

**Review of links between external, formal support
and community, household support to children
affected by HIV and AIDS in Zimbabwe**



Final Report



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This paper was prepared for the Joint Learning Initiative on Children and HIV/AIDS (JLICA). The Joint Learning Initiative on Children and HIV/AIDS is an independent, interdisciplinary network of policy-makers, practitioners, community leaders, activists, researchers, and people living with HIV, working to improve the well-being of HIV-affected children, their families and communities. All reasonable precautions have been taken by JLICA to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall JLICA be liable for damages arising from its use.

Executive summary

Children affected by HIV and AIDS are a group with increasing health and social needs. This study carried out by TARSC and National AIDS Council Zimbabwe sought to identify these needs and the responses to them from state and non state institutions, community institutions and members and children, and to look at the adequacy and effectiveness of these interventions and the interaction between them. It sought to identify what organizational, institutional and process features of the formal state and non state institutions to community networks have greatest relevance, coverage and equity in relation to needs of vulnerable children.

The research was implemented through sequential phases of

1. Review of secondary literature and evidence
2. Implementation of participatory action research in one district (Gutu district) to explore and fill possible gaps in the literature and documented evidence through systematized community experience
3. Key informant interview with eight district level and twelve national level informants to interpret and reflect on findings and evidence

Triangulation of the three sources of evidence was then done to draw conclusions on the research questions.

The study found that definitions of orphanhood and vulnerability are relatively consistent from international to local level, with some consensus therefore on who the targets for action on child vulnerability *should* be. International frameworks and national policy provide reasonable guiding frameworks for identifying vulnerable children but are less successful as prescriptions for strict targeting. Both to identify the children that are vulnerable in different community contexts, to engage communities and service providers beyond negative stereotypes and to bring children themselves into the discussion, it would be useful through participatory approaches to build shared understanding and locally identify vulnerable children.

Vulnerability was clearly associated with material deprivation and fallout from services, of the children and their communities, and with the additional social and psychological trauma, stress and deprivation of orphanhood or situations of abuse, neglect or poverty linked to child vulnerability. Vicious cycles are possible as deprivation in one form brings children into environments and life styles that increase their risk of other forms of vulnerability.

Population surveys are a key source of evidence on vulnerable children as many other facility based routine data sources may exclude vulnerable children, given poorer uptake of these services in poor households. With such a high level of orphanhood and vulnerability in children, the questions included in the Zimbabwe Demographic and Health survey can be reviewed to ensure that they map the distribution of needs and service coverage and uptake to deal with child vulnerability, to inform planning and the distribution of resources for the response. A striking feature of the published literature, however, is the absence of community and childrens views and voice and research on vulnerable children needs to include this more systematically, using participatory tools. This is particularly important as different groups appeared to tend to see as priorities the needs they could act on, and children gave significantly greater priority to needs that reflected experiences of abuse, disempowerment and emotional deprivation. Responses to these issues were seen to be critical to open pathways to meeting material needs.

The first line of support for children was consistently seen to come from families, extended families and communities, through arrangement of innovative means, although with increasing stress as numbers of vulnerable children increase together with household poverty. At the same time there is report that initiatives at community level receive limited external technical or financial support and rely largely on their own skills and material resources. This is not because other inputs do not exist. There are a range of formal state and non state institutions providing activities and services to support vulnerable children, including for education, access to food, health, water and sanitation (livelihoods management), education on nutrition and food security, education on health and hygiene, child protection, psychosocial support and counseling and birth registration. These are unevenly distributed within provinces, with areas such as large scale farms or informal settlements relatively isolated from services. The physical presence of state services does not necessarily translate into coverage of or access by vulnerable children, and NGO services, while they may provide innovation and intensity of interventions. In all cases the resources are inadequate for the scale of need, signaling the need for more effective ways of using scarce resources to meet the range of needs of vulnerable children. Hence while comprehensive laws and policies exist to address the needs of vulnerable children, the lack of integration of these policies into wider plans and budgets may limit financing of specific needs of vulnerable children through routine social spending and leave such support highly dependent on social welfare assistance and on external support.

This raises two issues:

- ♦ Firstly the need for stronger links between formal institutional inputs from state or non state institutions, and the inputs provided by FBOs, other initiatives organised at community level, and families and children, particularly where these build the capability of households to look after children. It was felt that in a child centred approach, services should be built first around the institutions that children are most likely to be in contact with, naming these as schools, clinics, the Child Protection Committees, churches and support groups. Various examples of positive links already exist and are reported on that can be widened and consolidated institutionally. The importance of capable and effective co-ordination mechanisms within the VAC and DAC was raised for such links to work well.
- ♦ Secondly the need for communities, families *and* children to be more informed of and involved in decisions on forms of support and their outreach. Choices on how to use limited resources appear to be currently made at higher levels of NGOs and state institutions, and participatory processes could be used to prioritise measures and review interventions with communities and children, locally. Further monitoring of resource flows and programmes was generally felt to be necessary, involving the DACs as presently the case, but involving communities and vulnerable children.

Particularly in the community level discussions, it was felt that young people and vulnerable children can be empowered and play a stronger role in responses to children's needs, by involving children in their programmes, within joint committees, supported by skills training, projects that exhibit their talents, enhance their autonomy (including income generating projects) and through services that are oriented to youth (such as youth friendly corners). Organisations working with youth thus need to take specific measures and conduct regular needs assessments to facilitate youth involvement. Participatory methods provide a useful means for engaging this contribution and enabling action at local level.

The triangulation of evidence from three sources (documented literature, key informant interview and local participatory inquiry) reveals commonly identified features of vulnerability in children and the responses to it, as well as differences discussed in the previous section

that perhaps highlight the need for responsiveness to different 'lenses' on the issue, from children to community, local organizational and national institutional level. It is suggested that responses to child vulnerability be framed on a mix of evidence from formal sources (surveys and information systems) and participatory inquiry, given the problems of limited coverage of marginal communities in formal databases and of poor inclusion of key parameters such as psychosocial support, nurturing and social cohesiveness in more quantitative sources.

On the basis of the three sources of evidence it is recommended that

- i. Explicit age cutoffs and formal criteria for children affected by HIV and AIDS and other vulnerable children be supported by participatory methods to identify local dimensions of child vulnerability, and that community registers of vulnerable child beneficiaries be established with community involvement
- ii. The allocation of national government resources for children affected by HIV and AIDS across geographical areas could be more fairly done using a resource allocation formula that takes into account the level of need (poverty, HIV prevalence, numbers of children affected by HIV and AIDS) and the level of current resources for the response, using indicators of current formal and community safety nets. Follow up research is needed to identify indicators for the latter, covering education, health care, food security, shelter and some index of community networks
- iii. The allocation of local government resources be linked to a co-ordinated plan involving local institutions and community representatives, with individually allocated resources using the register of vulnerable children compiled in the district with community input, and with community roles and capacities to monitor and evaluate the delivery and effectiveness of resources allocated and interventions made.
- iv. Wherever feasible, approaches that provide benefits at a wider, more inclusive level with community involvement be chosen to avoid problems of individual targeting. (eg ensuring school books reach all children, removing fee barriers at clinics, or providing inputs for community food plots).
- v. Entry points for vulnerable children be locally mapped (eg schools, health services, social welfare offices, churches, community associations and support groups) and adequately staffed, resourced, trained and oriented to make links with and provide services to vulnerable children and the households supporting them.
- vi. Formal organisations from government, NGOs and private sector address barriers to recognition of children affected by HIV and AIDS, such as birth certificates; build community and vulnerable children's capacities, and strengthen community leadership to input to programme design; give preference to mechanisms that distribute resources directly to recipients and that are signed for; co-ordinate with each other and have adequately staffed structures to community level; use local structures, avoid creating parallel structures and have clear means for reporting issues and problems, and for solving them and build community capacities to implement these functions.
- vii. Structures that exist within the community that provide co-ordination, including child protection committees and the village, ward or district AIDS Committees have greater input to local design and application of formal state and large NGO programmes, within broad guidelines, with provision for regular planning, dialogue and review meetings, including using PRA approaches, and support for community and local CBO capacities and skills to effectively voice issues and approaches in these committees.
- viii. The monitoring and evaluation framework that exists at national level, be decentralised further in its functioning to provide for strategic use and review of information at district level, and through more participatory methods with communities at local level, including with youth.

1. Background

According to the Zimbabwe National Action Plan (NAP) for orphans and other vulnerable children July 2004, a child is defined as a person below the age of 18; an orphan as one who has lost one or both parents, and vulnerable children as those with unfulfilled rights. In the Zimbabwe National Orphan Care Policy, orphans are children aged between 0-18 years whose parents have died. Vulnerable children include children with one parent deceased (in particular the mother), children with disabilities, abandoned children, destitute children, abused children, children infected and affected with HIV and AIDS, children living on the streets etc. There are an estimated 1.3 million orphans in Zimbabwe. In 2007 alone, 130,000 children were projected to lose one or both parents, and orphans to account for 25 per cent of children (UNICEF 2007).

Children orphaned and made vulnerable by AIDS are often seen as amongst the most common vulnerable social groups in Zimbabwe. *“These children are subjected to a wide range of social and economic difficulties: psycho-social distress, grief, stigma, discrimination, isolation, and economic deprivation, loss of educational opportunity, burdensome domestic responsibilities, and fear for their own future”* (Govt of Zimbabwe 2004 p8).

The National Action Plan (NAP) for Children affected by HIV and AIDS aims towards increased enrollment and retention of vulnerable children in schools; increased access to food and shelter; access to education, health and nutrition; protection from abuse; increased birth certification and increased resource mobilization for children affected by HIV and AIDS. While the policy intention exists in the NPA, application of the policy faces many constraints. Zimbabwe faces a mix of economic, HIV epidemic, public sector and social challenges that deepen vulnerability in the population, children included.

There are various responses to these challenges. Many published articles refer to community coping mechanisms, but community safety nets remain inadequately described and poorly understood. One review found that *“community safety nets target households in greatest need, respond rapidly to crises, are cost efficient, based on local needs and available resources, involve the specialized knowledge of community members and provide financial and psycho-social support. Their main limitations are lack of material resources and reliance on unpaid labour of women”* (Foster 2007). Changes noted in community safety nets signal the responsiveness and resilience of communities, although with observation of inadequate support from external actors.

Nearly 40 per cent households with children reported to have received at least one form of external support in 21 surveyed districts. The most common form of assistance was medical care, including medical supplies and medicine (Government of Zimbabwe and UNICEF, 2005). Non government support also includes food, medical care and education costs. From government, the National AIDS Council (NAC) offers support for school fees and school stationery, supports the Zunde Ramambo programme to support food security, while the Department of Social Welfare administers the Basic Education Assistance Model (BEAM) through the Ministry of Education. The funds for these government programmes come from Ministry of Finance budget allocations (BEAM) and

tax levies (National AIDS Council disbursements), and coverage, adequacy and uptake is limited and access is further challenged by hyperinflation, household poverty, limited coverage of birth registration and stigma (UNICEF 1998; USAID 2000; UNICEF 2007).

The 2006 National Health Accounts Study thus revealed that the household continues to bear a significant burden in looking after orphans and people living with AIDS (NAC, Ministry of Health and Child Welfare, UNAIDS, 2006). This household and community support is not only important to meet material needs, but to provide caring, and relationships of trust and solidarity (Loewenson 2007; Decosas 1999; Barnett and Whiteside 2002).

A 2006 joint NAC/ TARSC training on participatory approaches for Children affected by HIV and AIDS for District level NAC officers, NGO co-operating partners in districts and district youth co-ordinators verified these problems of inadequate coverage and quality of services for vulnerable children, with weak co-ordination between diverse organizations, despite the presence of co-coordinating mechanisms. Community institutions that have closest contact with vulnerable children were noted to themselves have weak linkages with formal sources of support (NAC/TARSC 2006).

With this background, questions arise about the most relevant and effective forms of support by formal state and non state institutions outside communities that would support family and community safety nets for vulnerable children.

The study reported here specifically, addresses research questions around this:

1. What are the priority needs of children affected by HIV and AIDS in Zimbabwe as identified objectively (from data) and as perceived by state and non state institutions, community institutions and members and by children affected by HIV and AIDS?
2. How are these needs being met by household, family and community forms of support? What is the nature and consistency of this support, provided by whom, in what form, with what resources or inputs?
3. What are the formal sources of support provided by state institutions and by formal national and international non state organizations from outside the community for needs of children affected by HIV and AIDS? How do these sources of support relate to the priority needs of children affected by HIV and AIDS?
4. How do formal sources of support from state and non state institutions from outside the community interact with household / community support for needs of children affected by HIV and AIDS? What is the nature of the links and resource flows? How complementary are their areas and means of support? How comprehensive is their coverage? How sustainable, equitable, relevant are the resource transfers? What provisions do they make for community, and child / youth empowerment and social cohesion? How are these forms of support rated by communities and children affected by HIV and AIDS?
5. What are the organizational, institutional and process features of the formal state and non state institutions to community networks found to have greatest relevance, coverage and equity in relation to needs of children affected by HIV and AIDS?

