

# Challenges of Copying with Orphans and Vulnerable Children at Household Level: A Caregivers Perspective

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**Abstract-** This study is an analysis of the challenges faced by care-givers in coping with OVC burden at household level. Using the quantitative and qualitative techniques the study was conducted among the rural care-givers in conveniently sampled wards in Gutu District of Zimbabwe. The study was largely informed by the Psychosocial Support (PSS) Model- the wheel model by Tigere (2006) and the Ubuntu Theology by Tutu (1994) and Mbiti (1995) who advocated for the strengthening of social fabric through a communitarian approach rather than individualism in child care and support. Data was gathered through semi-structured questionnaires and in-depth interviews. 10 community leaders were interviewed while 30 caregivers and 20 OVC completed questionnaires. The findings revealed that even in the face of severe socio-economic challenges, there is continued willingness by families to absorb OVC. In fact, some care-givers, particularly grandparents derive satisfaction from offering care and support. However, in spite of this willingness, the study found out that OVC care in families is fraught with several challenges whose scale and complexity often exceed the capacity of families to effectively mitigate. Consequently, most of the needs of OVC are either partly addressed or not addressed at all. To compound the challenges, majority of the care-givers were middle aged group of aunties, widows, uncles, sisters and brothers predominantly depending on subsistence income. Although they were able to provide a secure environment for children, they were to a large extent unable to meet the OVC's psychosocial, social and basic needs. With the resources at their disposal care-givers efforts were devoted to meeting the basic survival needs of OVC ignoring investment in initiatives like skills building that ensure long term survival and sustainability.

**Index Terms-** orphans, vulnerable children, caregivers, family, household, copying

## I. INTRODUCTION

In the past decade Zimbabwe, like many developing countries has been severely affected by HIV and AIDS pandemic which has exceeded wars in terms of cumulative deaths, morbidity and social disintegration of families at household levels. The National AIDS Council (NAC) (2001:2) informed by the Census (2002) revealed that there are approximately 5.6million Children in Zimbabwe of which 1.3million children are orphans. The UNICEF National Strategic Plan for the Education of OVC girls (2005-2010) in NAC (2001:1) estimated that there are

approximately 48 thousand child headed households in Zimbabwe housing approximately 100 thousand Children. Ministry of Health and Child Welfare (MoHCW) Centre for Disease Control and UNAIDS (2003:5) also revealed that about 165 thousand Children are living with HIV and AIDS which aggravate the challenges of the care-givers to cope with the OVC problems at household level.

In response to the escalated challenges of OVC burden upon the care-givers at household level, Zimbabwe as a signatory to the United Nations Conventions on the Rights of the Child (UNCRC) promulgated governing policies for child care and support which include; The Zimbabwe Orphan Care Policy (1999), The Zimbabwe National AIDS Strategic Policy, National Action Plan For Orphans and Vulnerable Children (NAP for OVC) and National Gender Policy (NGP) to mention but a few. However, despite the presence of these governing policies of child care and support there remains a gap regarding the capacitating and empowerment of care-givers at household level. It seems government policies are putting more emphasis on OVC relegating the care-givers who are also vulnerable due to the escalated number of OVC. It is in light of this backdrop that this study sought to assess the challenges and strategies for coping with the OVC problems at household level with special emphasis on care-givers in Gutu district of Masvingo Province in Zimbabwe.

### 1.1 Problem Statement

The government of Zimbabwe in partnership with non-governmental organizations is putting a lot of resources towards the care and upbringing of orphans and vulnerable children. The same effort is not being put towards capacitating of caregivers of OVCs at household level, especially in rural areas. It is therefore essential to explore the challenges faced by caregivers at household level and the copying strategies they employ in the backdrop of the uneven distribution of resources.

### 1.3 Objectives

The following objectives underpinned the study

- i. To assess the challenges faced by care givers in care and support of the OVC at household level.
- ii. To identify strategies adopted by care-givers to mitigate the challenges they face in caring and supporting OVC at household level.

### 1.4 Limitations

The limitations of this study are predominantly premised on the nature, scope and research design employed. There were

possibilities of non-cooperation by some informants such as orphans who felt that they were being traumatized and care-givers who thought they may be victimized. However, to ensure cooperation the researchers exercised extra caution to persuade informants to be cooperative through seeking an informed consent and making them understand the purpose of this study. This study was carried out in only 6 (six) wards of Gutu District in Zimbabwe and therefore the generalisability of results is limited. The use of non probability sampling techniques could also have affected the results despite the effort put to counter the related effects.

