EXECUTIVE SUMMARY

A substantial proportion of children in Zimbabwe live in weakened families and communities where social support is diminishing, impoverishment is increasing and access to health, education and social services is on the decline. Abuse (physical, emotional and sexual), economic exploitation (child labour), orphanhood, street-life and institutionalisation, are some of the conditions that aptly describe or evidence the vulnerable state of these children. Generally, the prevailing negative impact of HIV/AIDS and the negative macro-economic environment result in a child unfriendly environment that threatens both the survival and development of children.

The Situation Assessment and Analysis of the Children and Women in Zimbabwe (1998) revealed that at community level people are concerned about all categories of children requiring special protection measures. While statistics are scant in this area, the CEDC study (1997) estimated disabled children at about 150 000, children in institutions at 5 000, abused children at 3 500, street children at 1 000. The Inter-Censal data of 1997 found 74 622 working children between the ages of 10-14 years of age estimated disabled children at about 150 000, children in institutions at 5 000, abused children at 3 500, and street children at 1 000.

As part of the process of developing a comprehensive national strategy for Orphans and Vulnerable Children in Zimbabwe, UNICEF Zimbabwe, in collaboration with the government, donors, and civil society, undertook studies in 2000 aimed at compiling a comprehensive information base on the various categories of vulnerable children. These include Children Affected by HIV/AIDS, Children Infected with HIV/AIDS, Working Children, Street Children, Children with Disabilities and Sexually Abused Children. In addition, a review of the various models of care has been undertaken regarding the care aspect of Orphans and Vulnerable Children in Zimbabwe.

In Zimbabwe, it is estimated that 23.7% (or 1 066 702) of all children under 15 years of age are orphans. These figures are expected to rise to 1 244 286 and 1 264 047 by year 2005 and 2012, respectively. By 1997, 543 000 children had lost one or both parents to AIDS and it was estimated that by 2000 orphans will be more than 800 000. By 2010 it is estimated that there will be 910 000 orphans (Hunter & Fall 1998). With a national HIV rate in Zimbabwe of 25% and the resulting morbidity and mortality, the impact on children, especially those living with sick parents or relatives, is obvious. Issues such as loss of income when breadwinners lose the capacity to work, loss of labour for subsistence production, increased expenditure on modern and traditional health care, and loss of assets and inheritance, have been reported to have a great impact on children.

There are between 57 000 and 100 000 children living with HIV infection in Zimbabwe. It is estimated that 9% of new-born babies are infected with the virus. Infection is almost exclusively transmitted to the children from their infected mothers during pregnancy, delivery, and in the postpartum period through breast-feeding. Twenty-five to 40% of HIV infected pregnant mothers pass the virus to their infants in this way. On average 30% of pregnant women in the country are infected with HIV. HIV-infected children have received minimal attention and have been little recognised as a group with special protection needs. They tend to receive attention incidentally as a result of providing services for orphans. The chain of infringements of the child's rights that follows infection with HIV has not generated much debate in the literature, nor an outcry in the media and society in general. Consequently their needs have not been specifically catered for in interventions targeted at disadvantaged children.

In the National Disability Survey of Zimbabwe (1982) childhood disability (0 - 15 years) accounted for 53% of all disability in the country (140 000). Average disability occurred between 0 and 4 years and this accounted for 41% of the disablement. The study on Children in Especially Difficult Circumstances in Zimbabwe (UNICEF, 1997) estimated about 150 000 children with disabilities in the country. The Inter-Censal Demographic Survey (ICDS, 1997) recorded a total of 218 421 people with disabilities in the country. Of these 57 232 were children and adolescents with disabilities (45 228 or 79% were from rural areas while 12 004 or 21% were from urban areas).

Overall Objective

The overall objective of each study was to compile, consolidate and validate available information on orphans and other vulnerable children in order to facilitate the development of a long-term national strategy aimed at promoting, protecting and fulfilling their rights. Specifically, each study sought to analyse causal factors, identify legislative, policy and programmatic gaps in current interventions, and to recommend further interventions aimed at wholistically addressing the plight that children in these categories face.

Methodology

A comprehensive literature review was undertaken for each category above and major issues emanating from the literature review were highlighted. Field research was then undertaken, with a focus on validating the issues that required validation. An effort was made to ensure sample sizes were designed in a manner that is nationally representative. Fieldwork specifically focused on obtaining information on causes, effectiveness, adequacy and relevance of interventions, existing opportunities and risks and views on the way forward (including perceived roles of various actors).