It is argued that a simple collection of secondary evidence will not adequately answer the research questions, given the gap between documented evidence and changing community experience. The research was thus implemented through sequential phases of

- ♦ Review of secondary literature and evidence
- ♦ Implementation of participatory action research in one district to explore and fill possible gaps in the literature and documented evidence through systematized community experience
- ♦ Key informant interview to interpret and reflect on findings and evidence
- ♦ Triangulation of the three sources of evidence to identify robust conclusions on the research questions.

2. Methods

This work aims to build on existing background literature review (Foster 2007) and on participatory inquiry implemented by TARSC and NAC at district level. Over the period August 2007 to January 2008, the following steps were implemented:

- i. Secondary evidence from published and grey literature, district operational reports, organizational reports of organisations working with children affected by HIV and AIDS in Zimbabwe was compiled by consultants from NEDICO with input from TARSC and NAC on
 - ♦ the forms of household, family, community, organizational (NGO, state and private) support to the needs of vulnerable children
 - ♦ the interactions between household / community and formal organizational support in relation to the needs of vulnerable children, their complementarity, comprehensiveness of coverage; resource transfers, equity in burden sharing; sustainability; community and youth empowerment and social cohesion.
 - ♦ The organizational, institution and process features of positive interactions household / community and formal organizational support.
- ii. Using participatory reflection and action (PRA) processes, the TARSC and NAC team explored in one district the community and local organizational experiences and perceptions of
 - ♦ the forms of household, family, community, organizational (NGO, state and private) support for the spectrum of needs of vulnerable children
 - ♦ the interactions between household / community and formal organizational support in relation to the spectrum of needs of vulnerable children, and their positive and negative features
 - ♦ options for enhancing positive interactions household / community and formal organizational support at district and community level in Zimbabwe.
- iii. Key informant interviews were implemented at national level by NAC and at district level by TARSC. The key informant interviews aim to explore policy and public official perceptions of options for enhancing positive interactions household / community and formal organizational support at district and community level in Zimbabwe.

Evidence from the three different sources (review of secondary evidence, key informant interview and participatory community level inquiry) and the common and different features of the findings from the three sources were then assessed to identify

- ♦ areas of learning on interactions between household / community and formal organizational support at district and community level and options for strengthening positive interactions in Zimbabwe;
- ♦ implications for policy review, organizational practice and for sources of evidence and monitoring systems to inform policy setting or programme development on community support for vulnerable children.

It is intended that this report will be made available to district and national stakeholders for follow up discussion of the implications.

2.1 The literature review

The literature review was implemented in August – September 2007, and gathered, reviewed and synthesized secondary evidence from published and grey literature at district, national and international levels. Key words related to concepts of vulnerability, children and orphanhood were used to search information from libraries (both electronic and physical), websites and providers of support for children affected by HIV and AIDS in Zimbabwe. The sources varied from case studies, surveys and already existing reviews. Surveys offered more generalized information with a wider geographical coverage, though not much detailed. Case studies provided more focused, detailed but also more anecdotal evidence. The sample sizes for case studies tend to be small, limiting their wider generalisability. The literature reviewed drew from that covering poverty/livelihoods, HIV and AIDS and child protection, mostly from the HIV and AIDS materials. There was a gap in the literature from other social sectors, and much of the literature addressed issues of vulnerable children through the lens of HIV and AIDS. The draft paper was peer reviewed internally including in the light of the follow up research to be implemented through participatory and community inquiry.

2.2 The district participatory reflection and action

Gutu district in the Masvingo Province, and specifically Mupandawana growth point, approximately 180 kilometers outside Harare was jointly identified by NAC and TARSC as the site for the participatory inquiry. It is one of the 12 districts (covering all provinces) where prior PRA work has been done (to draw on and reinforce existing mapping and capacities) and where there is potential for follow up support through local mechanisms of responses to needs of vulnerable children. It was originally intended to visit three districts, but as notified to the JLI, the limited budget and inflation of costs in Zimbabwe meant that the resources available only enabled us to visit one district.

The main economic activities in Gutu are communal crop and livestock farming. The district participants to this meeting were drawn from community support groups, representatives of AIDS Service Organisations, Government officials and the various Ministry bodies, including Ministry of Health and Child Welfare, Ministry of Labour and Social Welfare, and the Ministry of Education Sports and Culture. Councillors, village traditional leaders and the Chief, Madondo, heavily represented local leadership. Other officials at the meeting included the Police, and the District Administrative Officer. The PRA process was implemented in a two-day meeting to explore community and local organizational experiences and perceptions of vulnerable children, their needs, the forms of household, family and community support for these needs, and their relevance,

adequacy and sustainability. The PRA process was also used to obtain local perceptions of the relevance, coverage, adequacy and effectiveness of formal organizational (state and non state) support for children's needs and for household and community responses, and the options for enhancing positive interactions between household / community levels and formal organizational support at district and community level in Zimbabwe. While the methods were used to obtain community based evidence, they also encouraged local dialogue and planning of community based actions.

2.3 The key informant interviews

District level key informant interviews obtained perceptions of vulnerable child needs and of options for enhancing positive interactions household / community and formal organizational support at district and community level in Zimbabwe. A range of district level personnel were interviewed, including the

- ◆ Local leaders: District councilor; Headman; Chief
- ◆ Village health worker; Health centre nurse
- ◆ Headmaster
- ◆ Church leaders
- ◆ Children in and out of school
- ◆ District social welfare officer, and the
- ◆ NAC district co-ordinator

Further national level interviews were of non government organisations and international agencies supporting programmes at community level, and of senior staff from relevant government and non state institutions, covering

- ◆ National government departments (Department of Social Welfare; Ministry of Health and Child Welfare; Department of Nutrition, MoHCW; Department of child protection, Ministry of Labour and Social Welfare; Ministry of Education and Culture;
- ◆ Zimbabwe Republic Police
- ◆ International agencies (World Food programme, UNICEF, SCF (UK); World Vision International; Plan International; Care International) and
- ◆ Selected national NGOs working at community level (Farm Orphan Support Trust).

Key informants were similarly asked for their views and evidence on the needs of vulnerable children, forms of household, family and community support and resource gaps, forms of support from state and non state organizations for these needs, the major barriers to resources from state and none state institutions reaching community and family institutions that support orphans, and the organizational, institutional and processes that they perceive to provide relevant and sustainable support to community networks.

This report has been compiled by TARSC and NAC. Principal investigators in the work were R Loewenson (TARSC) and A Mpofu (NAC) and contribution to the field work was made by S Dhlomo, T Chikumirike (TARSC) and S Marunda (NAC), and to the literature review by V James and A Milanzi (NEDICO).

3. Findings

3.1 Definitions of orphanhood and vulnerability

An “orphan” is relatively commonly defined as a child under 18 years of age, who have lost one or both parents (UNAIDS, UNICEF, USAID, 2004; UNICEF CSO, 2007). While vulnerability is often associated with orphans from the AIDS epidemic, children can be orphans and not vulnerable, or can be vulnerable without necessarily being an orphan.

There is limited documented evidence on community views on a definition of orphanhood in Zimbabwe. According to rural community surveys, orphans (*nherera / intandane*) are defined as children who had lost one or both parents, consistent with official definitions. Communities took cognizance of fostering of children by adult guardians as a further protection against vulnerability, and did not impose age limits on children, seeing the end of dependency as when people are able to look after themselves or are married (BRTI, HSRC, NIHR and FACT, 2006).

Vulnerability is often associated with deprivation of rights, due to loss of parents, disability, abandonment, destitution, abuse, HIV infection, food insecurity and life on the streets (GoZ, 2004; UNICEF, 2001; World Vision 2002; UNICEF 2005c). Within Zimbabwe, the ‘National Plan of action for Orphans and Vulnerable Children’ defines vulnerable children as children under the age of 18 who need some extra help to live better, healthier lives (Government of Zimbabwe, 2006) Children are seen to be vulnerable when they:

- Live in a household in which at least one adult is chronically ill, or whose caregivers are too ill to continue looking after them, dying, deceased, very old or frail
- Are orphaned, or living in households that foster children / orphans;
- Are abandoned or neglected, or living in child headed-households;
- suffering from deprivation due to deepening poverty, living on and off the streets;
- disabled; or
- married or sexually, physically or emotionally abused (Government of Zimbabwe 2004c).

National level key informants identified children affected by HIV and AIDS as those

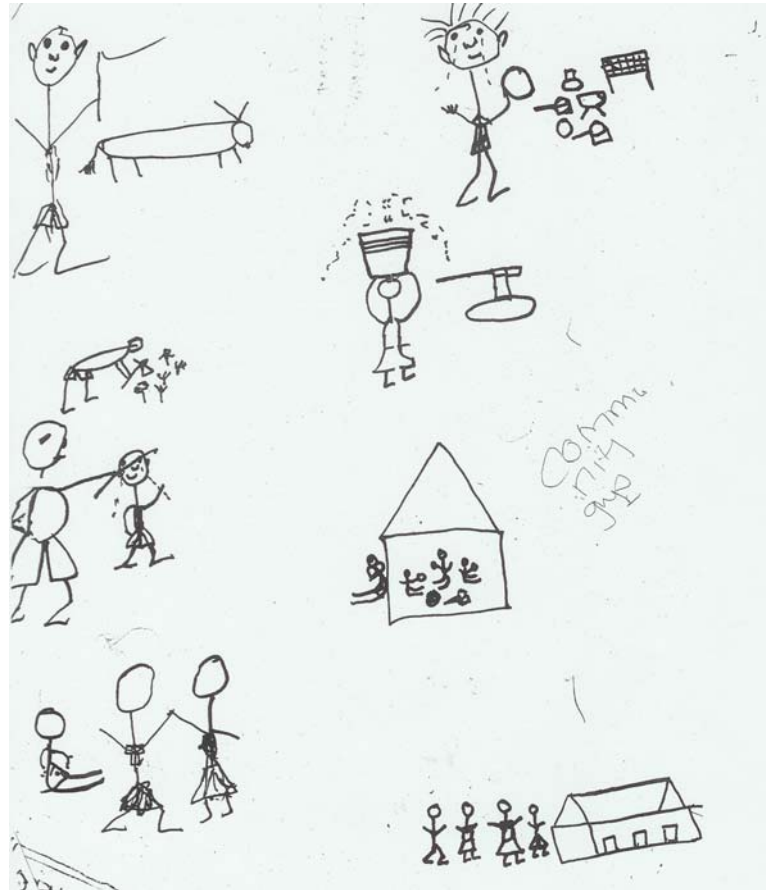
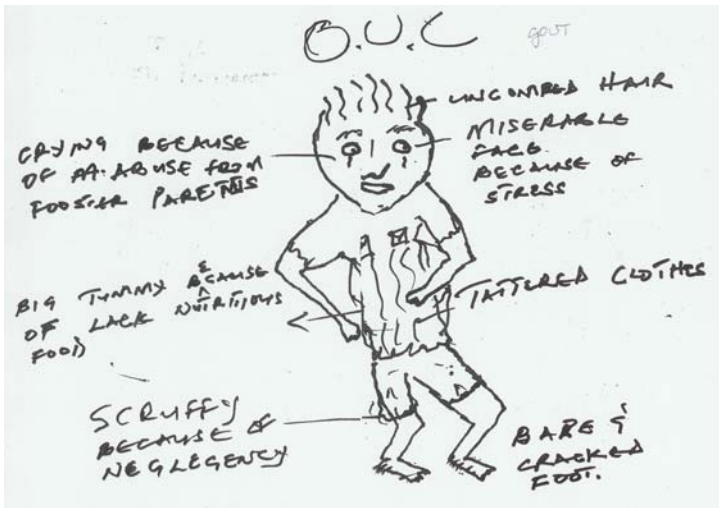
- ♦ Who do not have one or both parents, or whose parents are unable to provide for their basic needs due to ill health, age or disability
- ♦ Who are exposed to abuse
- ♦ Who are adversely affected by their circumstances.

Community level surveys report that communities identify children as vulnerable when they are separated from caregivers, malnourished, abused, neglected, out of school, disabled, ill, required to do excessive work, or lack access to services food, protection, health care, clothing, education, adult supervision, and emotional support (Richter et al, 2006; HSRC, BRTI, NIHR and FACT, 2006). In the participatory inquiry in this study, drawing and discussion was used as means of understanding how government, NGO, child and community participants perceived orphans and vulnerable children. No direction was given to the drawings.

