

**AN INVESTIGATION INTO CHALLENGES FACED BY COMMUNITY-
BASED INTERVENTIONS FOR ORPHANS AND VULNERABLE
CHILDREN IN MUTARE, ZIMBABWE.**

By

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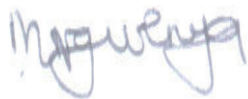
FEBRUARY 2015

DECLARATION

I declare that: AN INVESTIGATION INTO CHALLENGES FACED BY COMMUNITY-BASED INTERVENTIONS FOR OVCs IN MUTARE, ZIMBABWE is my own work. All the sources used in this research and quoted are acknowledged by means of complete references.

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27/02/2015

SIGNATURE

DATE

DEDICATION

Dedicated to my family and to all who care and support Orphans and Vulnerable Children.

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I would want to acknowledge the following people for impacting in my walk of writing this dissertation:

I would like to thank and acknowledge my Supervisor, Ms SE Koen for dedicating her time to guide me throughout the writing process of my dissertation.

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SUMMARY

This research was designed to explore the challenges faced by community-based interventions for orphans and vulnerable children in Mutare, Zimbabwe. This study employed qualitative case study method which focused on the two community-based organisations, FACT and Simukai. Cross-case data analysis relating to research questions was done using transcriptions organised by themes and sub-themes from focus group discussions with volunteers, in-depth interviews with caregivers and staff from both CBOs. Findings show that communities are committed to the care and support of OVCs by offering their voluntary services. Despite volunteer/caregivers' commitment to care and support OVCs, some challenges noted by caregivers were: caregiver fatigue, lack of material resources for OVCs during visits and lack of interest in young people taking up voluntary work. Simukai and FACT interventions were found to be mainly education, psychosocial support, medical assistance, project management, capacity building and financing of self help projects for OVCs and their families.

Key words: Orphans and vulnerable children, community intervention, caregivers, volunteers, HIV and AIDS, care and support

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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARVs	Anti-Retroviral Drugs
BEAM	Basic Education Assistance Module
BRTI	Biomedical Research and Training Institution
CBO	Community-Based Organisation
COPE	Community-based Orphans for Protection and Empowerment
FACT	Family AIDS Caring Trust
FGD	Focus group discussion
FBO	Faith Based Organisation
FOCUS	Families, Orphans and Children under Stress
HIV	Human Immunodeficiency Virus
MMC	Medical Male Circumcision
MoPLSW	Ministry of Public Service, Labour and Social Welfare
MTO	Medical Treatment Order
NAC	Zimbabwe National AIDS Council
NGO	Non-Governmental Organisations
NOCP	National Orphan Care Policy
OVC	Orphans and Other Vulnerable Children
OI	Opportunistic Infections
PMTCT	Parent Mother to child transmission
RAAAP	Rapid Country Assessment, Analysis and Action Plan
SAFAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SC-US	Save the Children Federation of the United States
SCN-Z	Save the Children Norway-Zimbabwe
STRIVE	Support to Replicable, Innovative Village/Community-Level Efforts for Vulnerable Children
UNAIDS	United Nations Programme on HIV and AIDS
UNAIDS	United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session

UNICEF	United Nations Children’s Fund
U.S. PEPFAR	United States President’s Emergency Plan for AIDS Relief
WHO	World Health Organisation
ZDHS	Zimbabwe Demography and Health Survey
ZNAP	Zimbabwe National Action Plan
ZNASP	Zimbabwe National HIV and AIDS Strategic Plan
ZIMSTAT	Zimbabwe National Statistic Agency

CHAPTER 1: SITUATING THE RESEARCH PROBLEM

1.1 INTRODUCTION

Zimbabwe is one of the countries in sub-Saharan Africa that has experienced an increase in the number of orphans and vulnerable children (OVCs) as a result of the impact of HIV and AIDS and has had its own challenges in responding to the OVCs crisis. The growing number of OVCs has led to the emergence of community-based responses to address the needs of OVCs and as a result, challenges have also emerged as these communities come together to provide care and support for the OVCs.

This study investigates challenges faced by community-based interventions for orphans and vulnerable children in Mutare, Zimbabwe. The investigation uses the case study method in order to explore, describe and understand the challenges faced by two community-based organisations, namely the Family AIDS Caring Trust (FACT) and Simukai. The collective efficacy theoretical framework will be used to guide this study and to assist the researcher to come to an understanding of the collective social efforts to improve the lives of OVC in Mutare, and the challenges associated with these collective efforts.

This first chapter presents a general background to the study, states the research problem which generated the researcher's interest in undertaking the study, outlines the research objectives and the research questions of the study, explains the rationale for the study, briefly highlights the research setting, research design and methodology and theoretical framework and provides definitions of key terms used in this study.

1.2 THE RESEARCH PROBLEM

1.2.1 Background to the research problem

Zimbabwe is one of the countries with the largest numbers of orphaned children in Africa as a result of the AIDS epidemic. UNAIDS (2012:42) posits that Zimbabwe is one of the countries in the world hardest hit by HIV and AIDS epidemics. The impact of these epidemics is seen most dramatically in the number of children orphaned by AIDS. The Global AIDS Report for Zimbabwe (2012:34) estimates that averages of 30% of all children in Zimbabwe are orphaned and that 40% of all children are vulnerable mainly due to AIDS. The Zimbabwe Country Report (2014:52) states that according to the National HIV Estimates in 2010 there were more than 1.4 million orphans in Zimbabwe and that one million of these children are orphaned by AIDS-related deaths. This highlights the need for an urgent response to provide care and protection for this vulnerable group.

High HIV prevalence in Zimbabwe has led to decreasing life expectancy causing the number of OVC to grow to unprecedented levels. SAFAIDS (2010:12) estimated that the percentage of all orphaned children living in Zimbabwe rose to 34% by end of 2010 compared to the 30% in 2005. SAFAIDS (2010:5) further indicates that by 2008, there were 1.4 million OVCs in Zimbabwe with some of the children also infected with HIV. The Zimbabwe National AIDS Council (NAC) (2013:41) which is the HIV and AIDS national governing body estimates that by end of 2011, there were about 1.6 million orphans in Zimbabwe.

In 1999 the government of Zimbabwe introduced a mandatory 3% AIDS Levy to all payee and corporate taxes. NAC manages the 3% AIDS Levy to help fund the national response to the HIV, AIDS and OVCs crisis. However, due to the socio-economic hardships that Zimbabwe has been experiencing for the past ten years, the AIDS Levy has not been sufficient for the government to meet the plight of OVCs.

The government of Zimbabwe recognised the problem of mass orphanhood as one of its most serious development challenges. In 1999 Zimbabwe's Cabinet Ministers adopted a National Orphan Care Policy (NOCP) which established a partnership between government ministries, the community, faith-based organisations, traditional institutions and non-governmental organisations. This policy emphasised that communities are best positioned to determine the vulnerability of children and their families. Community members therefore have an obligation to render all necessary support needed by the OVCs in order to help them live a better life. The NOCP further contend that norms and values of any community are best passed on to the next generation by community members themselves because failure to do so will have negative consequences as well as spill-over effects that impact not only on OVCs but on the community and the nation at large.

Such negative impacts could manifest in the increased number of OVCs on the streets, some turning to prostitution, further perpetuating the HIV and AIDS pandemic. Others may engage in criminal activities because they lacked parental guidance due to death or staying with very sick parents. The Zimbabwean Department of Social Welfare was tasked to lead the coordination, implementation, monitoring and information-sharing activities concerning the rights of OVCs and the referral services provided by different organisations which have been approved by the government at national and sub-national levels (UNICEF, 2010:58).

In 2005, the government of Zimbabwe launched a National Action Plan (NAP) with the aim to reach out to all orphans and vulnerable children in Zimbabwe. The NAP is now a legal document in Zimbabwe and is used to strengthen community-based support as an indirect means in assisting OVCs to have access to basic shelter, food, clothes, health facilities, birth registration and education. Zimbabwe has three key national policies supporting children: the National AIDS Policy (1999), the Zimbabwe National Orphan Care Policy (1999) and the National Action Plan for orphans and vulnerable children (2005).

The overall goals of these policies are to ensure that OVCs receive the basic services mentioned above, either through community interventions or the local government which is represented by the Department of Social Welfare or NGOs. It is against this backdrop of an OVC crisis that community initiatives of collective caring and support for OVCs emerged (NAC 2011:48).

1.2.2 Problem statement

In Zimbabwe, the number of OVCs by 2013 was estimated to be at 1.6 million (NAC 2014:36). This rising number of OVCs coupled with inter-related social, cultural, political and economic forces has resulted in families and communities being over-stretched with regard to their coping capabilities to care for and support OVCs. There are disturbing trends of poverty among the Zimbabwean communities due to persistent droughts, shortage of foreign currency and political and economic forces which have in recent times incapacitated families, communities and government in giving care and support to OVCs. Zimbabwe's relations with the international community, especially developed countries, has largely been strained due to some political policies and sanctions. These sanctions have resulted in the country failing to access funding from the international community necessary for purchasing ARVs to reduce morbidity and mortality in both parents and OVCs. The family, being the primary socialisation agent and a safety-net for the care and support of the underprivileged, including orphans and vulnerable children, no longer performs its functions due to above mentioned trends (USAID/Nigeria, 2010).

UNAIDS/Zimbabwe (2014:13) posits that Zimbabwe has an estimated 152,000 children under the age of 15 who are living with HIV and this makes them vulnerable. For example, these children may be discriminated against at schools, experience lack of appropriate care and access to ARVs as there is shortage of ARVs in the country as a result of decreasing external funding. The follow-up edition of the United Nations General Assembly Report (UNGASS 2010: 26) states that of the 1.6 million children made

vulnerable by HIV and AIDS epidemic, only 0, 3% are cared for in institutions, with 97% being cared for by their extended families and communities (Zimbabwe Global AIDS Report, 2012:39).

Communities have been in the forefront with regard to the responses to the OVC crisis and community-based initiatives lie at the centre of Zimbabwe's attempts to provide holistic services to OVCs. Family Health International (FHI 2006:10) define "community" as a group of people with shared interests, a common fate, social and political history, ethnicity and a sense of purpose or vision and cultural affinity. The NAP (2004:15) defines "orphans" as children aged 0 to 18 years whose parents have died and "other vulnerable children" as children who are subjected to a wide range of social and economic difficulties and whose rights such as right to shelter, education, food and treatment are threatened.

The presence of children orphaned due to AIDS-related deaths in Zimbabwe has resulted in the customary networks of care and support, such as the extended family, breaking down (Rusakaniko, Chikwasha, Bradley & Mishra 2010:7). Some of Zimbabwean African families believed in living together as extended families where a child could be cared for and supported by other family members outside their nuclear family. The kinship relations in Zimbabwe are mainly observed through marriages or the blood lineage connections of grandparents. The care and support of the extended family's children was done even when the parents of the child were alive and well, therefore, in the event of the death of one or both parent(s) of the child, the child's welfare would easily be taken care of by the remaining extended family members (Rusakaniko et. al. 2010:13). However, as earlier discussed, socio-economic and political challenges facing Zimbabwe currently, have left family groups weakened, resulting in extended families carrying out fewer traditional functions and becoming smaller and more unstable, weakening the cultural values of families (Masuka, Banda & Mabvurira (2012: 54).

The extended family, as a traditional social security system in Zimbabwe, has been weakened because parents, aunts and uncles are dying of AIDS. Extended families are also under severe strain as a result of migration in search of jobs, demographic changes and families now preferring to live together as nuclear families rather than extended families due to economic hardships. These family cultural values were the backbone in maintaining extended families knitted together and as a way of passing family values from one generation to the other. Consequently, the disruption in family values may result in orphans and vulnerable children becoming involved with deviant peer groups that can endanger successful transition into mainstream adulthood.

In Zimbabwe, traditional values are still maintained in most rural areas and this has helped extended family safety-nets to remain preserved by having OVCs absorbed within extended families. In responding to the OVC crisis in Zimbabwe and preserving the families through networks, the traditional leadership has revived the traditional safety-net concept called "*Zhunderamambo/Isiphala se Nkosi*." This is a traditional system in which chiefs or head of villages reserve a piece of land for community use (BRTI: 2008:15). All families under the jurisdiction of the chief contribute labour to till the land and tend the produce from the plot. The produce is kept by the chief and then distributed to families in need of food and to OVCs. However, the urbanised extended family safety-nets in Zimbabwe have been weakened by the economic meltdown. In urban areas like Mutare city, there are no plots for communities to till the land and produce food for OVCs, compared to their counterparts in rural communities.

Urban communities rely mostly on hard currency to purchase food and other necessities which is difficult as the financial strain is exacerbated by the unemployment rate in Zimbabwe which by year 2013 stood at 80% according to the report by (Poverty Reduction Forum Trust, 2013.18). As

stated above, the economic challenges facing the country and the AIDS epidemic have led to the erosion of traditional safety-nets.

This study is being carried out in an urban environment where extended family safety-nets have failed to absorb the OVCs, resulting in communities taking initiatives in providing care and support to the OVCs within their communities. Community organisations such as FACT and Simukai evolved in order to compensate for the breaking down of traditional supportive networks for OVCs.

However, community safety-nets are also being weakened by the growing impact of AIDS epidemic and the ever rising numbers of OVCs. Lack of resources in Zimbabwe has hampered the implementation of community-based interventions as families are already stretched in their own homes financially and materially to look after their own children as a result of the economic destabilisation that has characterised the country. Access to financial resources has also been a challenge in Zimbabwe due to a hyper-inflationary environment and the use of multi-foreign currencies has resulted in high costs of projects operations. Most communities therefore, need assistance from either the government or non-governmental organisations (NGOs) with regard to funding in order to obtain, among others, training on how to coordinate their activities in terms of the interventions being implemented in their communities.

Biomedical Research Training Institute (BRTI 2008:18) and the Ministry of Health carried out a situational analysis of services and support systems for OVCs within the communities. BRTI (2008) study found that living conditions for OVCs were generally poor; food was cited as the main need of OVCs, as well as educational assistance. The study highlighted that most communities were willing to support the OVCs among them. However, their activities were not well coordinated, which resulted in some OVCs double dipping while others had received nothing. Information on the number of OVCs within each community was not available and this information gap resulted

in OVCs being deprived of care and support. The study further revealed that there was need for local schools and community members to share their OVC registers as some OVCs were registered only within their communities while others were recorded in both school and community registers.

The coordination of information sharing about the number of OVCs within a greater community, inclusive of schools, was found to be effective for the benefit of all OVCs. The coordination of care and support services for OVCs was also found to be critical in that communities could share different skills among themselves, for example counselling skills and business and marketing skills, all of which, if well coordinated, could benefit the OVCs. The sharing of best practices in the care and support of OVCs could also help other communities who are facing challenges in providing care and support as they learn from others on alternative ways which have been tried and tested by others (Southern Africa HIV and AIDS Information Dissemination Service, (SAFAIDS 2010:25).

Sampson, Raudenbush & Earls (2006: 112) invented the notion of “collective efficacy”. Sampson describes collective efficacy as a resource that is activated in crucial times as was seen in the United States when communities were bound together to control disorderly and criminal behaviours in their communities. They hypothesised that when people in a neighbourhood trusted and supported one another, they had a basis of working together to control disorderly, criminal behaviours and solving identified problems within their communities. This construct of collective efficacy implied that when disruptive conduct arose, as is the case with large numbers of OVCs in the urban communities of Zimbabwe people in the neighbourhood could act in an “effective” way to solve these problems if they had the necessary level of cohesiveness. In some studies carried out by Sampson et. al. (2006), the construct of collective efficacy was linked to reduced violence in communities.

While many studies have found that the presence of collective efficacy in communities leads to low levels of crimes, other studies have found that there are certain community characteristics that must be present for collective efficacy to develop (Spradlin 2006:12). Fagen (2005:89) further asserts that the model of collective efficacy argues that when communities have common goals, values and beliefs they tend to experience high level of collective efficacy and in turn low levels of street crimes. Sampson et. al. (2006) used “trust and cohesion” in their study on crime and found that communities characterised by a uniformity of values also displayed a high degree of social control. They concluded that cohesion directly leads to intervention. Consequently the researcher was interested during this study to uncover and explore community characteristics present in the city of Mutare, Zimbabwe that could have facilitated the development of collective efficacy in terms of the care and support of OVCs.

Mutare city is located in an urban setting of Manicaland province and comprises of diverse groups of people from different parts of Zimbabwe with different religions and traditions. Foreign people from countries like Mozambique, Malawi and Democratic Republic of Congo also form part of the dwellers in this city, further bringing in a wider diversity of traditions, norms and values which are foreign to the Zimbabwean community. This diverse urban set-up is in far contrast to the rural areas in Zimbabwe where village, family and kinship structures are patrilineal in nature, tracing descent through the father and grandfather, and where community members live under the guardianship of a chief who is the custodian of that community’s traditional norms and values. Spradlin’s (2006) study on tolerance of diversity, collective efficacy, and criminal victimisation on a college campus in Virginia had a similar set-up to that of Mutare city, Zimbabwe in that in a college campus there are diverse groups of people with different traditions, norms and values. With such diversity of people on the campus, Spradlin’s (2006:34) study found that the presence of collective efficacy in the neighbourhood leads to low levels of crime and an increased

quality of life for residents only if an individual feels a sense of belonging with the group.

Tolerance of diversity leads to a sense of belonging, this belonging further leads to cohesion (which includes value similarity) and this cohesion leads to collective efficacy. The researcher was interested during this study to also explore how cohesion developed in an ethnically heterogeneous community like Mutare city and how this impacted on addressing the challenges faced by community-based interventions in the care and support of OVCs.

1.2.3 Focus of the study

The study focuses on two community-based interventions that support orphans and vulnerable children in Zimbabwe, namely the Family AIDS Caring Trust (FACT) and Simukai and in particular, on the challenges experienced by these two community-based interventions.

1.3 OBJECTIVES OF THE STUDY

This study primarily aims at exploring and describing the challenges faced by two community-based interventions for OVCs, namely FACT and Simukai.

The specific objectives of the study were to:

1. Explore FACT and Simukai's reasons for becoming involved in OVC community-based intervention.
2. Describe types of care and support interventions provided for OVC by FACT and Simukai in the City of Mutare.
3. Describe the factors that influence the effectiveness of OVC Interventions provided by FACT and Simukai.
4. Explore factors influencing sustainability of OVC interventions Provided by FACT and Simukai..
5. Identify the challenges faced by OVC community-based interventions provided by FACT and Simukai.

1.4 RESEARCH QUESTIONS

The researcher was guided by the following research questions:

1. What caused the community-based organisations in Mutare city to intervene in the OVC crisis?
2. What OVC interventions are being provided by the two CBOs, FACT and Simukai?
3. What are the factors influencing effectiveness of service delivery to OVCs?
4. What are the factors influencing the sustainability of the two CBOs?
5. What are the challenges faced by OVC community-based interventions?

1.5 RATIONALE FOR THE STUDY

UNAIDS (2011:26) posits that the traditional extended family and other support systems have been overwhelmed by the extent of the OVCs crisis in Zimbabwe. There has been a decline in support services for OVCs due to the impact of hyper-inflation on national budgets and the impact of social, cultural, political and economic forces in Zimbabwe, thus further burdening those caring for OVCs. Due to urbanisation and the AIDS epidemic, traditional community structures for child care and support have been decimated resulting in social problems such as the street children phenomenon. Most of Zimbabwe cities, Mutare city included have seen a rise in children living on the streets as shelter is one of the challenges faced by OVCs. There was an unprecedented economic downturn in Zimbabwe as the international community slapped the country with sanctions as a result of the government's land reform programme.

In 2005 the Zimbabwean government embarked on a violent land reform programme which resulted in most of the white commercial farms being seized. This resulted in a shortage of food, especially in grain reserves.

The subsequent closure of industries, further exacerbated poverty, which in turn increased the social and economic marginalisation of the already disadvantaged OVCs.

Schenk, Michaelis, Sapiano, Brown & Weiss (2010:333) states that community-based interventions for OVCs are interventions providing the care of children within their own communities which requires community engagement, commitment and initiative in programme implementation. In Zimbabwe, such community-based initiatives have been realised through supplementary feeding schemes for OVCs, agriculture programmes and the provision of school uniforms and fees. Such good community initiatives have been well documented and researched by other researchers (SAfAIDS, 2010:27).

The researcher's interest in investigating the challenges faced by community-based interventions for OVCs began in 2004 while the researcher was attached to a church programme that provided psycho-social support to OVCs in the community. The researcher was working as a volunteer on this programme. It was during this time that the researcher became aware of some of the challenges that community-based interventions for OVCs face. The community members, especially women through their church structures, organised themselves and formed a community-based organisation which identified OVCs first within their church and later expanded to identify OVCs within their household locations.

This community-based organisation mobilised resources like food, clothes and school uniforms which were later distributed to the OVCs. The gap created by the state as a result of a lack of social service delivery for OVCs due to economic meltdown was then filled by the communities. Many studies have been carried out in Zimbabwe and other African countries on the positive impact that community organisation have had in response to the plight of OVCs (Masuka, Banda & Mabvurira, 2012:60), yet not much has been documented or researched on the challenges these communities face as they volunteer to help OVCs in their communities. The researcher was

therefore interested in investigating the challenges faced by community-based interventions for OVCs through the theoretical lenses of the collective efficacy theory.

This study was undertaken to help identify relevant community challenges that may not have been highlighted in other community-based research in relation to community-based organisations' initiatives in the care and support to OVCs within their communities. This research may also help refine community-based interventions and thus could contribute to fostering the continuity and sustainability of these community-based interventions. The findings of this study might also be used to improve community-based interventions for OVCs through shared knowledge on best practices in community-based interventions for OVCs care and support. Not much research has been done in relation to the challenges faced by community-based interventions for OVCs that focus on people working collectively and believing in their collective capabilities to address the problems faced by OVCs.

The identified community-based organisations' challenges could be forwarded to relevant authorities such as policy makers and local authorities and could be incorporated in policies that address community-based OVCs care and support initiatives. Community organisations could also be given information about other community-based organisations' best practices for the OVC care and support by the researcher through the dissemination of study results to the community. This study could further assist community members to identify their strengths and weaknesses in their operations as a collective and find possible solutions to strengthen this aspect.

The successes of the two organisations being studied, FACT and Simukai, could be highlighted too, so that other community-based initiatives may build upon the successes experienced by FACT and Simukai. The study may provide recommendations to policy makers and other stakeholders based on the data collected with regards to challenges faced by the two

community-based organisations being studied. The significance of this study therefore could lie in recognising that as much as communities have responded positively to the plight of OVCs, there are challenges associated with collective action.

1.6 THE RESEARCH SETTING

Zimbabwe is a land locked country, with a population of approximately 12.7 million according to the 2012 National Census (Central Statistic Office Census 2012). Zimbabwe is located in southern Africa, between the Zambezi and Limpopo rivers, bordered by South Africa to the south, Botswana to the west, Zambia to the north and Mozambique to the east.

There are ten administrative provinces in Zimbabwe which are Bulawayo, Matabeleland South, Matabeleland North, Midlands, Mashonaland West, Mashonaland Central, Masvingo, Mashonaland East, Harare, and Manicaland. Mutare city is situated in the central mountainous province of Manicaland, on the eastern borders of Zimbabwe and is 263 km from Harare, the capital city. This study will be done in Mutare city. Mutare city has an urban population of 188 243, inclusive of children from the last census conducted in 2012 (ZIMSTAT, 2012). The population in Mutare city is predominantly Shona speakers.

The Biomedical Research and Training Institution (BRTI, 2008) posits that no surveys have been conducted in Mutare city to determine the exact number of OVCs and as a result, there is no centralised database for OVCs in Mutare city. Community-based organisations, NGOs, support groups and the local government working with OVCs in Mutare city all have their own individual registers or numbers of OVCs they are assisting. The researcher collected and analysed data on challenges faced by the two community-based organisations being studied with regards to the care and support services provided to the OVCs.

The two community-based organisations' interventions being studied, FACT and Simukai are both operating in the high-density suburbs of Mutare.

Simukai is operating from Sakubva, a high density suburb, being the oldest suburb in Mutare city, the Dream House and Garikay/Hlalanikuhle suburbs. FACT operates mostly in Sakubva and other less densely populated suburbs such as Chikanga and Dangamvura in Mutare city.

1.7 RESEARCH DESIGN AND METHODOLOGY

The methodological approach employed in this study is principally based on qualitative methods of enquiry, and specifically the case study design. Creswell (2007:40) asserts that “We conduct qualitative research because a problem or issue needs to be explored. This exploration is needed, in turn, because of a need to study a group or population, identify variables that can be measured, or hear silenced voices.” Qualitative research enables the researcher to gain a detailed understanding of the contexts or settings in which participants in a study address a problem or issue, for example in this study, the way in which participants attempt to address the challenges faced in the care of OVCs. The researcher chose a qualitative approach for this study in order to explore challenges faced by community-based organisations interventions for OVCs in Mutare, Zimbabwe. In-depth face-to-face interviews, among others, were used to explore and describe challenges experienced by these two community-based organisations.

Yin (2009:240) postulates that the case study method is relevant when there is a unique social phenomenon which requires an extensive and “in-depth” description within its real life context. The researcher chose to use the case study method to gain an in-depth understanding of the challenges faced by the two selected community organisations. Multiple sources of information such as in-depth individual interviews, observations and focus group discussions (FGDs), were used. Methodological triangulation helped the researcher search for converging findings from different sources on challenges faced by the two community-based organisations who provides care and support to OVCs. Yin (2009:358) posits that cross-case analysis is a research method that facilitates the comparison of commonalities and differences in the events, activities and processes that are the units of analysis in case studies. A cross-case analysis was employed by the

researcher to examine the similarities and differences between FACT and Simukai with regard to the challenges they are facing in the care and support of OVCs.

The two community-based organisations (CBO) were purposively chosen because in the city of Mutare, Zimbabwe, they were among the first CBOs to take lead in responding to the plight of OVCs using community resources for their care and support. The two CBOs also have some documentation on the work they have carried out regarding community-based interventions for OVCs in Mutare city.

For the purpose of this study, key informant interviews will be carried out with staff and community members from each CBO to get an in-depth understanding of the challenges faced in the care and support of OVCs in Mutare city. Focus group discussions consisting of six caregivers each from FACT and Simukai were also conducted to gather information about challenges faced by community-based organisations from the perspective of caregivers as the latter are the providers of OVC services.

1.8 THEORETICAL FRAMEWORK

In this sub-section the theoretical assumptions employed as the frame of reference for this study are reviewed. Sullivan (2006) contends that the key role of theories is to tell the story of why something occurred and also to help us organise data gathered through research into a meaningful whole. It is against this backdrop that this study employs the theory of collective efficacy to explain community-based interventions in response to the plight of OVCs.

Sampson et. al. (2006:112) invented the notion of “collective efficacy”. Sampson et. al. (2006:114) hypothesised that when people in a neighbourhood trusted and supported one another, they choose to form groups to control disorderly and criminal behaviour. This notion of collective efficacy purports that when disruptive conduct arises, people in the

neighbourhoods have the cohesiveness to act in an “effective” way to solve their problems. Collective efficacy is therefore, a resource that is activated in crucial situations. The first application of this concept was implemented when communities wanted to contain crime in their neighbourhoods.

The theory of collective efficacy argues that people do not live their lives in social isolation and that many of the challenges and difficulties they face reflect group problems requiring sustained collective effort to produce any significant change (Bandura 1986:449). Could the above mentioned statement be true in the case of the urban setting of Mutare city? In this instance the community, faced with an unprecedented increase in and the plight of OVCs, decided to have one common goal of pulling their resources together to provide care and support to the OVCs. This study, through the theoretical lenses of collective efficacy explore and describe some of the challenges faced by community-based organisations such as FACT and Simukai in providing care and support to OVCs.

1.9 DEFINITION OF KEY TERMS

1.9.1 Orphans and vulnerable children

For the purposes of this study, the UNAIDS and the Zimbabwe National Action Plan’s (2004:11) definitions for “orphans” and vulnerable children will be used. They both define an “orphan” as a child less than 18 years of age whose parents have died. There are three categories of orphanhood, a child who has lost a mother is referred to as a maternal orphan, one who lost a father, a paternal orphan while a child who has lost both parents is referred to as a double orphan. “Vulnerable” children are defined according to the Zimbabwe National Action Plan (2004:11) as children subjected to a wide range of social and economic difficulties and whose rights are threatened for example, the rights to shelter, food, birth registration, education and treatment.

1.9.2 Community-based interventions

In this study, “community-based interventions” refer to programmes designed by community members in response to the problems faced by orphans and vulnerable children in their community (World Bank 2006:80).

1.9.3 Community-based organisations

Community-based organisations are grassroots associations established by the inhabitants of a particular community to address community needs (BRTI 2008:141). Community-based organisations for the purpose of this study will also be referred to as non-profit associations established with the major objective of improving the lives of the needy, the marginalised and underprivileged OVCs.

1.9.4 Challenges

“Challenges” according to the Zimbabwe National Action Plan (2004:15) refers to difficulties and obstacles in implementing interventions. The researcher explored and described the challenges faced by community-based interventions in the City of Mutare, Zimbabwe. This helped to bring to light the difficulties these organisations experience in the provision of care and support to OVCs.

1.9.5 Volunteers

Community-based interventions are carried out by volunteers. In this study, “volunteers” are those people in the community who offer their services freely and without pressure or coercion in caring for and providing support to OVCs. The services offered are for humanitarian and charitable causes where there is no expectation of compensation. (USAID Zimbabwe 2006:28).

1.9.6 Community

“Community” in this study refers to a group of people with shared interests, a shared social history and ethnicity, a sense of purpose or vision and cultural affinity (FHI 2006:10). For these communities to succeed in their attempts to assist and care for and support OVCs, communities need other stakeholders to help them.

1.9.7 Stakeholders

“Stakeholders” are partners who have a buy-in for the services provided by CBOs to the OVCs and offer support to enable the CBOs to meet the needs of OVCs (FHI 2006:10). For this study, stakeholders are considered as those individuals, government departments, groups or organisations that take responsibility and interest in assisting the OVCs through community-based organisations.

1.9.8 Beneficiaries

OVCs are the beneficiaries of the services offered by the community. “Beneficiaries” are therefore defined as orphans and vulnerable children receiving services provided by the community (Zimbabwe National Action Plan 2004:15).

1.9.9 Collective efficacy

Sampson et. al. (2006:114) defines “collective efficacy” as a linkage of mutual trust among community members and willingness to intervene on social issues affecting their community. This will be the working definition for this study to bring insight and understanding regarding the challenges faced by community-based interventions for OVCs in Mutare city.

1.10 CHAPTER OUTLINE

This dissertation comprises of five chapters. **Chapter one** introduces the research problem that was being investigated in this study. It highlights the research problem, provides a background to the study and outlines the problem statement. The chapter further spells out the focus of the study, indicates the objectives of the study, provides the research questions and states the rationale of the study. The research setting is outlined together with the research design and methodology. Definition of keys terms used in the study is also provided in this chapter.

Chapter two provides a detailed review of the relevant literature pertaining to challenges faced by community-based interventions for OVCs. It also addresses debates surrounding community-based interventions for OVCs using the theoretical lenses of the collective efficacy approach. It further identifies the findings of and common themes that run through previous studies.

Chapter three focuses on the discussion of the research methods employed in order to generate the empirical data for this study. A qualitative approach using a case study method was used to study the two CBOs, FACT and Simukai. This chapter outlines the philosophical underpinnings of qualitative research and gives a rationale for the adoption of a qualitative methodology and the use of the case study method. The chapter also outlines the use of in-depth, face-to-face interviews, focus group discussion and observations as methods to generate qualitative data.

Chapter four: The researcher presented and interpreted the findings of this qualitative study in this chapter. The data was analysed manually according to themes that emerged. The interpretation and presentation of the findings focused mainly on the examination of findings as they pertain to the five main research questions of the study as well as theoretical considerations as proposed by the collective efficacy theory discussed in chapter 2.

Chapter five discusses the implications and contributions of this study for policy makers, researchers and other interested parties that advocates for community-based interventions as an effective way of responding to the plight of OVCs. The concluding chapter reflects on what the study has achieved. Further research questions are identified on the basis of the findings of this study and recommendations made in light of the study's findings. This chapter also summarises the findings by stating its main conclusions and highlights the limitations of the study.

1.11 CONCLUSION

This first chapter presented a general background to the study, stated the research problem which generated the researcher's interest in undertaking the study, outlined the research objectives and research questions of the study, explained the rationale for the study, briefly highlighted the research setting, research design and methodology and the theoretical framework then provided definitions of key terms used in this study.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Zimbabwe has experienced a steep increase in the HIV prevalence rate from 1999 up to 2012, but the country still has a generalised HIV epidemic of 13.1% (UNAIDS, Zimbabwe Country Report (2014:52). HIV prevalence in Zimbabwe was estimated to be 29% in 1999, then declined to 23.7% in 2001, further declined to 18.4% in 2005 and continued to decline to 13.1% in 2012 (Global AIDS Response Report 2014:39, Republic of Zimbabwe). The generalised HIV epidemic in the country remains a concern for the nation as HIV prevalence still stands at double digits of 13.1% (UNAIDS, 2011:21). The WHO (2011:32) defines a “generalised epidemic” as one where most new infections are through heterosexual sex contact in the general population with an adult HIV prevalence among the general adult population at more than 1%. Surveys that were conducted by Imperial College in Manicaland, Zimbabwe show significant behaviour change in partner reduction among adults and deferred sexual inception among the youth (WHO 2011:156). These sexual behaviour changes have played a major role in reducing HIV prevalence in Zimbabwe. Since early 2000, Zimbabwe endured political and economic hardships, severe droughts, budget deficits and hyperinflation which rocked the nation up to 2009.