## II. LITERATURE REVIEW

### The Context of OVC Care and Support in Zimbabwe

The UNAIDS (2003) in National Plan of Action For Orphans and Vulnerable Children (NPA for OVC) (2004:7) defined orphans as children under the age of 18 years whose parent (s) have died, while vulnerable children are children with unfulfilled rights. This definition is in line with the Zimbabwe National Orphan Care Policy (ZNOCP) (2000) which defines orphans as those aged 0-18 whose parent(s) have died. While Vulnerable children are defined as children with unfulfilled rights and mainly identified as follows: Children with one parent deceased (in particular the mother), Children with disabilities and affected and or infected by HIV and AIDS. Concurrently, NPA (2004:8) added that vulnerable children entails the abused children (sexually, physically and emotionally), abandoned children, children living in the streets and married children. As if these were not enough NPA (ibid) included the neglected children, children with chronically ill parent(s), Child parent and destitute as vulnerable children in need of care and support in Zimbabwe to cite but a few.

This definition, though widely adopted, is fraught with limitations especially in the context of resource constrained environments in which many OVC live. For instance, the use of the chronological age ignores many young persons above age eighteen years whose parents are deceased and exposed to intense vulnerability context bereft of any family or external support. As noted by Killian (2009), the definition implies that by merely attaining the age of 18 years, one is automatically weaned from OVC category to non-orphan-hood and vulnerability regime. As a result, this transition ceases one to be an OVC who still needs to be cared and supported. However, in a reality his/ her plight may not be any different from those below that age that live with him/her in a similar environment. Put simply, while the secondary care-givers who include the government, close friends or extended families and NGOs to mention but a few presumes that the post 18 years of age era means one is able to look after himself and herself yet in real terms it is not true. Accordingly, the above assertion was further attested in the Situational Analysis of OVC (SAOVC) in Zimbabwe by the UNICEF (1998) and USAID (2000) who revealed that the use of age as a criterion in providing assistance for education was penalizing teenagers who started schools late by excluding them from continued educational support once they turned eighteen years old. Hence, this poses more challenges to household care-givers who will mandatorily oblige to support and care for them through their limited resources.

Traditionally, within the Zimbabwean context orphans were absorbed with the extended families that would bore the responsibility to care and support them. In the same vein the vulnerable children would be also absorbed by the extended families and the community through the *ZundeRamambo* care and support network. These support networks for OVC were conceptually referred to as *ubuntuismby* (Tutu, 2004). According to Louw (1998) *Ubuntu* serves as the spiritual foundation of many African communities and cultures. It is a multidimensional concept that represents the core value of African ontology's – such as respect for human beings, for human dignity and human life, collective sharedness, obedience, humility, solidarity, caring, hospitality, interdependence, and communalism. The *Ubuntu* version can be translated as "I am human because I belong". Thus *Ubuntu* can be seen as a radical reflection of our humanity, yet also has the universal appeal of traditional community values (Hailey, 2008:1). What is underscored above is that *Ubuntuism* is a socio-economic framework that can be analogically interpreted as the veins of the society that upholds human solidarity.

Hence, the *Ubuntu* model of child care would be seen in the willingness of the community and extended families to take care and support the deceased's children and other vulnerable children in the community. As such, the term OVC within the African context (*Ubuntu*) had little meaning as the community, one's brothers and sisters were considered to be fathers and mothers of the deceased's children in real traditional African cultures (Tutu, 1999 and Mbiti, 1995). Concurrently, the Wheel Model by Tigere (2006) exhibited that an OVC is the central focus of the community and the families. As a matter of fact, in a situation where the uncle or aunt lived, and was willing to care for the child, the child was not considered to be an OVC. Contrary to the OVC definitions above, Mbiti (ibid) and Tutu (ibid) attested that an OVC is only applicable to a child who has no parents and no substitute care-giver. According to these proponents (Mbiti and Tutu) labeling of a child as an OVC in African context is not only stigmatizing of the child, but a direct insult to those participants in the social network providing care and support to the child.

In this case, the predominant form of extended families in Zimbabwe is that of kinship including the frontline relatives such as paternal uncles and aunts. Again, these include the paternal and maternal grandparents. These frontline relatives are traditionally responsible for assuming the care and support of orphans upon death of parents and vulnerable children in case of abandonment or otherwise. Ordinarily, one member of the extended family network assumes the primary care-giver role while others may periodically contribute resources as secondary care-givers.

Like elsewhere in Africa, the traditional system of Childcare in Zimbabwe has been shifted in response to the major social changes. These social changes resulted from the growing poverty, socio-economic transformation and the increasing number of OVC. As a result, these shifts seem to have weakened the social ties and traditional philosophy of mutual obligation (*Ubuntuism*). However, the traditional philosophy of family care and support remains the only mechanism for responding to OVC problem and this explains why OVC are still being cared for by the extended families despite of the prevalence of secondary

care-givers (Mugurungi, 2006). The study in OVC care and support in Tigere (2006) further attest to the predominance and appropriateness of household level as the best model for OVC care in today’s communities. Despite its prominence as the most viable mechanism to OVC care and support, the household has begun to show signs of distress. For instance, when the family is pressed hard, some households begun to offer differential care and often discriminates and verbally stigmatize the OVC under the guardian in regard to the allocation of resources between the deceased’s children and their own.