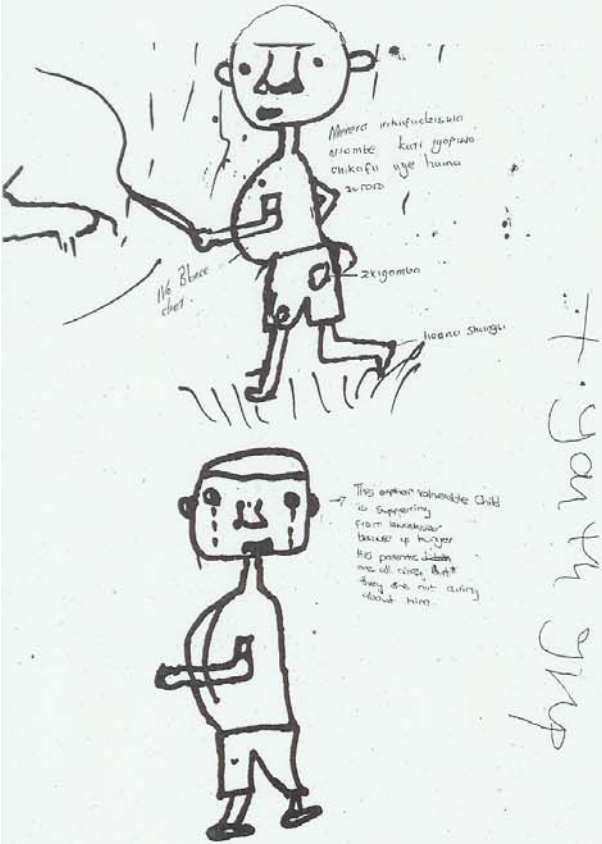
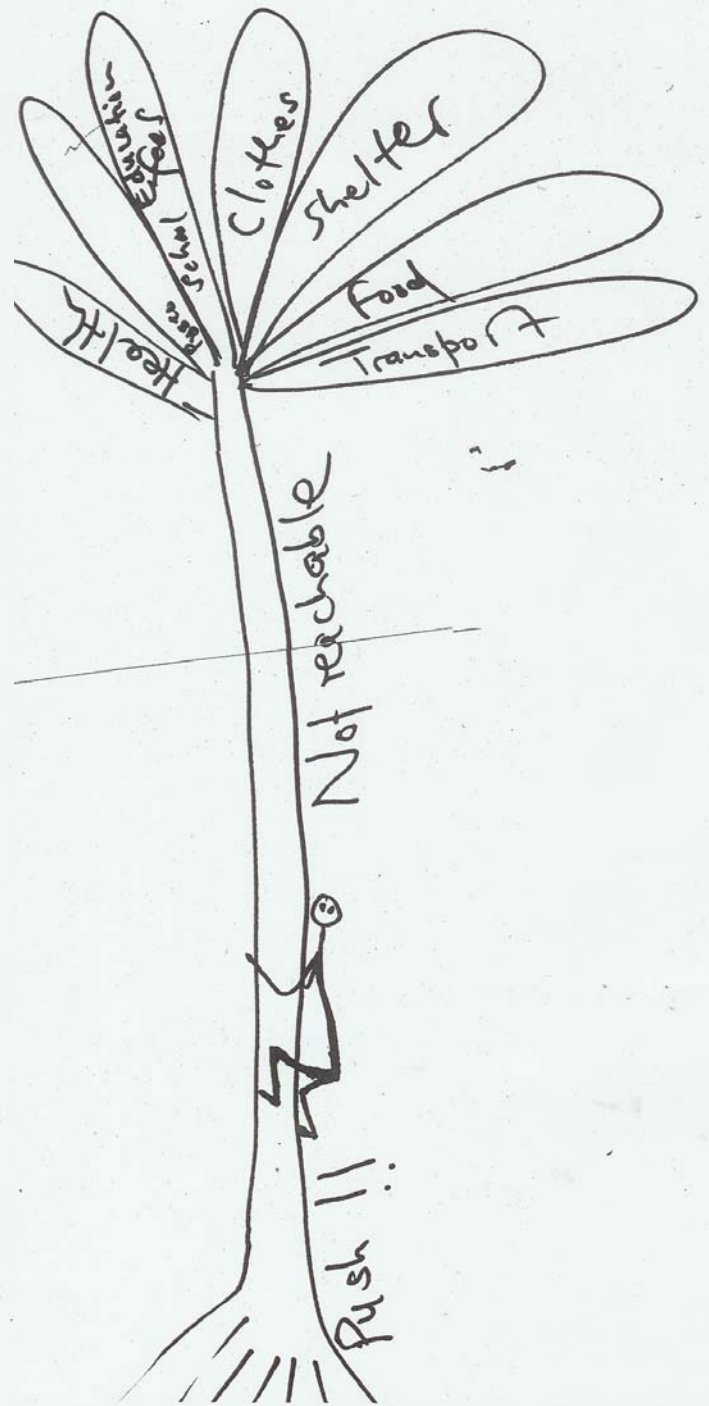
- ♦ Government participants: drew a person with unkempt hair, tattered clothes, bare and cracked feet, a big stomach from poor nutrition, crying because of abuse from foster parents, and a miserable face because of stress.
- ♦ NGO participants: drew a tall tree with a little person trying but not able to reach to the branches where there was good health, food, shelter, clothes, education, school fees, and transport.

- ♦ Community members: drew a child being beaten with a very big stick, a child carrying a bucketful of water, washing plates whilst crying, herding animals, working in the field, and a child staying at home while other children are going to school.
- ♦ Children: drew a child herding cattle in the rain, with a big stomach with kwashiorkor, hungry, being chased away from home by foster parents into the rain, with tattered clothes, and being forced to work so that they earn money for their school fees.

The process provoked debate on the different perceptions and confronted some of the negative terminology and perceptions people had, while still projecting a harsh reality for the children. For example, people felt that the term “street children” was not acceptable, as streets cannot bear children, and preferred the term “children living in the streets”.



Drawings of vulnerable children from (i) government, and (ii) community groups



Drawings of vulnerable children from (i) children and (ii) NGO groups

Common to the drawings were images of poverty (poor clothing, undernutrition), unhappiness, stress, neglect and deprivation, relatively negative stereotypes. In the government, community and childrens drawings there were also aspects of active abuse, such as of being beaten or chased away. In the community and children's drawing there was a further dimension, of children taking on work or activities to support their own or family needs, earning money for school fees, or carrying out farming. The children identified compulsion around these tasks. It would appear that the NGO focus was more on the areas of deprivation of basic needs, while the children's focus was more on experiences of active abuse and oppression, with deprivation of emotional support and childhood. District level key informants had relatively similar definitions, adding that in some cases, children have themselves run away from home and live in bus terminuses or informal settlements.

The definitions of vulnerable children that each group formed are summarized in Table 9 below. As in the surveys cited in the literature, age is not an issue for community and child members. Vulnerability is linked to parental death, but also to other reasons for deprivation of parental support: neglect, abandonment, remarriage or because parents suffer mental and physical illness or disability or poverty.

Table 1: Perceptions of vulnerable children and children affected by HIV and AIDS

From government and NGO participants	From the community	From children and youth
<ul style="list-style-type: none"> • Children are below the age of 18 • Two views: Children with both parents deceased and Children with one parent alive and the other deceased. • Children of negligent parents • Children of physically disadvantaged parents. • Children living in the streets • Children of mentally disturbed parents • Children with parents who are HIV positive • HIV positive children 	<ul style="list-style-type: none"> • Two views: Children with both parents deceased and Children with one parent alive • Children who do not know their parents (dumped children) • Children of poor parents. • Children of terminally ill parents. 	<ul style="list-style-type: none"> • Children without parents • Children who face some problems even whilst both parents are alive. • Children who are abused because the parents remarried. • Children living with people who are not their parents, with their parents unknown or eloped.

“Nherera dzirikuramba dzichiwanda muno muGutu, asi toita sei?”

”Numbers of orphans and vulnerable children continue to increase in Gutu, so what will we do about it?”

Community participant

In the same four groups, participants mapped their communities, identifying the different types of vulnerable children and their points of contact in the district. In the study district, the vulnerable children in the community were identified as those who:

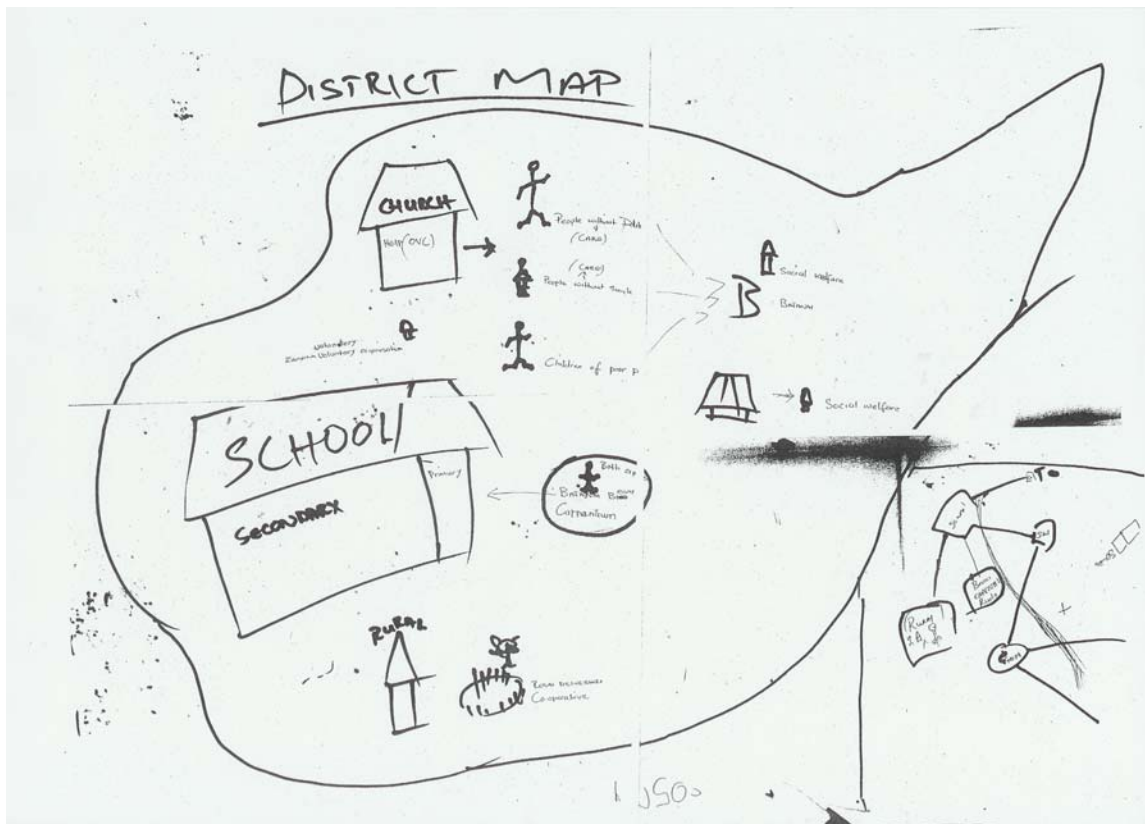
- Had both parents deceased
- Had HIV positive parents or who were HIV positive themselves.
- Were neglected, living in an informal settlement area called “magwidi³”, or abandoned by parents who had gone to find jobs in big cities (Child headed homestead)
- Living in the streets

Further one type of deprivation, like abandonment, was observed to make children more vulnerable to others, like abuse.

“KuMagwidi nherera dzirikutambudzwa”

“In the makeshift homes areas children are being seriously abused.”

Community participant



Community map from NGO groups

A range of contact points were identified in the maps, where vulnerable children are most likely to be found. Most commonly identified were primary and secondary schools, while the hospital and the ‘magwidi’, bus termini and waiting rooms were also identified. Peri-urban areas, co-operatives, churches, the social welfare department and community support groups were also noted as points of contact for vulnerable children (UNICEF 2007).

³ Magwidi are poor settlement areas with makeshift homes. .

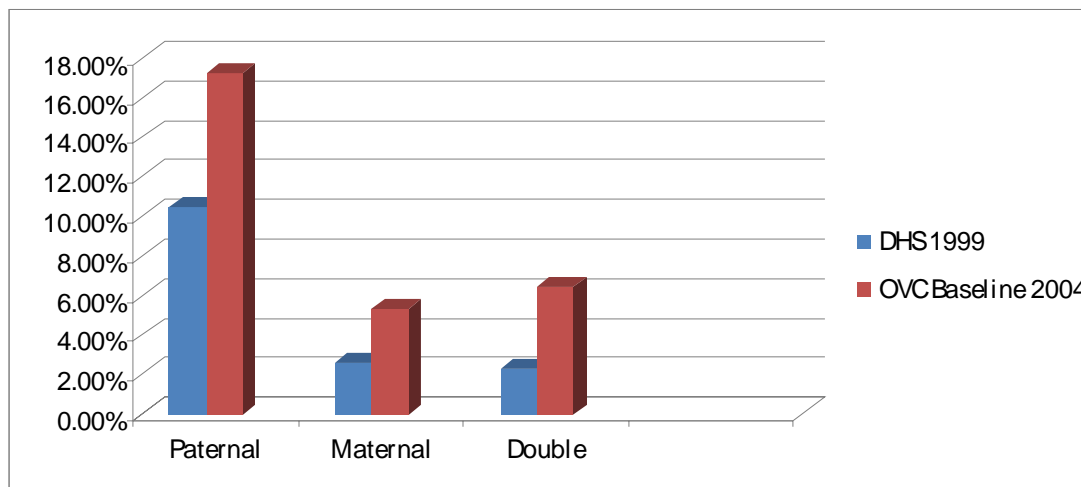
It would appear that definitions of orphanhood and vulnerability are relatively consistent from international to local level, with some consensus therefore on who the targets for action on child vulnerability *should* be. The international frameworks and national policy provide reasonable guiding frameworks for identifying vulnerable children.