Assessment of the problem by age/sex and distribution of target population, geographic location, socio-economic indicators and analysis of key causal factors was undertaken for each study. To facilitate this, a one-day training on the fundamentals of a human rights approach to research was organised for the research team—in order to empower them to undertake causal, responsibility and capacity analyses.

Major Findings

Children Affected by HIV and AIDS

Field validation was carried out on a cross section of the Zimbabwean population including those residing in rural areas (plus growth points), urban, peri-urban, commercial farm, mining and resettlement areas. Methods of data collection included administration of questionnaires to individuals and groups, focus group discussions with community opinion leaders and with children. A total of 253 people were interviewed of whom 85 were male and 168 were female. Fifty-four percent of respondents were children under 18 years of age, with an additional 16 who were aged between 19 and 24. These were single, heading households and considered as children by communities. Thirty-two children and 105 adults participated in the focus group discussions, and 36 representatives of 19 institutions participated in group interviews. The youngest child heading a household interviewed was 10 years old, and the oldest grandparent heading a household interviewed was 75 years old. Forty-nine children heading households and 60 grandparents heading households were interviewed. One hundred families were living with a surviving sick parent and 98 relatives were caring for children affected by AIDS, of whom 62 were maternal and 36 were paternal relatives. Sixty-four percent of deaths recorded were due to AIDS and 47 children were identified as immediate care-givers to parents before they died. Fifty-five percent of the deaths occurred at home. Relatives were identified as most helpful during funerals, but were not readily available during illness and after funeral, leaving children to bear the bulk of caring for sick parents and looking after siblings following the death of parents.

Children affected by AIDS were identified as highly mobile as they moved from one household to another. Forty-eight percent of families had moved from their original home after the death of the parents, and 167 children had left home, the majority going to the rural areas to ease economic hardships in the urban areas. Some children moved to urban areas and commercial farms in search of employment, while others were reported to have run away and no one knew where they were. The researcher concluded that these children could possibly be living on the streets.

Children with Disabilities

The study was conducted throughout Zimbabwe covering urban areas, rural areas, mines, farms and peri-urban areas. It focused on children and adolescents with disabilities, their care-givers and officials of institutions that look after children and adolescents with disabilities. A triangulation of methods was used to assess the extent of the problem, analyse the causal factors and come up with recommendations. Three structured questionnaires were used in collecting data and targeted the following groups: 1) care-givers; 2) children with disabilities themselves; and 3) officials of institutions. The study also used focused group discussions and interviews of key informants to collect data.

One hundred and seventy care-givers participated in the study. A total of 293 children and adolescents with disabilities responded to the structured questionnaire. These included both male and female participants and represented children who are hearing impaired (39%), visually handicapped (33%) and physically disabled (28%). In addition, twenty-eight officials from institutions participated in the study.

In both the review of literature and the field validation, attitudes, beliefs and stigmas that are negative to disability and children and adolescents with disabilities, featured prominently. Both Shona and Ndebele cultures evidence negative beliefs on the causes of disabilities, associating with such aspects as witchcraft, promiscuity by the mother

reacted, with horror, fear, anxiety, distaste, hostility and patronising behaviour towards children and adolescents with disabilities. The results included increased isolation, discrimination and prejudice against them.

The study confirmed that there is limited social acceptance of children with disabilities by their families (particularly their fathers and paternal relatives), and the communities they lived in. Interventions for people with disabilities are mostly viewed as charitable, largely undertaken by NGOs. The field validation noted that 87% of the care-givers of children with disabilities in the study were unemployed and had no other sources of steady income.

Institutions catering for children with disabilities show that age is a qualifying factor for admission into facilities, irrespective of any other factors, while others emphasise the ability of the child to hear and speak and to wheel himself or herself (mobility).

The study established that most children did not have supportive devices and equipment such as hearing aids and wheelchairs. They were isolated, discriminated against and lonely; and some were begging on streets, buses and in homesteads. Others were not in school and some were sickly, unkempt and wore poor clothes. This was largely attributed to inadequate and poor management of family resources; negative attitudes towards disability; limited access to health, education and counselling services; and inadequate child care practices.

The underlying causes were identified as ignorance of causes of disability; economic problems - loss of income; cultural beliefs; stigmas and labelling inadequate Government policies; and failure to implement existing Government policies. Poverty and HIV and AIDS were identified as the basic causes.

