs. Germain, & me. I went with ONLY... I was in tears by the time I said these words. It was like a sick patient saying his/her last words to his relatives. I was told not to cry for I haven't done the testing yet and also live to be strong. I was asked for the last time "DO YOU WANT TO BE TESTED?" I said "yes" with a calm voice. I was told to follow the counselor to the testing room. This time I was shivering. It did not take a long time there before I was told to go and sit at the Administration room and wait for the results. It was not the really me by that time. I sat with Mrs. Germain and she was asking me some few questions about the counseling. I was off minded by the time. It was like we were playing each other yet we were together [one on one].

Cont.....

3

We sat for about 15 minutes then my name was called. Mzwangedwa fell into my eyes. I couldn't see what exactly was happening & also could not judge that day myself. Three lovely words released my soul

COME WHAT MAY.....

I'm ready for every answer. The counselor asked me if I'm ready to receive the results then I said YES.....



It was like a morning star. I couldn't believe the sight my eyes were seeing, nor see how that Mzwangedwa left me. Only a white paper marked NEGATIVE was "in front of me.

It was difficult for me to believe that but I did coz I had to.



Mzwangedwa is left in a corner of which he has no where to go now. ONLY DEATH WAITING! POE HIM...



.....FUTURE



WHAT IS IN STORE FOR ME?
WHAT STRENGTH DO I HAVE
THAT I SHOULD STILL HOPE?
DO I HAVE ANY POWER TO
HELP MYSELF?

MY HEAD HAS GROWN BIGGER THAN MY BODY DUE
TO THE THOUGHTS INSIDE ..

*** WHEN I THINK ABOUT MY FUTURE, I BELIEVE I
CAN JUMP AND CLIMB SKY HIGH THUS TO
ACHIEVE MY HOPES AND DREAMS.

*** I BELIEVE I'LL STILL BE HAVING THE ZEAL
AND STRENGTH THAT WILL MAKE ME WHAT
I'VE ALWAYS WANTED...



WHEN I THINK ABOUT MY FUTURE,
I BELIEVE SOMEDAY I'LL BE SMILING
AFTER HAVING ACHIEVED ALL FROM MY
SWEAT.....

MY FINGERS ARE ALWAYS CROSSED FOR THE DAY

2010



PATIENCE
&
PERSEVERANCE
OVERCOME THE
GREATEST
DIFFICULTIES.....

ALL THINGS ARE FULL OF WEARINESS;
MY EYE IS NOT SATISFIED WITH SEEING NOR
MY EAR FILLED WITH HEARING.
TRULY I CANT BELIEVE THIS. IS IT TRYE THAT
I'M FROM THE UNITED STATES OF AMERICA.
REALLY!!! FORESURE, THE LORD GIVES LIGHT
TO THE EYES OF BOTH. I'M NOW A CARE GIVER
AM VERY VERY PRID OF MY JOB. AS YOU CAN
SEE THE PICTURE ABOVE, I'M FROM U.S.A.
AM CLIMBING DOWN FROM AN AEROPLANE
IT WAS MY FIRST TIME TRAVELLING BY AIR
I ENJOYED A LOT.

I NOW OPEN MY MOUTH WIDE, JUDGE
RIGHTEOUSLY. I MAINTAIN THE RIGHTS OF
THE POOR & NEEDY. STRENGTH & DIGNITY ARE
MY CLOTHING. I'M ALWAYS THERE FOR THE
NEEDY.

THE TEACHING OF KINDNESS IS IN MY TONGUE.

2010

MY HEARTFELT THANKS:

TO SO MANY WONDERFUL PEOPLE. MY SPECIAL FRIENDS WHO HAVE TAKEN MY LIFE SERIOUSLY. THE COLLECTIVE POWER OF YOUR LOVE HAS HAD A PROFOUND IMPACT IN MY LIFE.



MR & MRS SEEMANN → FOR TEACHING ME TO BELIEVE THAT THERE IS GREATNESS WITHIN ME.

" → FOR BEING WITH ME ALWAYS.

MY SEANNY → FOR HER LOVE AND CONSISTANT SUPPORT.

THE ALMIGHTY GOD → FOR CARRYING ME WHEN THERE WAS ONLY ONE SET OF FOOTPRINT.