The socio-economic hardships had a domino-effect on most Zimbabweans who had multiple sexual partners as resources and income became scarce and people could not afford supporting multiple partners (BRTI, 2008:142). Extensive education and information sharing on HIV and AIDS by the government, communities, non-governmental organizations (NGOs) and the international community also facilitated the behaviour change as people responded to information on HIV and AIDS-related deaths (BRTI, 2008:145). As the hyperinflation soured, the government of Zimbabwe was at the same time isolated by international community as a result of its controversial land redistribution policies and practices. This further crippled

the government's ability to provide resources for the care and support of OVCs.

When the government failed to provide care and support for OVCs, the communities took initiatives to support the OVCs, using their meagre resources. However, Zimbabwe's HIV and AIDS epidemics coupled with poverty, economic meltdown and persistent drought, have had severe impacts on communities who have taken initiatives to care and support OVCs.

UNICEF (2010:2) posit that OVCs are subjected to a wide range of social and economic difficulties, psychosocial distress, stigma, grief, discrimination, isolation and economic deprivation, loss of educational opportunities, burdensome domestic responsibilities and fear of their own future. Due to these difficulties faced by OVCs, communities have responded to their plight by initiating support for OVCs through community-based organisations (CBOs).

Although HIV prevalence is declining in Zimbabwe, OVC prevalence and incidence continue to increase (Fraser, Ruark, Gorgens, James, Milanzi, Colvin, Ibbeston, Mpofu & Nzima, (2011:48). The scourge of HIV and AIDS has destroyed the family fabric which has been a means of providing safety nets and shielding OVCs (Fraser et. al. 2011:50). The extended families and the community upheld the concept of "*Unhu/Ubuntu*" embedded in the African culture of caring for each other within families and communities. The nuclear family and extended families set-up have been greatly affected by HIV and AIDS. Masuka et. al. (2012:60) posit that the extended family culture of caring has begun to disintegrate and the safety net provided by these extended families to OVCs is undergoing tremendous social and economic change that has a direct impact on the care and support for OVCs. For example, in Zimbabwe, during the economic meltdown from 2000 up until 2009, there has been break-up of extended families, especially with regard to the productive members as they migrated to other countries in search of employment and better living conditions, leaving the elderly

without much strength to work and produce resources for the care and support of OVC.

As a result of these migrations and the rise in cost of living, family ties have also been stretched hence the rise in community-based initiatives. The OVC crisis has awakened the need for alternative solutions to the problems of OVCs. These new alternatives gave prominence to the growth of CBOs and their interventions (Rusakaniko, et. al. 2010:10). The HIV and AIDS epidemics and the reduction in the caring capacity of the government for OVCs became a major concern for the communities to provide care and support to OVCs (USAID, STRIVE Project 2008:38). Omwa & Titeca (2011:31) suggested that there is need to conduct studies that assess the viability and capacity of community members to support OVC as this would better inform policy debates on how much assistance should be directed to the communities by government and NGOs. This study investigated the challenges faced by community-based interventions in Mutare city, Zimbabwe to further inform policy debates as suggested by Omwa & Titeca (2011:32).

2.2 THE HIV AND AIDS EPIDEMIC

2.2.1 Nature of the HIV and AIDS epidemics in Africa

The HIV and AIDS epidemics remain one of the most serious health challenges globally and regionally according to the UNAIDS Global HIV and AIDS Report (2012:36). HIV and AIDS has affected the socio-economic status of people across the African continent, with sub-Saharan Africa bearing the biggest share of the global burden (UNAIDS, WHO, UNICEF Global HIV and AIDS Report 2014). Of the global 34 million people living with HIV in 2013, 23.5 million adults and children are from sub-Saharan Africa (UNAIDS, 2012:36). The sub-Saharan Africa region continues to bear the burden of HIV and AIDS worldwide. The above statistics indicates the intensity of the HIV burden in sub-Saharan African countries. HIV and AIDS prevalence vary between countries and regions within Africa, for example the Southern Africa sub-region continues to experience the most severe HIV

epidemics in the world with 34% of all people living with HIV globally in 2013 residing in ten countries in Southern Africa (UNAIDS 2014:19).

However, there have been smaller proportions in the populations living with HIV and AIDS in the Western and Central Africa where the adult HIV prevalence was estimated to be 2% or less (Global HIV and AIDS Report 2012). Since 2001, the UNAIDS (2012) indicates that the number of newly infected people in North Africa has increased by more than 35% from 29 000 to 46 000 from 2001 to 2012. Sub-Saharan Africa remains severely affected with nearly 1 in every 20 adults living with HIV and accounting for 69% of people living with HIV worldwide by 2012. UNAIDS (2012:35) further suggests that, the epidemics in eastern Africa began declining by year 2005 and have since stabilised in many eastern countries. In 2011, 1.7 million people died from AIDS-related causes worldwide yet sub-Saharan African accounted for 70% of all the people dying from AIDS in 2011 (WHO, 2012). North Africa experienced significant increases in mortality (Global HIV and AIDS Report 2011), while sub-Saharan Africa experienced decline of 32% from 2005 to 2011 of people dying from AIDS-related causes. This alarming percentage of AIDS-related deaths shows the magnitude of the OVC burden the sub-Saharan region has. UNAIDS (2012:36) postulate that since 1995 antiretroviral therapy has saved 9 million life-years in sub-Saharan Africa and this has increased employment prospects among individuals receiving antiretroviral therapy thus subverting further increase of OVCs.

Between 2001 and 2014, most African head of states have been actively involved in the quest to reduce new HIV infections by being signatories to the global HIV and AIDS Declarations for example, UNGASS Declaration which member states committed to mitigate the epidemic impact on children by implementing national strategies to support OVC.

Zimbabwe currently has an operational national OVC plan. The Zimbabwean OVC national plan ensures that OVCs are able to access education, food, health services, birth registration and protection from abuse

and exploitation (BRTI, 2008:141). Southern Africa in particular, where HIV and AIDS accounted for 80% of all people who died from AIDS in 2013 have experienced a downturn in AIDS-related mortality in recent years (UNAIDS, 2014).

This downturn is attributed to favourable changes in risky sexual behaviours, increases in condom use and uptake of voluntary medical male circumcision which was recommended by WHO and UNAIDS in 2007 (Global HIV and AIDS Report 2012).

The question asked by many researchers is why the Southern African region is burdened by HIV and AIDS more than any other part of the world? Research has been carried out by both independent researchers and government ministries of health to find out the drivers of the epidemics. According to the Republic of South Africa Global Report (2012:30), Malawi, Zambia, Botswana, Zimbabwe, Mozambique, Lesotho and Swaziland all have similar drivers of the epidemic as indicated in their Global HIV and AIDS Reports (2012). All the above mentioned countries shared the same drivers of the epidemic. For example, from surveys and surveillance conducted in these countries, drivers of the epidemic were identified as intergenerational sex, multiple concurrent partners, and a low level of condom use, excessive use of alcohol and low rates of male circumcision. Malawi also cited discordance in long-term couples where condoms are not being used, late initiation of HIV treatment, transactional sex related to income and other social and material benefits, gender inequalities, including harmful cultural practices such as cultural/sexual initiation practices that often expose young girls to HIV, and stigma and discrimination.

Intergenerational sex was found to be driven by subsistence needs and materialism, owing to unequal power dynamics in relationships, causing exacerbated vulnerability for young girls who may not have the skills and power to negotiate for condom use (Global HIV and AIDS Report 2012). Research suggests that concurrent sexual partnerships – sexual relationships that overlap in time – are common in South Africa. South

Africa's HIV and AIDS epidemic remains the largest in the world with an estimated 5.6 million people living with HIV in 2013 (UNAIDS 2014:19:).

The epidemics in Botswana, Namibia and Zambia declined especially among women between 2004 and 2008. Mozambique, Lesotho and Swaziland also seem to follow suit in HIV prevalence decline, however, in all these countries, the proportion of the population living with HIV remains exceedingly high (UNAIDS, 2014:20). The Southern Africa sub-region continues to experience the most severe HIV epidemics in the world according to the UNAIDS (2012:51) Report.

Most of the HIV transmission in sub-Saharan Africa is through heterosexual contact and mother-to-child transmission during pregnancy, at birth and through breastfeeding (UNAIDS 2012:18). This indicates the need for behaviour change in the affected populations' sexual behaviours for HIV incidence to decline and to be realised towards the proposed zero new HIV infections (Zimbabwe Country Report, 2014). Governments in the different country reports for 2014 (UNAIDS, 2014:49) were urged to scale up ART supplies to all health institutions and human resources for health workers so that the PMTCT programme could be accessed by most mothers, even in the remotest parts of the country, to save the lives of children and also to ensure zero new HIV infections in the case of unborn children (UNAIDS, 2014:30).

The Southern African countries' Global HIV and AIDS Reports (2012) also show similar trends in percentages of urban to rurals' 15 - 49 years rate of infection by 2012. Zambia, for example, had the highest percentage of adults aged 15 to 49 years infected with HIV at 23.1% in urban areas to 10.8% in rural areas (Zambia Country Report, 2012) , Malawi 17% in urban areas and 9% rural (Malawi Country Report, 2012), Botswana 19.1% urban and 17.1% rural (Botswana AIDS Impact Survey III, 2008), Zimbabwe's HIV prevalence was found to be modestly higher also in urban areas than in rural areas with a 14.7% and 15% rate respectively (ZIMSTAT, 2011:239).

2.2.2 Nature of the HIV and AIDS epidemics in Zimbabwe

Zimbabwe is a land locked country which is located in the Southern African region, the current epicentre of the global AIDS pandemic. UNAIDS (2014) reported that in 2013, about 81% of all people living with HIV resided in sub-Saharan Africa region, Zimbabwe being part of that region (UNAIDS, 2014:49). The USAID, PEPFAR study (2012:42) found that HIV and AIDS spread faster in conditions of poverty, powerlessness and social instability. Zimbabwe has endured economic and political hardships since year 2000 up to 2009 when the inclusive global political agreement was formed between the three main political parties: MDC-T, ZANU PF and MDC-N. The political agreement of 2009 was disbanded in July 2013 when the ruling party ZANU PF won the national elections with the majority votes. The next general elections will be held in 2018.

The Zimbabwean dollar was also discarded in 2009 due to hyperinflation and multi-currency was introduced in order to alleviate poverty and revive the economy. The introduction of multi-currencies helped Zimbabweans to be able to import food and medicines and shops were filled. During the hyperinflationary period all shops ran out of food supplies and industries closed. The rate of unemployment was alarming and people could go for days without food (USAID, 2008:38).

From the Zimbabwe (Central Statistic Office Census 2012) it is estimated that Zimbabwe has a population of 12.7 million. Of the 12.7 million people, an estimated 1.400,00 adults and children were living with HIV and AIDS in 2014 and an estimated 597,293 adults and children were in urgent need of antiretroviral therapy by end of 2011 (UNAIDS, 2014). HIV and AIDS are also prevalent among children in Zimbabwe. Duri, Babill & Muller (2013:18) suggests that mother to child transmission (MTCT) of HIV is a huge problem in Zimbabwe, which has become the major cause of infant and child mortality by 2013 it was the most significant (90%) source of HIV infection in children below the age of 15 years. As of 2014, it is estimated that about

190 000 children between the ages 0 – 14 were living with HIV and AIDS of which 3.4% of children aged 10 years are long-term survivors following MTCT (NAC, 2014)

UNAIDS (2014:29) suggests that in 2013 sub-Saharan Africa experienced a decline in HIV prevalence due to, among other factors, sexual behaviour change, reduction in multiple sexual partners and the uptake of condom use. Zimbabwe is the first country in Southern Africa to record a significant, sustained decline in the national prevalence of HIV infection among adults, which fell from 29% in 1997 to 16% in 2007 and to 13.1% in 2012 (UNAIDS 2012). The National AIDS Council (NAC, 2014) further indicates that Zimbabwe had an HIV and AIDS decrease of new infections from 1.18% in 2012 to 1.05% in 2013 (NAC, 2014). The Zimbabwe Demography and Health Survey (ZDHS 2012:199) ascribed the decline in HIV prevalence and Incidence to change in sexual behaviour, in particular a drop in the number of sexual partners, increased condom use and mortality.

The ZDHS (2012:205) further indicates that the mode of HIV transmission in Zimbabwe remains predominantly sexually driven and sexual transmission accounts for over 90% of new infections. According to the *Modes of Transmission* study conducted by ZDHS (2012:213), the majority of new infections occur in the 20-29 age groups. This is the reproductive age group which has been found to be vulnerable due to unemployment as the nation is coming out of sanctions and a hyperinflationary environment which hindered economic growth. NAC (2014) postulate that Zimbabwe continues to be one of the countries in the world with a high HIV infection rate, with about 1.4 million people in Zimbabwe estimated to be living with HIV and AIDS by 2013 and over 905, 368 people who are in need of ART in 2014 (NAC 2014). Opportunistic Infections and Antiretroviral Therapy (OI/ART) was introduced by MoHCW in 2004. 60% of all ART patients in 2013 were reported to be females and males were found to be coming late for ART initiation as they came for the services when they were too sick (NAC 2014).

Despite economic hardships and sanctions that saw many NGOs reducing or withdrawing their funding from the Zimbabwean government, antiretroviral coverage has increased from 55% in 2009 to 93%⁷ in 2014 (Zimbabwe AIDS Response Progress Report 2014:6). Zimbabwe has shown a 38% decline in general mortality rates after antiretroviral therapy access was expanded (Zimbabwe AIDS Response Progress Report 2014:9). Despite the lack of donor funding, Zimbabwe continued to experience a decline in HIV prevalence as it focused its response to HIV and AIDS on educating people to stop having multiple sex partners (Foster: 2010). Foster further suggested that Zimbabwe's response has focused on behaviour change rather than simple condom use promotion because research has shown that Uganda made great strides in reducing HIV prevalence and incidence due to behaviour change among the population.

Evidence for changes in sexual behaviour surveys were conducted by National Statistic Agency (ZIMSTAT) in 1988, 1994, 2005 and 2010 - 2011 respectively. The HIV prevalence in 2012 was found to be modestly higher in urban areas than in rural areas (17% and 15% respectively). The decline was attributed to behaviour change, availability of ART and the uptake of medical male circumcision (MMC). Zimbabwe adopted MMC as one of its key HIV prevention strategies.

The social and sexual behaviour change according to a study conducted by Gregson (2006:25) in one of Zimbabwe provinces, Manicaland was attributed to economic hardships experienced in Zimbabwe since year 2000 resulting in poor and limited resources. Gregson (2006:28) indicated that in a resource strained environment, people reduce substance and alcoholic abuse which researchers found to be partly responsible for irresponsible sexual behaviours that facilitate the spread of HIV and AIDS. The survey participants reported that due to socio-economic challenges, they delayed sexual debut, increased condom use and had fewer non-regular partnerships (Gregson, 2006:28). The Zimbabwean government increased

access to ART which prolonged lives of those living with HIV to work and to provide for their children. Although HIV prevalence is declining in Zimbabwe at 15% in 2014, the prevalence is still considered high compared to other eastern countries with a 2% HIV prevalence (NAC, 2014).

Zimbabwe's first HIV and AIDS case was reported in 1985 but sadly in Zimbabwe, there had been so much denial by government and health institutions until 1990 when HIV and AIDS issues started being debated in the public domain (Duri et. al. 2013:18). The government of Zimbabwe in 2009 rolled out a full scale public education on issues surrounding HIV and AIDS (Zimbabwe Country Global AIDS Report 2012). Zimbabwe's HIV epidemic has unfolded in a context of multiple other hardships, including recurring droughts, food shortages and a wide range of political and economic problems but just like Uganda, Zimbabwe is mentioned among a few countries where HIV prevalence has significantly declined.

2.3 SITUATION AND PLIGHT OF OVCs

2.3.1 Situation and plight of OVCs in Africa

David, Nkomo, Mfecane, Skinner & Ratele (2006:74) conducted a study on interventions for OVCs and the core dynamics affecting OVCs in the communities of three countries, namely South Africa, Botswana and Zimbabwe. The study found that poverty was felt to be the major factor that would lead to OVCs not being cared for in future. OVCs were found to be more vulnerable due to poverty, abuse, violence and many other causes. The UNAIDS (2014:26) Global AIDS Epidemic Report indicates that more than 24% of the children who acquired HIV infection in 2014, live in Sub-Saharan Africa. The Malawian Global AIDS Report (2012), postulate that the number of OVCs in Malawi has increased tremendously due to the HIV and AIDS epidemics. A lot of young reproductive men and women have died and continue to die, leaving behind children and elderly men and women who cannot take care of themselves. In 2010, 12.6% of the children aged

less than 18 years in Malawi were orphaned. In 2010 and 2011 OVCs in Malawi had increased to 623,466 from 576,458 (UNAIDS, 2014).

Owing to an overstretched social fabric, some of these OVCs have been left destitute without proper care and support, which leaves them at risk of abuse and exploitation that may ultimately bring them into the HIV and poverty vicious cycle. By 2012, 17% of children in Malawi aged below 18 years were either orphans or vulnerable (Malawi Country Report, 2012). UNAIDS (2012:42), estimates that over 3 million (19.6%) children in South Africa are orphaned and vulnerable. More than 90% of children who became infected with HIV in 2013 live in sub-Saharan Africa, while there has been some decline in the number of newly infected children in six countries like Burundi, Kenya, Namibia, South Africa, Togo and Zambia. North Africa is the only region that has yet to see a reduction in the number of children newly infected (UNAIDS, 2014:32).

The reduction in newly infected children is attributed to the increase and uptake of antiretroviral therapy or prophylaxis by pregnant women especially in the sub-Saharan region which was at 59% and 86% by 2013 of the children with HIV infection who live in sub-Saharan Africa, the region with the highest prevalence of HIV infection among women of reproductive age.

USAID, UNICEF, UNAIDS and World Food Programme (WFP) in 2005 carried out a Rapid Country Assessment, Analysis and Action Planning (RAAAP) in 17 sub-Saharan Africa countries to assess the level of support for OVCs and to identify and analyse the range of services being provided to OVCs. The RAAAP survey found that families and communities have long been the safety nets for a sustainable response to the OVC crisis and that caregivers in all 17 countries reported that without immediate direct financial support, OVCs' access to food, healthcare and education will deteriorate. The study also confirmed that poverty among families and communities in sub-Saharan countries hindered the good initiatives of OVC care and support.

Across all 17 countries, it was noted that OVCs had challenges in obtaining birth registrations due to stringent government systems and requirements for birth registrations. For example, in Zimbabwe for a child to receive a birth registration, one need to either have the child's birth clinic/hospital card as proof that the child was delivered there, the father or mother's identification card or one has to bring a witness who can testify that they know the child's parents. Terminally ill parents of OVCs find it difficult to endure the long waiting ques to be served at the registrar's office which has the national mandate to issue birth and death registrations.

For those children whose parents have died, studies have found that other extended family members may fail to produce the required documentation to register the orphans. Facing such challenges, OVCs find it difficult to obtain official records like birth certificates and national identification (ID) cards which are used to conduct business transactions. OVCs may also fail to obtain passports since one needs a birth certificate and ID to register for a passport, as some may receive scholarships to further their education in other countries. The highlighted OVC challenges were found to be common across many African countries.

2.3.2 Situation and plight of OVCs in Zimbabwe

UNICEF (2010:15) suggests that Zimbabwe has one of the highest rates of OVC in the world with 25% of all the children in Zimbabwe either staying with terminally ill parents or one or both parents having died due to HIV and AIDS related causes of death. The National AIDS Council of Zimbabwe (NAC 2014) reported that by 2014, Zimbabwe had 889,319 OVCs. NAC (2014) also indicated that not all OVC have been identified or assessed for support, hence not all OVCs are receiving support. Challenges identified by NAC were the government's financial constraints to meet the needs of OVCs, inadequate monitoring and evaluation systems to monitor the provision of basic services to OVC, lack of capacity within government to facilitate OVC service delivery like health care and educational needs and inconsistent quality of service for OVCs. Rusakaniko et. al. (2010:29) posits

that irrespective of the declining trend in HIV prevalence in Zimbabwe, the prevalence of OVC continues to rise. Duri et. al. (2013:18) postulates that the ever-increasing OVC numbers has created new social costs for the state and households to bear, resulting in situations where grandparents and communities struggle to fend for OVCs. Gurutsa (2011:53) posit that although the government of Zimbabwe has established a baseline for its National Action Plan (ZNAP) for OVCs, it has failed to meet its obligation of caring for OVCs. The ZNAP was first established in 2004 and its mandate was to ensure that OVCs are able to access education, food, health services, and birth registration and are protected from abuse and exploitation through coordinated efforts by government and communities, with the full participation of OVCs.

Munyati, Rusakaniko, Mupambireyi, Chandiwana & Mahati (2006:61) conducted an OVC census in 2003 in two Zimbabwean districts, namely Chimanimani in the Manicaland province and Bulilimamangwe in the Matabeleland South province. The study found that OVC prevalence in the two districts was 16%. The study also found that Zimbabwe had no population figures available for OVCs at national level. The data available on the OVC population was found to be fragmented, scant and only available at organisational level. For example, NGOs, government departments, schools and CBOs had their own registers indicating the number of OVCs provided with care and support by these different organisations. The study found that urbanisation and the AIDS epidemic challenges that prevailed in Zimbabwe since 2005 had, to a large extent led to the erosion of the practice of having safety-nets for OVCs provided by the extended family or communities.

The Biomedical Research and Training Institute (BRTI, 2008:144), carried out a situational analysis of services and support systems for OVC in 2006 in 21 districts of the 56 districts in the country. These are administrative districts situated in 10 administrative provinces in the country. Their study found that the living conditions of OVCs were generally poor; food was cited

as the main need by OVCs, as well as educational assistance. With the deteriorating economic situation in Zimbabwe and the weakening of support structures at all levels, that is, at individual, family and community levels, OVCs have been negatively affected. Rusakaniko et. al. (2010:30) posits that the burden of OVCs was becoming heavy on the communities as they sometimes found it difficult to cope due to strained resources.

The main needs of OVCs reported in the study done by Rusakaniko et. al. (2010) were food, financial and educational needs which were also identified by RAAAP in 2005 in 17 sub-Saharan Africa countries. Several studies have noted that before the advent of AIDS, OVCs were usually absorbed within extended family networks. The extended family, as a traditional social security system in many African countries, has been weakened because parents, aunts and uncles are dying of AIDS-related diseases. Apart from the HIV and AIDS epidemics, the extended family is under severe strain as a result of migration, demographic changes and a trend towards the nuclear family structure (BRTI, 2008:29).

In responding to the OVC crisis, the traditional leadership has revived the traditional safety-net concept called *Zhunderamambo/Isiphala seNkosi* (chief's granary) (Foster, 2008). This is a traditional system in which a chief or village head reserves a piece of land for community use. All household/families under his/her jurisdiction are supposed to contribute labour to till the land and tend the produce from the plot. The seeds are donated by the government or NGOs. The produce is harvested and kept under the control of the traditional leader, who then distributes it to families in need of food. The study found that communities were trying by all means possible to reduce the suffering of OVC, but were failing in some instances due to poverty (BRTI, 2008:141). On the other hand, it was reported that some families were not supportive of OVCs as they first looked after the needs of their biological children before giving attention to the OVCs under their care. The study also indicated that some caregivers assigned OVCs to do difficult household tasks, such as herding cattle, while they did not give

their biological children the same kind of hard work. Child labour as it is not recognised in most communities in Zimbabwe, because people argue that children have to be taught life skills (BRTI, 2008:141).

In the same study conducted by BRTI in 2008, it was reported that some OVCs were asked to work in the fields or look for firewood or water before going to school and at times they would not be given food. If they did not work, some OVCs were said to be denied food while others were forced into early marriages by guardians. Poverty was also found to be forcing some OVCs to engage in prostitution. A qualitative study done by the “*Regai Dziveshiri*” (let the young people fly like birds) Project in Manicaland found that when a household cannot afford school fees for all children, OVCs are forced to drop out first and have to then spend time at home doing household chores. In a Manicaland HIV and AIDS prevention study conducted in 2005, caregivers and OVCs reported that children living in extreme poverty experience psychosocial disorders like depression, anxiety, social integration, self esteem and behaviour challenges (BRTI:2008). These psychosocial disorders were found to have negative effects on OVCs’ social behaviours and school performances as some never received grief and bereavement counselling when their parents died or when they were caring for their terminally ill parents.

Rusakaniko et. al. (2010:37) in their National household survey of *Trends in the burdens of OVCs*, found that OVCs affected by HIV and AIDS suffer numerous deprivations and vulnerabilities such as dissolution of family, depression, malnutrition, lack of access to education and health care, homelessness, stigma and discrimination, abuse, increased risk for HIV and other sexually transmitted Infections and unintended pregnancies. Parental AIDS-related illness and death often lead to changes in living arrangements, displacements and reduced resources for schooling, health care and food. Economic difficulties in Zimbabwe have forced some female OVCs to engage in transactional sex for money or goods to sustain themselves and their siblings.

In Mutare city, no survey has to date been conducted in the district to determine the exact number of OVCs and as a result, there is no centralised database for OVC (BRTI, 2008:144). NGOs, CBOs and individuals working with OVCs have their own registers or numbers of OVCs to whom they provide assistance. The Ministry of Education, Sports and Culture concurred with BRTI, (2008:141) that OVCs crisis was getting out of hand as approximately 50% of the children in the schools were OVCs. Lack of control was cited as a major problem among OVC because they had no one to control their behaviour and give guidance on good norms and values. Sexual abuse of OVC by elderly people, some of whom are their guardians, was reported to be on the increase. Some OVCs failed to report the sexual abuses as they felt that if they were to report these cases, they would have no shelter, food or education, especially if they were under the custody of the abuser.

Poverty was cited as a factor that may force OVCs to engage in early sexual activity, thereby compromising their future and putting them at risk of HIV (Rusakaniko et. al. 2010:29). BRTI (2008:145) study came up with recommendations from caregivers in urban settings that government should provide food handouts in towns as they do in the rural areas. Giving food handouts to rural communities only was felt to be discriminatory. A social worker reported that other than material things, communities should also give love and affection to OVCs.

USAID Zimbabwe in 2006 carried out an assessment on OVCs and reported that OVCs dependency on community members carries inherent risks as the basic survival needs of volunteers become more critical, they have less time to help OVC (USAID, 2006). Chandiwana's (2009:41) study found that the main threats faced by OVCs are the same as those previously highlighted by other researchers, for example, shortage of material resources such as food, school stationery, clothing, shelter, blankets, school uniforms and sanitary pads for girls. Chandiwana (2009:48) suggests that there should be

training of guardians in child care, nutrition and drug adherence for those children who were born infected with HIV and who are on ART.

From the studies carried out in Zimbabwe on OVCs and their well being, challenges and services provided by different organisations and the government reviewed above, it is evident that OVCs are living in difficult conditions and are subjected or exposed to many risks, such as HIV infection and sexual and child labour abuses. In the light of all the challenges faced by OVCs, the government and communities have taken some steps to try and alleviate their plight. The government has come up with policies and guidelines that are directed at protecting OVCs. Some of these policy documents and guidelines are discussed below.

2.4 POLICY DOCUMENTS THAT GUIDE THE RESPONSE TO THE PLIGHT OF OVCS IN ZIMBABWE

2.4.1 Zimbabwe National Action Plan (ZNAP) for OVCs

Zimbabwe has made progress in planning and developing its national response to the challenges faced by OVCs in the light of the country continuing to play host to the epicentre of the epidemic (Cardoso, 2010:29). Gandure (2009) suggests that the Zimbabwean National Action Plan (NAP) for OVCs was set up to deal with the increasing number of OVCs due to burgeoning poverty and the effects of HIV and AIDS-related adult deaths. The overall framework of the NAP aims to provide for the protection, care and support of OVCs living in a world of HIV and AIDS through a comprehensive set of interventions which include birth registration, education, health care services, food, water and sanitation provision, child protection, psychosocial support, strengthening coordination structures for OVC programming and increasing OVCs' participation in programmes (Tiku, 2006:41). The NAP also seeks to standardise the quality of services that community structures, the government and other stakeholders provide to OVCs.

The NAP according to Cardoso (2010:31) was developed as a tool to advocate for increased mobilisation of action by the government and other stakeholders to support OVCs. The Ministry of Public Service, Labour and Social Welfare is responsible for the dissemination of the NAP guidelines and implementation information to all government ministries, other civil society organisations and major stakeholders involved in OVC programming and services. The NAP's approach is to reach out to communities and strengthen their capacity through the government structures of the Department of Social Welfare and other stakeholders such as NGOs, in order to identify and provide psychosocial and material support to OVCs. The implementation of the NAP is donor-funded in Zimbabwe, mainly by Save the Children UK and UNICEF.

A case study conducted by Cardoso and Save the Children UK (2010:32) on the monitoring, implementation and review of the NAP since its launch in 2005, has indicated some gaps and challenges in the implementation process. The case study found that a major aspect of successfully implementing the NAP for OVCs was to build or strengthen coordinated structures within communities in order for them to meet the quality of service delivery as set out in the NAP. The study indicated that there was little evidence regarding community structures providing care and support for OVCs, especially since measures to strengthen such structures had not been evaluated in terms of their long term impacts. However, the case study noted that the initiation and expansion of community-based organisations structures for OVC care is useful to learn more about the current state of best practice.

The study recommended that although communities continue to be key players in providing care and support to OVCs, their role should not be considered a substitute for involvement and accountability by the government. The study further recommended that programmers should introduce mechanisms to assess the effectiveness and impact of community-based organisational structures aimed at improving OVCs'

wellbeing and that the assessment needs to be in line with both qualitative and quantitative indicators relating to service delivery as stipulated in the NAP of 2005. Further recommendations state that such evaluation should focus on the cost, sustainability and effectiveness of such structures. Government was urged to establish functional social services within the spaces where OVCs live, for example, by providing physical structures such as schools with qualified human resources, quality services and with the necessary allocation of funding for social services.

The case study's findings show that during the first five years of the NAP implementation, gaps and challenges were exposed and that there were some positive indications of how the NAP framework could help improve the lives of OVCs if identified gaps and challenges could be resolved. The NAP is a ten year plan which runs up to 2015 and Save the Children UK and UNICEF are major funders of this Action Plan. The question asked is, would the government of Zimbabwe continue with this framework when funding timelines come to an end and to what extent would the NAP have impacted on the lives of OVCs? Cardoso (2010:33) posits that the government of Zimbabwe has the political will to continue with the NAP beyond 2015 funding; however, the challenge is that the nation is still recovering from economic meltdown and as a result, funding may be a hindrance to the sustainability of NAP.

2.4.2 Basic Education Assistance Module (BEAM)

The educational needs of OVCs are targeted through the government's Basic Education Assistance Module (BEAM) where communities identify OVCs and register them at schools for school fees payment. The BEAM is administered through the Department of Social Welfare and it provides guidance on how OVCs can be assisted with regard to school fees and examination fees. The BEAM facility was launched by the Government in 2001. BEAM community selection committees are responsible with the selection of OVCs eligible for the BEAM.

The BEAM community selection committees consist of teachers' representatives, community leaders that participate in school selection committees, school development associations, representatives of NGOs and FBOs who are involved in OVC programmes, local authorities and district education officers. This diverse representation was put in place mainly to capture as widely as possible all OVC referrals from institutions or individuals who may know about the plight of OVCs in their respective constituencies (Zimbabwe teachers Association, 2012:16). Nominations for beneficiaries are also submitted by community members to the selection committees. The BEAM programme provides tuition, levy and examination fee assistance. The list of selected OVCs is publicised to enhance transparency and accountability of the selection processes (Tiku, 2006:38).

2.4.3 Medical Treatment Orders (MTO)

Masuka et. al. (2012:64) state that the medical treatment order is a form of assistance provided by government as a waiver or voucher to OVCs to facilitate access to government health services such as clinics, provincial and national hospitals. The medical treatment orders facilitate access to free health services at government health institutions by OVCs through the Department of Social Welfare which is responsible of issuing vouchers for the provision of free medical services to OVCs.

The communities alert the Department of Social Welfare authorities of the medical requirements of OVCs and apply for MTO on behalf of OVCs. Gandure (2009) posits that since 2002, the scheme has faced many challenges due to insufficient government funding, inefficiencies in the health delivery system caused by, among others, a shortage of doctors, with a vacancy rate of 72% to be filled. Shortage of all categories of medical drugs is rampant in all government health institutions. This state of affairs has resulted in these free treatment orders being an ineffective social protection service for OVCs seeking medical help (Masuka, et. al. 2012:64). These challenges makes the treatment service unpredictable, inconsistent and of poor quality, resulting in the service not being fully beneficial to OVCs.

2.4.4 OVCs Birth Registrations

The National Action Plan Report (2009) baseline findings suggests that a significant 28% of OVC participants did not have birth certificates, which are a basic requirement for every individual to claim citizenship in Zimbabwe and in any other country the world over. The Zimbabwe Children's Act, the Guardianship of Minors Act (art. 7 and 8) states that a "child has to be registered immediately after birth, to have a name and have nationality". The right to identification therefore, becomes one of the fundamental child rights. The Department of Social Welfare intervenes by assisting OVCs to get birth certificates. Community awareness and education has been conducted by the government through their legal outreach programmes to assist OVCs with birth registrations through identification of some of the relatives who could facilitate the birth registration processes (Masuka et. al. 2012:64). In Zimbabwe, birth certificates are required for accessing a number of services such as health facilities, school's examination registration processes and obtaining national identification cards.