Street Children

The study conducted involved the interview of 260 street children (220 males and 40 females) in Harare, Bulawayo, Gweru, Mutare and Kadoma and an additional 31 street children were included in focused group discussions, bringing the total to 291. Twelve street child-care workers (10 males and 2 females) and focused group discussions with 24 street adults (16 males and 8 females) were also interviewed.

Results from the study confirmed the typology of children “of”, “on” and both “on and of the streets”. Many of the children interviewed were “of the street”. Contrary to popular belief, this study showed that children who slept both at home and on the streets were more vulnerable to a range of risk factors than any other category of children working on the streets. These children were more vulnerable to sexual abuse, abuse of intoxicants, and were more likely to engage in sex and contact STIs. Interestingly, many of the children “on the street” preferred not to be called street children. They saw themselves as entrepreneurs or small businesspeople.

The study confirmed that street children continue to be treated with scorn, dislike and violence by the general public and law enforcement agents. Child sexual abuse continues to be a major issue concerning street children. Many had been sexually abused at home and on the streets. A good number of the children had risky sex behaviour, engaged in casual sex, were subjected to rape, prostitution and participated in sex for exchange of goods and services (mainly protection services).

The majority of the children had been forced by poverty onto the streets. However, the immediate causes ranged from death of a parent to child abuse in step-parenting situations. Many of the children interviewed left home when conditions were very bad, when there was no care and support from adults. Family dysfunction and disruption appeared to be strong factors in pushing children onto the streets.

The study shows the presence of wide gaps in responsibility for the welfare of street children. The death of parents has created gaps in provisions for the basic needs of children. The majority of the children who lost their parent(s) through death had moved in with the extended family. Most of these children and those who lived with step-parents, reported high levels of physical and sexual abuse.

Working Children

The review notes that information on working children, or child labour as it is often referred to in Zimbabwe, has been extremely limited. The few studies that charted the way were mainly small and independent, with no support or participation of state agencies. Therefore, in 1999 the Government of Zimbabwe, in partnership with the ILO, embarked on a nation-wide survey that sought to establish the extent and magnitude of the “problem” of working children or child. The survey relied heavily on quantitative research methods, with less discussion on the implica-

tions of the figures presented.

Problems associated with working children range from working long hours with little or no payment; being subjected to abuse of physical, verbal and sexual nature, to carrying out activities that are not commensurate with their physical strength. The demands of the work environment, which is generally hostile to the needs and welfare of a young and growing child, generally lead to poor physical growth (stunting), mental stress in some instances depending on the nature of the work, and threaten the moral well-being of the child.

This report made use of mainly qualitative studies, which show that working children throughout history, have played an integral part of the work force on commercial farms and in communal areas. In the latter, where most of the able bodied members of the community are in cities in search of employment, children together with women and elderly people, are an integral part of the unpaid household labour force. The study also shows that in the cities, the lack of available formal employment opportunities, force people to eke out an existence in the informal sector, where they work long hours with very limited returns. Children are also an integral part of this economy, where they assist their parents to economise on scales of outreach in vending and selling of various trinkets, amongst other activities. The study presents a similar trend in informal mining operations as well.

Children Infected with AIDS

Interviewees for the field study were drawn from rural and urban areas of eight of the ten provinces in the country. A questionnaire was administered to care-givers of 213 children with HIV infection, and interviews were conducted with 38 health professionals and 8 administrators of children's homes. Seventy-five percent of care-givers were interviewed at home and 24% in hospitals and other institutions. The interviews covered problems faced by HIV infected children and their care-givers, prevention of HIV infection in children, and the care of children infected with the disease.

The greatest majority of children (114 or 54%) were in the 5 to 14 year age group. Twenty or 9% of the children were infants less than one year of age, 73 or 34% were aged between 1 and 4 years, and 6 or 3% were aged between 15 and 18 years. A substantial number of the children are also orphans, with the majority of parents having died of AIDS. A quarter have no mothers, a fifth no fathers and more than one-tenth have lost both parents.

In the hospitals visited, HIV infection was the single leading cause of admission and death in the paediatric wards. The children suffer from repeated episodes of chronic disabling conditions such as tuberculosis and chronic diarrhoea; life-threatening conditions such as pneumonia and meningitis; and disfiguring conditions such as herpes zoster and other skin diseases; and recurrent parotid gland enlargements, conspicuous dental caries and chronic discharge from the ears. They are often miserable and have no energy to enjoy their childhood to the full. These children are also chronically undernourished. However there is no set approach in diagnosing HIV-infection in children, the management of the sick child, and the management of the parents or care-givers. Treatment is basically palliative and supportive. In most cases the parents of the HIV infected children are not informed or counselled about the problem. Care-givers complained that inadequate food is one of their main problems. Others have restricted food intake or diminished absorption due to conditions such as mouth and throat sores and recurrent diarrhoea.