In a study on experiences of orphans care in Northern Uganda, Oleke et.al (2007) revealed many instances where orphans were not wanted, cared for, or loved by their care-givers .due to the burden imposed upon them. The study indicated that the inadequate and discriminatory care for OVC was mostly manifested through OVC relatively heavy workloads, inadequate feeding, clothing, shelter and limited joy compared to other children in some households. Ntonzi and Gapere (1995) similarly noted that despite the existence of the extended family system, the OVC were stunted and malnourished because they would not cope with OVC problem. They concluded that most OVC were deprived of education, parental care, clothing and the legal protection of their parents’ property.

In an endeavor to strengthen the capacity of the traditional system of child care and support which seem to be over-strained with the OVC problem. The Government of Zimbabwe (GoZ) in June 2005 endorsed the NAP for OVC in an effort to complement the traditional systems (*Ubuntu*) and current

government efforts in OVC programming and address perceived information gaps (Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), 2010). As such, the SAfAIDS in partnership with the National Association of Non-Governmental Organization (NANGO) were appointed as implementing and information dissemination agency on behalf of the NAP for OVC secretariat. In this case, the context of OVC care and support in Zimbabwe is deemed a GoZ’s project with various implementing agencies such as NGOs, FBOs, *Zunde Ramambo* (ZR) and AIDS Service Organizations (ASOs) among others. However, despite all these secondary care-givers, this study identifies that the primary care-giver at household level still remains the prominent and the most appropriate model of OVC care if well furnished with adequate resources to carry the burden. Now that the context of care and support of OVC in Zimbabwe has been reviewed the discussion turns into the nature of OVC care and support.

### III. METHODOLOGY

Methodological triangulation was employed as a measure to increase the trustworthiness findings and well as construct and content validity. Thus both qualitative and quantitative methods and techniques were used respectively. The table below summarizes the methodology used at a glance.

**Table 1: The Mixed Methods Matrix Used**

ASPECT	QUALITATIVE	QUANTITATIVE
<b>Paradigm</b>	<b>X</b>	<b>X</b>
<b>Method/design</b>	phenomenological	survey
<b>Sampling</b>	Convenient sampling was used to come up with respondents at ward level	Simple random sampling was used to come up with 6 wards
<b>Data Gathering/Collection</b>	In-depth face to face interviews were used to gather data from 10 government and NGO officials as well as community leaders	Structured questionnaires were used to collect data from 30 caregivers and 20 OVC.
<b>Data Analysis/Interpretation</b>	Inductive analyses of emic interview responses	Descriptive analysis of etic questionnaire responses
<b>Representative sample</b>	The representative sample consisted of 10 community leaders (government, NGOs and Traditional), 30 caregivers and 20 OVC	
<b>Ethical Considerations</b>	Written informed consent was sought from all respondents and participants. Issues of confidentiality and privacy were also spell out. No real names were to be used.	
<b>Validity, Reliability/ Trustworthiness</b>	Pilot study was conducted in one ward that was not included in the sample. Questionnaires were pretested. Pre-interviews were also conducted. Questionnaires were in Shona and English.	

<b>Period</b>	The study was carried over a period of one month.
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IV. FINDINGS AND DISCUSSION

4.1 Biographic Data

**Table 2: Profile for Respondents/Participants**

RESPONDENTS CHARACTERISTICS	CAREGIVERS (N=30)		OVC (N=20)	
	N	%	N	%
<b>SEX</b>				
Male	20	70	13	65
Female	10	30	7	25
<b>Total</b>	<b>30</b>	<b>100</b>	<b>20</b>	<b>100</b>
<b>EDUCATIONAL LEVEL</b>				
None	9	30	2	10
Primary	5	17	10	50
Secondary/Tertiary	16	53	8	40
<b>Total</b>	<b>30</b>	<b>100</b>	<b>20</b>	<b>100</b>
<b>AGE OF RESPONDENTS</b>				
14-15			8	40
16-18			12	60
19-30	6	20		
31-40	12	40		
41-50	5	17		
51-60	4	13		
61+	3	10		
<b>Total</b>	<b>30</b>	<b>100</b>	<b>20</b>	<b>100</b>
<b>MARITAL STATUS</b>				
Single	3	10		
Married	18	60		
Separated	1	3		
Widowed	8	27		
<b>Total</b>	<b>30</b>	<b>100</b>		
<b>RELATIONSHIP OF CAREGIVER TO OVC</b>				
Mother	4	13	4	20
Father	5	17	6	30
Grandparents	6	20	3	15
Brother/Sister	2	6	3	15
Uncle/Aunt	13	43	4	20
<b>Total</b>	<b>30</b>	<b>100</b>	<b>20</b>	<b>100</b>
<b>SOURCE OF INCOME</b>				
Self-employment	13	43		
Salary/Wage	6	20		
Crops/livestock	11	37		
Other				
<b>Total</b>	<b>30</b>	<b>100</b>		

Table 2 shows that about 60% of the OVC who participated in this study were aged between 16 and 18 years and 40% were between the age of 14 and 15 years. In terms of relationships to the care-givers, 30% of the OVC who participated were living with their fathers and mothers, while 20% were living with their

aunties and uncles, 15% were living with the grandparents and the other 15% were under the guardian of their brothers and sisters.