They are perhaps less successful as prescriptions for strict targeting. Communities are less preoccupied by age limits than by different forms of dependency, and children are more preoccupied by emotional and material deprivation and oppression that go along with neglect and loss of parenting. While immediate portrayals of vulnerable children sometimes project harsh negative stereotypes, portraying them more as objects than subjects in their community, participatory approaches have some potential for bringing different lenses on the issue together, to deepen discussion beyond stereotypes to explore dimensions of vulnerability, to recognize children’s experiences and to build a common and deeper understanding from which to locally identify vulnerable children.

3.2 Scale and dimensions of orphan-hood and vulnerability in children

The AIDS epidemic has led to an increase in the number of vulnerable children. In 1990, fewer than 1 million sub-Saharan African children under the age of 15 years had lost one or both parents. By 2002, it was estimated that this figure had risen to 13 million children, mostly focused in Sub-Saharan Africa (UNAIDS, UNICEF and USAID, 2002). With a high prevalence of adults with HIV and still low rates of treatment access in Sub-Saharan Africa, the number of children who have no living parents due to AIDS will nearly triple by 2010 (UNICEF, 2003). This trend is also found in Zimbabwe (See Figure 1) where 30% of the child population in rural and urban high density areas of Zimbabwe were found to be orphans in national surveys (NAC, MoHCW, UNAIDS, 2006; GoZ, UNICEF 2005).

Figure 1: Percentage of orphaned children in rural Zimbabwe by type, 1999 to 2004



(Source: Government of Zimbabwe and UNICEF, 2005)

The 2005/6 Zimbabwe Demographic Health Survey (ZDHS) found 60% of Zimbabwean children under the age of 18 years in households sampled were not living with both parents. More than 25% were not living with either parents, and 25% were orphaned. Rural

children (26%) were more likely to be orphans compared to urban children (19%). A comparison with the earlier 1994 ZDHS survey indicates that there has been a dramatic increase in orphan-hood from 9% to 22%. The proportion of paternal orphans increased from 7% to 19%, maternal orphans from 3% to 9% and double orphans from 1% to 6% between 1994 and 2005-06 (CSO, 2007).

A range of household and community contexts underlie child vulnerability. Vulnerable children are documented to live in bigger households headed by older family members, such as grandparents (UNICEF, 2003), as well as in child headed households. In both of these situations, parental support may still be available, but communicated remotely due to migrancy, through cash remittances or packages of food and clothing sent from other countries. This leaves children without adult supervision or guidance, and sometimes without support (UNICEF, 2003; UNICEF 2001).

The strong extended family protection of vulnerable people in the past was a basis for the assertion that traditionally, *'there is no such thing as an orphan in Africa'* (UNICEF, 2001; Foster et al, 2000a). More recently, beyond mortality and migrancy, weakening levels of family stability and support are documented to arise due to household poverty, and to increasing barriers to accessing basic services, despite increased needs. Women and children affected by disability are reported to be more vulnerable to these effects (The Synergy Project, 1998; Richter et al, 2006; UNICEF, 2003; Bernard van Leer Foundation, 2005; Lansdown, 2001).

Despite this, the extended family is argued to remain the main source of caring for orphans in communities in Africa with a generalized AIDS epidemic (Ankrah, 1993; Foster et al, 1995; Ntozi, 1997a). However households are doing this in the face of negative economic impacts of AIDS, economic decline, food insecurity, unemployment and rising cost of living, leaving children more vulnerable to deprivation (UNICEF, 2005; UNDP, 1998; CSO, 2007; Foster, and Jiwli 2001; ZIMVAC 2005). The combination of increased orphan numbers, reduced numbers of prime-age caregivers and weakened extended families results in orphans slipping through stressed extended family and community safety nets (Foster et al, 2000a). Meanwhile households coping with economic stress through means such as reducing the number of number of meals per day, or reducing expenditures on education or health risk further increasing childrens vulnerability (ZIMVAC 2005).

The dimensions of vulnerability in orphans and other vulnerable children in Zimbabwe are varied. While Zimbabwe has high levels of primary school enrolment (90% in the 2005/6 ZDHS survey) , transition to secondary school is much lower, with only 24% of children aged 13- 18 attending secondary school (CSO, 2007). Drop out from schooling is highest in poorest households, with drop out attributed to inability to pay school fees, need to help with house labour, or caring for a sick parent or younger siblings (CSO, 2007; USAID, 2000) While some assessments report children affected by HIV and AIDS to be twice as likely to drop out of school (UNICEF, Government of Zimbabwe, 2005; ZIMVAC 2005), the 2005/6 ZDHS suggests only slight disadvantage in orphaned children with respect to primary school attendance, with 89% attending school compared to 91% of other children. Yet children affected by HIV and AIDS were found in the survey to be disadvantaged in other respects, including lower access to food security, health care, protection from sexual abuse (See Table 2): 21% of orphans under 5 years of age were underweight (<2 standard deviations on weight for age), compared with 16% of other children, with worse levels in urban than rural children.

Table 2: Comparison of needs surveyed children generally and for children affected by HIV and AIDS

Specific Needs	General Level of Children who access the need	Specific Level of children affected by HIV and AIDS who access the need	Source
Birth Registration	70%	No data	GoZ, UNICEF, 2005
Access to Education	91%	89%	ZDHS 2005-2006
% Children <5 yrs underweight	16%	21%	ZDHS 2005-2006
% eating less than 3 meals per day	34%	67%	USAID 2000
Basic Material needs for personal care	49%	35%	GoZ, UNICEF ,2005

(Source: CSO 2007; Government of Zimbabwe and UNICEF, 2005)

These population surveys are a key source of evidence on vulnerable children as many other facility based routine data sources may exclude vulnerable children, given poorer uptake of these services in poor households in both urban and rural areas (Government of Zimbabwe and UNICEF, 2005), and poor reporting of sexual offenses and other abuses (UNICEF, 2001). With such a high level of orphanhood and vulnerability in children, it is important that the Zimbabwe Demographic and Health survey map and measure the distribution of needs associated with child vulnerability as comprehensively as possible, to inform planning and the distribution of resources for the response.

Ad hoc surveys provide further information on the nature of vulnerability: Survey reports and policy documents cite a number of areas of vulnerability and need, including birth registration, educational assistance, access to health care and nutritional support, psychosocial support, shelter, tenure security, protection from physical and sexual abuse opportunities for sustainable livelihoods (See Table 3). Birth registration is important for children to access public and welfare services and education beyond grade seven, and to prove lineage to inherit property or death benefits (UNICEF, 2005a). In 2004/2005 nearly 70% of children surveyed in 21 districts were registered, more so in urban areas (UNICEF, 2005b).

Table 3 Vulnerable children’s needs as identified in different sources.

Vulnerable children’s need	International and national policy documents recognising the need
Support to access education	UNDP(2007); European Coalition of positive people (2003); Ministry of Education Strategic Plan(2000-2006)
Access to Health Services and Food	Government of Zimbabwe(2004) UNCRC Article 24; UNICEF(2005a)
Protection against sexual and physical abuse	CRC Article 19,33-37 Government of Zimbabwe(2004); ZDHS (2005-2006)
Birth Registration	GoZ, UNICEF(2005a) Government of Zimbabwe(2004)
Psychosocial Support	OVC Support Tool Kit, Family Health International and International HIV/AIDS Alliance; Government of Zimbabwe(2004)
Shelter	FOST (2002)

The Zimbabwe Vulnerability Assessment Committee (ZIMVAC) (2005) found that most orphan headed households were food insecure and engaged in negative coping mechanisms, including reducing the number of meals per day (62%), reducing expenditure on education (41%), on health (36%) and on agricultural inputs (35%). One study found that orphans were significantly more likely to have less than three meals per day compared to their counterparts (67% vs 34%) (USAID, 2000).

While these needs are found in vulnerable children in all areas, the data cited earlier suggests higher levels of material deprivation and service fallout in rural children. Children on commercial farms were by 2002 particularly disadvantaged, with about 20% of the one million children that lived on commercial farms at that time estimated to be orphans, and weak support from extended families due to high levels of historical migrancy from surrounding countries onto farms, and weak contact, even in Zimbabwean nationals, with extended families living in communal areas (SafAIDS, CFU 1996). Children on large scale farms have been reported to have lower levels of school enrollment than national levels, with long distances to schools (SCF UK, 2000). They are reported to experience poverty, exclusion, sexual harassment and hunger, to live in poor housing, have poor access to health care, to work as casual labour and to lack birth registration certificates (SafAIDS, CFU 1996). While these conditions have been reported over a long period on large farms, a 2002 FOST study of 17 orphan households in farm worker communities in two provinces of Zimbabwe found through follow up visits after 6 months that children's situations had significantly worsened due to the weakening capacity of communities to provide support, pushing older children into risky behaviors, exposing themselves to high risk of HIV infection, abuse and exploitation (Walker, 2002). Such conditions may also be found in other sectors, such as in the informal mining sector shown in the box below.

Box 1: Children in informal mining sector in Mutorashanga and Shamva

About 20% of primary school age children in the informal mining sector in two districts of Mashonaland West were out of school, whilst only five percent who could have been at secondary school were attending school. Teachers indicated that most of the children leave school after grade seven and start work on the adjacent farms or join their parents in the informal mining sector.

These children are involved in a range of forms of labour that often take precedence over schooling, including seasonal work on the commercial farms, or helping to till, plant and weed crops in the fields of rural homes. Children drop out of school for a month or two while they earn their school fees. Primary school children also walk distances of between five to ten kilometers to the nearest school. They face further barriers, including lack of motivation of parents, lack of birth certificates, and inaccessibility of schools during rainy seasons. Teenage pregnancies account for 10% of children who drop out of school. Some of the children reported that the teachers force them to fetch water and firewood for them so they do not go to school to avoid this.

Malnutrition and respiratory diseases were also found to be common amongst vulnerable children in the informal mining sector. Teachers reported that children routinely come to school hungry, and some faint from lack of nourishment or are unable to concentrate at school, which militates against learning.

Save the Children-UK, 2000

These features of vulnerability are not simply those of the child, but of the household and wider community context within which children live. The focus in published literature is on material and service dimensions of vulnerability (income poverty, food and nutrition, shelter,

access to services) that create the conditions for further vulnerability, in vicious cycles. The next section examines the interventions that aim to mitigate impact and break cycles of vulnerability. Less commonly raised in these published sources are issues of psychosocial support and nurturing.

This focus on material needs was also found in the key informant interviews. District level key informants prioritised needs on vulnerable children as food (8 informants) school fees and uniforms (6) accommodation (6); medical care (4). Only one indicated protection from abuse. Urban children were seen to have better circumstances than rural (better access to birth certificates, and to non government services). While the latter were felt to have better access to caring communities and shelter, they were reported to have higher levels of poverty, and greater distances to travel to services. National key informants held similar views, identifying priority dimensions of vulnerability as food (10 informants) education (10) shelter (8); and health care (9). However at this level greater attention was given to social issues, including love, social inclusion and psychosocial support (7) safety, security and protection (3) while one mentioned child participation in issues that affect them. National level informants felt that children in both urban and rural areas experienced these areas of vulnerability.

In general, the differences across areas was seen to be a combined function of capabilities of community networks and access to public services. Key informants felt that children on large scale farms experienced particular distress (See Table 4) while rural extended family and community support was felt to be stronger, but undermined by higher levels of poverty. Child headed families were generally seen to be most vulnerable, as they may lack the means to access community support.

Table 4: Dimensions of child vulnerability across areas, identified by key informants

Need	Economic and service dimensions	Social dimensions
Urban	Fragile safety nets; Children may be less identified by services	Weak community networks; children on streets and exposed to drug, alcohol and sexual abuse
Rural	High levels of poverty;	Strong community cohesiveness; exclusion greater in child headed households
Large scale farm	High levels of poverty , insecurity; poor services, schooling; poor access to land for own food, may be involved in child labour	Weak community cohesiveness; lack formal documents for birth registration

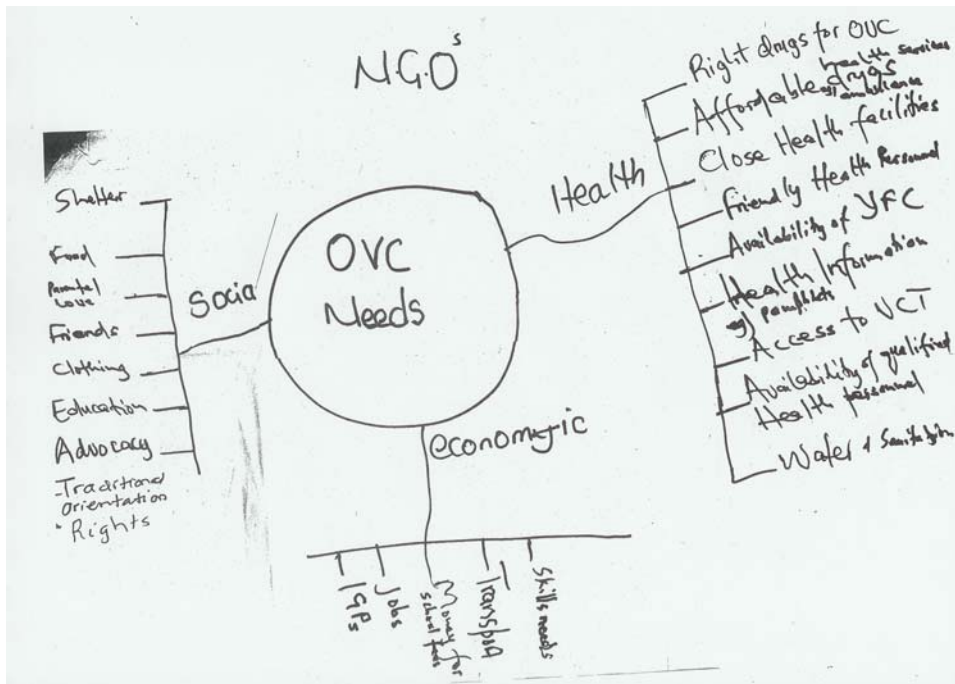
A striking feature of the published literature is the absence of community and childrens views and voice. In one sample survey in 2000 by Save the Children UK (2000) children and their caregivers gave their views on the range of difficulties vulnerable children face in sustaining school attendance, including poverty, early marriage and sex, lack of birth certificates and various forms of social exclusion (see Table 5). In a survey on large scale commercial farms children expressed their needs as clothing, shelter, education, and food, as well as parental love, and need to learn social norms. If these needs are not met, the children report moving to live on the streets, and to experience further ill-treatment, hunger, and deprivation of clothing, schooling, psychological and emotional support (SafAIDS, CFU, 1996).