The care-givers portrayed a picture of frequent episodes of illness in the child, disruption of personal lives, loss of friends, declining resources, inability to provide for the child, lack of external support, permanent fear for the child's imminent death and overall desperation. Resources for the child's sustenance are often scare. Most care-givers who are not parents (40%) are often old relatives who are 60 years and over and have no reliable income from which to provide for the child. The majority of the care-givers who are younger are either unemployed or are informal traders in hawking and vending with irregular and inadequate income. Mothers are often themselves ill which showed prominently in the results. Care-givers are in constant fear of being ridiculed, losing friends, being evicted from lodgings and being associated with loose morals.

Major reasons contributing to HIV infection among children include:

- inadequate case management of infected pregnant women, particularly among those lacking information about HIV and pregnancy;
- inadequate counselling and testing due to little knowledge and skills in sections of the health work force and human material resources;

- inadequate health services capacity for optimal management of pregnant women and HIV infected children;
- lack of preventive treatment;
- lack of adequate psycho-social support for the children and their care-givers due to weak social support programmes in the community;
- limited community mobilisation and education about the HIV infected child;
- cultural and gender imbalances in reproductive matters; and
- lack of preventive legal instruments against infection of children with HIV.

Most school-aged children are too sick to go to school and therefore miss out on education. Those who do go to school are often too ill to fully enjoy and benefit from normal school activity. Frequently these children are teased by the other children because of their often stunted and sickly appearance.

The extended family is expected to care for children affected by AIDS. Paternal relatives were said to be more active during funerals whereas maternal relatives would care for the children after death, especially of the mother. There was total agreement from all sectors interviewed that the care of children affected by AIDS should be the full responsibility of the extended family network. Thus, the development of structures that strengthen the capacity of the extended family in providing consistent support for children affected by AIDS, is fully appreciated.

Communities are socially helpful. When properly mobilised, the community had the capacity to support the extended family to care for children affected by AIDS. These communities however had limited resources. When communities are spearheading programmes, they should receive enough support from the government and NGOs.

Most institutions were identified as useful, but some were not accessible especially those in resettlement and rural areas. Education institutions came across children affected by AIDS more frequently than any other institution. It was not clear whether personnel in such institutions were well -equipped for the extra task of meeting the needs of these children, especially in areas of counselling and psychological support. It was also noted that almost all institutions had no perspective on the extent of the problem of children affected by AIDS. This led to these institutions assisting those children they came across without necessarily finding out whether they most deserved such services.

Most respondents were uninformed about the role of local government. Councillors were identified as “key” if they assumed their duties properly. However, these were said to be most active during times of elections only. Respondents indicated the need to be trained or educated on the role of local government for them to be able to know what necessary support they could access.

Government was recognised as the custodian of all children. Respondents had high expectations on what the government could do for children affected by AIDS.

Emerging Gaps and Recommendations

Children Affected by HIV and AIDS

Emerging Gaps

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

- Although support provided to various governments by donors, NGOs and CBOs has improved the quality of life of orphans and other vulnerable children at community level, this support poses some limitations. There may be poor organisational management skills by service providers, lack of adequate funding and limited technical support at community level to sustain projects when donors pull out. The results of the field validation exercise and the literature review reinforce the need to set up mechanisms which respond to locally identified determinants in order to decrease the vulnerability of communities to HIV/AIDS. The results of the study also reinforce the need to strengthen community responses, which significantly reduce the vulnerability to HIV AIDS.

- Specific monitoring indicators which measure the success or failure of programmes based on time, materials,

money, manpower and the extent to which stakeholders and politicians are willing to support the child care programmes, have not been developed at policy and programmatic levels.

- Current approaches to pilot projects lack clearly defined project monitoring mechanisms which provide information on the sustainability and ability to replicate project activities at policy and programmatic levels.

Despite existence of Orphan Care and HIV/AIDS policies, there is still lack of clarity as regards to overall leadership and co-ordination of the various role players. Other gaps include:

- Lack of awareness programmes on child protection and child rights and limited awareness of the roles of government and other actors by communities.