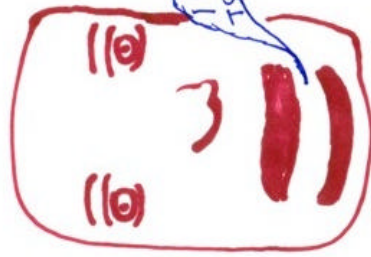
AS A CARE GIVER.

I THINK MY LIFE NOW IS EXTEA TIME AND IVE GOT TO MAKE THE MOST OF IT.....
BY CHANTELE THERE

LAST FAMOUS WORDS.

GUYS TRUST & BELIEVE IN YOURSELF & CAPABILITIES OR EVEN ABILITIES.

I WANT TO SAY TO SET WHAT YOU WANT FOR ITS NOT AN EASY ROAD. IT WANTS YOU AND YOUR MAXIMUM COMMITMENT.



..... MOREOVER STAND & FIGHT FOR WHAT YOU STRONGLY BELIEVE IN.



Appendix 9: Detailed CHH coping strategies

Coping task demand	CHH coping strategy	Observed use		
		Not	Weak	Strong
Food / nutrition				
	Ask from neighbours food support	3	35	67
	Substitute expensive with low cost food	0	9	96
	Stole food from shops or neighbourhood	87	16	2
	Grew food on own yard	7	25	73
	Grew food on urban council allocated plot	83	19	3
	Gathered wild fruits, roots and vegetables	18	74	13
	Visited neighbours for meals	6	18	81
	Hired out own labour for food	11	55	39
	Good use of food storage and preservation	52	40	13
Health aspects				
	Use of medicinal herbs	36	52	17
	Eating a healthy diet	31	43	31
	Obtained health service fee exemption	76	19	10
	Engaged in regular fitness	20	76	9
	Prayer for healing	19	34	52
	Visited local clinic	45	39	21
	Consulted traditional healer	54	42	9
Educational aspect				
	Access support from BEAM	82	19	4
	Older sibling left school to keep younger once at school	27	47	31
	Income generating activities to pay for school fees	3	29	73
	Rented out rooms to lodgers to raise school fees	14	45	46
	Accessed school fee support from Churches or OVC programmes	24	24	57
(reporting total 57)	Older girls have 'Sugar Daddies' (relationship with older men for school fee support, at times with teachers)	36	16	5
(reporting total 23)	Frequently absent to raise school fees, especially during term start	6	8	9
	Changed to vocational training or trading skills development	92	10	3
(reporting total 23)	Frequent change of school to avoid accumulated debt	15	4	4
Social aspect				
	Seek information on parenting practices	15	71	9
	Division of roles and responsibilities	2	23	80
	Developed family by-laws and mechanisms for discipline	18	63	24
	Invest in building good neighbourhood and peer relationships	11	41	53
	Developed mechanisms for conflict resolutions at HH level	29	62	14
(reporting total 57)	Elderly girls got boyfriends to provide companionship and support	38	14	5
Protection aspects				
	Developed relationship with friendly adult (neighbour) for protection	3	23	79
	Developed preventative, assertive behaviour	32	45	28
	Avoidance of risk situations	9	23	73
	Share problems and abuse with trusted adult	18	77	10
Spiritual aspects				
	Active participation in FBO	8	28	69
	Maintain or develop friendship with peers in FBO	11	23	71
	Seek spiritual support in times of difficulties	5	17	83
	Regular prayer	14	41	50
	Sought counsel from friendly adults in congregation	39	51	15
	Changed FBO with the hope to get better social and economic support from the new congregation	71	29	5
	Engaged in traditional religious rituals	27	60	18

Economic aspects				
	Engaged in petty trade and other small jobs for income	1	17	87
	Reduce / substitute unnecessary expenditures	0	31	74
	Hired out labour for income	9	73	23
	Sold household valuables and property	15	58	32
	Sold productive assets	12	84	9
Emotional aspects				
	Develop active emotion-focused coping strategies	9	75	21
	Teens engaged early in love relationship	43	39	23
	Participate in organised group support e.g. Kids Clubs	5	63	37
	Share problems and seek counsel among siblings	8	52	45
	Withdraw during emotionally difficult times	67	33	5
	Show symptoms of depression during difficult times	78	22	5
	Demonstrate high-levels of resilience	6	25	74

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