However, despite the government of Zimbabwe having ratified most of the conventions and international instruments that guarantee protection of children's rights, and in particular those of OVCs, by putting in place legislation and policies like National Action Policy (NAP) and the Orphan Care policy, to articulate and address the special needs of OVCs. Birth registration remains a challenge for OVCs due to the beauracatic processes involved in attaining a birth certificate if birth registration documents are not in order. In such scenarios where documentation is not in order, the Department of Social Welfare provides documentation to facilitate the birth registration of OVCs. However, the economic downturn resulted in many Social Workers leaving the country for greener pastures in other countries, resulting in a huge gap being created within the government social service delivery to OVCs. The gap left by Social Workers has been filled by community members who have assumed the facilitating role of OVC birth registration (Dhlembeu, 2010).

2.4.5 Zimbabwean National HIV and AIDS Strategic Plan (ZNHASP 2011 -2015)

The Zimbabwean National HIV and AIDS Strategic Plan, (ZNHASP, 2011 – 2015) estimates that by December 2011, there were about 800,339 OVCs in Zimbabwe. Through the ZNHASP, the government has adopted a decentralised and collaborative approach to the care and support of OVCs. This national AIDS policy recognises that the foundation of an effective response to the plight of OVCs is to reinforce the capacities of families and communities as first line providers of OVC care and protection since government social service delivery systems crashed in 2005 till to date 2015 due to economic meltdown.

During the period 1985 to 1999, biomedical interventions in Zimbabwe emphasised controlling the prevalence of HIV infection and ignored some of the most important issues, such as the plight of OVCs. Initially, government departments and top government officials were also complacent in accepting the presence of HIV and AIDS and its effects on the adult population and on children. In 1999, the government of Zimbabwe embarked on a broad-based and multi-level consultative process to develop the National AIDS Policy (UNAIDS 2012:41). This policy was developed “in order to promote and guide present and future responses to AIDS in Zimbabwe” (National HIV and AIDS Policy Zimbabwe1999:2). The policy helped to address the impact of increasing numbers of AIDS-related orphans and vulnerable children. For example, the government introduced free access to the ART programme, which resulted in reduced morbidity and mortality. Some studies have shown that ART is prolonging the life expectancy for persons living with HIV and in turn, parents have opportunity to work for their children’s upkeep (Duri et. al. 2013:113). The policy also states that the rights of children and young people infected with, or affected by HIV and AIDS must be protected and that these children should have access to knowledge and life skills needed to prevent becoming infected with HIV.

After developing the National AIDS Policy, still in 1999, the government of Zimbabwe put in place the National Orphan Care Policy which provides basic care and protection guidelines for orphans and includes a commitment of resources to enhance access to education and health services (BRTI 2006:3). The National AIDS Policy also has a component that deals with care and support programmes for OVCs, specifically addressing child abuse, stigma and counselling.

2.4.6 Zimbabwean National Action Plan (NAP for OVC)

The National Care Policy of 1999 led to the drafting of the Zimbabwean National Action Plan (NAP) for OVCs in 2004, which was based on the Save the Children Norway's (SCN-Z 2004) HIV and AIDS mitigation project and was endorsed by Cabinet in 2004. The NAP for OVCs was set-up to deal with the increasing numbers of OVCs due to burgeoning poverty and the high mortality rate as a result of HIV and AIDS pandemic. The NAP's approach is to reach out to communities and strengthen their capacity through the government structures of the Department of Social Welfare and other stakeholders such as CBOs and NGOs in order to identify and provide psychosocial and material support to OVCs.

The NAP is now a legal document that is used in Zimbabwe to strengthen community-based support systems as an indirect means to assist OVCs and build the capacity of community-based systems for sustaining care and support to OVC households over the long term (Mahati, Chandiwana, Munyati, Chitiyo, Mashange, Chibatamoto & Mupambireyi, 2006: 53). The NAP involves two different phases of four years in duration, Phase I was initiated in 2004 and the four year duration ended in 2010. Phase II was developed in 2011 and its duration runs up to 2015. Both Phases I and II are jointly managed by donors (through basket funding to UNICEF) where different donors channel all their financial support through UNICEF and UNICEF further manages the implementation of NAP through the Zimbabwean Ministry of Public Service and Social Welfare. Phase II builds on the successes of and lessons learnt from NAP Phase I for OVCs which

was launched in 2005. The successes noted were that community organisations, if given support by the government and other stakeholders such as NGOs, provide a better service to the OVCs as they know the immediate needs of the OVCs in their communities.

The volatile political and economic environment in Zimbabwe impacted negatively on the implementation of the NAP (Phase I) as this programme was donor dependent. During the volatile political times of 2002, farm invasions and the passing of NGOs Bill, it became difficult for NGOs to operate in Zimbabwe as a result of political interference by the government. Subsequently, most NGOs withdrew their support from the Zimbabwean government projects and this stifled the implementation of NAP (Phase I). It is this slow pace of the government's interventions to address the plight of OVCs in Zimbabwe that has led to communities taking it upon themselves to assist orphans and vulnerable children (Cardoso, 2010:32).

2.4.7 Children's Protection and Adoption Act of 1999

In Zimbabwe the Children's Protection and Adoption Act of 1999 [Chapter 5:06] provides legal protection in terms of children's inheritance of their deceased parents' assets and their right to have birth certificates (Masuka et. al. 2012:59). This Act provides minimum standards and guidelines for civil society to monitor and respond to the situation of OVCs. Furthermore, the UNGASS Country Report (2007:27) suggests that the high number of OVCs in Zimbabwe resulted in community intervention initiatives to provide and facilitate educational, medical, legal and psychosocial assistance to OVCs. Establishing these community interventions, however, posed some challenges as the country since 1998 up to 2014, has been experiencing socio-economic challenges. Zimbabwe has become increasingly isolated in the international community since the year 2000, both politically and economically, due to some policies such as the Land Reform Bill. In 2000 the government authorised its chaotic land redistribution programme, with most of the white owned farms being seized and redistributed to war veterans. With limited experience in large commercial farming and difficulty

in obtaining bank loans, the new farm owners were unable to properly cultivate the land and food production in Zimbabwe declined rapidly.

What followed were a series of events that plunged the nation into deep poverty, for example, severe macroeconomic instability resulted in continuous economic decline, characterised by hyperinflation, chronic shortages of basic commodities and a decline in essential social facilities. Zimbabwe's economic situation was further worsened by political and economic isolation which further plunged the nation into unprecedented economic conditions characterised by an inflation rate of 100,000% by January 2008. (AVERT 2011:4). At that time, the economy had a one hundred trillion dollar note circulating which was worth buying only bread and a packet of sugar (see Figure 1 below). This further exacerbated the plight of OVCs as the macro economic developments had clear repercussions for their welfare. For example, there were increased cases of child malnutrition due to shortage of food. The NGOs' food distributing programmes were stifled by government under the NGOs Bill due to political reasons. Below is a picture of a one hundred trillion bearer cheque which was circulated around 2008, demonstrating the hyperinflationary environment and the desperate situation Zimbabwe was in.



Fig 1A one hundred trillion bearer cheque

2.4.8 Non-Governmental Organisations (NGO) Bill on OVC Programmes

The 2004 NGO Bill banned some of the NGOs' activities and this effectively limited external humanitarian support for the country's OVC programmes. This Bill was viewed by NGOs as hostile to the international community, for example the NGOs Bill that was passed had stringent registration processes. This crippled some of the NGOs because of government interference in NGO operations (UNDP, 2009). Some of the stringent NGO registration processes imposed by the government were that, before any registration is granted, NGOs should provide names, nationality and addresses of their funders, 3 year plans and their constitutions which must provide prescribed information requested by government.

The NGO Bill governs the operations of all national and international NGOs in Zimbabwe. During the hyperinflation period, it became very difficult for NGOs, especially those who were involved in the OVC feeding programmes or school fees payments, as the value of the Zimbabwean dollar depreciated every hour and made it very difficult to compile budgets and provide 3 year plans. It is equally difficult even in this present day for NGOs to give such projected 3 year plans under the multicurrency phase (it is not yet known when Zimbabwe will have her own currency) and the effects of new currency to prevailing budgets and programme plans. Under this new NGO Bill, NGOs are further required to register annually and pay annual registration fees. NGOs argue that these processes are too bureaucratic in nature and lead to delaying the implementation of projects since NGOs do not have control as to when they receive funds (Red Cross, 2009).

The government, through the NGO Bill, requires that whatever assistance these organisations might offer ought to be channelled through the relevant government ministries. This has been a major bone of contention between the government and the NGOs as, NGOs see government as corrupt and ineffective beyond any hope in terms of development of the poor (Red Cross, 2009). The NGO Bill is therefore viewed by NGOs as a draconian

piece of legislation which the ZANU PF Party, being the majority in government, uses to advance their political interests to the poor by using NGO resources and presenting to poor communities NGO interventions as government initiatives to alleviate the suffering of the people (Red Cross, 2009). Consequently the intended OVC beneficiaries may further be disadvantaged and not receive the support intended for them due to political interference.

These stringent registration and operations requirements according to Moyo, (2005) severely affected the NGOs that were working with OVCs, especially in cases where their activities were not approved by the government, and NGOs had to suspend their services until they submitted a plan which was supported by the government. This unprecedented economic downturn brought about increased poverty which, in turn, increased the social and economic marginalisation of already disadvantaged groups like OVCs. However, a positive development came forth in 2009 when the Zimbabwean Government of National Unity, which was formed in 2008 authorised the use of the United States Dollar, the British Pound, the South African Rand and the Botswana Pula as official trading currencies. Currently, Zimbabwe still has no currency of her own.

The above mentioned political and economic challenges has strained extended families, once the safety nets for vulnerable children, as they are fast disintegrating due to poverty, high rates of unemployment, hyperinflation and the impacts of HIV and AIDS epidemics (NAP 2010). Foster (2005:12), defines safety nets as the formal or informal mechanisms that mitigate the effects of poverty and other risks on vulnerable households during times of severe stress. The vulnerability of children is therefore now in the limelight due to the breakdown of the various coping mechanisms that existed in the past, especially community coping mechanisms, such as “*Zhunde raMambo*” (Chief’s granaries) where communities pooled together their resources and worked on common fields whose harvests assisted a family in need by providing it with food from the granaries (Mashunje, 2006).

Unfortunately persistent droughts and economic challenges in Zimbabwe have reversed the gains of this community service initiative and have negatively impacted on the care and support of OVCs due to poor crop harvests. Because of the deepening poverty, it has become a challenge for households and communities to absorb OVCs when they cannot afford to provide for their own basic needs (Mashunje, 2006). Foster, (2005:11) suggests that poverty among households has resulted in the OVC crisis becoming more amplified and the extended family safety nets, as the first line defence for OVCs, also becoming vulnerable to the socio-economic shocks.

Foster (2005:12) further postulates that where extended family and community safety nets are both weakened, poor households and OVCs facing income shocks are in danger of slipping through both safety nets, ending up destitute. Despite the HIV and AIDS epidemic, poverty, economic and political challenges having destroyed the social fabric of extended family and community safety nets in Zimbabwe, it seems that communities have remained resilient and that the HIV and AIDS epidemics and economic shocks have generated greater cohesion among community members in response to OVC crisis (Foster, 2005:15).

2.5 COMMUNITY-BASED INTERVENTIONS FOR OVCS

The United States President's Emergency Plan for AIDS Relief (U.S. PEPFAR, 2012:125), suggests that community members serve as frontline responders, identifying and responding to OVCs in crisis before they come to the attention of governments and that they also monitor their well-being and advocate on their behalf. The community is the first to know about the plight of OVCs as the latter lives among them. The community may also be the first line of help which these OVCs may seek help when they are in economic or psychosocial distress. Cardoso (2010:32) share the same views as PEPFAR (2012:125) that community-based interventions form an integral part of the response to ensuring that the needs of OVCs are addressed, as they provide first line support and act as safety nets. Omwa &

Titeca (2011:29) postulate that community-based interventions are the most cost-effective way of meeting OVCs' needs as resources are pulled within community structures. According to them a typical community OVC response initiative is characterised by voluntarism, a consultative decision making process and community reliance on own resources or services.

According to Foster, (2008) voluntarism among community members stem from the African culture which originally looked at a child as being the responsibility of the whole community in terms of care and support and guidance in both good and bad times. Consultative decision making processes have always been part of the African culture where members of the clan discuss clan issues and agree on the way forward with the involvement of the local community elders. Abebe (2009) posits that some community based initiatives rely on their own resources, often derived from revolving savings from savings associations' set-up -to help community members who may need short term loans for their basic needs, care and support of OVCs. However, Mathambo and Richter (2007) suggests that very little is known about the underlying forces that drive, motivate and sustain their initiatives in cases of multiple shocks from the impact of structural forces like HIV and AIDS, poverty and conflict.

A study conducted by Omwa & Titeca. (2011:38) in Northern Uganda, sought to get a better understanding of the forces which drive community initiatives, the challenges they face and opportunities which many OVC community initiated groups can nurture (if appropriately supported). From this study on community-based interventions for OVCs, two schools of thought emerged, firstly the social rupture thesis which argued that there is a total breakdown in family structures and that the traditional social support systems and safety nets for OVC care are overstretched and eroded. The study revealed that the support systems provided by families and communities are collapsing at an alarming rate due to strains imposed by the escalating numbers of OVCs (Omwa & Titeca. 2011:37). According to the second school of thought, the social resilience thesis, which was

developed in response to the criticism on the social rupture thesis, contends that families and communities are not disintegrating and support systems are not faltering but communities are rather responding with innovative systems (Abebe & Aase, 2007). The supporters of the social resilience thesis therefore believes in a community's ability to withstand hardships without necessarily altering a community's values, exploiting opportunities and resisting or recovering from negative effects of changing environment (Abebe & Aase, 2007). This resilience is demonstrated for example by initiatives such as community members' out-of-pocket spending or in-kind-gifts towards OVCs care and support.

BRTI (2008:146) concur with Omwa & Titeca (2011:38) in that their study's findings indicate that community OVC care and support initiatives are funded by community members where they contribute some money which is used to purchase uniforms, food, and clothing and to pay school fees for OVC. Some communities are able to provide food to OVCs through the establishment of nutritional gardens where produce from the garden is given to OVCs for consumption and some garden produce is sold to provide money for school uniforms. OVCs were also found to be assisted in establishing small projects such as vegetable gardens and selling sweets and *maputi* [pop corn] to raise money for their food and soap (BRTI, 2008:149).

The Boston University (2010:23) reviewed some literature on OVC care and support and their findings identified various community-based interventions as only providing for the basic necessities of life such as food, shelter, clothing as well as psychosocial support. The Boston University (2010:24) also found that not much research has been done specifically to address the issue of situating community-based initiatives at the forefront when it comes to meeting the needs of OVCs, or the debate surrounding forces which drive communities' determination to care for and support OVCs and address the challenges they face as they execute their interventions.

Rusakaniko et. al. (2010:29) conducted a cross-sectional survey of psychosocial experiences of OVCs in the Chimanimani and Bulilimamangwe districts of Zimbabwe, and the study was conducted in preparation for a future OVC intervention. The researchers found that 25% of OVCs had feelings of unhappiness, worry, frustration, anger, fear or sleep problems. About 5% of OVC said they sometimes think about committing suicide due to the problems they face, such as physical and sexual abuse, and are afraid to report such cases as some of the abuses are perpetrated by close guardians and if they report abuses, they risk being evicted from their homes. Among 15 to 18 years old OVCs, 47% reported that their guardians were treating them caringly, 9% reported they were treated roughly and 24% said they were treated differently by their guardians compared to the guardians' own children.

The study recommended that programmes should train caregivers and communities to understand grief and bereavement and how to help children cope with emotional problems. Rusakaniko et. al. (2010:30) study further recommend that government and NGOs should provide counselling training to the community members caring and supporting OVCs to reduce anxiety and help OVCs report cases of sexual and physical abuse to the police.

Schenk et. al. (2010:333) reported that community-based interventions for OVCs take many forms, including educational assistance, home-based care, legal protection and psychosocial support. Educational assistance is provided by paying school fees and providing school uniforms for OVCs by the community, while home-based care is provided to parents of OVCs who are chronically ill to alleviate the burden carried by OVCs to care for their sick parents so that they may be able to attend school while knowing someone is taking care of their sick parents. With regards to community-based interventions, legal protection is provided by community members who facilitate the reporting of cases of sexual or physical abuse of OVCs to the Zimbabwean Republic Police and the Department of Social Welfare for perpetrators to be prosecuted in the courts of law.

UNICEF (2006:43) posits that community-based interventions are the most practical way to help OVCs given the financial and human resources limitations of the public sector and government. For example, Zimbabwe for the past decade has been going through hyperinflationary socio-economic challenges resulting in a brain drain of professionals such as doctors, nurses and social welfare workers whose services left a huge gap in the care and support of OVCs. Some of the community-based interventions in Zimbabwe are facilitated by social workers through the Department of Social Welfare who issue for example, medical treatment orders to OVCs for them to receive free treatment at government health institutions. A shortage of human resources such as doctors and nurses in these government health institutions further defeats government initiatives aimed at alleviating health related challenges for OVCs since such intended free treatment cannot be provided due to shortages of medicines.

The USAID, (2012:125) suggests that community-based interventions are the most cost-effective way of meeting OVCs' needs since resources are pulled within community structures. The community's response to issues of OVCs has largely been based on the extended family providing care and support from resources pulled within the family structures (USAID, 2012:125). The family institution emphasises the need to provide to every extended household member economical and psychosocial support. However, in Zimbabwe due to economic hardships that has resulted in unemployment, traditional family and community mechanisms to support OVCs have been under considerable financial strain, resulting in more children facing difficulties accessing education and other basic amenities such as shelter and food. Cardoso (2010:31) posits that communities are finding it hard to support and protect OVCs because of limited resources such as food, money to pay school fees and buy school uniforms as the urban economy has not been able to absorb those in need of gainful formal employment. In the last decade the number of OVCs in Zimbabwe has

swelled to unprecedented levels and this can be attributed to economic meltdown and the HIV and AIDS pandemic.

The urban areas have been experiencing a number of challenges in the past decade, such as unemployment, chronic shortages of basic commodities such as food, water and shortage of shelter, which resulted in most families only caring for their nuclear family members (Rusakaniko, et. al. 2010:30). The decline in essential social services saw Zimbabwe slide into a complex socio-economic crisis which further precipitated household and individual poverty as well as vulnerability and consequent social exclusion of OVCs. The ripple effects of households' socio-economic challenges and government's failure to provide social services resulted in OVCs being cared for and supported by the larger community, which may not be either paternally or maternally blood-related to them (USAID, 2012:126). Such effects of family safety nets being eroded due to the AIDS epidemic, socio-economic challenges and poverty may have long term effects on family values and norms not being passed on to OVCs. Furthermore, the separation of siblings may further destroy the bonding of siblings (UNAIDS, 2009:11).

A lack of bonding between siblings as they grow-up may further perpetuate individualism among OVCs as they may not have been nurtured in the same way and different norms and values may have been imparted to them as they are raised in different environments. USAID (2012:126) concur with UNAIDS (2009:11) that extended families and communities provide the foundation for children's well-being and provide a social setting where children grow, develop and thrive and the same family or community norms and values passed on to them.

However, there are some community projects that have been evaluated and found to have demonstrated sustainable and replicable models of good community-based care for OVCs. In Malawi for example, the Community-Based Options for Protection and Empowerment Project (COPE) is a project

that was implemented with the help of the Save the Children Federation of the US (SC-US). This project has utilised a systematic approach to mobilising community-based responses to the needs of OVCs as a result of the impact of HIV and AIDS. Through this COPE project, communities mobilised themselves to provide care and support that included food, clothes, school fees, nurseries, communal gardens and money raised through fund raising activities (Strebel, 2004:9).

2.5.1 Family AIDS Caring Trust (FACT) brief history

FACT was instituted in 1987 by Dr. Foster as Zimbabwe's first AIDS service organisation in response to HIV positive people who needed home-based care and has worked with community-based volunteers since its inception. Dr. Foster worked through the local churches to recruit and train community volunteers to provide counselling and home-based care services to families including children. Dr. Foster's initiatives are supported by World Bank (2011:16) which suggests that community responses are initiated by individuals or existing structures either in response to the needs of others [which is what Dr. Foster did, responded to the needs of others] in the community or in response to their own needs

The initiative was to provide psychosocial, apart from medical support which was provided in hospitals and clinics. As the burden of illness in families grew, the focus turned from just providing home based care for the sick parents to finding ways of alleviating the plight of OVCs as parents became too sick to work and provide for their children or parents succumbed to AIDS related illnesses resulting in death. FACT is an organisation run by Board of Trustees chaired by Dr. Foster supported by five other board members, Programme managers, finance and administration managers, nurses, counsellors, social workers and other support staff. (FACT Report 2011: 10). FACT Report, (2012: 6) indicates six pillars of programmes, administrative departments and sources of funding for different FACT interventions.

The six pillars are as follows:

1. Health and HIV (Palliative care and HIV).
2. Research and knowledge management (community ethics research Sensitization and monitoring and evaluation of all FACT programmes and interventions.
3. Livelihoods
4. Behaviour change
5. Orphans and vulnerable children
6. Finance and administration

All the above mentioned FACT pillars have various funders and specific operational requirements. This study's main focus is on one of FACT's six pillars which are the orphans and vulnerable children.

Through its six pillars, FACT writes project proposals to source funding for various interventions. Some of the funding agencies identified by the FACT Report (2012:6) are as follows:

- Regional AIDS Training Network
- United Nations International Children's Emergency Fund (UNICEF)
- United States Aid International Development (USAID)
- Churches under Tearfund UK and Netherlands
- World Health organization (WHO)
- Canadian International Development Agency (CIDA)
- United States Department of Health and Human Services Centre for Disease Control
- Research Triangle International (RTI)
- United States President's Emergency Plan for AID Relief (PEPFAR)
- Evangelischer Entwicklungsdienst (EED)
- United Nations Population Fund (UNFPA)
- Global Fund (GF) and National AIDS Council (NAC) of Zimbabwe
- Christian Education Development Relief (CEDR)

2.5.2 Simukai Child Protection Programme brief history

Simukai Child Protection Programme is one of the leading CBOs offering street-kids a second chance to rebuild their lives. It was set up in 2000 as a community response to the plight of abused, neglected and abandoned children who are found in the streets. Simukai was founded by Scripture Union Eastern Region with the help of FACT which was involved in home based care for those adults with HIV and AIDS. It had been set up by the Family Aids Caring Trust, Scripture Union and Roman Catholic Church in an attempt to alleviate the suffering of street-children (Simukai Annual Report 2010:8). Simukai is run by Management Board incorporating youth drawn among the beneficiaries of OVC programme.

The management Board is supported by professionals like teachers, social workers, nurses, finance and administrative staff, community volunteer caregivers and funding partners. Simukai as an organisation aims to rehabilitate street children through directly building relationships of mutual trust and respect with OVCs. Simukai offers different programmes to OVCs from Mutare urban streets, like education and rehabilitation, medical support, counselling, psychosocial, behaviour change, spiritual counselling, recreational and livelihoods activities. Simukai operates in the high density suburbs of Sakubva, the oldest and overcrowded high density suburb in Mutare, Dream House and Garikayi suburbs. Simukai networks with other organisations such as the following indicated on the table below:

Organisation	Services offered
Family Support Trust	Medical Examination
Justice for legal Trust	Legal advice
Victim Friendly Unit-Police Department	Survivors of abuse report cases to this department
Psychological services	Psychological assessment to OVCs
Department of Social Services	These are the custodians of children according to the constitution of Zimbabwe as such refer children for place of safety

Table 1: Simukai service collaborating organisations: Source: Simukai Annual Report 2011

Simukai heavily relies on funding from their partners to support the OVC programmes. According to Simukai Annual Report (2012:11) some of Simukai funding partners are as follows:

- HOPE HIV
- Swedish organisation for Individual Relief
- Five Light Foundation
- UNICEF-Funded National Action Plan for orphans and vulnerable children
- Local well wishers

2.6 CHALLENGES FACED BY COMMUNITY-BASED INTERVENTIONS FOR OVCs

2.6.1 Situating challenges faced by community-based interventions for OVCs

Rusakaniko et. al. (2010:29) contends that very little has been done to examine trends in challenges faced by community-based organisations in providing care and support for OVCs. The national OVC household survey conducted by Rusakaniko et al. (2010:30) from 1994 to 2006 found that there is need to further conduct studies that will inform policy makers on challenges faced by CBOs when providing community-based interventions.

Information from such studies would significantly inform the expanding CBOs and interventions provided for OVCs. The communities in Mutare and other parts of the country have taken it upon themselves to respond to the effects of HIV and AIDS on OVCs due to the death of their parents or having to take care of terminally ill parents.

These community initiated responses are derived from the cultural roots, norms and values that encourage mutual responsibility. For example, in Mutare, Zimbabwe, such cultural norms and values are referred to as “*hunhu*”, meaning being a responsible human being in caring for others and self. These community initiated responses are a result of shared community resources and experiences grounded on the traditional value of keeping families together (Rusakaniko et. al. 2010:34). Communities provide care and support for OVCs by using their scarce resources such as finances, food, clothes and shelter which are basic in meeting the survival needs of OVCs. Major challenges faced by community-based interventions related to the care and support for OVCs highlighted in the national OVC household survey results conducted by Rusakaniko et. al. (2010:34) were: providing basic materials for OVC such as food, clothes and shelter, educational needs and.

The national OVC survey results also indicate that community leaders reported that getting food was a problem because in Zimbabwe, food is very expensive as the country heavily relies on food imports from neighbouring countries. Foster (2008) further postulates that, other challenges are that communities themselves are emotionally and psychologically stressed by the impact of HIV and AIDS on OVCs, as well as the demands that are placed on themselves to provide care and support for OVCs. As a result of the above mentioned challenges, Foster (2008) suggests that community volunteers opt out of OVC programmes and OVCs are left with few or no caregivers to support them. Rusakaniko et. al. (2010:8) in their National household survey of OVCs found that as the number of OVCs increases,

the range of interventions for them also has to increase, which further strain the CBOs' interventions and resources.

David et. al. (2006:74) study identified some challenges faced by CBOs in providing care and support for OVCs. Some of the highlighted challenges identified by David et. al. (2006:74) were lack of money and resources, as the insufficient financial support impacts on the number of OVCs to be served. The study further identified lack of participation by the majority of the community as affecting effective community delivery of services to OVCs, such as home visits and the provision of food. The study also found that those community members who volunteer to participate in the care and support of OVCs tend to lack skills, such as financial management skills, due to their low levels of education, which may result in the misuse of money targeted for OVC use. Unemployment, poverty and a shortage of food were also cited as major problems (Deters & Bajaj, 2008:38). This study therefore, seeks to further examine the challenges faced by community-based interventions for OVCs in Mutare, Zimbabwe.

2.6.2 Resources

Cardoso (2010:29) and Save the Children UK, in their study that reviewed national plans of action for OVCs in Southern and East Africa found that communities play a fundamental role in providing the first line of support although their capacity and resources continue to be stretched as the cumulative burden of HIV and AIDS, poverty and food insecurity increases. BRTI's (2008:149) study on a situational analysis of OVCs in eight districts of Zimbabwe found that most resources, such as financial resources and assets were becoming depleted due to the chronic illness of people living with HIV and AIDS. Since most of these resources were being channelled towards treatment and nutritional foods for the sick many children are being left vulnerable to food shortages and money shortages for school fees.

The depletion of resources within the communities is further exacerbated by the current socio-economic situation in Zimbabwe which has resulted in

OVCs' basic survival needs of food and health services being unmet. Gurutsa, (2011:60) contend that the severe economic decline of the past decade, persistent droughts and shortage of foreign currency to import food for the nation have further endangered OVCs and their families, causing high unemployment, significant out-migration and food insecurities. A skilled farming labour force also succumbed to HIV infection and AIDS-related illnesses, resulting in reduced food production and harvesting of crops.

The Boston University's (2010:24) review paper also cited that the capacity of extended families and communities to adequately care for OVCs is highly constrained in Zimbabwe, resulting in most families having to resort to reducing the number and quality of meals. This study by Boston University (2010:23) further found that some OVCs were being pulled out of schools and their productive assets being sold to raise money for basics necessities such as food, shelter and clothes. USAID-Zimbabwe (2009:62) believes that the majority of OVCs have no extended family networks to rely on for their food and health needs and only 30% of OVCs have been reached by support services, leaving about 70% of OVCs without any help due to the impact of hyperinflation on national budgets, further burdening community members caring for OVCs. Chandiwana (2009) cited by SAFAIDS (2010:12) suggests that shortage of material resources such as school uniforms, sanitary wear for girl children, shelter, clothing and blankets has resulted due to a lack of financial resources since Zimbabwe is currently using multi-foreign-currency and communities are now finding it very difficult to get hold of the scarce hard currency.

Lack of resources may also have resulted in the non-implementation of laws and policies such as the Sexual Offenses Act, Children's Act, Education Act, Guardianship of Minors Act and Age of Legal Majority Act. All the above mentioned Acts are meant to protect all children and especially OVCs. For example, the situational analysis study conducted by BRTI in 2008 in eight of Zimbabwean districts found that many community members violated some of laws such as Sexual Offenses Act, Child Labour Act and the Legal

Age of Majority Act. Some of the OVCs were reported to be having been denied food, chased away from home, exploited for their labour, denied access to education and forced into early marriages as punishment for refusing to do some household chores (BRTI, 2008:150).

Lack of human resources due to brain drain, which has resulted in most professionals leaving the country for greener pastures in foreign countries, was also cited as a contributing factor for government's failure to reach out to communities and educate them on these laws. The results of the BRTI (2008:149) study also found that some communities were aware of the laws and policies, especially about child labour which states that children aged 5 to 11 years working in economic activities are considered to be engaged in child labour, yet communities/families consider this as training a child to learn to work for their survival. The Children's Act states that every child has a right to live, to have food and to have access to health services and shelter but the BRTI (2008:146) study noted that some OVCs were denied food or sent away from home as a disciplinary measure for failing to participate in domestic work such as digging in the garden to help meet family needs.

Beating a child is physical abuse and such practice is prohibited under the Children's Act, while community members said beating should not amount to ill treatment but be considered as form of enforcing discipline in children. In such instances, enforcing laws was a challenge as there are delays in reporting such cases resulting in OVCs living in abusive homes silently (BRTI, 2008:146). Children in Zimbabwe therefore, seem to be subjected to a dual legal system comprising of customary law and legislation found in the Constitution and statutes (NAP 2010:34). Community interventions might be in contrast with some of the legal laws but in compliance with customary laws, such as beating a child is considered a form of enforcing discipline. SAFAIDS (2010:12) posits that OVCs programmes should channel resources towards training community members in the laws that affect

children so that they are aware of such laws as they implement care and support interventions for OVCs.

2.7 SUSTAINABILITY OF COMMUNITY-BASED INTERVENTIONS

Omwa & Titeca (2011:28) in their study on community-based initiatives in response to the OVC crisis in North Central Uganda noted that community-based interventions were more sustainable when community members are able to identify with, adopt and take ownership of such initiatives. Omwa & Titeca (2011:28) further established that sustainability of community-based initiatives is realised as this approach builds upon traditional systems of child care and require less training and input from external sources and community members can easily identify and accept the initiatives from within themselves. For example in Zimbabwe, the OVC crisis led to the traditional leadership to revive the traditional safety-net concept called “*Zhunderamambo*” (Chief’s granaries) where all households/families under the jurisdiction of the chief contribute labour to till the land and tend the produce from the field.

Community members find it acceptable to provide labour in the field as this practice does not require any financial resources from their strained budgets but only labour. The harvest is kept under the control of the traditional leader, who then distributes it to families in need (Foster, 2008). The seeds and other farming inputs like fertiliser are usually donated by the government or NGOs. This type of community leadership involvement, leads to the harnessing of local resources and bring about a sense of ownership which is important to the long-term sustainability of the response to OVC care and support (Abebe 2009).

The sustainability of the granaries approach however, may be affected by droughts of which Zimbabwe is prone to or delay in provision of farming inputs. Poverty has also been identified as a major hindrance to the sustainable development of community interventions (UNICEF, 2007:77). Poverty among community members and families could be reduced by

increasing household investments such as savings, livestock, land for growing crops and the ability to generate income. For example, micro-credit where small amounts of credit is availed to groups of community members to support existing community activities, would enhance sustainability of community-based interventions (UNAIDS, 2009:62).

Abebe (2009) noted that OVC community-based initiatives' over-reliance on volunteers to sustain the response to OVC crises without incentives to keep volunteers motivated has resulted in high attrition rates of volunteers. Economic hardships were also cited by Abebe (2009) as a contributing factor to high attrition rates among community volunteers and this has affected the long-term sustainability of OVC care and support as community volunteers search for resources to take care of their families. SAFAIDS (2010:43) suggests that there are too few success stories documented to inform the sustainability of programs run by community members due to a lack of expertise to evaluate their efforts.

Some examples of success stories of community-based interventions in Zimbabwe cited by SAFAIDS (2010:17) are the "*Zvandiri*" project (which simply means "as I am"). The *Zvandiri* project was established in 2004 by a medical doctor in Harare, the capital city of Zimbabwe, with the help of other community members, to provide psychosocial support to OVCs living with HIV. The OVC support group started with twenty children and youths and by 2010 the support group had fifty OVCs. Funding for the support group came from individual community members.