- Mechanisms in place at hospitals and clinics are not accommodative of children carrying out adult functions, e.g. children not accompanied by adults are denied treatment in health centres.

- Insufficient involvement of children in the issues that affect them.

- Unclear programming for children who are currently assuming adult responsibilities

- Lack of follow-up and feedback of research findings to communities which leads to research fatigue in communities most researched.

- There has been no evident factoring in of the gender implications during planning. Inadequate resources, especially human resources in relevant departments that deal with the CABA issue, e.g. Social Welfare and Health Departments.

Recommendations

It is recommended that the Government of Zimbabwe, with support from other organisations, strengthens service provision through the dissemination of policy and programmatic information to all sectors of the community and through capacity-building and resource allocation.

Policy/Legislation Level

- The Government needs to clarify the responsibility of various departments in implementing and monitoring child care and child protection activities at policy and programmatic levels. This move will assist support organisations and other stakeholders to co-ordinate their activities effectively and to direct specific resources to the appropriate ministries.

- The NPA Secretariat should encourage all stakeholders to support projects, which have as their major focus, **the Best Interest of the Child.** Results of the field validation exercise and the literature reviewed have revealed efforts made by some stakeholders to shift from dormitory type child care facilities to family-based facilities. This positive shift of emphasis needs to be encouraged at policy level before being overshadowed by other issues and developments.

- Zimbabwe should strengthen the provision of basic services since these services are key to the survival and development of orphans and other vulnerable children.

- The Government of Zimbabwe needs to disseminate policy information to all communities and service providers, through a variety of media and languages. These policies assist community members to make informed decisions regarding child-rearing practices. The policies also benefit service provision because they reinforce the right of the child to remain within the biological nuclear family and, they assist various stakeholders to develop strategies that support national needs.

- Laws linked to registration of births, inheritance and property disputes should ensure that all children are identifiable and that orphaned children inherit their parents' property. **Legal education** should also be an integral component to community-based awareness programmes.

- Enforce and monitor existing policies that protect children with special emphasis on**:**

- Protection of children against neglect and abuse;
- Protection of inheritance rights' of orphans;
- Right of children to education (both primary and secondary); and
- Increase availability and accessibility of social welfare support for children affected by HIV/AIDS.

· Mechanisms should be put in place for CABA to benefit from AIDS Levy

· Improve access to health facilities especially for OVC

· Empower personnel in relevant departments to provide counselling services to CABA (e.g. DSW, Health and MOH)

Programmatic Level

Traditional child care coping mechanisms are currently weakened by poverty, HIV/AIDS and the increasing number of households which are in need of support. This development has resulted in community members losing confidence in their ability to care for their own vulnerable children. However the GOZ, supported by various stakeholders, can ensure sustainable development of programmes by empowering community members to implement and monitor their projects. COPE, an NGO in Malawi, provides a demonstrable example on how to foster the confidence of community members during programme implementation. Attempts to sustain programmes can also be done through:

· **Costing** community-based child care activities. This approach helps to determine the impact of service provision. FACT, an NGO in Zimbabwe, has demonstrated that it is possible to cost time, personnel and material inputs.

· Adopting a **holistic approach to service provision** at community level. This can be achieved through the development of a mechanism that ensures the involvement of community members to assess, register and monitor the needs of vulnerable children. Community members can also be involved in determining the support required at household level, the impact of service provision and the constraints encountered.

· The provision of comprehensive **Professional and Life Skills Education** for children and adolescents since they need to access appropriate, non-discriminatory counselling and reproductive health facilities. Their participation will enable them to make informed decisions about their own lives.

· Strengthening and supporting **sustainable and replicable** community-based child protection initiatives which:
  - localise the allocation of resources
  - reinforce the management and marketing skills of CBOs
  - train stakeholders on designing, managing, monitoring and evaluating project activities
  - establish non-discriminatory fora for NGOs and CBOs to exchange ideas and experiences
  - build links between donors, Government, NGOs and CBOs to ensure a co-ordinated approach to service provision at community level.

· **Community Based Income Generating Initiatives**, for example, savings and credit schemes which rely on community participation to ensure sustainability. The main role of support organisations is to facilitate the process through awareness raising, training and the provision of time, personnel, and financial and material inputs. Concerted efforts should be made through community-based structures. For example, the Child Welfare Forum could involve the private sector to participate more in supporting these initiatives because the private sector is strategically placed to provide the business and marketing expertise needed to sustain income generating initiatives.