Table 5: Difficulties that inhibit schooling

Views from children	Views from adults
<ul style="list-style-type: none"> • Lack of interest on the part of the child • No money for school fees • No money for school uniforms • Becoming an orphan • Early marriages • Desire to work (on farm, small mining sector, growth point, urban city) • Teenage pregnancies • Absence of birth certificate • Looking after siblings • Fear of teacher's beating and rape • Lack of parental support for education 	<ul style="list-style-type: none"> • Lack of interest on the part of the child • No money for school fees • No money for school uniforms • Food shortages at home • Distance from school • Children having to work • Families too large to afford fees • Early marriage • Lack of secondary school • Parental illness • Lack of parental support for education

(Source: Save the Children UK, 2000)

This report thus adds further evidence to how communities and particularly children see child vulnerability. Using participatory tools such as a spider diagram of needs, as shown in Table 6, there was generally agreement between state, and NGO personnel, community groups and children on vulnerable children's needs. Children and community members gave more emphasis to issues of freedom from abuse and right to speak and be heard, while NGOs and service personnel gave more focus on services. NGOs uniquely raised issues of investment in the income earning and production potential of children affected by HIV and AIDS, while others expressed economic needs more in terms of to support to access basic needs and services.



Spider diagram of needs

Table 6: Vulnerable children’s needs identified at community level

Needs	Government personnel	NGOs	Community	Children
Social	Love, security, guidance, counseling, care, traditional orientation, involvement and empowerment in decision-making, spiritual support.	parental love, friends, clothing, Advocacy, expression and protection of child rights	Accommodation, sympathy, to be given equal opportunities to other children, care, love, protection, to be listened to, life skills education	Life skills, protection from abuse, friends, care, love, support, respect of rights, especially to be heard. Advocacy and practical skills.
Health	Nutritious food Child friendly affordable drugs in favourable dosages, Friendly services by trained personnel, Subsidies for medical fees (AMTO), rehabilitation, sanitation, clean water, Education on reproductive health.	Food Appropriate, accessible affordable drugs, VCT, health services Support for transport to services, Friendly services, corners, Health information, Available qualified personnel, Water and sanitation.	Nutritional food Medication, Sanitation, clean water.	Nutritious food Proper clothing and sanitary items, Access to services
Eco- nomic	Education, transport, clothing, skills training Shelter.	Education Shelter Job opportunities, transport, Money for school fees, Income generating projects, and skills training.	Education Funds for school fees, food, clothing, stationery for school	Good education Money for school fees, clothes

It could be argued that groups identify dimensions of vulnerability that they can deal with, so that government services identify shortfalls in services, education or skills, while community members are more likely to identify issues of shelter, food, life skills. This makes children’s own views more important, as theirs reflects perhaps more closely the needs as children experience them. Children highlight problems such as who to communicate with on their changing bodies, especially for girls where the surviving parent is male. Children appeared to voice the loss of parents and the decline in extended family fostering most strongly, although all groups noted this. People raised the importance of any elderly person in the community being viewed as a ‘parent’ so orphans are not stigmatized, but also noted that displacement, urbanisation, westernisation together with economic difficulties have generated more individualistic approaches, leaving children more unsupported.

“ These days it has to be each man for himself and God for us all. Nobody can afford to properly feed his family let alone somebody else’s children....”

Community member, Gutu district

Using participatory ranking and scoring methods, these different needs were ranked, first individually and then as a whole group, the outcome shown in Table 7 below.

Table 7: Ranking of vulnerable children’s needs by the different groups

Need	Child ranking	Community Ranking	NGO ranking	Government ranking
Love	1	1		2
Nutritional food	2	2	2	1
Education and School fees	2	4	1	6
Care	3	3		6
Shelter	6	4	4	3
Health care, medication, health information	8	6	3	5
Clothing	9	6		4
Security, sense of belonging	5	4		5
Skills training – life skills	10	6		
Clean water and sanitation		6		4
Counselling, social and spiritual support		5		6
Money	4			
Transport			4	
Rehabilitation				6
Voice; to be heard and able to express themselves	7			

All groups at community level generally agree on the priority to be given to love and nutrition. Education was also highly rated, as was shelter. As noted earlier while love had a higher rating for the community members and children and material and service needs were prioritized by NGO and government personnel, this can be a reflection of where people they have the means to intervene. If this is the case it suggests a vital need for a link between the more formal services who respond to material needs and the community level networks who organise social and emotional support, as they are linked. For the community, the presence of a humane response, or love, caring, concern and empathy (ubuntu, hunhu) ensures that material needs are provided through unconditional assistance. Children felt that while education will empower and help them escape poverty, they cannot effectively learn without food and caring.

3.3 Sources of support for vulnerable children

Families and local communities are consistently reported to be the front-line caregivers for orphans and vulnerable children, starting with parents and children, and extending to wider family and community support (Foster, 2003; The Synergy Project, 2004). In 2005, UNICEF reported that 90% of orphans in Zimbabwe were being cared for by extended families, significantly reducing the frequency of child-headed households, found in another study to be only 1% of all Zimbabwean households (UNICEF 2005a; SADC FANR, 2003).

A number of traditional and new community safety nets exist. Communities have devised creative ways of identifying and assisting families in their midst, including labour sharing arrangements for day care and nutrition centers, play centres, agriculture work and other income generating projects, home repair, and home care for the ill and for orphans. Community members have formed child-welfare committees to monitor, fundraise for and support childrens needs (Save the Children Norway and MPSLSW 2005; The Synergy Project, 1998; SADC FANR 2003; Shisana, Simbayi, 2002). Local community volunteers give spiritual, material, educational, and psychosocial support, identify and visit child

headed households, with volunteers becoming like surrogate parents. A range of community development trusts provide community-based orphan care, education support, medical care, nutritional gardens, husbandry projects, manufacturing cooperatives, buying and selling initiatives to support vulnerable children, give support to people infected by HIV (Southern African AIDS Trust, 2007; Foster, 2003; BRTI, HSRC, NIHR and FACT 2006). These activities not only provide support, but are also reported to give children and community members experience in networking and managing projects (Foster, 2003).

The Zunde Ramambo – chief's granary – is a community scheme that aims to provide food for destitute children. It decentralizes this support to local level, through land allocated for cultivation by the community. Its effectiveness depends on reasonable harvests and access by vulnerable children. The programme has thus been supported by the National AIDS Council (NAC), through the National Trust Fund, with funds disbursed to 300 chiefs nationwide to enable them to purchase seed, fertilizer, and other inputs (Save the Children Norway Zimbabwe, 2005; Kaseke 2002; NAC, 2006).

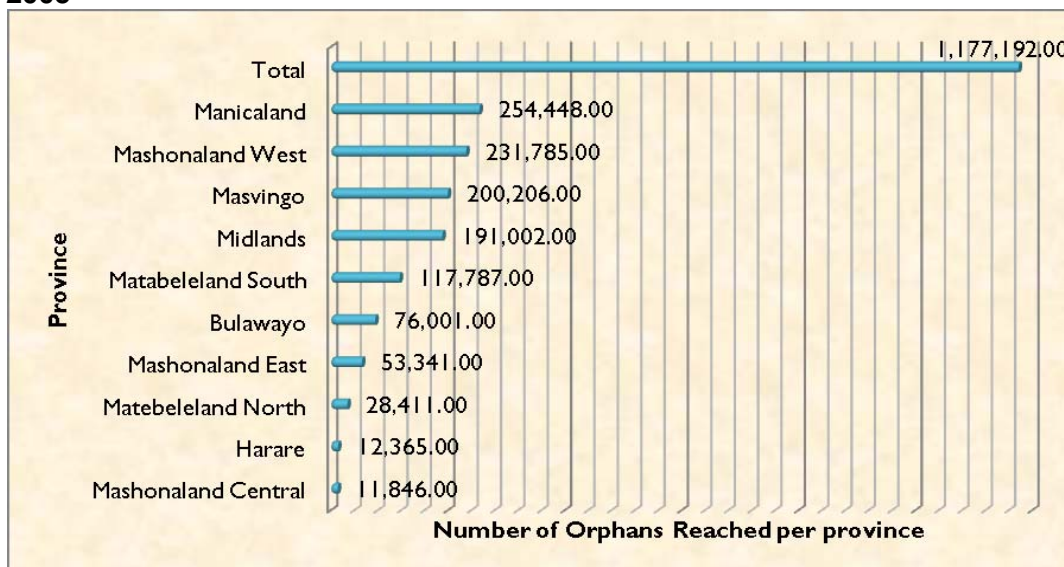
Faith based initiatives provide children with religious teachings and spiritual support, together with material support, school assistance and HIV prevention activities and counseling for children affected by AIDS. Foster (2003) reports that material support (clothing, food, school fees, uniforms, books) is the commonest support activity for children, provided by 71% of faith based organization (FBOs). Many FBOs initiatives also provide counseling and psycho-social support.

Community support is reported to be the mainstay of the response to needs of children affected by HIV and AIDS, providing more services and direct support than formal state and non state institutions (Policy project, UNICEF 2005). This form of support may however not be sufficiently continuous or robust to cope with the needs of large numbers of vulnerable children, and the extended demands that are reported to be placing stress on households. The full extent and nature of this stress appears to be poorly documented. The presence of orphans is documented, for example, to challenge food security in host households, who are more likely to reduce consumption and switch to less preferred foods and wild foods than other households (SADC FANR, 2003 ; ZIMVAC 2005).

There are also a range of formal institutions providing activities and services to support vulnerable children, including for education, access to food, health, water and sanitation (livelihoods management), education on nutrition and food security, education on health and hygiene, child protection, psychosocial support and counseling, birth registration and child participation (Buhler et al., 2005). In Zimbabwe, sample surveys have identified about 140 implementing partners involved in such interventions for orphans and vulnerable children, unevenly distributed across provinces, with uneven reach to and coverage of vulnerable children (See Figure 2) (GoZ UNICEF 2005b).

Government has decentralised its care and support for children to local authorities through Child Protection Committees at district, provincial and national levels. Government support includes the Basic Education Assistance Module (BEAM), where tuition fee, levy and examination fee assistance is provided to vulnerable children; and assistance to vulnerable families with basic living costs through the Public Works Fund-Cash Transfers to Vulnerable Groups, Public Assistance fund, Drought Relief and assisted Medical Treatment Order (Government of Zimbabwe, 2004).

Figure 2: Number of children affected by HIV and AIDS assisted per province, 2005



(Source: GoZ UNICEF, 2005b)

Table 5 summarises the range of non government institutions involved in supporting vulnerable children. Organizations such as Farm Orphan Support Trust (FOST), Save the Children UK, World Vision and UNICEF have also supported a network of community based organizations to provide support to children. While the table can only be indicative of the range of institutional support, it highlights responses in key areas of children's need as identified in policy and surveys, particularly in support for education, psychosocial and health needs. Less institutional support appears to exist for shelter, birth registration or legal support.

Within provinces, however, there may be very uneven access to these state and non state services, with some areas relatively isolated from services. This is documented, for example in the informal and large scale farm sector, where, as shown earlier, needs for this support may be even higher (See Box 3).

Box 3: Children's support services in Informal mining and commercial farm sectors

Informal mining and commercial farm communities are often geographically isolated, and excluded from most national development programmes. Informal mining communities have limited access to health care and education (SCF UK, 2000). Children in former commercial farming communities experience poor access to health care and other social services, partly as a result of poor provision within the former farming areas. Vulnerable households are not in a position to afford even the smallest of user charges for health care, nor to pay the high transport costs to reach the few existing facilities. In some former commercial farms, now resettlement areas, services such as schools, clinics and clean water sources are non existent or very far from settlements (FOST 2003).