"*Zvandiri*" 's interventions include ART adherence counselling, positive living education, recreational activities such as dancing clubs, skills training in sewing and cooking and assistance with education and medical bills. The interventions also emphasised the training of peer educators who will be able to carry on with the work on their own. Income generating projects like sewing and production of story books ensures sustainability of the project as OVCs are involved in the activities. Government and donor support should

therefore be encouraged to stimulate community awareness and responses to achieve sustainability (USAID, 2010:35).

2.8 THEORETICAL FRAMEWORK

2.8.1 Introduction

This section of the dissertation explores the theoretical frame of reference employed for this study. The collective efficacy theory is employed in this study to explore challenges faced by community-based interventions in Mutare city, Zimbabwe. The social cognitive theory, from which collective efficacy was developed, posits that individual behaviour is primarily learned through observation of others, as well as through interaction with the environment (Dimopoulou, 2012:515). The social cognitive theory of human functioning was developed by Bandura in the mid 1980s in order to explain how individuals develop and how the human behaviour is interlinked with the self and the influences of the environment. Collective efficacy refers to the perceived “performance capability of a social system as a whole” (Dimopoulos, 2012:516).

2.8.2 Collective efficacy theory

Based on the social cognitive theory, Bandura expanded the construct of self-efficacy to the larger, social construct of collective efficacy within group settings (Goncalo, Polman & Maslach, 2010:17). The concept of collective efficacy is similar to self-efficacy in that it focuses on the amount of effort and persistence dedicated to a task and the perception of the success of that task (Bandura, 2000:75). Collective efficacy is therefore a component of the social cognitive theory which contends that people have little motivation to take action if they do not believe they can create change (Bandura 2000:77).

With the advent of HIV and AIDS epidemics, Zimbabwe has been experiencing an increase in the number of OVCs who are in dire need of help to meet their basic needs like food, shelter, clothes and access to

health services. In response to the plight of OVCs, community-based organisations were formed to mitigate the suffering of OVCs. It appears that communities believed they could make a difference in the lives of OVCs as enacted in the concept of collective efficacy, which highlights the capacity of residents, organisations and other groups to exert social control and thereby reduce crime, violence or social problems within communities (Swatt, Varano, Uchida & Solomon, 2012: 5). Collective efficacy reaffirms the importance of thinking about social ways to approach social problems and plays a protective role, particularly in at-risk communities (Sampson et. al. 2006:112). The scourge of HIV and AIDS, and the increase in the number of OVCs in Zimbabwean communities and the world at large has awakened communities to be proactive in protecting families and communities from the shocks of the epidemic.

Angelle & Niles (2011) state that the concept of “community collective efficacy” captures the link between cohesion in working trust, mutual engagement and shared expectations for action. Goddard, LeGerfo & Hoy (2006) further contend that as a group construct, the level of collective efficacy is essential to understanding the norms of an organisation or group by “encouraging certain actions and discouraging others” as well as establishing common expectations for action and goal attainment and group’s response to problems. Goncalo, Polman & Maslach, (2010:18), however, posit that as the group develop roles and responsibilities as well as their task related abilities and work styles, “conflict related to controversies over how a group should go about completing a shared trust may arise”.

Goncalo et. al. (2010) research on collective efficacy, conflict and group performance found that, as groups go through initial forming stage in which the members get to know each other, test interpersonal boundaries and orient themselves to the tasks, negative consequences may be experienced by the group. Such negative consequences could be in form of process conflict where a strategy on how to solve the problem and logistical issues

such as “scheduling deadlines and division of labour can affect the group’s execution of task” (Goncalo et. al. (2010:35). It is therefore prudent at the formative stages of groups, to allow some time to pass in order for the group to learn its teammates’ expertise. Such expertise are characteristics of what people bring to the group right from the start, for example, collective efficacy may be influenced by characteristics of the group itself such as knowledge, skills and abilities of other group members.

The diverse knowledge, skills and abilities in a group may be the source of conflict if there are dominating voices. Angelle & Niles, (2011:17) postulate that the success of the collective efficacy approach to community governance is tied ultimately to the equitable implementation of “voice” in the process of building a working trust among the group members. Giving each group member the opportunity to share their ideas on ways to approach social problems allows group members to interact and consolidate their ideas. Dimopoulos (2012:516) states that “group attainments are the product not only of shared intentions, knowledge and skills of its members, but also of the interactive, coordinated and synergistic dynamics of their transactions”.

Collective efficacy influences what people choose to do as a group, how much effort they put into group’s objectives and their persistence when the group fails to produce results (Bandura, 2000:77). The literature on the work that has been done in Zimbabwe and Africa as a region in response to the plight of OVCs, confirms what Bandura, (2000) observed during the development of the construct of collective efficacy in the early 1980s. Bandura, (2000:78) further asserts that a group’s success is related to what team members believe they can accomplish collectively. Collective efficacy therefore, as a shared belief that the group can execute a task successfully, becomes fundamental to the group’s motivation, performance and effectiveness. Sampson et al. (2006:113) describes “collective efficacy” as resource that is activated in crucial times, an example of this was seen in the United States when individuals took personal action to control disorderly

and criminal behaviours in their communities. Collective efficacy in Sampson et al. (2006) implied that when disruptive behaviours erupted in the community, people in those neighbourhoods had the cohesiveness to act in an “effective” way to solve the particular problem (Sampson et al. 2006:112).

In the case of this particular study, the following critical question should be asked: What caused the community in Mutare city to intervene in the OVC crisis? The answer may lie in the concept of collective efficacy. The willingness to intervene by the community in helping OVCs may also be similar to the willingness to guard OVCs from susceptibility and vulnerability to HIV infection so that the scourge of HIV is minimised among them. These collective community interventions may also help in the development and socialization of OVCs to be responsible citizens. Cohesiveness to act in the OVCs crisis has resulted in community initiatives for the care and support of OVCs. Collective efficacy is generally defined as shared willingness among communities to intervene on behalf of the common good, for example, in this case taking action to alleviate the plight of OVCs. Researchers like Frankenburg (2004), Fagen (2005), Spradlin (2006), Gibson (1999), Mozerolle, Wickes and McBroom (2010), Sampson (2004) and Carol and Reese (2005) have carried out some research on collective efficacy in different settings in the United States and their research findings highlighted some similarities and differences on how collective efficacy can impact a community, negatively or positively.

Fagen (2005:81) asserts that the model of collective efficacy argues that it is the communities with common goals, values and beliefs that experience high levels of collective efficacy and in turn low levels of street crimes. Could this above mentioned statement be relevant with regard to the urban setting of Mutare city where people of different origins, cultures, professions, norms and values could come together as a group and work together towards caring of OVCs? Could such a diverse group of people work together for the cause of OVCs and not experience any challenges?

This study aims to uncover and explore some of the challenges faced by community-based interventions for OVCs in Mutare, in the context of collective efficacy approach to interventions and the ways in which organisations such as FACT and Simukai conduct their operations within the community. Spradlin (2006) indicates that other studies have found that there are certain neighbourhood characteristics that must be present for collective efficacy to develop in a community. Some of identified characteristics by other researchers such as Goncalo, Polman & Maslach, (2010), Dimopoulou (2012), Bandura (2000) and Swatt, Varino, Uchida and Solomon (2012) are:

- The presence of friendship
- Networks
- Residential mobility and poverty
- Knowledge, skills and abilities of other group members in relation to the attainment of a specific task, for example, care and support of OVCs.

Mutare city lies in the eastern border with Mozambique and has recently experienced an influx of some foreign nationals due to diamonds discovered in Marange which is a few kilometres away from Mutare city. Mutare city has become a residential area for some of the foreign workers in the Marange diamonds mines which further increase the diversity of norms and values of the Mutare city community. The characteristic of friendship and kinship in such a mixed community may cause challenges for a successful degree of collective efficacy development in order to provide care and support to OVCs.

The issue of residential mobility and poverty in Mutare city may also be a source of challenge for collective efficacy since Zimbabwe is currently going through economic challenges and this has resulted in people being mobile and having a community that is ethnically heterogeneous. It is therefore

possible that some of these characteristics could contribute to challenges faced by community-based organisations' interventions for OVCs in Mutare city. Can some of the above identified collective efficacy characteristics be a source of challenge for community-based interventions for OVCs in Mutare since the communities in the Sakubva, Dangamvura, Chikanga, Hobhouse, Dream House and Garikayi/Hlalanikuhle townships where FACT and Simukai operate, are mostly economically disadvantaged?

Sampson and colleagues cited by Spradlin (2006:36) postulate that collective efficacy is more often found in structurally organised communities whereby community members create a sense of agency and assume ownership for the state of the community. Cultural variables such as trust and cohesion also influence the levels of collective efficacy. Studies done by Sampson and colleagues also found that established value systems within the community facilitate a high degree of social control within the neighbourhood. Their studies concluded that collective efficacy is influenced by cohesion, working trust and willingness to intervene in times of social problems in a community.

Collective efficacy therefore, is strong when individuals feel a sense of belonging to the group and when individuals become tolerant of diversity within their group. Spradlin (2006:38) concluded in his study that tolerance of diversity in skills, knowledge, abilities and norms and values of the group, leads to a sense of belonging. This sense of belonging leads to cohesion (value similarity) and this cohesion leads to collective efficacy. Collective efficacy therefore becomes a process where participation of every group member is important and the issues that lead the group to trust and become cohesive, become an integral part of collective efficacy. USAID (2010:47) suggests that the collective action of community-based organisations' members is enhanced through a participation process. Every group members' contribution is valued and their voices are heard by others and not despised. This participation process facilitates communities to

collectively identify the social problem and agree on approaches in solving the identified social problem.

2.9 CONCLUSION

This chapter reviewed the literature on community-based organisations' interventions for OVCs and some of the challenges they face in the care and support for OVCs. The HIV and AIDS epidemics remain one of the most serious challenges globally and in sub-Saharan Africa. Although Zimbabwe's HIV prevalence has been declining in the past decade, the OVC crisis remains a major challenge as OVC numbers continue to increase. The plight of OVCs has been documented in a number of literatures and concerns a lack of basic necessities such as food, shelter, clothes and a lack of access to health and education services.

Zimbabwe has enacted some laws and put in place policies in response to the plight of OVCs, however, due to economic downturn, the government has faced some challenges in enforcing some of the laws due to lack of financial and human resources. Poverty in Zimbabwe has been cited by researchers as stifling community-based interventions. As the country is experiencing socio-economic challenges, community resources have been stretched and this has negatively impacted on the care and support given to OVCs by community members. The sustainability of these community-based interventions has been found to be under threat as a result of the economic downturn in Zimbabwe. Collective efficacy has been found to influence what people choose to do as a group and how much effort the group put towards the successful attainment of their task.

In the next chapter, qualitative research design using case study method is defined and explained in detail how it was applied in this study. Sampling procedures using nonprobability purposive sampling are discussed; data sources and data collection methods used in this study are described below. Data analysis and interpretation using cross-case analysis to facilitate comparison of commonalities and differences in OVC care and support activities and processes within FACT and Simukai are elaborated in the next

chapter. Issues of validity and reliability are discussed and steps taken to ensure validity and reliability. Ethical issues of confidentiality and informed consent are explained in detail below. Pilot study to test data collection instruments for this study is also explained in the following chapter.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter describes the methods used in conducting the case study research, undertaken to explore in-depth the challenges faced by two community-based interventions for orphans and vulnerable children in Mutare, Zimbabwe. This chapter explains why the case study methodology was selected, the rationale for procedures adopted in this case study and how the collected data was analysed and reported. This chapter therefore provides, among others, a brief overview of the qualitative research design and outlines the reasons for choosing the case study method over other methodologies.

A discussion of the research design, the case study method, sampling techniques, sample size, data sources, the research instruments, analysis of data, validity and reliability, ethical issues and the pilot study are presented in this chapter.

3.2 RESEARCH DESIGN

The researcher employed a qualitative research design, using the case study method. Qualitative research is a broad approach that seeks to study social phenomenon and to have an in-depth understanding of the activities and perceptions of people. Mack, Woodsong, MacQueen, Guest & Namey (2011:15) posit that qualitative research is an unstructured, exploratory research methodology based on small samples, which provides insights and understanding of the problem. Biggerstaff (2011:177) further suggests that qualitative methods have much to offer when one needs to explore people's feelings or ask people to reflect on their experiences.

Case studies are a means of undertaking a preliminary exploration of a phenomenon through the careful examination of a particular instance. A case study approach was deemed appropriate by the researcher for an in-depth exploration of the challenges faced by two community-based organisations who provide services to OVCs in Mutare city, namely FACT

and Simukai. Yin (2009:347) defines the case study research method as an empirical inquiry that investigates a phenomenon within its real-life context and in which multi- sources of evidence are used. For example, in the case of this study, community members' motivation to provide care and support to OVCs may be influenced by a range of personal, societal and relationships factors. Furthermore, challenges faced by community-based organisations which provide services to OVCs in Mutare, Zimbabwe may also be exacerbated by particular behaviours and complex relationships among community members, OVCs, the government and other stakeholders. The case study approach was employed to explore such experiences of challenges faced by community-based intervention for OVC care and support in Mutare.

Yin (2009:354) further postulates that, the case study method has the advantage that it can be applied to real-life, contemporary, human situations which are also publically accessible through written documentation. Moriarty (2011:15) also defines the case study as an in-depth exploration from multiple perspectives of the uniqueness of a particular project, institution, programme or system in a "real life" context. The researcher consequently chose to use the case study method in this study in order to explore and tap into the real-world, experiences, problems and challenges of the two selected CBOs.

Gilson (2012:163) posit that the case study method is very flexible and can support explanatory inquiry to gain a better understanding of a certain situation or to generate ideas and concepts for use in follow-up work. The case study method also allows for a detailed description of particular experiences at individual and communities/social group/organizational level. The case study research enabled the researcher to gather data from a variety of sources such as in-depth interviews (ie one-on-one interaction between the researcher and key informants) focus group discussions and observations. The case study methodology further enabled the researcher to converge the data to illuminate the challenges faced in two cases of

community-based interventions for OVCs in Mutare city. Moriarty (2011) further posits that case study's advantage of documenting and analysing developments as they occur provides timely insights into the factors that researchers consider to be critical to the outcomes of the case under examination. This case study also helped to document multiple viewpoints and highlighted areas of consensus and conflict.

Baxter & Jack (2008:547) postulate that a researcher should consider using a qualitative case study method when one seeks to cover contextual conditions that one believes are relevant to the phenomena. The above assertion by Baxter *et al* (2008) guided the researcher to seek a contextual understanding of the challenges faced by community-based interventions by FACT and Simukai as pioneer CBOs for OVC care and support interventions in the city of Mutare. Baxter *et al*. (2008:547) further posits that case study research enables the researcher to answer "what, how and why" type of questions while taking into consideration how a phenomenon is influenced by the context within which it is situated. For example, the scourge of HIV and AIDS in Africa and indeed in Zimbabwe has resulted in unprecedented increase in the numbers of OVCs and their plight has resulted in the communities taking initiatives in the care and support of these OVCs. Community-based organisations such as FACT and Simukai were selected for case study analysis because they were the pioneers, ie, the first organisations to take up initiatives related to the care and support of OVCs in Mutare.

The researcher adopted the use of case study approach to explore the challenges faced by community-based interventions for OVCs in Mutare city through the theoretical lenses of collective efficacy. However, a noted disadvantage of the case study is that it is impossible to generalise from a single case or only a few cases. Furthermore, there is a tendency for verification that is, for researchers to use data to confirm their preconceived notions (Suryani, 2008:121). Because of the above mentioned disadvantage of the case study, this case study was used for exploratory purposes – the

data collected may further be explored by other researchers. Suryani (2008) further posits that the credibility of a case study might be enhanced through continuously making descriptions and interpretations during the period of the study. The researcher continuously searched for patterns from data related to the research topic and then organised data according to themes, classifying and editing data during the data collection and analysis stage.

3.3 SAMPLING PROCEDURES AND SIZE

Mack, Woodsong, MacQueen, Guest and Namey (2006:16) define nonprobability sampling as a subjective method used to decide which elements are included in the sample. For example, non-probability purposive sampling was used to select the participants for this study. Mack et. al. (2006:16) further defines purposive sampling as a sampling strategy which groups participants according to preselected criteria relevant to a particular research question. For example in this study the focus was on challenges faced by community-based interventions for OVC care and support provided by volunteer care givers.

Participants from, Simukai and FACT, were selected in order to explore and deeply understand issues related to providing care and support for OVCs in Mutare city, as well as the challenges faced in this regard. Curry et.al (2009) contends that purposive sampling seeks to identify participants based on selected criteria and that purposive sampling is most successful when data review and analysis are done in conjunction with data collection. The criterion on which the decision was made to specifically select FACT and Simukai for this case study was related to the fact that these two CBOs were among the first CBOs to take initiatives in the care and support of OVCs in Mutare city.

To explore the research questions, the researcher requested permission from the two CBOs (Simukai and FACT) to interview community volunteers/care givers and personnel working with these two CBOs (see attached Annexure 1). The terms caregiver and community volunteer will be used interchangeably in this study as the two CBOs use these terms

interchangeably because these persons play the the same roles in the case of these two CBOs. The two CBOs' management teams granted the researcher written permission to interview their staff and volunteers/care givers (see attached Annexures 7 and 8) which enabled the researcher to continue with firstly conducting a pilot study to test the data collection instruments. The pilot study is discussed in more detail in section 3.9 of this chapter.

Two staff members each from FACT and Simukai as well as five community volunteers/caregivers per CBO were individually interviewed in-depth and face-to-face. The names of volunteers were provided to the researcher by the two CBOs' management who facilitated contacting them. In addition, two groups comprising of six members each from each of the two CBOs participated in the focus group discussions as beneficiaries of these organisations' community-based interventions. Permission to participate was sought from all the individuals who participated in the study and was granted by them first verbally before interview date then on interview date, written consent was granted by each participant before the commencement of interview. . The researcher speaks Shona fluently and conducted face-to-face interviews and focus group discussions in Shona language. (see attached Annexure 2)

The researcher was well received by both staff and volunteers of the two CBOs and appointment dates for interviews were set according to the availability of participants. Moriarty (2011:17) suggests that qualitative methods typically focuses in-depth on relatively small samples selected purposefully. Thus, this small sample size used in this study reflects the researchers aim to do explorative, descriptive research. The researcher in this study was not aiming at producing findings that would be statistically representative of the challenges faced by all community-based intervention for OVCs in Zimbabwe, as is the case with most quantitative approaches. Pseudonyms were used for to maintain the confidentiality of the participants.

3.4 DATA SOURCES

The data for this study was generated from both primary and secondary sources. (Boslaugh, 2007) defines primary data as research that produces data that is only obtainable directly from an original source and are data that were previously unknown and which have been obtained directly by the researcher for a particular research study. The primary data originated by the researcher in this study was collected from both FACT and Simukai staff and community volunteers/caregivers through in-depth interviews and focus group discussions with caregivers (see attached Annexures 3 and 4).

Secondary data is defined as a report on the findings of another primary source and data which was not collected by the researcher her- or himself. Secondary sources are research reports that use primary data to solve research problems, written for scholarly and professional audiences (Boslaugh, 2007). The researcher reviewed literature from secondary sources to gain an understanding of the challenges faced by community-based interventions in the care and support of OVCs and used what she read to contextualise their own findings. As part of literature review, the researcher reviewed the two CBOs' OVC registers to have an appreciation of the extent of the burden Simukai and FACT have in support and caring of OVCs. The OVC registers are the two CBOs' own records of identifying how many OVCs are served and by what interventions. These registers also reflected other information such as counselling comments by community members on issues that OVCs go through and need help or referral for further assistance. The information on registers was not used for analysis in this study, but for appreciation of the workload caregivers have in the care and support of OVCs. Most of the secondary sources for this study therefore, are thus reflected in the literature review discussed in chapter 2.

In this regard the researcher used library sources to gather data on community-based interventions for OVCs, and on theoretical models that explained the challenges faced by community-based interventions for OVCs. The theoretical postulations helped in exploring what enabled the

resilience of community members to continue providing care and support for OVCs, the issue of the importance of the norms and values of community-based organisations, factors that facilitated working trust among the community members, group roles and responsibilities, the group's knowledge of issues related to OVC care and support, the skills and abilities of each group member, and how group members share their ideas on OVC care and support as well as the team's shared belief in executing successfully the care and support for OVCs. For a clearer and understanding of these phenomena, several studies conducted on these topics were researched.

3.5 DATA COLLECTION METHODS

The researcher personally collected all the data from the research participants by tape recording all the interviews and FGDs and documenting her field notes in a diary, indicating observations about the interview content, the participant's non-verbal communication and the general environment at the CBOs. All interviews were conducted in the Shona language which is the local language spoken in Mutare city the language preferred by the participants. Participants were asked to identify a suitable and comfortable place for them where the interview could be conducted which provided them with privacy. In this study, the focus group

3.5.1 In-depth Interviews with OVC volunteers/caregivers and CBOs staff

Moriarty (2011:13) defines the in-depth interview as a technique designed to elicit a vivid picture of participant's perspective on the research topic. An "in-depth interview" is further defined as an unstructured direct personal interview in which a single respondent is probed by a skilled interviewer to uncover underlying motivations, beliefs, attitudes and feelings on a topic being researched (Moriarty, 2011:17). In-depth interviews were conducted with key informants from both FACT and Simukai. These key informants included staff from the two CBOs and the community volunteers/caregivers

providing care and support to OVCs in Mutare city. The aim of the interviews was to investigate challenges faced by community-based interventions for OVCs in Mutare city, Zimbabwe.

The semi-structured interviews consisting of open-ended questions were used by the researcher to allow the participants to openly disclose their opinions, experiences, personal feelings and their personal perceptions regarding challenges they face in providing care and support to OVCs and working as a group in their OVC interventions. Zucker (2009:14) posits that in the case of semi-structured interviews, the interviewer needs to have a set of broad questions to ask and the interviewer needs to have identified a number of aspects he/she wants to be sure of addressing. For this study semi-structured questions and aspects that need to be addressed on challenges faced by community-based interventions for OVCs in Mutare were employed, please refer to (Annexures 4 and 5)

The key informant interviews provided data or information which covered most of the important areas covered by the research questions. The process involved identifying CBO staff members who were most directly involved and knowledgeable about their community interventions for the OVCs in Mutare city and the challenges they have experienced in executing these interventions. In-depth interviews were conducted face-to-face with key informants. Mack et. al. (2011:43) contends that key informant interviews are a valuable method of identifying the depth and breadth of the problem areas. The advantage of in-depth interviews is the use of open-ended questions and probing which gives participants the opportunity to respond in their own words (Mack et. al. 2011:43). All four key informants' interviews from both FACT and Simukai were conducted in their respective offices at head office. The first key informant interview at Simuaki with a a key staff member took about 35 minutes to complete while the second interview from the same CBO took about 45 minutes. The two interviews with key informants from Simukai staff were conducted on same day. The FACT interviews with key informants were spaced by a day each and the first

interview with the lasted 40 minutes while the second interview lasted 45 minutes.

The interviews with the community volunteers from both FACT and Simukai were done at their respective homes. The researcher was escorted to each volunteer's home by one of the CBOs' staff, but interviews were conducted in privacy with the participant only, while the CBO staff took the opportunity to do some home visits within the area in which the researcher was conducting the interviews. A whole day was in each case dedicated to interviews from one suburb served by the two CBOs. Two of Simukai volunteers were interviewed on the same day in Hob House suburb while the following day three volunteers from Simukai again were interviewed from Dream House suburb. In a space of a week, the FACT volunteers were also interviewed at their respective homes either from the Dangamvura or the Chikanga and Sakubva suburbs.

Two FACT volunteers were interviewed from the Dangamvura suburb, one from Sakubva and two from the Chikanga suburb. In all of the FACT volunteer interviews, the researcher was escorted by FACT staff who also took this opportunity after the interview was completed, to get feedback from their volunteers and conduct home visits together with their volunteers, which is a practice they normally do once in a while. Each interview with the volunteers lasted between 35 to 50 minutes.

3.5.2 Focus group discussions with OVC the two CBOs' care givers/volunteers

In this study, focus group discussions (FGDs) were used as a method for generating data (insights) from the two CBOs' volunteer caregivers. Mack et. al. (2011:66) defines focus group discussions as guided discussions among a small group of people who share a common characteristic central to the topic of interest. For example, in this study the common characteristic for the FGD participants was that they were all volunteer caregivers who worked with either FACT or Simukai in providing care and support to OVCs in Mutare city and who also were beneficiaries of these services. Mack et. al. (2011:69) further posits that the group interaction can serve as a catalyst

to generate unique insights into understanding shared experiences and social norms. The CBOs' caregivers in this study's FGDs shared their experiences and the challenges they face in providing community-based interventions for the OVC care and support.

The FGDs for all the two CBO volunteer caregivers were conducted in Shona, the local language predominantly used in Mutare city. Permission was sought from the two CBOs working with the OVCs' caregivers. The six participants per FGD for both FACT and Simukai were selected through purposive sampling, that is; by virtue of them being beneficiaries of the care and support interventions provided by the two CBOs, FACT and Simukai. The researcher was introduced to one of caregiver per CBO and then used the snowballing sampling technique to get the other five participants for the FGDs.

Mack et. al. (2006:16) posits that snowballing is a type of purposive sampling method where participants or informants with whom contact has already been made use their social networks to refer the researcher to other people who could potentially participate or contribute to the study. After individually explaining to participants what the aims and purpose of the research were and how the FGD was going to be conducted, as well as the limited confidentiality of the group discussions, participants were individually asked to provide consent. Written consent was given to participate in the FGDs which were tape recorded. A discussion guide consisting of open-ended questions designed to stimulate discussion on challenges faced by community-based interventions for OVCs in Mutare city were used.

The researcher transcribed the individual interviews and the focus group discussions soon after they took place. The tape recorded interviews and transcripts were stored in a secure password protected computer and a locked cabinet at the researcher's work place. Observations during interviews were noted as the interviews progressed. The researcher had indicated to the participants that there she may need to take a few notes

during the interviews. Some other observations were written down by the researcher immediately after the researcher had left the participant's home. Mack et.al. (2011:49) suggests that the transcription of recordings and typing of field notes should begin as soon as possible after the data collection event.

3.5.3 Research journal

The researcher took down some field notes during the interviews with the community caregivers/volunteers and the CBO staff. Some of the field notes were taken during the interviews in the form of brief notes and were later elaborated on by the researcher immediately after either the FGDs or interviews with key informants and community volunteers. These field notes captured some observations noted before and during the interviews, such as a participant's perceived reception of the researcher, observed physical appearance of the participants and their home settings, their facial expression or emotional feelings, illustrations, areas of emphasis or empathy during the course of the interviews from the researcher's perspective. The researcher wrote notes as a summary of the interview in their journal after every interview.

3.6 DATA ANALYSIS AND INTERPRETATION

Creswell (2007:184) asserts that qualitative data analysis transforms data into findings and that this involves reducing the volume of raw data, sifting for significant patterns and constructing a framework for communicating the essence of what the data reveals. Creswell (2007) further posits that researchers need qualitative research because one often needs a complex, detailed understanding of a particular issue. Qualitative research allows participants to tell their own story in their own words concerning the phenomenon under study within the context of their lives and their communities.

The researcher used a cross-case analysis which facilitated the comparison of commonalities and differences in OVCs care and support activities and processes within FACT and Simukai. The cases of FACT and Simukai are

alike because they are both community-based organisations who were among the first to respond to the OVC crisis and the plight of OVCs by initiating community-based interventions in Mutare. Holldorson (2009) posits that a cross-case analysis allows the researcher to compare cases from one or more settings, communities or groups. Holldorson further argues that a cross-case analysis provides opportunities to learn from different cases and gather critical evidence to modify policy and to learn from the specifics of particular cases. Yin (2009) further postulates that the in-depth study of a few cases represent rich holistic examples of experiences and facilitate comparisons of cases in relation to patterns of similarities and differences.

Patterns of similarities and differences (Mack et. al. 2011:45) concerning challenges faced by community-based interventions for OVCs in Mutare were coded. The data was analysed according to emerging themes and sub-themes regarding these patterns of similarities and differences. The researcher utilised data generated from both the in-depth interviews and FGDs to identify various challenges and related themes and sub-themes. The presentation of the researcher's analysis and interpretation of the gathered data is supported by the data generated from the field, including quotations from the research participants and observations noted by the researcher during the course of interviews. The findings of this study are presented in detail in the next chapter, Chapter 4.

Yin (2009) argues that using the technique of cross-case analysis to search for patterns keeps the researcher from reaching premature conclusions since it requires that the researcher looks at the data in many different ways. The researcher used cross-case analysis since two CBOs were being studied. Yin (2009) further contends that cross-case analysis divides the data by type across all cases investigated and when a pattern from one data-type is corroborated by the evidence from another, the findings is stronger. Cross-case analysis was used to examine similar pairs for differences and dissimilar pairs for similarities from the data collected from

FACT and Simukai, using descriptive codes written on the right hand margin of the transcribed text.

3.7 VALIDITY AND RELIABILITY

Validity in qualitative research is defined as whether the data is plausible and credible and whether it can be defended when challenged (Ali & Yosuf 2011:36). Validity is also defined by (Brink, 2006) as the ability of an instrument to measure the variables that it is intended to measure whereas reliability refers to the consistency and dependability of a research instrument to measure specific variables. Yin (2009:348) postulates that a key strength of the case study method involves using multiple sources and techniques in the data gathering process. Yin (2009) further suggests that cross-case examination techniques along with a literature review helps to ensure external validity

The data collection tools developed for this study were shared with the researcher's supervisor and field tested with key informants, community volunteers and caregivers from both FACT and Simukai during a pilot study to ensure that they are well understood and could generate the information to investigate challenges faced by community-based interventions for OVCs in Mutare city.

The pilot testing of instruments was done to check instrument validity, to determine whether the tool precisely addressed the main objectives of the research to be undertaken. After the pilot study's questions were reviewed by the researcher's supervisor, some questions were modified and the need for further probing was highlighted. Leo (2008:15) posits that good case studies use a number of different tools to increase validity, for example, interviews, documentation reviews and observation. Gibbert & Ruigrok (2010:33) postulate that case study research should utilise construct validity, which is defined as the extent to which a study investigates what it claims to investigate, that is, the extent to which a procedure leads to an accurate observation of reality. The construct validity has already been covered above where the researcher used different data sources such as interview data or observations. Construct validity is relevant during the data collection

phase while internal validity was applied to the data analysis (Gibbert & Ruigrok, 2010). Internal validity for this study was derived from literature on theoretical framework of collective efficacy to indicate challenges faced by community-based organisations for OVC interventions.

Leo (2008:16) defines external validity as how well data can be applied beyond the circumstances of the case to more general situations, for example applying the data beyond the two CBOs to other CBOs providing services to OVcs. This helped the researcher search for similarities and differences between the two CBOs in their OVC care and support interventions. To ensure that the data reflects validity and trustworthiness, interviews were conducted with two staff members each from the two CBOs, five of the community members caring for and supporting OVcs from each of the CBOs and FGDs were conducted with a group of six community caregivers from each of the two CBOs. To ensure reliability, the researcher employed documentary research to supplement the information which was collected from the interviews and to find out more about the challenges faced by community-based interventions for OVcs in Mutare city.

3.8 ETHICAL CONSIDERATIONS

3.8.1 Informed consent

Family Health International (2012:34) defines informed consent as a mechanism for ensuring that people understand what it means to participate in a particular study so they can decide in an informed way whether they want to participate or not. The researcher explained issues of confidentiality, voluntary participation and participant's right to withdraw from the study or to skip any questions which they were uncomfortable to answer. This was done by the researcher to ensure participants were well informed on what the study is all about and why it is done before consenting to participate. All participants provided written informed consent before participating in the study.

Informed consent is one of the most important tools for ensuring the ethical principle of respect for persons participating in research. Informed consent can be written or given verbally, but for this study, participants were asked to give a written informed consent and all participants agreed to provide a written consent. Creswell (2009:186) posits that there are ethical issues during data collection that the researcher needs to observe such as not putting participants at risk, to respect their right to participate voluntarily and the right to withdraw anytime. Informed consent was obtained from individual participants before participation in this study. Participants were notified about the reasons and expectations of the study prior to their participation. Shona language was used to accommodate informants who were not conversant with English. Information received from participants was coded so that the information could not be traced back to identify the informants, except by the researcher.

3.8.2 Confidentiality

There are also ethical issues in the data analysis and interpretation such as protecting anonymity of participants by disassociating names from responses during the coding and recording process (Creswell, 2009:185). For this study, the researcher used pseudonyms for participants.

Confidentiality is a process, or condition, in which information revealed by an individual in a relationship of trust will not be disclosed to others without the permission of the informant. UNAIDS/WHO (2007) guidance 18, states that researchers must ensure full respect for the confidentiality of participants' identity by preventing the disclosure of their identity to other than authorised individuals. During the transcription and data analysis phases, anonymity was ensured through the allocation of pseudonyms to ensure participants do not suffer any social or other forms of harm from the CBOs they work with and the community at large. All participant interviews were done indoors with participant only in the room except in the case of the FGDs where six participants were in one room during the discussions. Participant data was separated from identifiers to avoid linking participants with responses and their names. Data was kept in a secure cupboard.

3.8.3 Debriefing

The researcher will fulfil the ethical obligation of results dissemination by sharing the findings with participants and CBO management after final assessment of the dissertation and if deemed successful by the university. The researcher, due to financial constraints, will hold one meeting for all the research participants to disseminate the results and then go to each CBO management office which granted permission to interview their staff, volunteers and caregivers to share with them the dissertation results.