· **Strengthening the capacity** of the Department of Social Welfare (DSW) to effectively manage, implement, monitor and document community-based responses to child care. The DSW, through the Ministry of Public Service, Labour and Social Welfare, is mandated with the responsibility for the care and protection of children. The DSW is also responsible for co-ordinating the functions of the **Child Welfare Forum**, the **only** structure which has decentralised child welfare activities.

· Reports and documents compiled by NGOs should be integrated into the national database. The Child Welfare Forum, through the Department of Social Welfare, needs to develop a co-ordinated approach to data collection,

reporting and documentation of community-based child protection initiatives. This approach will strengthen the quality of data for advocacy.

- Stakeholders need to provide tangible benefits, which **augment the livelihoods of volunteers**, the majority of which are **women.** The women could be afforded:

  - access to education, particularly education for the girl child
  - access to credit to run their own income generating projects
  - preferential access to land for agriculture, including the initial inputs
  - membership to housing schemes, etc.

- The **participation** of **children** in programming community-based child-care initiatives should be encouraged. Currently, traditional culture allows children to participate in specific activities, for example, in carrying out basic household chores. Service providers should therefore strengthen this existing approach by integrating, in a sensitive manner, other components vital to child participation.

- Provide counselling services to children living with sick parents, bereaved children and children who have assumed adult roles and responsibilities;

- Ensure that intervention benefits families in most need through a structured prioritisation process;

- Strengthen the integration of orphan programming with PWA support groups, home-based care programmes for succession planning purposes. In succession planning intervention, identify children affected by AIDS before they are orphans.

- Children diagnosed as HIV infected should be considered as being children in need of special protection measures, and should be exempted from paying clinic and hospital fees. This policy should apply at all levels of health care in public institutions including mission and local authority health services. Use of the AIDS levy to partially defray the cost of care should be considered. Government must adopt strategies based on new developments that offer effective methods of reducing the problem. There is need to assess new technologies for affordability, cost effectiveness, sustainability and appropriateness for local conditions.

- There is need to urgently produce practical national guidelines, including clinical management protocols on the management of childhood HIV disease and management of the pregnant woman in the HIV/AIDS era. In-service courses for health workers on childhood HIV should be introduced. These courses should, as far as is possible, be conducted at local, district, or provincial levels. Topics to be covered can be determined through a quick survey of nurses and doctors. Programmes for HIV infected children should in future take into account the increasing number of school-going and teenage children, who will have different physical, psychological and social needs from the younger children. As well, all women/couples should be sensitised on their vulnerability to HIV infection and the consequences of this to their unborn children, as a matter of routine. Optional HIV testing, and information about feeding options should also be provided.

- Street children need to be considered in the broader context of a national policy on child welfare and development. However, the fact that children's issues and policies are seen within a welfare framework (Health & Child Welfare, Department of Social Welfare) may limit opportunities accessed by children in especially difficult circumstances as they are pushed to the fringes of "welfare". The weakness of a welfare approach lies in the fact that it is very reactive and focus needs to be placed on preventive work. Thus, there is a need to consider children's issues in a development framework. Departments like Child Welfare and Social Welfare should seriously consider redeployment into child and social development.

- Despite an absence of knowledge of street children's HIV sero-prevalence, the study shows that street children are a high-risk group for HIV infection. Thus, policy and programmatic responses need to reflect this risk factor. HIV and AIDS interventions must consider the factors that push children onto the streets, as it is their presence on the streets without support from responsible adults, that put them at risk for contracting sexually transmitted infections (STIs), including HIV.

- The fact that street children are abused, treated with scorn, hostility and violence by the general public and

those charged with enforcing the law, defeats all efforts at rehabilitating street children. Intervention and responses to street children's rights therefore need to note that they will only succeed if the community is prepared to support, respect, protect, defend and create opportunities for street children.

- It is important for programmers in child welfare and development to invest in research on the effects of children living and/or working on the streets. This body of research is important to counteract those who romanticise street life and set their programmes to maintain children on the streets.

Children with Disabilities

Emergency Gaps

- No clear policies and laws on the education of children and adolescents with disabilities in Zimbabwe.

- Few policies that Government departments use to provide services to children and adolescents with disabilities. Unfortunately, these policies are not made public. Hence, parents and other interested parties are not informed about them. Once the child has been identified by the clinic or hospital as having a disability, there are no clear-cut policies on what happens next. Care-givers seemed to grope in the dark and shop around for assistance without guidance.