**4.2 Challenges faced by Care-givers in Coping with OVC Burden**

This section presents findings from the study with regard to challenges that families are facing in providing care to OVC. The challenges were discussed and presented along the five core elements of care that families provide as described in previous sections. These include; food and nutrition, education, psychosocial support and health care.

#### 4.2.1 Food and Nutrition

With regard to food and nutrition, the study found out that families were to a large extent able to meet their own feeding requirements with locally produced food such as wild fruits, vegetables, maize and sweet potatoes. However, due to high population density in the study area, land shortage was acute especially to those in living in Gutu Growth Point. As a result, involved in gardening had begun to negatively impact the household capacity to produce adequate food. These household faced with shortages of land rented pieces of land on which to grow seasonal crops such as maize, sweet potatoes and beans among others in the rural areas. Besides carrying a prohibitive cost, renting of land was reported to limit household initiatives to diversify the crops and consequently led to limited dietary diversity. This finding was consistent to Guzura and Chigora (2011) who pointed out that the coalition government of Zimbabwe has failed to consider the grassroots in their land redistribution of 2002 which reflected by the most poor people still landless despite the redistribution that have taken place.

During the interviews the community leaders indicated that the care-givers were unable to provide the different types of food that children often demand. Ministry of Health officer had to say during an interview:

*“Most of the children especially between the age of one to ten years often suffer from malnourishment due lack of balanced diet. Some of them are even dying at that age due to diseases associated to malnourishment. This is of course a sign that care-givers at household level are unable to adequately provide their children not only OVC with enough food for survival”.*

What the health official said concurred with what most of the care-givers predominantly indicated that they were not satisfied with care and support they are offering to their OVC. The care-givers indicated that due to chronic poverty, they could not afford to buy food to supplement they local food they grow in their fields. The food they pointed to unaffordable though available in the market includes; bread, rice and meat to mention but a few. To the care-givers failure to provide these foods especially at festive days like Christmas was a common source of stress that care-givers and parents often perceived themselves as having failed to sustain the welfare of the household.

It was interesting to note, however that although care-givers were finding difficulties in meeting the feeding and dietary needs of their children including the OVC under their guardianship could not blame themselves but the community leaders who failed to stand with them. One of the grandparents was quoted saying:

*“How can we feed the Orphans on our own? We are not working neither are pensioners nor able to do any business. We thought the government would help or assist with food so that we can be able to feed these children. I have sold all my cattle in order to bring these children up”.*

Generally, the community leaders attributed the food shortages to chronic poverty, which grossly affected the people's agricultural activities in Zimbabwe as highlighted by (Gomba, 2011 and Ngwerume, 2005). By implication the foregoing findings converged with the findings revealed by the WHO (2010) which pointed out that generally the care-givers were unable to meet the conventional requirements standards for feeding the children especially in most of the developing countries to chronic poverty they are subjected to.

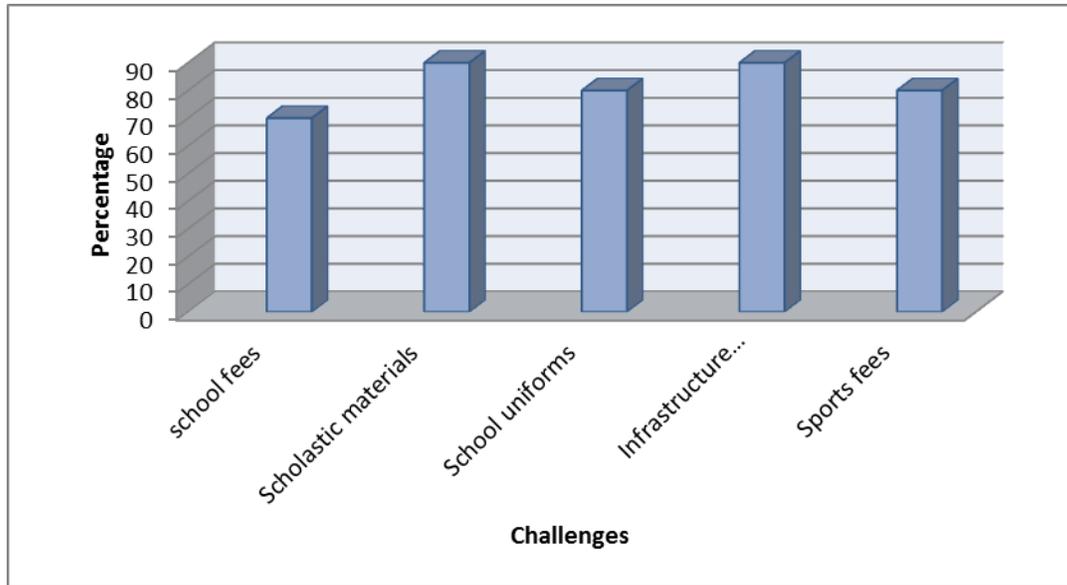
#### 4.3.2 Education

With regard to education for OVC, the challenge was how to raise money to pay school fees and other scholastic materials required by the schools. However, most of the primary schools were receiving government support through the BEAM but still indicated that it was not sufficient to meet other necessities such as uniforms, development fees and teachers' incentives. Besides the provision of school fees through BEAM by the government it was indicated that schools also required parents to contribute towards things like teacher's incentives and maintenance fees. All these translated into a substantial hindrance to accessing education by OVC. This was verified by Chambari, Mangoma and Dhlombo (2008:20) who noted that;