3.9 PILOT STUDY

To field test data collection instruments, the researcher conducted a pilot study with one of each CBOs staff, one of each CBOs' community volunteers and also conducted FGDs with four caregivers from each of the CBOs, which are Simukai and FACT. After transcribing the pilot study interviews and sending transcriptions to the research supervisor for review, some questions on the interview schedules were modified while some questions found to be irrelevant in response to the research questions and objectives were dropped. Those who took part in the pilot study did not participate in the final study.

3.1 CONCLUSION

This chapter provided an in-depth discussion of the following issues: research design, the case study method, sampling procedures and sample size, data sources, research instruments, data analysis, validity and reliability of qualitative data. Ethical issues were also addressed to ensure that research was done in accordance with national, international and institutional ethical guidelines.

The next chapter presents the data collected in the study using a qualitative research design. The data was gathered from Simukai and FACT's staff, community volunteers and caregivers. A cross-case data-analysis was conducted to discover patterns and themes that were related and the data was grouped according to the emerging patterns, themes and sub-themes.

CHAPTER 4: DATA PRESENTATION

4.1 INTRODUCTION

This chapter presents case-specific findings collected during the fieldwork phase of the study by using a qualitative case study methodology. The findings from the cross-case analysis have been structured around the grouping of emerging themes and sub-themes. This structure facilitated capturing variety of research participants' experiences regarding challenges faced by community-based interventions for OVCs and also includes the researcher's observations and opinions during the data collection and analysis phases.

This chapter presents the cases from two CBOs namely FACT and Simukai, each with three separate groups interviewed. Section 4.2 introduces FACT. The structure of the discussion under section 4.2 is as follows:

- 4.2.1 Biographical characteristics of FACT research participants
- 4.2.2 The aims of FACT
- 4.2.3 The origins of FACT OVC Interventions
- 4.2.4 Reasons for becoming involved in OVC care and support interventions
- 4.2.5 Types of FACT Interventions provided for OVCs
- 4.2.6 Effectiveness of FACT OVC Interventions
- 4.2.7 Factors Influencing sustainability of FACT Interventions
- 4.2.8 Challenges associated with OVC community-based Interventions.

Section 4.3 covers findings from Simukai and introduces the Simukai case findings. The structure of the discussion under section 4.3 is as follows:

- 4.3.1 Biographical characteristics of Simukai research participants
- 4.3.2 The aims of Simukai
- 4.3.3 The origins of Simukai
- 4.3.4 Simukai as an organisation
- 4.3.5 Reasons for becoming involved in OVC care and support interventions
- 4.3.6 Types of Simukai interventions provided for OVC

4.3.7 Effectiveness of Simukai OVC interventions

4.3.8 Factors influencing sustainability of Simukai interventions

4.3.9 Challenges associated with OVC community-based interventions.

Section 4.4 provides a comparison between the findings on FACT and Simukai as they relate to their community-based interventions for OVCs in Mutare, Zimbabwe, while section 4.5 concludes the chapter

4.2 FACT

4.2.1 Biographical characteristics of FACT research participants

Participants group A consisting of two (staff) and five community volunteers constituted key informants, while participants group B consisting of six caregivers were in Focus Group Discussions (FGDs). All participants who took part in this study were females. All key informants had at least a First degree and one of them was pursuing their Masters degree. Both key informants were below 40 years. Of the five volunteer informants, three were married and two widowed. Two of the volunteers were above fifty years; one was below 45 while two were above 60 years but below 65 years. Of the six caregivers who took part in the FGDs, three completed their four years of secondary education (O' Level), while three completed two years of secondary education (Form 2). Four of the caregivers were married, one widowed and one single. Only one caregiver was 35 years, two were 43 and 45 years respectively, one was 56 and two were 69 and 66 years respectively.

The table below shows the pseudonyms, occupation, educational qualifications, marital status, gender and age of FACT research participants.

Pseudonym	Occupation	Educational qualification	Marital Status	Gender	Age	Years In service
Key informants – CBO staff members						
Farai	OVC Programmes Coordinator	Nursing degree	Married	Female	38	10
Dorothy	OVC projects manager	Degree Social work	Married	Female	30	5
Key informants-community volunteers						
Runako	Volunteer	O' level	Married	Female	55	20
Taurai	Volunteer	O' Level	Married	Female	42	10
Mary	Volunteer	O' Level	Widow	Female	51	12
Chido	Volunteer	O' Level	Widowed	Female	60	19
Farai	Volunteer	O' Level	Married	Female	64	21
Focus group participants-caregivers/ beneficiaries						
1	Caregiver	O' Level	Single	Female	35	9
2	Caregiver	O' Level	Married	Female	43	10
3	Caregiver	O' Level	Married	Female	45	15
4	Caregiver	Form 2	Married	Female	56	17
5	Caregiver	Form 2	Widow	Female	69	20
6	Caregiver	Form 2	Married	Female	66	20

Table 2: FACT participants key informants' and FGD participants' biographic characteristics

The maximum years in service as a volunteer or caregiver with FACT was 20 years while minimum was 10 years. Community volunteers and

caregivers from FACT represented a degree of diversity with regard to their ages and education.

4.2.2 The Aims of FACT

FACT is a Christian-based AIDS CBO located and found in Manicaland province in Zimbabwe with its Head Office situated in Mutare city. The purpose of FACT is to serve the marginalised communities with love and provide care and support to HIV and AIDS infected and affected families (FACT Report 2012:11). Relating to the purpose of FACT in OVC care and support, one of the key informants, Dorothy indicated that:

“FACT is driven by the spirit to serve the marginalised and they are guided by the biblical Scriptures from “Galatians 5 verse 13” which instructs us; “by love serve one another” so FACT is there to serve OVCs who are in poverty, out of school and infected or affected by HIV and AIDS.”

Another key informant, Farai stated that FACT has built relationships with local churches and other international well wishers from different churches. She stated:

“The support from churches helps FACT source resources to continue offering services for OVCs as churches encourage volunteers to continue serving the less privileged children”

One of the key informants, Runako remarked:

“FACT trains volunteers in different skills like counselling; home-based care, First Aid and these trainings have helped us [FACT] reach out to many OVCs and paying school fees for OVCs.”

4.2.3 The origins of FACT OVC intervention

The plight of OVCs was brought to light by FACT volunteers who provided home-based care within the community. FACT key informant, Rutendo had this to share:

“Due to illness of parents and death from HIV and AIDS related diseases, coupled with the economic meltdown in Zimbabwe in the last decade; most children dropped out of school. So because so many children had dropped out of school, they needed to be reintegrated back to school and FACT intervened in school fees and uniforms for these OVCs to be reintegrated back to school again. Poverty, forced many children to leave school in search of jobs to supplement food at home as most parents became bed-ridden or died and left children without any money for food as they would have exhausted all the resources on their medication”.

In the same vein, key informant Taurai buttressed the origins of FACT when she stated:

“FACT was birthed during the late 80s’ scourge of HIV and AIDS when there was no treatment, hospitals were getting congested and sick people were sent back home due to lack of hospital beds.”

The above statements indicate that FACT was initiated by Dr. Foster in partnership with the local church community and some investment was done in training volunteers from within churches which were approached by Dr. Foster. FACT was purely a community based initiative to alleviate the plight of both the infected and affected families.

4.2.4 Organisational structure

FACT has rapidly transformed itself to be a broad community centred organisation with its sources of support, integration, association and target populations having grown to cover the broader community structures. Initial focus on HIV has been expanded to cover broader developmental issues such as livelihoods, wider health concerns, capacity development and research (FACT Report 2012: 19).

Key informant, Farai who participated in this study pointed out that:

“FACT pays school fees for all OVCs under their care and support with the financial support from some organisations such as USAID and the Christian Education Development Relief (CEDR) which is a group of churches based in Hong Kong. EDCR has been supporting FACT since 2004 to date. As part of the education intervention, FACT also provides uniforms, books and pens to mostly child headed families.”

4.2.4.1 FACT sources of funding

Despite international and local sources of funding, key informant Chido indicated that:

“In as much as the donor community is supporting FACT on various interventions on OVC care and support, resources remain inadequate to cater for most OVCs who are struggling with food, clothes and accommodation needs.”

Key informant Chido's views on funding are supported by the World Bank (2011:7) which noted that financial crisis of 2008 turned the upward funding trend into a plateau and funding trends have been reversed.

In the same vein, key informant Mary asserts that:

“OVCs used to be provided with food packs before 2005, but during the economic challenges of 2005 to 2009, food packs were stopped and now children are suffering, and have no food in most homes.”

4.2.4.2 Long term partnership

Commenting on long term partnerships, key informant Dorothy indicated that:

“One major factor contributing to FACT’s effectiveness in service delivery can be attributed to long term partnerships such as with Christian Education Development Relief (CEDR). When you have a long term relationship it’s easy to have a long term plan. The partnership is a small grant but as you can see it has touched the lives of the needy and transformed their lives.”

Reflecting on the long term partnerships with FACT, another key informant Mary posits:

“The commitment of volunteers, for example FACT staffs come and go, they have no attachment to the community but volunteers are part of the community and they know the children and continue to follow them up. I feel these are some of the factors that have contributed to the effectiveness of the interventions.”

Echoing the same sentiments, caregiver 1 asserted that:

“The other contributing factor of effectiveness is the long partnership FACT has with the community, use of community structures, local churches owning the project.”

4.2.5 Reasons for Becoming Involved In Ovc Care and Support Interventions

This section presents how participants responded to the question of reasons for becoming involved in OVC interventions which caused FACT to provide care and support for OVCs. Most of the key informants and caregivers expressed that they were concerned about the plight of children who were mainly orphaned or became vulnerable due to the HIV and AIDS pandemic in Zimbabwe.

4.2.5.1 Family dissolution/death of parents

Key informants who participated in this study generally shared the same views on the effects of breaking down of the safety nets of protection for OVCs following the death of their parents or guardians. The following is what the Key informant Taurai described on how the scourge of HIV and AIDS affected OVCs. She stated that:

“Communities witnessed the breakdown of family structures as most parents died in the early 1990s before ART was available and children were being evicted from their places of lodgings due to no payment of rentals while some children’s homes were taken by their relatives resulting in children having to go and stay on the streets.”

In the same vein, FACT key informant Runako remarked that:

“Here in urban areas it’s different from rural areas where people in that community are either paternal or maternally related and help for OVCs is based on kinship. Whereas in urban areas people are individualistic and this has created a huge gap in the caring of OVCs as people in urban areas are just neighbours who may be totally strangers who do not relate with each other. Now when parents die, children left behind have nowhere to go or no one to help them.”

In a similar vein, another Caregiver 5 expressed her sadness on aftermath of OVCs’ parents’ death. She lamented:

“It’s sad at times to see children on the streets as young as 4 years taking care of themselves and one ask themselves, where are the relatives of this child? Many people have become so individualistic especially in urban areas and only mind their own businesses without paying much attention to what is happening next door.”

4.2.5.2 Abuse

Narrating her experiences on child abuse, Caregiver 5, indicated that:

“I [Caregiver] have seen and heard some of the OVCs being sexually and physically abused by the relatives who are supposed to be caring and protecting them. In urban settings; neighbours may be aware of the child abuse and never report the cases for fear of victimisation by perpetrators. Upon being alerted of any child abuse, I [Caregiver] have visited such homes and helped children report such cases to the police. Such abuses have resulted in OVCs running away from homes to stay on streets and becoming abusers themselves on the general public by insulting people or snatching people’s bags in town or their shopping baskets.”

4.2.5.3 Crimes

Most of FACT caregivers and key informants highlighted that crimes committed by OVCs within the community necessitated some OVC interventions. Care giver 3 pointed out that:

“When children lack food, hunger will drive them to steal even though they do not want to steal. To reduce some of the crimes within the community, I think community members thought it would be better to help these OVCs and get them to go to school so that they could do something for themselves that can improve their lives with the education they would have received from school.”

In a similar vein FACT key informant Mary had this to say:

“There were increased burglaries in the neighbourhoods and the community realised that most of these crimes were committed by OVCs who were poor and had no food at their homes. Whenever these OVCs were caught, they would say they stole neighbours’ gadgets and sold them to buy some food.”

Concurring with key informant Mary, FACT caregiver 6 stated:

“I became involved in OVC intervention to reduce rate of crimes within our community which was perpetuated by idle OVCs who were not going to school and also lacked food and clothes. Community also decided to curb these theft behaviours by offering help to OVCs through FACT.”

4.2.5.4 Drug use and child prostitution

Drug abuse and child prostitution was reported by most of the caregivers. Responding to a question on some of the reasons for FACT becoming involved in OVC interventions, caregiver 4 said:

“The community was worried about the rate of drug use in the streets by children. Child prostitution also, resulting in girl child falling pregnant and adding to already large numbers of OVCs in the streets. The spread of HIV and AIDS increased in children as some were abused by older people for food while others were abused by other children on the streets or in their homes by relatives.”

Buttressing the same view on drug use and child prostitution, another FACT caregiver 5 reiterated:

“Due to limited resources to buy food for the OVCs, some of the OVCs are engaging in early sexual activities resulting in them contracting STIs or HIV. There has been an increase in STIs due to recently discovered diamonds in Chiyadzwa area on the outskirts of Mutare city. There are many illegal diamond dealers who have lot of money to spend with those who do sex for money and these OVCs because of challenges at home, end up engaging in early sexual activities and when they get infected, the dealers would have left the city and by the time they discover they are infected they no longer have the money to go for treatment.”

4.2.5.5 Compassion of volunteers

The love for one another taught in churches, where most of the volunteers were drawn from by Dr. Foster coupled with compassionate hearts, was a contributing factor for OVC intervention. Caregiver 2 retorted:

“I am moved by compassion even though I am not related to the OVCs to offer my help and at church we are taught to be Good Samaritans and support OVCs since the government is doing much in alleviating the suffering of the OVCs due to economic challenges.”

As caregiver 2 explained that community was moved by compassion to provide care and support to OVCs.

One of FACT key informants, Runako postulated that:

“Community acted out of compassion to help OVCs because most of the OVCs’ parents had died and these OVCs were left with grandparents who no longer have strength to work as they, themselves were being supported by the very parents of these OVCs”.

In addition to the above findings, another key informant Mary expressed her personal involvement in voluntary service. She explained:

“For me I did not start helping OVCs through FACT, personally I have always felt compassion for the OVCs whenever I knew there was death in the community since I attend funerals within the communities. I joined FACT as a volunteer moved by compassion to help and seeing OVCs in my area going for days without food, some being sick and failing to access medical facilities, medicines and children dropping out of school as a result of parents’ death. I could relate with the challenges these OVCs are going through because my children also suffered lack of food and lack of school fees when my husband who was the breadwinner died.”

In a similar vein, FACT key Informant Chido stated:

“During my home visits where I provided home-based care services to the sick parents, I was moved by compassion seeing children suffering in these homes watching helplessly their parents die without anyone providing them with any help.”

Caregiver 1 remarked, concerning involvement in OVC interventions. She said:

“Personally I always felt compassionate for the children whenever I knew there was death in the community because as a caregiver, you already know the situation of that home and what the children are going through as you might have bonded with these children during home-based care visits and as church members within the community too.”

4.2.6 Types of FACT OVC interventions

Key informants and caregivers indicated that there are various interventions provided by FACT for OVCs in Mutare. The following section examines the initiatives of FACT in alleviating the plight of OVCs. It identifies methods of interventions, how they are implemented and by whom.

The interventions for FACT are modelled alongside identified OVCs' needs such as educational, shelter, food, access to health facilities and clothes. FACT OVC interventions in Mutare city cover high density residential areas of Sakubva, Chikanga and Dangamvura. FACT interventions do not cover the whole of Mutare city, but have three selected suburbs which they work with and other rural districts within Manicaland province. In those areas FACT's OVC interventions include:

4.2.6.1 Educational sponsorship programme

Educational intervention was sighted by all caregivers and key informants as the main intervention which assists OVCs in coming out of poverty and from the streets.

Relating to the same educational intervention, key informant Chido pointed out that:

“OVCs receive school fees payments and at times child headed families are provided with school uniforms and some stationary.”

Key informant Dorothy explained the following:

“FACT staff and caregivers facilitate registration of OVCs at schools, and then we [FACT staff] periodically visit schools to check on OVCs’ progress and engaging their teachers to give us feedback about their performances and attitude towards school work. Caregivers then continue with support and monitoring OVCs’ homework for the child headed families. We [FACT] monitor every school term performance and OVC school attendance. We compile reports on OVC performances at school and the information helps us [FACT] to identify areas which a child may need to be strengthened or counselled.”

Caregiver 2 expressing her joy for the educational intervention remarked:

“I have 20 OVCs under my care and support; all of them are covered in their educational needs. I have one OVC in my group who is at the university while some are at primary and high schools”

Key Informant Fadzie also explains:

“FACT has a relationship with most schools where OVCs under their programmes are enrolled. Because of cordial relationship with various schools, FACT engages teachers to check on behaviours of these OVCs, their school attendance, performance and any other challenges or good behaviours exhibited by OVCs.”

4.2.6.2 Generational Gap

The educational intervention has been strengthened by one of the strategies called “The Generation Gap”. Key informant Dorothy explained the Generational Gap strategy. She pointed out that:

“The Generational Gap is a description of values and ways of life that is evident between the young and their old guardians like grandparents. Generation Gap is a training offered by FACT to grandparents and other older guardians having realised that there was an information gap between older guardians and the OVCs. For example, older guardians would not allow children to go to schools and insist that they do vending or do household chores instead of encouraging them to go to school first then do any other duties. This caused disharmony in the home and affected school attendance. So grandparents are trained on children’s rights and what constitutes child abuse. The Generation Gap training has helped grandparents to now enforce school attendance and homework even though they may not be able to assist in homework.”

As much as the elderly take care of the OVCs due to death of their parents, it is not an easy task as described by Key informant, Dorothy above.

4.2.6.3 BEAM Programme

Discussing the educational intervention strategies, caregiver 6 remarked:

“I thank FACT for reaching out to the government BEAM programme to facilitate enrolment of more OVCs into the school, as this reduces the burden on FACT’s finances. Through the BEAM programme more OVCs are incorporated into the schools and they are assured of their continued education. FACT sends to the BEAM school committee names of children who are under their care and support but are not included in the FACT school budget due to budgetary constraints.”

Buttressing on the BEAM programme key informant Mary explained:

“FACT continues to engage government on BEAM Programme and advocating for more OVCs to be included in the programme. The church members within the community also help in notifying school heads of any new OVCs which may need BEAM program support.”

One of the key informant-community volunteers remarked:

“As a volunteer, when I do home visits and I find that there are children who are not going to school and they are not covered by FACT school fees payment programme, I go to FACT and present a report on the situation. FACT staff then comes to do their own assessment and then refer these children to the BEAM selection committee at their nearest school. FACT staff write their own report about the conditions of the child’s home, indicate if the home is child headed or children live with grandparents or other guardians. After a child has been accepted in the BEAM programme, FACT then can buy school uniforms for the children.”

4.2.6.4 Positive Prevention

Another key informant, Taurai said there are other strategies they [FACT] use in order to motivate OVCs to take up seriously their school work. She remarked:

“Positive Prevention is a strategy FACT uses to teach OVCs not to focus on their challenges which may lead them to risky behaviours and jeopardise their education and future but encourages OVCs to have positive mind about their life. Positive prevention training also involves guardians, they are trained on how to positively affirm the children in a positive way either in their school work or house hold chores. Positive prevention challenges OVCs to maintain good academic grades, good behaviours and helps motivate OVCs to aim high for their school results and not engage in drugs or early sexual life.”

4.2.6.5 Sustainable livelihoods

Education and psychosocial interventions could not cover some gaps in OVC's lives concerning their livelihoods. So FACT had to come up with another intervention which cushioned OVCs and their guardians from the shocks of the economic challenges that Zimbabwe is facing. Key informant, Dorothy had this to say concerning the sustainable livelihood intervention. She reckoned:

"We [FACT] have also integrated some self help group concept through income savings and lending to the guardians so that they will not solely depend on project accessories like pens, food hampers because previously FACT used to give food hampers but now FACT is at a weaning stage. FACT want OVCs to be able to sustain themselves not rely on project funds. A group of guardians make a group constitution, agree on a certain amount to collect and then they loan it for an interest. This becomes their income generating project which can then cater for their food needs, school accessories needs like pens, books and school uniforms."

Describing how the sustainable livelihoods training programs and seed money have helped her [caregiver] becomes self reliant, she explained:

"I have received training in business management, I am now able to manage and account for my chicken business knowing if I had profit or loss as I was taught how to calculate my profit. This has helped me run my business effectively and gain income on monthly basis. I want to thank FACT for facilitating my business start-up."

This was also supported by key informant Chido when she revealed that:

"OVCs who did not do well at school were also given another chance of making a living out of their gifts/talents. FACT trained those [OVCs] in drama performance, art or music, hairdressing, carpentry and they are making a living out of their talents which were developed by

FACT support. They are now able to stand on their own without FACT support.”

4.2.6.6 Psychosocial support

All key informants affirmed that psychosocial support plays an integral part in rehabilitation of and as a means of coping strategy for OVCs. Various strategies are used to help OVCs manage some of the challenges they go through without parents. Key Informant Runako posited:

“OVCs are grouped according to their ages in what we [FACT] call “kids clubs” where they have sessions and discuss issues relevant to their ages or conditions. For example there is a support group for those OVCs living positively and are taking ART. They meet on their own too, after sessions with a larger group of OVC to encourage each other about the importance of not defaulting and how to overcome their HIV positive living challenges. FACT also provides funds for a one-off bigger camping once a year where children go out for camping and do team building activities. Kids club sessions help OVCs bond with each other as they share their life experiences and achievements. This is a time children have fun outside their daily routines and environment”.

4.2.6.7 Spiritual guidance

Commenting on other psychosocial strategies for OVCs, Caregiver 4 said OVCs are given opportunities to attend churches of their own; they participate in prayer meetings and spiritual guidance and counselling. She elaborated:

“Some of the OVCs have had traumatic experiences during their parents’ illness period and subsequent death, so we [FACT] realised some need spiritual counselling and we have found out that spiritual counselling is helping OVCs cope with some of the issues they may not fully understand but these are covered under the spiritual guidance. We work with churches, so it has been easy for the children to choose church of their own choice.”

Another Caregiver 6 disclosed that:

“Counselling sessions by care givers/ volunteers during home visits have had a positive impact because some of these children are too young to understand why they are in the situations they are in, looking after themselves without an adult. Counselling sessions help the children deal with their anxiety, fears and challenges”.

4.2.6.8 OVC access to health facilities

The issue of paying school fees for the OVCs and not paying attention to their health needs may result in financial resources being wasted in educational fees for a child who is not able to attend due to ill health. FACT developed another intervention to cater for the health needs of OVCs as some of them are living positively and even those who are not HIV positive at times get sick and miss school lessons.

Caregiver 6 pointed out that:

“The project covers health access fees where FACT pays for health services rendered to the OVCs to any local clinic or government hospital. There is provision for psychosocial support like counselling and monitoring those who are on ART so that they do not default on their drugs. As caregivers, this is one the most important assignment, monitoring the dates of ART resupply for all OVCs under my care.”

Explaining how the access to health facility for OVCs work, key Informant Farai disclosed that:

“Caregivers when they do home visits and find out that a child is not feeling well, they refer that child to any health facility for example local clinic or government hospital and the child gets free medical attention. The medical bill is then sent to FACT for settlement or the caregiver calls FACT nursing staff to come and assess then recommend for further assistance or treat immediately.”

4.2.7 Effectiveness of FACT OVC interventions

4.2.7.1 Long term Volunteer commitment

The backbone of community-based interventions for OVCs relies on the cordial relationships between FACT and volunteers who were part of FACT at the very inception of interventions. Acknowledging the role volunteer caregivers play in sustaining effectiveness of OVC interventions, Caregiver 2 reiterated:

“Commitment by volunteers to continue for example some of us [Caregivers] have more than 20 years volunteering without being paid. The reason being, our service is driven by compassion and love and believing in God’s love to help that are in need. Support from our local churches and church leadership has also influenced the effectiveness of the service delivery to OVCs. For example, where the OVCs meet every weekend, we were given the space by the local church and we use the church premises for free”.

Caregivers in the focus group discussions shared the same sentiments of many years of voluntary service in OVC care and support despite not being paid for their services but however, indicated that what motivated their continued support for OVC interventions were their religious convictions to help the less privileged and feeling of empathy for the children. Focus group discussion caregivers also stated that the trainings they receive from FACT is what keeps them in voluntary service as these trainings equips them with different skills.

Buttressing the above position, key informant Chido asserted that:

“The total commitment of caregivers on OVC home visits, provision of trainings in activities such as drama, sewing and market gardening help shape the future of OVCs in a positive way. These trainings help the OVCs participate in income generating projects on their own like selling second hand clothes which they order from Mozambique using project money loaned by FACT, and using performing arts as

source of income and selling vegetables after school in the markets. The community's participation in the OVCs' identification and support in general from community members and the church leadership has influenced the effectiveness of service delivery to OVCs."

Similarly, one of the key informants Taurai had this to say concerning the factors influencing the effectiveness of FACT OVC interventions. She remarked:

"Effectiveness of service delivery to OVCs by FACT has been influenced by mainly volunteers like me who have been working with them [FACT] for some time to help OVCs".

4.2.7.2 Effectiveness of educational intervention

For the educational intervention one of the key informant Mary, retorted:

"We [FACT] have our first graduate from a child headed family and this is now encouraging other OVCs that everything is possible if they work hard at school and utilise the opportunity given by FACT. This OVC is now looking after his siblings and has withdrawn them from FACT sponsorship to create a room for other OVCs who need more help than his siblings. He is also now helping in the kids' session planning where he now comes as a mentor and role model that it is possible to come from being an orphan to a great man"

In the same vein, another key informant, Farai, stated:

"The education intervention is very effective because we are seeing fewer children on the streets as children are now attending school and from the school reports we are receiving most of the children are doing well. For example we have some OVCs who have completed their A' Levels [sixth year high school examinations] and awaiting enrolment at the universities, teachers' colleges and polytechnic colleges. This makes us [FACT] happy and keeps us looking for more donors to support this worthy cause."

In a similar vein, key informant Taurai implored:

“FACT interventions for OVCs are effective as I told you that they helped my children when I [volunteer] was too sick to do anything and one of my children is now a teacher and the other one is at the university. I give all thanks to FACT intervention of school fees payment and provision of uniforms. Now the one who is working is supporting other siblings and FACT can use the money which was supporting my family to uplift the lives of other children.”

The above position is similar to the postulates of key informant Runako who attested this concerning education intervention:

“The school fees payment is very effective because in my group of 20 OVCs, I have one OVC who is at the university now, one at teacher’s college and out of 20 in school I only have one who dropped out of school and is now pregnant. You know these girls when they lack food at home they think of having sex for money and they end up falling pregnant or getting STIs or HIV and AIDS.”

4.2.7.3 Effectiveness of sustainable livelihoods

Supporting the effectiveness of the sustainable livelihood intervention key informant Mary explained:

“I [volunteer] have seen the lives of children changing for the better from poverty to businesses that are viable through skills training. I have seen one girl who is now acting plays on national television, it all started at kids’ club drama practices and she perfected her skills now she is earning money out of her acquired skills from FACT”.

In a similar vein, Dorothy one of the key informants revealed that:

“The project only supports guardians and volunteers’ clubs with what FACT call seed money. This is just a small amount to support what they [OVCs and caregivers] are doing. As I [FACT staff] said we are no longer giving those [OVCs] food hampers, in one area of Dangamvura suburb, grandmothers actually on a monthly basis,

contribute some money then take some of the interests and buy some groceries. These groceries are stored at one household then at the end of the year for example; in 2013 they invited FACT personnel at the sharing ceremony, sharing the groceries for Christmas. One grandmother also said if one of them is sick, they can also conduct a home visit and encourage each other with some bit of groceries.”

4.2.7.4 Psychosocial support intervention’s effectiveness

The effectiveness of the psychosocial support intervention was described by one of the key informants Chido she disclosed that:

“Under psychosocial support, children meet at their local churches for bible lessons and prayer meetings. These prayer meetings help build confidence of children as they affirm themselves in prayer that they are fearfully and wonderfully made by God.”

In a similar vein, Caregiver 3 retorted:

“OVC counselling sessions have been effective in bringing in behaviour change where OVCs are counselled about the decisions they make in life and the consequences of every decision and actions they do in life. Some OVCs who were exhibiting delinquent behaviours changed after going through some counselling sessions.”

4.2.8 Factors influencing sustainability of FACT interventions

This section explores some factors which influences sustainability of OVC intervention provided by FACT.

4.2.8.1 Long term partnerships

Relating to long term partnership for sustainability of OVC interventions for care and support, key Informant Dorothy stated that:

“The major factor in FACT’s sustainability of OVC interventions probably can be attributed to long term partnership with funders and some well wishers. Some partnerships are small grants but as you can see, they have touched the lives of the needy.”

Another key informant, Chido claimed that:

“FACT’s partnership with the community, community structures and local churches has facilitated the sustainability of the OVC interventions as community owns the interventions and manages them through involvement of community volunteers/caregivers.”

Another Caregiver explained some factors which influenced FACT OVC care and support sustainability of their interventions. She narrated:

“As volunteer caregivers, despite not being paid for our voluntary work we have continue to provide support to FACT and OVCs and I guess we [caregivers] also have an important role to play in sustaining the care and support interventions for OVCs. Volunteer care givers are the ones who are in the community, so they quickly know before FACT staff knows about any child who is suffering and volunteer care givers become the eyes and ears of FACT. I think these are some of the things which have sustained FACT.”

4.2.8.2 Educational intervention sustainability

Elaborating on the factors which promotes sustainability of OVC interventions at FACT, one of the key informants Dorothy mentioned that:

“The education intervention has been sustained through donor funding and also those OVCs who will have done well at school and graduated they take responsibility of their siblings thereby creating room for other OVCs to be included in other educational programmes. The BEAM programme also has been facilitating the sustainability of educational needs for OVCs as it enrolls quite a number of OVCs up to completion of secondary level [high school] and if children excel at “A” Level, they apply for government scholarship with the help of FACT staff to further their education.”

Expounding on the issue of sustainability of OVC interventions by FACT, another key informant Mary asserted:

“In 2012, FACT realised that they cannot continue to be there for life to support families and OVCs in everything for their survival, FACT then started the livelihoods activities in form of savings and lending. At the end of the year the families share the interests earned from lending. In Dangamvura grandmothers have actually started using some of the interests to buy groceries which they share at the end of the year. Such livelihood activities have actually uplifted the life styles of the OVCs and community members at large. Now the livelihood programme can sustain itself through revolving fund for those groups who want to start small projects and FACT gives them small seed money which they return after an agreed period.”

4.2.8.3 Sustainability of access to health facilities

Key informant Farai pronounced that:

“The health intervention has been sustainable through partnership with all local health facilities within the public sector where FACT has Memorandum of Understanding (MOU) pertaining to medical services offered to OVCs under FACT care and support. The OVCs no longer have to stay at home and not go to school when they are not well due to lack of treatment, but they seek medical attention early and this facility has helped in reducing the number of absenteeism in schools due to sicknesses. Those on ART also FACT has seen reduction in numbers of defaulters in medication intake because care givers are always monitoring and liaising with the local and government health care centres.”

FACT Caregiver 3, expressing herself on issues of sustainability disclosed that:

“FACT has helped us [Caregivers] to reach out to many OVCs by providing training on counselling skills, report writing, home based care and palliative care. The skills training we received from FACT are not just to benefit OVCs, but the larger community and our family

members. When there are people within the community who are too sick and relatives have been told to do home-based care for that person, they always look for us because we have the skills and it's another source of income for us as people pay us for the services if it's private and not FACT related service."

4.2.8.4 Sustainability of livelihoods

Another Caregiver 4 buttressing on the value of skills training and how the trainings have helped sustain the OVC care and support asserted:

"The relationship that FACT has with care givers has also helped in sustaining OVC care and support because us as caregivers conduct home visits to OVCs on behalf of FACT. Because we live with OVCs in our communities as caregivers, it is easy for me to be constantly in touch with OVCs and know what is happening to them on almost daily basis. So I think funding from donors, having a pool of volunteers with long time service and relationship and involving the wider community in OVC projects planning has helped FACT sustain their care and support for OVCs."

Describing what influences FACT, OVC care and support interventions sustainability another Caregiver 6 mentioned that:

FACT has trained some OVCs to run their family projects or as a group of OVCs. These OVCs choose what they think they can embark on in business and are trained in that field and on business management principles. After training, OVCs are then given some start-up loan to do their business. For example some are into chicken feeding, chicken egg production, motor mechanics or hairdressing. Some are also into drama/plays and music. All these activities help OVCs in their sustenance as they continue to have income and can further help some of their family members without the help of FACT.

In a similar vein, key informant, Runako pointed out the following:

"FACT provides caregivers with uniforms, first aid kits, and constantly training caregivers whenever there are new laws concerning children."

The trainings help caregivers monitor children's school attendance and immediately report to FACT whenever children stop going to school or bunk lessons. The involvement of grandparents in Generational Gap discussions which we[volunteers] hold with grandparents every fortnight also help grandparents to identify any delinquent behaviour in children and report them to caregivers. Such interventions have seen some children getting assistance before the situation goes out of hand."