- A policy gap in financing disability, which is evidenced by the poor allocation of funding by some key ministries with departments or sections working with disability. Some areas that require financial assistance by Government and which should be covered by clear policies include support devices and equipment, education, health, food security and shelter. Care-givers were worried about post-secondary education and the training of their children with disabilities.

- Absence of nationally representative data on people with disabilities in the country. The Central Statistics Office does not have statistics based on the National Census on the number of people with disabilities in the country.

- No programmes specifically to provide counselling services for children and adolescents with disability. Various efforts exist in terms of health, education and social welfare, but no counselling services are in place. Most children with severe to profound multiple disabilities are not in school.

- Negative attitudes, beliefs and stigmas against disability are prevalent in Zimbabwe. Yet, there are no deliberate programmes to educate the public on disability. This should be done beyond the awareness level. People need to be sensitised and made conscious about the issues associated with disability.

- Husbands and male Care-givers featured prominently either as not being involved with their children with disabilities or as being negative to the whole situation. There are no programmes in place to intervene on that problem. It is an identified gap that needs to be addressed.

- The issue of poverty as a basic factor that triggered other problems ran throughout the research. Programmes that empower Care-givers to generate independent financial resources to be able to care for their disabled children are extremely few.

Recommendations

- The current Disability Act is not comprehensive and is non-committal. There is need to re-do the Act so that it clearly spells out who is responsible for what, especially on Government's responsibilities.

- The main Ministry responsible for people with disabilities is the Ministry of Public Service, Labour and Social Welfare. Already, there is a mindset among policy-makers that people with disabilities are welfare cases. There is need to integrate the needs of children with disabilities across ministries.

- Each Ministry that has a department or section to do with a disability should have a clear budget for that section. This will demonstrate Government's commitment.

- Specifically the Ministry of Education, Culture and Sport needs to come up with a Special Needs Education Act (Special Education Act). Such an Act should be comprehensive, detailing who is responsible for what and who pays.

- Children are becoming disabled in some cases due to diseases that can be prevented (e.g. polio, measles, tuberculosis). There is need for the Ministry of Health to ensure that all children are immunised and have access to health when they are sick. Money needs to be put into immunisation programmes. Some of the money should be used to educate parents on the importance of immunisation. There are certain religious groups that do not believe in immunisation. The education programmes should target such people. There is need for village health workers and the local clinic to educate pregnant mothers on their own good nutrition and good health. Poor health and nutrition by pregnant mothers is a high risk for the child to be born disabled.

- Currently, several organisations have programmes in the field working with disability in one way or the other. There is no co-ordination of interventions, which may in turn lead to either duplication or omission of important issues. In view of this, there is need for an audit of the existing programmes by various voluntary service organisations to establish gaps in service provision for children with disabilities.

- There is a need to mobilise parents of disabled children that they form support groups to help each other. In some disability areas, such groups exist and they need consolidation. Parents supporting each other in their communities would be ideal. It was noted that each district hospital has a rehabilitation technician. It is suggested that rehabilitation technicians be given the responsibility to start parent support groups in their districts. This was apparent in Gokwe where the rehabilitation technician at Gokwe Hospital was mobilising parents into support groups. This is a good model that could be replicated and incorporated at each district hospital.

- A multi-prolonged approach to public awareness is required, empowering people with disabilities to be their own advocates. Public awareness campaigns are necessary as a continuous exercise and people with disabilities themselves can be at the forefront of these campaigns. Existing organisations of the disabled (e.g. National Council of Disabled Persons Zimbabwe) can run such a programme. Private companies should be encouraged to use people with disabilities as models to advertise their products and the mass media to show or report on cases of successful people with disabilities in society. Emphasising successful people creates a positive image of disability.

- There is a need for representation in government of people with disabilities by people with disabilities themselves. In the last Parliament of Zimbabwe, there was an individual who was disabled and who represented people with disabilities in Government. Unfortunately it is no longer the case now. Unless people with disability have two or three people in Parliament standing for their rights, many of the efforts being put in advancing the cause of disabled people will be lost.

- The Registrar General's Office should be required to include in the census form a section on disability so that whenever a National Census exercise is undertaken, the number of people with disabilities in the country is collected and known.

Street Children

Emerging Gaps

It is difficult to run effective intervention programmes for street children since street children are manifestations of profound social and economic situations that do not respond to quick and easy solutions. Failure has characterised many programmes that have not considered the children's rights, personal needs and freedom of choice in the provision of services and those that have addressed the symptoms rather than the causal factors. Failure has also characterised programmes that address street children as children without looking at the wider contents of family and community.