*“Some respondents (district education officials) mentioned inadequate funding and delays in receiving school fees and BEAM budgets from the government which drove teachers to find resources from families, many of whom could not afford them and consequently the children dropped out of school. Indeed the household survey showed that orphaned children had a higher rate of school drop-out”.*

As indicated in figure 3 below almost all the educational needs for the OVC were above 70% of the participants' responses as challenges to the OVC's access to education. Although all the educational needs are all at high level but the scholastic materials and infrastructure development are predominantly a very high level which close to 90% of the total number of respondents.

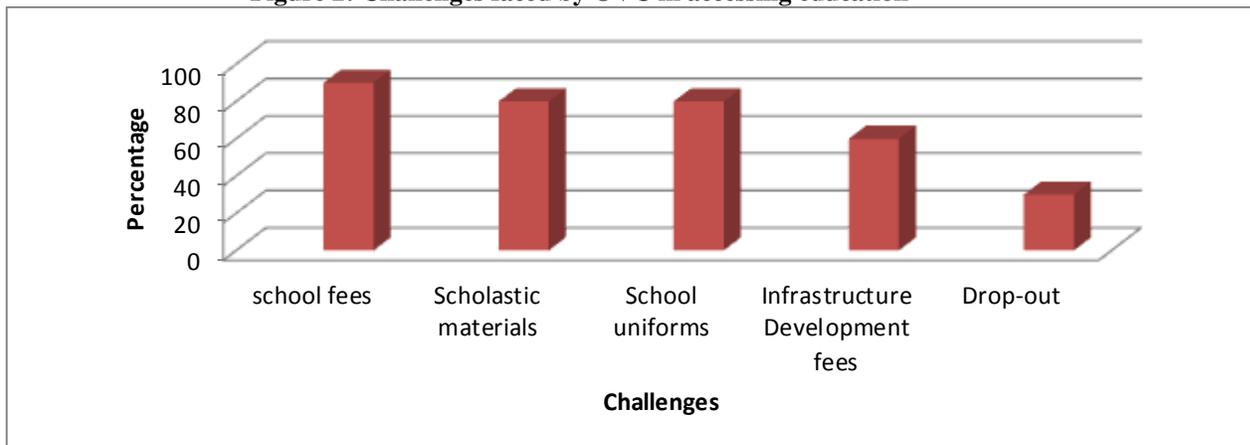
**Figure 1: Challenges faced by Care-givers in educating OVC**



A cross- tabulation of the challenges faced by care-givers and OVC as highlighted by Figure 3 above and 4 below, there was a convergence of evidence to verify the gravity of challenges faced by the care-givers. Regardless of a slight different that on OVC table school fees predominantly took centre stage as the main challenge at about 90%. The scholastic materials, schools uniforms and infrastructure development are slightly above 80%, which shows an insignificant variation with the findings on the

care-givers' experiences. Hence, the concurrence of the OVC and care-givers' experiences on challenges shown in the OVC access to education shows that both school fees, infrastructure development, uniforms, scholastic materials are fundamental aspects to OVC access to education. As a result of its prevalence, contributes to above 30% of OVC drop-out of schools as shown in figure 4 below.

**Figure 2: Challenges faced by OVC in accessing education**



A triangulation of primary and secondary data revealed that there was a convergence of findings as Ngwerume(2005) indicated that BEAM was not adequately meeting the needs of OVC to be in schools. This same finding was verified by Mangoma, Chambari and Dhlombo (2008) in their study about OVC challenges in Zimbabwe when they discovered that the poor delivery system by the government is also affecting children in their fees being paid in time and hence always found wanting despite them being registered by BEAM.

**4.2.3 Healthcare**

Challenges in regard to health care for OVC were directly linked to apparent lack of quality health services in the study area. All the wards covered by this study had satellites health centres with an average of four (4) kilometres. However, as noted from the study that good geographical distance is not in itself sufficient to guarantee access to quality health care. The quality of these health services were regarded to be inadequate, characterized by drug shortage and irregular attendance or total lack of health workers.