4.2.9 Challenges associated with OVC community-based interventions

Despite recorded successes in OVC community-based interventions, there are some challenges associated with the implementation of some interventions. Key informant Mary posited:

4.2.9.1 Funding challenges

"One major challenge FACT is facing is funding. We are now competing with so many organisations for funding and most of these funders are reducing funding as a result of global economic challenges and this has a negative impact on our OVC programmes as we solely rely on donor funding from both national and international partners. Due to reduced funding, some of our food interventions for OVCs have since stopped. FACT no longer provide food packs for OVCs and this at times has cascaded to further more challenges in school attendance because OVCs will be hungry. OVCs may decide to go out on streets and beg for food or look for menial jobs. This in turn will mean these OVCs absent themselves from school resulting in failure at school."

Expressing the same views of funding challenges, another key informant Fadzie explained:

"The Vana/Bantwana [Children] (VB) project which caters for educational needs of OVCs is a 5 year funded project, so it means while we [FACT] are running the 5 year project we have to be

sourcing new funding before end of the project so that those OVCs already at school are not disadvantaged. The challenge though is when you get a different funder they may have different funding rules and expectations. This tends to affect programming of interventions as we [FACT] constantly adjust the intervention packages to suite the new funder.”

In a similar vein, one the key informant Farai mentioned that:

“FACT is not able to provide a full package to OVCs which include shelter, food, clothes, blankets, health facilities, school fees, uniforms and books. So at the end of the day, lack of any of the basic needs for OVCs, presents further challenges and affect interventions because we [FACT] pay school fees but the home environment for the child may not be conducive for studying. For example, some guardians or children may be sharing one room in a family of 5 or 6 people. How does a child study in such instances? The child will then perform badly at school, not that they are dull, but the environment at home does not promote studying values and FACT is not able to finance housing.”

4.2.9.2 Challenges of working with local churches

Key informant Chido shared her experiences concerning challenges related to working with the churches. She said:

“FACT’s entry point into the community was through the churches. They first trained local pastors on child caring and support before caregivers were recruited from within churches. So when trained pastors are transferred, the incoming pastors at times are not interested in working with OVCs and FACT. This affects OVC programmes since most of the meetings done by OVCs and their care givers are held in local church premises free of charge and spiritual guidance is also provided to OVCs for free.”

4.2.9.3 Volunteer caregivers challenges

Caregiver 3 during focus group discussions expressed their challenges as they implement OVC care and support within their communities. She lamented:

“My challenge is burnout, volunteering work at times overwhelms especially here in the communities, if people know you are FACT volunteer at times they think you have answers for all their home based care problems and they think once they have told you of their problem, you need to deliver answers as soon as possible. Yet it’s a process to have OVCs assessed and all back ground information collected before they are enrolled into FACT programme.”

Another caregiver 5 describes the challenges they face during home visits. She reckoned:

“I am now in my 60s and walking is a challenge when I do home visits. I also have a challenge of poverty in some of the OVCs’ homes because FACT is only providing school fees and uniforms and there is hunger in those OVCs’ homes and a home visit without food may not be appreciated as a hungry man is an angry man. You find at times these children being hostile and unreceptive to you as a caregiver especially if you visit their home when they do not have food and you also have nothing to give them.”

The above descriptions of what caregivers go through as they offer their voluntary services indicates the waning spirit of voluntarism and sign of resignation at times. Most caregivers in the focus group discussions showed this fatigue.

Related to child abuse reporting caregiver 6 bemoaned:

“We [caregivers] also at times face persecution from the community members because they know we report them if they abuse OVCs by overworking them beyond their age.”

Buttressing on personal experience of challenges as volunteer caregiver 5 pointed out and said:

“My personal challenge is when I do home visits with an empty hand knowing fully that these children have no food. Children will look at you and say “what have you brought us?” if you say nothing, some will tell you in their anger that they don’t eat home visits and may not even listen to you when telling them something. The other challenge I have faced is that of sick children, those who were born HIV positive, especially in homes where one child is positive and others are not, that child might not receive any help from other family members. They are usually discriminated by other family members and when I do home visits, other family members think I am supposed to be only talking to the HIV positive child.”

One of the key informants Mary giving her own perspective said:

“I see this country [Zimbabwe] being a country of the old people only because all young people as soon as they finish their education they cross borders in search of jobs. Industries have closed in Zimbabwe, so the economic situation in Zimbabwe does not promote an environment for voluntary work. I think this is the reason why we [FACT] are failing to attract young and middle aged volunteer caregivers for us to pass on the button of voluntary work to them.”

Caregiver 1 shared her experiences on home visits and challenges associated with home visits. She asserted that:

“At times I [caregiver] walk long distances within my community considering my age of 60s because I have no money for transport. I do 3 home visits a day and at times these OVCs maybe far apart, looking at my age, I no longer have the strength I used to have when I joined FACT as a volunteer. So I may have passion to do more home visits but age is failing me and I am on high blood pressure medication and need more rest now but how do I rest when children

are suffering and those with strength are not availing themselves to serve these OVCs?”

Relating to challenges associated with working as a diverse group of caregivers, care giver 1 had this to say:

“The challenge I have faced in my group of caregivers has been that of having to step in for those who are not well and do their home visit rounds especially for those of advanced ages and others who have openly disclosed that they are living positively at times their health condition fails them even when the desire to do home visits is there.”

Explaining their [caregivers] relationship with the larger community and challenges they face, caregiver 3 retorted:

“Some people in the community doubt our sincerity in working for free for more than 15 to 20 years, they think it’s not possible for one to commit for such a long period without being paid. The assumption is that they think we are benefitting from OVCs’ plight and at times these individuals they tell OVCs that these volunteer caregivers are stealing from you; they do not give you what they claim on your behalf. Now when these OVCs are desperate for food they are told to come to our [caregivers’] homes because we have the food packs which were meant for them which its not true because FACT no longer provides food packs due to financial constraints and OVCs were notified of these changes. Such community attitudes causes disharmony between caregivers and OVCs as they plant seeds of mistrust between us [caregivers] and OVCs.”

4.2.9.4 Livelihoods / Income generating projects challenges

Caregiver 4 lamented wasted opportunities by some OVCs, she said:

“Some OVCs who had been trained in different capacity building skills and given project start-up finances misuse the seed money and fail to adhere to their own [OVC] projects constitution and end up being withdrawn from beneficiaries’ list and opportunity extended to other deserving OVCs.”

In a similar vein, another caregiver 2 had this to share about challenges they [caregivers] experience in monitoring OVCs' income generating projects and implementing their own income generating projects which were funded by FACT. She remarked:

“The challenge is that most people in Zimbabwe are used to be given supplies by donors due to economic meltdown and poverty in the country, people no longer want to work but just receive. Some people have been trained in business management skills and given money to start business projects by FACT but have misused the money to buy for example, clothes instead of investing that money in a business venture.”

4.2.9.5 Educational intervention challenges

Lamenting on missed opportunities by some OVCs who had been privileged to be on FACT education programme, caregiver 4 stated that:

“I was disappointed that one of the intelligent girls in my group who was still in high school fell pregnant and now she is seated at home raising her child alone. She was impregnated by a married man and it saddens me to see such a gifted child lose her education opportunity in such a way.”

Citing some challenges associated with OVC education, caregiver 6 explained that:

“Yes, school fees payment is good, but due to poverty OVCs lack food in homes. Would a child go to school on an empty stomach? No, that’s when we see these children going to the streets to beg and then absent themselves from school.”

4.3 SIMUKAI

4.3.1 Demographic Characteristics of Simukai Key Informants and Focus Group Discussion Participants

Seven research participants constituted key informants while six participants participated in the Focus Group Discussions. Of the seven key informants,

two were OVC programme coordinators while five were community volunteers. There were six female and one male key informant interviewees while the other six female (caregivers) participants took part in the focus group discussions.

The table below shows the pseudonyms, occupation, educational qualification, marital status, gender and age of Simukai research participants

Pseudonym	Occupation	Educational qualification	Marital Status	Gender	Age	Years service
Key informants – CBO staff members						
Shinga	OVC Programme Coordinator	Education Degree	Widow	Female	45	8
Munyaradzi	OVC Street Connect Coordinator	Degree Social work	Married	Male	33	5
Key informants – community volunteers						
Makanaka	Volunteer	O' level	Married	Female	50	14
Sibongile	Volunteer	O' Level	Married	Female	46	10
Shiela	Volunteer	O' Level	Married	Female	41	9
Tapiwa	Volunteer	Form 2 (2 years of High School)	Widow	Female	62	10
Cynthia	Volunteer	O' Level	Married	Female	44	10
Focus group participants – caregivers / beneficiaries						
1	Caregiver	O' Level	Married	Female	37	10
2	Caregiver	O' Level	Married	Female	49	5
3	Caregiver	O' Level	Married	Female	52	12
4	Caregiver	O' Level	Widow	Female	58	14
5	Caregiver	Form 2	Widow	Female	63	14
6	Caregiver	O' Level	Married	Female	60	13

Table 3: Simukai Key informants and Focus Group Discussions (FGDs) participants' biographical characteristics

4.3.2 The aims of Simukai

Simukai is a Christian based organisation which aims to bring hope and a future to OVCs through care and support with their operational guiding principles based on biblical values and grounded on biblical scriptures from Jeremiah 29 verse 11 which says, “For I know the plans I have for you says the Lord, plans to prosper you not to harm, plans to give you hope and a future.” Simukai uses this scripture (Jeremiah 29:11) to encourage OVCs that there is hope and good future if they work hard and change their ways of life (Simukai Annual Report 2013:10). Key informant Munyaradzi pointed out that:

“As the plight of children became evident on the streets, for example an influx of homeless children on the streets who went about picking food from the bins and at times snatching food from passers-by, Simukai intervened to address the plight of OVCs.”

4.3.3 The origins of Simukai

Simukai started with the “contact “programme to deal with children on the streets [having face-to-face contact with children on the streets]. Key Informant, Shinga from Simukai explained:

“There was an outcry from caregivers who were providing home-based care interventions for adults as they realised that while everyone was or organisations were worried about scourge of HIV and AIDS and its toll on adult population, not much attention was paid on what the children were going through as a result of staying and watching their parents die slowly.”

Buttressing on the same point on why Simukai came into being, key informant Ratidzo shared her opinion and stated:

“I think it was the alarming rising numbers of children on the streets. As you know children on the streets have no one to guide them so there are bound to do things like stealing, grabbing people’s food on the streets and the community saw the need to help these children before they became a menace to the society. I think the other reason

was crime, poverty and compassion for children by community members.”

The above identified several factors which include family disintegration due to death of parents, poverty, crime and compassion by community members are cited as major causes for OVC care and support interventions by Simukai. Similarly, another key informant Cynthia retorted:

“The shocking ever increasing numbers of children who were loitering on the streets and the unruly behaviours by some OVCs on the streets like snatching cell phones, handbags even paper bags from passersby, was cause for concern for community to act.”

In response to the same question on causes for Simukai to intervene on the care and support of OVCs, another key informant Sheila, had this to say:

“There was increased crime on the streets especially at night to both motorists and pedestrians. Community had therefore, concern for the welfare of children and compassion.”

4.3.4 Simukai as an Organisation

4.3.5 Reasons for becoming involved in OVC interventions

There were various reasons cited by key informants and participants in the focus group discussion for becoming involved in OVC interventions. Key informant Makanaka commented that:

“Community members in Mutare city responded to the suffering of OVCs, poverty and sickness among many OVCs especially those who were born infected with HIV. The other cause for intervention was a growing number of children out of school and community she [Makanaka] said “what kind of generation are we raising?” A generation which is uneducated, this will perpetuate the suffering of children into their adulthood.”

4.3.5.1 Family dissolution/death of parents

Dysfunctional families as a result of parents' deaths, old guardians who no longer have energy to work and support children, poverty in homes and

general abuses and violence in homes were all shared by both key informants and caregivers as reasons for family dissolution. Caregiver 2 had this to share:

“Some children found themselves homeless due to family disintegration caused by parents’ death, poverty and economic challenges in Zimbabwe.”

Key informant Munyaradzi explaining the effects of economic meltdown in Zimbabwe and its effects on OVCs’ lives he revealed that:

“Many young adults left the country in search of jobs in other countries taking with them their immediate family members and leaving the OVCs with no one to take care of them [OVCs].”

4.3.5.2 Abuse

When parents die, children are often left at the mercy of those who are willing to take them in, in their own families or children have to learn to take care of themselves. However, for those OVCs who are adopted by their relatives find themselves in different forms of abuses in those homes resulting in them [OVCs] choosing street life over home. Key informant Ratidzo expressed the following concern:

“The streets have now become their [OVCs] homes following various forms of abuse in homes. It is only when you engage them on a personal level that you will realise that it is not about them living on the street but the abuse they are facing at home that drove them on the streets.”

In a similar vein, Caregiver 4 lamented:

“Other OVCs face abuse from their own family members who stay with them under one roof and these abuses are in various ways leading those [OVCs] to form surrogate families with other children on the streets. Some abuses come in form of children being denied proper food, good health and time to play and all sorts of basic rights children should enjoy.”

Another Caregiver 6 pointed out that:

“Some children were being abused in the streets especially girl child either by their peer street children or by some older people who took advantage of their vulnerability.”

4.3.5.3 Drug and child prostitution

One of the key informants Sibongile who is involved in the street connect programme which interacts with street OVCs face-to-face on daily basis remarked the following with concern:

“Some of the girls are not seen during the day, they mainly surface during the night for prostitution purposes as means of survival. Boys end up taking drugs and are sodomised by some men who they don’t name. They protect the identity of these men as they are their means of survival.”

Key informant Munyaradzi had this to say concerning OVC child prostitution and drug trafficking: He affirmed that:

“Children often took refuge in the streets, but then were further subjected to more challenges in their new-found homes. Some of them are forced into prostitution and crime for survival while others are subjected to rape and drug abuse.”

The same remarks have been echoed by Caregiver 6 when she disclosed that:

“Most children on the streets were involved in drug trafficking and some involved in prostitution.”

Echoing the same sentiments, Key informant Shinga involved in street connect programme shared his own experiences on girl child prostitution. He explained that:

“At times for girl child, we [Simukai staff and caregivers] go to night clubs because some of the OVC girls are now into prostitution and the night club staffs also know these girls from the streets from any

other girl child who comes from a home but only coming for sex work business.”

4.3.5.4 Compassion of volunteers

Most caregivers interviewed in this study had different stories to tell about their involvement in OVC care and support voluntary work. Caregiver 2 mentioned that:

“I [caregiver] was moved by the compassion which was shown to me by Simukai when I was staying at the industrial dump site with my children without a home and my children not attending school. Simukai through my children who were picking plastic bottles for resale at the industries offered me a place to stay with my children and took my children back to school. I later felt compassion for other OVCs who did not have their parents with them and offered my services to Simukai as they had shown compassion to me too through their caregivers.”

Caregiver 1 had similar views on volunteer compassion. She retorted:

“I realised that if someone can have compassion for my children while I am alive, what more of those children without parents? From there I decided to help other children who are worse off than mine by volunteering my time and effort supporting and caring for OVCs.”

In a similar vein, caregiver 6 reckoned that:

“Some children were left to look after themselves and their suffering moved community’s compassion to offer help.”

In a similar vein, caregiver 3 posited that:

“Before Simukai reunified me with my late sister’s children, I used to cry everyday whenever I was eating and would say, God what are my sister’s children eating right now? So I provide care and support to the OVCs as a volunteer with that understanding of compassion, pain and agony I went through when my late sister’s children ran away from my home to stay on the streets until Simukai found them and reunited them with me. As a volunteer I understand what these

children go through and that is what keeps me strong in my service of care and support for OVCs.”

4.3.6 Types of Simukai OVCs interventions

All Simukai interventions focus on OVCs who have been removed from the streets, counselled, fed and taken to safe house for the processes of reunification with family and reintegration into the school system. Simukai started with children on the streets but later realised that it was beneficial for both the OVC and family members if interventions addressed all issues concerning the child when a child is within a home environment. Simukai OVC programmes covers specifically three overcrowded suburbs in Mutare which are Hobhouse, Dream House and Garikayi. These are the suburbs which were developed by the government after the demolition of shacks in 2004. Most of the residents in these three areas were affected by the demolitions and were once homeless with their children. These three suburbs had the highest numbers of OVCs found on the streets because children became homeless when the government embarked on the demolition of shacks code named “*Murambatsvina*” (which means refuse trash). As a result of demolitions, it was evident that the influx of street children on the streets could not be contained and the community was shocked by the number of OVCs on the streets.

4.3.6.1 Street Connect intervention

Most of Simukai OVCs are children who would have been taken from the streets and counselled for possible reunification with their families. Simukai staff and caregivers engage OVCs from the streets and build some relationship with these OVCs through an intervention called Street Connect. Key informant Munyaradzi implored that:

“Our first intervention at Simukai is the “street connect programme”. This is the first contact programme with street children where we go to the streets to engage the OVCs. We discuss about their intentions on street life. We then bring these children to the Simukai safe house

were we ask them to take a bath, then feed them, allow them to be children and play games. As these children gain confidence in us, they start coming to the safe house on their own for bathing and meals. We counsel them, engage them in getting to talk about their family, why they left their homes, who is at their homes, their last school name and ask if they would want to consider going back home. When we are done with their profile, we [Simukai] start the process of reunification.”

The street connect intervention is done by Simukai staff and care givers. These are professionals in handling children and would have been cleared by the police to have contact with the children.

4.3.6.2 Simukai Safe House

Simukai has safe houses which houses OVCs taken from the streets and are in the process of being profiled in preparation for reunification with their family members. The processes starts at street connect sessions with OVCs. Safe house is Simukai’s temporal shelter used for OVC rehabilitation in preparation for reunification with family. OVCs are rehabilitated in hygienic practices, speech and language use since some children would have learnt obscene language from the streets. Explaining the OVC stay at safe house Key informant Shinga remarked:

“These OVCs from the streets by the way, we [Simukai] have to win their trust before we can ask them to come with us at the safe house especially the new cases since we will be strangers to them.”

Echoing the same sentiments, Caregiver 3 stated that:

“When we [Simukai] win their trust they come to the safe house then we do psychosocial activities like counselling, playing games, prayer and spiritual counselling in preparation for the next interventions of reunification and reintegration into schools.”

Buttressing on the processes which takes place at Simukai safe house, key informant Tapiwa disclosed that:

“At Simukai safe house, some children who have agreed to be reunited with their families are housed there for a period up to the time of reunification, while some street children who are not yet ready for reunification just come for bathing and laundry, feeding and OVCs being educated on health habits and counselled on dangers of street life, drugs and substance abuse.”

4.3.6.3 Family Tracing and Reunification

All the operations of engaging the children and tracing their families are done under the guidance of Social Services Department. Clearance to work with the street children is provided for by the Social Services Department. This is a government arm which protects the rights of the children and has the responsibility to support these OVCs but due to economic challenges and shortage of social workers in government institutions, the institution is no longer functional in terms of taking the responsibility of helping children but now plays a facilitating role to community organizations working with children who have the financial and professional capacity to work with these children.

Relating on the family tracing process, key informant Shiela explained that:

“The reunification process starts with family tracing where the child would have given Simukai staff all the details they possibly remember about the family during profiling of the OVCs. The child is asked about the last school they attended because more information could be accessed and readily available in schools about the child’s profile. The child provides all the information about the relatives they know or remember, after collecting all the information Simukai then starts the process of family tracing.”

Commenting on the process of reunification of OVCs with their families, key informant Shinga stated that:

“Simukai seeks to re-unify street children with their families and the community. Simukai believes it is most sustainable to re-unify a child

and his or her family, to place them in school, pay their fees and give them educational assistance. This would reduce the chances of them relapsing and going back to the streets as they would be gainfully occupied.”

Key informant Munyaradzi had this to say concerning reunification process:

“Reunification is a process which can take months to be completed. For example, Simukai first takes profile of the child if they have expressed their interest of going back home. When information about the child’s background is collected, Simukai staff with the help of caregivers, visits the home of that child. First visit is verification of family details, and notifying the family about their child. Then Simukai makes an appointment with family to discuss reasons why child left home, family expectations from child and counselling family on how to receive the child and at safe house, the child will also be counselled.”

Buttressing on the same view point on reunification, key informant Makanaka elaborated:

“Simukai can conduct three to four visits to the family before bringing together the child and the parents/guardians. This [reunification] is a costly exercise as Simukai would want to make sure that when the child gets home everyone is psychologically ready to receive the child and the child themselves are also psychologically prepared to start a new life back home.”

Echoing the same sentiments, Caregiver 5 affirmed that:

“When OVCs are taken back to their families, Simukai does follow-up visits to check if the child has settled well. After reunification, Simukai also reintegrates the child to school and pay school fees, buy uniforms and books.”

4.3.6.4 OVC School reintegration and educational support

Commenting on the school reintegration for OVCs, key informant Sibongile asserted that:

“When a child has settled at their family home after reunification, Simukai starts the process of reintegrating the child back into the school system by engaging school heads and explaining to the school heads the situation of the child and how Simukai will assist with the OVC’s educational needs.”

Another key informant Cynthia explained:

“We [Simukai] also have a reintegration intervention for those OVCs who are school going age and are still interested in going back to school. We register the children in schools; we pay school fees, buy school uniforms, exercise books and pens. Some we enrol them to school through the government BEAM programme. However, BEAM does not provide school uniforms so we provide school uniforms to those who are under the government BEAM fund. Simukai takes responsibility of facilitating the registration under BEAM programme by engaging the school committee responsible for recommending children who are less privileged.”

The above describes the level of involvement required to get the OVCs back to school and the amounts of resources used in getting all the parties ready for reunification and reintegration into schools and meeting school requirements for the child to be fully equipped and ready for school. After all these processes have been completed, Care givers 3 disclosed that:

“Simuaki has trained all care givers on how to handle child counselling and report writing. So when the reunification and reintegration processes are completed by Simukai staff, each caregiver is allocated their own group of OVCs for them to care and support. As a caregiver, I also start to build relationship with the

children and trust so that we [caregiver and OVC] can help each other without any hindrances of mistrust. Mind you, these children are taken from street where there were no values instilled in them and they were living in a harsh environment. It may take some patience and time for them to adjust to a family life again where they are guided by family rules and values although some quickly relapse and go back to the streets again.”

4.3.6.5 BEAM

Caregiver 5 commenting on BEAM programme for OVCs and its funding said:

“I think the government should through the BEAM programme take a holistic approach where the government looks at the child in totality because what happens to this child if a school fee is paid and there is no food at home, this child will definitely absent themselves from school and go to the streets to look for food. Can you blame the child for doing that? I don’t think so, because how does one concentrate at school if they are on an empty stomach?”

4.3.6.6 Sustainable livelihoods

Another key informant said besides intervention on reunification and reintegrating of OVCs into schools, Simukai has expanded its interventions to cater for the sustainable livelihood activities through its empowerment intervention called Income Generation Activities for sustainable livelihoods (IGASL). Key informant Munyaradzi posited:

“The empowerment programme looks at the child holistically by engaging both the child and the family and this has been the strength of the intervention. So for the empowerment programme to be viable, Simukai staff and caregivers work with both child and guardians so that they all have the same understanding and processes of running a family business because we tell them it’s not an individual business but a source of income for the family. We constantly get feedback

from caregivers on the progress because we support the family project for 3 years then we wean them off and get a new set of family for the programme.”

Commenting on the empowerment programme, Caregiver 4 pointed out that:

“Those OVCs found on the streets and above 16 years but below 18 years and who are not willing to be reintegrated into schools are trained in income generating projects like gardening, buying and selling of different goods, motor mechanics, hairdressing, vegetable vending and some are trained on how to conduct cross boarder trading. These OVCs use the learnt skills to run their own family projects which supports the whole family and are given seed money to start the project.”

4.3.6.7 Psychosocial support

Psychosocial support for OVCs is the backbone for Simukai’s interaction with the children from the streets. Through psychosocial activities like counselling, art therapy and spiritual counselling, children do open up for discussions with Simukai staff and caregivers for them to be further helped and reunified with families.

4.3.6.8 Art therapy strategy

Concerning art therapy, and the impact of it [art therapy] on OVCs from the streets, key informant Munyaradzi shared the benefits of art therapy. He said:

“Art therapy help children open up and tell their story on why they decided to be on the streets and what their home set-up is like, whether parents are deceased or alive and poor. During art therapy, OVCs also talk about kind of abuses they went through at home before they left for the streets. The discussions that emanate from art therapy also help us [Simukai staff] to assess if the child ran away

from home out of rebellion and delinquency or there was an element of abuse.”

In a similar vein, Caregiver 2 pointed out that during art therapy:

“OVCs encourage each other on issues of reunification with their families and reintegration into school system. The art therapy is also a process of bringing healing to the OVCs as they recount their ordeals before they left home and cry over it as they release their emotions, healing takes place.”

4.3.6.9 Family counselling

When OVCs accept being reunified with their families and have released their emotions during art therapy and counselling sessions and are ready for reunification, key informant Tapiwa had this to share:

“Before a child could be reunited with their family, Simukai engages family about expressed interest by their child of returning home. Family is counselled on child current behaviours, identified challenges of the child and how the child has undergone counselling themselves. The family’s acceptance of the child and what it means living with the child who has lost family values while on the streets starts the process of rehabilitating OVC from the street and reintegration of the child into the family and school”

Sharing her personal experience on benefits of family counselling Caregiver 5 shared the following:

“My children ran away from home when my family shack was destroyed by the government during the 2004 “Murambatsvina” [refuse trash] era when we were left homeless. I never knew where my children had gone until Simukai staff found me through my children from the streets. I was told my children were at Simukai Safe House and wanted to come back home. I was counselled together with one of my daughter who had remained with me on how to start a new life with our children who had been on the streets for four years and how to help them get back to school. Today I am a caregiver with

Simukai because of my children and the counselling i received from Simukai.”

4.3.6.10 Health access facility

Simukai values the health of the OVCs as some are living positively and others acquired STIs while there were still in the streets. Key informant Munyaradzi said:

“Simukai has signed some Memorandum of Understanding [MOU] with the local clinics and the government hospitals for them to attend to any OVC under Simukai programme whenever they come seeking medical attention. Simukai will later pay for the services provided and the caregiver must be informed about their OVC if they have received appropriate treatment.”

Another key informant, Makanaka, describes how they operate and shade light on some of the strategies for the health access intervention. She mentioned that:

“For those OVCs who are living positively as caregivers we [caregivers] remind them two days before the due date and we wait for them at the clinic to facilitate their quick service so that they do not stand in long queues with adults. As they come in for their ART resupply we mark our registers that they have received their supplies. I have seen that our presence encourages them to continue coming for their supplies because prior to this strategy of us being present at clinics, we used to have a lot of children defaulting and getting sick frequently thereby disrupting their school attendance.”

Similarly, Caregiver 6 had this to say:

“Simukai has a mobile health clinic where nurses from Simukai visit all OVCs whom caregivers would have visited and found them not well. They are treated by Simukai nurses and if they assess the children’s conditions and see that there are in a serious condition, they then refer that child to the hospital or take that child to the hospital themselves. As caregivers, we are all trained in home based care and some are trained in first aid so we have our own first aid kits

to administer first aid if we find a sick child at home during our home visit or if we are called to come and see a sick child”.

4.3.7 Effectiveness of OVC interventions

In terms of how effective are the interventions provided by Simukai, key informants and caregivers responded to questions pertaining to their assessments of interventions and the feedback they get from community members and OVCs. The key informants indicated that they are confident of the OVCs’ interventions provided by Simukai that they have been effective.

4.3.7.1 Effectiveness of Funding

Key informant Sheila shared her views on effectiveness of funding for Simukai interventions. She revealed that:

“The major factor has been funding for Simukai because most of our [Simukai] programmes for OVCs for them to be very effective we [Simukai] need to have enough funding. Funding is the major activity that makes our OVCs from the streets and our reunification programmes very effective .Funding is also needed for keeping these OVCs taken from streets in safe house and travelling costs in tracing the family members of the OVCs. For example a child may tell you my family is in Harare which is 350 km from Mutare or Bulawayo which is 600 km from Mutare so the staffs at Simukai have to drive all the way to locate these family members”

4.3.7.2 Effectiveness of Street Connect programme

Key informant Tapiwa commenting on the effectiveness of the street connect programme explained:

“The street connect programme is very effective because Simukai has managed to take some children out of the streets and reunited them with their families and get them back to school again. Our [Simukai] interventions have been successful especially the family tracing intervention, all the children we have traced their families have been reunited even though at times it’s a challenge when the

parents of the child are deceased and relatives are not willing to take in the child.”

Buttressing on the same point concerning street connect intervention, another key informant Makanaka said:

“I think the factors which have influenced the effectiveness in service delivery for OVCs has been the relationship building that Simukai staff have with the OVCs from the streets, especially looking at children from the streets it’s not many organisations which are assisting the OVCs on the streets. But the way Simukai is engaging the OVCs on the streets through relationship building is quite a success story. Simukai staff and volunteers have built a relationship to the effect that these children when they see our staff walking on streets they offer to carry their paper bags to the car. The street connect intervention has also seen an influx of children coming on their own to Simukai centre for some game activities, counselling, meals and treatment of different ailments. These children from the streets continue to refer each other to Simukai centre, so for me that’s a success story.”

4.3.7.3 Effectiveness of Reunification programme

As a beneficiary of reunification Caregiver 3 expressed her gratitude to Simukai and pointed out that:

“Reunification programme is very effective because as you see me [Caregiver], I benefitted from that programme. My children and I were reunified in a dignified way and provided with a home and my children also got to go to school and now I have a teacher in my family and the other one wants to be a nurse and she is doing well at school. If Simukai had not found my kids on the streets and through my children located me from the industrial site, I can tell you that I might be on the streets now and my children also living a street life maybe having had their own children also from the streets and the cycle of street life and poverty would have continued to the next generation of my grand children.”

Buttressing the same views on the effectiveness of reunification programme another Caregiver 5 share that:

“The reunification programme is very effective, my late sister’s children were brought back home from the streets by Simukai through their street connect programme and now we are a happy family. I used to cry every day whenever I was eating and would say God where are my sister’s children what are they eating right now? Because my sister’s children had run away from home they thought when I gave them household chores to assist with work at home, I was mistreating them and they left home to stay on streets. So for me it’s very effective. I have also seen other families reunited by Simukai especially in my OVCs’ group I know these children because they have been reunified with their families for me to be able to provide care and support to them.”

The same sentiments were also expressed by another Caregiver 2 when she stated that:

“I think reunification is effective because now my children are going to school and are staying at home thanks to Simukai’s reunification programme. I had lost my children even when I tried to search for them on streets of Mutare whenever I got to city centre, I would not see them maybe they used to see me first and run away from me. My friend’s children were also brought back home by Simukai staff, so I think this reunification programme is very effective because it’s not good for children to stay on the streets. The tracing intervention before reunification has been successful and effective because all the children’s families have been traced and reunited”

Commenting on Simukai reunification intervention, Caregiver 6 implored that:

“My children were staying on the streets of Mutare city as they were running away from poverty and hunger at home since I am a widow

and not employed, then Simukai through their street connect and reunification interventions located me and brought my children back home and sent them to school”.

4.3.7.4 Effectiveness of Educational intervention

In response to the educational intervention provided by Simukai, Key informant Shinga mentioned that:

“In 2007 Simukai recorded its first graduate case of a girl who had been living on the streets. She was followed by two former street boys graduated from the University of Zimbabwe in Bachelors of Economics and Administration and since then, Simukai has recorded success stories of OVCs graduating every year in different fields of specialities like teaching, garment making, motor mechanics and other areas of their choices.”

In a similar vein, Caregiver 6 disclosed that:

“Those OVCs who have been reintegrated into schools, some have finished their O’ Levels [four years of high school] while some are still at primary, secondary school or at tertiary colleges. We [Simukai] can safely say we now have a generation of educated young people instead of being on the streets, children are found in classrooms.”

Key informant Tapiwa had this to say about the effectiveness of the reintegration into schools and education intervention:

“Our [my family] life has changed because one of my children who used to stay on streets and was reunified with me by Simukai staff has recently graduated as a nurse and is now supporting me and her siblings and we are no longer dependant on Simukai help anymore. Some OVCs have been taken aboard by Simukai because my family can now support itself through the education assistance which was afforded to my child. I will always thank Simukai for educating my child and removing him from the streets”.

Commenting on the effectiveness of the educational intervention provided by Simukai, Caregiver 2 shared that:

“Paying school fees for the OVCs has been effective because it reduces number of OVCs from the streets as children are kept in schools. I have some OVCs in my care and support group who completed their ‘O Levels’ and passed. Two of them are currently undergoing nursing training and one is completing teacher’s training. I think the education intervention of paying school fees for OVCs and reintegrating them back into school system is effective because most guardians are not prepared to sacrifice their own children’s scarce resources for OVCs.”

Key informant Munyaradzi elaborating on the educational assistance they receive from the government, said:

“The education intervention is effective because Simukai even though they are overwhelmed in financial resources to cater for most OVCs’ educational needs, they have outsourced some help from the government’s BEAM programme by facilitating the registration processes of OVCs so that they become beneficiaries of the BEAM programme. The BEAM programme covers quite a number of OVCs although it does not cover the supply of school uniforms. Some of the OVCs have managed to go up to university or technical colleges’ levels through the government sponsorship under Simukai facilitated educational intervention.”

4.3.7.5 Effectiveness of Sustainable livelihoods

The sustainable livelihoods intervention is one of Simukai’s best interventions because it removes OVCs and their families from the dependency syndrome but empowers them to have a decent life through income generating projects. Concerning the above statement, one of the key informants Shinga commented:

“The empowerment programme to be viable and sustainable, Simukai works with both the child and parents/guardian so that they all have the same understanding and processes of running the family

business because we [Simukai] tell them it's not an individual's business but a source of income for the family. We [Simukai staff] constantly get feedback from both the caregivers and the children or family members on the interventions we are doing in the community."