Recommendations

From this research a number of short-term recommendations emerge:

- There is need for co-ordination of responses to street children's rights.

- There is need to conduct a best practices survey or study of responses to street children and to share this with all stakeholders.

- A process could be initiated through child welfare fora to review existing legislation on children and how these could be strengthened.

- There is need for research to be conducted to fill the information gap on the effects of street environments on child development.

- The Government of Zimbabwe should be seriously consider re-deploying its welfare departments into development departments. This would mean that the Departments of Child Welfare and Social Welfare would focus more on child and social development. The fact that it is much more expensive to "cure" than to "prevent" cannot be overstated.

- Many of the organisations working in the area of street children have been in existence for a few years. In the long-term it could be beneficial for these to have a capacity assessment in order for intervening around NGO, CBO or organisational capacity-building.

- Community mobilisation should be a priority in ensuring duty-bearers are "keeping their promise" to children of Zimbabwe, including street children.

- Programmes need to focus on family tracing and re-unifying since this is a best practice. Street children as are all other children in especially difficult circumstances, need to be cared for within the context of their families and culture. Strategies for intervention need to consider ways of strengthening families' responsibility for their children. Children should only be placed in homes or foster placements as a last resort.

Working Children

Recommendations

- A revisit of the school timetable in some communities may be necessary where there is a high incidence of school drop-outs in order to allow children to successfully combine work and schooling.

- In most programmes in the country, there tends to be a separation or division of children by category. For example, street children are often not treated as though they are a working group. Thus, the focus tends to be on the very few children who live on the streets (known specifically as children "of the streets", in comparison to those who still have a home to go to, often referred to as children "on the streets"). Children "on the street", are no doubt working children but children "of the street" are also working children.

- There is need to sensitise children on their rights. This would enable children engaged as a group, such as on tea estates and farms, to be able to bargain collectively for reduction of working hours per day, to have access to protective clothing, etc., for the betterment of their working conditions. At the same time this is in line with creating an informed work force/society that often will be aware of its rights in given circumstances.

- Children must lead the process of gathering information and analysis in partnership with parents/guardians and other sympathetic adults.

- There should be a working children sub-committee of the National Child Welfare Forum and a pool of experts to facilitate carrying out sector-wide situational assessments and analyses on the phenomenon of working children. The purpose would be to highlight issues impacting children, which the children themselves could participate in arriving at solutions. Plans of action (be it sector or area within sector) would be established following the completion of situational assessments and analyses.

- Linking child-protagonism with national frameworks of child self-expression and participation (though a tokenism at the moment), such as the child parliament, the junior mayors and the junior chambers, in order to establish a solid and true democratic representation of children into national structures of governance.

Child Sexual Abuse

With the sensitivity surrounding sexual abuse, it was treated as a crosscutting issue within all the categories. However an exhaustive literature review was also undertaken—and findings from prior pilot studies undertaken in Chikomba and Beitbridge were used to substantiate some major issues emanating from the literature review.

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

A total of 35 case histories from the Harare Magistrate's Court were sampled based on availability, and analysed. The data reveals that all the children wanted to report the abuse but were suffering from self-blame, lack of energy and fear of the authorities, i.e. the mothers, fathers, nurses and the police. The majority of children who were aged less than 9 years, were too young to understand what had happened. Of concern is that fact that a significant number of the abused girls were discovered through the diagnosis of sexually transmitted disease and with the possibility of having contracted HIV/AIDS.

Studies also highlighted that many young girls cannot or dare not express what happened to them. It is often only found out because they have been badly hurt or ill or because someone else has seen the incident. The respondents favoured longer sentences for the offender, protection of the child from further abuse, removing the alleged offender from the home, and treatment for the child and his/her family. Respondents also stated that offenders should receive treatment and should not necessarily be prosecuted if they can be rehabilitated, despite their belief that stiffer sentences for abusers were appropriate and their ambivalence about offender rehabilitation.

The discussions were varied across gender for both adults and children, and included whether a child was in school or not. The children also expressed perceptions of a sexual nature in their responses. In order to address the topic of sexual abuse of children in Zimbabwe, some researchers have examined the relationship between child sexual abuse and more general attitudes towards sex and children in society. Typically parents do not directly discuss sexual matters with their children. Several definitions of a child and child sexual abuse emerged from the study. Child sexual abuse was defined as the rape of a child by a family member, relative, or any other person.