Even when the health workers are available, the OVC and care-givers reported that they would be given only prescriptions and referred to go and buy the drug to the private pharmacies. With no disposable income, care-givers have raise money to pay for health care from selling crops, contract labour(*maricho*), borrowing or even liquidating the assets. The study has found out that quite often OVC and care-givers were reluctant to seek medical care from these facilities in the knowledge that they would not find required treatment at health centres. As an option they would consult traditional healers and faith healers (prophets) for assistance. One of the FBO leaders had this to say in an interview;

*“I am helping quite a lot of people including children who are in dire need of health care because there are no drugs in hospitals. Sometimes even if drugs are there but generally people have hope in God because he can heal any disease compared to hospitals where they are clearly told that some disease are not curable, which not the case here. We cure diseases such as Nhova, evil spirits and HIV and AIDS among others he added”.*

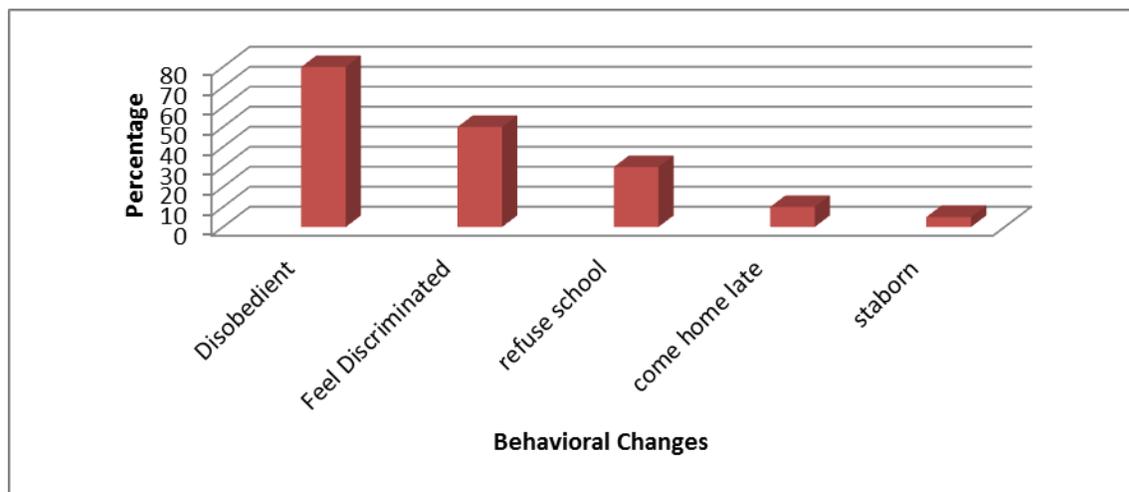
#### 4.2.4 Psychosocial Support

With regard to psychosocial support and emotional care, it was generally acknowledged that care-givers lacked knowledge

and skills to diagnose and effectively address psychosocial needs of the OVC under their care. Instead, they considered emotional and psychosocial with a broader realm of care that OVC received. This may have profound impact on the future of children since the nature of response to the psychosocial needs of these OVC may have far-reaching impact on their social and emotional development. Care-givers reported great challenges associated with upbringing of the children. In a household where OVC were under the care of other relatives not their biological parents efforts were made to ensure that they are brought up in the same way as care-givers own children.

However, despite the foregoing revealed effort, it was reported that still some OVC predominantly shows various challenging behavioural problems as shown in figure 5 below. In this case, figure 5 indicated that 80% of the care-givers revealed that disobedience is the most common behavioural problem of the OVC, while 50% of the care-givers concurred that the feeling of being discriminated was part of the behavioural challenge of the OVC, 30% of the respondents indicated that the OVC under their care refuse to go to school and 10% indicated that their OVC come home late.

**Figure 3: Behavioural Challenges for OVC**



When asked the reason why these children behaved that way, it was discovered that even the care-givers did not know why these children behaved that way. However, when triangulated one of the OVC when asked why they always feel discriminated was quoted as saying;

*“We are always beaten up even for no apparent reason with our aunt and forced to work very hard while her children are seated at home. So this causes me and my young sister to feel unwanted and discriminated in the household”.*

This finding corresponds to the findings of Tigere (2006) who revealed that most of the OVC suffer from psychosocial and emotional challenges due to the fact that the care-givers are not able to holistically provide for all the needs such as spiritual, physical, mental and social needs among others.

#### 4.3 Strategies in Coping with OVC burden at household level

Faced by inevitable need to provide care and support to OVC in the context of inadequate resources, care-givers came up with various strategies to cope with OVC challenges. In some instances, the OVC themselves adopted their own coping strategies. Following is the discussion of these coping strategies along the four core elements of child care namely food and nutrition, education, health care and psychosocial support.

##### 4.3.1 Food and Nutrition

A couple of strategies were applied by OVC care-givers at household level in order to address their food and nutrition needs. In order to cope with increased family sizes or to accommodate loss of adult labour, children were found to have assumed greater roles in food production. The need for children to provide agricultural labour was widely reported by care-givers as one of the primary reasons why children were kept in public

schools near homes, despite of their reservations on the quality of education offered in the schools.