Buttressing the same point on sustainable livelihoods intervention, Caregiver 5 shared:

"Some OVCs in my care group have completed some skills training and they are running their own income generating projects like motor mechanics, garment making and hairdressing."

Another Caregiver 1 asserted that:

"OVCs are benefitting from their entrepreneurial training from Simukai's livelihoods intervention and some older OVCs are currently running very good business that generates income and they are supporting their siblings from that income. They are no longer receiving hand-outs from Simukai."

In a similar vein, key informant Cynthia posits:

"As a volunteer beneficiary of the livelihood intervention from Simukai, having been taken from the industrial site squatter place with my children were we survived on picking plastics and selling them, our lives have been transformed by Simukai livelihoods intervention where as a family we were given seed money to start our chicken project. The project has been doing very well and we are now standing on our own and have managed to extend our two roomed house which we were given by the government to a six roomed house through the money earned from our family project. We all participate in chicken rearing with my children."

4.3.7.6 Effectiveness to health access facilities

Commenting on the access to health intervention, key informant Shinga explained that:

"When OVCs are sick, they get treated for free at any nearest clinic or hospital and Simukai pays for the medical fees."

Caregiver 6 commenting on the services she offers to OVCs retorted:

“As a caregiver, I facilitate access to health facilities by OVCs by referring them or taking them to the clinics. I also send reminders to those OVCs who were born HIV positive and are on ART on their due dates for resupply. This has been an effective way of making sure OVCs do not default on their medication.”

In the same vein, key informant Munyaradzi revealed that:

“Simukai offers access to health facilities to all street children at their [Simukai] safe house and have a mobile clinic too to cater for OVCs within their communities. The care givers may report that a child is sick at home then nurses from Simukai mobile clinic visits the child. They either treat the child or refer to a government hospital or local clinic for further management.”

4.3.8 Factors influencing sustainability of interventions

This section explores factors attributed to sustainability of Simukai interventions in Mutare city. It identifies some of the strategies used to sustain interventions and some factors which hinders or stifle the sustainability processes of interventions adopted by Simukai.

In response to sustainability of Simukai OVC care and support interventions, key informant Sibongile asserted that:

“Passion that Simukai has for OVC care and support keeps staff, volunteers including funders and donors offering their services despite economic challenges which have also affected our international funders. Simukai staff continues to write project proposals to donors for continued funding for OVC interventions and the continued funding by donors sustains Simukai interventions.”

4.3.8.1 Sustainability of education intervention

Describing how Simukai sustain their education intervention, Key informant Tapiwa said:

“Simukai approaches government’s ministry of education to finance some of the OVCs who would not have found funding through their

resources to pay school fees for OVCs through their BEAM programme. From the year 2000 up to date, Simukai has funded education for more than 1 600 OVCs who had been taken off streets and reunited with their families.”

Another key informant Cynthia asserted:

“Simukai runs an education and rehabilitation centre in Sakubva suburb which was given to Simukai by Mutare city council for free and this centre is hired by churches for their services and other social community functions like weddings, parties. All proceeds from the hiring of the centre help sustain the educational intervention and rehabilitation of OVCs from Sakubva suburb.”

4.3.8.2 Sustainability of livelihoods

Commenting on factors facilitating livelihoods sustainability of OVC care and support at Simukai, one of the discussants caregiver 3 posits:

“The empowerment programme for livelihoods activities for OVC projects run for 3 consecutive years while mentoring and training both OVCs and their family members. After 3 years they are released and they will have acquired enough skills to run the projects on their own and manage their finances and business well. During the 3 year mentoring and training period, care givers make follow-ups on business run by OVCs and their family members, record their income, challenges or positive growth points in that business so that it could be replicated by other OVCs.”

4.3.8.3 Long term volunteer/caregiver relationship

Narrating how she has been involved for the past 14 years with Simukai, Caregiver 3 shared the following views on sustainability of OVC care. She attested that:

“The sustainability of OVC care and support has been made possible by the long term relationship that Simukai has with its volunteers. Most of us volunteers with Simukai either had our children on the streets and were reunified and provided with a place to live or us

parents were destitute, living with children on the streets and Simukai came to our rescue and offered us training on child care, counselling, entrepreneurship skills and gave us seed money to start projects for our livelihoods while we continue doing our voluntary care and support for OVCs.”

Buttressing on the same view of volunteer relationship with Simukai, one of the key informants Shinga said:

“Volunteers have contributed to the sustenance of OVC interventions through their dedicated voluntary services because Simukai has no cost to the home visits being conducted by caregivers to OVCs. Volunteers do most of the intervention follow-up work. Also partnering with the community in identifying OVC interventions has contributed to the sustainability of Simukai interventions as communities take ownership of these interventions and this translates to having communities become custodians of these interventions.”

4.3.8.4 Collaboration with other organisations

One of the key informants Tapiwa echoed similar sentiments concerning sustainability of the livelihoods programmes. She pointed out that:

“Collaboration with different organisations such as the police, the legal project centre, Youth alive, and churches has helped sustain Simukai interventions in different ways of their specialties. For example, the church provides spiritual counselling and guidance within the community. If a child experiences some spiritual challenges, they are immediately attended to within the community before their depression or challenges affect their school work.”

In the same vein, another Caregiver 4 postulated that:

“The police help Simukai sustain the rights of the children by training volunteers and community members on the rights of children and by facilitating in all cases which involve children’s inheritance issues, abuses and other legal requirements. This collaboration also helps the children’s cases not to take too long to be resolved so that children do not unnecessarily miss school while attending court

cases. The legal project collaboration also plays an important role in facilitating hearings of children court cases so that children pay more attention to their school work and not court cases.”

4.3.9 Challenges associated with OVC community-based interventions

This section of the chapter presents key Informants and caregivers’ views on challenges faced by OVCs’ community-based interventions in Mutare city.

There are certain challenges that Simukai faces despite some successes recorded in some of their interventions. The major challenges identified were mainly financial, volunteer fatigue, failure by families and some volunteers to repay loans advanced to them for projects, corruption among selection committee members for BEAM programme beneficiaries at the expense of deserving OVCs and lack of support from the government through social services department. Key informants and volunteer care givers highlighted the following concerning challenges associated with Simukai OVC care and support Interventions.

4.3.9.1 Funding challenges

Key informant Makanaka commented on the funding challenges associated with Simukai’s OVC care and support Interventions reckoned:

“Funding is one of Simukai’s major challenges because going to the streets everyday requires some resources. For example one cannot go to the streets and want to speak to street children who are hungry without buying them food. So when Simukai staff goes out to form relationships and trust with the street children, they have to carry some eats so that as you discuss, they have something to eat. This is how Simukai wins trust of OVCs in the streets. They would know that these people come to talk to us but they also bring us food and at times our nurses treat them or take them to our [Simukai] clinic.”

In a similar vein, explaining the funding challenges key informant Munyaradzi said:

“Due to funding challenges, intake of new OVCs into Simukai programmes has been tremendously reduced. Simukai is currently

concentrating with those OVCs already in their system to take them through their education.”

4.3.9.2 Reunification challenges

Buttressing on the same point of street connect intervention, another informant Makanaka had this to say:

“Transforming a street child from uncontrolled life style to a life guided by home rules and values is a challenge. So many things go wrong if a child stays for too long on the streets for example their conduct changes, speech and hygienic practices degenerate. When these children are reunified some of them fail to cope with home environment where they have to abide by the family rules and values. Rebuke from either a parent or guardian to such children results in that OVC relapsing back to the streets because they are used to being masters of their own. This becomes a costly exercise because resources would have been used in tracing the family and reintegrating the child into school system.”

In a similar vein, another informant Sheila remarked:

“The reunification process involves the Department of Social Services; they are supposed to give Simukai clearance letter to start the process of tracing family members. But due to shortage of staff in this department, it takes longer to receive response from the Social services. This becomes costly to Simukai because when we [Simukai] start processes of tracing, the child would have been taken into Simukai safe house and they need to be clothed and fed. The safe house can only take a certain number of children so if the backlog is not cleared, quickly some children who would have registered interest of being reunified might go back to the streets before they are reunified.”

Buttressing the point on reunification processes: another key informant Tapiwa lamented:

“Social services offices in Mutare have a jurisdiction of Mutare urban only and would attend to issues of relocations to Mutare urban only.

So, sometimes we take a case to Mutare urban social services office and they further refer our case to rural district social services office if the child's family is in the rural home. Again, this prolongs the reunification process and has some travel costs for Simukai of back and forth reporting. There is a negative impact in such processes of being referred from one office to another as it takes longer to resolve the child's case of reunification."

Sharing the same sentiments with the above key informant, Caregiver 6 said:

"Poverty in homes where children would have been reunified is a challenge resulting in these children falling out of school again due to lack of basic necessities like food at home, inadequate accommodation and other needs like clothes and blankets. At times if there is too much poverty at home the child may relapse and go back to the streets again and at times this cycle goes on and on."

Key informant Cynthia lamented lack of adequate resources for their [Simukai] follow-up visits for reunified children. She said:

"Due to limited resources, Simukai is no longer able to do follow-ups to see what happened to the OVCs whom they would have reunified with family in rural areas. We [Simukai] do not know the fate of those children because we have not been doing follow-ups for the past three to four years now. Maybe they have gone to other towns to stay on streets again and these are some of the resources which might have gone to waste due to non-follow-up."

4.3.9.3 Education challenges

Responding to question pertaining to challenges associated with the education intervention, another key informant Tapiwa said:

"Those OVCs referred to government BEAM programme for their school fees assistance at times face challenges of their school fees not being remitted in time to schools by the government thereby

forcing the heads of schools to refuse to take more children on BEAM programme in their schools.”

Another key informant Makanaka lamented on issues to do with BEAM funding. She claimed:

“At times some of the OVCs we refer for BEAM are not considered because they have to go through BEAM selection committee and at times there is corruption where you find some children who do not need assistance being taken abode and those OVCs who genuinely deserve assistance continue to be disadvantaged. Corruption has become rife in Zimbabwe due to economic challenges so those in selection committee may have bias towards their own relatives.”

4.3.9.4 Sustainable livelihoods challenges

There have been some success stories on Income generation projects undertaken by OVCs and their families and Simukai volunteer caregivers. Despite these success stories, there have been some challenges too associated with income generation projects for sustainable livelihoods. Buttressing on the challenges, Caregiver 5 remarked:

“The Income Generation Activities for Sustainable Livelihoods (IGS) is a loan facility to help OVCs and their families start income generating projects, but the challenge has been that some beneficiaries mismanaged the funds and have nothing to show off for the money they were given to start business. The challenge again is that we cannot do anything to these families because they are poor, you can’t take them to court nor recover that seed money.”

Another key informant Sibongile lamented:

“It is sad at times after all the investment in the OVCs considering all the cost of tracing, reunification, reintegration and empowering the OVCs that you find some children not putting much efforts on their projects work and misusing the profits. However Simukai gives children 3 warnings and support visits to such deviant behaviours before they remove an individual from the group.”

Caregiver 3 bemoaned lack of seriousness in some OVCs in utilising opportunities availed to them through the empowerment intervention. She echoed:

“If these children only knew how much time we spend trying to help them improve their lives without us being paid, they would value these opportunities and work harder to uplift their lives because the projects are theirs and their families not for Simukai, but alas! It’s sad when you see a child you have been helping to improve their lives, risking your own family because of the time I give to OVCs as a volunteer losing everything that they have been invested into through drug abuse and slowly slipping back into the streets. You then look up to God and say, God what a wasted time and effort, help this child. Remember caregivers are not paid for their services so whatever I do. I do it with the understanding that I am helping a child who desires to improve their present situation for the better.”

4.3.9.5 Volunteer/caregiver challenges

All caregivers in the focus group cited volunteerism as a challenge after their generation has gone. Caregiver 2 said:

“I am living positively and no longer have the strength to do home visits as I used to do. So I sometimes ask my fellow friends to do home visits on my behalf. As you can see, all of us [volunteer caregivers] are above 40 years and some 60 years. Young people do not want to do voluntary work anymore in Zimbabwe due to economic challenges in the nation. Young people are going to neighbouring countries in search of jobs.”

Buttressing the same line of volunteer/care giver challenge another Caregiver 6 said:

“Who will continue after we have left?” because most of us are getting old and very soon we may not be able to provide care and support to OVCs or do home visits.”

In a similar vein, another Caregiver 3 had this to say:

“Some volunteers/care givers are no longer as committed as they used to be some eight years ago, this is caused by economic

challenges in Zimbabwe and volunteers are now looking for alternatives for their survival and this has a negative impact on the quality of care and support now provided to OVC.”

4.4 COMPARISON BETWEEN FACT AND SIMUKAI

Both FACT and Simukai are CBOs which have an interest in the welfare of OVCs specifically their livelihoods and education. Their [FACT and Simukai] interventions are directed at reducing the plight of OVCs both from the street and within the communities they [OVCs] live in. Both FACT and Simukai have differences and similarities in the ways they implement their OVC care and support intervention.

4.4.1 Similarities in OVC interventions

There are similarities in OVC interventions between FACT and Simukai. The following are some of the OVC similarities in the care and support interventions.

4.4.1.1 Aims of FACT and Simukai

Both FACT and Simukai are Christian based organisation founded on biblical foundations and values of the community in Mutare city, Zimbabwe. FACT bases their service to OVCs on the biblical scriptures from the book of “Galatians 5 verse 13” which encourages them [FACT] to serve with love. The purpose of FACT is therefore, to serve the marginalised with love and provide services to the HIV and AIDS infected and affected. While Simukai base their service to the OVCs from biblical scriptures from the book of “Jeremiah 29 verse 11” which encourages OVCs to have a hope and look-up for a brighter future and not to be limited by their vulnerability. The purpose is Simukai is to serve OVCs from the streets and reunite them with their families and provide educational assistance.

4.4.1.2 Origins of FACT and Simuka

FACT was founded by Dr. Foster together with the church community members in the early 80s to mitigate the suffering of parents who were too sick in homes and had no one to provide home-based care. The OVC care

and support came as a response to the suffering of OVCs who were infected and affected by HIV and AIDS. Simukai was founded by the religious body Scripture Union of Manicaland province and FACT. Simukai was founded as a response to the influx and alarming rising numbers of children on the streets in year 2000, 12 years after the establishment of FACT.

4.4.1.3 FACT and Simukai as organisations

Both FACT and Simukai are run by Boards of trustees with support staff of different professional backgrounds and caregivers. Both CBOs rely heavily on funding from local and international funders, volunteer services and other stakeholders' support in services for the implementation of OVC interventions.

4.4.1.4 FACT and Simukai's reasons for becoming involved in OVC care and support interventions

Both CBOs responded to the plight of OVCs which was a result of family dissolution/death of parents mostly due to HIV and AIDS, child abuse which was on the increase in homes and on the streets, crimes committed by OVCs as a result of poverty in their homes and noticeable drug use and child prostitution among OVCs. Compassion was also noted as one of the reasons for OVC care and support interventions by both volunteers and community members.

4.4.1.5 Types of Interventions provided for OVCs by both FACT and Simukai

Both FACT and Simukai have similarities in their interventions. They both share educational, psychosocial and sustainable livelihoods interventions. For educational intervention, they both provide school fees and some school accessories like pens, books and school uniforms to the OVCs. These two CBOs [FACT and Simukai] both receive some OVC educational support from the government BEAM programme. For the sustainable livelihoods intervention, both FACT and Simukai have funded and trained both OVCs

and their family members on business management skills and provided mentoring and follow-ups to the projects undertaken by OVCs and their families. Caregivers are also beneficiaries of the sustainable livelihoods interventions where they have received trainings and funding for their own family businesses from FACT and Simukai respectively.

The psychosocial support interventions are also provided to the OVCs by both FACT and Simukai although they differ in implementation strategies which will be discussed under differences sub-heading. Besides psychosocial interventions, FACT and Simukai offer access to health facilities to OVCs where OVCs receive medical attention from local clinics and hospitals without any payment. These two CBOs [FACT and Simukai] both provide mobile clinics for OVC home visits.

4.4.1.6 Effectiveness of OVC interventions for both FACT and Simukai

All key informants and caregivers from both FACT and Simukai who participated in this study acknowledged the effectiveness of educational, psychosocial and sustainable livelihoods interventions provided for by the two CBOs. The effectiveness of the educational interventions was measured by key informants and caregivers of both CBOs in terms of the number of graduates who have benefitted from the school fees payments programmes and financial support for vocational college and university training. The number of school children currently attending school at both primary and secondary school levels was shared by key informants and caregivers as an indicator of the effectiveness of their educational interventions. A reduction in the number of street children who live on the street and who are now attending school again, was also highlighted as evidence of the success of these interventions. The psychosocial support interventions are similar in that both CBOs work with churches who provide spiritual support and counselling sessions to OVCs to assist them with dealing with the various challenges they face, be it educational, psychological or social challenges.

4.4.1.7 Factors influencing sustainability of FACT and Simukai's Interventions

Similarities were also noted by both key informants and caregivers from FACT and Simukai on issues surrounding sustainability of interventions. A long term partnership with both funders and volunteers was cited as pillar to sustainability of OVC interventions provided by both FACT and Simukai. Sustainability of access to health facilities is achieved through partnerships with local clinics and hospitals for the OVC medical requirements. The trainings offered to OVCs and their families on business management and provision of projects seed money for OVCs and their families including caregivers has reduced poverty in those families.

4.4.1.8 Challenges associated with OVC community-based interventions

Despite successes indicated by both FACT and Simukai key informants and caregivers, some challenges have also been noted. Challenges of funding, volunteer fatigue/burnout, volunteer old age, lack of food for OVCs during home visits by caregivers emerged as major challenges for FACT and Simukai respectively. Noted similarities on sustainable livelihoods intervention was challenges of seed money loaned for projects financing for both OVCs and caregivers not being paid back. Also misuse of project money by beneficiaries for other personal use other than the intended business project. For educational interventions both FACT and Simukai face similar challenges of some of the OVC girl child falling pregnant and dropping out of school or children leaving school due to poverty at home and going back to the streets.

4.4.2 Differences

The discussions with key informants and caregivers from both FACT and Simukai revealed that as much as both CBOs' focus is on reducing the plight of OVCs within the communities, there are noted differences in the origins of CBOs, some of the interventions embarked on by either FACT or Simukai, strategies used and some challenges faced in the implementation of those intervention.

4.4.2.1 Differences in the origins of FACT and Simukai

FACT was established in 1987 as a response to the HIV and AIDS scourge which incapacitated adult population of breadwinners in families and left children without anyone to care and support them. Simukai was founded as a response to the influx of children on the streets in year 2000; 12 years after FACT establishment.

4.4.2.2 Differences with regards to the nature of OVC interventions provided

Simukai runs a street connect intervention where Simukai staff and caregivers go into the streets and engage the street children with the purpose of reunifying them with their families, while FACT working with the community members and caregivers identifies OVCs within the community who are in desperate need of care and support. Simukai operates a safe house for OVCs where street children come to this safe house for feeding, bathing, washing of their clothes, hygienic practices lessons, counselling and recreational activities. On the other hand, FACT does not have a safe house but work in collaboration with Simukai when need arises. FACT works directly with OVCs from within the communities they live in.

Simukai has family tracing and reunification intervention of street children with their families, while FACT does not have this intervention [family tracing and reunification]. For the psychosocial support strategies, Simukai employs Art Therapy for children to open up and tell their stories so that Simukai can use the information to counsel and locate family members of OVCs. On the other hand, FACT uses what they call “kids clubs’ where children have discussion sessions of sharing their life experiences and achievements. The kids’ club sessions help the children mentor each other and bonding. While most of FACT volunteers were recruited from the local churches, Simukai volunteers were beneficiaries of Simukai reunification intervention either through their children from the streets or parents having to stay with their children on the streets as a result of the 2004 government clean- up

campaign code named “*Murambatsvina*” which left many families without shelters after their shacks were demolished by the government.

4.4.2.3 Differences with regard to challenges associated with FACT and Simukai OVC intervention

As FACT and Simukai implement their OVC interventions, they face different challenges. Simukai caregivers and key informants pointed out some of the different challenges peculiar to their organisation. Challenges are experienced with regard to the reunification programme when children give false information and resources are wasted trying to locate family members, or when family members, especially guardians where both parents of the OVC are deceased, refuse to accept the child into their family although the child was willing to stay with the guardian. FACT does not have the problem of reunification because they work with OVCs who are already within homes and the community. However, FACT faces challenges related to children running away from their homes due to poverty. Simukai faces another challenge associated with reunification, that of OVC relapsing to the streets

4.4.3 Applying the theory of collective efficacy

The collective efficacy theory illustrates the power of a community with common goals, values and beliefs to overcome and reduce poverty among OVCs through their interventions, voluntary care and support services. Collective efficacy further provides a deeper understanding of what causes the community to take responsibility in the midst of the crisis belidelling their communities. Sampson et al. (2006:113) describes collective efficacy as a resource that is activated in critical times which requires some form of trust and cohesion in a group. Sampson further explains that collective efficacy is the willingness among communities to intervene on behalf of the common good for example, in this study the community took action to alleviate the plight of OVCs by offering their voluntary services of care and support. The research findings of this study, illustrated that volunteer/caregivers for both from FACT and Simukai have dedicated their lives to helping the OVCs,

some for more than 20 years as is demonstrated by their years of service with these two CBOs.

Collective efficacy reaffirms the importance of thinking about social ways to approach social problems and plays a proactive role, particularly in at risk communities (Sampson et al. 2006:112). The collective efficacy theory highlights how communities' quest for change in their social lives and interactions caused them to rise and take responsibility to improve their living conditions and those of their peers within the community. The scourge of HIV and AIDS, increase in number of OVCs on the streets of Mutare and Zimbabwe in general, drug abuse by children and prostitution among young girls has awakened communities to be proactive in protecting their families and communities from the shocks of the epidemic. The findings showed challenges of burnout in continuous voluntary work and long years of service. Despite above mentioned challenges, volunteer/caregivers continue to offer their care and support services to OVCs and this resilient spirit can only be attributed to their determination to reduce or eliminate suffering of OVCs and crime within their communities through a coordinated approach of being the community gate keepers on issues to do with OVC care and support.

Dimopoulos (2012:516) postulate that the success of collective efficacy approach to community governance is tied ultimately to the equitable implementation of "voice", in the process of building a working trust among the group. The findings also showed how caregivers interact with each other outside their home visit schedules and how they care for each other during times of sickness by their colleagues and standing in the gap for one another if their colleagues are unable to do their home visits. Both FACT and Simukai volunteer/caregivers have demonstrated that they speak with one voice, that OVCs need to be cared for and helped by reintegrating them back into schools, providing them with life skills, training and assisting OVCs in developing livelihoods projects for self sustenance.

This study focused on exploring challenges faced by community-based interventions for OVCs in Mutare city, Zimbabwe. The collective efficacy theory provided some theoretical postulations on which the objectives and questions were based in unpacking challenges faced by community-based interventions for OVCs. This provided insight and understanding of the challenges community-based interventions and volunteer/caregivers succumb to and what motivates them to continue providing care and support services to OVCs despite encountering some challenges such as poverty within the communities they serve and among themselves, challenges of old age, burnout, street children, child abuse and child prostitution and how they overcome these challenges. The theory of collective efficacy brings out the sense of social cohesion in the communities based on trustworthiness of community members and their capacity to act as agents of informal social control of alleviating the plight OVCs. Throughout all the interviews for both FACT and Simukai, it was evident that volunteer/caregivers are the custodians of the interventions within their communities as some reported that they liaise with the police in reporting any forms of child abuse within their communities and that some community members themselves alert the caregivers if their neighbours abuse OVCs. The social persuasion came out as a source of collective efficacy information which strengthened volunteer/caregivers' conviction that they have the capabilities to care and support OVCs within their communities. Sustainability of long term volunteer/caregivers' continued services for OVCs' care and support emerged as a challenge as most of the volunteers are getting old and some are sick yet the modern young generation has no interest in voluntary work due to economic challenges in Zimbabwe. It was encouraging however, to note the resilient spirit the old generation of volunteer/caregivers have in offering their voluntary services for more than a decade and are still looking forward to serve OVCs despite facing some challenges.

The motivation to continue providing OVC care and support by volunteer/caregivers also emerged as a result of individuals' interview responses where they indicated that they are driven by compassion as most

of the volunteer/caregivers were drawn from churches with religious convictions to help the less privileged and some being beneficiaries of support from both FACT and Simukai. Most of the volunteer/caregivers feel they have an obligation to sow back into the community which offered them help when they needed it most. The success of collective efficacy within the Mutare community is also attributed to the organised nature of the two CBOs and the sense of belonging by both OVCs and volunteer/caregivers.

4.5 CONCLUSION

In conclusion, this chapter presents the qualitative case findings based on the research objectives and providing evidence to the research questions of this study. The cross-case analysis in this chapter has been structured around the groupings of themes and sub-themes. FACT and Simukai are both guided by some Christian values in their operations. Most of FACT and Simukai's caregivers and community volunteers have served OVCs within their communities for more than ten years. Educational requirements and attainment of OVCs is the priority for FACT and Simukai's staff, community volunteers and caregivers.

In the next chapter, the researcher presents summary of the key findings, overall conclusion of the study, recommendations and limitations.

CHAPTER 5: CONCLUSION, RECOMMENDATION AND LIMITATIONS

5.1 INTRODUCTION

The previous chapter presented the perspectives of the two CBOs, FACT and Simukai's key informants, and caregivers' focus group discussion relating to their views and experiences on challenges faced by OVC community-based interventions in Mutare city, Zimbabwe. This chapter presents discussion on findings of this study. This study is anchored on the collective efforts of the community's responses to OVC crisis and the challenges faced by community-based interventions in Mutare city, Zimbabwe through the theoretical lenses of collective efficacy. FACT and Simukai are examples of structurally organised community-based organisations whereby community members organised themselves to provide care and support of OVCs using community resources.

In order to scientifically explore challenges faced by community-based interventions for orphans and vulnerable children in Mutare, Zimbabwe as well as some strategies that FACT and Simukai adopted to facilitate implementation of interventions, the study focused mainly on the examination of five major questions:

1. What caused the community-based organisations in Mutare city to Intervene in the OVC crisis?
2. What OVC interventions are being provided by the two CBOs, FACT and Simukai?
3. What are the factors influencing effectiveness of service delivery to OVCs?
4. What are the factors influencing the sustainability of the two CBOs?
5. What are the challenges faced by OVC community-based Interventions?

The summary of the findings will be presented in terms of these research questions. Consequently section 5.2 presents a summary of this study's findings with regard to the reasons each CBO became involved in interventions to address the OVC crisis. Section 5.3 presents a summary of this study's findings with regard to the types of interventions being provided by Simukai and FACT. Section 5.4 presents a summary of this study's findings with regard to the factors influencing effectiveness of the interventions of these CBOs, while section 5.5 presents a summary of this study's findings with regard to the factors that seem to influence the sustainability of the OVC interventions provided by FACT and Simukai. Section 5.6 presents a summary of this study's findings with regard to the challenges faced by OVC community-based interventions. Section 5.7 and 5.8 respectively addresses the limitations of the study and the study's recommendations with regards to challenges faced by community-based interventions for OVCs in Mutare city, Zimbabwe.

5.1.1 Research question 1: What caused FACT and Simukai to Intervene in the OVC crisis?

The data collected from this study concerning causes of CBOs' interventions to OVC crises indicates the following findings.

5.1.1.1 OVC neglect by NGOs and the community

The data collected from this qualitative case study found out that the burden of OVCs came to light out of an outcry from volunteer care givers who provided home based care interventions for adults and realised the effects of HIV and AIDS on children. These care givers brought to the attention of both FACT and Simukai the plight of OVCs that there was a neglected constituency of vulnerable population (OVCs) as all organisations in Zimbabwe were busy concentrating on containing the spread of HIV and AIDS and treating the infected, while children were suffering silently. The community's responses to the observations brought to light by caregivers are in line with what Sampson et al. (2006) described as "collective efficacy" where communities activate their resources in crucial times and take initiatives to intervene.

The caregivers' call for action to support the OVCs within their communities is supported by Bandura's (2000:78) coining of "collective efficacy" as a shared willingness among communities to intervene on behalf of the common good.

This study revealed that the community was overwhelmed by number of OVCs who were out of school, involved in drug trafficking and drug abuse, child prostitution, poverty, increased numbers of OVCs on the streets and number of children who were born positive and had challenges in accessing health facilities and their medication. It also emerged that the community was moved by compassion to act on the plight of OVCs.

The phenomena of OVC crisis and lack of government support propelled communities to take initiatives of care and support of OVCs. Findings from Rusakaniko et. al. (2010:30) study, support the above position that OVCs suffer numerous vulnerabilities such as family dissolution, abuse, increased risk of HIV and other sexually transmitted diseases (STIs) and unintended pregnancies and consequently they end up not realising their full potential and falling back to the community for help. As they fall back to the community, the community continues to carry the burden of supporting them. Swatt et. al. (2012:25) also confirms that when there is social disorganisation, community members create a sense of urgency and assumes ownership for the state of the community through a process of collective efficacy.

5.1.2 Research question 2: What types of interventions are being offered by FACT and Simukai?

It is evident on the basis of the findings of this study that there have been efforts by CBOs like FACT and Simukai to acknowledge the plight of OVCs and respond to their needs. The findings of this study revealed that CBOs are at the forefront in the provision of care and support to OVCs and that the Zimbabwean government seem to be overwhelmed by the national economic crisis and is therefore unable to uphold its social responsibilities as they relate to OVC care and support. Duri et. al. (2013:8) study's findings

observed that the ever increasing OVC numbers have created new social costs for the government of Zimbabwe, resulting in situations where communities have taken it upon themselves to provide care and support for OVCs despite communities' own challenges.

However, Duri et. al. (2013) study findings contradicts with findings from this study's findings which indicated lack of government capacity to provide care and support in other areas like health and social welfare of OVCs. Caregivers and the two CBO staff members lamented the brain drain of professionals to other countries due to economic meltdown and subsequent shortage of social workers to assist OVCs with assessments in order to refer them to appropriate institutions for further help. The government suspended social grants in 2005 due to budgetary constraints and economic sanctions imposed on Zimbabwe in 2009. Cordoso (2010: 32) buttresses the assertion from his study findings that community-based interventions form an integral part of the responses to ensuring that the needs of OVCs are addressed, as they provide first line support and act as safety net. Cordoso's (2010) findings are similar to the findings of this study as evidenced by the two CBOs, FACT and Simukai which were formed out of community's concerns for the plight of OVCs who were dropping out of school and staying on the streets of the city of Mutare.

5.1.2.1 Education support

This study identified that educational support was provided to OVCs by both CBOs from primary and secondary school levels up to tertiary level. The scope of educational support provided by both FACT and Simukai was through the provision of school fees, uniforms and books. The findings of this study also noted that the Zimbabwean government, through its BEAM programme, is involved in an attempt to meet the educational needs of OVCs. The impact of educational support interventions shows that there has been a decrease in the number of school drop-outs and an increase in the number of OVCs excelling in their academic and professional achievements.

This data is in conformity with the findings of Tiku (2006:39) whose study revealed that keeping children in schools is a crucial to ensure that their rights and well-being are protected. Tiku (2006) study further pointed out that when a child needs additional assistance during the school year, communities are better placed to provide help in this regard. The findings of this study indicated that the strategies used by both CBOs in encouraging OVCs to excel at school were found to be effective. For example, the “positive prevention” strategy seems to create a conducive environment in which OVCs are able to challenge each other on their school performances, resulting in OVCs aiming for higher grades at school. The right to education for OVCs in this study was found to be of high priority for both CBOs, FACT and Simukai as suggested by Tiku (2006) findings.

The findings of this study further indicated that the “generation gap” strategy employed by FACT was conducive to education in the home environment since grandparents or guardians received training as part of this strategy to bridge the generation gap, resulting in both the OVCs and their guardians appreciating the importance of education and allocating enough time for OVCs to spend on their studies while also helping in the home by doing some household chores.

The disharmony at homes which was caused by lack of appreciation of each other’s needs, that is, the grandparents’ need for a helping hand at home and OVCs’ need for study time and school attendance, was minimised through the sharing of information on issues that dealt with school attendance and performances. Schenk et. al.(2010:331) citing findings from the Horizon studies conducted in Zambia, Zimbabwe and South Africa support the concerns and challenges of elderly caregivers at homes as described in their study findings that in communities that are deeply affected by AIDS, care for OVC falls heavily on the elderly especially women. It is not only the material support that incapacitates the elderly to care for the OVCs, but as revealed by key informant Dorothy, the values separated by the Generation Gap can bring misery to both the elderly and the OVCs.

5.1.2.2 Psychosocial intervention support

This findings of this study highlighted that OVCs go through traumatic experiences during the parents' illnesses and after their death. The two CBOs, FACT and Simukai, initiated psychosocial programmes which cater for OVC psychosocial needs such as counseling, support groups and spiritual counseling and biblical teachings. The findings in this study also indicated that both FACT and Simukai's operations are based on Biblical foundations and guided by biblical scriptures and principles from Galatians 5 verse 13 and Jeremiah 29 verse 11 respectively. The findings of this research highlighted the innovative strategies by both FACT and Simukai in providing psychosocial support. Studies done in Mozambique by Boston University (2012:47) indicated that psychosocial support help children have a decent behaviour and plays an important part on the development of the child in relation to the child adherence to education and spiritual support help the child know there is God.