Table 5 Institutional Responses to needs of children affected by HIV and AIDS in three provinces M= Manicaland, MI= Midlands, MA = Masvingo

AREAS OF INTERVENTION						
Organisation	Support in birth certificate registration	Education Assistance	Shelter	Psychological Support	Health and Nutritional Support	Legal assistance in inheritance
Dept Social Welfare	MI			MA	MI, MA	
Zimbabwe Republic Police				MA		MA
BEAM		M, MI, MA		MA		
District AIDS Action Committee		M, MI, MA			M, MI, MA	
Catholic Relief Services					MI	
Diocese of Mutare Care Programme		M			M	
Girl Child Network		M		M, MI	M, MI	
Midlands AIDS Service Organisation	MI	MI			MI	
UDACIZA		MI		MI	MI	
SOS Childrens village		MA				
Zimbabwe Red Cross		MI, MA	MI	MI, MA	MI, MA	
Population service Zimbabwe					MI	
AIDS Among Us		M		M	M	
Africare		M, MI		M	M	
Chipinge Children Trust		M		M	M	
FACT		M		M	M	
FOST		M, MA		M	M	
RUDO		MA		MA		
Dananai Child care	MI	MI				
Adventist development and Relief Agency		MI		MI	MI	
Oxfam					MI	
Save the Children Norway					MI	
World Vision		MA	MA		MA	
Plan International		M, MA		M	M, MI, MA	
Care International		MA				

(Source: Government of Zimbabwe and UNICEF, 2005b) see list of acronyms page 47

In the key informant interviews, national and district informants reported that communities provide support to vulnerable children through

- ♦ Fostering, socialization, livelihood skills and direct care
- ♦ Contributions of land, seed, fertilizer, tillage and labour to Zunde Ramambo and to fields for vulnerable children;
- ♦ Providing food and school fees; and
- ♦ Supporting and maintaining homes for vulnerable children, re-thatching and repairing homes, providing shelter and security.

These forms of reported support respond closely to the priority needs identified for food, shelter, education and psychosocial support. They were reported to be provided through schools, churches and local health services or to guardians. Only one informant from an NGO orphan support programme reported peer to peer support amongst children. In this programme, children in “Kids clubs” support each other in doing their homework and providing social support. This form of horizontal support seemed to be underestimated among both the national and district informants.

In the participatory assessments at community level the state, NGO, community and child participants developed social maps to identify the range of stakeholders involved in caring and supporting vulnerable children in the district (see Table 6 below). Government and faith based services were reported by all these social groups at community level to cover all wards in the district, while NGOs were reported to have more limited coverage. This is no reflection of the depth, intensity or quality of services, but purely of their presence. As noted earlier and discussed later, the extent to which the physical presence of a school, clinic or church translates into effective coverage of children in need depends on how these institutions reach, resource and are accessed by children. However their presence suggests a potential infrastructure for widening the scope of services to children, which should not be underestimated. NGOs in the social maps were observed to complement such core services, such as with additional support for production activities, shelter, inputs for schooling and environmental inputs.

Table 6: Institutions working with vulnerable children and services provided

Institution/ Organisation	Coverage (of 36 wards) and programmes
Ministry of Education Sport and Culture	Covers all wards with psychosocial support and education assistance
Ministry of Health and Child Welfare	Covers all wards with health care and 6 wards with PMTCT, post exposure prophylaxis
Ministry of Labour and Social Welfare	Covers all wards with AMTO, Bus warrants, co-ordinating the action plan for vulnerable children, financial assistance, and legal aid.
National AIDS Council	Covers all wards with monitoring and uniforms
Scripture Union	Covers all wards with social support
Zimbabwe Red Cross	Covers all wards with supplementary feeding
Regai Dzive Shiri	Covers all wards with life skills and peer education programmes.
Care International	Covers 12 wards with shelter provision, nutritional gardens, herbal gardens, and gardening.
Batanai	Covers 8 wards and provide care and support, to HIV positive children, such as transport to health facilities.
Christian Care	Covers 7 wards with School feeding
Rudo	Covers 6 wards with gardens, grants, school fees, uniforms, feeding and psychosocial support.
Oxfam	Covers 4 wards with water and sanitation, capital, small livestock.
United Methodist Church	Covers 4 wards with assistance for fees, stationery, uniforms, textbooks and food assistance

The participatory reflection was used to explore further the actual support given by these institutions to vulnerable children, as experienced by communities (See Table 7). Love as a form of support was seen to be expressed in physical forms such as provision of shelter and food, but also in listening to children, encouraging them at school and giving them an opportunity to express themselves. Providing support to children, whether by

households or formal institutions, was seen in part to be dependent on the wider services and resources accessible to households generally. This included, for example, contributions to farming, such as land and draught power. When outside support, such as from the District Development Fund for tractors, is not forthcoming, it is difficult for families to play their role. This raised two issues in the community discussions: First the need for families themselves to have greater control over production and welfare resources and secondly for a more effective coverage and transparent sharing of resources coming in to support those families who lack these capacities.

Table 7: Identified sources of support for vulnerable children’s needs

Need	From families	From community	From government	From NGOs
Love	Care for all children, even if not in the family, counseling, nurturing and helping children grieve	Visits to children affected by HIV and AIDS, taking them to church, organising child focused events, community counselors	Community level committees and resources, including AIDS levy. Clinics with Professional counselors Co-operation with NGOs	Training community counselors, programmes for children affected by HIV and AIDS that build life skills, organizing community camps follow up mechanisms. Fundraising.
Food	Labour, time, seeds from previous harvest, ploughing	Gardens, draught power communal harvesting (ilima),	Seeds, chemicals, fertiliser, tractors, technical advisors, farming skills training	Seedlings, supplementary feeding. Small livestock eg. goat and chicken projects.
Education	Support for fees Encouragement in and support to in school work for both boys and girls.	Business support to school fees. Church support to uniforms. Advocacy for children not accessing education due to abuse, or poverty.	BEAM support for fees stationery, Psychosocial support programmes	School fees, stationery, uniforms, Psychosocial support programmes

National level key informants felt that the more successful programmes were those that co-ordinated state support, provided resources directly to child beneficiaries, such as through supplementary feeding, and linked to community level mechanisms to channel resources. Both professional and community involvement in identifying beneficiaries were identified as features of successful interventions. Informants also felt that support that built the capability of households to look after children were more successful.

National public sector funds like the National AIDS Trust Fund, BEAM support for school fees and Zunde support for food were seen as having the potential to reach large numbers of children, and District AIDS Committees to have the potential to provide effective co-ordination when they work well with community and faith based organisations. However, informants noted that such programmes did face problems in design and implementation that weakened their positive impact. Programmes often have a pre-defined package of benefits, without community involvement in decisions on what is appropriate and sustainable. Programmes do not have inadequate resources to adequately cover all children in need; and fail to adequately involve all community members and children. The study was not able, with the resources available, to carry out a substantive mapping of the coverage of these state funds and the groups included/

excluded. While national coverage is generally best assured through public sector schemes and funds, this is only the case where these equitably reach those in need, are distributed according to need and without barriers to access. It was not clear that this was the case with these funds and not part of the scope of this study to provide such detailed field assessment.

The community level discussions indicated that communities also perceived a key role for government services, particularly in education and health care, to provide services, to ensure outreach to and access by vulnerable children and to work with NGOs and communities to link services to leveraging responses to wider needs, such as food, shelter and psychosocial support. These links across organisations are discussed in the next subsection.

There is no systematic documented mapping of the resources from different flowing to orphans, and an exercise similar to the National Health Accounts that maps the sources, intermediaries and beneficiaries in a more systematic manner could be a useful tool to do this in future work. A limited picture can be drawn from published sources. The funds flowing through formal sources are substantial, even if inadequate for need. The estimated three year budget for support of children affected by HIV and AIDS for the country in 2004 was US\$1 210 033, 00 (Donor contribution-US\$1 085 850,00 or 90% and Ministry contribution US\$124 184,00 or 10%) (GoZ 2004).

Table 6: Average intervention costs per child for interventions for children affected by HIV and AIDS, 2004

Intervention	Average 2003 Cost/Child/ Month (US\$)	Average 2003 Cost/Child/Year (US\$)	Average 2003 Cost/Child/ Year (US\$ adjusted for Inflation)
Food	0.33	3.96	11.88
Education	1.04	12.48	37.44
Health	0.20	2.40	7.20
Psychosocial Support	0.59	7.08	21.24
Finance Assistance	0.17	2.04	6.12
Legal/Protection	0.42	5.04	15.12
Other-capacity building	0.21	2.52	7.56

(Source: Government of Zimbabwe, 2004)

The average intervention costs per child based on data from local non- governmental organisations, faith based organisations and international organisations for 2003 are shown in Table 6, indicating that with a total inflation adjusted cost of \$107 for all areas of need, the total budget allocated of \$1,2 mn from all sources would only cover 11 310 children, or 0.6% of the total orphan population. This signals the need for more effective ways of using scarce resources to meet the range of needs of vulnerable children.

In part, the pressure for this improved resource flows to vulnerable children is reduced by children being largely absorbed within family networks, making the crisis “less visible” and weakening expressed demand for these resources from poor households. Governments facing competing claims on financial resources may thus be less pressured to allocate resources to this area (UNICEF/UNAIDS, 2004). However there are also shortfalls on policy links between plans for children affected by HIV and AIDS and national poverty alleviation plans, national HIV strategic plans or national social security policies. A range of specific policies exist, including the recent Zimbabwe National HIV and AIDS Strategic

Plan 2006-2010 (ZNASP), the National strategy on children in difficult circumstances 2001; and the 2004 National action plan for orphans and vulnerable children; and a range of laws also protect vulnerable children (see Table 7).

Table 7: Laws protecting orphans and vulnerable children

Key concern / need	Protective legislation / Basic right applying in Zimbabwe	Benefit to the child
Birth registration and access to inheritance	Birth registration is recognized as a right in Article 7 of the CRC and Netherlands Institute of Human Rights 2007 (article 6 of the ACRWC) Government of Zimbabwe 2004	Birth registration gives access public services, schooling and welfare support and is key to acquisition of National ID, passport, driver's license, employment and other services and support
Education and educational support	Office of the UN High Commissioner for Human Rights 1996 (article 6, 23, 28) Education Act (Chapter 25-04) Strategic plan 2000-2006, Ministry of Education Zimbabwe	Schools are a safe environment for children to socialize, to improve opportunities for success in life, to strengthen health and delay early marriage and unwanted pregnancies
Health and Nutritional support	UNCRC Article 24 Government of Zimbabwe 2004	Nutrition and food security support the physical requirements for growth and development
Psycho-social support and participation	Office of the UN High Commissioner for Human Rights (OHCHR) 1996 in Article 13, Article 14, UNCRC: Article 15, NCRC: Article 16, UNCRC: Article 17, UNCRC:	A supportive environment enables freedom of expression, thought, conscience and religion, association and protection from stigma and discrimination
Protection from Physical and sexual abuse	Office of the UN High Commissioner for Human Rights 1996 (Article 19, 33-37, of the CRC) Netherlands Institute of Human Rights 2007 (Article 16 of the ACRWC)	Child remains in a family environment Child is safe from harm and concentrates on positive productive things Children affected by HIV and AIDS especially girls remain longer on school and delay early marriages

Source: Government of Zimbabwe (2004); Netherlands Institute of Human Rights, 2007; Office of the UN High Commissioner for Human Rights (1996); Education Act (Chapter 25-04); Ministry of Education Strategic Plan 2000-2006; European Coalition of Positive People (2003); UNDP (2007)

However there is a threat that these laws and policies remain in theory due to inadequate prioritization of this area and inadequate resources thus reaching children and the services they need. The lack of integration of issues affecting children affected by HIV and AIDS into wider plans and policies means that funds may not be earmarked for community-based programs for children affected by HIV and AIDS within the budgets for these policies or financed through routine social security financing. This leaves such support highly dependent on social welfare assistance and on external support.

Key informants at district and national level reported this shortfall in the resources for vulnerable children and the coverage of interventions, with limited inputs from the business community, inadequate resources in local government services and public assistance programmes and inadequate transport infrastructures. Some communities have formed community based groups to mobilize resources and organise community inputs, but these too were seen to be inadequate relative to need, given the level of local poverty and the negative impact of drought and economic shocks. They also reported limited direct support to communities to sustain these inputs. These resources are not always financial: Families were seen to need information and training to support

psychosocial issues. On the one hand they felt that this called for increased public funding of national programmes like the BEAM programme and reduced fee and cost barriers to health services to reduce household spending on vital services, and on the other they felt that resources from non state institutions should be more effectively channeled to households, including through strengthened co-ordination of different inputs. It was suggested, for example, that support be channeled directly to wards, not through other district structures and be more responsive to the needs raised directly by communities. The role of churches and community based organizations in identifying children affected by HIV and AIDS and transferring support was cited by two informants as a successful means of channeling resources to these children.