In a traditional African family setting, children constitute a strong source of labour for agriculture. Hence, this was considered predominantly as a legitimate coping strategy as assuming that children are supported to acquire agricultural experience and skills in the long term. However, some respondents indicated that there were instances where children were indeed overworked as a coping strategy to supplement livelihoods at household level. For instance, one of the grandparents had this to say when asked a question as how they are coping with the burden:

*“Yes they have to work very hard during the weekends to compensate the days when they are at school. They go to work in the gardens or fields from morning till evening because our fields are not close to our homes”.*

Overworking of children was also confirmed by local leaders as a prevalent practice. It was noted that children are overworked against their will in a bid to raise the extra resources needed for welfare of the household. One of the councillors (local leader) when interviewed was quoted saying:

*“The care-givers have no money and they make orphans overwork especially during the weekends. They are made to be working in the fields from morning to evening. Some of these children come to report to me about such issues”.*

Furthermore, it was also reported that some widows and single mothers were involved in prostitution in Gutu Growth Point as a coping strategy. For instance, one of the single mothers in ward 34 clearly indicated that prostitution is one of her coping strategy. She indicated that that’s her business during the night while her children are asleep and during the day she will be buying and selling vegetables in market.

In a nutshell, the coping strategies revealed by respondents include; getting the OVC to work in the gardens, fields and for others to supplement food, buying and selling of vegetables, fruits and cross border trading and prostitution even though some were not prepared to reveal this as a strategy because of its illegality.

#### **4.3.2 Education**

The study established that in the context of limited resources, very few care-givers were exercising preferential treatment when it comes to schools where their children would go. It was interesting to note that almost 90% of the respondents’ children and OVC were attending government or public schools near their home as a strategy to cope with educational expenses in private and public boarding schools. Only 20% cases were evidenced by few segregation cases where care-givers caring for non-biological orphans keeping OVC at public near home schools while their own biological children were sent to private or public boarding schools which are costly and quality education.

During in-depth interviews with the local leaders, segregation in the allocation of resources, particularly in regard to the type of schools where children went was pointed out as a serious and prevalent practice among care-givers who are not biological parents for OVC in the households. Local leaders reported that segregation was a major cause of stress for OVC and in some cases it leads to anxiety and school drop-out.

However, as a coping strategy keeping children in public schools was because the public schools are relatively cheaper and less demanding than private schools. Moreover, besides keeping those in public schools care-givers came up with other initiatives to assist them cope with challenges of providing education to the OVC under their care. For instance, many care-givers reported that they established relationships with the school administration officers that they should allowed to pay their fees through instalments and in some cases late. This was the only strategy that was employed by the majority of care-givers. However, they acknowledged that though this strategy was helpful, they have had to endure anxiety associated with defaulting on the deadlines agreed with the school administration.

In the same vein, OVC reported that they had various initiatives adopted to ease the burden associated with the cost of education; some of the adolescent OVC reported that they engaged in the activities that raise income which is used to defray some school expenses and also contributed towards family welfare. Activities undertaken include; selling vegetables and wild fruits or herding other people’s livestock during the weekends or holidays in order to get money for schooling in return. When interviewed one of the OVC was quoted as saying:

*“We work in other peoples’ fields and herding the cattle during weekends and holidays to get money for schooling but the work we are mandated to do is sometimes is too heavy that we end up getting ill or injured”.*

Although the efforts made by OVC to ward off pressure on care-givers were acknowledged, some of the activities they engaged in were found to be inappropriate for children at their age. One instance involved selling of vegetables and fruits and working in other peoples’ fields at the same time they were obliged to do school homework. As such, children under the care of poverty stricken and elderly headed households were particularly found to be more vulnerable. They frequently forced to leave school in order to engage in productive activities to raise income for sustaining the households.

There was no information available in households covered by the study to verify the performance of children who combine school with work. However, common experience has shown that provision of casual labour often interferes with the school performance and it can be expected that some OVC could have performance problems. In the study carried out by UNICEF (2010) in Zimbabwe confirmed that school performance for OVC deteriorated partly because of the need to engage in income generating activities and partly because of anxiety. Other coping strategy adopted by OVC includes using their scholastic materials sparingly by writing in all the lines in the book and ensuring that all pages are intact. It was also reported that children were taught to live within the available means and do without some needs such as school bags, shoes and in some cases uniforms.

#### **4.3.3 Healthcare**

With most of the health care sought from public providers, care-givers has established relationships with the government that they are allowed only on critical issues to get medication on credit. Ultimately, these medical bills had to be paid and it remained a challenge in the care of OVC when the care-givers would sell their assets to pay off the hospital bills. In poor families especially those headed by elderly grandparents, health

care for OVC was reported to a major problem draining resources that could otherwise have been devoted to other needs. One of the grandfathers had this to say responding to an in-depth questionnaire:

*“The health care of these children has made me poor. When I sold all my livestock for the medication of this girl sited next to you. It stressed me and I fell sick for two months doing nothing and not even going to the fields”.*

Faced with these challenges, some care-givers resorted to seeking formal or modern health care only when the illness was perceived to be grave. This was verified by one of the widow who had this to write in her response to in-depth question;

*“If the child gets fever, I use herbs to treat it and that reduces the amount of money that I would spend on treatment. If the fever gets severe, that is when I take them to the clinic or health centres for treatment and that is very expensive”.*

Mugurungi (2006) similarly noted that without access to ready cash, many care-givers postponed seeking health care and preferred to self-treatment or visit a traditional healer and it was only when the health situation became desperate enough that they were forced to visit a formal health facility at the eleventh hour. In almost all the households covered in the study, care-givers reported that traditional forms of care, usually use of herbal medicine was the first line of treatment used when children fall sick.