The findings concurs with Boston University (2012) that psychosocial activities like FACT's "kids club" programme encourages OVCs' interactions with each other and these interactions help children open up and tell their stories so that they may receive appropriate help or counsel. Simukai also has a similar innovative "art therapy" strategy were children open up and tell their stories through art.

5.1.2.3 Simukai reunification intervention

The findings of this study revealed that Simukai has a unique intervention designed specifically for street children. Simukai connects with children from the streets, trace their families, compile the profile of the child then reunite and reintegrate the child with his or her family and school respectively. Engaging children from the streets to gain confidence and trust in strangers from whom they need help requires highly trained and skilled personnel. This study found that communication and counseling skills are highly essential for the street engagement with OVCs, profile mapping of OVCs,

tracing of family members and subsequent reunification of the OVC and family.

The reunification intervention is synonymous with Simukai only while FACT does not carry out any reunification interventions because all their interventions are done from within the community and family settings of OVCs. Findings of the USAID (2009:62) study conducted in Nigeria, also affirmed that the extended family and community systems have become so weakened that they rarely provided any safety net for OVCs. The government structures have become weakened also in terms of providing support for OVCs. The layers of protection for OVCs are totally gone or ineffective (USAID, 2009:62). The postulation of some of the studies conducted in Uganda by Samson (2010:11) citing (Abebe & Aase 2009) points out that community initiatives ignores the fact that OVCs may feel ill-treated and resented in their new homes and may not take into account changes in the guardians circumstances leading to migration by OVCs to seek opportunities elsewhere like on the streets.

5.1.2.4 Sustainable livelihood Intervention

The data gathered during the course of this study showed that both FACT and Simukai engage OVCs and family in income-generating projects by firstly investing in capacity building skills training and business management skills. The findings of this study showed evidence of positive results in this regard as reflected in the testimonies a volunteer/ caregiver who have been weaned off from both CBOs because they were now able to sustain themselves and their families through engaging in projects like loan savings and lending, hairdressing, vegetable vending, motor mechanics and chicken rearing. These sustainable livelihoods interventions seem to have positively reduced poverty in the OVCs and caregivers' families. Omwa and Titeca (2011:28) findings established that sustainability of community-based initiatives is realised as the approach builds upon traditional systems of child care and require less training and input from external sources in resulting

community members easily identifying and accepting the initiatives from within themselves

5.1.2.5 Access to health intervention

The findings of this study indicated that the access to health services interventions provided by both CBOs provide a cornerstone for ensuring that OVCs attend school and participate in income-generating projects, because without good health, children will miss school or may not have strength to work in their chosen fields of projects.

The finding of this study highlight that both FACT and Simukai have signed MOUs with local health centres and government hospitals for OVCs under their programmes to access treatment whenever in need. Both CBOs have trained their caregivers in First Aid, home-based care, palliative care, counselling and adherence counselling. Both FACT and Simukai have OVCs who are living with HIV and who constantly receive ART from local clinics. Shortage of all categories of medical drugs is rampant in all government health institutions. (Masuka et. al. 2012: 64). Findings indicated a negative state of affairs in government medical institutions where OVCs are referred to for treatment but these institutions lack adequate supplies of medications. These challenges makes the treatment service unpredictable, inconsistent and of poor quality, resulting in the service not being fully beneficial to OVCs (Masuka et. al. 2012)

5.1.3 Research question 3: What are factors influencing effectiveness of OVC interventions?

This study's findings revealed that the OVC interventions provided by both FACT and Simukai have been effective, primarily because of the community's participation in the identification of OVCs and in providing services to them. The volunteer community has also influenced the effectiveness of OVC interventions provided by FACT and Simukai through their dedication in the provision of care and support to OVCs for many

continuous years without being paid but just providing a service to these children. SAFAIDS (2010:13)'s findings on effectiveness of community-based interventions for OVC documented that "zvandiri" [as I am] project for children living positively was a success story of effectiveness as a result of community ownership and participation..The findings are similar to the findings of this study, that FACT has been offering services of care and support to OVCs with the same caregivers for the past 25 years and these caregivers have ownership of FACT and participate in FACT OVC care and support voluntarily.

5.1.3.1 The role of donors and other stakeholders

The findings of this research revealed that all the interventions provided by both FACT and Simukai require funding. Both FACT and Simukai utilises their relationships both nationally and international partnership to source funding for OVC intervention. The continued support by these partners has yielded positive results in some of the OVCs who have worked hard at school. For example, FACT has had long term partnership with one of their international funders since 1994 and this long term partnership has facilitated long term planning for OVC interventions has benefitted many OVCs. Cordoso (2010:24) confirms in their findings that "it has been recognised that resources need to be channeled to the community level in order to reinforce and strengthen community action in OVC care and support."

5.1.3.2 Volunteer care givers' long term service

The data in this study shows that the two CBOs, FACT and Simukai's interventions effectiveness have been influenced by care givers' unconditional long term service support for the OVC care and support programmes. Most of the care givers have been with their CBOs for more than 10 years and others have been with their CBO, especially FACT for more than 20 years. Both FACT and Simukai said CBOs' staff may come and go because they are employees, but the care givers are part of the community and will continue to have an attachment with the OVCs because they are also part of that community. The continued skills training provided

to care givers has offered a pool of expertise in areas such as home based care, palliative care, child counselling and home visits techniques.

This investment done by both FACT and Simukai in building capacity to care givers has resulted in improved service for OVCs. The skills, knowledge and abilities are a result of training investments done by both CBOs. The characteristics of caregivers is similar to the those identified by (Dimopoulou, 2012:516)'s study which found out that for collective efficacy to develop, certain neighbourhood characteristics should be present, to attain a specific task, such as OVC care and support characteristics like knowledge, skills, networks and abilities of other group members. Catholic Relief Services findings (2007) cited by Cordoso (2010:25) state that it is essential to strengthen the capacity of communities to continue to be key players in the response for providing care and support to OVCs and families in need and their role should not be considered as substitute for involvement and accountability by government. Volunteer care givers play a pivotal role in adherence counselling to those OVCs living positively and the reports indicate a decline in number of defaulting children in taking up their ART.

Simukai has had most of their volunteers through reunification programme where either their children were living on the streets or their relatives' children were taken from the streets and reunified with them. These care givers are very much committed because they also receive capacity building in running their own businesses and provided with loans to start their own income generating projects. With the skills training and start up loans, care givers' home visit intervention and schools follow-up on OVC performance has been very effective because OVCs' home visits are conducted at almost every day by various care givers. This data therefore reflects a culture of serving the less privileged by people of Mutare city. The same sentiments are shared by USAID (2013:25) Zambian study on caregivers and community response to OVC plight that caregivers' compassion and empathy is a driver to community organising themselves to solve the OVC problems affecting their community. The caregivers' views conform to

Catholic Relief Services (2012:16) (CRS) assertion that there are factors that motivate volunteers such as caregivers and these factors include feelings of empathy, religious convictions, community norms and family obligations, ambitions to get job opportunities, material and financial support and acquiring knowledge and skills.

5.1.3.3 Effectiveness of the educational intervention

The findings in the study indicate that education has been prioritised by both CBOs. The bulk of the funding is invested in OVCs' education as evidenced by both CBOs testifying that they had university graduates who have come through their educational care and support intervention. There are also testimonies indicating that there are some OVCs who were academically gifted who have been weaned off the support of both CBOs because they graduated from colleges and got employed. This is an indication of the effectiveness of educational intervention by both CBOs. Children, who were taken off the streets by Simukai and reintegrated into schools, some have graduated with different degrees, diplomas and certificates while others are still pursuing their studies at different levels of their education which is primary, secondary and tertiary institutions.

This study is guided by the theoretical framework of collective efficacy which has demonstrated the power of community coming together to make a difference in OVCs' lives by taking them off the streets and putting them back to schools. Testimonies of graduates from street children have been highlighted by caregivers and reduction of crimes by street children as they are reintegrated back to school. The success of collective efficacy is shared also by Dimopoulou's (2012:515) study on collective efficacy which found out that the presence of collective efficacy in a neighbourhood leads to lower levels of crime and increased quality of life for the residents.

5.1.3.4 Effectiveness of sustainability livelihoods interventions

Findings of this research showed that the sustainable livelihoods interventions implemented by CBOs, FACT and Simukai have been effective as they are all inclusive of the OVCs and their family members. Both FACT and Simukai provide skills training on business management

skills and entrepreneurship before they fund any project for OVCs and their family members. This study revealed that families' livelihoods have improved and some have been weaned off CBOs' support because they are now living out of their business incomes and able to pay school fees and feed the family. The findings confirms the evaluation findings of a study done in Malawi which asserted that cash assistance interventions indicated that families are out of destitution, have improved food security as well as nutritional, educational and health outcomes (Boston University, 2010:23).

5.1.3.5 Effectiveness of Psychosocial support intervention

Psychosocial support intervention has been effective as described in this study that both FACT and Simukai care givers provide the services of psychosocial services in form of promoting support groups meetings were children meet and share their experiences. Those who have achieved in their businesses or academic work, they become role models and mentors to other OVCs and demonstrate that being an OVC does not mean one cannot amount to anything but dedication, respect and honour of those who guide you will take you to another level.

The OVC support groups for those who are HIV positive, has been effective in reducing the number of defaulters as OVCs encourage each other during their meetings and teach each other on strategies they use not to forget taking their ART. Simukai's psychosocial support counselling meetings with street children has been effective as indicated by the number of OVCs who have been taken off the streets and reunified with their families. Through kids clubs and art therapy, administered by both FACT and Simukai respectively, OVCs have been able to open up and tell their stories and this has resulted in OVCs being appropriately counselled and referred for further assistance. The health of OVCs has improved and an increase in school attendance has been recorded as a result of psychosocial interventions.

5.1.4 Research question 4: What are the factors influencing sustainability of OVC interventions for FACT and Simukai?

5.1.4.1 Care givers commitment

This study identified passion for serving by caregivers as one of the factors which have sustained the continued provision of home visits and follow-up visits on OVCs' school work and school attendance. The findings of this study highlighted that caregivers serve in the communities in which they live and that most of volunteer caregivers from FACT were recruited from churches while Simukai volunteers were beneficiaries of the Simukai street connect and reunification programmes. These findings are supported by USAID (2013:10) in their study in Zambia, where they found that volunteer caregivers enter into volunteer services simply out of conviction or they are encouraged by church members or friends, while others are in voluntary service in anticipation of future material support.

Walsh et. al. (2012:11) supports the findings of this study in this regard when they highlight the role volunteer care givers play in the sustainability of CBOs' interventions. They found in their study that CBOs' sustainability depends on the community of those volunteers who provide services. These findings are supported by USAID (2013:10) in their study in Zambia, they found out that. Volunteer care givers enter into volunteer services simply out of conviction or they are encouraged by church or friends while others are in voluntary service in anticipation of future material support. Walsh et al. (2012:11) supports the role volunteer care givers play in sustainability of CBOs' interventions, their study found out that CBOs' sustainability depends on the community of those volunteers who make the services happen.

5.1.4.2 Loan facility and skills training

The study also found that the sustainable livelihoods interventions which provide skills training and loan money for business start-ups have contributed in the sustainability of some of the OVC interventions. The loans are a revolving fund which can be accessed by OVC family guardian and OVCs and also care givers are cushioned through this revolving fund to start their own businesses. As families repay the loan other families benefit from

that loan facility and skills training. UNAIDS (2009) confirms the above finding. Based on their own findings, they posit that the ability of families to cope with the care and support of OVCs depends largely upon their capacity to increase their income. The level and stability of household and community resources depend on two factors which are existing resources such as savings and land for growing crops and the ability to generate income such as micro-credit where small amounts of credit often to groups of women to support existing activities (UNAIDS, 2009:62).

5.1.4.3 Government BEAM educational assistance

The government BEAM programme has a great impact in sustaining educational needs for both FACT and Simukai OVCs as most of them are registered under the BEAM programme for their education although the registration processes are facilitated by both CBOs. The BEAM funds only cater for school fees and for those OVCs under FACT or Simukai OVC programmes and are child headed, receive school uniforms assistance and books. OVCs under BEAM funding continue to attend school without any disturbances even when the government defaults in payments, OVCs are not affected once registered. Long term partnerships funding FACT and Simukai programmes have sustained the continued support of OVC education above the government BEAM funding.

5.1.4.4 Church partnership with CBOs

The findings of this study indicate the involvement of churches from the inception of both FACT and Simukai. The partnership with local churches provides OVCs with spiritual guidance and counselling. Churches have contributed towards sustainability of OVC intervention by providing their church facilities to be used for free for meetings by OVCs and their care givers. The churches also partnered with both FACT and Simukai in providing community networks for donations of cash or in kind for OVCs within their churches and beyond. These findings of this study are also in line with Omwa and Titeca (2011:21) who asserts that community safety nets can be churches whose mandate is to cushion OVCs and other vulnerable groups from the shocks of the death of parents and severe economic challenges

5.1.4.5 Partnership with significant others (Stakeholders)

This study's findings highlighted that both FACT and Simukai network with other organisations; they do not work in isolation. For example, both CBOs closely work with the police who clear all volunteer caregivers and staff of having any criminal records before they have any contact with OVCs. Caregivers and staff who took part in this study indicated that they work closely with police friendly corners in handling child abuse cases where children could go and report any form of abuse in a non-threatening environment.

Both Simukai and FACT also cooperate with other NGOs in some of their skills training programmes. For example, the legal project centre represents OVCs in court cases dealing with issues such as inheritance disputes, child abuse or issues to do with acquiring birth certificates for OVCs. Island hospice trains some caregivers on palliative care and both CBOs have working partnership with city of Mutare health department and government hospital for referral of OVCs when they are sick and treatment of OVCs at any given time without demanding for payment first as access to health fees are paid later to various health facilities after an OVC has been attended to. School heads and teachers are also significant stakeholders in the sustainability of the education interventions provided by both FACT and Simukai for OVC school attendance records and academic performance reports or any other general concerns teachers may have concerning OVCs under the two CBOs' programmes.

5.1.5 Research question 5: What are the challenges experienced by both CBOs and their volunteer caregivers?

According to the findings of this study, CBOs and volunteer caregivers encountered a number of challenges with regard to the implementation of OVC interventions. Despite some successes recorded by both FACT and Simukai in this regard, they both faced the challenge of inadequate funding for meeting the demands of the ever increasing numbers of OVCs. The growing numbers of OVCs now supersede the limited financial resources.

5.1.5.1 Funding challenges for CBOs

This study has identified challenges associated with funding. Both FACT and Simukai have not significantly increased their intake of new OVCs into their programmes due to diminished funding opportunities. Some of the interventions have been affected by reduced funding for example, Simukai's reunification programme has been affected in that for the children who have been reunified, for the last 3 to 4 years; no home follow-ups have been done. The processes of follow-up cost a lot of money because some of the reunified OVCs are in other towns outside Mutare and in rural areas.

5.1.5.2 Challenges faced by volunteer care givers

In this study caregivers highlighted some challenges which they faced in their day-to-day service delivery to OVCs. Almost all caregivers from both Simukai and FACT shared the same sentiments on challenges that bedevil their care and support services. This study found that most volunteer caregivers have been with their CBOs for more than 10 years and that they do not receive any income from the services they provide. Zimbabwe is currently going through economic challenges as a nation and poverty and the liquidity crunch are affecting the caregivers too. Samson's (2010:24) study conducted in Uganda noted that there are socio-cultural factors which counter voluntarism which are related to the deplorable poverty situations in the community since people's means of livelihoods were destroyed by poor economies in most African countries. Care givers in this study sighted poverty within OVCs' homes and their distressful experiences during home visits where they are able to provide psychosocial support only while these children are hungry and their living conditions deplorable; yet the caregivers' hands are tied since they have no material support to offer.

Both Simukai and FACT used to provide food packs but due to funding challenges, this support has been withdrawn and only in rare cases is food packs provided to OVCs. The caregivers do not have any resources to spare for those children whom they find in dire need of food, clothes or blankets. The challenges with regard to resources highlighted by the findings of this study are also confirmed by Cardoso (2012:24) in their study

where they found that despite communities' good will, their capacities continue to be stretched as the cumulative burden of the HIV and AIDS epidemics, poverty and food insecurity increases and those providing care and support lack the necessary resources.

5.1.5.3 FACT and Simukai Intervention challenges

This study noted that Simukai and FACT have similar and dissimilar challenges in their different interventions. Simukai in their reunification intervention has faced challenges of relapses where OVCs who have been reunified with their families and reintegrated into schools find themselves back on the streets again. The relapses have a negative impact on the reunification budget because at times these OVCs come back to the centre again and ask to be taken back home again. Another challenge noticed is that OVCs when they get back home they find it difficult to readjust and fit into the family structures again. The above mentioned abuses are in line with the findings of Samson (2010:18) in which OVCs revealed that some of their guardians providing care and support deny them food, spank them, give them heavy workloads and use abusive languages. Samson's study (2010:24) also found that community-based interventions can have negative impacts on OVCs for example, forced marriages for girl child which leads to predominance of domestic violence

The study further found that some OVCs are not performing well at school and by the time they finish their secondary level, they would not have passed therefore reducing chances of being employed. Failure is not only attributed to OVCs' lack of seriousness at school, but living conditions at some OVCs' homes which is not conducive for children to do their school work for example overcrowded homes.

5.2 LIMITATIONS OF THE STUDY

This study was designed as a qualitative case study in order to capture the variety of challenges faced by community based interventions for OVCs. Noted limitations of case study are that it is impossible to generalise findings from case study with limited sample size (Suryani, 2008). This study

provided descriptions of challenges faced by community based interventions for OVCs from data gathered from interviews with key informants and focus group discussions with care givers from both FACT and Simukai.

5.3 RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher suggests other future studies explore how CBOs could mitigate the challenges of recruiting young people into volunteer work and ways of attracting this new generation of care givers. Further exploration research on the ever increasing street children giving birth and how reproductive health education can reach out to street children and family planning for street girl child. Focus should also be on OVCs streets' access to health care facilities and further explorations on why relapses for those children who would have been reunified with their families and ways of mitigating the effects of poverty in homes. Further studies could look at redefining voluntary work for care givers as old care givers retire, succumb to old age or HIV and AIDS.

5.4 RECOMMENDATIONS FOR POLICY DEVELOPMENT AND IMPLEMENTATION

The role of CBOs' interventions in mitigating the OVCs' challenges cannot be over emphasised. Several studies have been conducted in Zimbabwe on OVCs' needs and the role of CBOs in alleviating the plight of OVCs. Nevertheless, not much attention has been paid on challenges faced by CBOs and caregivers as they implement their interventions. The results of the study indicate that CBOs and caregivers are overwhelmed by the ever increasing numbers of OVCs who need their care and support, yet there are challenges in recruiting new young and energetic volunteer care givers. Funding growing numbers of OVCs given the government's economic challenges and neglect of her social responsibility further burdens the CBOs.

This study recommends the following:

Further research should focus on interventions provided by CBOs and the care givers' concerns on old age, long service, what could be done by the

communities to motivate young care givers men and women to take up volunteer care giver work. This would enable researchers, policy makers and other stakeholders to measure the impact of interventions provided by CBOs and the care giver burden of home visits for more than 20 years if there is value addition or the visits have become routine and monotonous. Other researchers should compare the impact of HIV and AIDS OVC care and support interventions on household welfare of those OVCs who have been beneficiaries of CBOs' interventions and those who have not benefitted.

Provision of attractive working conditions for care givers

The CBOs are highly recommended for taking initiatives in OVC care and support which is mainly supposed to be the government's social responsibility.

There is need to ensure that for other interventions' benefits to be realised, all children's needs must be covered so that they fully benefit from the school fees interventions and pay maximum attention to their school work and not look for jobs to supplement their family income at the expense of their education. This would reduce distress from care givers when they conduct home visits knowing children are fully catered for and enhance the relationships between care givers and OVCs. Are there any retirement guidelines for care givers as the researcher observed that some care givers are now old or too sick to be effectively delivering their care and support effectively? These are some of the questions that need to be further researched.

Based on the past studies, the researcher has confirmed that there are challenges faced by community based interventions for OVCs. The study investigated the challenges faced by community based interventions for OVCs in Mutare, Zimbabwe. The study focused on types of interventions provided by FACT and Simukai as the two case studied, factors influencing effectiveness of OVC interventions, factors influencing sustainability of OVC interventions and challenges faced by community based interventions.

Qualitative case study method was used in this study to interview two staff each from FACT and Simukai respectively, 5 volunteers each from the two CBOs and six per FGD care givers from both FACT and Simukai.

This study revealed the commitment existing among volunteer care givers driven by compassion and their church values to help those in need although quite a number of challenges were highlighted which stifle the service delivery to OVCs. The study found out that most of the volunteer care givers from Simukai were past beneficiaries of street connect and reunification of OVCs with their family members, therefore want to give back what the community did for them by serving as care givers. The study findings point to a collective effort by groups of volunteer care givers who encourage each other to continue serving OVCs despite their old age or health failing them; they remain committed to give their best service.

Government's full responsibility on the welfare of OVCs is critical and yearned for by most care givers to lessen the burden from their shoulders. There is evidence that CBOs are continuously providing capacity building to care givers by their response to skills capacity building responses that all the care giver have been trained as child counsellors, home based care, some First Aid and palliative care, entrepreneurial skills and business management .The capacity building skills trainings for both OVCs and volunteer care givers enhanced sustainability of OVC interventions in the communities of Sakubva, Dangamvura, Chikanga, Dream house and Garikayi where FACT and Simukai implement their interventions respectively.

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APPENDICES

APPENDIX A: Introductory letter requesting permission to carry out research

Research project on Investigation of the challenges faced by community-based Interventions for orphans and vulnerable children (OVC) in Mutare, Zimbabwe

My name is Mandla Ngwenya and I am currently doing Masters in Social Behavioural Studies in HIV and AIDS at UNISA. My student number is 41745795 and my National ID number is 08-440191V56. I am undertaking a research project which attempts to investigate challenges faced by community-based Interventions for orphans and vulnerable children as a fulfillment of my MA degree programme with UNISA. I am requesting for your permission to interview some of your staff that are involved in the community-based interventions for OVCs, some of your community members offering voluntary services for the care and support of OVCs and some of your OVC beneficiaries. The interviews will be face-to-face In-depth interviews and Focus Group discussions. The interviews will be tape recorded if the concerned participants consent to be recorded and if tape recording is declined by the participants, notes will be hand taken. Your organisation has been purposively selected because of the community-based intervention work you are already involved in with OVCs and your work has been well documented by yourselves and other researchers. All information collected from interviews will be kept confidential and the resulting interview transcripts will have all identifying information removed from them. For further information or clarification pertaining the study on challenges faced by community-based interventions for OVCs in Mutare, please contact if you need to speak with anyone after I have left, my Programme Convener, Mr. Leon Roets at +27 (0) 12 429 6587, Fax: +27 (0) 12 429 6491, Email address: Roetshjl@unisa.ac.za or my supervisor, Ms E. Koen, email address elizekoen18@gmail.com I would greatly appreciate if my request is favourably considered.

Yours Sincerely

Mandla Ngwenya

APPENDIX B: Informed Consent Form

Research project: challenges faced by community-based interventions for OVCs in Mutare.

My name is Mandla Ngwenya and I am a student from the University of South Africa (UNISA) doing a Masters of Arts in Social and Behavioural Studies in HIV and AIDS degree with the Department of Sociology. I am conducting a research project on the challenges faced by community-based interventions for OVCs in Mutare. I am doing the research as partial fulfilment of the degree's requirements.

Your participation is voluntary and under no circumstances are you forced to take part in this study. If you choose to participate in this study you will not be prejudiced in any way. If you agree to participate, you may stop me at any time and tell me if you want to skip any questions or when you no longer want to continue with the interview. If you have questions at any point during our conversation, please do not hesitate to ask me.

Confidentiality Issues:

I will not be writing your name, address or telephone numbers down anywhere during the interview and no one will be able to link you to the answers you give. Only the University will have access to this information. Your identity will remain confidential and the study notes will be discarded once the study is completed.

Request to use tape recorder

I would like to audio record this discussion so that I can listen more closely to the information provided by you. Tapes and transcripts from this discussion will be kept safely under lock and key. The transcripts will have all identifying information removed from them. Contact details of University Staff

If you need to speak with anyone after I have left, you may contact my research supervisor Ms. S.E. Koen, Email address: elizekoen18@gmail.com

CONSENT

I hereby agree to participate in the research on challenges faced by community-based interventions for orphans and vulnerable children (OVCs) in Mutare. I understand that I am participating freely. I also understand that I have the right to stop the interview at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this research is purely academic and will not necessarily benefit me personally. I understand that my particulars will remain confidential.

I have received the telephone numbers of persons to contact should I need to speak about any issues which may arise in this interview.

Signature of Participant..... Date:

Signature of the Researcher..... Date:
.....

CONSENT TO AUDIO TAPING

In addition to the above, I hereby agree to the audio recording of this interview for the purpose of data capture. I understand that no personally identifying information be revealed; neither will a recording concerning me be released in any form except to the research supervisor or the examination panel if requested. I understand that these recordings will be kept in a secured place and that they will be destroyed whenever they are no longer needed by the University and the researcher.

I understand that this interview will be recorded and transcribed and I consent to this. I understand that the transcripts will be available to the university staff concerned in this study. I am also assured that my name will not be recorded on the transcript and that my identity will be kept confidential.

Signature of participant..... Date:
.....

Researcher signature----- Date -----

APPENDIX C: Focus group discussion guide for caregivers

My name is Mandla Ngwenya, I am a student at the University of South Africa (UNISA) doing a Masters of Arts in Social Behavioural Studies in HIV and AIDS degree in the Department of Sociology. You have been selected to participate in this interview because you have been identified as a caregiver who plays an integral role in the care and support of OVCs in Mutare city.

The purpose of the research is to acquire information on the CHALLENGES FACED BY COMMUNITY-BASED INTERVENTIONS FOR OVCS IN MUTARE. In this study the term OVC refers to all children who are in difficult circumstances under the age of eighteen who have either lost one parent or both parents and also children who are exposed to factors that threaten their well being. The information collected will be used for educational purposes and maybe used by the CBOs for their OVC intervention programming. You will be given pseudonyms during this discussion. The focus group discussion is expected to last at least 1 hour.

1. What are the needs of the OVCs in your care?

PROBE: identify all the needs you have personally observed and come across during your OVC care and support visit.

PROBE: How have these needs been met by the CBO?

2. How long have you been receiving support from the CBO?

3. What support do you receive from the CBO?

4. How did you find out about services available to you from the CBO?

5. Do you receive any other support from any other organisation or person than this CBO you have been involved with?

PROBE: If so, what type of support and by whom?

6. Do the OVCs in your care still attend school?

PROBE: If not, what are the reasons for not attending?

7. Do you think these organisations / individuals could do more? If yes, in what ways?

8. What do you think are the challenges faced by this CBO in their efforts to provide care and support to the OVCs in your care?

9. PROBE: any identified challenge

10. Do you think services provided to you by this CBO are sustainable?

PROBE: any suggestions on how the services could be better sustained?

11. How often do you interact with the CBO staff who provide support to you and the OVCs in your care?

PROBE: Do you initiate some of the interaction times or do you wait for them to come to you or call you?

12. Do you feel comfortable talking about your challenges to staff and?

PROBE: If so, what made you feel comfortable and if not, what are the challenges in sharing your concerns with CBO staff?

13. If you had a chance to give advice to other OVC caregivers as they try to seek assistance, what advice would you give?

14. If you had a chance to give advice to CBO staff what advice would you give?

PROBE: What advice would you give to the government and other NGOs on the services you need?

15. Is there anything else you would like to share with me?

APPENDIX D: In-depth interview guide for the key informants CBO staff

Introduction

My name is Mandla Ngwenya. I am a student at the University of South Africa (UNISA) doing a Masters of Arts in Social Behaviour Studies in HIV and AIDS in the Department of Sociology. You have been selected for this interview because you have been identified as one of the OVC programme coordinators directly inter-facing with OVCs. All information gathered will be used for educational purposes and assist the CBOs on the outcomes of the study for their consideration for future OVC community-based interventions programming. All information discussed will be treated with highest form of confidentiality. The interview is expected to last between 45minutes to 1 h

1. How many years have you been working with this CBO?
 - How many years have you been involved with OVCs?
 - How do you identify OVCs?
 - What are the ages ranges of OVCs in your support?
 - Geographic areas you serve?
 - Can you tell me about the history of this CBO? I will ask you questions about community-based interventions for OVCs in Mutare city
2. What caused the community members in Mutare city to intervene in the OVC crisis? Probe:
 - Was it crime in the neighbourhood?
 - Poverty among OVC?
 - Compassion to change OVC status?
 - How are you involved?
 - How did you become involved?
 - Why did you become involved?

I will ask you questions about factors influencing the effectiveness of service delivery to OVCs

3. What has been the factors influencing the effectiveness of the service delivery to OVCs?

- Which methods do you use in the attempt to address the plight of OVCs?
- In your own opinion, how effective are these CBO interventions for OVCs give reasons?
- How effective is each intervention method you are using (Identify best practice models)
- What are the legal operational requirements affecting the effectiveness of service delivery for OVCs?
- What challenges are you facing that may negatively affect your OVC interventions?
- Is there anything about your community that really worries you when thinking about effectively responding to OVC needs?

I will ask you questions about sustainability of community based interventions

4. How has the CBO been able to sustain their care and support interventions for OVC?

- Role of community members in the CBO operations?
- What capacities do you see that would be beneficial in providing care and support to OVC?
- Economic resources?
- Social resources?
- Individual community members values, attitudes and resources?

I will ask you about challenges associated with working as a diverse group

5. What have been the challenges of working as a diverse group in providing services to OVC?

- Your shared beliefs and expectations of OVC care and support?
- Norms of the organization?
- Common expectations for action and goal attainment of services provided to OVC?
- Skills, knowledge and abilities of the group?
- Effort and time spent on OVC care and support services?
- The presence of friendship, networks, residential mobility and poverty

Thank you so much for your time. It has been great speaking with you today. If I have questions as I move forward, would you mind if I contacted you again for quick follow-up? Thank you.

APPENDIX E: In-depth Interview guide for community volunteers

Introduction

My name is Mandla Ngwenya; I am a student with the University of South Africa (UNISA) doing a Masters of Arts in Social Behavioural Studies in HIV and AIDs degree with the Department of Sociology.

You have been selected for this interview because you have been identified as a volunteer who plays a significant role in providing care and support services to OVCs in Mutare city under a local community-based organisation.

The purpose of this research is to gather information on challenges faced by community-based interventions for orphans and vulnerable children in Mutare. All information gathered from this interview will be used for educational purposes and could assist the CBO in programming interventions for OVCs and contribute to OVC policy formulation. Your participation is purely voluntary and you may choose not to proceed with the interview at any stage or choose to skip any question if you are not comfortable in answering a particular question. Your name will not appear in any of the publications from this research. I will ask of your time for the interview for about 1 hour, although the actual interview may take less than an hour.

1. How many years have you been working as a volunteer with this CBO?
 - How many years have you been involved with care and support OVC?
 - How do you identify OVC?
 - What are the ages ranges of OVC in your support?
 - Geographic areas you serve?
 - What is the magnitude of the OVC phenomenon?
 - PROBE: response of phenomenon for explanation.

I will ask you questions about community-based interventions for OVCs in Mutare city

2. In your own opinion, what caused the community members in Mutare city to intervene in the OVC crisis?

PROBE:

- Was it crime in the neighbourhood?
- Poverty among OVC?
- Compassion to change OVC status?
- How are you involved?

I will ask you questions about factors influencing the effectiveness of service delivery to OVC

3. What has been the factors influencing the effectiveness of the service delivery to OVC?

PROBE:

- Which OVC interventions methods are you involved in?
- In your own opinion, how effective are these community-based interventions for OVC?
- How effective is each intervention method you are using (Identify best practice models)
- What does the community see as OVC needs?
- What would you improve for OVC to recover from these needs?
- How are the needs met by community interventions?
- What challenges do community members face in implementing OVC interventions? (time, money, knowledge)?
- How has the OVCs responded to the care and support you provide?
- Is there anything about your community that really worries you when thinking about effectively responding to OVC needs?

I will ask you questions about sustainability of community-based interventions

4. In your own opinion, how has the CBO been able to sustain their care and support interventions for OVC?

- Role of community volunteer in the CBO operations?

- What capacities do you see that would be beneficial in providing care and support to OVC?
PROBE: for any trainings, skills capacity building
- Do community members specifically work with other organizations outside the CBO?
- What has been the effect of collaboration?
- Economic resources?
- Social resources?
- How trust of community members affect your services for OVCs?
- Trust from other organisations and public trust?
- Would you describe your community as resilient?
- What affects your community's resilience?
- In your own opinion, what is community established value systems?
- Do you have a database or some other tool that you use to find different resources?

I will ask you about challenges you have experienced as a volunteer

5. What have been the challenges of working as a volunteer in providing services to OVC?

PROBE: Nature of the group of volunteers associated with the CBO

- Your shared beliefs and expectations of OVC care and support?
- Norms of the organization?
- Common expectations for action and goal attainment of services provided to OVC?
- Skills, knowledge and abilities of the group?
- Effort and time spent on OVC care and support services?
- The presence of friendship, networks, residential mobility and poverty?

Thank you so much for your time. It has been great speaking with you today. If I have questions as I move forward, would you mind if I contacted you again for quick follow-up?

Thank you.