“Some people are not aware of the assistance that is available and might not come to ask for it”

District Social welfare officer

One barrier to resources reaching households and children in need observed by informants was the fact that communities are often not informed of the sources of support, or face barriers like transport in accessing them. Poor attention to such issues was noted by one national informant to lead to skewed targeting at community level, particularly in the context of scarce resources. Choices have to be made on how to use limited resources, and while these choices over how to direct resources appear to be currently made at higher levels of NGOs and state institutions, several key informants felt that choices are best made by community and state institutions jointly, using participatory processes to prioritise measures and review interventions. One criteria that they felt should apply was for priority to be given to programmes that link resources directly to children and that strengthen household abilities to meet children’s needs.

The mapping and participatory review suggested that in a child centred approach, services should be built first around the institutions that children are most likely to be in contact with, naming these as schools, clinics, the Child Protection Committees, churches and support groups. These were seen to have the closest links to vulnerable children and their families. Vulnerable children were reported to spend more time with these agencies, to interact with other children there and the environment was seen to be more child-friendly. They are accessible, near the family places of residence, and are led by community members. While not all can be assumed to be currently playing positive roles, participants viewed that these institutions largely have a vital role play to support family responses, and thus need to strengthen co-ordination between themselves, flush out ghost beneficiaries, and work closely with community level structures.

A key issue raised by several informants was the need for transparency and accountability in the functioning of institutions working with children, in resource flows and decision making on beneficiaries and operations. A range of concerns were raised by key informants around state and non state funds: of funds not reaching the vulnerable children, of political interference affecting resource distribution, and of families or community organisations abusing resources meant for children, such as by using the food for vulnerable children for other family members, or abusing children sexually or through child labour.

“ Mamwe machurch haana hanya nenherera varikuvatora kuita vakadzi ”

Translated; “ Some churches do not care for vulnerable children but they abuse them and make them wives.”

Community member, Gutu district

While monitoring of resource flows and programmes was generally felt to be necessary, it was less clear who should do it. A monitoring and evaluation framework is managed by the DACs and reported on by NAC at national level. Several informants felt that communities and vulnerable children should play a stronger role in this monitoring. For example, there appeared to be a gap in the public reporting and strategic review of monitoring information at district level, including through participatory methods with communities and children.

“The planning for any community programme should involve the vulnerable children themselves. Direct support is better to avoid leakages. The community should be involved in the monitoring of any programme targeting vulnerable children.”

International NGO official

The transfer of resources from formal organisations to communities to better reach children affected by HIV and AIDS was perceived in the participatory assessments to need a transparent means to identify child beneficiaries, using explicit, written and agreed protocols, with external monitoring of the distribution of resources and prosecution of people who misuse or steal these resources. Fairness was thus seen to be a priority for these links. The community was also perceived to play an important role in holding this system accountable, keeping written records of beneficiaries, holding organizations with resources accountable, and ensuring that resources reached vulnerable children.

3.4 Links across formal organisations, communities and vulnerable children

While the previous sub-section suggests that the range of organisations providing support to vulnerable children is wide, it also reports a disconnect between formal institutional inputs from state or non state institutions, and the inputs provided by FBOs and other initiatives organised at community level, inadequacy in resources and coverage of prioritized interventions, still limited co-ordination and organization of resources around the community, family and formal institutions closest to children and limited participation by children and families in the decisions on resource flows. It also suggests from published and key informant reports that where links are made between international and local NGOs to channel funds to community level, there are gains for both larger and community based organisations. As noted earlier, these links are best centered around the institutions that are closest to children. This sub-section explores the findings on these issues further.

Table 8 highlights the potential areas of complementarity between different institutions in support to vulnerable children. For large organisations, smaller intermediaries can be more effective at addressing certain areas and reaching community levels.

Table 8: Sources of support, nature of links and resources flows

	Community level response	CBO/NGO support	Creating an enabling environment
Community Level Groups	<p>Awareness of children's needs and involve children in the solution.</p> <p>Assess community needs and capacity before scaling up.</p> <p>Build on existing community activities, relationships and resources.</p> <p>Awareness of the especial vulnerability of girls</p> <p>Actively maintain local ownership.</p> <p>Are accountable to stakeholders.</p> <p>Monitor activities, using methods appropriate to their own capacity.</p>	<p>Identify and prioritize own needs.</p> <p>Willing to share their experience and also take on new ideas – for example, through exchange visits.</p> <p>Provide honest feedback to CBO/NGO support providers.</p> <p>Willing to host mentoring and exchange visits.</p>	<p>Publish achievements to encourage other communities.</p> <p>Use traditional and other leadership structures to influence government on children's issues.</p> <p>Avoid perpetuation of harmful cultural practices/beliefs that stigmatize or have a negative impact on children affected by HIV and AIDS.</p> <p>Address stigma & discrimination towards children affected by HIV and AIDS.</p> <p>Promote the involvement and participation of children and young people.</p> <p>Are aware of the influence of gender roles, and be prepared to challenge them where appropriate.</p>
CBO/NGOs	<p>A catalyst for community responses.</p> <p>Sensitive to the needs of communities and CBOs, and avoid imposing programme expansion on others.</p> <p>Provide appropriate technical and financial support to community groups.</p> <p>Help to link community initiatives with other support services.</p> <p>Work with community groups to document good practice.</p> <p>Develop joint proposals with local NGOs/CBOs</p> <p>Help to identify gaps in skills.</p> <p>Work with communities to explore and challenge inequality.</p> <p>Advocate for on community groups.</p> <p>Facilitate participatory monitoring.</p> <p>Ensure ownership of community initiatives within the community.</p>	<p>Develop a long-term vision based on realistic targets or expectations.</p> <p>Strengthen their own technical and managerial/administrative capacity.</p> <p>Network with peer organizations, nationally, and internationally.</p> <p>Advocate for funds to build community capacity to care for children affected by HIV and AIDS, and ensure they do not keep too much funding for themselves.</p> <p>Provide mentoring and training to CBOs in long-term partnerships.</p> <p>Assist organizations wishing to make the transition from implementing organization into developing a CBO/NGO support role.</p> <p>Make an effort to communicate and collaborate with government, especially other government sectors.</p>	<p>Act as a channel of communication between communities, governments and donors.</p> <p>Actively participate in development of policy for children affected by HIV and AIDS at the national level, based on field experience.</p> <p>Build their own advocacy capacity and train community groups on advocacy.</p> <p>Prioritize the issues for advocacy.</p> <p>Collaborate and learn from/share with others, rather than entering into competition.</p> <p>Facilitate the formation of networks between community programmes.</p>
Govern-	Seek to protect and provide welfare	Promote civil society organizations	Initiate, develop, implement and review supportive

ment	<p>services for the most vulnerable children. Sensitize public service workers to support community responses.</p>	<p>and community initiatives to meet needs of children affected by HIV and AIDS. Develop a long-term vision for the response to children affected by HIV and AIDS, based on realistic targets, and including recognition of the role of intermediary and implementing organizations. Consult NGO support providers on national policy development and include them on National AIDS Committees.</p>	<p>policies for children affected by HIV and AIDS through consultation with all relevant stakeholders. Develop a national strategic plan, which integrates work on children affected by HIV and AIDS with other strategies. Promote the expansion of community initiatives through active political support.</p>
Inter-national NGOs	<p>Encourage governments to support civil society responses. Facilitate exchange of experiences and information. Work with local intermediaries, rather than directly with local communities. Mobilize resources for community use. <input type="checkbox"/> Enable operational research.</p>	<p>Facilitate and create linkages, networking and lesson sharing. Provide appropriate technical and financial support to local/national CBO/NGO support providers in long-term partnerships. Develop joint proposals with local/national CBO support providers. Help support provider organisations with strategic planning to scale up.</p>	<p>Identify, document and share good practices on community initiatives and CBO/NGO support. Accurately articulate the views and experiences of communities in policy/ advocacy work with their governments and donors. Catalyze and support national policy formulation on issues facing children affected by HIV and AIDS. Mobilize financial resources for national and local efforts.</p>
Donors	<p>Understand community dynamics and existing community responses/strengths. Work through local intermediaries, rather than directly with local communities. Provide resources, but not impose scale-up or their own agenda. Hold recipients of funding accountable.</p>	<p>Adopt a long-term perspective and long term funding cycle. Support both implementing and capacity building activities. Encourage/support documentation of good practice. Avoid imposing scale-up or specific programmatic responses on CBO/NGO support providers.</p>	<p>Create a relationship with NGO support providers and governments. Provide funding for expanded and improved work, including organizational development, technical support and policy/advocacy activities. Work with local partners in policy development. Identify and share good practice. Engage government and influence policy. Develop projects and strategies based on evidence and experience. Avoid imposing own organizational policies on intermediary organizations.</p>

(Source: FACT and The International HIV/AIDS Alliance, Workshop, 2001)

For example support from the Southern Africa AIDS Trust, a large organization, is documented to more effectively reach vulnerable children when channeled through community based NGOs and local community mechanisms, to provide a wide range of supportive inputs, including parenting skills to child-headed homes and training to foster parents; free legal services to disadvantaged children and/or guardians in civil or criminal matters, including child sexual abuse, child labour, child maintenance custody and guardianship and legal advocacy. The children are identified through local leaders such as headmen, chiefs and communities (Southern African AIDS Trust 2007).

When such links are made there is report of improved outcomes for children. For example Tsungirirai, a local CBO operating in Norton area, went into partnership with Catholic Relief Services an international NGO, to build community capacities for orphan care and support activities, establish community care committees and train volunteers in program management (Mucheru, 2004). In Mberengwa district the community identified all the households living in dilapidated homes and with grossly inadequate resources.

The community provided for these children, helped them repair their homes and ensured that children went to school (Save the Children Norway Zimbabwe, 2005). Local volunteers can give spiritual, material, educational, and psychosocial support, and liaise with relevant CBOs to provide external support for more material needs, help to engage local leaders in responding to the needs of vulnerable children and organize and support activities that enable community members to talk more openly about their needs (BRTI, HSRC, NIHR and FACT, 2006; UNICEF/UNAIDS, 2004; The Synergy project, 1998).

Key informants urged for more effective links across formal institutional and community sources of support. Community level organizations like churches, village heads, community level NGO staff play a role in making home visits and making direct contact with families, while community level state personnel like teachers and police officers make the link between communities and wider services, including to district and national level. Key informants thus called specifically for

- ♦ resources to be linked to the register of vulnerable children compiled in the district;
- ♦ formal institutions to make home visits;
- ♦ local committees to bring community issues and make collective decisions;
- ♦ regular planning, dialogue and review meetings, especially using participatory approaches, that bring communities and services together to discuss ways of working together

Formal organisations from government, NGOs and private sector were perceived in the community discussions to be most relevant and useful to families and communities supporting vulnerable children when they

- Address barriers to recognition of orphans and vulnerable children, such as birth certificates
- Build community and children's capacities, and strengthen community leadership to input to programme design
- Run sustainable, adequately resourced development programmes with explicit resources and focus on children's needs identified at community level, and avoid imposing programmes designed without community inputs;

- Have clear policies, protocols and accounting systems and reporting,
- Ensure all distributed resources go direct to recipients and are signed for
- Co-ordinate with each other and have adequately staffed structures to community level
- Use local structures, avoid creating parallel structures and have clear means for reporting issues and problems, and for solving them.

To provide such investments in community and children's capacities, the community level discussions indicated that formal organizations also needed to strengthen their own capacities and resources at community level and to be transparent and have clear systems for access to and use of these resources.

Some key informants, particularly youth, also called for greater community and youth empowerment, to enable youth to take control over their lives when they leave school. This was seen to cover not only social empowerment, but also economic empowerment, through employment and activities that generate income. Suggested community roles included reporting abuse to police, monitoring that resources reached child beneficiaries and raising social pressure over practices such as sexual abuse. Where communities are involved in making links with and inputting to decisions on resources and programmes, it was noted that this was generally through specific adults, such as the chief, headmen, church leaders and NGO staff, through the DAC. For these leaders themselves and for the communities, the wider participatory meeting held in the research, mapping needs and issues and enabling dialogue between state, NGO, community personnel and children was a unique and structured opportunity to widen inclusion in planning and decision making.

"We would like to thank you for bringing the various stakeholders together to discuss orphan and other poor children's problems. You should continue coming so that communities, government departments and agencies will see the need to work together for the benefit of our children".

Chief, Gutu district

On the one hand therefore key informants felt that the co-ordination across institutions involved with supporting vulnerable children needed to be strengthened, horizontally at village and district levels and vertically from local to national level. The structures for this exist (in the VAC, DAC mechanisms), but this co-ordination function was felt to need capacity support.

On the other hand, people, particularly in the community level discussions, felt that young people and vulnerable children can be empowered and play a stronger role in responses to children's needs. It was felt that this can be better achieved by involving children in their programmes, within joint committees, supported by skills training, projects that exhibit their talents, enhance their autonomy (including income generating projects) and services that are oriented to youth (such as youth friendly corners). Organisations working with youth thus need to take specific measures and conduct regular needs assessments to facilitate youth involvement.

As noted above, while the participatory research was designed to better understand community views on needs and institutional responses, the design also meant that the findings were produced and 'owned' directly at community level. This gave immediate information to community level for their own follow up and participants to the process themselves proposed to take the understanding and actions proposed from the meeting into relevant community meetings and local social groups to sensitise people on vulnerable children and their needs, and raise further how to better support these needs. It was also proposed that the WAAC, VAAC, and Child Protection Committees work through youth leaders to sensitise community members about the 'National Action Plan for orphans and vulnerable children', the areas of support and to strengthen their functioning in line with the recommendations made.