#### **4.3.4 Psychosocial Support**

The study revealed that psychosocial support was critical need but due to lack of skills to appropriately diagnose and respond to it, it was largely neglected. It was evident from the study that while care-givers were expected to be the main source of psychosocial support for OVC, they also have needs for emotional support to address challenges for providing care for OVC in a context of limited resources. In their response, the majority of care-givers indicated that they do nothing in case of an emotional challenge. However, care-givers who had a strong spiritual orientation indicated that they turn into prayer and singing as a way of dealing with stressful situation. This was verified by another respondent who had that to write:

*“When i feel stressed, I just go to my bedroom and pray. I like singing, so I sing church songs and that is how I forget my problems”.*

As such when asked most of the care-givers predominantly indicated that they pray or go to church as a coping strategy with emotional challenges. There was also a significant portion of care-givers who indicated that they do nothing, while others resorted to other calamitous strategies such as drinking, scolding at children or simply keeping quite. This could be a reflection of poor access or lack of awareness about psychosocial services in the study area. The ultimate impact could be that care-givers could get burned out which could have severe long term implications on the welfare of OVC under their care. Further analysis of this finding indicated that more women than men resorted to prayer as a mechanism for addressing stress. On the other hand, more men than women were seeking mainly informal and included peers, friends and close relatives. None of the care-givers indicated that that they sought psychosocial care from formal organization.

## **V. CONCLUSION**

The study found out that despite the escalating socio-economic challenges and structural transformation, the family remains the strongest and most prominent unit of care and support of OVC. The study did not find any children living on their own and neither were there orphans living with care-givers whom they had no blood relationship. This attests to the strength and resilience of the extended family and its continued prominence within the overall OVC response in Zimbabwe. In the foreseeable future, households' families will remain the major asset to be drawn upon in handling the challenges associated with OVC care and support.

In this study, the middle aged group provided the bulk of care and support to OVC contrary to the traditional findings that the old aged group were commonly found as providers of care and support to OVC. This shows that the young generation is grasping the cultural heritage of Ubuntu theology in child care. However, despite the middle aged group dominating the scene of care and support of OVC, this study established that old aged group was almost equally featuring in support and care of OVC, which implies that the greatest burden of care and support was laid upon an already weakened age group and economically strained groups as evidenced by gross level of unemployment of the care-givers.

The findings also revealed that the household size overstretched the little resources available for food, clothing, health and education. Consequently, the OVC needs were either partially or not at all addressed. This manifested through children dropping out of school, malnourishment, taken to hospital when they at the point of death and not being able get desired foods. With the limited resources available, care-givers were exclusively pre-occupied with fending for resources available to meet the immediate survival needs, particularly food, health and shelter. Little was done towards investment in human capital in terms of accessing OVC quality education and vocational training. As such, based on the study findings, it is rational to conclude that the capacity of families to guarantee the future of the OVC remained questionable. When the OVC fail to get quality and appropriate education, they will be most likely suffering permanent low productivity and will not be competitive.

Experience in Zimbabwe has already shown that children with minimal education or employable skills can live in profound vulnerability are found doing work such as vending, gardening, domestic working and commuter omnibus hosting (*hwindi*) at bus terminus. Generally, the observers believe that the desperation of the OVC makes them more vulnerable to exploitation and abuse. Ultimately, there is a risk that Zimbabwe will be faced with big mass of unskilled low income earners who will be poverty transmitters to the next generation since their children also stand high chances of falling into poverty trap.

The study also revealed that psychosocial care for both OVC and care-givers was largely an ignored and one of the most lacking services in the study area. Due to lack of skills and the preoccupation with survival needs there was little emphasis either in attempting to diagnose or addressing the psychosocial problem of the OVC and their care-givers. Hence, the long term impact of psychosocial problem is that children may grow up with low esteem, depression and in extreme cases of

psychosomatic disorders. Similarly, the quality of motivation for care-givers to care for OVC will deteriorate and may in extreme cases translate into various forms of child abuse. In response, care-givers and OVC initiated several strategies to address their needs, particularly raising incomes to meet the extra needs. However, the study indicated that these strategies remained haphazard and reactive to the immediate needs rather than long term needs and survival of OVC. For instance, selling of vegetables and fruits, prostitution and working for others do not generate sustainability of livelihood in the long term.

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