4. Discussion

The study has shown that definitions of orphanhood and vulnerability are relatively consistent from international to local level, with some consensus therefore on who the targets for action on child vulnerability *should* be. International frameworks and national policy provide reasonable guiding frameworks for identifying vulnerable children but are less successful as prescriptions for strict targeting. Both to identify the children that are vulnerable in different community contexts, to engage communities and service providers beyond negative stereotypes and to bring children themselves into the discussion, it would be useful through participatory approaches to build shared understanding and locally identify vulnerable children.

Vulnerability was clearly associated with material deprivation and fallout from services, of the children and their communities, and with the additional social and psychological trauma, stress and deprivation of orphanhood or situations of abuse, neglect or poverty linked to child vulnerability. Vicious cycles are possible as deprivation in one form brings children into environments and life styles that increase their risk of other forms of vulnerability. Population surveys are a key source of evidence on vulnerable children as many other facility based routine data sources may exclude vulnerable children, given poorer uptake of these services in poor households. With such a high level of orphanhood and vulnerability in children, the questions included in the Zimbabwe Demographic and Health survey can be reviewed to ensure that they map the distribution of needs and service coverage and uptake to deal with child vulnerability, to inform planning and the distribution of resources for the response. A striking feature of the published literature, however, is the absence of community and childrens views and voice and research on vulnerable children needs to include this more systematically, using participatory tools. This is particularly important as different groups appeared to tend to see as priorities the needs they could act on, and children gave significantly greater priority to needs that reflected experiences of abuse, disempowerment and emotional deprivation. Responses to these issues were seen to be critical to open pathways to meeting material needs.

The first line of support for children was consistently seen to come from families, extended families and communities, through arrange of innovative means, although with increasing stress as numbers of vulnerable children increase together with household poverty. All groups recognise the role of family, extended family and community as vital to support of vulnerable children, inasmuch as neglect and abandonment are seen as a source of vulnerability. The social, emotional and caring support that comes from fostering families and communities is uniquely provided from these levels. Further communities are reported to provide support to

areas such as food and shelter through helping with farm inputs, home repair and contributing to caring and needs for children affected by HIV and AIDS. While the high level of fostering and low level of child headed households is testimony to the high coverage of such household responses, these inputs are perceived to be directly challenged by the scale of the problem, household poverty, and the absence of skills or resource support to households to provide such inputs.

At the same time there is report that initiatives at community level receive limited external technical or financial support and rely largely on their own skills and material resources. This is not because other inputs do not exist. There are a range of formal state and non state institutions providing activities and services to support vulnerable children, including for education, access to food, health, water and sanitation (livelihoods management), education on nutrition and food security, education on health and hygiene, child protection, psychosocial support and counseling and birth registration. These are unevenly distributed within provinces, with areas such as large scale farms or informal settlements relatively isolated from services. The physical presence of state services does not necessarily translate into coverage of or access by vulnerable children, and NGO services, while they may provide innovation and intensity of interventions. The more formal mechanisms for resource transfers to vulnerable children are largely framed as mechanisms for individual support, and intended to be universal. While the collective mechanisms tend to be more involving of community level organisations, these more individually targeted mechanisms are delivered through formal services (schools, health services, social welfare offices) and their staff.

Several issues arise in these different forms of support for children affected by HIV and AIDS. Those that provide individual benefits are noted by informants and community to face constraints in coverage and access, due to problems with beneficiary definition, adequacy of resources, transparency and fairness of systems and involvement of communities in holding processes accountable. They depend on the staff who administer them holding them accountable, and the point is raised that greater involvement of communities in receiving report on the performance of these systems would be necessary to safeguard children's access and interests. Further for these systems to be effective there was agreement across community and key informants that they needed to be more adequately funded and staffed. The shortfall in funding of these mechanisms was evident from the literature and underlies shortfalls in meeting needs of children affected by HIV and AIDS. Access can be dependent on how well informed communities are about the benefits and how easily they can overcome transport and institutional barriers to overcoming them, which can lead to the more disadvantaged vulnerable children not being covered.

Those approaches that provide benefits at a wider, more inclusive level may avoid problems of individual targeting. Hence for example ensuring school books reach all children, removing fee barriers at clinics, or providing inputs for community food plots may make the issue of individual beneficiary identification less central to access benefits, and appears to more centrally involve communities, including through chiefs, councillors or support groups, in organising systems or distributing benefits. These social approaches provide mitigatory inputs (eg food) but also help to build resilience through encouraging local production capabilities and networking. These social mechanisms are however also reported to need mechanisms for ensuring fairness and transparency, so that they are scrutinised by outside personnel, such as state or NGO personnel, and reported to communities.

In all cases the resources are inadequate for the scale of need, signaling the need for more effective ways of using scarce resources to meet the range of needs of vulnerable children. Hence while comprehensive laws and policies exist to address the needs of vulnerable children, the lack of integration of these policies into wider plans and budgets may limit financing of specific needs of vulnerable children through routine social spending and leave such support highly dependent on social welfare assistance and on external support.

This raises two issues:

Firstly the need for stronger links between formal institutional inputs from state or non state institutions, and the inputs provided by FBOs , other initiatives organised at community level, and families and children, particularly where these build the capability of households to look after children. It was felt that in a child centred approach, services should be built first around the institutions that children are most likely to be in contact with, naming these as schools, clinics, the Child Protection Committees, churches and support groups. Various examples of positive links already exist and are reported on that can be widened and consolidated institutionally. The importance of capable and effective co-ordination mechanisms within the VAC and DAC was raised for such links to work well.

Secondly the need for communities, families *and* children to be more informed of and involved in decisions on forms of support and their outreach. Choices on how to use limited resources appear to be currently made at higher levels of NGOs and state institutions, and participatory processes could be used to prioritise measures and review interventions with communities and children, locally. Key informants called for resources to be linked to the register of vulnerable children compiled in the district; formal institutions to make home visits; local committees to bring community issues and make collective decisions; regular planning, dialogue and review meetings, especially using PRA approaches, that bring communities and services together to discuss ways of working together. Further monitoring of resource flows and programmes was generally felt to be necessary, involving the DACs as presently the case, but involving communities and vulnerable children.

Particularly in the community level discussions, it was felt that young people and vulnerable children can be empowered and play a stronger role in responses to children's needs, by involving children in their programmes, within joint committees, supported by skills training, projects that exhibit their talents, enhance their autonomy (including income generating projects) and through services that are oriented to youth (such as youth friendly corners). Organisations working with youth thus need to take specific measures and conduct regular needs assessments to facilitate youth involvement. Participatory methods provide a useful means for engaging this contribution and enabling action at local level.

The evidence gathered suggests some dimensions of enhanced responses that build on existing practice and priorities:

- Programmes designed to provide individual benefits through formal institutions and social benefits through community networks and organisations need to specifically consider, *in their design, resourcing and functioning*, the cross links between different dimensions of the response and the opportunities for synergies at local level.

- Specific community level processes need to be set up to map, discuss, monitor and review the spectrum of vulnerability and adequacy of the response, preferably using participatory processes that draw input from different groups.
- Formal and community/ household responses have key entry points in the community, including schools, health services, social welfare offices, churches, community associations and support groups. These entry points need to be adequately staffed, resourced, trained and oriented to be effective and co-ordinated at community level, including with external resources from state and private sector.
- Community co-ordination mechanisms, including child protection committees and the village, ward or district AIDS committees need to have some flexibility for local staff to make changes based on local conditions, for planning around locally identified priorities. Community, local CBO members and local levels of state and non state services also need to invest in the capabilities of people to implement planning, monitoring and review roles.
- Having child watchdogs and strong monitoring and reporting systems was seen to be vital to identify gaps and barriers and make more effective links across different resource inputs to the community. One idea suggested was for the actors in formal systems- teachers, health workers, social welfare officers - to more actively monitor and report on community based and NGO programmes, and for community members including churches, local leaders, women and youth to monitor, obtain and review reports on formal programmes, such as fee benefits provided in schools and health services. Community organisations carry out home visits and other forms of direct interaction that are also useful to verify whether benefits do reach children. Joint committees provide a forum for sharing information on such monitoring.

5. Conclusions and recommendations

The triangulation of evidence from three sources (documented literature, key informant interview and local participatory inquiry) reveals commonly identified features of vulnerability in children and the responses to it, as well as differences discussed in the previous section that perhaps highlight the need for responsiveness to different 'lenses' on the issue, from children to community, local organizational and national institutional level. It is suggested that responses to child vulnerability be framed on a mix of evidence from formal sources (surveys and information systems) and participatory inquiry, given the problems of limited coverage of marginal communities in formal databases and of poor inclusion of key parameters such as psychosocial support, nurturing and social cohesiveness in more quantitative sources.

On the basis of the three sources of evidence it is recommended that

- i. Explicit age cutoffs and formal criteria for children affected by HIV and AIDS be supported by participatory methods to identify local dimensions of child vulnerability, and that community registers of vulnerable child beneficiaries be established with community involvement
- ii. The allocation of national government resources for children affected by HIV and AIDS across geographical areas could be more fairly done using a

- resource allocation formula that takes into account the level of need (poverty, HIV prevalence, numbers of children affected by HIV and AIDS) and the level of current resources for the response, using indicators of current formal and community safety nets. Follow up research is needed to identify indicators for the latter, covering education, health care, food security, shelter and some index of community networks
- iii. The allocation of local government resources be linked to a co-ordinated plan involving local institutions and community representatives, with individually allocated resources using the register of vulnerable children compiled in the district with community input, and with community roles and capacities to monitor and evaluate the delivery and effectiveness of resources allocated and interventions made.
 - iv. Wherever feasible, approaches that provide benefits at a wider, more inclusive level with community involvement be chosen to avoid problems of individual targeting. (eg ensuring school books reach all children, removing fee barriers at clinics, or providing inputs for community food plots).
 - v. Entry points for vulnerable children be locally mapped (eg schools, health services, social welfare offices, churches, community associations and support groups) and adequately staffed, resourced, trained and oriented to make links with and provide services to vulnerable children and the households supporting them.
 - vi. Formal organisations from government, NGOs and private sector address barriers to recognition of children affected by HIV and AIDS, such as birth certificates; build community and children's capacities, and strengthen community leadership to input to programme design; give preference to mechanisms that distribute resources directly to recipients and that are signed for; co-ordinate with each other and have adequately staffed structures to community level; use local structures, avoid creating parallel structures and have clear means for reporting issues and problems, and for solving them and build community capacities to implement these functions.
 - vii. Structures that exist within the community that provide co-ordination, including child protection committees and the village, ward or district AIDS Committees have greater input to local design and application of formal state and large NGO programmes, within broad guidelines, with provision for regular planning, dialogue and review meetings, including using PRA approaches, and support for community and local CBO capacities and skills to effectively voice issues and approaches in these committees.
 - viii. The monitoring and evaluation framework that exists at national level, be decentralised further in its functioning to provide for strategic use and review of information at district level, and through more participatory methods with communities at local level, including youth.

It's a common end paragraph in such reports that direct youth representation and voice in mechanisms and systems for support of children affected by HIV and AIDS are weak. This was found in this review. In the literature there was little direct representation of evidence from children, and the feedback from the PRA process and key informant interviews indicated that children do have valuable input to make but lack organised means to provide this input. The PRA process provided one means of enhancing this input, but a more systematic and focused assessment is

needed of this issue. What was apparent from the overall findings, however, is that simply adding youth to existing mechanisms will not provide for youth empowerment. A wider set of measures are needed to recognise the responses to children's issues where communities and children do have voice, to strengthen these, and to explicitly provide for links to these processes in more powerful, better resourced formal responses. As noted, this is not simply necessary to enhance the accountability and performance of formal support for vulnerable children. It recognises that community responses provide for critical social and emotional dimensions of vulnerability that are seen to be central by youth themselves.

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List of Acronyms

ACRWC:	African Charter on the Rights and Welfare of the Child
AIDS:	Acquired Immune Deficiency Syndrome
BEAM :	Basic Education Assistance Model
BRTI	Blair Research and Training Institute
CEDAW:	Convention on the Elimination of Discrimination Against Women
CBO:	Community Based Organization
CHS:	Community Household Surveillance
CSO:	Central Statistics Office
FOST:	Farm Orphan Support Trust
GDP:	Gross Domestic Product
GFATM:	Global Fund for AIDS
HIV:	Human Immunodeficiency Virus
INGO:	International Non-Governmental Organization
MDG:	Millennium Development Goals
NAC:	National AIDS Council
NAP:	National Action Plan
NGO:	Non Governmental Organization
PLWA:	People Living with AIDS
PRA:	Participatory Reflection and Action
PMTCT:	Prevention of Mother to Child Transmission
SADC:	Southern Africa Development Community
TARSC:	Training and Research Support Centre
UNICEF:	United Nations Children`s Fund
UNGASS:	United Nations General Assembly Special Session
USAID :	United States Agency for International Development
ZIMVAC:	Zimbabwe Vulnerability Assessment Committee
ZDHS:	Zimbabwe Demographic Health Survey